Court File No. _____

ONTARIO
SUPERIOR COURT OF JUSTICE

B E T W E E N :

ONTARIO HEALTH COALITION AND ADVOCACY CENTRE FOR THE ELDERLY

Applicants

- and -

HIS MAJESTY THE KING IN RIGHT OF ONTARIO AS REPRESENTED BY THE ATTORNEY GENERAL OF ONTARIO, THE MINISTER OF HEALTH, and THE MINISTER OF LONG-TERM CARE

Respondents

AFFIDAVIT OF JANE E. MEADUS
(Affirmed April 11, 2023)

I, **JANE E. MEADUS**, of the City of Oshawa, in the Province of Ontario, MAKE OATH AND SAY:

1. I am a lawyer employed as a Staff Lawyer and Institutional Advocate, by the Advocacy Centre for the Elderly ("ACE"), a specialty community legal clinic funded by Legal Aid Ontario, which provides legal advice and representation to low-income seniors. As such, I have personal knowledge of the matters deposed in this affidavit.

2. I was called to the Bar in 1993. I commenced my employment at ACE in October, 1995. My practice is specifically focused on the representation of seniors related to their being institutionalized. The bulk of my work relates to residents of long-term care homes and hospital patients relating to discharge issues. Attached hereto is my

Curriculum Vitae as **Exhibit A.**

3. I am the author of many publications and articles regarding long-term care homes and admissions issues, mostly relating to hospital discharge to long-term care homes, including "Waiting for placement: Discharge from hospital to long-term care in Ontario" published in *Healthcare Management Forum* in 2014 (attached hereto as **Exhibit B**). In June 2021, I was appointed as a member of the National Long-Term Care Services Standard Technical Committee. The Committee's mandate was to draft national standards for the delivery of safe, reliable and high quality long-term care services in Canada. The National Standards were published on January 31, 2023.[1]

4. ACE is a specialty legal clinic under the *Legal Aid Services Act* that was established to provide a range of legal services to low-income seniors in Ontario. Its mission is to uphold the rights of low-income seniors, and its purpose is to improve the quality of life of seniors by providing legal services which include direct client assistance, public legal education, law reform, community development and community organizing. ACE has been operating since 1984 and was the first legal clinic in Canada with a specific mandate to serve older adults and with expertise in elder-law issues.

5. ACE is governed by a Board of Directors comprised of 13 members, five of whom must be age 55 or older. Board members are elected by the ACE membership at its annual general meeting. ACE Board members come from a wide variety of backgrounds where everyone shares an interest in and commitment to the legal issues of older adults.

6. ACE currently employs six lawyers, which include the Executive Director, three litigation lawyers, and two lawyers who are the Institutional Advocates. ACE employs three paralegals, one of whom is the Community Outreach Co-Ordinator;

[1] https://healthstandards.org/standard/long-term-care-services-can-hso21001-2023-e/

an administrative coordinator; and a receptionist. On average, ACE annually receives over 4,000 calls from older adults, families of older adults, health and social service providers and other callers. More than 65% of the intakes and client cases that ACE assists with are in the area of health law. Most of the telephone inquiries come from the Greater Toronto Area with approximately 20% originating from other areas of the province. From time to time, ACE also receives inquiries from outside of Ontario.

7. Clients regularly seek our advice on issues relating to long-term care. Specifically, ACE has received numerous calls regarding:
   a. Callers (people seeking information, summary advice or representation, which I will refer to as "callers") being unable to access long-term care due to waiting lists;
   b. Callers encountering difficulty making applications to long-term care homes from hospital;
   c. Callers being pressured into inappropriate health care or housing arrangements;
   d. Callers advising that they do not receive sufficient care and attention to meet their health care needs; and
   e. Callers concerned about the poor quality of long-term care home services;

8. ACE also has a high number of calls regarding unregulated care facilities that are used by hospitals and Home and Community Care Support Services ("HCCSs") to house "alternate level of care" ("ALC") patients while waiting for placement into long-term care homes.

9. ACE advocates for the legal rights of seniors in many ways, including through educational presentations and speaking engagements to community groups and professional organizations; participating in governmental and non-governmental committees; providing both written and oral briefs on proposed legislation at local, provincial and national levels; and writing on various elder-law topics in peer-reviewed journals, its newsletters, plain-language pamphlets, and stand-alone

articles. From 1998 to 2010, ACE produced the *Long-Term Care Facilities: The Advocate's Manual*, a comprehensive guide to the law relating to Ontario's long-term care home system and related subjects, the third edition of which ran to almost 600 pages.

10. When a senior-related issue arises in the public forum, ACE is often contacted by the media to comment on the issues as its relates to the rights of seniors

11. ACE lawyers have been involved in numerous inquests and inquiries representing the voice of seniors, including the 2005 El-Roubi Lopez Inquest into the murder of two long-term care home residents by another resident; the Gillese Inquiry (2017-2019) into the homicides and assaults against long-term care residents and community care recipients by Elizabeth Wettlaufer; and fire death inquests into the deaths at the Meadowcroft Place Retirement Home, Muskoka Heights Retirement Home and Spencer House Nursing Home.

12. The following account of the processes and practices surrounding the admission to a LTC home, and of the experiences of those seeking or who have been granted such admission is based on the first hand experience that I and my colleagues have had in dealing with thousands of individuals who have sought our assistance and counsel concerning these matters.

Long-Term Care Homes

13. Long-term care homes are part of Ontario's healthcare system. Long-term care homes are regulated, funded and inspected by the Government. The current Ministry in charge is the Ministry of Long-Term Care ("the Ministry"). Residents pay for accommodation and food, which rates are set by the Ministry no more than annually. Accommodation rates vary depending on type of accommodation, and sometimes by age of the home. Funding is by way of "envelopes" whereby specific funds are designated for specific uses. The envelopes are: (1) Nursing and

Personal Care; (2) Program and Support Services; (3) Raw Food; and (4) Other Accommodations. The Nursing and Personal Care envelope is adjusted annually depending on the Case Mix Index calculated from the prior year, which is the measurement of complexity of the residents. An average amount is calculated, and the home gets a percentage of the global funds available from the Ministry based upon their complexity related to the average. The other envelopes are all set amounts per resident. Profits in for-profit homes can only be taken from the "Other Accommodation" envelope. Charitable, municipal, and non-profit homes may add extra money to homes' budgets which may result in higher wages, more staff, more programming, etc.

14. Prior to July 1, 2010, there were three pieces of legislation which governed these facilities: the *Homes for the Aged and Rest Homes Act,* the *Charitable Institutions Act*, and the *Nursing Homes Act*. These reflected three types of institutions: Municipal Homes for the Aged, Charitable Homes for the Aged, and Nursing Homes (which could be profit or not-for-profit). Each piece of legislation had historical differences; however, by the late 1990s they were all overseen by the Ministry of Health and most of the governance was via the Ministry of Health's *Long-Term Care Facilities Program Manual*.

15. On July 1, 2010, the *Long-Term Care Homes Act, 2007* ("*LTCHA")* came into force and all three types of facilities were now governed by one piece of legislation. Except for Municipal Homes, all homes were issued licenses. Municipal homes do not require a license, as the legislation requires most municipalities to have at least one home, or a joint home. The length of the licenses varied, based upon whether the home met the most current Design Standards Manual (at the time it was the *Long-Term Care Home Design Manual 2009,* currently the *Long-Term Care Home Design Manual 2015*[2]*)*. Homes that did not meet the most current standards were graded and the length of the licenses issued were shortest for those homes with the

[2] Ministry of Health and Long-Term Care, February 2015
https://www.health.gov.on.ca/en/public/programs/ltc/docs/home_design_manual.pdf

lowest grade . The goal was that the homes would be rebuilt or renovated during the time span of the license so that all homes would eventually meet the most recent design standards.

16. However, very few homes rebuilt or renovated during this time period, and their licenses had to be extended. While the Ministry has been granting proposals for rebuilds, there are many challenges and it remains to be seen how many and how quickly these homes will be brought up to the most recent design standards.

17. On April 11, 2022, the *LTCHA* was revoked and replaced with the *Fixing Long-Term Care Act, 2021* ("*FLTCA")* While there were some changes, the majority of the Act and its regulations remained the same. For ease of reference, all home management structures, unless specifically stated otherwise, are referred to in the legislation as "licensees" and we will do the same herein.

Discharge from Hospital

18. The issue of discharge from hospital to long-term care has always been a serious issue, and the most common single issue for callers to ACE. In 2012, ACE received approximately 250 such calls. In 2016, this rose to about 500 calls, and by 2017 we were receiving approximately 700 calls annually. While these numbers dipped during the COVID-19 pandemic, they have been steadily rising since. It is not unusual for us to have several inquiries a day on the topic.

19. For many years, ACE has published articles on the topic of discharge from hospital to long-term care in its newsletter and as stand-alone items. In 2013, these articles were amalgamated into one document entitled *Discharge from Hospital to Long-Term Care: Issues in Ontario*, which was amended in 2014, and is attached hereto as **Exhibit C**.

20. These documents were not only provided to many callers to ACE so that they could advocate on behalf of themselves or their loved ones, but were also available on the ACE website where they were free to download and use by anyone looking for information on this topic on the internet.

21. We published these documents because of how common it was for those seeking our advice to have been misinformed about the long-term care home admission process from hospital. I deal with this problem in more detail below.

Regulation of the Long-Term Care Home Placement Process

22. Beginning in the 1990s, there has been a shift away from hospitals and long-term care homes playing the dominant role in managing the transition from hospital and placement process. This was because of the all too common practices they engaged in, including misinforming the applicants about the rules and their rights, and engaging in favouritism in the process, often in contravention of the laws and policies governing long-term care homes at the time (*The Municipal Homes for the Aged and Rest Homes Act*, the *Charitable Institutions Act*, the *Nursing Homes Act*, and the *Long-Term Care Facilities Program Manual*).

23. During this period, there was no provincial organization that was mandated to oversee the admissions process to a LTC home. In our experience dealing with thousands of individuals and families seeking our advice, hospitals often attempted to manipulate patients, and created policies which not only varied from hospital to hospital, but were contrary to the rules in place at the time. This often included requiring the applicant to choose a large number of homes: sometimes this would be all the homes in the area, or requiring them to choose at least a certain number from short-listed homes or those with available beds. Hospitals might also have required the applicant to take the first available bed, no matter that this home had not been applied to. At the same time, the individual homes were managing their own admissions lists. Bed admissions could be manipulated to favour certain

individuals over others, for example if the applicant or their family knew someone in the management of the home, or had some other type of relationship with the home. It was also easieir at that time for homes to "cherry pick" applicants, whereby homes turned down or did not make offers to persons that they felt were not "suitable" for their home or did not meet their own, and usually un-transparent, preferences.

24. Because of such widespread practices, in 1994, the Government established a province-wide centralized placement system under the auspices of the "Placement Co-ordination Services", whose role it was to process long-term care applications in a fair and unbiased manner and provide accurate information to the applicant or their substitute decision-maker.[3] In 1997 the Placement Co-ordination Services became the 43 "Community Care Access Centres" ("CCACs"), which consolidated both management of placement into long-term care as well as arranging for homecare services.[4] In 2017, the CCACs were transitioned into the 14 existing "Local Health Integration Networks" ("LHINS") which had increased health management and planning roles.[5] On April 1, 2021, the LHINs began operating under the business name "Home and Community Care Support Services" or "HCCSS", which continues to have placement and homecare functions.[6] These organizations not only took over the application and eligibility processes for long-term care, but eventually also managed the waiting list and bed offer process.

25. The intent of the centralized placement system was to create an independent and fair system for placement into long-term care homes for all eligible persons, which upheld the rights of the applicant and removed the pressure often placed by

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[3] *Placement Co-ordination Services Manual*, Draft 3, Implementation Copy, July 1, 1994. Government of Ontario, p. 0404-01.
[4] *Annual Report.* Office of the Auditor General of Ontario. 1998. Value for Money Audit 3.05: Ministry of Health: Long-Term Care Community Based Services Activity, p. 103.
[5] https://www.health.gov.on.ca/en/news/bulletin/2017/hb_20170127_21.aspx#:~:text=On%20June%2021%2C%202017%2C%20Erie,their%20transition%20to%20LHIN%20s
[6] https://www.health.gov.on.ca/en/common/system/services/lhin/facts.aspx

hospitals and their employees on patients or their substitute decision-makers to go to homes that were not of their choice.

26. Nevertheless, non-compliant practices by some hospitals continued. For example, on February 15, 2011, the Erie St. Clair LHIN sent out a press release that the hospitals in their area were instituting a "first available bed policy" which would require patients to accept admission into any available bed in the system, including ones to which they had never applied, or pay a co-payment of $600/day. The matter was brought up in the Ontario Legislature[7] and eventually resulted in the Memorandum dated February 23, 2011 from Ruth Hawkins, Assistant Deputy Minister (A) at the Ministry of Health and Long-Term Care (attached hereto as **Exhibit D**), where she clearly stated that hospitals had no such authority, that this was not consistent with the legislation, and that such charges were in violation of the *Health Insurance Act*. Unfortunately, ACE continued to field complaints from patients and substitute decision-makers who received similar threats.

27. On January 9, 2013, the Ministry of Health and Long-Term Care again had to clarify that patients who were in hospital and required long-term care admission could not be forced into the community when they were eligible for long-term care. While the memo (attached hereto as **Exhibit E**) encouraged the consideration of community care when appropriate and not force patients into long-term care when they could be cared for in the community, it recognized that community care was not sufficient for everyone, especially many of those waiting for long-term care.

Placement Process Prior to Bill 7

28. In order to be admitted to a long-term care home, pursuant to the *FLTCA* (and prior to that from July 1, 2010 to April 11, 2022 pursuant to the *LTCHA*) an applicant had to first be determined to be eligible for long-term care home admission by a

[7](Legislative Debates, 39th Parliament, 2nd Session, February 22, 2011 (Andrea Horvath, Hon. Deb Matthews).

placement co-ordinator. (Unless there is a difference, the sections quoted will be from the *FLTCA* but are identical to what appeared in the *LTCHA.)* The placement co-ordinator is currently an employee of the HCCSS. Anyone who believes they may be eligible, may apply for such a determination.

29. To be eligible, a number of assessments must be completed and provided to the placement coordinator who shall use them to determine eligibility. The applicant must:
    a. be 18
    b. have an OHIP card (or be eligible for one upon admission),
    c. require
        i. nursing care available on-site 24 hours a day
        ii. assistance with activities of daily living at frequent internals throughout the day, or
        iii. on-site supervision or monitoring at frequent internals throughout the day to ensure their safety or wellbeing;
    d. have needs that cannot be met by publicly-funded community based services available to them, and that other caregiving, support or companionship arrangements available to them are insufficient as well; and
    e. their care needs can be met in a long-term care home.[8]

30. The assessments which must be completed to determine eligibility are:
    a. an assessment of the applicants physical and mental health and the applicant's requirements for medical treatment and healthcare, completed by a physician or registered nurse;
    b. an assessment of the applicant's functional capacity, requirements for personal care, current behaviour, and behaviour during the year preceding the assessment, completed by a qualified employee of the HCCSS; and
    c. any other assessment required by the regulations; and

[8] O. Reg. 246/22 s. 172(1).

d. any additional information and documentation necessary to establish whether the person meets the eligibility criteria.[9]

31. The assessment by the HCCSS is completed using the Resident Assessment Instrument – Minimum Data Set (RAI-MDS) which is basically a series of questions about the applicant's care needs which are entered into a computer program. This results in a score being generated for the applicant which helps inform the HCCSS as to their eligibility.

32. If an applicant is determined by the HCCSS to be ineligible for admission to a long-term care home, the applicant may apply to the Health Services Appeal and Review Board for a hearing to review the determination of ineligibility.[10]

33. The applicant's capacity to make a decision regarding admission to a long-term care home pursuant to the *Health Care Consent* Act ("*HCCA"*) and the *FLTCA* is determined by an evaluator during the assessment process. While any person entitled to be an evaluator pursuant to *HCCA* s. 2 can perform the evaluation, it is generally completed by an employee of the HCCSS, as it up to the HCCSS to ensure that valid consent is obtained from the individual or a duly authorized person.[11]

34. A person is presumed to be capable with respect to personal care decisions, including placement into a long-term care home. Under the *HCCA*, if an evaluator has reason to believe that the person may not be capable to make a decision with respect to admission to a long-term care home, they will evaluate the person's capacity with respect to that issue. A person is capable if they have both the ability to understand the decision that is relevant to making a decision about placement, and the ability to appreciate the reasonably foreseeable consequences of a decision

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[9] *FLTCA* s. 50(4).
[10] *FLTCA* s. 50(9).
[11] O. Reg 246/22 s.203.

or lack of decision.[12] While there is a form to guide the evaluator as to the types of questions to ask when making this determination, the evaluator must probe and verify the information provided in order to determine capacity.[13] If the applicant is found by the evaluator to be incapable, they will be provided with rights information, and can apply to the Consent and Capacity Board ("CCB") for a review of the evaluator's finding that they are incapable to consent to admission to a long-term care home.[14]

35. Once the applicant is determined eligible by the placement co-ordinator, the applicant may choose between one and five homes to apply to for admission. If the applicant has been determined to meet the definition as requiring a "crisis placement" under the *FLTCA*, the applicant may, but is not required, to apply to as many homes as they wish. Applicants will also choose the class of bed (basic, semi-private or private) to which they wish to apply.

36. The applicant or their substitute decision-maker(s) must consent to their application being sent to each home. Applicants are free to choose any home in Ontario that they wish to apply to that meets their personal needs. Applicants are encouraged to identify their needs and priorities regarding which homes would be suitable for them. They are encouraged to visit homes before choosing them, and those who are unable to see homes themselves are encouraged to have family or friends visit the homes on their behalf (see Government of Ontario webpage "Choosing a long-term care home").[15] Online virtual tours may also be available.

37. Finding a long-term care home that is suitable for you or your loved one is a complex issue. Most of those seeking assistance from ACE know little to nothing about individual long-term care homes prior to having to look for one for themselves or their loved one. Sometimes people know about one or two homes, as

[12] *HCCA* s. 4.
[13] *Re Koch*, 1997 CanLii 1238 (ON SC.
[14] *HCCA* s. 60(1).
[15] https://www.ontario.ca/page/choosing-long-term-care-home

they have a friend or relative that lives or works in a home, or belong to a group that supports a home. However, the actual process of placing themselves or someone else may arise very quickly, due to a sudden change in health condition. Choosing a home that can meet your needs and where you will likely live for the rest of your life can be a daunting challenge, especially if you are expected to do so quickly at a time when you have just gone through a health crisis.

38. Most people will begin by asking friends, family and neighbours if they have any experiences with a long-term care home. They may try to visit people they know, or set up a visit to the home. Prior to the pandemic, homes gave tours of the home to prospective applicants and their substitute decision-makers and loved ones. However, homes often scheduled tours at times that were difficult for people who worked to attend, were infrequent (sometimes only once a month), and often had waiting lists. During the pandemic, all tours were stopped. While homes are no longer prohibited from holding tours (except during some outbreaks), many are not providing this service. This means that people are being asked to make life-altering decisions about where they are going to live for the rest of their lives without ever having set foot in the home.

39. Since July 1, 2010, every inspection report on every long-term care home in Ontario has been available online.[16] These reports are vital tools in making placement decisions, as they can provide important information, for example: the home's compliance history; the number and types of issues that they have been cited for; whether they been issued compliance orders; or have been issued an administrative monetary penalty. One can also find out if the home is municipal, charitable, or privately owned, who owns it, whether it is for-profit or not-for-profit, and whether or not they have a management company that oversees the day-to-day operations in that home.

[16] publicreporting.ltchomes.net

40. The Government of Ontario recognizes that individuals should be choosing their own homes based upon their needs, and has published a guide titled "Choosing a long-term care home"[17] which, among other things, indicates what a person should consider when identifying whether a home is appropriate to their needs or that of their loved-one. Amongst the important issues to be considered are:

* medical and personal needs
* culture, language or religious focus
* a location that works well for family and friends to visit
* setting – for example, near shops or on or by a park
* type of accommodation – for example a semi-private or private room

41. The Ministry also provides a checklist available online that identifies issues which may of particular importance when looking for a long-term care home that can best suit the applicant's needs.[18]

42. The Ministry recommends that one should take time and ask questions when visiting a prospective LTC home. If the applicant does not have anyone to assist them with this, they may ask the placement co-ordinator for help. The placement co-ordinator is required to consider the applicant's preferences based upon ethnic, religious, spiritual, linguistic, familial and cultural factors.[19]

43. If the applicant has been determined to be incapable of making decisions regarding placement, their substitute decision-maker(s) will consent on their behalf including choosing homes for them. However, the substitute decision-maker(s) is required to comply with the principles for giving or refusing consent when making their decision as follows:

    a. If the substitute decision-maker knows of a wish expressed by the incapable person while capable and over the age of 16 that is applicable to the

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[17] https://www.ontario.ca/page/choosing-long-term-care-home
[18] https://www.ontario.ca/files/2021-12/mltc-visiting-a-long-term-care-home-checklist-en--2021-12-15.pdf
[19] FLTCA s. 51(3) & (4).

circumstances, the substitute decision-maker must give or refuse consent in accordance with that wish.

b. If the substitute decision-maker does not know of a wish applicable to the circumstances that the incapable person expressed while capable and over the age of 16, or if it is impossible to comply with the wish, then they must act in the incapable person's best interests. In deciding what the person's best interests are, the substitute decision-maker must take into consideration:

i. the incapable person's values and beliefs held while capable and which they believe they would act upon if they were still capable;

ii. any wishes expressed by the incapable person regarding the admission that the substitute decision-maker is not already required to follow; and

iii. the following factors:

1) Whether the admission is likely to

a. Improve the incapable person's quality of life

b. Prevent the incapable person's quality of life from deteriorating or

c. Reduce the extent to which or the rate at which the quality of the incapable person's life is likely to deteriorate

2) Whether the quality of the incapable person's life is likely to improve, remain the same or deteriorate with admission to the long-term care home,

3) Whether the expected benefit of the admission outweighs the risks or negative consequences to the incapable person;

4) Whether a course of action that is less restrictive than admission to a long-term care home is available and appropriate in the circumstances.[20]

44. One of the issues that an applicant is encouraged to consider, and that a substitute decision-maker must consider if making a decision under the best interest test, is the difference between staying in hospital for an extended period of time waiting for their preferred homes versus possibly choosing a home with a shorter waiting list.

[20] *HCCA* s. 42.

It is recognized that in Ontario, staying in hospital for an extended period of time often leads to a deterioration in the condition of the patient, especially of elderly patients. Further, there is little to no programming in hospital, which may also lead to the patient's deterioration. While applicants can make their choices in any way they wish, substitute decision-makers are required to comply with the principles of decision-making as outlined above.

45. Substitute decision-makers must also take other issues into account when making placement decisions including whether family would be able to visit the resident, the reputation of the home including regulatory compliance, and access to the applicant's wider community, for example friends, social groups, and religious communities.

46. The placement co-ordinator then sends the application to any home that has been chosen. All homes do not have to be applied to at the same time. If the applicant is making their first application, any home chosen within the first six (6) weeks is deemed to have been made when the first application was made.[21] Otherwise, any changes to the homes selected are dated on the day that the addition, deletion or change was made.

47. Once a licensee receives an application, it has five (5) days to approve or withhold approval for the admission, or to request more information. There are currently only two (2) reasons a licensee may refuse an application:
    a. if the home lacks the physical facilities necessary to meet the applicant's requirements, or
    b. If the staff at the home lack the nursing expertise necessary to meet the applicant's care requirements.[22]

[21] O. Reg. 246/22 s. 200(2).
[22] *FLTCA* s. 51(7).

48. If the licensee withholds approval for the admission, the licensee must provide written notice to both the applicant and the placement co-ordinator of the:
    a. ground(s) on which approval is being withheld;
    b. a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care;
    c. an explanation of how the supporting facts justify the decision to withhold approval; and
    d. Information on how to contact the Director at the Long-Term Care Inspections Branch at the Ministry of Long-Term Care.[23]

49. Once a licensee has approved the applicant for admission, the applicant will either be offered an available bed at the home in the appropriate class of bed, or will be placed into the highest waiting list category that they qualify for in each home.

50. Waiting lists for LTC homes are kept by HCCSS. While waiting lists used to be publicly accessible and updated frequently on the former LHIN websites, the last published lists are from April 2022. Once they have approved applicants, licensees have no authority over who is offered a bed in their home when one becomes vacant. Placement onto waiting lists is governed by the regulations to the *FLTCA*.

51. The priority given to an application for placement in a long-term care home is assigned according to the following categories, in descending order of preference:
    * Category 1 – Crisis category[24]
    * Category 2 – Spouse/partner reunification[25]
    * Category 2.1 – Former specialized unit and high acuity priority access bed residents[26]

[23] *FLTCA* s. 51(9).
[24] O. Reg. 246/22 s. 188
[25] O. Reg. 246/22 s. 189
[26] O. Reg. 246/22 s. 190

* Category 3A & 3B – Religious, ethnic or linguistic beds[27]

* Category 4A & 4B – Other beds[28]

52. I have attached hereto as **Exhibit F** my summary of the details as to how placement into categories works as well as discussing the other specialized waiting list categories that may come into play in the placement process. Due to bed shortages and high demand, currently the vast majority of placements are from the Category 1 – Crisis List.

53. The ranking of the waiting list categories, excluding designated beds, is found in O. Reg. 246/22 s. 199. Who will be offered the next bed from the waiting list depends on a complex ranking which is set out in O. Reg. 246/22 s. 200.

54. When a bed becomes available, the long-term care home staff contacts the appropriate person at their designated HCCSS and advises them of the vacancy. It is up to the HCCSS staff to determine who the bed will be offered to based upon the class and gender of bed available, using the waiting lists and ranking system.[29] The HCCSS will contact the applicant or their substitute decision-maker and make the bed offer.

55. Once the bed offer is made, the applicant has 24 hours to accept or reject the bed offer. If an applicant in the community rejects a bed offer, they are removed from all long-term care home waiting lists and will have to reapply anew no earlier than 12 weeks hence, unless there is a deterioration in their condition or circumstances. If a patient is in hospital, they are not removed from waiting lists; however, even prior to Bill 7, a patient who refused a bed offer in one of their long-term care choices, but who could not be discharged because of their care needs, would be

[27] O. Reg. 246/22 s. 191
[28] O. Reg. 246/22 s. 192
[29] While it is not in the regulations, placement co-ordinators often take other things into consideration such as whether they believe the applicant requires a locked unit

advised that they would be charged the "uninsured rate" as set by the hospital, which often was as much as $1800 day for every day they remained in hospital.[30]

56. Once a bed is accepted, the applicant has up to five (5) days to move into the home, or lose the bed.

Interim Beds for ALC Patients

57. One way that the government dealt with the issue of ALC patients prior to COVID-19 was the creation of the "Interim Bed Short-Stay Program" which has been continued under the *FLTCA*.[31]

58. Temporary licenses were given to long-term care homes for specific beds, and some stand-alone long-term care homes received temporary licenses for interim beds.

59. Only ALC patients occupying a bed in an acute care hospital under the *Public Hospitals Act*, who has been determined by their physician that they no longer require the acute care services provided by the hospital, and who is eligible for admission to long-term care can apply. It was up to the patient or their substitute decision-maker to decide whether to apply for an interim bed. The requirements for admission included that the patient must have applied and be approved for the unit and also be on the waiting list for at least one long-stay bed in a long-term care home.[32]

60. The initial admission is authorized for a period of up to 120 days.[33] If a bed has not been offered in a home of their choice at the end of that period, the placement co-

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[30] Usually the hospital based the "uninsured rate" on the Ontario Hospital Interprovincial per diem rates https://health.gov.on.ca/en/pro/programs/ohip/bulletins/docs/interprovincia220408/2022-2023_ontario_hospital_interprovincial_inpatient_per_diem_rates.pdf

[31] O. Reg. 246/22 s. 207-215.

[32] O. Reg. 246/22 s. 210(1).

[33] O. Reg. 246/22 s. 214 2.

ordinator will authorize 60 more days,[34] which will continue until the resident is placed or the interim bed or facility is closed

61. If the resident refuses a bed offer or is not on a waiting list for a long-stay bed, the placement co-ordinator cannot extend the placement.[35]

62. These beds allowed ALC patients to be admitted to homes without competition from community placements, including crisis placements, into facilities that were licensed and inspected by the Ministry, instead of languishing in hospital in ALC units, or being pushed into inappropriate placements in the community. The interim beds and facilities were required to have the same programs and comply with the legislation the same as all other long-term care homes.

The Impact of COVID-19 in Ontario Long-Term Care Homes

63. A number of changes to the regulation of long-term care homes admissions under the *LTCHA* were implemented starting in March 2020 to contend with the impact of the Covid-19 pandemic, which I have summarized in **Exhibit G** hereto.

64. Because of the devastating effect of the pandemic on long-term care residents, the Long-Term Care COVID-19 Commission was established to investigate how and why COVID-19 had spread into Ontario's long-term care homes pursuant to s. 78 of the *Health Protection and Promotion Act.*[36] This Commission, led by Justice Frank Marrocco, was given nine months to inquire into the health crisis and produce a report. *Ontario's Long-Term Care Covid-19 Commission: Final Report, dated April 30, 2021 (*(attached hereto as **Exhibit H)** was 322 pages in length and found that the high number of deaths was due, amongst other things to a lack of government preparedness for a pandemic in long-term care homes; the overall

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[34] O. Reg. 246/22 s. 214 3.
[35] O. Reg. 246/22 s. 214 3i, 215.
[36] Order-in-Council 1058/2020, https://www.ontario.ca/orders-in-council/oc-10582020 .

failure of the system to meet the needs of long-term care home residents during the pandemic; complex rules and systems which failed to ensure the safety of long-term care home residents and in fact, at times contributed to the lack of care and deterioration in health of the long-term care home residents.

65. One of the key findings was that the barring of visitors in long-term care homes had a devastating effect on residents. The Commission noted that visitors had historically provided supplementary care in long-term care homes, which relieved staff from some of their duties. When visitors were barred from homes, this meant that the long-term care home staff care burden increased. Further, due to illness and other issues, staffing shortages in long-term care homes were rampant, meaning residents were not always getting the care they required. The report went on to state:

> One resident described the experience by saying it was if reality had been suspended and a nightmare had set in. Many residents experienced symptoms of what is known as "confinement syndrome". This term is typically used in medical literature to describe symptoms shown by people placed in solitary confinement. Due to visitor restrictions and limited staff, many residents died alone in their rooms, with no none to ease their passing.[37]

66. The Commission also found that residents' well-being plummeted without access to caregivers and family visitors. It stated that the mental and physical well-being of many of the residents was dependent upon those family and friends.[38] It also found that it was extremely important for long-term care home residents to have visitors. In their final report, they made two key recommendations regarding visitors:

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[37] Commission Report pp. 22-23.
[38] Commission Report p. 177

> The Ministry of Long-Term Care should amend Ontario Regulation 79/10 to include a presumption against prohibiting all visitors to long-term care homes experiencing an outbreak because of the negative effects of isolation on the quality of life and health of long-term care residents. Any changes to visiting rules during an infectious disease outbreak must seek to place the minimum possible restrictions on visits to long-term care residents.
>
> In order to avoid the separation of residents from their families and loved ones in future disease outbreaks, the province should amend Ontario Regulation 79/10 to recognize the role of "essential caregiver" (individuals "designated by the resident and/or their substitute decision-maker … to provide direct care to the resident"). Essential caregivers may be family, loved ones or people hired to provide care to the resident. Basic IPAC training, including the appropriate use of personal protective equipment, should be required in order to quality as an essential caregiver. The training should be mandated for all essential caregivers at least annually and at the onset of any infectious disease outbreak. The amendment should ensure that essential caregivers who have complied with these training requirements are allowed to enter the home.[39]

67. These sections made it abundantly clear that the Commission felt that long-term care residents having consistent access to visitors was a key to their wellbeing.

68. The Commission also opined on the systemic neglect that had occurred in the long-term are sector. It stated:

> Even before COVID-19 ravaged Ontario's long-term care homes, the systems in which they operate was at a tipping point. For decades, successive provincial governments had neglected the long-term care

[39] Commission Report pp. 232-233.

> sector. In 2020 and 2021, however, those decades of in attention came home to roost as a novel coronavirus raged through homes that were chronically understaffed and underfunded, structurally deficient, and inadequately overseen by the province. For too many of Ontario's most vulnerable citizens, the consequences were deadly.[40]

69. The Commission also reviewed the long-term care inspection system. Under the legislation, whether it be the *LTCHA* or the *FLTCA*, the government Ministry in charge, currently the Ministry of Long-Term Care, is required to inspect long-term care homes.

70. Resident Quality Inspections ("RQIs"), were developed specifically for Ontario's *LTCHA.* The Ministry of Health and Long-Term Care contracted Dr. Andrew Kramer of the University of Colorado to adapt the Quality Indictor Survey used in the United States for Ontario to ensure statistical accuracy for the new Ontario comprehensive long-term care home inspection regime (see **Exhibit I** attached hereto.

71. The Commission reported that in 2014, the Ministry of Health and Long-Term Care committed to completing an RQI annually in every home.[41] However, in 2018, the Ministry became focused on risk-based inspections, due to a backlog of almost 3,000 complaint and critical incident reports. While the intention was to inspect every home annually, the legislation did not state that these were required to be RQIs. In 2018, only 329 homes had received an RQI, and in 2018, the number had plummeted to 27.[42]

72. The Commission stated that once any type of inspection was completed in a home there would often not be any further inspections in that home for the rest of that

[40] Commission Report p. 35.
[41] Commission Report p. 63.
[42] Commission Report p. 64.

year. The focus on reactive inspections based on complaints and critical incidents also meant that issues such as Infection Prevention and Control ("IPAC") and emergency preparedness, which would have been inspected on during an RQI inspection, were not commonly inspected. They opined as follows:

> This may explain why hospitals and the military found homes in varying states of disarray and uncleanliness that appeared to pre-date COVID-19. The Commission heard that one hospital spent almost $500,000 to deep-clean a single home.[43]

73. The Commission was also critical of the lack of enforcement and follow up by the Ministry. It noted that in 2019, the most common actions resulting from an inspection were a Written Notification and a Voluntary Plan of Correction, neither of which required follow-up by the Ministry to ensure compliance.[44] The Commission also noted that the more effective tools that the Ministry had were rarely used. It further noted that evidence before the Commission was that fines or prosecutions for failure to comply with orders under the *LTCHA* were rarely applied.[45] In fact, we are unaware of any prosecutions having ever occurred under the *LTCHA.*

74. Another issue that the Commission identified as contributing to the spread of COVID-19 in long-term care was the fact that there were 31,399 beds still in use that did not meet current design standards. It also noted that most of these beds were in for-profit homes.[46] It went on to note that while the government had committed to both building new beds as well as redeveloping existing older beds, continued delays meant that these goals were not being met.[47]

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[43] Commission Report p. 64.
[44] Commission Report p. 65.
[45] Commission Report p. 65.
[46] Commission Report p.73-74.
[47] Commission Report p. 76.

75. While there were some new homes built during COVID known as rapid builds, the majority of older beds have not yet been rebuilt. Currently the Government has a goal of 60,000 new and rebuilt beds by 2028, which is currently five years away.[48]

Fixing Long-Term Care Act, October 2021

76. On October 28, 2021, the Minister of Long-Term Care introduced Bill 37, the *Providing More Care, Protecting Seniors and Building More Beds Act, 2021*. The main purpose of this bill was to repeal the *Long-Term Care Homes Act*, *2007,* and replace it with the *Fixing Long-Term Care Act*, *2021.*

77. While the *FLTCA* did have some changes, such as those relating to residents rights, inspections, palliative care and the introduction of direct hours of care targets, the vast majority of the legislation and subsequent regulations were identical to those found under the *LTCHA*.

78. Starting in the spring of 2021, to encourage patients to consider homes with shorter waiting lists, there had been a waiver of long-term care fees for hospital patients if they consented to admission to a home that was not their first choice. Coinciding with the introduction of the *FLTCA*, this waiver was no longer offered as of December 15, 2021, although those already on waivers continued to get it (see **Exhibit J** attached hereto).

79. The *FLTCA* came into force on April 11, 2022. The regulations and policies related to admission to long-term care and waiting lists remained virtually the same. As noted above, the waiver of fees for those not admitted to their first choice long-term care home was no longer offered, although those already on waivers continued to get it. The other change related to the special pandemic rules. Special rules for

[48] See Ministry of Long-Term Care, Press Release March 3, 2023, https://news.ontario.ca/en/release/1002780/ontario-breaks-ground-on-new-long-term-care-home-in-huron-county

admission from hospital to long-term care were set out in O. Reg. 246/22 s. 242 which continued to allow the placement co-ordinator to choose homes for the applicant with the applicant still being required to consent to the actual admission. However, the section was set to be replaced on October 11, 2022 and would have removed the ability of the placement co-ordinator to choose homes on behalf of applicants, but retained their right to proceed using modified rules regarding determinations of eligibility. However, due to Bill 7 the changes to take place on October 11, 2022 were rescinded.

The Inspection of LTC homes

80. On October 26, 2021, Minister of Long-Term Care Rod Phillips announced a new Proactive Inspections Program which would replace the RQIs (attached hereto as **Exhibit K**). These proactive inspections differ from the RQIs in a variety of ways, including regarding how they are conducted, and replacing the 31 Inspection Protocols with 23 Inspection Guides (attached hereto as **Exhibit L**). The Ministry's goal for these proactive inspections was to have 5% completed by spring 2022 (approximately 31 homes), with every home to have a proactive inspection by the end of 2024 (attached hereto as **Exhibit M**). According to statistics produced by the Ministry, from April 11 to December 31, 2022, only 15 proactive inspections have been held.[49]

81. While inspection reports continue to be publicly available on the governments' long-term care public reporting website,[50] a change in the way that the reports are posted has made it even more difficult to review. Previously, Inspection Reports were posted indicating what type of inspection it was, the date of the inspection, and whether there were orders made. More recently, reports just indicate that it was an inspection, and do not indicate what type or whether there were orders or other

[49] Presentation by the Director Inspections Branch, Ministry of Long-Term Care during a webinar on March 23, 2023).
[50] http://publicreporting.ltchomes.net/en-ca/default.aspx

actions taken, such as administrative monetary penalties which are new under the *FLTCA*. This makes it much more difficult for the user who may be looking at a large number of homes when making an admission decision to determine what their compliance record is.

The Role and Capacity of the Ontario LTC System

82. In addition to questions about the overall capacity of the system and related wait lists, it is important to appreciate that there is no "maximum" level, or requirement for care, that LTC homes are precluded from being called upon to provide, that is set out in legislation. Queries by ACE to the Ministry to determine what level of care is too much care to be managed in a long-term care home was met with a response that there is no such cap. Attached hereto as **Exhibit N** is my email correspondence with Wendy Lewis, A/Director/Senior Manager, Long-Term Care Inspections Branch, Ministry of Long-Term Care October 29, 2020 and November 3, 2020.

83. My colleagues and I have seen this occur systemically, as more complex, higher needs patients are being admitted to long-term care, such as incapable ventilator patients being pressured to move from chronic care to long-term care as the hospital no longer wished to provide this important care. While many long-term care homes have excellent staff and care, they are still limited in the amount of care they can provide to an individual due to their funding and staffing model. For example, ventilator patients require close monitoring, suctioning, and specialized care to ensure that they are breathing properly and not choking, a common hazard. This requires the care of registered staff, usually an RN. However, RNs in long-term care have many responsibilities, and do not have the ability to provide the level of care that the patient would receive in hospital, where there is a better ratio of registered staff to patient with fewer patients per registered nurse. In fact, no matter the size of the home, the legal requirement is only that they have **one** RN on at any

time.[51] Even then, due to shortages, many homes have found it difficult to meet this requirement, and it is not uncommon to see this cited as an issue of non-compliance in Inspection Reports. One cannot see how a ventilated resident who cannot use a call bell could ever be cared for properly in a long-term care home. Yet this is a distinct possibility under this new regime.

84. A similar issue occurs with psychiatric patients. More and more long-term care homes are being used as quasi-psychiatric facilities due to the lack of psychiatric beds and supportive housing for this population. Instead of creating appropriate housing, those requiring long-term psychiatric care are sent to long-term care homes. Long-term care home staff are generally not equipped to handle persons with major mental health disorders, and find it difficult to provide them with care. These residents often also find it difficult to live within a home with elderly persons with dementia, and deaths have occurred due to altercations. Further, the services for younger residents with psychiatric illness living in long-term care homes are not only not appropriate, they are often unavailable. Psychiatric services, be it visits with psychiatrists or assistance provided by Behavioural Support Ontario, are geared towards persons with dementia exhibiting behaviours associated with that diagnosis. Geriatric psychiatrists providing service to the home will usually not see the younger residents, and because they are only scattered throughout the system, having a more appropriate psychiatrist do on-site visits is almost impossible. Further, Behavioural Support Ontario views patients through a geriatric lens, which is often inappropriate when it comes to persons with major psychiatric disorders or for those who are younger. However, the relative ease in which hospitals can now "get rid" of these patients by sending them to long-term care is occurring in higher numbers than we have previously seen.

[51] *FLTCA* s. 11(3).

Bill 7, *More Beds, Better Care Act, 2022*

85. On August 18, 2022, the Minister of Long-Term Care Paul Calandra introduced Bill 7, the *More Beds, Better Care Act*, 2022. As a close observer of government policy and law concerning long-term care, the tabling of this Bill was for me entirely unexpected, and I am not aware of any meaningful consultations or discussions prior to its introduction.

86. Despite its name, the legislation does not, in fact create any new beds, nor does it make any changes to the provision of care in long-term care homes.

87. Instead, the legislation gives new powers to both hospital staff, physicians and HCCSS placement co-ordinators. The key element of this legislation is that it empowers placement co-ordinators to make all placement decisions on behalf of ALC patients and takes away their autonomy as to where they wish to live for what could be the rest of their lives.

88. The focus of the legislation is on expediting the process of having ALC patients discharged from hospital and admitted to long-term care homes. The legislation gives new powers to hospital staff and doctors, who previously had no legal authority in the placement process other than completing the required medical form. It allows both the attending clinician and the HCCSS placement co-ordinator to take steps towards placing the patient into a long-term care home without their consent.[52] Critically, the legislation gives HCCSS placement co-ordinators the authority to proceed with the entire placement process on behalf of an ALC patient without their consent or that of their substitute decision-maker. Placement co-ordinators now have the authority to do the following without consent:

* determine eligibility for admission to long-term care
* provide personal health information to the long-term care home;
* authorize admission to the home; and;

[52] *FLTCA* s. 60.1(3.

* transfer the responsibility for placement of the patient to another placement coordinator who would have the same authority to act without consent.[53]

89. The only actions not permitted are the physical restrain or transfer of an ALC patient from the hospital to the LTC home without consent.[54]

90. Despite public concern about long-term care and this initiative, the government passed a time allocation motion to move the Bill quickly from second to third reading with no referral to a Committee for public consultation, as is normal for most bills. The Bill was then passed and received Royal Assent on August 31, 2022, less than two weeks from it having been introduced and following only five (5) days of debate.

91. At the time, Minister Calandra stated that regulations would be released "no later than one week following the passage of the bill".[55] This did not occur. Instead, Minister Calandra and Minister of Health Sylvia Jones held a press conference at 3:00 PM on September 14, 2022, thirteen minutes after the legislature had been adjourned for a six week break for the purpose of releasing the regulations and supporting materials. No public consultation on the regulations were held.

92. O. Reg.485/22 set out the amended regulations relating to the admission of ALC patients into long-term care homes. Pursuant to these amendments, certain information is to be given to the ALC patient or their substitute decision-maker(s) about the rules and their implications. Included information is the length of waiting lists and approximate times to placement, vacancies in homes, and how to obtain information about homes. If the ALC patient or their substitute decision-maker(s) refuses to make applications to homes that the placement co-ordinator deems reasonable, the placement co-ordinator is given broad authority to share the

[53] *FLTCA* s. 60.1(3)2.
[54] *FLTCA* s. 60.1(7).
[55] Legislative Debates, 43rd Parliament, 1st Session, August 22, 2022 (Hon. Paul Calandra).

personal health information of an ALC patient with a variety of service providers without the consent of the ALC patient or their substitute decision-maker to expedite their admission to a LTC home the patient may have rejected.

93. The document "Admissions to Long-Term Care Homes for Alternate Level of Care Patients from Public Hospitals – Field Guidance to Home and Community Care Support Services Placement Co-ordinators ("the Field Guide") was released at the same time as the regulations. It provides guidance to placement co-ordinators as to how they should proceed with ALC placements into long-term care and is attached hereto as **Exhibit O**.

94. When choosing homes without the applicant's consent, the placement coordinator is to take into consideration the patient's condition and circumstances, the class of accommodation requested, if any, and the proximity of the home. However, placement co-ordinators are encouraged to choose homes with either idle beds or short waitlisted homes within their region and appropriate geographic parameter.[56]

95. The homes chosen for ALC patients by the placement co-ordinators must be within 70 kilometres from the patient's preferred accommodation, or 150 kilometres if the patient lives in either the North East or North West Local Heath Integration Networks. If there is no home, or limited vacancies, within that 150 kilometre radius, the placement co-ordinator shall choose a home or homes that is next closest to the patient's preferred location.[57]

96. The rules regarding consent and choice that were otherwise guaranteed by the *HCCA* and *FLTCA* were exempted for those ALC patients who do not consent to an application of applications being made on their behalf to one, or any number of particular long-term care homes. However, if at any point the ALC patient or their substitute decision-maker consented to add homes that they otherwise found to be

[56] Field Guide p. 12.
[57] O. Reg. 246/22 s. 240.2(7) & (8).

unacceptable, then their participatory rights in the process including to decide whether and with whom their personal health information would be shared, would apply.[58] Regulatory amendments were also made to the regulations to the *Public Hospitals Act*. Under O. Reg. 485/22, s. 16 of Reg. 965 was amended to allow attending clinicians to designate a patient as ALC if they did not require the intensity of services provided in the hospital setting. It also stated that a patient was no longer in need of treatment in hospital if they have been designated as ALC and their admission to a long-term care home has been authorized pursuant to the *FLTCA*, allowing for the discharge of the patient.

97. These regulations came into effect on the same day that the legislation took effect, which was September 21, 2022.

98. A separate regulatory amendment to Reg. 965 s. 16 under the *Public Hospitals Act* was also filed O. Reg. 486/22, but did not come into effect for 60 days (November 21, 2022). This regulation requires that if a discharged patient does not leave hospital within 24 hours after a discharge order was made, the hospital is required to charge the patient $400 for every day that they remain in the hospital. The coercive influence of the threat of such charges is self-evident.

99. Placement co-ordinators are advised that they must provide "sufficient information" regarding the implications of staying in hospital and that this information should be readily available and understood throughout the process.[59]

100. The push to obtain consent from ALC patients or their substitute decision-maker(s) for other long-term care home choices is also highlighted in the Field Guide, with the placement co-ordinator being reminded that they should ensure that the ALC patient understands:

[58] *FLTCA* s. 60.1(5) & (6).
[59] Field Guide p. 6.

a. that they can provide consent at any time without having to start from the beginning, and
b. the implications of consenting or declining to consent during the process.[60]

101. When discussing consent, reference is made in the Field Guide to *FLTCA* s. 49-51 which includes the elements of consent; however, no reference is made to the requirements of informed consent set out in *FLTCA* s. 52, nor does it reference the legal obligations of substitute decision-makers under *HCCA* s. 42. Further, the information that the Field Guide suggests should be discussed is available accommodation types, payment, and possible financial supports,[61] which is important information, but is only tangential to requirements for informed consent for admission under FLTCA s. 52(1) and HCCA s. 42.

102. The *FLTCA* sets out the elements of informed consent,[62] establishing the applicant's right or that of their substitute decision-maker to make an informed decision about whether long term care is the most suitable care options for the patient, and to choose the home or homes that are able to provide that care. As previously discussed, the principles of consent that the substitute decision-maker is required to follow are set out in *HCCA* s. 42.

103. The Field Guide offers little to no direction on how to obtain a valid informed consent, and in fact, the whole purpose of the Field Guide is to free hospital beds, not to ensure compliance with the legal requirements of consent or the legal obligations of the substitute decision-makers when making decisions on behalf of an incapable person.

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[60] Field Guide p. 7.
[61] Field Guide p. 7.
[62] *FLTCA* s. 52.

Placements in LTC care homes under Bill 7 are very unlikely to be "temporary"

104. During the legislative debates on Bill 7, on August 23, 2022, the Honourable Paul Calandra, Minister of Long-Term Care who had introduced the Bill, shared his time with John Jordan, the member for Lanark-Frontenac-Kingston, who also presented on behalf of the government. Regarding the waiting list issue, Mr. Jordan stated as follows:

> The next part—this is very important to me, in particular, and to the whole program: Furthermore, hospital patients who have applied to live in a long-term-care home but have been moved into another suitable home temporarily will remain on the wait-list and be prioritized to permanently move once a bed becomes available at one of their preferred homes. In other words, they won't lose their place in the queue. Change is hard, so they can also choose to remain permanently in the initial home that they are moved to.[63]

105. When the regulations were released, a Fact Sheet about Bill 7 was also provided. That document stated as follows:

> Starting September 21, if there is no bed available in a long-term care home that is on the patient's preferred home list, the placement co-ordinator may authorize the patient's admission to a home where the patient can live while they continue to wait for a spot in one of their preferred homes. The patient would be placed in priority status on the wait list while they wait (attached hereto as **Exhibit P**).

106. In a memo to the health sector from both the Deputy Ministers of Long-Term Care and Health, as well as the President and CEO of Ontario Health, the purpose of the

[63] Ontario Legislative Debates, 43rd Parliament, 1st Session, August 23, 2022, at 0934 (John Jordan).

new regulations was set out as being the ability of the HCCSS to work collaboratively with hospitals and long-term care homes to "facilitate an eligible ALC patient's admission into a temporary long-term care home, while they wait for a preferred home" (attached hereto as **Exhibit Q**).

107. From these statements, it is clear that the message to the public was that these placements would only be "temporary", and that the resident should expect to be transferred to one of their preferred homes, if they still chose to do that.

108. Despite the emphasis made on the admission being "temporary", there is no indication that the patient or their substitute decision-maker is informed that whether a placement will actually be "temporary" depends in large measure on whether they have agreed to add a home that they did not want, or whether the placement co-ordinator has chosen the home and authorized the patient's admission without consent.

Placement without Consent

109. If the process is completed without consent and a bed is offered and authorized by the placement co-ordinator, and the patient acquiesces to the move, once in the long-term care home, the person will remain on the Category 1 - Crisis List for every home on their list.[64] If the patient has put no homes on the list, they have 60 days in which to add up to five homes, and they will be put on the Crisis List for those homes. If a resident is then admitted to one of the homes that they had put on their list, they will revert to the regular waiting list protocol for any higher homes. If the resident was offered a bed in a home and turns it down, or if they have no other homes on the list within 60 days of the admission, they revert to the regular waiting list protocol for any other home.[65] The regular lists would be Category 3A/4A for the first home on their list and, Category 3B/4B for all other homes on

[64] O. Reg. 246/22 s. 240.3(3.
[65] O. Reg. 246/22 s. 235.3(10 & (12.

their list, unless they qualify for a higher category, for example, spousal reunification.

110. However, even being on the Crisis List for a transfer does not mean that the person will be moved quickly. According to the Field Guide, priority is to be given to those with the highest need for admission, no matter where they are located. Given that there are in the neighbourhood of 36,000 Ontarians waiting for placement into long-term care, and that many of them have been waiting years, there are likely thousands of applicants waiting in the community in what are very difficult situations. Even then, the placement co-ordinators are told to take into consideration the urgency for ALC patients to be placed from hospital, versus the possibility of a person in the community requiring hospitalisation imminently.[66] This is in line with what we have been seeing: that priority is given to ALC patients on the Crisis List over those who have been waiting for lengthy periods of time in the community. I understand that there are people in the community who have been on the Crisis List for over a year and some multiple years, without being offered a bed.

111. Our experience with transfers between long-term care homes for residents on the crisis list is that ire is a very lengthy wait, if it happens at all. Therefore, while those who are placed in a home they do not want to be in on the authorization of the placement co-ordinator are technically on the crisis list, the reality is that they will be the lowest on the Crisis List priority scale, and will always be bumped by ALC patients or those in crisis in the community. In truth, with the current waiting lists, there is only a small chance that even they will be transferred to a home of their choice in the near future.

Placement with Consent

112. The situation for those who bow to the pressure from hospital personnel and placement co-ordinators to add homes they do not actually want is more dire: these

[66] Field Guide p. 14.

applicants are unlikely to evert be moved to a home that was their true choice. The reason for this is that when the ALC patient or their substitute decision-maker agrees to put one or more of these homes on their list and the bed is offered, when they move into that home they will not be on the Crisis List for transfer to their remaining homes. Because the home they have been admitted to was made one of their "choices", when they are admitted to the home that they believe to be "temporary", they are placed on the regular waiting list for transfer to another home, which is Category 3A/4A for their first home, and Category 3B/4B for any other home, unless they qualify for a different category, such as spousal reunification.[67] (Unfortunately, the Field Guide at page 19 gets this wrong, as they indicate that the person would be on the 3A/4A list for their homes, when in fact it is only for their top choice home. The actual placement category is made somewhat clearer in the Appendix to the Field Guide "Overview of Modified Waitlist Management Process Following Admission for ALC Patients".[68]) The Field Guide also advises that it is only on admission to the first home that the placement co-ordinator is to tell the resident about the length of the waiting list for their preferred home and approximate time to admission, which is too late to make an informed decision as required by law.

113. Nowhere in the Field Guide is there any requirement for the placement co-ordinator to advise the ALC patient that they will be on a higher waiting list if the placement co-ordinator chooses the home they do not want without their consent, than if the ALC patient succumbs to the pressure and consents to put that same home they do not want onto their choice list.

114. Given the number of ALC patients who are waiting for long-term care, as well as those in the community, the chance of an offer being made to an applicant on the Category 3A/4A list is extremely unlikely. Offers must be made to persons in higher categories first, most of which will be from the Category 1 – Crisis List.

[67] O. Reg. 246/22 s. 191 & 192.
[68] Field Guide p. 22.

Only if there is no one in a higher category will an offer be made to someone on a Category 3A/4A list, no matter how long they have been waiting. The likelihood of persons being transferred to one of the more desirable homes, which is usually where people are waiting to transfer, is likely non-existent as there will always be people on the Crisis List who will be available to fill the spot.

Bill 7 and the Confidentiality of Personal Health Information

115. Bill 7 also deprives ALC patients' of their rights to determine who can see their health information.

116. Health records contain very detailed and personal information about the applicant that they often do not want, nor would it be appropriate, to share except where necessary. Placement co-ordinators are empowered to make value decisions about private information – and may know little about the patient other than what is in their chart, and nothing about whether or not a patient may not want this information shared far and wide. Nevertheless, placement co-ordinators are empowered to share the patients' personal health information with as many homes as they see fit in order to find a home that might accept and have a bed for the person, and do so without the patient or the substitute decision-maker's consent.

117. Besides information about physical illness, applications include information about things like "behaviours" which can occur when a person has disorders such as dementia. Striking out and other similar behaviour may occur due to the confusion that occurs, especially when in unusual surroundings such as hospitals, but is not something that one wants shared widely. People with frontal lobe issues, for example, can become disinhibited: the kindly, shy person can all of a sudden exhibit sexualized behaviour, swear, and have other behaviours which are out of character. Issues from the past can also be included in these documents. Criminal records from 30 or 40 years ago are known to be included in these forms, even though they may be irrelevant to the placement. And all of this is being sent out

without the consent of the applicant or their substitute decisions-maker: in fact, it could be sent out despite their objections.

118. Prior to Bill 7, if an applicant knew that there might be a person at a home that they knew and did not want them to be aware of their health situation, they had the option of not applying to that home. For example, persons who are members of the LGBTQ community may not want their health information going to certain homes, as they may have had experience with persons at that facility who did not accept their sexual preference, gender, etc., or they may not have been "out" to everyone in their community. Sending their personal information to that home which would then "out" them have disastrous effects. When choosing homes on behalf of a person, the placement co-ordinator would have no way of knowing about these types of issues, and could easily send information to homes and cause harm to the applicant.[69]

Failure to Inform, or Misleading Patients About Their Rights

119. To understand the manner in which the new powers of "persuasion" and the inducements of Bill may be deployed, it is important to appreciate the dubious practices that hospitals have relied upon to discharge patients from hospital to long-term care homes when the patient wished to be cared for at home, or in a home or homes that may have waiting lists.

120. Since I commenced working at ACE in 1995, I have dealt with literally thousands of hospital patients, their substitute decision-makers and family members, who were seeking information and advice from our clinic about admission to long-term care homes from hospital.

[69] For a discussion of LGBTQ issues for seniors in LTC see "LGBTQ seniors fear renewed discrimination in long-term care" *The Globe and Mail*, August 6, 2018, https://www.theglobeandmail.com/politics/article-lgbtq-seniors-fear-renewed-discrimination-in-long-term-care/.

121. Often, the caller's questions concerned the process for admission to long-term care and the information that they were receiving from either hospital personnel or placement co-ordinators. While the caller wished to comply with any laws or rules that are in place, they questioned what they were being told, and called our office for information and assistance.

122. Based on the calls our office received, we often found that misinformation was being provided to the patient, substitute decision-maker or family members, and that there was a great deal of pressure being put on them to make decisions that they did not feel were in the best interest of the patient. Because of this, we prepared a document called *Discharge from Hospital to Long-Term Care: Issues in Ontario* (attached hereto to as **Exhibit C**) which provided legal information on the admission process. It addressed the most common misrepresentations reported to us, some of which we are still having to deal with on behalf of clients. Misinformation that we often hear includes:

- that hospital patients cannot apply for admission to long-term are and that the patient must go to the community, which could be home, to a retirement home, or other type of housing, and only then can they complete an application;
- that the patient requires approval of hospital management in order to apply for long-term care from hospital;
- that an applicant must have five homes on their choice list in order to submit it;
- that the patient has to have a specific number of "short list" homes on their choice list in order to submit it;
- that the patient must "accept" an idle bed or the first "available" bed even if they have never applied to it;
- that the hospital has policies regarding the admission to long-term care process and that these "override" the law; and
- that the placement co-ordinator cannot commence a long-term care home application on behalf of a patient unless they have the authorization of the hospital.

123. For many of my clients this is one of the most difficult times of their lives, having to go to long-term care or put a loved one into long-term care after they have suffered a health crisis. They report that the pressure put on them by the hospital staff to get the patient out is unbearable. Many of these people call us in tears because they have been under so much stress from the situation, only to be advised by us that the information they were given was untrue. The callers often describe the difficulty of challenging the hospital staff, and their concern about the patient or that they themselves will suffer repercussions for doing so. Fortunately, in my experience, if the patient, substitute decision-maker or family member tells the hospital staff or placement co-ordinator that they have received advice from the Advocacy Centre for the Elderly that a certain representation is untrue, the staff will back down. In some cases, we have had to be retained to contact the hospital or placement co-ordinator in order to have the matter resolved. In most cases, we have been successful in resolving the issue in our client's favour as the hospital or placement co-ordinator have not been complying with the law.

124. However, for patients or families that are unaware of, or who would fail to qualify for the services a legal clinic offers, or do not have the resources to retain their own counsel, the pressure to accede to the demands that hospital and HCCSS staff are empowered to exert will be formidable and most patients or substitute decision-makers are likely to simply consent given the apparent futility of resistance.

125. With the introduction of Bill 7, if a patient or substitute decision-maker refuses to "choose" certain homes they will now have to deal with the opprobrium of being unco-operative, selfishly taking up beds for "more deserving" patients, and that ultimately their wishes and needs are simply unimportant. These are persons who may be nearing the end of their life.

126. Substitute decision-makers for these applicants are in a doubly difficult position. They are required by law under s. 42 of the *HCCA* to make a decision in compliance with a known wish or if not, in accordance with the best wishes of the

person as set out in that section. While the substitute decision-maker is obligated to comply with the law, under Bill 7 they may simply be told by the hospital staff or placement co-ordinator that despite these legal requirements, their decision is going to be ignored and the patient is going to be placed elsewhere.

Are ALC patients or their substitute decision-makers acting unreasonably?

127. I have reviewed the affidavits of Samir Sinha and Amit Arya. Their description of the reasons why people choose to apply for admission to certain long-term homes and not others is entirely consistent with my experience and that of my colleagues in advising and representing patients and their substitute decision-makers making such choices.

128. For example, for many of the people that have sought our advice or counsel, homes were often rejected because they were too far from family, friends and community, and would result in the isolation of the applicant. Spouses who often were elderly themselves would be separated due to distance and travel issues. Applicants would also lose the assistance of essential caregivers, often family members who provided much-needed care, support and advocacy to the resident.

129. In other instances, homes that applicants were being "encouraged" to apply to were unsuitable for other reasons. While theoretically. transfers to one of their preferred homes was possible, as discussed previously, due to lengthy waiting lists these transfers, were very uncommon, and therefore these homes were very likely to be the last home that the applicant will live in Patients and substitute decision-makers are often concerned that being placed in an unsuitable home could increase the likelihood of deterioration and death, due to isolation, inability of the home to provide the necessary care, etc.

130. Often our clients had visited or attempted to visit numerous homes, and had difficulty in doing so. If they are able to visit, they may have noticed a stark

difference between homes. Visits provide insight into the home that are otherwise not discernable, providing insight to the visitor that the home would not be suitable for themselves or their loved one.

131. In my practice I have encountered many reasons that explain why, on the rare occasion that an applicant turns down a bed from hospital, that they have done so appropriately. Sometimes this occurs because that the patient or substitute decision-maker was simply unaware of their rights when it came to choosing a home and been pressured into putting homes on the list that they did not want. They then get the "offer" only to discover that because of the home's record, its distance from family, or because it does not meet their ethnic, linguistic or religious requirement, it is unsuitable.

132. In such circumstances, and as noted, it is not uncommon in cases that ACE has assisted with on behalf of the patient or their substitute decision-maker who have been misinformed by hospital staff about their rights under the Act. When the bed from one of these homes was offered, the offer would often be made more quickly than the applicant or someone on their behalf could arrange a visit, as scheduled tours in many homes might be restricted, for example occurring only monthly. If the applicant or their loved ones were successful in arranging a personal tour, they may quickly discover that the home did not meet their needs and was unacceptable. Because they already had the bed offer, they may be looking at being penalized for something they only consented to under duress. Other reasons for a placement to be refused have arisen when the patient's health status had changed, or when it was discovered, after contacting the home to make admission arrangements, that the home was unaware of and unable to meet the specific needs of the patient.

An existing but unused measure to deal with an unreasonable substitute decision maker

133. A great number of ALC patients have substitute decision-makers and at any point in this process, should the substitute decision-maker(s) not comply with the requirements of *HCCA* s. 42 in making decisions, the person responsible for authorizing admission, which is the placement co-ordinator at the HCCSS, can apply to the Consent and Capacity Board under HCCA s. 54 (a "Form G Application"). This is an application to determine whether the substitute decision-maker(s) has complied with the requirements set out in *HCCA* s. 42. If the Consent and Capacity Board determines that there has not been compliance with *HCCA* s. 42, they will order the substitute decision-maker(s) to comply, or forfeit their right to make this decision.

134. Generally, such Form G applications are brought by the placement co-ordinator when a substitute decision-maker refuses to make an application to long-term care. However, there is no reason that an application could not be made by the HCCSS to challenge the substitute decision-maker's choice of homes. Hospitals often complain that substitute decision-makers will choose only one home which has a lengthy waiting list, and that this is not in the best interest of the incapable person. A Form G application could be made to challenge these decisions.

135. However, a review in CanLii of written decisions by the Consent and Capacity Board regarding Form G applications under the *HCCA* found no such applications. Twenty Form G applications regarding long-term care placement were identified, with the earliest being in 2004. All of these cases were applications with respect to whether the person should go to long-term care at all, not the choices of homes being made by the substitute decision-maker.

136. HCCSSs and their placement staff have been made aware of this possibility for years. I have had discussions with various placement co-ordinators and their

managers about this option, and I have made the point in educational programs on Consent and Capacity law that I have been involved with over the last 27 years, and some of these have been geared specifically to placement co-ordinators and hospital discharge planners. Despite this avenue being available to challenge the substitute decision-makers choices and whether or not they apply to the requirements of the *HCCA*, this has not been done.

In sum:

137. At one of the most difficult times in the applicant's and their family's lives, which is the possibility of being admitted into a long-term care home, applicants, their substitute decision-makers and families have often been coerced by various unethical and even unlawful means to accept placements in long-term care homes that are unsuitable, or unable to meet their needs.

138. The amendments to the *FLTCA* contained in Bill 7, along with the regulatory changes, mean that ALC patients are now faced with similar same unethical practices that have now been given the imprimatur of Parliament.

139. I swear this affidavit in support of this application.

AFFIRMED BEFORE ME by Jane E. Meadus of the City of Oshawa, in the Province of Ontario on April 11, 2023 in accordance with O. Reg. 431/20 Administering Oath or Declaration Remotely.

JANE E. MEADUS

Commissioner for taking affidavits

Amanda Marie O'Brien, a Commissioner etc.
Province of Ontario, for Goldblatt Partners
LLP, Barristers & Solicitors
Expires November 15, 2024

This is **Exhibit "A"** referred to in the Affidavit of **Jane E. Meadus**, affirmed this 11 day of April, 2023, in accordance with O. Reg 431/20, Administering Oath or Declaration Remotely.

A Commissioner for taking Affidavits etc.(*or as may be*) (pursuant to O. Reg 431/20)

Amanda Marie O'Brien, a Commissioner etc.
Province of Ontario, for Goldblatt Partners LLP, Barristers & Solicitors
Expires November 15, 2024

JANE E. MEADUS

Education:

McMaster University, B.A. (Anthropology), 1984.
University of Ottawa, LL.B., 1991.
Called to the Bar of Ontario, 1993.

Employment:

1995 – Present — Institutional Advocate/Staff Lawyer, Advocacy Centre for the Elderly, Toronto.

Lawyer at a specialty legal clinic in Toronto representing institutionalized, elderly clients. Provide summary advice and legal representation to clients residing in long-term care homes, psychiatric facilities, hospitals and retirement homes, as well as generally in the area of consent and capacity and mental health law. Represented clients at various levels of Court, before the Consent and Capacity Board, Health Professions Appeal and Review Board.

Counsel for Canadian Pensioners Concerned at the 2003 Wilson Inquest into the fire death of a long-term care home resident.

Counsel for Concerned Friends at the 2005 El-Roubi/Lopez Inquest into the murder of two residents at a long-term care home by another resident.

Counsel for the Ontario Association of Residents' Councils at the 2018 Gillese Inquiry into the eight murders and six attempted murders of residents of long-term care and home care recipients by a registered nurse.

Systemic advocacy including education to seniors, care providers, professionals and community members; oral and written presentations and submissions to various levels of government; and providing written materials, both to the general community as well as in professional publications.

Responding to media requests, including print, radio and television interviews and appearances.

1995	Barrister & Solicitor, Korman and Company, Toronto. General legal practice specializing in mental health and disability law. Also provided legal advice and representation in many other areas of law, including family law, criminal law and immigration matters. Appeared in various courts and tribunals.
1993-1994	Barrister & Solicitor, Swadron Associates, Toronto. General legal practice specializing in mental health and disability law. Provided legal advice and representation in a variety of legal areas.
1991-1992	Articling Student, Swadron Associates, Toronto.

PUBLIC APPOINTMENTS:

National Long-Term Care Services Standards. Technical Committee Member. 2021 – Present.

SELECTED PUBLICATIONS:

"Chapter 9: Medical Issues, Housing Costs and Special Care Arrangements: Practical Considerations", in the loose-leaf service *Financial & Estate Planning for the Mature Client*. Butterworth's.

Long-Term Care Facilities in Ontario: The Advocate's Manual, 1st, 2nd and 3rd editions, Advocacy Centre for the Elderly (contributing author).

"How to Prepare for a Hearing", Consent and Capacity, Part 2: Hearings and Court Applications. Canadian Bar Association – Ontario, Continuing Legal Education, June 16, 1997.

"The Forgotten Residents: Can they Afford Long-Term Care?", *Advocacy Centre for the Elderly Newsletter*, Fall 2000, Vol. 3, No. 2, pg. 1.

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"Waiting for placement: Discharge from hospital to long-term care in Ontario", *Healthcare Management Forum,* Vol. 27, No. 2, Summer 2014, 69-72.

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"Pharmacy Services in Long-Term Care Homes", *Advocacy Centre for the Elderly Newsletter,* Fall/Winter 2016, Vol. 13, No. 2, pg. 1.

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"Whither Consent? Substitute Decision-Making in Ontario and Quebec." First Annual Canadian Conference on Elder Law, October, 2005.

"Rights and the Older Adult." First Annual Canadian Conference on Elder Law, October, 2005.

"So You Think You Need a Nursing Home." Featured Speaker, Renfrew Law Fair, April 8, 2006.

"The El-Roubi/Lopez Inquest." Canadian Institute's 6th Annual Managing Legal Risks and Responsibilities in Mental Health Care, April 10, 2006.

"A Review of Admission of Alleged Incapable Persons to Long-Term Care Homes Across Canada: Are these Admissions Legal and What Authority Do the Homes Have to Detain these Persons?" Second Annual Canadian Conference on Elder Law, Plenary Speaker, October, 2006.

"Whose Right is it Anyway?" – Restraints in LTC: A Canadian Perspective." Second Annual Canadian Conference on Elder Law, October, 2006.

"*Away from Her*: Thinking About the Rights of People with Alzheimer's Disease and Dementia." Third Annual Canadian Conference on Elder Law, November, 2007.

"Is There Justice in Long-Term Care? The Ontario Experience." Third Annual Canadian Conference on Elder Law, November 2007

Oral presentation to the Standing Committee on Social Policy, Bill 140, *An Act*

Respecting Long-Term Care Homes, on behalf of the Advocacy Centre for the Elderly, January 17, 2007.

"Elder Abuse in Canada: How to Avoid Being the Test Case." Canadian Institute's 8th National Summit on Institutional Liability for Sexual Assault, Abuse and Harassment, March 31, 2008.

"Placement and Alternative Level of Care Issues." Presentation at Borden Ladner Gervais for CCAC Executives, April 23, 2008.

"Can I Have My Timmy's? Issues of Consent and Capacity in Long-Term Care Homes in Ontario." Canadian Conference on Elder Law, November 14 – 16, 2008.

"Shades of Grey: Dealing with Incapacity." Living Alone/Diversity Forum. Alzheimer Society of Toronto, November 21, 2008.

Oral presentation to the Standing Committee on Justice Policy, Bill 115, *Coroner's Amendment Act, 2009,* on behalf of the Advocacy Centre for the Elderly, March 26, 2009.

"Mental Health in Long-Term Care." Managing Legal Risks and Responsibilities in Mental Health, April 2 – 3, 2009.

"Protecting Rights of Geriatric Psychiatric Patients – Minimizing Liability." Canadian Institute, April 10, 2009.

"Evaluation of Capacity for Admission to Long-Term Care." Ontario Association of Community Care Access Centres Knowledge and Inspiration 2009 Conference, June 4, 2009.

"Issues in Elder Law." Consent and Capacity Board AGM, October 23, 2009.

"Into the Abyss: Adventures in Long-Term Care." Speaker at Annual General Meeting for Concerned Friends of Ontario Citizens in Care Facilities, November 5, 2009.

"Zero Tolerance of Elder Abuse in Long-Term Care Homes." World Study Group on Elder Abuse", Centre for Excellence in Elder Law, Stetson Law, Gulfport, FL, November 20/21, 2009.

"Elder Abuse and the Right to Live at Risk." Regional Geriatric Program of Toronto, January 29, 2010.

"Long-Term Care Homes Act, 2007 Grave Consequences: Traps and Pitfalls in Contemporary Estates Law." The 35th Annual OBA Institute of Continuing Legal

Education - Trusts and Estates Law Section, February 16, 2010.

"Supporting Client Choices and the Challenges of Substitute Decision-Making." Ontario Association of Community Care Access Centres Knowledge and Inspiration 2010 Conference, June 14, 2010.

"Restraints and Personal Assistance Services Devices." Webinar for Ministry of Health and Long-Term Care, August 31, 2010.

"*Health Care Consent Act* and *Substitute Decisions Act.*" Webinar for Ministry of Health and Long-Term Care, August 17, 2010."

"First Available Bed Policies." Canadian Elder Law Conference, October 29, 2010.

"Ontario's New *Long-Term Care Home's Act*: Impact on Consent and Capacity Issues." Canadian Elder Law Conference, October 30, 2010.

"Advance Care Planning." Ontario Long-Term Care Association Applied Research Education Day, November 23, 2010.

"Ontario's New *Long-Term Care Homes Act.*" Canadian Association on Gerontology Conference, December 3, 2010.

"Mental Illness and the Elderly: An Advocate's Perspective." Institution of Administrative Justice, Keynote, September 26, 2011.

"Placement into Long-Term Care Homes: When Policies and Rights Diverge." Ontario Association of Community Care Access Centres Knowledge and Inspiration Conference 2012, June 18, 2012.

"Health Care Consent and Advance Care Planning Workshop." Canadian Bar Association, National Elder Law Conference, April 15, 2013.

"Discharge from Hospital into Long-Term Care." Managing Transitions: Continuing the Dialogue: Ontario Hospital Association ER/ALC Conference, May 28, 2013.

"Solution to ALC Crisis." Ontario Association of Community Care Access Centres Knowledge and Inspiration Conference 2013, June 20, 2013.

"Admission to Long-Term Care from Hospital." Ontario Hospital Association Webinar Series - four separate sessions, 2013.

"Sex and Long-Term Care Homes." Sex, Rights and the Law panel, World Pride Day, June 16, 2014.

"Protecting the Patient's Information." Ontario Association of Community Care Access Centre 2014 Knowledge and Inspiration Conference, June 17, 2014.

"Consent and Capacity Law Workshop." Ontario Society of Occupational Therapists Conference 2014, September 19, 2014.

"Residents Rights in Long-Term Care." Ontario Long-Term Care Physicians Association, November 8, 2014.

"Understanding Legislation for Long-Term Care" and "Resident Safety and Quality of Life in Long-Term Care Facilities Panel." Informa Long-Term Care Safe and Secure Environment Conference, November 26 & 27, 2014.

"Video Surveillance in Long-Term Care." Ontario Association of Non-Profit Homes and Services for Seniors, Privacy Law Webinar, March 25, 2015.

"Alternative Level of Care - Transitions for ALC Patients: Myth Busters and Open Mic." Ontario Hospital Association, May 20, 2015.

"Practice before the Consent and Capacity Board and Appeals – Discussion Panel." Law Society of Upper Canada, June 3, 2015.

"Admission to Long-Term Care Homes: Legal Issues." Crown Summer School Legal Education Conference, June 16, 2015.

Privacy Issues in Long-Term Care. Healthcare Insurance Reciprocal of Canada. March 31, 2016.

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Elder Law for *Elder Abuse Investigation*, Toronto Police College, October 2016 – present.

"Where Will We Live: Who Will Look After Us?" Public Hearing Report. Sarnia. September 28, 2017.

New Voices: The Public We Service. Ontario Nurses Association. June 7, 2017.

Elder Law for *Elder Abuse Course*, Durham Regional Police Service, 2017 – present.

"The Law As It Relates to Long-Term Care: What Clinicians Need to Know." Ontario Long-Term Care Clinicians Annual Conference. October 20, 2017.

"Health Care Consent and Advance Care Planning in Ontario: What You Need to Know". Hospice Palliative Care Ontario. 2017.

"Strengthening Quality and Accountability for Patients Act, 2017". AdvantAge Ontario. April 18, 2018.

"Remedies for Abuse and Neglect of Older Adults in Congregate Settings in Ontario". Canadian Bar Association. March 28, 2018.

"Rules regarding Applications for Long-Term Care". Ontario Association of Residents' Councils. April 24, 2018.

"Bill 160: Amendments to the *Long-Term Care Homes Act"*. Ontario Association of Residents' Councils. May 9, 2018.

"Understanding Capacity". Trends in Care for the Elderly. Freeport Hospital Education Day. May 2, 2018.

"Issues in Mental Health in Long-Term Care". Brainxchange. October 16, 2018.

"Consent and Capacity in Long-Term Care". Annual Conference for Coroners and Pathologists. Office of the Chief Coroner of Ontario. November 8, 2018.

"Implications for Residents and Families" at Medical and Recreational Cannabis in Senior Care Settings Workshops. AdvantAge Ontario. November 1 and December 6, 2018.

"10 Lessons Learned at the Gillese Inquiry". Ontario Bar Association's Annual Institute. February 6, 2019.

"Sexuality in Long-Term Care". Behavioural Supports Ontario. April 20, 2019.

"Privacy in Retirement Homes and Long-Term Care Homes". Privacy Law and Older Adult Clients" Intersections and Issues. Ontario Bar Association. May 27, 2019.

"The Gillese Inquiry into the Safety and Security of Residents in Long-Term Care following the Wettlaufer Murders: Perspectives Past, Present and Future". Annual NICE Knowledge Exchange. May 30, 2019.

"Issues to Consider when Advocating for People in Institutional Settings". 22nd Estates and Trusts Summit. Law Society of Ontario. October 17, 2019.

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following the Wettlaufer Murders". Advocacy Centre for the Elderly AGM. October 29, 2019.

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"Human Rights for People Living with Dementia". Canadian Elder Law Conference. November 15, 2019.

"Selected Legal Issues Relating to Police Interaction with Seniors". Elder Abuse Investigation Program. Ontario Police College. 2019 – Present.

"Controversial Issues in the Use of Restraints, Detention and Locked Units". The 2020 Guide to Legal Risk Management in Long-Term Care. Osgoode Continuing Education. January 23, 2020.

"Marijuana Use in Assisted Living and Long-Term Care". The Canadian Bar Association. March 12, 2020.

"Ageism and Neglect during COVID-19? How Can We Do Better?" Canadian Institute for the Administration of Justice. June 23, 2020.

"LTC and Retirement Homes in the Midst of a Pandemic". COVID-19. Osgoode Continuing Education. July 23, 2020.

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"Long-Term Care Homes: Residents Rights and Prevention of Abuse". Osgoode Continuing Education Elder Law Certificate. April 21, 2021.

"Detention and Restraint". Osgoode Continuing Education Elder Law Certificate. April 21, 2021.

"Admission into Long-term Care". Osgoode Continuing Education Elder Law Certificate. April 21, 2021.

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The Current. CBC Radio One. January 10, 2013. Topic: Canada's hospitals strained caring for elderly patients with nowhere to go.

The Agenda with Steve Paikin. TVO. February 13, 2013. Topic: Residence Life, Senior Style/Legislating Assisted Suicide.

Canada AM. CTV. August 20, 2013. Topic: Senior's Health Care.

Here and Now. CBC Radio One. December 9, 2013. Topic: Long-Term Care for Seniors.

Afternoon Shows: – various across Canada. CBC Radio One. December 11, 2013. Topic: Admission to Long-Term Care.

CTV News with Dan Matheson. CTV News Channel. January 10, 2014. Topic: Winnipeg man dies outside home after discharge from hospital.

The Morning Show. Global TV. November 6, 2014. Topic: Shortage of long-term beds in Ontario.

Goldhawk Live: AM 740 Radio. March 17, 2015. Topic: Compliance issues in long-term care.

Ontario Today. CBC Radio. October 25, 2017. Topic: Allegation of Murders by Elizabeth Wettlaufer in Long-Term Care Homes.

CTV National News. October 25, 2016. Topic: Allegation of Murders by Elizabeth Wettlaufer in Long-Term Care Homes.

The Current. October 26, 2016. Topic: Allegation of Murders by Elizabeth Wettlaufer in Long-Term Care Homes.

CBC Newsnet with Ian Hanomansing. January 18, 2017. Topic: Elizabeth Wettlaufer case.

Global News. January 25, 2017. Topic: Elizabeth Wettlaufer case.

theZoomer. March 27, 2017. Topic: Nursing Home Violence. Panel Discussion.

The Current. CBC May 17, 2017. Elderly patients in hospital need adequate long-term care plans before discharge, say families.

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The Agenda. TVO. September 9, 2022. Will Bill 7 Really Relieve Ontario's Health Care Crunch?

Globe and Mail. October 3, 2022. Vulnerable, complex patients at risk under Ontario's new long-term care law, experts warn.

CONFERENCE AND EDUCATION ORGANIZER:

Co-Chair 1997 Joint Ontario Bar Association/Law Society of Upper Canada seminar on Consent and Capacity Law (Videotaped, Mandatory Programme for Admission to the Mental Health Panel of Ontario Legal Aid Plan)

Conference Organizers, *Nuts and Bolts of Consent and Capacity Law* and *Appearances Before the Consent and Capacity Board (CCB)*, December 5 and 6, 2005. (Videotaped, Mandatory Programme for Admission to the Mental Health Panel of Legal Aid Ontario)

Co-Chair – *Advising the Elderly Client – Key Issues- Best Practices – Practical Approaches, 2011, 2012, 2013, 2014, & 2015.* Osgoode Professional Development.

Co-Chair - *The Osgoode Certificate in Elder Law.* 2015, - present. Osgoode Professional Development.

Co-Chair - *The Legal Guide to Consent, Capacity & Substitute Decision Making,* 2016 to Present.

Co-Chair – *Advising the Elderly Client: The 2016 Practical Guide for Legal Professionals.* Osgoode Professional Development.

UNIVERSITY GUEST LECTURER/INSTRUCTOR:

McMaster University - Gerontology. Guest Lecturer: Law, 2011, 2012.

Ontario Institute of Technology – Faculty of Health Sciences. Guest Lecturer. Managing Health Care Teams, 2010.

Queens Law School. Guest Lecturer: Elder Law, 2007.

University of Ottawa Law School. Guest Lecturer: Elder Law, 2015.

University of Toronto – Faculty of Social Worker. Guest Lecturer: Elder Law, 2008, 2013 – Present.

University of Toronto Law School. Guest Lecturer: Mental Health Law, 2009.

University of Toronto Medical School. Guest Lecturer: Geriatric Medicine Residence Program, 2020.

University of Windsor Law School. Guest Lecturer: Mental Health Law, 2011.

University of Windsor Law School. Guest Lecturer: Public Health Law. 2021.

York University - Osgoode Hall Law School. Guest Lecturer: Law & Psychiatry, 2006, 2007, 2008, 2010, 2011, 2014, 2016, 2017, 2018, 2019, 2020.

York University – Osgoode Hall Law School. Guest Lecturer: Health Law. 2019 – Present.

York University – Osgoode Professional Development. The Osgoode Certificate in Mental Health Law, 2009, 2010, 2012, 2013 (keynote) & 2014 (keynote), 2015 (keynote), 2018.

York University – Osgoode Professional Development. Legal Risk Management for Long-Term Care Homes. 2009 & 2010, 2012.

York University – Osgoode Professional Development. Teleseminar on *Cuthbertson v. Rasouli*, 2013.

York University – Osgoode Professional Development. 2015 Guide to Legal Risk Management in Long-Term Care. 2015.

SELECTED COMMITTEE MEMBERSHIPS:

CCB Board and Bar: Consent and Capacity Board.

Clinic Compensation Review Project: Legal Aid Ontario.

Compliance Transformation Advisory Group: Ministry of Health and Long-Term Care.

Consent and Capacity Panel Standards and Supports: Legal Aid Ontario.

Long-Term Care Homes Act Regulations Dialogue – External Planning Group: Ministry of Health and Long-Term Care.

Long-Term Care Quality Inspection Program Advisory Committee: Ministry of Health and Long-Term Care.

Placement Co-ordination Advisory Group: Ministry of Health and Long-Term Care.

Quality Assurance Program Advisory Group: Legal Aid Ontario.

Retirement Homes Act Regulations Round Table – Care Services: Ontario Seniors' Secretariat.

Retirement Homes Act Regulations Round Table – Detention and Restraint: Ontario Seniors' Secretariat.

Legal Clinic Colocation: Toronto Specialty Clinics.

Toronto Central LHIN ALC Task Group on Transition & Flow.

Toronto Central LHIN Intersectoral Working Group on Common Discharge Processes.

SAFER – Staffing Alliance for Every Resident. Coalition of Long-Term Care homes, Unions, Resident Groups.

Ontario Association of Residents' Councils, Bill of Rights Education Advisory Group.

PROFESSIONAL AFFILIATIONS:

Member: Law Society of Upper Canada.
Member: Mental Health Legal Committee.
Distinguished Fellow: Canadian Centre for Elder Law Studies.

COMMUNITY INOLVEMENT:

Gemini Gymnastics (Not-for-Profit) Oshawa, Ontario.

2009 – Present	First Vice-President
2009 – 2012	Chair – Publicity Committee
2009 – 2010	Chair – Fundraising Committee
2008 – 2009	Director at Large
2006 - 2010	Fundraising Committee
2007 - 2008	Parent Representative

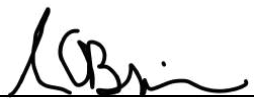
All Saints Anglican Church, Whitby, Ontario

2013 – 2016	Parish Advisory Council
2014 – 2016	150th Anniversary Organizing Committee
2014 – 2021	Social Media Advisory Committee
2018 – Present	Synod Delegate.

OTHER:

Computer Literate: Word, PowerPoint, Outlook, Internet Research, Quicklaw.

This is **Exhibit "B"** referred to in the Affidavit of **Jane E. Meadus**, affirmed this 11 day of April, 2023, in accordance with O. Reg 431/20, Administering Oath or Declaration Remotely.



A Commissioner for taking Affidavits etc.(*or as may be*) (pursuant to O. Reg 431/20)

Amanda Marie O'Brien, a Commissioner etc.
Province of Ontario, for Goldblatt Partners LLP, Barristers & Solicitors
Expires November 15, 2024

ORIGINAL ARTICLE

Waiting for placement: Discharge from hospital to long-term care in Ontario

Jane E. Meadus, BA, LLB

Abstract—Great pressures are placed on hospitals to promptly discharge patients. This is especially true of patients deemed "alternate level of care," often referred to pejoratively as "bed blockers." To alleviate these pressures, hospitals enact policies, both formal and informal, to discharge alternate level of care patients who are awaiting placement into long-term care homes. In addition to being dangerous for some of the patients discharged, these discharge policies also leave the hospital, its employees, physicians, and Community Care Access Centres open to legal liability. In 2013, the Advocacy Centre for the Elderly received more than 300 individual requests for legal service in 2013 on behalf of patients, relating to conflict with hospital policies and the placement process. This article analyzes the legal requirements relating to discharge from hospital and admission to long-term care.

As of July 1, 2009, Ontario invoked a Provincial Alternate Level of Care (ALC) definition that applies to all patients awaiting other levels of care in an acute or post–acute care hospital. The definition provides as follows:

> When a patient is occupying a bed in a hospital and does not require the intensity of resources/services provided in this care setting (acute, complex continuing care, mental health, or rehabilitation), the patient must be designated ALC at that time by the physician or her/his delegate. The ALC wait period starts at the time of designation and ends at the time of discharge/transfer to a discharge destination (or when the patient's needs or condition changes and the designation of ALC no longer applies).[1]

Patients may be ALC for a number of destinations, such as to their homes, a rehabilitation or complex continuing care facility, or a retirement home. However, patients awaiting placement into Long-Term Care Homes (LTCHs) are the ones who most often come into conflict with hospital procedures and policies, and they are the focus of this article.

According to statistics compiled by Access to Care on behalf of the Ontario Hospital Association, on November 30, 2013, there were 3,951 ALC patients in hospital beds in Ontario. Of those, 46% were waiting for placement into LTCHs.[2] This is an average of 14% of beds being occupied by all ALC patients monthly,[3] of which, 7% of beds would be waiting for admission to a LTCH.

The most recent figures available show that on March 31, 2012, 32,000 people were on the waiting list for long-term care, with 19,000 of them waiting for an initial placement into a LTCH (the rest were awaiting transfer to a preferred LTCH).[4] Publicly available waiting lists (Community Care Access Centres (CCACs) publish these monthly on their web sites) for each LTCH in Ontario show that most homes have waiting lists, some many years long. Hospital patients do not get any preference on the waiting lists, except for admission to specially designated interim facilities. It is therefore unlikely that patients will be able to go to a LTCH of their choice immediately on being medically able.

To maximize patient flow and utilization of resources, hospitals enact policies and procedures to move ALC patients as quickly as possible into the next level of care. Although these policies may move patients out quickly, they may not comply with Ontario law and may not meet the needs of patients. Hospitals are not only interfering with patients' legal rights, they may also be exposing themselves, their staff, and physicians to complaints, regulatory investigations, and civil liability.

Although the specifics of each hospital's discharge policies are unique, the positions taken are similar. The following is a list of common policies that, it will be argued, are not compliant with the relevant legislation:

- advising that patients cannot commence the application for a LTCH from hospital,
- requiring that patients include 5 homes on their waiting list,
- requiring that patients choose a certain number of homes from "short lists,"
- requiring that patients accept beds that are "available" even if they have not chosen those homes,
- stating that patients will be charged the uninsured per diem if they do not comply with discharge policies,
- requiring that patients move to a retirement home and wait for placement there,
- requiring that patients go home with home care when they need admission to a LTCH, and
- stating that hospitals must discharge patients even if they are waiting for admission to a LTCH.

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ELIGIBILITY FOR ADMISSION TO A LTCH

Admission to a LTCH is governed by the *Long-Term Care Homes Act (LTCHA)*.[5] The determination of eligibility and management of the application process is entirely within the purview of the Community Care Access Centre.[6]

The CCAC case manager owes a duty to patients—this duty includes advising patients of their right to apply for admission to a LTCH. If they or their Substitute Decision-Maker (SDM) requests that an application be completed, the CCAC must take the application and determine eligibility[7] (although they may discuss appropriateness of timing based on patients' health).

Hospitals policies may discourage or restrict patients from starting applications for admission, stating they cannot apply without special permission, or that they cannot apply from hospital at all. This is not only contrary to patients' legal rights but is counterproductive. The more quickly eligible patients are put on waiting lists, the faster they will receive a bed offer. Furthermore, being on a waiting list does not preclude patients from considering other options while waiting for placement.

Failing to comply with the legislation and misleading patients/SDMs regarding their right to apply for long-term care could also lead to complaints against both the CCAC and hospital employees as a breach of their professional responsibilities (as most case managers are nurses, the most relevant legislation is O.R. 799/93). They could also be civilly liable for a breach of their duty of care towards their client.

CHOOSING A LTCH

Choosing a LTCH is the most difficult part of the application process, as it will likely be where people live for the rest of their lives. It is also a very personal decision as each applicant has unique requirements.

The LTCHA authorizes the person (or the SDM) to choose the LTCHs:

> A person who has been determined to be eligible for LTCH admission may apply to a placement coordinator for an authorization of admission, by the appropriate placement coordinator, to such LTCH or homes as the person selects.[8]

For the choice to be valid, the LTCHA requires that the consent must relate to the admission, be informed, be given voluntarily, and not be obtained through misrepresentation or fraud.[9] Any consent obtained through misrepresentation, which includes being told that one "must" choose a short-list home, for example, would not be legally valid.

Hospital policies may also require patients to "choose" the maximum of five homes allowed under the LTCHA, or that a certain number of homes from a short list must be chosen. This is again contrary to the regulations, which states this number is a maximum. There are no requirements as to the length of waiting lists.[10]

However, although patients may choose the home in any way they wish, the legislation requires that the SDM make the decision in accordance with principles in the *Health Care Consent Act*.[11] These require complying with any known wish the person expressed while capable, or acting in the incapable person's best interest.

SDMs must take into consideration all of the necessary information, which not only includes considering each LTCH but also the effect of a lengthy hospital stay, waiting lists, bed availability, and the option of going home or to a retirement home.

Patients/SDMs must also be informed that they will not be made a crisis admission while in hospital and that being in hospital does not give them any advantage on the waiting list.

The Ministry of Health and Long-Term Care has consistently stated that they will not change the requirement for choice in the long-term care application process. In a recent *Toronto Star* article, Sheamus Murphy, Director of Communications for the Minister of Health and Long-Term Care stated, "The primacy of choice and consent" is entrenched in the LTCHA and that the government has no plans to remove applicant choice.[12]

FIRST AVAILABLE BED POLICIES

An example of a policy that attempts to interfere with the right to patient choice can be found on the web site for Southlake Regional Health Centre, which states as follows:

> It is the policy of Southlake to transfer patients awaiting placement in a long-term care facility to the first available bed where their care needs can be safely met, until a bed becomes available in their chosen facility.[13]

This policy appears to require that the patient accept a bed in any home that the hospital determines meets the patient's needs, even if it is not a home to which the patient has previously applied. This policy and others like it are in contravention of the LTCHA.

This is a common policy in hospitals, where available or short-listed beds are identified as meeting patients' needs and they are told they "must" go to them. As this is contrary to the requirements of informed choice, such policies are contrary to the law. In fact, if the patient has not applied for the home, the law does not allow the bed to be considered for that person.

DISCHARGE AND PER DIEMS

Despite the clear requirement for consent under both the LTCHA and the *Health Care Consent Act*, hospitals may threaten to charge a "per diem" rate should the patient not comply with their discharge policies. An example of this occurred in 2011, when the Erie St. Clair Local Health Integration Network (LHIN) announced that hospital

patients waiting for placement into a LTCH would be designated "crisis" and be required to take the first available bed in the region or pay a $600.00 per day fee.[14] These charges were illegal, as they exceeded the allowable fees for persons awaiting placement into a LTCH pursuant to the *Health Insurance Act*. Under the *Health Insurance Act*, although hospitals can charge the uninsured rate if people refuses to leave after being offered a bed in a LTCH of their choice, they cannot be charged for refusing to go to a home to which they have not applied.

The Ministry of Health and Long-Term Care quickly responded to the Erie St. Clair LHIN's announcement with a memo to all LHIN CEOs advising them that they could not enact such policies at the expense of patient consent and choice.[15]

Per diem rates can only be charged in 2 instances. First, if the patient is properly discharged pursuant to the regulations of the *Public Hospitals Act*,[16] and refuses to leave the hospital (which does not include a patient who is waiting for admission to a LTCH). The second is if a patient/SDM refuses a bed offer from one of his or her chosen homes.[17]

The only case heard to date on the issue of discharge from hospital to LTC is *Duffy v. OHIP*,[18] arising from an appeal after a denial of Ontario Health Insurance Plan (OHIP) benefits. In that case, Mrs. Duffy, a patient at Joseph Brant Memorial Hospital, was awaiting placement into LTC. Although applications for 3 homes had been submitted, the hospital required that more homes be added (at the time, the legislation did not include a maximum number of homes that could be applied to). The hospital was requesting that 10 homes be included in the application. When this was not done, OHIP was advised that the patient had been discharged but remained in hospital. OHIP payments for the bed were discontinued and the hospital began to charge Mrs. Duffy $120 per day for the bed. An appeal was brought before the Health Services Appeal Board by Mrs. Duffy who argued she was entitled to OHIP coverage for the hospital fees. The Board held that the rate being charged by the hospital appeared completely arbitrary and there was insufficient evidence that the appellant or her family had been advised of the discharge policy. In any event, the Board concluded that discharge did not simply mean "to leave the hospital on the day of discharge" as had been argued by OHIP. In fact, "discharge" meant an appropriate placement into LTC. Therefore, the Board ruled in favour of Mrs. Duffy and ordered coverage of the fees by OHIP.

Although physicians have a duty to discharge under the regulations to the *Public Hospitals Act*, the regulations to the *Health Insurance Act* make it clear that patients can wait in hospital for admission to a LTCH. Physicians owe a duty to patients under their care to ensure a safe discharge, and when they require a LTCH, this may mean waiting until one is available. Just as one would not send a patient home from Intensive Care Unit to wait for a medical bed, one cannot require a patient to go home to wait for a LTCH.

HOME FIRST/WAIT AT HOME PHILOSOPHY

"Home first" and "Wait at home" has been described as a "philosophy" intended to break down the assumption that LTCHs are the only option for the frail elderly.[19] Pursuant to this philosophy, patients are encouraged to return home with enhanced CCAC services and given the opportunity to improve and make decisions about their future or wait for placement while in the comfort of their own home.

Unfortunately, this philosophy has often been translated into requirements that patients must leave the hospital to apply for admission into a LTCH, and that they cannot stay in hospital to wait for placement. This is completely untrue.[20]

Although patients have the right to wait in hospital, it may or may not be in their best interest, depending on their personal circumstances. Each patient's unique situation must be reviewed and discussed, and all options presented. However, given that these patients may be the LTCH applicants with the most complex needs, it may not be safe for them to go home. It will be up to the patients/SDMs to decide, after being presented with all the information, what will best meet their needs.

DISCHARGE TO RETIREMENT HOMES

Retirement homes are not equivalent to LTCHs and should never be presented as such. Retirement homes are tenancies, governed by the *Residential Tenancies Act*[21] and the *Retirement Homes Act*.[22] They are entirely user pay and do not meet the same standards as LTCHs. Although they may be a viable option for some patients waiting for a LTCH, this is a personal choice and is never mandatory.

Hospitals need to be aware of the potential liability that may befall them in transferring patients to a retirement home. In the *Nineteenth Annual Report of the Geriatric and Long-Term Care Review Committee to the Chief Coroner for the Province of Ontario*, the committee was critical of an ALC program that transferred care of a woman awaiting placement in a LTCH to a retirement home setting. The committee summed up their findings as follows:

> The circumstances surrounding this woman's death should alert healthcare professionals that, despite pressures to move the frail elderly out of hospitals to other settings, such as private care homes to await placement in a long-term care home, it is important to remember that these elderly clients are awaiting long-term care home placement precisely because their care needs are so heavy that they are difficult, if not impossible, to provide in a community, private care setting.[23]

DISCUSSION

The law gives patients and their SDMs the ability to choose the homes to which they apply and does not give the hospital any authority over the process. Using policies and

procedures that are not in compliance with the legislation creates a barrier between the hospital and patients or their SDMs. Once they are advised of their rights, they will no longer wish to participate in any discharge planning with the hospital.

Instead of rigid policies, hospitals must change their role to be a positive influence in the process. Being frank with patients/SDMs about their choices will be more helpful, including advising them of the drawbacks of staying in hospital and the benefits of LTCHs, and the realities of multi-year waiting lists, will do more in a positive way to assist them in making informed choices. In general, neither patients nor their SDMs want them to remain in hospital any longer than they need to be, but without all of the requisite information, they may believe it is the only choice.

There will always be outliers who insist on sticking to their one choice even if it means years in hospital. However, these cases will likely be few and far between.

CONCLUSION

LTCH applications are highly regulated under the LTCHA, where the placement process is no different in hospital than in the community. Hospitals cannot enact policies that are in contravention of these laws. However, if hospitals and CCACs would work together within the boundaries of the law, at the same time being both frank and informative with patients and their SDMs, the goal of moving patients through the system could be accomplished without the added stress and upset that presently occur.

ACKNOWLEDGMENTS

The author would like to thank Brendan Gray, staff lawyer at the Advocacy Centre for the Elderly, for his assistance in editing this article.

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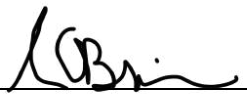
This is **Exhibit "C"** referred to in the Affidavit of **Jane E. Meadus**, affirmed this 11 day of April, 2023, in accordance with O. Reg 431/20, Administering Oath or Declaration Remotely.



A Commissioner for taking Affidavits etc.(*or as may be*) (pursuant to O. Reg 431/20)

Amanda Marie O'Brien, a Commissioner etc.
Province of Ontario, for Goldblatt Partners LLP, Barristers & Solicitors
Expires November 15, 2024

DISCHARGE FROM HOSPITAL TO LONG-TERM CARE: ISSUES IN ONTARIO[1]

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Updated February 2014

Hospitals in Ontario are overcrowded. Thousands of people are on waiting lists for long-term care homes. As a result, people requiring long-term care (LTC) are confronted with a variety of "policies" and "programs" developed to "deal" with these issues despite the legislation governing placement.

LTC homes in Ontario are publicly funded and governed by the *Long-Term Care Homes Act, 2007* (*LTCHA),* which was enacted on July 1, 2010.[2] This legislation, while having some changes, substantially continued the rights that applicants for placement into LTC homes had under the previous legislation.[3]

In 2012, the Advocacy Centre for the Elderly (ACE) had over 250 requests for assistance relating to discharge from hospital. In the first six months of 2013, this number skyrocketed to 200 such requests! Patients requiring admission to other care settings or requiring additional care in the home are often told that they must comply with hospital or Community Care Access Centre (CCAC) policies. These policies may "require" the patient or substitute decision-maker (SDM) to select possible LTC homes from a "short list" where a bed is or will soon be available. If they do not comply with the policy, the hospital threatens to charge the uninsured daily rate which ranges anywhere from $500.00 to $1,500.00 or more per day. Hospitals may also require the patient/SDM to sign a "contract" indicating that they "agree" with this policy. In fact, no one is required to sign such a contract. More and more frequently, hospitals are blocking LTC home applications and CCAC workers are refusing to take applications from hospital patients, based on their interpretation of hospital policies or Home First/Wait at Home Program requirements.

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[1] This article updates and amalgamates three previous articles prepared by ACE called *First Available Bed Policies & Discharge to a Long-Term Care Home from Hospital*, *The Role of Community Care Access Centres in Admission to Long-Term Care from Hospital* and *Discharge from Hospital to Long-Term Care: Issues in Ontario*.
[2] S.O. 2007, c. 8.
[3] *Charitable Institutions Act*, *Homes for the Aged and Rest Homes Act* and *Nursing Homes Act*.

ADMISSION INTO LONG-TERM CARE HOMES AND DISHARGE POLICIES

Placement into LTC is regulated by the *LTCHA* and its regulations. The placement coordinator from the CCAC must work with the applicant or their SDM, if the person is incapable, to ensure the needs of the person are met. No role in the placement process is given to hospital workers, such as discharge planners or social workers, under the *LTCHA*.

When a hospital patient requires admission to a LTC home, the patient/SDM will complete an application, if it has not already been done in the community. Hopefully, both the hospital and the patient/SDM will agree that this is the best course of action.[4] While awaiting placement to LTC in hospital, the person will be designated by the physician as "Alternate Level of Care" or "ALC." This simply means that the person is in hospital awaiting a different type of care somewhere else that is not presently available.[5]

To determine eligibility and the person's care requirements, an assessment is completed by the hospital CCAC case manager, which includes a "RAI" (Resident Assessment Instrument) application. An evaluation of the person's capacity to make the placement decision will also be completed in order to determine who makes the decision for placement.[6] Once the person is assessed by the CCAC as being eligible for admission to a LTC home,[7] the person will be asked to choose homes to which they wish to apply. A person may choose up to **five** LTC homes.[8] This is the maximum number, unless the person is put in the crisis category waiting list (which is unlikely if they are in hospital). While an applicant/SDM is not required to apply for the maximum number, we encourage people to do so if at all possible when they are awaiting placement from hospital. Hospitals are not appropriate places to stay for great lengths of time when the patient does not require acute care. The applicant/SDM must also act "reasonably" when applying to LTC from hospital as there are other hospital pressures in play.

Hospitals often have policies requiring applicants to make one of the following so-called "choices": accept the first available bed in any LTC home; return home to wait for their home of choice; go to a retirement home to await their home of choice;

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[4] Where the patient or SDM refuses to consent, the process will either be discontinued or one of a number of hearings may be heard pursuant to the *Health Care Consent Act*.
[5] The Ministry of Health and Long-Term Care's standard definition for ALC can be found at https://www.cancercare.on.ca/ocs/alc/.
[6] Until a person is evaluated and found incapable of making a decision, no one else can make a personal care decision for them, even if they have been named as the attorney in a power of attorney for personal care.
[7] If the person is found to be ineligible for long-term care, they may apply to the Health Services Appeal and Review Board for a review of the determination of incapacity: *LTCHA,* s. 43(9).
[8] O. Reg. 79/10, s. 166(1)(d).

or pay the "daily rate" for the hospital bed (also known as the uninsured rate). However, the legislation is clear that this is not legal. In a recent *Toronto Star* article, Sheamus Murphy, Director of Communications for the Minister of Health and Long-Term Care stated: "The primacy of choice and consent" is entrenched in the *LTCHA* and that the government has no plans to remove applicant choice.[9]

Consent for admission into a LTC home is regulated by both the *LTCHA* and Part III of the *Health Care Consent Act*.[10] It is up to the applicant/SDM to choose the homes where they want to apply. Valid consent, as defined in the *LTCHA,* is required prior to placing the person on the waiting list for a home:

> **Elements of consent**
> 46(1) The following are the elements required for consent to admission to a long-term care home:
> 1. The consent must relate to the admission.
> 2. The consent must be informed.
> 3. The consent must be given voluntarily.
> 4. The consent must not be obtained through misrepresentation or fraud.
>
> **Informed consent**
> (2) A consent to admission is informed if, before giving it,
> (a) the person received the information about the matters set out in subsection (3) that a reasonable person in the same circumstances would require in order to make a decision about the admission; and
> (b) the person received responses to his or her requests for additional information about those matters.
>
> **Same**
> (3) The matters referred to in subsection (2) are:
> 1. What the admission entails.
> 2. The expected advantages and disadvantages of the admission.
> 3. Alternatives to the admission.
> 4. The likely consequences of not being admitted.

Where there is an SDM, they are required to comply with specific rules set out in the *Health Care Consent Act:*

> **Principles for giving or refusing consent**
> 42(1) A person who gives or refuses consent on an incapable person's behalf to his or her admission to a care facility shall do so in accordance with the following principles:

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[9] *Toronto Star,* Long-term health care: A look inside the often baffling system (June 21, 2013), http://www.thestar.com/news/insight/2013/06/21/longterm_health_care_a_look_inside_the_oftenbaffling_system.html.

[10] S.O. 1996, c. 2, Sched. A.

1. If the person knows of a wish applicable to the circumstances that the incapable person expressed while capable and after attaining 16 years of age, the person shall give or refuse consent in accordance with the wish.
2. If the person does not know of a wish applicable to the circumstances that the incapable person expressed while capable and after attaining 16 years of age, or if it is impossible to comply with the wish, the person shall act in the incapable person's best interests.

Best interests

(2) In deciding what the incapable person's best interests are, the person who gives or refuses consent on his or her behalf shall take into consideration,

(a) the values and beliefs that the person knows the incapable person held when capable and believes he or she would still act on if capable;

(b) any wishes expressed by the incapable person with respect to admission to a care facility that are not required to be followed under paragraph 1 of subsection (1); and

(c) the following factors:

1. Whether admission to the care facility is likely to,
   i. improve the quality of the incapable person's life,
   ii. prevent the quality of the incapable person's life from deteriorating, or
   iii. reduce the extent to which, or the rate at which, the quality of the incapable person's life is likely to deteriorate.
2. Whether the quality of the incapable person's life is likely to improve, remain the same or deteriorate without admission to the care facility.
3. Whether the benefit the incapable person is expected to obtain from admission to the care facility outweighs the risk of negative consequences to him or her.
4. Whether a course of action that is less restrictive than admission to the care facility is available and is appropriate in the circumstances.

The requirements on SDMs when making choices are restrictive, meaning that they can **only** make their decision in compliance with these principles. This list is exhaustive: neither the *LTCHA* or the *Health Care Consent Act,* or their regulations, allow for any other matters to be taken into consideration by the SDM. There is no mention of hospital policies, the requirements of the acute care system or any other programs in the decision-making process. As the government has chosen not to include any of these policies or considerations in the recently enacted *LTCHA*, it is further evidence that hospitals cannot "override" the legal decision-making process by creating their own policies.

The question then becomes whether the hospital is required to keep the applicant while they wait for their choice of home. Many homes have lengthy waiting lists. Does the hospital have to keep the person until their choice becomes available?

The regulations to the *Public Hospitals Act* require a person to leave the hospital no later than 24 hours after a discharge order has been made. Looking at this provision, it would appear that once a patient no longer requires treatment, they must be discharged from hospital, with the only exception being a 24-hour grace period. However, the reality is that there are many people in hospital who no longer require treatment but who stay until a LTC home bed or other type of accommodation/facility becomes available.[11]

Hospitals rely on this section of the legislation to require people to comply with their internal policies about accepting the first available bed, moving to a retirement home or going home with some assistance from the CCAC. However, we do not believe that this is supportable in law.

First and foremost, one must understand that it is the **attending physician, registered nurse in the extended class, midwife, or dentist who is an oral and maxillofacial surgeon** who discharges, not the hospital. In almost all cases, it would be the attending or "most responsible" physician who must discharge. IF they discharge a patient inappropriately because of a "hospital policy", this could be grounds for a complaint to their College or potential civil litigation.

The regulations to the *Health Insurance Act* specifically contemplate that patients will have to wait in hospital until a LTC bed is available. The government has set a maximum daily fee that can be charged while the person is waiting for placement from hospital; it is the same amount that a resident in basic accommodation at a LTC home can be charged (including any applicable rate reductions).[12] If the regulation was applied equally across the board, it would meant that **everyone** who required LTC or other accommodation/ facility would be discharged within 24 hours of no longer requiring acute care, whether a bed was available or not; this is not the case.

It is also clear in law that both the hospital and the attending physician owe the patient a duty of care, which includes a safe discharge. LTC is part of our health-care system, and as such, the person is entitled to a seamless transition from one level to the next. Keep in mind that it is not the hospital, but the physician, that discharges the patient.

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[11] R.R.O. Reg. 965, s. 16.

[12] R.R.O. Reg. 552, s. 10. The rate is currently $56.14 per day. The provincial government adjusts the rate annually on July 1st.

There is often a disagreement about what a "safe discharge" means. If the hospital/ doctor say that the person must go to a retirement home and either apply for or await LTC placement, is this safe? Retirement homes are, first and foremost, tenancies.[13] They are not equivalent to LTC homes and are not part of the health care system.[14] While many people choose retirement home living for a variety of reasons, one cannot be forced into a retirement home as an alternative to a LTC home. Not only are retirement homes less regulated with no required standards, they are entirely private pay and outside of the public health system.

There is also often disagreement as to what an "acceptable" bed means. Obviously, not every "available" bed is appropriate for every person awaiting placement from hospital. For example, one person may require a bed on a secure unit while another person does not. This is often the crux of the discharge issue – the hospital believes a bed is suitable while the applicant/SDM disagrees.

Placement into homes which are not of a person's choosing can be detrimental to both their physical and mental health. Homes may be located far from families and other support systems, leading to deleterious effects on the person's health, including death. In other cases, there may be available beds because the homes themselves are unsatisfactory in some way.[15] Luckily, both the *LTCHA* and the *Health Care Consent Act* provide that it is up to the applicant/SDM to make the placement decision: nowhere does the law give this role to hospital staff. For this reason, a person cannot be "offered" a bed to which they have not applied, and not taking such a bed can therefore not be deemed a refusal. Beds can only be offered after the applicant/SDM consents to an application being sent to a specified home, the home accepts the application, and the CCAC offers the bed in accordance with the regulations.

Generally, the main issue is whether the choice of LTC homes made by the applicant/SDM is appropriate. Legally, the hospital or CCAC cannot simply disagree and ignore the decision and force the person into a home to which they have not consented. If the patient has been evaluated as being incapable of making the placement decision, the authority to make that decision passes to their SDM. However, this cannot be done merely because the team does not like the decision

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[13] Retirement homes come under the definition of "care homes" which are tenancies under the *Residential Tenancies Act, 2006*, S.O. 2006, c. 7.

[14] The *Retirement Homes Act, 2010*, S.O. 2010, c. 11 has been passed but only certain sections have been enacted. Retirement homes must be licensed and there is a process for reporting of improper treatment, abuse and neglect to the Retirement Home Regulatory Agency. However, their ability to inspect and take action when problems are found is limited.

[15] Applicants/SDMs should always visit the LTC home prior to including it on their waiting list. Inspection reports on homes can be found on the Ministry of Health and Long-Term Care's website – http://www.health.gov.on.ca/en/public/programs/ltc/26_reporting.aspx.

of the person. If it is the decision of the SDM which is determined to be unacceptable, the CCAC (and only the CCAC) may challenge the decision of the SDM by bringing an application to the Consent and Capacity Board alleging that the SDM is not complying with the statutory principles for giving or refusing consent set out in the *Health Care Consent Act.*[16] There is no ability to challenge the decision of the competent person who is not "complying" with "hospital policy" regarding choices.

The only case heard to date on the issue of discharge from hospital to LTC is *Duffy v. OHIP,*[17] arising from an appeal after a denial of OHIP benefits. Mrs. Duffy, a patient at Joseph Brant Memorial Hospital, was awaiting placement into LTC. Although applications for three homes had been submitted, the hospital required that more homes be added.[18] When this was not done, OHIP was advised that the patient had been discharged but remained in hospital. OHIP payments for the bed were discontinued and the hospital began to charge Mrs. Duffy $120 per day for the bed. An appeal was brought before the Health Services Appeal Board by Mrs. Duffy who argued she was entitled to OHIP coverage for the hospital fees. The Board held that the rate being charged by the hospital appeared completely arbitrary and there was insufficient evidence that the appellant or her family had been advised of the discharge policy. In any event, the Board concluded, it was clear that a discharge did not simply mean "to leave the hospital on the day of discharge" as had been argued by OHIP but in fact meant an appropriate placement into LTC. Therefore, the Board ruled in favour of Mrs. Duffy and ordered coverage of the fees by OHIP.

This case does not mean, for example, that an applicant can simply wait in hospital for a specific LTC home where that home has a three-year long waiting list, unless it can be proven that that home is the only one which can meet the person's needs.[19] Applicants and their SDMs must act "reasonably" when making their choices. However, there is no clear definition of what "reasonable" means and it will change in each individual situation. In addition, staying in hospital may is often not in the best interests of the person. Hospitals do not provide the same assistance and social programming as LTC homes. The likelihood of the patient deteriorating while waiting for placement, including loss of mobility and incontinence, are high. Finally, staying in hospital for prolonged periods of time increases the chance of contracting hospital borne infections, such as *MRSA*, *VRE*, and *C. difficile*. One must weigh all of these considerations when making a placement decision.

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[16] *Health Care Consent Act*, s. 54.
[17] Health Services Appeal Board (February 4,1999).
[18] At the time, the legislation did not include a maximum number of homes that could be applied to. The hospital was requesting that 10 homes be included in the application.
[19] An example of this would be an applicant who required peritoneal dialysis, which is only offered at a very limited number of homes in Ontario.

In general, patients in hospital are not eligible for a "crisis" designation which would put them in the highest general waiting list category. A person will be placed in the crisis category "by the placement coordinator if the applicant requires immediate admission as a result of a crisis arising from the applicant's condition or circumstances."[20] Local Health Integration Networks (LHINs) are also now able to designate hospitals as being in "crisis" if the hospital is "experiencing severe capacity pressures."[21] Even when a hospital is designated as being in crisis and ALC patients are moved to the top category of the list, they are not required to take any bed simply because it becomes available or is an "idle bed". The crisis designation means that the person is placed into the crisis category of waiting lists for all the homes that they have chosen. When in the crisis category, applicants/SDMs are no longer limited to five LTC home choices but can choose as many homes as they like.[22] Placement from the crisis category is based upon the applicant's need and not by date they are placed on the wait list as is the rule in other categories. It is up to the placement co-ordinator to determine who will be put into the crisis category and the priority within that list.

It is also important to understand that when on the crisis list, the placement is made as of need, not as of the date on the waiting list. It is therefore quite possible to be "bumped" by someone who was just put onto the list because their needs are greater than your own.

REFUSAL OF ADMISSION TO HOSPITAL DUE TO LONG-TERM CARE CHOICES

Recently, we have been informed that some rehabilitation and complex continuing care hospitals are refusing admission due to the patient's long-term care application choices. Sometimes, rehabilitation or complex continuing care is expected to be a stepping stone into long-term care. But, these hospitals have refused to accept applications on the basis that the patient has not chosen a certain number of homes or a certain number of short-listed homes.

Again, we believe this is illegal. Hospital admission is based only upon need and relevant clinical criteria, not on perceived issues of discharge. We believe such actions are contrary to the requirements of universality and accessibility, as set out in the *Canada Health Act*[23] and the admission provisions of the *Public Hospitals*

[20] O. Reg. 79/10, s. 171(1). Similar wording appears in s. 39 of the *Health Care Consent Act* which states that pertaining to admission, a "crisis means a crisis relating to the condition or circumstances of the person who is to be admitted to the care facility."
[21] O. Reg. 79/10, s. 171(4).
[22] O. Reg. 79/10, ss. 164(4) and 171.
[23] R.S.C., 1985, c. C-6, s. 7.

Act.[24] Hospitals cannot try to do on admission what they cannot do on discharge; that is, force patients to make applications that they do not want.

PLACEMENT FROM HOSPITAL: ISSUES WITH THE CCAC

Under the *LTCHA,* CCAC placement coordinators are delegated specific placement duties which cannot be designated to others (such as hospital social workers or discharge planners). The placement coordinator must determine eligibility when requested and then authorize the admission of the person to the LTC home in accordance with the *LTCHA*. The CCAC must comply with specific rules regarding the eligibility and admission process, including the following:

- If an applicant/SDM requests that the placement coordinator determine eligibility for placement into LTC, the placement coordinator **must** take an application and determine eligibility in accordance with the criteria set out in the regulations.[25]

- The placement coordinator can only authorize admission to LTC homes **which have been selected by the applicant/SDM***.*[26]

- The placement coordinator shall, if requested by the applicant/SDM, assist the person in selecting homes.[27]

- When assisting the person in choosing a home, the placement coordinator is to consider the following criteria: the applicant's preferences relating to admission based on ethnic, spiritual, linguistic, familial and cultural factors.[28]

- The placement coordinator can approve eligibility or authorize admission to a specific nursing home only if the applicant/SDM **specifically applies** for such admission.[29] Therefore, if the applicant/SDM does not consent for the application to go to that home, there is no way the person can be considered for that bed. While there may be an "available" bed in a home which meets specific criteria (i.e., a basic room for a female), the placement coordinator cannot determine its appropriateness unless authorized to do so by the person/SDM.

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[24] R.S.O. 1990, c. P.40, s. 20.
[25] *LTCHA,* s. 43(1) and O. Reg. 79/10, s. 155(1).
[26] *LTCHA*, s. 44(1).
[27] *LTCHA*, s. 44(3).
[28] *LTCHA*, s. 44(4).
[29] *LTCHA*, s. 43.

- "Matching Programs" operated by CCACs, which use data from applications to identify homes which may meet residents' needs, are for information purposes only. There is no requirement that the person either applies or be admitted to a home because they have been "matched."

- If a person has already applied to five homes, their eligibility for admission to another home cannot even be **considered** until the person removes one of their choices from the list.[30] Again, a home can only be removed from the choice sheet with the express consent of the applicant/SDM.

Nothing in the legislation makes the application process any different for patients in hospital than it would be for applicants living in the community, with the exception of applications for interim LTC homes.[31]

Refusal by the CCAC to Determine Eligibility/Take an Application

CCAC staff cannot refuse to take an application to determine eligibility for placement. The legislation is clear that the CCAC placement coordinator **must** take an application and determine eligibility upon request.[32] For example, the CCAC cannot require a person to return home or comply with hospital policies before an application will be accepted.

It is also the obligation of the placement coordinator to ensure that consents is valid, meaning that they comply with the *LTCHA* and the *Health Care Consent Act*. If LTC "choices" are made based upon misinformation, such as applicants/SDMs being told that they **must** choose from a short list or that they **must** choose a specific home, then the consent is not valid and cannot be accepted by the placement coordinator. The placement coordinator must ensure that the rules have been explained to the applicant/SDM and compliance with the law. In fact, where there is an SDM, the placement coordinator has an obligation to advise them of the decision-making rules contained in section 42 of the *Health Care Consent Act*.[33]

Refusal of the CCAC to Accept Choices or Changes

The person/SDM not only has the right to choose the LTC homes to which they want to apply, but they can also amend choices or withdraw consent to this list at any time prior to a bed offer being made. This is important as people may initially

[30] O. Reg. 79/10, s. 166(1)(d).
[31] Interim short-stay beds can only be applied to from hospital. The applicant must be on a wait list for a regular LTC home. The interim bed application is not included as one of their five choices and once the person is admitted, they do not drop in any category on the regular waiting list.
[32] *LTCHA,* s. 43(4).
[33] *M.A. v. Benes*, 1999 CanLII 3807 (ON C.A.).

include certain “choices” because they felt they had no other option due to “hospital policy.” If this occurs, the applicant/SDM should immediately contact the placement coordinator to change their choices. Placement coordinators cannot refuse to make such changes on the basis that it will violate “hospital policy.” They cannot agree to accept the change only if other criteria are met, such as the discharge planner “approving” the change or exchanging one “short list” home for another, as this is also contrary to the legal requirements.

The right to withdraw consent or to change choices is absolute. The law does not allow the placement coordinator to restrict the person’s choices to LTC.

Refusal of the CCAC to Take an Application from Hospital Patients

Some CCACs refuse to take applications to determination eligibility for LTC from hospital patients, or they only accept such applications under strict circumstances. Generally, this is associated with the Ministry of Health and Long-Term Care’s “Aging at Home Strategy.” Under this strategy, hospital patients are encouraged to return home with increased levels of care from the CCAC in the hopes that they can either wait at home until a LTC home bed becomes available or a bed is no longer necessary.

While this program is laudable in theory and may be beneficial to some people, there have been increasing problems in practice. Patients are being told by the hospital and CCAC that they must return home before a LTC application will even be taken. As discussed above, this is contrary to the legislation, which requires that an application be taken and eligibility determined, upon request. The result of these refusals has been that people who cannot be managed at home or who have no home to return to, are being told that they have to leave hospital before they are even allowed to apply. Such rigid policies are not only against the interest of patients, but may be dangerous to those very individuals that the CCAC has an obligation to assist. These policies often only serve to assist hospitals with their bed capacity issues.

“Wait at home” and “home first” strategies or programs are not a universal panacea and are not appropriate for all. Participation in these programs is not mandatory and the person must be provided with all the information necessary to decide whether such a program is right for them in their individual circumstances, have their eligibility determined upon request, and apply to LTC homes in accordance with the legislation. The CCAC cannot require persons to enter these programs by threatening to withhold other types of services.

Requirement of Admission into a Retirement Home

Applicants are more frequently being told that they must go to a retirement home pending placement in a LTC home. As previously mentioned, retirement homes are **not** part of the publicly funded system, nor is the care provided in them presently regulated. While the placement coordinator has an obligation to advise the applicant about other options that the person may wish to consider,[34] there is no obligation on the person to go to a retirement home when they qualify for publicly funded LTC.

Refusal to take an Application and Determine Ineligibility

It is clear that where requested, the placement coordinator **must** take an application for admission and determine eligibility. Placement coordinators cannot simply refuse to take an application because they have pre-determined that the person might be ineligible. If no application is taken, the person's right to apply to have the finding of ineligibility reviewed by the Health Services Appeal and Review Board is negated.[35]

MINISTRY OF HEALTH AND LONG-TERM CARE

In response to the many complaints that it has received regarding the admission process for LTC from hospital, the Ministry of Health and Long-Term Care has sent at least three memos to the LHINs regarding the legality of the process.

Early in 2011, the Erie St. Clair LHIN announced that it was instituting a "first available bed" policy requiring persons waiting for LTC homes in hospital to "accept" the first available bed or be charged the uninsured rate. Ruth Hawkins, Assistant Deputy Minister (Acting), wrote a memorandum to the LHIN CEOs dated February 23, 2011 stating that this was not consistent with the *LTCHA* and hospitals/LHINs were prohibited from making such policies. She further confirmed that the maximum amount that hospitals could charges patients awaiting LTC beds was the maximum co-payment allowed under the regulations to the *Health Insurance Act*, known as the "chronic care co-payment." Ms Hawkins confirmed that LHINs/hospitals could not vary the legislative rules for application and placement onto waiting lists and into LTC homes.

On May 23, 2012, a letter from Rachel Kampus, Assistant Deputy Minister (Acting), clarified that the uninsured rate could only be charged to patients if a bed from one

[34] O. Reg. 79/10, s. 154(1).
[35] *LTCHA*, s. 43(8).

of their legally chosen pre-selected lists of homes was offered and refused. It was necessary to clarify this point as some hospitals had believed that a person could not be charged unless they refused their first choice home. The imposition of the uninsured rate makes sense, as it is expected that a person is only putting homes on their list if they are willing to except them. Refusing to go to one of these homes when offered would be similar to other patients refusing to return to their home in the community.[36]

The most recent memo was sent to the LHIN CEOs from Catherine Brown, Assistant Deputy Minister, on January 9, 2013. This memo was in response to complaints the Ministry had received regarding the "Home First Programs" being operated in many of the LHINs. Ms Brown emphasized that these were not "programs" but a "philosophy," and must comply with the requirements of the *LTCHA* and other legislation. It further stated that patients are able to apply to LTC from hospital, and that such programs were only one of the number of options that a person might have when requiring care upon discharge.

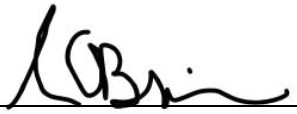
While the Ministry does not directly inspect hospitals, we recommend that complaints regarding hospital policies be sent to the Ministry where they are not in compliance with the law. The Performance Improvement and Compliance Branch of the Ministry does inspect CCACs, however, and complaints can be made through the ACTION Line if CCAC employees are refusing to take applications or not complying with the legislation.[37]

CONCLUSION

The *Long-Term Care Homes Act* clearly sets out the rights of applicants for long-term care, supporting the model of consent and choice of the individual. Neither hospitals nor CCACs have the right under the legislation to make "choices" for the applicant. It is hoped that by having the correct legal information, the applicant/SDM will have the tools to better advocate for their rights.

[36] This only applies where informed consent has been obtained. If the choices were made through misinformation or coercion (e.g., telling the person they "had" to make certain choices), this does not apply.
[37] The Ministry of Health and Long-Term Care toll-free ACTION Line is 1-866-434-0144.

This is **Exhibit "D"** referred to in the Affidavit of **Jane E. Meadus**, affirmed this 11 day of April, 2023, in accordance with O. Reg 431/20, Administering Oath or Declaration Remotely.



A Commissioner for taking Affidavits etc.(*or as may be*) (pursuant to O. Reg 431/20)

Amanda Marie O'Brien, a Commissioner etc. Province of Ontario, for Goldblatt Partners LLP, Barristers & Solicitors
Expires November 15, 2024

Ministry of Health
and Long-Term Care

Assistant Deputy Minister
Health System Accountability
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Ontario

HLTC2980AC-2011-366

MEMORANDUM TO: LHIN CEOs

FROM: Ruth Hawkins
Assistant Deputy Minister (A)
Health System Accountability and Performance Division

DATE: February 23, 2011

RE: Crisis Designation and First Available Bed Policy

The Ministry has been made aware of the Erie St. Clair LHIN's decision to establish "a temporary crisis designation" within Essex County and for local hospitals to reinstate a "first available bed" policy on an ongoing measure. While the ministry understands the pressures faced by the region and the challenges of maintaining hospital bed flow, this situation can only be addressed with policies and practices that comply with legislation, including the *Long-Term Care Homes Act, 2007*, and not at the expense of patient consent and choice.

Hospitals do not have the authority to require applicants waiting for a bed in a long-term care home to take the first available bed because this practice is not consistent with the *Long-Term Care Homes Act, 2007.*

In addition, with respect to hospital co-payments, section 10 of Regulation 552 under the *Health Insurance Act* provides that a hospital patient who requires chronic care and is more or less a permanent resident of a hospital or other institution - including a patient waiting for an available long-term care home bed - may be charged a regulated co-payment of $53.23 per day.

.../2

The attending physician is responsible for determining whether a patient is no longer in need of treatment in the hospital and thus must be discharged. A patient who has been discharged but refuses to leave the hospital may be charged an unregulated amount at the discretion of the hospital. Charges to patients who do not leave the hospital after being discharged in accordance with the *Public Hospitals Act* and its regulations are not regulated or controlled by the Ministry. The hospital can set its own rate (sometimes referred to as the "full daily rate"). However, the Ministry would expect that the hospital would start discharge planning early on and discuss the options with patients and their families. This would include referrals to the CCACs for those patients who may require admission to a LTC home. CCACs would also be expected to work with patients and their families and inform them about the various options available in the community after discharge, including admission to LTC homes.

Patients who have been charged in a manner that does not comply with the applicable legislation should be reimbursed.

Under the *Long-Term Care Homes Act, 2007* (LTCHA) which came into effect July 1st, 2010, all persons seeking admission to a Long-Term Care (LTC) home must contact the Community Care Access Centres (CCAC) in the person's area. As the designated placement co-ordinator, the CCAC is responsible for determining eligibility for admission, priority for admission, monitoring waiting lists and authorizing admissions to LTC homes. Hospitals do not have this authority.

The maximum number of LTC home waiting lists on which an applicant can be placed has increased from three to five (unless the person is in the crisis category on the waiting list.) A hospital cannot choose a LTC home for a person. Before an admission can be authorized by the CCAC, the person (or if the person is incapable, their substitute decision-maker) must provide valid consent to the admission.

The regulations under the LTCHA provide that a person who is applying for admission to a LTC home can be placed in category 1 of the waiting list (crisis category) if the:

1. person is a hospital patient;

2. person requires alternate level of care (ALC);

3. person requires an immediate admission to the LTC home; and

4. LHIN has verified to the CCAC in writing that the hospital is experiencing severe capacity pressures and has set out the period of time for which the verification applies.

.../3

The LHIN determines whether to make the verification and in doing so must take into account consultation with the affected hospital and the CCAC. The CCAC then determines whether each applicant meets the requirements above. Category 1 (crisis) is the highest of the numbered waiting list categories. Persons in this category are ranked in accordance with urgency of need. The crisis category includes persons in the community who require an immediate admission as a result of a crisis arising from their condition or circumstances.

The content of the February 15, 2011 news release from the Erie St. Clair LHIN is not consistent with the provisions set out above. Therefore, the LHIN cannot continue to implement the policies and procedures described in the news release. Neither the hospital nor the LHIN have the authority to override the legislative and regulatory provisions referred to above. Patients, including those waiting for a bed in long-term care homes, must only be charged what is allowed under the law and the admission process for homes must be conducted in accordance with the LTCHA and its regulations.

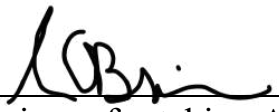
I trust that this clarifies the position of the Ministry and I trust that you will take immediate steps to rectify this situation and bring your policies into compliance.

Thank you for your support and co-operation.

Ruth Hawkins

c: Tom Closson, President and Chief Executive Officer, Ontario Hospital Association
Betty Kuchta, Chief Executive Officer, Erie St Clair CCAC
Sandra Coleman, Chief Executive Officer, South West CCAC
Kevin Mercer, Chief Executive Officer, Waterloo Wellington CCAC
Melody Miles, Chief Executive Officer, Hamilton Niagara Haldimand Brant CCAC
Cathy Hecimovich, Chief Executive Officer, Central West CCAC
Caroline Brereton ,Chief Executive Officer, Mississauga Halton CCAC
Stacey Daub, Chief Executive Officer, Toronto Central CCAC
Cathy Szabo, Chief Executive Officer, Central CCAC
Don Ford, Chief Executive Officer, Central East CCAC
Jackie Redmond, Chief Executive Officer, South East CCAC
Gilles Lanteigne, Chief Executive Officer, Champlain CCAC
Bill Innes, Chief Executive Officer, North Simcoe Muskoka CCAC
Richard Joly, Chief Executive Officer, North East CCAC
Tuija Puiras, Chief Executive Officer, North West CCAC

This is **Exhibit "E"** referred to in the Affidavit of **Jane E. Meadus**, affirmed this 11 day of April, 2023, in accordance with O. Reg 431/20, Administering Oath or Declaration Remotely.



A Commissioner for taking Affidavits etc.(*or as may be*) (pursuant to O. Reg 431/20)

Amanda Marie O'Brien, a Commissioner etc.
Province of Ontario, for Goldblatt Partners LLP, Barristers & Solicitors
Expires November 15, 2024

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Ontario

HLTC2980IT-2012-1012

JAN 0 9 2013

MEMORANDUM TO: LHIN CEOs

FROM: Catherine Brown
Assistant Deputy Minister
Health System Accountability and Performance Division

SUBJECT: The Home First Philosophy

We recognize that LHINs have made great strides towards supporting seniors to live in their homes through initiatives such as the province-wide roll-out of the "Home First" philosophy. This philosophy is shifting the focus to discharging elderly patients to their home after an acute episode in hospital where appropriate, instead of assuming that a long-term care (LTC) home is the only option. We acknowledge the extensive work of the LHINs and their health service providers over the past two years to embrace this philosophy, through cultural and organizational changes. LHINs have expanded community supports so that patients being discharged from hospital have the supports needed to return home in a timely manner, or to return home while awaiting their choice of LTC home.

The ministry continues to receive a number of complaints regarding *the Home First Program*. This memorandum is intended to clarify that Home First is a **philosophy**; it is not a **program** with defined parameters and hours of CCAC services from which one is discharged after a specified period of time.

While hospitals and CCACs may implement a philosophy that home is the best place for the person, the requirements under current legislation/regulation/ policy relating to the provision of hospital and community services still apply.

.../2

The questions and issues raised are related to the following:

Hospital Discharge and Appropriate Discharge Destination

Patients can only be discharged once the attending physician or other attending health care professional has determined that the patient is no longer in need of treatment in the hospital.

The development of the discharge plan with the hospital discharge planner/CCAC case manager must be in collaboration with the patient/family/substitute decision-maker. There are no pre-determined destinations that a patient must accept, such as a retirement home, LTC home or their home.

The Home First philosophy must comply with admission requirements set out in the *Long-Term Care Homes Act, 2007* (LTCHA). While going home with the necessary community supports and taking time to understand the implications of a move to a LTC home provides elderly patients and their families with more time to consider options, this is not a requirement. Patients can apply to a CCAC placement coordinator for admission to a LTC home while in a hospital bed.

The Provision of Community Services and Service Maximums

The community services provided by CCACs are regulated under the *Home Care and Community Services Act, 1994* (HCCSA). Under the HCCSA, the CCAC case manager must assess the needs of the client, determine eligibility and develop a plan of service that sets out the amount of each service to be provided to the client.

The eligibility criteria and service maximum amounts for personal support services provided by CCACs are set out in Regulation 386/99 under the HCCSA. CCACs must comply with these eligibility criteria and service maximums when providing services to all clients, including those being discharged from hospital.

A client is eligible for personal support services provided by a CCAC if the person has an OHIP card, the place where services are to be provided has the necessary physical features to enable the provision of the services and the risk to a service provider of serious physical harm is not significant, or if significant, the service provider can take reasonable steps to reduce the risk. The CCAC does not have the authority to apply more restrictive criteria, such as only providing personal support services to "high risk seniors".

The maximum amount of homemaking and personal support services that can be provided by CCACs in a person's residence is 120 hours, in the first 30 days of service, and 90 hours, in any subsequent 30-day period.

.../3

However, if a CCAC case manager determines as part of a client's assessment that there are extraordinary circumstances that would justify the provision of additional services, the CCAC may provide more than the maximum amount of homemaking and personal support services to a:

- Person who is in the last stages of life (no time limit);
- Person who is currently on a CCAC waiting list for admission to a LTC home (no time limit); or
- Any other person for up to 90 days in any 12-month period.

Key Messages

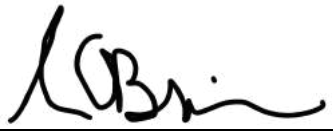
The implementation of the Home First philosophy must comply with the requirements set out in the HCCSA and the LTCHA. Please work with your CCAC to ensure that their services are provided in accordance with these requirements. When implemented correctly, the Home First philosophy will uphold the ministry's commitment to providing appropriate care in the appropriate setting and reduce any further misunderstanding by the public.

Thank you,

Catherine Brown

c. Kathryn McCulloch, Director, LHIN Liaison Branch
Susan Paetkau, Director, Health Policy and Care Standards Branch
Rachel Kampus, Director, Performance Improvement and Compliance Branch

This is **Exhibit "F"** referred to in the Affidavit of **Jane E. Meadus**, affirmed this 11 day of April, 2023, in accordance with O. Reg 431/20, Administering Oath or Declaration Remotely.



A Commissioner for taking Affidavits etc.(*or as may be*) (pursuant to O. Reg 431/20)

Amanda Marie O'Brien, a Commissioner etc. Province of Ontario, for Goldblatt Partners LLP, Barristers & Solicitors
Expires November 15, 2024

WAITING LIST CATEGORIES AND CRITERIA UNDER THE *FIXING LONG-TERM CARE ACT*

1. The following are the general waiting list categories set out in the regulations to the *Fixing Long-Term Care Act, 2021*;
   * Category 1 – Crisis category
   * Category 2 – Spouse/partner reunification
   * Category 2.1 – Former specialized unit and high acuity priority access bed residents
   * Category 3A & 3B – Religious, ethnic or linguistic beds
   * Category 4A & 4B – Other beds

2. In addition, there are the following special categories:
   * Related, temporary, re-opened, and replacement long-term care homes
   * Veterans' priority access beds
   * Exchanges
   * Re-admissions
   * Reunification Priority Access Beds (RPABs)
   * High Acuity Priority Access Beds
   * Direct Access Beds

3. Within each category, there are specific rules regarding the ranking of applicants within the category.

4. A person can be placed in different waiting list categories for different homes. However, you always go to the highest category for which you are eligible for each home.

General Waiting List Categories

Category 1 – Crisis Category[1]

5. The crisis category is for persons who require immediate admission as a result of a crisis arising from the applicant's condition or circumstances. The applicant could be living anywhere, but historically most crisis admissions were persons who were living in the community. Examples of situations which might require the crisis designation could be:

   (1) where the person was living alone which had become unsafe even with homecare services;

   (2) their caregiver was no longer able to provide the necessary care due to their own health or other needs;

   (3) the caregiver could require hospitalization or long-term care themselves; or

   (4) the person had a sudden drastic change in their life, such as their caregiver dying or a fire in the home.

6. Applicants in the crisis category are ranked internally on the basis of urgency, and when equal, would generally be by date. The HCCSS uses a "Crisis Priority Ranking" or similar tool to assess whether the person should be deemed crisis as well as where they would be ranked on the basis of need. In addition, there is always some measure of subjectivity by the HCCSS dependent upon the assessed situation of the applicant.

7. Prior to the COVID-19 pandemic, hospital patients waiting for long-term care would be designated as "Alternate Level of Care" or "ALC" in accordance with the Provincial Definition as set by Cancer Care Ontario.[2] These ALC patients were not

[1] O. Reg. 246/22 s. 188.

[2] Cancer Care Ontario, Alternate Level of Care Reference Guide, Version 2, January 2017, page 13, https://ext.cancercare.on.ca/ext/databook/db2021/documents/Appendix/ALC_Reference_Manual_v2.pdf

placed onto the crisis list. Instead, they were placed into the 3A or 4A categories (see below), unless they qualified for a different category.

8. The exception, which continues to exist under the current regulations, was that if a hospital was experiencing severe capacity pressures, the Agency (currently as identified as Ontario Health in s. 3 of the *Connecting Care Act, 2019* but was previously by the LHIN), in consultation with the hospital and the appropriate placement co-ordinator, could verify those pressures and authorize in writing to the placement co-ordinator that the patients in that hospital waiting for admission for long-term care would be placed on the crisis list for a specified period of time. This did not change the choices of the applicants, it merely moved them into the crisis category of waiting lists if they were not already in a higher category.

9. During the COVID-19 pandemic, amendments were made to the regulations to the *Long-Term Care Homes Act, 2007 ("LTCHA")*, which put all ALC patients awaiting long-term care onto the crisis list. These amendments were incorporated into the *FLTCA* regulations which came into effect on April 11, 2022. However, the regulation requiring all ALC patients to be designated crisis was to be repealed on October 11, 2022, reverting ALC patients back to being assessed for waiting list categories the same as those in the community, with most being either a 3A or 4A category. However, the regulations that accompanied Bill 7 changed that, and the special ALC crisis designation was no longer to be repealed. This means that all hospital ALC patients waiting for long-term care admission are now placed in category 1 (crisis) unless they qualify for a higher category.[3]

[3] O. Reg. 484/22, s.2; O. Reg. 246/22 s. 240.3(2).

Category 2 – Spouse/Partner Reunification[4]

10. The Spouse/Partner Reunification category recognizes the importance of spouses/partners living together. First, the applicant must meet the definition of spouse (including common-law), or partner. Partner is defined as a person who they lived with for at least one year and who have a close personal relationship that is of primary importance to both person's lives.[5] This could be parent and child, siblings, friends or have other relationships that meet this definition. One spouse/ partner must already be living in that home, and the applicant would be placed in Category 2 only for the home that the spouse/partner already resides in. The applicant must also meet all the regular criteria of a person requiring admission to a long-term care home but not be crisis. Bed offers in this category would not guarantee that the spouse/partner was admitted to the same or area of the home; however, once admitted they could request an internal transfer to be closer to or share a room.

Category 2.1 – Former specialized unit and high acuity priority access bed residents[6]

11. This category allows for persons who are in specialized units such as behavioural units or who had high care needs and were admitted through that program to be transferred quickly to a regular bed in their preferred home. There are only a few homes with specialized units or high acuity priority access beds, so people agree to go to them for the specialized care even if the home would not otherwise be on their preferred list, on the understanding that they will get a higher priority for moving to a home from their preferred list once they know longer require the specialized care.

[4] O. Reg. 246/22 s. 189.
[5] O. Reg. 246/22 s. 170.
[6] O. Reg. 246/22 s. 190.

Category 3 – Religious, ethnic or linguistic origin[7]

12. Applicants self-identify their religious, ethnic or linguistic origin. If they apply to a home or unit that is primarily engaged in serving the needs and interests of persons who identify as that religious, ethnic or linguistic group, the person will be placed in category 3 unless they quality for a higher category. (Under the regulations, religion, ethnic or linguistic origins are not a consideration in any of the higher level categories.) Within this Category there are two sub-categories, 3A[8] and 3B[9].

13. To be placed in Category 3A, you need not only to meet the criteria above, but you must also:
    1) not currently be a resident in a long-term care home and you must require or are receiving high services levels from homecare;
    2) currently be ALC in a hospital bed;
    3) be in a long-term care home seeking to transfer to your first choice long-term care home; or
    4) be in a short-stay program seeking to transfer to the long-stay program in that home.

14. Historically, the vast majority of both community and ALC patients who met the religious, ethnic or linguistic origin would be placed into this category. The placement from this category is based on the date of the application, plus the type of bed (basic, semi-private, private), and the sex of the applicant. One would also be in this category if they had been placed into a different home already but the religious, ethnic or linguistic home remained on their list as their first choice.

[7] O. Reg. 246/22 s. 191.
[8] O. Reg. 246/22 s. 191(2).
[9] O. Reg. 246/22 s. 191(3).

15. Applicants would be placed into Category 3B do not meet the criteria of Category 3A. The most common examples would be:
    1) a person who is already in another home and is waiting for placement into a religious, ethnic, linguistic home that is not their first choice; and
    2) an applicant whose spouse is living in the religious, ethnic or linguistic home and wishes to live with their spouse.

    Spouses/partners qualify for admission if they are at least 18 years old and have an OHIP card even if they have no care needs of their own, although in recent years it has been extremely rare for anyone to be placed into a long-term care home on this basis.

Category 4 – Other[10]

16. If an applicant does not meet the criteria of any other admission category, they would be placed into this category. As with Category 3, it is split into 4A[11] and 4B[12].

17. To be placed in Category 4A, similar rules apply. You must:
    1) Not currently be a resident in a long-term care home and you must require or are receiving high services levels from homecare;
    2) Currently be ALC in a hospital bed;
    3) Be in a long-term care home seeking to transfer to your first choice long-term care home; or
    4) Be in a short-stay program seeking to transfer to the long-stay program in that home

[10] O. Reg. 246/22 s. 192.
[11] O. Reg. 246/22 s. 192(2).
[12] O. Reg. 246/22 s. 192(3).

18. Prior to the pandemic, the majority of people waiting in the community or who were ALC in hospital would be placed in the 4A category. People who applied for met all the criteria under 3A for admission to a religious, ethnic or linguistic home but did not identify themselves as belonging to the specified group would be in category 4A. Again, placement from this category is based on the date of the application, plus the type of bed (basic, semi-private, private), and the sex of the applicant. One would also be in this category if they had been placed into a different home already but another home was their first choice.

19. Applicants would be placed into Category 4B who do not meet the criteria of any other category. The most common examples would be:
    1) a person who is already in another home and is waiting for placement into a home that is not their first choice; and
    2) an applicant whose spouse is living in the home and wishes to live with their spouse.

    Spouses/partners qualify for admission if they are at least 18 years old and have an OHIP card even if they have no care needs of their own, although in recent years it has been extremely rare for anyone to be placed into a long-term care home on this basis.

Specialized Waiting List Categories

20. There are numerous specialized categories that are less well known to the public. Even though applicants may have qualified for these categories, it has been our experience that applicants may not have been advised of these categories or placed in despite qualifying. We often are the first to suggest that applicants might qualify for these categories which may give them a higher chance at moving, and advise them to speak to their placement co-ordinators about them or advocate for their placement on these other lists.

Related, temporary, re-opened and replacement home categories[13]

21. These are for situations specific to the home, where a home might be closed and the resident is being placed temporarily in a different home; where the home was temporarily closed and the residents were placed elsewhere and are going back into the reopened home; or where the home was closed and there is a new facility replacing the old one and the residents are being admitted into that home. Reasons for these home-specific issues are issues such as closures due to upgrading or rebuilding to new standards; or disasters such as floods or fires where residents must be displaced temporarily. These categories allow the original residents to be moved quickly.

Veterans' priority access beds[14]

22. While there are some specialized units in homes that have separate waiting lists, other homes may also have a few spots designated for veterans. These beds are generally virtual, meaning that they are not in a specific bed or unit. The veterans must apply for these beds and will be given preference over any other applicant.

Exchanges[15]

23. Applicants in specified health care institutions, including ones under the *Public Hospitals Act* as well as long-term care homes, can apply to be put on a long-term care home exchange list. There are two ways that this can be done:
    1) if the long-term care home has an agreement with the other facility and the exchange is to meet the specialized requirements of the exchanged resident or patient, or
    2) if there are residents in two different homes who each seek admission to the other home, they can be put on the exchange list.

[13] O. Reg. 246/22 s. 196-198.
[14] O. Reg. 246/22 s. 193.
[15] O. Reg. 246/22 s. 194.

Consent of the applicant is required for these exchanges, and cannot be used as a way to get around discharge rules.

Readmissions[16]

24. Under the *FLTCA*, residents who are in hospital must be discharged from their long term care home if they are in hospital for longer than 30 days for a medical admission, or over 60 days for a psychiatric admission.[17] When the person is ready to be discharged from hospital, their eligibility and requirements will be reassessed by the HCCSS and they can reapply for the home that they were discharged from. If the home they were discharged from accepts them, they will be placed on the readmission category only for the home that they had been discharged from.

25. An exception to this is the case of a resident who had been admitted to a specialized unit or high acuity priority access bed from another home but no longer needed to be admitted to that specialized unit or high acuity priority access bed. In that case they would be able to apply for readmission to the originating home. Applicants who were in a specialized unit or high acuity priority access bed and were discharged into the regular part of the home once they no longer required that type of bed can apply to return to the originating home and would be placed on the readmission list.

    There is no legal requirement that the patient return to the originating home and it is not uncommon for patients to not want to return to that home if they felt that their hospitalisation was related to poor care in the home. Just as in any other case, these applicants can apply to any home but would not be in the readmission category for them.

[16] O. Reg. 246/22 s. 195.
[17] O. Reg. 246/22 s. (150)(2)(a)&(b).

Reunification Priority Access Beds (RPABS)[18]

26. Every home is allowed to have two beds designated as "reunification priority access beds", commonly referred to as "RPABs". RPABS are virtual beds which can be any bed in the home, but only two persons at a time can be designated as being in one. To go onto the RPAB waiting list, the applicant's spouse/partner as defined under the *FLTCA* must already reside in that home and the applicant must otherwise qualify to be in Category 1 – Crisis.

27. Originally, the RPABs continued to be designated as such even if the resident's spouse/partner moved to another home, was discharged, or passed away. However, the regulations associated with Bill 7 have changed this and now when the spouse/partner of the person in the RPAB is discharged, the remaining spouse/partner is no longer deemed to be occupying the RPAB.[19]

High Acuity Priority Access Beds (HPABs)[20]

28. High Acuity Priority Access Beds (HPABs) were introduced by regulation on August 29, 2019[21] in order to reduce hallway medicine and to assist the placement of hard to serve applicants. These barriers could include high acuity needs of applicants, their financial circumstances and access to appropriate accommodation. These beds were available only in select long-term care homes. These beds were all in private rooms, but were deemed basic accommodation for the resident. This gave priority access was given to those applicants, and was created specifically to facilitate timely placement of those hard to serve applicants in hospitals. Homes received top-up funding from the Ministry of Long-Term Care for cost difference between basic and private for these beds.

29. The person can only be put in the waiting list for HPAB if they are:

[18] O. Reg. 246/22 s. 226-228.
[19] O. Reg. 484/22 s. 1(2).
[20] O. Reg. 246/22 s. 229-234.
[21] O. Reg. 295/19.

1) at significant risk of avoidable admission to a hospital under the *Public Hospitals Act* or a private hospital licensed under *the Private Hospitals Act* or to a psychiatric facility within the meaning of the *Mental Health Act* that is required to provide in-patient services in accordance with that Act;
2) occupying a bed in a hospital under the *Public Hospitals Act* or a private hospital licensed under the *Private Hospitals Act* or a psychiatric facility within the meaning of the *Mental Health Act* that is required to provide in-patient services in accordance with that Act and requires an alternate level of care, or
3) a long-stay resident in a long-term care home;

and they are determined to be eligible for admission to a long-term care home under the *FLTCA* and the placement co-ordinator is satisfied that based on the assessment and information provided, that the person requires and is likely to benefit from:

1. ongoing nursing and other personal care given by or under the supervision of a registered nurse or a registered practical nurse who has relevant expertise, whether as the result of experience or training, or
2. ongoing technology-based care that requires the support of a member of a college as defined under the *Regulated Health Professions Act*, *1991*.[22]

30. Applicants whose only issue was "responsive behaviours" were not entitled to be placed on the waiting list for HPABS.[23] Responsive behaviours are defined as behaviours related to unmet needs of the person, whether cognitive, physical, emotional, social, environmental or other, or whose behaviours are in response to circumstances in a social or physical environment that they may find frustrating, frightening or confusing.[24]

31. Once a resident no longer required to be in an HPAB, they would be moved into a regular bed in that home, or could apply to be readmitted to the long-term care home they had been in immediately prior to their transfer to the HPAB.

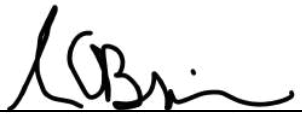
[22] O. Reg. 246/22 s. 230 (3).
[23] O. Reg. 246/22 s. 230(4).
[24] O. Reg. 246/22 s. 1.

Direct Access Beds[25]

32. Direct Access Beds were created during the pandemic[26] and are specially designated by the Minister of Long-Term Care under such terms and conditions as the Minister of Long-Term Care specifies. The person would have to require immediate admission to a long-term care home and be eligible for admission. Further, the person would be required to be an ALC patient in a hospital designated by the Minister of Long-Term Care. Although it was entrenched in the regulations, the only designation of Direct Access Beds we are aware of was an 18-bed pilot project at North York General Hospital and Seniors Health Centre commencing in July 2020.

[25] O. Reg. 246/22 s. 235-238.
[26] O. Reg. 361/20.

This is **Exhibit "G"** referred to in the Affidavit of **Jane E. Meadus**, affirmed this 11 day of April, 2023, in accordance with O. Reg 431/20, Administering Oath or Declaration Remotely.



A Commissioner for taking Affidavits etc.(*or as may be*) (pursuant to O. Reg 431/20)

Amanda Marie O'Brien, a Commissioner etc. Province of Ontario, for Goldblatt Partners LLP, Barristers & Solicitors
~~Expires November 15, 2024~~

REGULATORY AND OTHER CHANGES TO LONG-TERM CARE HOME ADMISSIONS UNDER THE *LONG-TERM CARE HOMES ACT, 2007* DURING COVID-19 PANDEMIC

1. On March 24, 2020, O. Reg. 82/20 was filed and came into force. This was the first regulation which changed the placement process under the *Long-Term Care Homes Act,* 2007 ("LTCHA") in reaction to the COVID-19 pandemic. The goal was to move people into long-term care homes as quickly as possible to free-up hospital beds for the expected COVID-19 patients. This regulation allowed the placement co-ordinator to make their determination of eligibility on the best information available at that time, and also allowed them to choose long-term care homes on behalf of the applicant. However, the placement co-ordinator could not authorize the admission without the consent of the applicant or their substitute decision-maker.[1]

2. The regulation also stated that once the pandemic pressure was resolved, anyone who was admitted under s. 208.2 would be deemed eligible for admission to homes that they had selected. In addition, some of the information requirements were waived, and the applicant and would be made a crisis for their top choice home.[2]

3. On April 23, 2021, O. Reg. 311/21 came into force. This was again aimed at moving ALC patients requiring long-term care out of hospitals and into long-term care homes that may not have been their first choice. Pursuant to this regulation, anyone admitted on or after April 23, 2021 to a home that was not their first choice pursuant to O. Reg. 79/10 would not have to pay the accommodation fee until they either moved to their first choice home, were in a home for 30 days without having chosen another home as their first choice, or they turned down an offer of their first choice bed.[3] Anyone who was exempted from payment under this regulation continues to be exempted if they were admitted prior to O. Reg. 246/22

[1] O. Reg. 79/10 s. 208.2.
[2] O. Reg. 79/10 s. 208.3.
[3] O. Reg. 79/10 s. 247.4.1.

coming into force on April 11, 2022.[4] This was made clear in December 2021, when a regulation was published clarifying that the fee waiver would not be authorized after the new act came into force.[5]

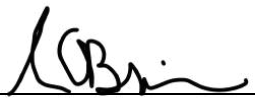
4. Placement from hospital to long-term care homes was also affected by various directives during the height of the pandemic. Directive #3 was the main directive issued by the Chief Medical Officer of Health under s. 77.7 of the *Health Protection and Promotion Act (HPPA)* related to long-term care homes. This legislation allowed the Chief Medical Officer of Health to issue precautions and procedures through directives to health care providers to protect the health of Ontarians. Directive #3 was specific to long-term care homes and retirement homes, and included directives regarding admission to long-term care homes about the admission process. Directive #3 was first issued on March 22, 2020 and was amended numerous times over the more than two years it was in place, until it was revoked on June 11, 2022.

5. During this time, the rules regarding admission contained in Directive #3 were ever-changing, depending on how the pandemic was affecting the general population at the time, the number of patients in hospital, the affect of the pandemic on long-term care home residents, and other factors. It was difficult to keep up with the rules given the frequency of the release of new versions of Directive #3.

6. Later in the pandemic, Directive #3 became less prescriptive regarding hospital discharge and admission to long-term care homes, as various Ministry of Health and Ministry of Long-Term Care Directives of Guidance Documents were put into place. These documents also contained direction regarding hospital discharge and admission to long-term care homes.

[4] O. Reg. 246/22 s. 296.
[5] O. Reg. 860/21.

This is **Exhibit "H"** referred to in the Affidavit of **Jane E. Meadus**, affirmed this 11 day of April, 2023, in accordance with O. Reg 431/20, Administering Oath or Declaration Remotely. .



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Expires November 15, 2024

Ontario's Long-Term Care COVID-19 Commission

Final Report

April 30, 2021

The Honourable Frank N. Marrocco, Chair
Angela Coke, Commissioner
Dr. Jack Kitts, Commissioner

Ontario's Long-Term Care COVID-19 Commission: Final Report
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COVID-19 Long-Term Care Commission

Final Report

In sharing this report, the Commission acknowledges that we have conducted our investigation on the traditional territories of Indigenous Peoples who have inhabited this land since time immemorial. Our recognition and respect for Indigenous Peoples as well as their traditional knowledge and lands guides our commitment towards reconciliation as we strive to collectively shape and strengthen Ontario.

ACKNOWLEDGMENT

Ontario’s Long-Term Care COVID-19 Commission

April 2021

Acknowledging everyone's contribution to this report requires so much more than simply reciting their names and attaching a perfunctory thank you.

The residents, their family members, loved ones, and long-term care staff who met with the Commissioners provided a first-hand oral history of the loneliness, anguish, and fear that, for them, forever marked this time in Ontario's history. Their willingness to relive their experiences humanizes the dry world of policies, directives, and statistics. The Commissioners were indelibly marked by what we heard.

It is not easy to describe what the Commission had to do to carry out its mandate, but perhaps a little information will help set the context.

The province appointed the Commissioners on July 29, 2020. The Terms of Reference creating the Commission required the Commissioners to deliver a final report no later than April 30, 2021. Between those dates, the Commissioners interviewed more than 700 individuals during more than 170 formal sessions. There are over 15,000 pages of transcripts of these meetings. Also, the Commission held confidential interviews, particularly with families and staff. The Chief Medical Officer of Health, the Minister of Health, and Minister of Long-Term Care met with the Commission the last week of February. On the eve of their meetings with the Commission, the province produced 211,000 documents and personal notes of each of these witnesses. We received and reviewed some 300 written submissions. Finally, we wrote a report of more than 300 pages delivered to the Minister of Long-Term Care on April 30, 2021.

To say that we received the total and unconditional commitment of everyone associated with the Commission to the completion of its work is simply a statement of the obvious.

Our public and private sectors combined to provide the Commission with the support it required. The volume of work was such that it is not possible to define what each group did neatly. However, we can say with certainty that every word in this report reflects the combination of both sectors' skills and their uniform resolve to meaningfully contribute to an overdue fundamental reform of how vulnerable members of our community finish out their days.

John Callaghan of Gowling WLG and Kate McGrann of Crawley MacKewn Brush led the legal side as co-lead counsel. Mr. Callaghan spent a significant time over the years on public inquiry work, including the Walkerton and Cornwall Inquiries. Ms. McGrann was recently lead counsel at the Collingwood Inquiry. Their leadership, work ethic, and commitment set an outstanding example. Also, they contributed their considerable practical experience with public inquiries, the value of which cannot be overstated.

Assistant Deputy Minister Alison Drummond led the Secretariat. When the province first created the Commission on July 29, there was, as you would expect, no infrastructure in place to support it. Ms. Drummond assembled from the Ontario Public Service an experienced, dedicated Secretariat staff.

An investigation like ours with a devilishly short timeline has many legal parts. Keeping all that moving in our case would not have been possible without K Lynn Mahoney, a senior member of the Gowling WLG Toronto Advocacy Group. Ms. Mahoney has acted as counsel to extensive public inquiries and high-profile independent reviews commissioned by the federal and Ontario provincial governments. Ms. Mahoney was an essential part of all aspects of the investigation, including leading evidence, preparing witnesses, and participating in all aspects of creating the Commission's report.

Of course, senior counsel could and did not carry out the required work necessary to prepare this report alone. We acknowledge an inestimable debt to Amanda Byrd, Max Libman, Patricia Brooks, Michael Finley, Peter Gross, Jennifer King, Jessica Boily, Magdalena Hanebach, Kavi Sivasothy, and Val Pelchat, all members of the bar who carried out their roles with professionalism and dedication. The hours worked preparing witnesses, preparing briefing notes, researching solutions to the legal problems presented, leading evidence, and assisting in drafting the report were extreme by any standards.

The Secretariat consisted of two Directors: Derek Lett, Director of Policy, and Dawn Palin Rokosh, Director of Operations. Mr. Lett not only contributed his considerable experience in the area of policy but oversaw the considerable drafting efforts of Secretariat staff to support the development of constructive policy recommendations. Ms. Palin Rokosh ensured the efficient functioning of the Commission. She also organized and contributed to Commission meetings with long-term care residents, family members, and staff working in long-term care homes. Also, Ms. Palin Rokosh and Mr. Alain Daoust made sure that we could interview and otherwise correctly communicate with these groups and anyone else in French.

The Ontario Public Service also contributed the experience and efforts of Ida Bianchi, a senior counsel with the Ministry of the Attorney General. Ms. Bianchi has considerable experience with commissions of inquiry, namely the Motherisk Commission and the Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System. Ms. Bianchi prepared witnesses, led evidence, facilitated meetings with residents, their families, and staff, and assisted in drafting portions of the report.

Jessica Franklin, Angela Walwyn, Adriana Diaz Choconta, Rose Bianchini, Angeline Hawthorn, Sanjay Bahal, and Alain Daoust provided capable, competent, and continuous support for Mr. Lett and Ms. Palin Rokosh.

Ms. Carla Novakovic and Ms. Lisa Di Felice, both also from the Ontario Public Service, provided critical and experienced administrative support.

Finally, the Commissioners acknowledge with thanks Mr. Peter Rehak, our Director of Communications. As he has for countless commissions, Mr. Rehak ensured that our Commission was transparent and that our message and motive were understood by those reporting on it.

All Commissioners thank them, one and all, for their professionalism, commitment to the Commission and its mission, and their outstanding work ethic.

Our genuine hope is that our report and its recommendations are a proper reflection of their excellent work.

Executive Summary

> To care for those who once cared for us is one of the highest honours.
>
> –Tia Walker, author

In late 2019, a novel coronavirus emerged in Wuhan, China. It quickly spread around the globe. In March 2020, the World Health Organization declared the virus that came to be known as COVID-19 a pandemic. Life in Canada, as in most countries, ground to a halt. As COVID-19 took hold through the spring of 2020, it ravaged the elderly, particularly those in congregate settings such as long-term care homes. By late spring, it was apparent that the infection and death rates in Ontario's long-term care homes were among the worst in the world. Of all COVID-19 deaths in Ontario in 2020, 61 per cent were long-term care residents. By the end of April 2021, 11 staff and almost 4,000 residents in Ontario's long-term care homes had died.

As the rate of infections and deaths in long-term care mounted, a horrified public demanded answers: How – in a wealthy province like Ontario, with a sophisticated health and social welfare system – were the elderly dying at such alarming rates?

The provincial government created the Long-Term Care COVID-19 Commission in the summer of 2020, as the first wave of the pandemic eased, to investigate the cause of the spread of the virus in long-term care and how it affected residents, staff, volunteers and family members. The Commission's purpose was to shine a spotlight on this tragedy, to determine its causes and to make recommendations to help prevent the future spread of disease in long-term care homes.

That spotlight revealed that Ontario was not prepared for a pandemic and that the province's long-term care homes, which had been neglected for decades by successive governments, were easy targets for uncontrolled outbreaks. Staff, long-term care residents and their families suffered terribly during this pandemic. Residents and long-term care staff who lost their lives to COVID-19 paid the ultimate price.

The province's lack of pandemic preparedness and the poor state of the long-term care sector were apparent for many years to policymakers, advocates and anyone else who wished to see. Ontario's policymakers and leaders failed during those years to take sufficient action, despite repeated calls for reform. Rather, the commitment and resources needed to prepare for a pandemic and address long-neglected problems with

long-term care were shunted aside in favour of more pressing policies and fiscal priorities. Many Ontarians took little or no notice until there was a parade of sickness and death in long-term care homes.

In 2003, Ontario was hit hard by an outbreak of Severe Acute Respiratory Syndrome (SARS). After SARS, several reports were prepared outlining what needed to be done to ready the province for a pandemic. All warned of dire consequences if the province failed to take these actions. For a time, those warnings were heeded. In the years following SARS, the province made influenza pandemic plans, created a stockpile of emergency supplies and began earnest preparations.

As the years progressed, however, pandemic preparedness ceased to be a priority; instead, it gave way to the “tyranny of the urgent.” Public health scares such as H1N1 and Ebola resulted in passing attention being paid to emergency readiness, but there was no lasting resolve to ensure the province was ready for a pandemic. By the time COVID-19 arrived, successive governments had allowed 90 per cent of the province’s stockpile of personal protective equipment (PPE) to expire and be destroyed, without replacement. There was no comprehensive plan to address a pandemic.

Worse yet, there was no plan to protect residents in long-term care.

Pre-pandemic, there had been numerous warnings that Ontario’s long-term care sector needed a significant overhaul. The infrastructure in many of the homes was outdated and not up to current standards. Containing a virus in such a setting would prove to be difficult.

In addition, the long-term care workforce was stretched to the limit long before COVID-19 struck. Several reports had called for additional staff to care for a population that suffered from more dementia and other complex medical issues than in prior generations. And yet, there was no plan to provide a surge of workers to replace those who inevitably could not or would not come to work in a pandemic. In most of the homes badly hit by COVID-19, the staffing collapsed. There were too few staff to take care of the residents. Those who continued to work were overwhelmed and overworked.

Adding to this already tenuous situation, much of the workforce lacked crucial training in infectious disease prevention and control and was also missing the leadership needed to guide them through these difficult times. In spite of the heroic efforts of those staff who remained on the front lines, long-term care residents continued to get sick and die.

Sadly, the second wave of the pandemic was more deadly than the first in Ontario’s long-term care homes. The story of how this province failed to protect its most vulnerable residents during the second wave is still unfolding. It is clear, though, that

problems such as insufficient staff, lack of training and aging home infrastructure were too deeply ingrained to overcome in the period between the first and second waves. It is plain and obvious that Ontario must develop, implement and sustain long-term solutions for taking care of its elderly and preparing for a future pandemic.

The balance of this summary will explain how this investigation was conducted and the major issues it identified as having contributed to the suffering and death experienced in Ontario's long-term care homes. It is the Commission's hope that Ontario's policymakers and leaders will – this time – heed the warnings.

Overview of the Investigation

The Commission conducted its investigation during the second wave of the pandemic, from September 2020 to March 2021. Despite the hard-earned lessons of the first wave, COVID-19 continued to batter long-term care homes during this time. The Commission heard from many stakeholders, including those on the front lines of the outbreak. These included families, residents, staff, hospitals, long-term care home licensees and operators, public health units, inspectors, experts, researchers, government officials, associations, advocacy groups, and others. In just over six months, the Commission heard from more than 700 people.

Because the investigation was conducted during the pandemic, the Commission received information in real time. As the issues confronting long-term care became clearer, the Commission issued two sets of interim recommendations. Consistent with its Terms of Reference, the Commission has not made any findings of fact with respect to civil or criminal responsibility of any person or organization.

It is important to specifically acknowledge the heart-wrenching stories that many residents, families and staff shared with the Commission. They suffered terrible trauma and yet were still willing, courageously, to tell their stories, allowing the Commission a glimpse of what it was like to live through this experience. People have suffered immeasurable loss. The Commission learned a great deal from these accounts. It is hoped that in sharing their experiences and their voices, those who came forward will help to spare others in the next pandemic.

Beyond thanking the surviving residents, residents' family members and staff for reliving these painful events, it is now up to the province to do something about the problems these people described to the Commission. The resolve to act on this Commission's recommendations cannot fail or falter with the passing of the next news cycle or economic downturn.

Many of the lessons of SARS were forgotten. We cannot forget the lessons learned from this pandemic.

The Commission makes its recommendations with the singular purpose of protecting long-term care residents, staff and their loved ones in the years to come.

Another pandemic should be expected. Next time, Ontario must be ready.

Overview of the Report

This report focuses on the actions and inactions that significantly contributed to the devastation experienced in long-term care during the COVID-19 pandemic.

The report strives to give readers an understanding of the state of the long-term care sector and pandemic preparedness before COVID-19. These topics are addressed in chapters 1 and 2. Chapter 3 addresses the response to the pandemic and some, but not all, of the successes and failures on this front. Chapter 4 looks at promising developments in long-term care. Ontario is fortunate to have many academics, advocates and providers who are continually developing new strategies to improve the well-being of the province's elderly and long-term care residents. Chapter 5 contains the Commission's recommendations. The appendices at the end of the report provide a primer that outlines the roles and responsibilities of key players in Ontario's health and long-term care sectors, and a brief review of the Commission's investigation process. They also include the Commission's interim recommendations.

Long-Term Care before COVID-19

When she appeared before the Commission, the Minister of Long-Term Care, Dr. Merrilee Fullerton, used the term "neglected" to describe the long-term care sector and its population. Her description also applies to the attitude taken toward this population by successive governments that were unwilling to tackle complex and costly problems. Many of the challenges that had festered in the long-term care sector for decades – chronic underfunding, severe staffing shortages, outdated infrastructure and poor oversight – contributed to deadly consequences for Ontario's most vulnerable citizens during the pandemic.

Ontario's legislative promise to long-term care residents is to provide residences that are "a safe, comfortable, home-like environment" that support "a high quality of life." Where legislated standards are not met – or the safety, security or rights of residents are compromised – the legislation further mandates that corrective action be taken. In order to ensure that the needs and safety of residents are being met, collaboration and

mutual respect among the residents, their families, long-term care providers, caregivers, government, staff and others are essential.

The challenge of meeting residents' needs and ensuring their safety has increased over the last 20-plus years. As mentioned above, the health needs of residents in Ontario's long-term care homes have become increasingly complex. With the present funding model, it has become difficult to provide the required level of care. This more medically complex population is susceptible to infectious diseases such as influenza, and outbreaks are common in long-term care homes. At the same time, the demand for long-term care has continued to grow along with the province's aging population, resulting in pressure to quickly expand an overtaxed system.

Staffing at long-term care homes has long been recognized as a significant problem. Constant shortages, excessive workloads, high turnover rates and heavy reliance on part-time workers are common in the sector. This is difficult work and it is largely done by women, with a very high representation of racialized, immigrant women in personal support worker (PSW) roles. The province has received multiple reports that clearly set out the staffing shortfalls and the solutions required, yet few changes have been made.

The system of funding, management and oversight in the long-term care sector compounds these problems. Long-term care in Ontario is funded by the provincial government, with contributions from those residents who have the means to do so. While the government has ultimate oversight responsibility for the sector, it does not deliver long-term care services. Instead, it relies on municipal, not-for-profit and for-profit providers to supply care services to the legislation's standards and requirements.

With an aging population and inadequate infrastructure, the demands for long-term care spaces and staff will increase significantly in the years to come. Years of neglect of long-term care have magnified this challenge. From 2011 to 2018, the population of those over 75 increased by 20 per cent (from 876,886 to 1,053,097). However, there was only a 0.8 per cent increase in the supply of long-term care beds – a net gain of 611 beds. There are now more than 38,000 Ontarians on the waitlist for long-term care beds. In this report, the term "bed" is used as shorthand to describe a space in a long-term care home and encompasses all aspects of care provided to a long-term care resident.

If Ontario continues to care for its seniors as it does currently, by some credible estimates the province will require an additional 96,000 to 115,000 long-term care beds by 2041 to accommodate the increased demand. While other solutions need to be explored, including better home care support, it is clear that more and newer beds will need to be built.

While the Commission repeatedly heard that COVID-19 has seriously undermined the reputation of for-profit homes, the need for tens of thousands of new and redeveloped beds will require significant capital. The substantial investment required to build new beds and redevelop old beds will amount to billions of dollars. The private sector has available capital for this task. There is, however, no reason that the accommodation and care of residents need to be handled by the same entity that creates or redevelops the beds.

Currently, there are not-for-profit, for-profit, and municipal homes. The characterization of homes based on their tax status is not helpful. It is more pertinent to consider if the owner is involved in long-term care as part of its mission or in order to profit. Some owners whose tax status is for-profit operate as mission-driven entities. Others have shareholders and owners whose motive is profit.

For example, in some cases, for-profit homes are owned by investment vehicles such as Real Estate Investment Trusts (REITs). While the REIT holds the licence and, therefore, the legal responsibility for the residents' care, it hires a separate company to run its long-term care home and provide that care.

This may be an excellent financial arrangement for the investors, but it is more difficult to understand why it is a suitable arrangement for resident care. Care should be the sole focus of the entities responsible for long-term care homes. Mission-driven entities, whether for-profit or not-for-profit, should have the responsibility for the care of residents.

The same does not apply to building infrastructure and other elements not associated with resident care. It is worth noting that the province already has privately funded hospitals, courthouses and light rail systems. While each example is slightly different, all involve the construction of infrastructure that is paid for upfront by private investors who receive a return on their capital with profit over time. However, others actually operate the infrastructure – the courts, hospitals, etc. – once built.

The province should adopt this approach for long-term care.

This approach would allow the private sector to satisfy the demand for long-term care facilities by accessing the capital required to construct the facilities; it would simultaneously ensure that residents receive care from a mission-driven provider whose focus is care, not profits. In a manner similar to that employed in the hospital sector, the province would then fund annual payments for an agreed-upon number of years sufficient to ensure that the developers recover their investment and an agreed-upon rate of return. This procurement strategy would also allow the province to require, upon the conclusion of this period, that the province (and not the developer) would own the long-term care facility and the land on which it is built.

Now is the time to revisit the delivery model for long-term care and adopt a better way to provide care for Ontario's seniors.

The oversight and enforcement of legislative standards is another problem facing long-term care. In her inquiry report on the Safety and Security of Residents in the Long-Term Care Homes System, released in mid-2019, the Honourable Justice Eileen E. Gillese found that the long-term care home inspection process required improvement. The pandemic exposed significant shortcomings with enforcement, which did little to ensure adequate infection prevention and control (IPAC) measures were in place in homes before the arrival of COVID-19.

Finally, the state of the long-term care infrastructure is an ongoing concern. Ontario has many older homes that were constructed at a time when the building standards allowed ward-style rooms with three or four beds and shared bathrooms, making the spread of disease easier. The older standards were not designed to meet current IPAC practices. Not surprisingly, these older homes were hit hardest by COVID-19. While the government has and is trying to upgrade older homes, these homes nevertheless comprise a large percentage of the long-term care homes in Ontario.

The issues outlined above are by no means an exhaustive list of the challenges that faced the long-term care sector prior to the COVID-19 pandemic. Not all COVID-19 deaths could have been prevented. However, these problems combined to create fertile ground for excess mortality.

Not one of these long-standing issues was a surprise to the government or to those who have worked, lived or advocated in the long-term care sector.

Ontario's Pandemic Preparedness

Like many jurisdictions, Ontario was unprepared for the COVID-19 pandemic. However, this need not have been the case. In 2003, Ontario bore the brunt of another deadly viral outbreak, SARS. After SARS, the Ontario and Canadian governments commissioned several studies that highlighted the failings of health and emergency response systems when it came to preparing for a deadly virus, at both the national and provincial level.

Excellent recommendations came out of those studies and, for a time, Ontario paid attention to them. The province strengthened its defences and began to prepare the health care sector to respond to a pandemic. Outbreaks of H1N1 and Ebola in 2009 and 2014–16, respectively, were grim reminders of the threat a disease outbreak could pose.

Despite these stark reminders, Ontario lost the will to make pandemic preparedness a priority. By 2017, the Auditor General was warning the government about major weaknesses in the province's emergency management programs that could make Ontario vulnerable to a large-scale emergency.

The Chief Medical Officer of Health (CMOH) told the Commission that, when the province is not in the middle of a public health emergency, pandemic preparedness often falls by the wayside in favour of more immediate concerns: "It is hard to keep [pandemic preparedness] always at the front table because the tyranny of the urgent always pushes things aside."

This is exactly what happened in the years leading up to the COVID-19 pandemic. The Ministry of Health did not do enough to meet its legislative obligation to plan for a pandemic, and the Ministry of Long-Term Care did not take sufficient steps to ready the vulnerable long-term care community.

As a result, the province had no up-to-date, cohesive pandemic plan in 2020. Ontario's most current plan was primarily designed to address an influenza pandemic and had not been updated since 2013. Subsequent government attempts to expand the scope of the plan beyond influenza were incomplete by the spring of 2020. Compounding this issue, neither Ministry conducted simulations or drills for a pandemic. In particular, there were no drills focused on long-term care, where some of the most at-risk Ontarians live.

In 2017, before COVID-19 hit Ontario, the majority of the province's stockpile of emergency health supplies, amassed after SARS, had expired and been ordered destroyed. By 2019, the province had destroyed 90 per cent of the stockpile, including surgical and N95 masks; these items were not replaced, even though the risks the stockpile was meant to address had not vanished. Instead of replenishing the stockpile, successive governments spent three years deliberating procurement policy options. Added to this, many homes lacked the necessary PPE to protect residents and staff. Prior to the pandemic, the province did not track the status of PPE supplies in long-term care and so was not aware of their supply status.

The economic cost of the pandemic has been significant, dwarfing the cost of proper pandemic preparation. Ontario's gross domestic product declined by approximately $45 billion as a result of the pandemic. In addition, the province anticipates approximately $25 billion in additional expenses and has allocated approximately $1.4 billion to purchase PPE. These numbers do not include Ontario's portion of federal spending. Against these numbers, the cost of properly preparing for a pandemic is insignificant.

COVID-19 may have arrived unexpectedly in 2020, but it was entirely predictable that a deadly pathogen would sweep the world at some point. It was also predictable that

a pandemic could disproportionately impact Ontarians in long-term care. Successive governments should have taken the warnings and lessons from SARS seriously. They should have proactively prepared instead of taking an episodic and reactive approach. If they had, the human and financial costs of the COVID-19 pandemic would have been significantly reduced.

Pandemic preparedness must be a constant priority. The lives of those most at risk depend on it.

When COVID-19 slammed into an already vulnerable long-term care sector, the cost of that lack of preparedness was on full display.

The COVID-19 Crisis in Long-Term Care

When COVID-19 struck Ontario, it devastated the long-term care sector. At the time of writing, 11 staff and almost 4,000 residents had lost their lives. Deaths among long-term care residents represent more than half of all of Ontario's COVID-19 deaths, even though long-term care residents make up only 0.5 per cent of the population. Many more residents and staff were infected, with a reported 14,984 resident and 6,740 staff cases by March 14, 2021.

As noted above, the long-term care sector was not sufficiently prepared for a pandemic, though it should have been. Making the problem worse, the province's response was slow and reactive when the virus arrived and began to spread. Critical decisions came too late, and the government's emergency response system proved inadequate to protect staff and residents from COVID-19.

In the aftermath of SARS, it was acknowledged that unless one acts quickly to contain a virus, the virus will gain the upper hand. Similarly, it was recognized that, in order to protect the public, public health authorities should follow the precautionary principle. That principle dictates that public health protection measures need not wait for scientific certainty before implementation. In his 1997 report on Canada's tainted blood crisis, the Honourable Justice Horace Krever described this principle as follows: "[w]here there is reasonable evidence of an impending threat to public health, it is inappropriate to require proof of causation beyond a reasonable doubt before taking steps to avert the threat." In an emergency, speed often trumps perfection. Unfortunately, in the first five months of 2020, many provincial public health measures were implemented too late to have a positive impact in long-term care homes.

The first government discussions about the new virus occurred in the first week of January 2020. Initially, preparations in Ontario focused on hospitals and not long-term care homes. In 2003, SARS had ravaged hospitals, and the province wanted to avoid a repeat of that experience. Early preparations to protect hospitals from the emerging

COVID-19 outbreak included transferring patients from hospitals to long-term care homes to free up hospital beds; this effectively reduced the space available in long-term care homes for isolation of COVID-positive residents, contributing to the potential spread of the disease.

As a representative from the Ontario Hospital Association told the Commission, “I think it is fair to say that right from the very beginning long-term care has been treated separately from the rest of the health care system when it comes to the coordination of the pandemic response.”

There were ample warnings, however, that the virus posed a risk to long-term care residents. Those warnings were not acted upon with sufficient speed. In February 2020, reports surfaced of outbreaks among cruise ship passengers such as those on the *Diamond Princess*, and in churches and prisons in other countries. The rapid spread of the disease in congregate settings such as these – places where many people live or gather in close proximity to each other – showed that long-term care homes would also be at risk. It had also become evident by this time that the virus posed a higher risk to the elderly and those who had pre-existing health issues.

In late February 2020, a long-term care home in Washington State experienced a COVID-19 outbreak. On March 7, Canada’s first long-term care outbreak was reported in British Columbia. By March 11, long-term care homes in Italy had suffered 827 deaths and 12,462 confirmed cases. One expert told the Commission that, at this time “we knew that the virus almost seemed to target care settings. The initial recognition of community transmission in both Washington State and British Columbia was associated with high mortality outbreaks in long-term care.”

On February 27, the Chief Medical Officer of Health chaired a meeting that included representatives from Public Health Ontario, the Ontario Hospital Association, physicians, and Ministry of Health personnel at which “[m]ost expert attendees agreed that the widespread incidence of COVID-19 is imminent and essentially inevitable.” Alarm bells should have been ringing loudly in Ontario.

Yet in early March 2020, the government continued to publicly assert that the threat of the virus was low and was related to travel, despite mounting evidence to the contrary. This messaging was included in the briefing notes prepared for the Minister of Health when addressing the Ontario legislature on March 10. On the same day, the province’s 37th confirmed case of COVID-19 was an individual who had not travelled internationally. By this point the Minister of Long-Term Care, a medical doctor, had independently concluded that the risk was not low and refused to state in a video that it was.

Unfortunately, Minister Fullerton's appreciation of the risk was not shared by the medical leadership in the government and did not translate into broader public communications. This included a failure to clearly acknowledge that COVID-19 could be spreading in communities instead of being tied only to people who had travelled. Community spread poses a risk to long-term care because it means anybody can bring the virus in – not just someone who has recently travelled. By mid-March 2020, government representatives were acknowledging that community spread could not be ruled out. However, as late as March 24 the Associate Chief Medical Officer of Health was still questioning whether community spread of COVID-19 was occurring.

Similarly, the government was slow to recognize and act upon the potential of asymptomatic spread – the possibility that a person not displaying symptoms could nevertheless infect others. By the end of January 2020, Chinese health officials had found that COVID-19 symptoms appeared within two to 14 days of exposure, and that people without symptoms could be infectious during that period, signalling the possibility of asymptomatic transmission. The Australian government's Health Protection Principal Committee released guidance on January 30, citing international evidence that suggested asymptomatic transmission. They believed "a highly precautionary approach" should be taken. These findings were provided to Ontario's Chief Medical Officer of Health by email on January 31.

The Minister of Long-Term Care told the Commission that she had concerns about asymptomatic spread of COVID-19 as early as February 5, 2020. Others were worried too. On March 18, an associate medical officer of health in Ottawa wrote to Dr. Williams to warn him that "the evidence is now sufficient that there are more asymptomatic infections than symptomatic infections" and that "asymptomatic infections likely cause more new infections than symptomatic infections do." Therefore, the email concluded, infected health care workers "who have not travelled and who are asymptomatic could be actively working in healthcare facilities." Unfortunately, the Chief Medical Officer of Health did not share this concern or the concern of the Minister of Long-Term Care. Dr. Williams told the Commission that "the evidence wasn't there for that." He did not act as if asymptomatic spread might be occurring and did not issue directives on that basis. He stated that the evidence was not clear until the summer.

Despite government inaction, some individuals within long-term care and local public health were taking proactive measures, having seen the threat of COVID-19 for what it was. The Medical Director of York Region's two municipal homes reached out directly to the homes in Washington State and British Columbia to seek advice in the wake of their outbreaks. In a long-term care home in Richmond Hill, the CEO began contacting PPE suppliers in late January and instituted staffing and IPAC policies to protect residents well in advance of similar government directives. Kingston's local medical officer of health monitored the situation in China and independently established

a protocol to visit, inspect and audit all long-term care facilities in the region. When restaurants and bars were closed by the province, he had the public health unit's food safety inspectors conduct inspections in long-term care.

The first outbreak in an Ontario long-term care home was declared on March 16, 2020. The virus then spread like wildfire.

Because the province had destroyed its emergency stockpile of PPE and numerous homes had an insufficient supply, many staff and residents were unable to protect themselves and others. As had been anticipated when the stockpile was created, the pandemic resulted in a restricted global supply and increased prices for essential items like PPE. As the virus raged, the province was left scrambling to secure supplies. Public servants worked around the clock chasing down whatever leads they could, and homes were instructed to ration their supplies.

Without sufficient PPE, staff did not feel safe at work. Without sufficient PPE, some staff who did not feel safe chose to stay home to protect themselves and their families. Due to a combination of illness and fear, an already precarious staffing situation was made much worse.

Decisions made by the province during the COVID-19 pandemic demonstrated a lack of urgency. As the world learned more about the new virus, other jurisdictions began to take a precautionary approach to protect residents. In many instances, Ontario lagged behind in taking similar precautions. Consider, for example, the decision regarding "universal masking" – the requirement that all people in a long-term care facility wear a mask at all times. One benefit of universal masking is protection against the spread of infection by those who have the virus but display no symptoms. These asymptomatic carriers inadvertently spread disease, not recognizing they are contagious.

By March 9, 2020, Public Health Ontario considered it a possibility that COVID-19 could be spread by asymptomatic people. A representative from the Office of the Chief Medical Officer of Health confirmed that this possibility would have, in his mind, invoked the precautionary principle. On March 18, the Chief Medical Officer of Health was warned that "when community transmission is evident or can be assumed, all HCWs [health care workers] should be assumed to be posing potential risk to other HCWs and to patients, and therefore that all HCWs should wear surgical masks from the time they enter the facility to the time that they leave."

Hospitals in Toronto implemented universal masking on March 24, 2020. Toronto long-term care homes were advised by local authorities to implement universal masking on March 29. The Chief Medical Officer of Health did not order universal masking until April 8. In a pandemic, days make a difference. Delay is deadly.

The delay in ordering universal masking was likely necessitated, at least in part, by the lack of supply of PPE.

The province was similarly slow to require long-term care staff to work at a single home in order to prevent the risk of infection spreading. Under the *Health Protection and Promotion Act*, the Chief Medical Officer of Health has the power to issue mandatory directives backed by legislated sanctions. Rather than use that power to restrict staff to a single site, the CMOH first issued a memo on March 19, 2020, suggesting that actions "should" be taken and that in some high-risk settings "it may be possible" to coordinate employees to work at a single site. That recommendation became a directive, called "Directive #3," on March 22. The directive stated that "wherever possible" it would be preferred for staff to work at a single site. The Directive was poorly worded, was not mandatory and was not universally followed.

It soon became apparent that Directive #3 was not effective and did not accomplish the goal of protecting the residents of long-term care. In speaking with the Commission, the Chief Medical Officer of Health stated that his powers did not allow him to issue a stronger directive – one that would have compelled employers to prohibit staff from working at more than one site. It was suggested that a Cabinet order was necessary.

A pandemic is no time to sort out the authority or jurisdiction of any public official, especially the Chief Medical Officer of Health.

The extent of the CMOH's powers should have been clearly established long before the pandemic. On April 8, 2020, the Secretary of the Cabinet's office reached out to the Ministry of Long-Term Care with an urgent request to strengthen the language used in Directive #3: "the goal is to have more direction … than encouragement." The government issued the single-site order on April 14, and compliance was not required until April 22. British Columbia, by contrast, implemented a single-site policy on March 26.

The majority of those who died in the first wave of the pandemic did so or were infected between March 22 and April 22, 2020, while the province was mulling over who had the authority to issue a compulsory direction and the associated policy considerations.

Whatever impact the single-site order had, it came far too late for far too many.

One of the lessons from SARS was the necessity of having an emergency structure in place before the emergency began. The interim report of the Ontario Expert Panel on SARS and Infectious Disease Control, also known as the Interim Walker Report, had identified this issue in 2003 when discussing the province's response to SARS: "without some of the necessary scaffolding and structures in place at the Ministry to respond in a highly coordinated manner to a communicable disease emergency, the province

essentially had to develop the plan on a day-to-day basis." The report could have been referring to the situation in 2020.

Without an established, practised plan in place, the government found itself making up its emergency response as it went along. As noted, a pandemic is an inopportune time to create a nuanced, well-thought-out and thorough response plan. In late March 2020, as homes began to go into outbreak, the government had not finalized its response structure. Indeed, it hired a third-party contractor in late March to do just that.

As a result, it was not always clear who was in charge. The same was true at the home level; the Commission heard from many staff members who noted that their home leadership was unable to make clear what was to be done and whose advice was to be followed. Once again, the province had failed to learn the lessons of SARS; in the final report of the Commission to Investigate the Introduction and Spread of Severe Acute Respiratory Syndrome, the Honourable Justice Archie Campbell had recommended that lines of authority be clear from the outset.

At the same time it was creating its new response structure, the province was still trying to determine what legislation would allow it to order emergency support for long-term care homes in crises. This also led to delays. With the government unsure of its powers to issue mandatory management orders, public health units and hospitals stepped in to fill the gap. In mid-April 2020, Durham Region's local medical officer of health took the initiative to use his powers under the *Health Protection and Promotion Act* to order hospitals to intervene and assist homes in distress. Other local medical officers of health followed suit. The Ministry of Long-Term Care did not develop a strategy to facilitate management takeover of homes until later.

With the sector already chronically understaffed, COVID-19 caused staff numbers to collapse in many homes – in some cases up to 80 per cent of the staffing complement was lost either because they refused to work out of fear for their own safety or because they, too, had been infected.

Many long-term care homes lacked adequate infection prevention and control knowledge and expertise when the pandemic hit. Even though the long-term care sector has experience with infectious respiratory illnesses such as influenza, many long-term care homes did not have the resources, knowledge or experience to implement effective IPAC practices. Without this important line of defence, outbreaks within long-term care homes were inevitable.

While the province grappled with increasing its testing capacity, the demand for COVID-19 tests continued to outpace laboratory capacity. Test results often took seven to 10 days to be received. Some results were lost. The Commission heard stories of homes receiving tests by fax and by regular mail. The delay in testing was the result of

Ontario's failure to plan over the years for a pandemic and to provide for an integrated lab response utilizing all of the province's public and private laboratory resources.

As residents became infected, slow testing turnaround times made it difficult or impossible to separate the sick from the healthy – a practice called cohorting. It was especially difficult to identify and cohort residents who were infected but asymptomatic. By the time homes received test results, the disease had spread.

Even if they had received the test results in a timely manner, many homes had limited experience with cohorting practices. The limited provincial guidance in this area did not improve knowledge in the homes, and the Chief Medical Officer of Health's direction on cohorting was unhelpful. Homes that did try to cohort failed to recognize that infected but asymptomatic patients were being moved from one room to another, inadvertently spreading the disease in the process.

Meanwhile, staff soldiered on without enough PPE – forced to reuse equipment or follow instructions on how to make their own out of pop bottles and plastic bags. One staff member likened the experience to combat: "It's like you're going to a war. You know you get bullets. You will get bullets on you. But you still have to step out there in the field and shoot."

Staff told the Commission about crying before, during and after work, vomiting in locker rooms from stress, and watching residents whom they loved die in great numbers. Often, they would then be required to wrap the resident in a body bag, put them on a stretcher, and wheel them outside to waiting funeral attendants. They described the guilt they felt in not being able to be with residents when they died, and the awful position of having to choose between staying home to keep themselves and their families safe and caring for the residents they knew well. One staff member who ordinarily conducted enjoyable recreational programs described the despair of her new role caring for dying residents: "For one resident, I sat at bedside after he died with the iPad because the family wanted to see him one more time. So, I watched and listened as his wife and adult children spoke of their love and silently wept under my mask and face shield." Many continue to be traumatized as a result of this experience and will require ongoing counselling and support.

In an attempt to stop the spread of COVID-19, the decision was made to bar visitors from homes. Visitors – particularly family members and loved ones – do more than visit, often taking care of many of the daily living needs of the residents. As a result of staff shortages, and with no family members to help, residents were confined to their rooms for extended periods without access to recreation programs or visitors. With visitor restrictions in place, the care burden on staff increased. One resident described the experience by saying it was as if reality had been suspended and a nightmare had set

in. Many residents experienced symptoms of what is known as “confinement syndrome.” The term is typically used in medical literature to describe symptoms shown by people placed in solitary confinement. Due to visitor restrictions and limited staff, many residents died alone in their rooms, with no one to ease their passing.

For family members, the inability to visit and to know what was happening to loved ones was devastating. They watched, remotely, as fathers, mothers and grandparents deteriorated before their eyes. Many were not able to say goodbye. When visits resumed, many families expressed shock and sadness at the rapid decline in their loved one’s cognitive and physical functions and increasing levels of depression; in some cases, they remarked on how once vibrant and alert residents had lost hope and were totally unresponsive.

Even with the lessons learned during the first wave, preparations for the second wave were not enough to prevent it from being worse. In fact, more long-term care residents died during the second wave than during the first. It is still unclear why this was so, despite the months both the province and the homes had to prepare. Some noted that high-risk homes were not sufficiently prioritized, given that 5 per cent of homes accounted for more than half of all resident deaths. Others point to the higher prevalence of COVID-19 in the province as a whole, and therefore in communities surrounding many homes, as a reason for greater spread in long-term care during the second wave.

What is clear is that IPAC preparations, staffing support, and partnerships between homes and other entities such as hospitals should have been critical priorities. Hospitals managed some homes through the crisis. However, once hospitals handed oversight of management back to the homes, there was concern that the problems that had given rise to these crises were not resolved. As part of the preparation for the second wave, the Ministry, through the Ontario Health regions, sought to formalize arrangements by pairing each home with a hospital. Using this partnership model, the Ministry created a hub-and-spoke system in which hospitals would assist homes with IPAC. However, this was not implemented until November 2020, and the delay meant that there was no chance for the hospitals to have a meaningful impact on creating an infection prevention and control culture before the second wave hit.

The province announced at the end of February 2021 that it was investing more than $115 million to train up to 8,200 new personal support workers. While long-term care homes certainly need more PSWs, this funding could not help homes through the second wave.

The Canadian Institute of Health Information (CIHI) cited a correlation between the lack of staff (particularly PSWs), the use of agency staff, and increased severity of a COVID-19

outbreak at a home in the first wave. There was also an association between these factors and greater resident mortality.

There should also have been a renewed role for provincial inspectors in the second wave. After not receiving any new funding for inspectors through the first wave, the government announced in November 2020 that 27 new inspectors would be hired to address COVID-19 issues. However, it takes eight to nine months to fully train an inspector. As a result, those newly hired inspectors would have been of little or no use during the second wave.

As more data are analyzed, it will undoubtedly be possible to better understand the factors that contributed to the spread of COVID-19, and therefore gain deeper insight into why Ontario's performance did not improve during the second wave. However, this will bring little comfort to the families and loved ones of the long-term care residents who lost their lives to COVID-19 during this time.

Best Practices and Promising Ideas

Leaders at every level must put their hearts, as well as their minds, into reimagining the care of the elderly in this province. This will require a philosophy of care that is anchored in respect, compassion and kindness for the people who live and work in long-term care. It is not just about building more homes. There needs to be a transformation to a person-centred care model, which motivates different behaviours and rewards innovation that leads to better outcomes for residents and staff.

There will need to be a multi-dimensional approach to this transformation – one that recognizes that these places are at the same time homes, care facilities and workplaces. Long-term care homes are also part of the broader health care system and the community.

Residents do not lose their rights upon entering a long-term care home. They have the same rights as everyone else in society, and those rights must be protected and respected. Residents are entitled to receive quality care and deserve to enjoy a quality of life.

We have to care about the workers in long-term care homes. Emotionally intelligent leaders are needed to drive an organizational culture change in order to create respectful and inclusive work environments in which all team members are valued, and where staff experience high levels of satisfaction and take pride in their work because they are empowered and supported to deliver excellent care. These principles are at the foundation of what the Commission recommends, moving forward, in order to protect residents, loved ones and staff.

In the midst of the great turmoil and tragedy caused by COVID-19, there were also many examples of strong leadership and promising practices that helped to prevent or mitigate the spread of the virus in several long-term care homes. These examples not only deserve recognition but also serve as models of innovative approaches that, if implemented, could help safeguard the health of older Ontarians and improve their quality of life.

Strong leadership proved critical in the face of unprecedented challenges in long-term care homes. The Commission found that key components of effective leadership were consistent regardless of the site or source. It also determined that the presence of these components could not necessarily be equated with an absence of COVID-19 outbreaks; instead, they offer insight into how well leaders responded and mobilized their teams in a time of crisis.

The key components, which are explored in greater depth in this report, included establishing practices that supported staff and improved their morale; recognizing the importance of pandemic preparedness; maintaining open and frequent lines of communication with families, staff and residents; and building and leveraging relationships with health partners.

Effective leaders not only drew on experience and expertise during the pandemic but also provided stability through their behaviour in a chaotic and uncertain time. They were nimble, visible and deliberate in their actions. In turn, they gained the trust and commitment of their teams, as well as of the residents and their loved ones. Increased investment by licensees and the Ministry of Long-Term Care in leadership development and crisis management training – for long-term care home Administrators, Directors of Nursing and Personal Care, and Medical Directors – must occur to support the effective management of homes in periods of crisis.

A number of innovative models and health care practices showed their effectiveness and provided hope, reassurance and stability during the pandemic. For example, the Commission heard evidence pointing to the value of having nurse practitioners in long-term-care homes. Whether engaging with homes through Nurse-Led Outreach Teams or as attending nurse practitioners, their distinct skillset and hands-on approach was consistently leveraged during the pandemic, especially when medical leadership was not on site. Nurse practitioners are a valuable resource and should continue to be deployed in long-term care homes across the province as needed.

Other innovative programs to strengthen quality of life and care in long-term care homes include the establishment of mobile community palliative care units; the creation of person-centred care models as a more effective alternative to current institutionalization

approaches; and better home design to meet the evolving needs and acuity of long-term care residents.

There is also a need to strengthen home care models – not to replace long-term care but to complement it. The Commission heard that people were at greater risk of infection if they lived in a congregate setting. Accordingly, people were safer in their homes during the pandemic. In its submission to the Commission, the Homecare 2020 group – comprised of Bayshore Healthcare, Saint Elizabeth Health and Victorian Order of Nurses Canada – cited data from Ontario Public Health indicating that the infection rates of home care workers was very low (0.01–0.2 per cent) compared to the infection rate of staff in long-term care homes (30 per cent).

Information shared with the Commission illustrated home care's cost-effectiveness and use of creative and flexible options that do not take a one-size-fits-all approach. Underlying all of these findings is the fact that most people want to age at home.

These strategies must not be presented as negating the necessity for new and redeveloped beds and facilities. Rather, they are needed as part of a continuum of care that will allow for safe and healthy aging whether at a long-term care home or otherwise.

Conclusion

At the time of writing, Ontario is currently in the third wave of the pandemic. The vaccination program will hopefully protect the residents and staff of long-term care. Nonetheless, given the new variants of COVID-19, it is premature to claim victory. Vigilance is still required.

This Commission was entrusted with the obligation to investigate what happened to cause the excessive sickness and death in long-term care homes and to make recommendations to prevent such a tragedy in the future.

This investigation has also considered the well-accepted conclusion that there will be a significant increase in demand for long-term care in the immediate future. Facility design and overcrowding contributed to the excessive long-term care fatalities that haunt this report. This supply problem must not be allowed to fester further. A new approach to the construction of long-term care facilities is required. The province should adopt the path to solving that problem described above and in more detail in chapter 1. In short, it should embrace a strategy that separates construction from care.

This investigation has shown that long-standing weaknesses in the long-term care sector figured prominently in the death and devastation COVID-19 inflicted on residents, their loved ones and the staff who care for them.

The same can be said for the lack of advance planning for such a crisis. The failure of successive governments to properly plan for a pandemic led to a lack of personal protective equipment, a cumbersome response structure, and slow government reaction time when COVID-19 hit. These issues were compounded by critical and early failures to adhere to the precautionary principle. Precautions with respect to asymptomatic spread, masking guidance and limiting staff working in multiple homes should have been taken sooner. This is also true for interventions in homes.

The homes and regions that acted early and proactively to take precautions fared better throughout the pandemic. Their example demonstrates what could have been done, and what must be done in the future.

As it should have done following the SARS outbreak in 2003, the province must now accept that there will be another pandemic; it is not a matter of if but when. Ontario must resolve to remember the lessons so painfully learned here in order to ensure that its long-term care homes are not doomed to repeat the past.

Introduction

> I have been in long-term care about ten years and never in my life have I experienced anything … that has terrified me more than this COVID-19 virus […] It has been a horrible experience in long-term care […] The fear is a torment. It elevates blood pressure. It elevates anxiety. The fear that we experience ... all of it is exploding in the last six months. It hurts. We are isolated, alone, without family or friends to visit with us. I don't want to go through this ever in my life again.
>
> –Barry Hickling, long-term care home resident and Delegate Board Member, Ontario Association of Residents' Councils

The years 2020 and 2021 will forever be remembered as the years of the pandemic – the years when a novel coronavirus ravaged the world with a disease known as COVID-19. Emerging in China in 2019, COVID-19 quickly swept across the globe in early 2020. Ontario was not spared. Within the province, the frail and elderly in long-term care homes were unsuspecting targets and suffered disproportionately to all other segments of society.

Early in the first wave of the pandemic, long-term care residents in Canada, including in Ontario, accounted for about 80 per cent of all reported COVID-19 deaths, one of the worst records among the world's industrialized countries. COVID-19 caused significant loss of life and untold suffering to residents in long-term care homes. As infections and death tolls mounted, families and staff were left shattered and dismayed. Many wondered how this tragedy had been allowed to unfold. Why were Ontario's long-term care and pandemic planning systems not better prepared to protect vulnerable residents? Why was the province unable to effectively respond to a pandemic that experts had long predicted?

This Commission was established during the first wave of the pandemic to investigate and report on how this tragedy occurred, and to make recommendations regarding what can be done to prepare our long-term care homes and protect the vulnerable seniors who will reside in them in the future. This report was written as COVID-19 continued to rage, resulting in infections, lockdowns, hospitalizations and death. Thankfully, vaccines have now been distributed to the long-term care community – a development that hopefully will curb the spread of the disease and spare residents from further infections, death and hardship.

Nevertheless, the question remains as to how Ontario, a province rich in financial resources and social supports, failed to protect its most vulnerable when they needed it the most. This report seeks to provide a deeper understanding as to how and why this

failure occurred. To do so, it is necessary to start with an overview of how this silent killer emerged and spread, stalking and stealing the lives of the elderly in Ontario's long-term care homes.

On December 31, 2019, the Wuhan Municipal Health Commission, located in the Hubei Province of China, notified the World Health Organization (WHO) Country Office in China about an outbreak of pneumonia cases with an unknown cause. The outbreak was linked to exposures at the Huanan Seafood Wholesale Market in Wuhan, which closed on January 1, 2020.

On January 7, 2020, one week after initially notifying the WHO, Chinese officials isolated a new type of coronavirus that causes the disease now known as COVID-19. On January 12, the WHO's Disease Outbreak News Update reported that 41 cases and one death had been confirmed.

For many, there did not seem to be any cause for alarm. Initially, COVID-19 appeared to be contained inside Wuhan, with no reported cases outside of the city as of January 12, 2020. However, as cases began to rapidly spread across Hubei and other provinces, it became increasingly clear that keeping the virus within China's borders was an impossibility.

By January 20, 2020, the global case count reached 282, with confirmed cases in Thailand, South Korea and Japan. Canada's first presumptive confirmed case, a 56-year-old man returning to Toronto after a three-month visit to Wuhan, was reported on January 25. By the time the WHO officially declared a global pandemic on March 11, the global case count had skyrocketed to nearly 120,000 cases, with more than 4,000 deaths confirmed. As COVID-19 swept through countries around the globe, the question was no longer how to keep it out but how to survive once it got in.

It was not as if no one saw this coming. There had been multiple warnings from global health organizations and epidemiology experts that a pandemic was imminent. As will be described in chapter 2 of this report, in the years leading up to the outbreak in Wuhan, countries were advised to shore up their preparedness plans and invest the resources necessary to protect their populations, especially those at heightened risk. Unfortunately, not all governments shared the same sense of urgency on this front. In Canada, the federal government moved resources away from its pandemic early warning system, while the Province of Ontario spun its wheels without a comprehensive preparedness plan. The lessons and tragedies of past epidemics and pandemics – including SARS in 2003, H1N1 in 2009, and Ebola from 2014 to 2016 – were largely ignored and did not spur sufficient action. This pattern of neglect, repeated by successive governments, would have dire consequences.

The distinct and deceptive characteristics of COVID-19 became more apparent as infection and fatality rates climbed. The possibility of human-to-human transmission before the onset of symptoms was flagged in late January 2020 by Chinese health officials. In February, reports examining outbreaks in China pointed to mild, presymptomatic and asymptomatic cases as likely contributing to increased numbers. And despite the fact that COVID-19 shared some common symptoms with other viral infections like influenza, it became increasingly clear that the new virus could attack and present in atypical ways, with often fatal consequences for older populations.

The risks were known, and in the first few months of 2020, the devastating impact of COVID-19 outbreaks in long-term care facilities was evident in countries such as Italy and the United States. And yet, when the virus breached the doors of a handful of Ontario's long-term care homes in March 2020, few were prepared for the horror that was to come.

The loss of human life due to COVID-19 is hard to comprehend. Between Canada's first COVID-19 death on March 8, 2020, and the one-year anniversary of that grim milestone, 22,239 Canadians died of the virus. By comparison, over the six-year period from 1939 to 1945, approximately 45,000 Canadians died in the Second World War.

A year into the pandemic, the numbers in Ontario's long-term care homes are staggering. There have been more than 1,300 outbreaks in long-term care facilities. More than 15,000 residents contracted COVID-19, and almost 4,000 died. It is important to recognize, however, that residents were not the only ones impacted by this devastating virus in long-term care homes. As of April 25, 2021, there were more than 6,700 staff cases of COVID-19, and 11 deaths.

What the numbers do not capture is the agony experienced by long-term care residents, their families and the staff who lived through and died during the pandemic. The numbers do not tell the stories of residents who begged for help and answers as life slowly drained from their bodies and light dimmed in their eyes.

The numbers do not speak to the extreme heartbreak of families who peered into windows of long-term care homes to see their loved ones locked down like prisoners. They do not illustrate their constant pleas, many of which went unanswered, and the tireless efforts of some long-term care staff to protect and save them.

The numbers do not reflect the incredible bravery, dedication and suffering experienced by long-term care staff and others who risked their own lives and worked countless days and nights to support and care for vulnerable residents amid the crisis.

This report is grounded in the death and devastation that has marked Ontario's long-term care homes during the COVID-19 pandemic. It serves to bear witness to the

tragedy experienced by residents, families and staff and to uncover the factors that contributed to this shameful period in Ontario's history.

Voices from the Front Line

“But the image I have of my mother, who was always a very active person in her community and [a] very intelligent and engaged woman who would set out her clothes the day before so that they all matched and had her pearls – So of all the pictures I have of my mother over the years, first as a young nurse/first responder during the bombing of London to all the beautiful family occasions we have, the one that’s burned into my mind forever is her lying there in a wet diaper without even a blanket to cover her with her arm up, stretched in the air begging for water and asking God why he had forsaken her when the priests always told her that he would never abandon her. So, it’s not something that you forget.”

–Family member of long-term care resident

“I have been in what I call a pandemic prison and solitary since April of 2020. The solitary happens when anyone tests positive in the entire home, and every single one of us must stay in our rooms without being allowed a shower; and even same goes for when we return from a hospital stay. Fourteen days isolation, no shower.”

–Sage, long-term care resident

“The bottom line is that dealing with my mom during the pandemic … is that we saved our mother’s life, and she likely would have died from neglect. She lost over 20 pounds in a matter of weeks and was nearing death by starvation because we were locked out and unable to help her while staff were off recovering from COVID.”

–Family member of long-term care resident

“I am just tired of seeing people crying and wishing that they would rather die from COVID than, you know, not see their families. That is wrong. It is wrong for any human being.”

–Wilbert, long-term care resident

“... I find the treatment since this has started has been inhumane towards people. We are not being treated like human beings. We are being treated like we are all residents who are incapable of taking care of ourselves.”

–Maria, long-term care resident

“... couldn’t get to a resident fast enough that was asking for some water. So here I am, still struggling with the thought of [i]s she thirsty still on her journey? Because I couldn’t get the water to her fast enough. By the time I’m going for the water, someone else is calling or calling out. I know COVID, it taught us all a lesson. We weren’t prepared for it. We didn’t understand it.”

–Long-term care staff member

Chapter 1: Long-Term Care before COVID-19

> I do believe this is a systemic problem that's been going on for decades. And no one government is to blame totally; they're all in on it. They're all culpable. A change in mindset. We are not doing them – the residents a favour. They're – the staff and the administration are not doing the residents a favour by caring for them or a favour to us. We all owe them. We have to change the mindset that they deserve a home that ... they can feel comfortable in, that they can be themselves in ...
>
> –Family member of long-term care resident

Even before COVID-19 ravaged Ontario's long-term care homes, the system in which they operate was at a tipping point. For decades, successive provincial governments had neglected the long-term care sector. In 2020 and 2021, however, those decades of inattention came home to roost as a novel coronavirus raged through homes that were chronically understaffed and underfunded, structurally deficient, and inadequately overseen by the province. For too many of Ontario's most vulnerable citizens, the consequences were deadly.

Provincial legislation mandates that long-term care homes be operated as if they are the primary home of their residents. The legislation recognizes that homes are to provide "a safe, comfortable, home-like environment" that supports "a high quality of life for all residents." It mandates that in order to ensure the needs and safety of residents are being met, there must be collaboration and mutual respect among the residents, their families, long-term care providers, caregivers, government, staff and others. Where legislated standards are not met – or the safety, security or rights of residents are compromised – the legislation further mandates that corrective action be taken. (See appendix B for a detailed discussion of the legislation governing long-term care homes, leadership and staff within homes, and an exploration of the roles and responsibilities of various government and public health actors.)

The challenge of meeting these goals has increased over the last 20-plus years as circumstances within the sector have evolved. The health needs of the residents in Ontario's long-term care homes have become increasingly complex, creating challenges around the level of care required to ensure residents' needs are being met. At the same time, the demand for long-term care has continued to grow along with the province's population of seniors, creating pressure to quickly expand an overtaxed system. By some estimates, more than twice as many beds will need to be built over the next 20 years than exist today.

For many years, staffing at long-term care homes has also been recognized as a significant problem, with challenges around retention, training and wage parity, among other issues. The province has received multiple reports that clearly set out the staffing shortfalls and the solutions required, yet few changes have been made. Had adequate attention been paid to staffing earlier, long-term care homes might have been better prepared and better able to manage when COVID-19 struck.

Compounding these problems is the way in which the sector is funded, managed and overseen. Long-term care in Ontario is funded by the provincial government, with contributions from those residents who have the means to do so. While the government has ultimate oversight responsibility for the sector, it does not deliver long-term care service. Rather, the government relies on municipal, not-for-profit and for-profit licensees to provide care services to the standards and requirements dictated by the legislation. The oversight and enforcement of those standards is questionable. With a better inspection and oversight system in place, weaknesses in areas such as infection prevention and control (IPAC) could have been addressed before the pandemic.

Finally, the state of the long-term care infrastructure is an ongoing concern. There are not enough beds to meet the current demand, let alone the projected demand of the province’s aging demographic. In this report, the term "bed" is used as shorthand to describe a space in a long-term care home and encompasses all aspects of care provided to a resident in long-term care. Of the beds that do exist, many were built at a time when the building design standards allowed for ward-style rooms with three or four beds and shared bathrooms, making it difficult, if not impossible, to manage the social distancing required during an infectious disease outbreak. These deficits have long been a topic of discussion, and modern design standards were in fact first introduced 20 years ago.

The province knew before the pandemic that it had to replace these old beds. The devastation of COVID-19 in many of these older, overcrowded homes made very clear that delay can be deadly.

The substantial investment required to build new beds and redevelop old beds will amount to billions of dollars. It is plain that the province needs a new model that will attract investment into the sector while also restoring Ontarians’ faith that the care of the elderly is a priority.

Throughout its investigation, the Commission repeatedly heard that COVID-19 has seriously undermined the reputation of for-profit homes, which tended to fare worse in COVID-19-related outcomes. And yet, it is not easy to see how the multi-billion-dollar need for tens of thousands of new and redeveloped beds can be satisfied without

private capital funding. There is, however, no reason that the accommodation and care of residents need to be handled by the same entity.

The province already employs models in which the construction and ownership of care facilities, such as hospitals, are separate from care provision. The province should adopt this approach for long-term care. Such a model would allow the private sector to satisfy the demand for long-term care facilities by accessing the capital required to construct the facilities and ensure that residents receive care from a mission-driven provider whose focus is care, not profits.

The pandemic has shown that the current long-term care model is not working: now is the time to revisit that delivery model and adopt a better way to provide care for seniors.

The issues outlined briefly above – and in greater detail in the balance of this chapter – are by no means an exhaustive list of the challenges that were facing the long-term care sector prior to the COVID-19 pandemic and that continue to affect it today. They are, however, the challenges that had some of the greatest impact, and some of the deadliest consequences, when COVID-19 struck. While not all COVID-19 deaths could have been prevented, these problems combined to create fertile ground for excess mortality. Not a single one of these long-standing issues was a surprise to the government or to those who have worked in, lived in or advocated for the long-term care sector. Yet, by spring 2020, the larger public experienced a rude awakening as it witnessed a parade of death in long-term care homes across the province.

COVID-19 brought a disproportionate amount of death and suffering to long-term care homes. During the first wave of the pandemic, long-term care residents accounted for 64 per cent of all of COVID-19 deaths in Ontario, despite representing only about 0.5 per cent of the province’s population. For the purposes of this report, the first wave of the pandemic is considered to have ended on August 31, 2020; the second wave is considered to have ended on March 14, 2021.

Addressing the chronic issues plaguing the long-term care system will not be easy. It will take sustained and determined effort to attract and retain staff, for example, and to better manage resident care. And there is no doubt that more beds will need to be built. But as many have said, the province cannot simply build its way out of this problem. In order to prevent the ravages of COVID-19 from being repeated, the way pre-COVID-19 long-term care was delivered must be changed. Doing so calls for creative solutions and sustained collective political will.

The Evolution of Long-Term Care

In order to understand how Ontario's long-term care homes so easily fell prey to COVID-19, it is necessary to explore the evolution of long-term care in the province.

The care of the elderly in Ontario began as a charitable endeavour in the latter part of the 1800s. Christian charities in the British colonies began to provide refuge for destitute elderly who would otherwise have been forgotten. The refuge, however, came with a cost, as the homes operated akin to workhouses. The modern era of long-term care began after the Second World War with the adoption of the *Homes for the Aged Act*, which provided modest standards and partial funding for homes. Soon enough, a collection of public, private and charitable homes sprang up, of varying standards. The adoption of the *Nursing Homes Act* in 1966 ushered in more changes. The new *Act*, as described by André Picard in his book *Neglected No More: The Urgent Need to Improve the Lives of Canada's Elders in the Wake of a Pandemic*, provided that "Elders would not work for their keep anymore; they would be cared for lovingly."

As Canada set about introducing universal health care in the 1950s and '60s, long-term care was not among the services provided; it continued to be a largely private service outside the reach of many. Picard explains that long-term care "wallowed, largely at the intersection of housing, social welfare and health." Dr. Samir Sinha, Director of Geriatrics at Sinai Health System and the University Health Network, told the Commission it was not surprising that long-term care was not initially covered by provincial health care, as few people lived long enough to consider long-term care a universal health need.

Changes to the *Canada Health Act* in 1984 still left much of the day-to-day care of the elderly outside of public funding. Through the 1980s and '90s, there continued to be a mixed model of for-profit, not-for-profit and municipal long-term care homes.

Today, the province provides funding for the staff, food and personal care of long-term care residents. There are additional funds provided by the government for specified programs, such as falls prevention equipment. Residents who can afford to do so are required to remit a co-payment that contributes to overhead, non-care staff, debt financing and profit. The government enters into agreements with the owners of the homes and regulates them through the *Long-Term Care Homes Act, 2007*, which contains a host of specified requirements.

The history of the expansion of beds in long-term care has been episodic. This tends to occur not on the basis of need but is dependent on the political will of the day. In 1998, the government announced that it would expand the number of beds by 20,000. From 2011 to 2018, however, the provincial focus shifted away from long-term care to home

care. During this period, only 611 net beds were built; in short, from 2011 to 2018, construction of additional long-term care beds stagnated while the waiting list for those beds expanded.

Current Care Options for Ontario's Aging Citizens

Services for the care of the elderly should provide Ontario's seniors with choices that enable them to maintain the highest possible quality of life and independence as they age. The reality, however, is that the province's elderly receive care from siloed sectors, with no management of how people move through the system as their care needs change. In fact, many seniors are being cared for at home by family members or loved ones with little to no support.

For those who do receive outside assistance, the current options consist of home care, retirement homes and long-term care homes. There are various organizations that support, to varying degrees, the ability of Ontario's elderly to remain in their homes and receive care as needed in order to "age at home" for as long as possible. In fact, some Ontarians are able to stay at home, supplemented with such care, for the remainder of their lives, with a spectrum of supports and services being provided as needed. It is estimated that between 6 and 8 per cent of seniors receive publicly funded home care. Of the services received, the top three are nursing care (51 per cent), medical equipment or supplies (43 per cent), and personal or home support such as help with bathing or housekeeping (41 per cent). The availability of these services, however, is limited due to a lack of government funding.

Other seniors choose to move to retirement homes, which come in several models. Some offer residents full independence, while others provide varying degrees of increasing care, with options to supplement care with an array of services on- or off-site. There are more than 750 licensed retirement homes in Ontario, each of which is privately owned and does not receive government funding: residents pay the full cost of their accommodation and any care services they require. Although retirement homes can provide a gradual transition for seniors into the care system, it is important to remember that they are not affordable for all Ontarians.

At the far end of the care spectrum are the long-term care homes. As the Commission has heard, long-term care homes are for those most in need of additional care. Residents often have some degree of dementia or cognitive impairment, with additional complex medical needs. Unlike in retirement homes, care at a long-term care home is included in the cost of residence, and a government subsidy is available for those who cannot afford the full resident co-payment amount.

Where governments should direct their efforts and funding and what parts of this continuum of care should be supported, and to what degree, have been the subject

of much debate. The Commission has heard about the importance of each of these options. Each has its time and place in the lives of the elderly. For the purposes of this chapter, however, the focus will be on the challenges specifically affecting long-term care.

A Brief Overview of Long-Term Care Ownership Models

There are 626 long-term care homes in Ontario, caring for over 78,000 residents. Approximately 58 per cent are for-profit (the highest proportion of private-sector involvement in Canada), 24 per cent are not-for-profit (e.g., charities, community organizations, hospitals) and 16 per cent are municipal. This translates to 355 for-profit homes and 271 not-for-profit and municipal homes.

Numerous studies and system reviews over the past two decades have highlighted the variations in quality of care and resident outcomes between for-profit, not-for-profit and municipal homes, including:

- **Staffing:** For-profit homes tend to offer lower wages and benefits to their staff, have higher staff turnover, and have lower staffing levels and staff-skill mix (i.e., the mix of medical and non-medical staff).
- **Quality of care:** Residents in for-profit homes tend to have a higher prevalence of pressure ulcers, more hospital admissions, and increased incidents of excessive and inappropriate use of psychoactive medications.
- **Infrastructure:** For-profit entities own more of the province's older homes; these homes were built according to the design standards in place at the time of construction, prior to the newer provincial structural and design standards; as a result, they have more three- and four-person rooms (and therefore crowding).
- **Consumer preference:** The long-term care waitlist is shorter for for-profit homes (32 per cent) compared to not-for-profit and municipal homes (68 per cent).

The Commission is aware that there is a genuine issue centred on the relative performance of "for-profit vs. not-for-profit" homes and a discussion of the merits of one over the other. It is worth noting that legally these terms only describe each entity's tax status, which can impact how they raise capital. When making a distinction between homes, it is more appropriate to refer to "mission-driven" enterprises and those operated solely as "commercial" enterprises. This terminology focuses the discussion on the real issue, which is the philosophy and actions of the operator rather than its corporate structure.

Mission-driven enterprises focus on goals rather than commercial success as an end in and of itself. Mission-driven enterprises are usually assumed to be charities,

foundations and not-for-profit companies, but they can also include for-profit companies that operate with non-commercial goals as a central purpose. In long-term care, all providers must operate in a commercially prudent manner in order to be financially sustainable, but the core value of mission-driven providers is to improve the care of their residents. Commercial entities have a profit motive as their core purpose: they exist to return a profit to investors who have contributed capital to build and expand the enterprise's operations. As a result of this access to investor capital, commercial providers have the ability to expand rapidly. However, for-profit homes come in many forms (aside from being commercialized or mission-driven). Some are owned by public companies traded on the Toronto Stock Exchange. Some are owned by investment vehicles such as Real Estate Investment Trusts (REITs). While a REIT holds a long-term care licence and therefore the legal responsibility for the care of the residents, it hires a separate company to run its long-term care home. Other for-profit homes are privately owned.

The Commission accepts that there are owners of "for-profit" homes, mostly those that are mission-driven, who provide good care to their residents. Ensuring consistent high-quality care across all homes for all residents must be the prevailing goal for this crucial government health care program.

Resident Care: Causes for Concern

Of the more than 78,000 residents currently in Ontario long-term care homes, a small proportion are younger and have needs that require the assistance of long-term care. The average age of long-term care residents, however, is 84. The Commission heard that residents typically enter a long-term care home in the last two years of their life, and that approximately 22,000 long-term care residents die every year. Residents suffer a host of ailments that make daily care challenging. These ailments leave residents at an increased risk of adverse health outcomes from infectious diseases.

To a large degree, the problems that existed in the long-term care sector prior to the COVID-19 pandemic reflect a system that has failed to keep pace with its residents' needs. Over the last two decades or more, the health profile of residents in long-term care has changed dramatically. The data demonstrate that the average long-term care resident today has many more physical and cognitive challenges than those who came before. As a result, more care is necessary for this generation of residents than those of years past.

Increasingly Complex Needs

When compared to long-term care residents a decade ago, today's residents experience higher percentages of cognitive impairment, physical disability, medical

instability and incontinence. In 2015, the Ministry of Health and Long-Term Care (since mid-2019, this Ministry has been separated into two Ministries, the Ministry of Health and the Ministry of Long-Term Care) noted that the average Activities of Daily Living (ADL) score – which measures the extent to which residents can independently manage activities of daily living such as brushing teeth, bathing and changing clothes – increased from 3.08 in 2010 to 3.22, suggesting increased levels of dependence. In line with this finding, the Canadian Institute for Health Information (CIHI) reported to the Commission that more than half of current long-term care residents have an ADL score of 4 or more, meaning they require extensive assistance or greater to complete activities of daily living.

Acuity levels (levels of severity of illness) have also increased, requiring higher-levels of care and daily assistance. More than 80 per cent of long-term care residents have some form of cognitive impairment, one-third of which is severe, and 86 per cent of residents need extensive help with daily living.

The Commission heard repeatedly that staffing requirements have not kept pace with the increased levels of care required as a result of residents' increased acuity and medical issues.

These challenges are increasing each year. In her inquiry report on the Safety and Security of Residents in the Long-Term Care Homes System, completed in mid-2019, the Honourable Justice Eileen E. Gillese found three reasons for the rising acuity of long-term care residents. First, a decade ago, the government was more focused on home care, which allowed some people to age at home more easily. Second, the stricter standards for admission to long-term care that are now in effect mean that only those with high or very high needs are admitted. Third, many current residents would in earlier days have been cared for in hospitals.

Justice Gillese concluded that, "[a]s a result, residents enter long-term care homes at a later stage of their cognitive and physical impairment, when their health is likely to be unstable, they are more physically frail, and their care needs are higher."

Residents are thus arriving at long-term care with more complex health challenges and requiring greater assistance with the activities of daily living. This situation creates a tension between preserving a home-like environment for more independent residents and creating an environment that meets the needs of residents requiring increasingly complex health care and more daily assistance. It also means that more long-term care residents than ever before are vulnerable to a viral illness such as COVID-19.

An Aging Population, A Growing Demand for Care

The population of those over the age of 75 in Ontario is growing. In November 2018, the Ministry of Health and Long-Term Care predicted that Ontario's senior population (i.e., individuals over the age of 75) would grow from 980,000 in 2015 to more than 2.63 million by 2040. It further predicted that the growth rate of the senior population would peak by 2023, but the total number of seniors would continue to grow, resulting in a higher demand for home and community care services, a higher demand for long-term care, and longer waitlists. As of January 2020, more than 38,000 people were on the waitlist for long-term care. The fate of those on the waitlist was never made clear to the Commission. Certainly, some do get residency in a long-term care home, but they often must wait for months at home, where help may be inadequate and their loved ones and caregivers are beyond fatigued.

The waitlist and the fact that long-term care home occupancy is designed to be at capacity means that while Ontarians are permitted to apply to as many as five homes, they often must take the first that becomes available. In this sector, there is no market discipline working to punish poorer-performing homes. Those on the waitlist have little choice but to accept whichever home is offered when it is offered. While a small percentage of those on the waitlist or in long-term care homes would arguably be able to live independently if more support was available in the community, the demographics clearly indicate a growing need for increased capacity in the long-term care sector.

In 2019, the Financial Accountability Office (FAO) – an independent body reporting to the provincial legislature – examined the future need for long-term care beds in Ontario. The FAO looked at the change in capacity in Ontario's long-term care sector from 2011 to 2018. While the population of those over the age of 75 increased by 20 per cent (from 876,886 to 1,053,097), there was only a 0.8 per cent increase in the supply of long-term care beds (from 78,053 to 78,664 – a net gain of just 611 beds). As the population ages, the demand for long-term care beds will increase. The FAO determined that by 2033, the province will need to build 55,000 new beds just to maintain a waiting list of approximately 37,000.

Ageing Well, a group of distinguished economists and health care experts at Queen's University, has also noted this trend. In calling for a shift in policy around the way in which seniors are housed and cared for, the organization determined that if care of Ontario seniors continues to be handled in the same way it is now, the province will require an additional 96,000 to 115,000 long-term care beds by 2041 to accommodate the increased demand, which presents what Ageing Well's Don Drummond called a "stark" and "horrendous" problem. There is little doubt that long-term care will be faced

with what Mr. Drummond aptly described to the Commission as a “tsunami” of seniors, and a range of solutions will be required to respond to this issue.

The predicted growth, declining health and medically complex needs of Ontario’s seniors – not to mention their susceptibility to respiratory illness – should have had the province on high alert for the potentially devastating effect of infectious disease outbreaks. As will be seen in later chapters of this report, much work has gone into studying these issues over the years, and many recommendations for improvements have been made. Yet successive governments failed to take meaningful action to protect long-term care residents in this province.

The Need for Palliative and End-of-Life Care

As discussed above, most long-term care residents are in the final chapter of their lives upon admission to a long-term care home. As one palliative care specialist told the Commission:

> Many of these residents would benefit from a palliative care approach, really, at the beginning, which doesn’t mean end-of-life care, but it means integrating sort of a focus on symptom management and having early and frequent goals of care discussions with the resident, along with their substitute decision-maker, which is usually their family or family members.

The reality of long-term care is that it is the last home for the majority of residents. As such, it would seem obvious that palliative care, which aims to relieve suffering and improve quality of life, should be a critical aspect of the care provided to residents. Shockingly, the Commission heard that among residents who died in long-term care in 2016 and 2017, only 6 per cent were recorded as having received palliative care in the last year of life. While the actual number of residents receiving “informal” palliative care (i.e., palliative care that was not recorded) may be higher, the finding that most long-term care residents with less than six months to live did not have a record of palliative care is concerning. This lack of palliative care suggests that homes are often not equipped to provide their residents with timely, equitable access to palliative services that meet their needs.

The Commission also heard of inconsistent practices and, at times, outdated attitudes toward end-of-life care protocols in long-term care homes. The provision of proper end-of-life care for residents at high risk of death in the coming months is of vital importance to quality of life.

Palliative and end-of-life care require a specialized skill set as well as training and practices that the Commission heard were often lacking in long-term care homes. Currently, there is no enforced standard of palliative or end-of-life care training required for long-term care staff. As a result, care services received by residents vary in quality and level.

Long-term care residents should have ready access to skilled clinicians with the training to provide palliative and end-of-life care in the home whenever appropriate. To ensure that this is the case, the government must, after consulting with palliative care and other relevant experts, require long-term care homes to implement best practices for palliative and end-of-life care.

A Lack of Responsiveness on Diversity

While appropriate medical care is clearly a vital concern within the long-term care system, it is not the only measure of success in caring for residents. Long-term care residents reflect the diversity of Ontario's population. That diversity includes linguistic, sexual orientation, religious, spiritual, racial and ethnic dimensions. Over the course of its investigation, the Commission heard that long-term care homes do not always recognize, acknowledge or value the diversity of their residents and that there are not enough culturally based homes. This can cause some residents to experience feelings of isolation and alienation. As one resident told the Commission:

> [T]here's a lack of understanding of the diverse experiences that comes with racialized individuals, and I think it's that lack of recognition for their backgrounds, their experiences, the culture aspects, the way that we interpret different things: There's a lot of miscommunication there.

The Commission also heard from a representative of the Senior Pride Network on this issue:

> For us, the LGBTQ seniors of Ontario, the COVID-19 pandemic is a stark reminder that the long-term care system in Ontario is neglectful of or unresponsive to our particular health issues, our care needs, our fears and concerns, and our social and emotional well-being.

The Ontario Federation of Indigenous Friendship Centres told the Commission that due to the legacy of oppression, violence and racism toward Indigenous people within the health care system, Indigenous people are often mistrustful and fearful of long-term care residency and services. One representative further stated that:

> … the experience that Indigenous people have in long-term care homes has resulted in … worsening symptoms of depression, increased instances of experiencing racism within those facilities, and an overall disconnection from community.

There are few Indigenous long-term care homes, which forces many Indigenous seniors to leave their community when they need long-term care. This leads to a loss of community and the traditional family mechanisms and supports in which intergenerational families live together. The Ontario Federation of Indigenous Friendship Centres told the Commission that friendship centres have seen "Indigenous Elders in long-term care, especially those who only speak [an] Indigenous language who are completely cut off from social contact with their families, with the local Indigenous community and with society overall."

The isolation that some residents feel in long-term care was exacerbated during the COVID-19 pandemic. Many were unable to communicate their needs to staff and were unable to reach out to their chosen loved ones for support. This was particularly true where language barriers existed. As one representative from Family Councils Ontario told the Commission:

> … we have to think about residents that might not speak English as a first language and how that's going to impact the level of care that they receive as well as how they are going to be treated and understood by the staff that's taking care of them.

The Commission heard that as individuals age, they often revert to their mother tongue and lose English when it is their second language. This is particularly true for residents suffering from dementia. For some, this means that the only way to communicate is through family members. Being cut off from families during the pandemic left these residents isolated.

With these issues in mind, the Ministry of Long-Term Care and long-term care home licensees, management and staff must respect and support diversity in the care and services provided to long-term care residents. It is imperative that residents' realities be respected and accommodated by long-term care home operators and staff. This should be reflected in staff training, in the homes' policies and operations, in the manner in which services and programming are delivered, and in the types of culturally and linguistically based homes that are available to Ontarians.

The Importance of Families and Loved Ones

Due to perpetual staffing shortages in the long-term care sector – a topic that will be explored further in the next section of this chapter – families and loved ones are critical to meeting the physical needs of residents. Often, they are relied upon to assist with the activities of daily living, including the bathing, feeding and toileting of residents. At the same time, families and loved ones are the linchpins supporting the psycho-social and emotional well-being of residents. One family member expressed the unique challenges of addressing their loved one's needs to the Commission as follows:

> Mom has dementia, and she also has aphasia, which means she can no longer talk except to say maybe, yes, and sure. She understands when she's directly spoken to. She responds by facial gestures. ... My sister and I are designated essential caregivers. So, prior to the lockdown, my mom – every single day, either my sister or I would visit her and spend two to three hours with her. ... So, after Mom – having somebody visit her every single day, suddenly after March 17th, there was no one to visit her.

The Commission heard that assistance from families and loved ones was important to residents before COVID-19 struck, and that it became critical during the pandemic:

> Some come daily and some even several times a day…[Y]es, there is a stronger bond with the resident as the family members who come in are often wives, husbands, daughters, and sons.

> However, there are others. There are individuals who come in of their own volition and care for an old friend or neighbour. There are others who are personal support workers and are paid to attend for meals, bathing, or other deportment functions. They're usually paid by a family member who lives so fay away, they can't attend to do this on their own…In the end, the long-term care home relied on many of these family members coming in so frequently to ease the burden on their staff in caring for residents.

The pandemic shone a spotlight on a reality that existed long before COVID-19 appeared: the long-term care system was, in some measure, subsidized by the unpaid and essential work of family members and loved ones.

When COVID-19 hit and access for family members and loved ones was restricted, many homes were left with not enough caregivers to properly care for the residents. Residents were neglected, scared, alone and cut off from those they love and depend on.

Summary

As described in this section, the last two decades have seen a significant increase in people needing long-term care, along with a commensurate need for more complex care. In many respects, this is the result of a population that is living longer. Even so, aging is inevitable and, for the vast majority, so is declining health. For many, the sunset of life will require the support of long-term care. To meet this challenge, Ontarians must accept that more must be done to provide a healthy, safe and inclusive environment for our long-term care residents.

Staffing: A Chronic Crisis

> [W]hen the pandemic hit the sector, there was already a crisis with respect to the workforce in long-term care. The vast majority of the facilities, particularly those operated in the for-profit sector, had already an unstable workforce and a severe shortage of staff.
>
> –Andy Savela, Director of Healthcare, UNIFOR

In a presentation to the Legislative Assembly, Dr. Merrilee Fullerton, the Minister of Long-Term Care, described the sector's staffing as being "in crisis" even prior to COVID-19. With insufficient human resources and no provincial plan for a potential surge in the number of staff required, resident care was already at significant risk – and the problems were bound to be insurmountable in the face of a health emergency.

The majority of staff in the long-term care sector lack full-time employment and are paid less than their counterparts working in hospitals. The largest group of employees in the sector are personal support workers (PSWs), who manage most of the daily care of residents. The majority of PSWs are hired into part-time or casual positions. To make ends meet, they work at multiple homes and often face challenging conditions. As a representative from Family Councils Ontario told the Commission:

> [M]any PSWs ... are racialized women. So there's a power imbalance. ... [T]here's still a gender and race divide and PSWs experiencing racism from their peers and in some cases from families, which also then leads them to leave either that home or the sector as a whole. Because who wants to work somewhere where you're delivering difficult, intimate, hands-on care and facing dehumanization on a regular basis?

Currently, the government provides an average of only two hours and 45 minutes of care per resident per day. This level has long been known to be inadequate. Prior to the pandemic, hardworking PSWs could barely keep up with the demands of caring for residents. This created frustration and concern among staff that proper care was not always being provided. With the onset of the pandemic and the resultant loss of staff – as many were afraid to come to work for fear of getting sick or exposing their own families to illness – those who remained in some of the hardest hit homes were left to do the work of many, in conditions that had deteriorated significantly.

The unmanageable workload added to an existing cycle of neglected residents and staff burnout and turnover.

The conditions that led to the staffing collapse in the worst-hit homes were foreseeable, as will be detailed below. In the decades prior to 2020, the issues that caused the staffing model to collapse were the subject of repeated calls for correction. These same issues, if left unattended, will create a significant impediment to improving long-term care in the years to come. Solutions are not hard to envision, but implementing them will take time, effort and sustained funding.

A failure to address the staffing challenge will mean that the generation that gave this country publicly funded health care will have been failed by it.

An Overview of Staffing in Long-Term Care

> COVID just brought forward all the wrongs that's been in long-term care for a long time.
>
> –Long-term care staff member

The long-term care sector employs more than 100,000 people across Ontario. Of these, 58 per cent are personal support workers, 25 per cent are nursing staff (which includes registered nurses and registered nurse practitioners) and 12 per cent are allied health professionals and programming support (including dietitians, speech-language pathologists and audiologists, physiotherapists, occupational therapists, recreation therapists, social workers and others). Long-term care homes also employ housekeeping, laundry, maintenance, food services and administrative staff. In addition, homes contract with attending physicians to provide care to the residents.

The staffing mix of a home is not prescribed under the *Long-Term Care Homes Act, 2007*; all long-term care homes in Ontario are nonetheless required to fill the following positions:

1. **Administrator:** in charge of the home and its overall management.
2. **Medical Director:** whose responsibilities include development, implementation, monitoring and evaluation of medical services in the home; advising on clinical policies and procedures; and addressing issues related to resident care, after-hours and on-call coverage. This position must be filled by a physician.
3. **Director of Nursing and Personal Care:** to supervise nursing staff and personal care staff in the home. This position must be filled by a registered nurse.
4. **Attending physician or registered nurse** in the extended class (i.e., nurse practitioner): to conduct a physical examination of each resident upon admission and annually thereafter, attend the home regularly to provide services, and participate in the provision of after-hours and on-call coverage.
5. **Registered nurse:** on duty and present in the home at all times.

The roles and responsibilities of these positions are discussed in more detail in appendix B.

During its investigation, the Commission met with many who work in long-term care. Whether speaking publicly or confidentially, these staff members shared first-hand stories about their work before and during the pandemic. It was abundantly clear that most of those who work in long-term care are dedicated to both their job and the residents. This includes the nurses, PSWs and those employed in other areas of the home. Also apparent was that the system in which they work is strained; there is no slack, and no excess capacity.

Staffing shortages in long-term care are chronic. Successive governments have been aware of the problem, although none has provided a workable solution – despite the many calls and promises to do so. In June 2020, the Registered Nurses' Association of Ontario (RNAO) released a list identifying 35 such reports and recommendations on long-term care staffing and funding in Ontario over the past 20 years.

In 2019, Justice Gillese's inquiry report called for the government to conduct a further study to determine adequate staffing levels for long-term care; the corresponding report was released in July 2020. The staffing shortage in long-term care has been thoroughly

considered. As discussed in the Commission's first set of interim recommendations (see appendix A), the time for studying the obvious is long past.

Contributing Factors

Several factors underlie the chronic staffing crisis in long-term care. While there are universal issues that contribute to the sector's staffing shortages, each staff group (nurses, PSWs, etc.) also faces its own unique challenges. One thing, nevertheless, is clear: funding to recruit and train new staff will continue to be wasted if the long-standing issues that created and continue to contribute to the staff-retention problem are not addressed.

Discussed below are some of the key issues contributing to the staffing shortages in long-term care, as shared with the Commission. It should be noted that this is by no means an exhaustive list. The focus here is on highlighting the long-standing issues that contributed to creating this fragile workforce and that, if left unaddressed, will result in similarly devastating effects when the next outbreak hits.

An exodus of personal support workers

The Commission heard that not enough people are entering the training programs for PSWs to meet the demand for these workers. While Ontario graduates approximately 7,000 to 7,400 personal support workers every year, 40 per cent of those graduates either never work as PSWs or leave the profession within one year of being trained.

PSWs are the largest workforce in long-term care. Unfortunately, they are also the most transient group. Recruitment and retention of PSWs has long been an issue. Every year, 25 per cent of these workers leave the sector. Some go to other parts of the health care system that offer better pay or more favourable working conditions, while many just leave altogether. This means that of the approximately 58,000 PSWs currently working in long-term care, 14,500 will leave the sector this year – and that is before considering those leaving due to the strain that COVID-19 added to an already challenging job.

Even prior to COVID-19, there was a net exodus of PSWs from the long-term care sector. This resulted in a shortage that was not addressed. Prior to COVID-19, the province estimated that between 6,200 and 6,400 additional PSWs were needed by 2023 to support long-term care expansion if the issues with retention were not solved. When COVID-19 hit – creating further staffing shortages due to illness, fear or government policies restricting workers to a single long-term care home – this meant many homes did not have enough PSWs to provide proper care to their residents. As of July 2020, the Ministry of Health estimated that the health sector needed an additional 6,000 PSWs, with around half being in the long-term care sector.

A lack of full-time opportunities

> I also want to just touch on the disturbingly precarious nature of the work in long-term care, and the studies have shown that working conditions have a direct impact on care conditions. ... There is an overreliance on part-time and casual staff industry-wide particularly among for-profit providers. The vast majority of jobs in these facilities are part-time jobs with no benefits, no paid sick days.
>
> –Candace Rennick, Secretary-Treasurer, CUPE

The lack of full-time employment opportunities available to long-term care staff, and to personal support workers in particular, is a key issue that must be addressed. Almost 60 per cent of all PSWs are employed on a part-time or casual basis. Of these, approximately half reported that they would prefer to work more hours. Similarly, 35 per cent of nurse practitioners, 41 per cent of registered nurses and 45 per cent of registered practical nurses work part-time in the sector, yet 76.1 per cent are reported to prefer full-time work.

The Commission heard that, as a result of the lack of full-time employment, a large proportion of long-term care staff are forced to piece together a number of part-time and casual jobs to make a living wage and support their families. The situation worsened during the pandemic, when staff were prevented from working at multiple long-term care homes; while this was necessary to limit the spread of COVID-19 between homes, it worsened the financial burden many staff face, as the single-site limit was often not met with an increase in hours or pay. Subsequently, one union reported that 7,500 of the nurses and PSWs it represents in Ontario had either left their jobs or were planning to leave due to financial constraints.

During the COVID-19 pandemic, staff were offered full-time employment by some homes, with positive results. As described by one CEO, full-time employment benefited the staff, residents and home:

> [I]n some cases, more than 75 percent of residents in long-term care have some sort of dementia, so having people around who they know and they trust go a long way in ensuring their well-being. And ... it is good from a company perspective because we have found turnover to be lower in full-time roles than it is in part-time.

As highlighted by the statement above, low staff turnover is not just important from a staffing numbers perspective – it is better for residents' quality and continuity of care.

While it is acknowledged that some part-time staff are needed due to the round-the-clock nature of long-term care, the current level of part-time staff – among both PSWs and nurses – is not beneficial to residents. The interim report of the Expert Panel on SARS and Infectious Disease Control, also known as the Interim Walker Report, concluded that "the availability of full-time employment for many healthcare workers

was clearly inadequate, and the Panel believed that existing rates of casual, part-time and agency employment were undermining efforts to ensure a stable and cohesive work place." Dr. David Walker and his panel recommended in their final report that, moving forward, 70 per cent of staff be full-time workers. The Registered Nurses' Association of Ontario has been recommending the same 70 per cent full-time/30 per cent part-time split in all health care settings for more than 20 years. The Ontario Nurses' Association also agrees with this 70/30 split.

These warnings and recommendations were ignored. As a result, the chronic lack of full-time staff negatively impacted the ability of long-term care homes to effectively respond to COVID-19.

In concert with efforts to recruit, train and retain more PSWs into long-term care, the Commission recommends the creation of more full-time direct care positions, including setting a target of 70 per cent full-time positions for nursing and PSW staff in each home.

A lack of wage parity

In addition to facing a lack of full-time employment opportunities, staff working in long-term care homes typically earn an average hourly wage that is lower than that paid to their counterparts working in hospitals. The lack of full-time employment opportunities exacerbates the issue, as most part-time staff very often do not have benefits to supplement or offset low wages. The Commission heard that this lack of wage parity with hospitals, as well as within the long-term care sector itself, aggravates staffing shortages and creates both recruitment and retention issues.

Care of the elderly in Ontario must include home care, acute care and long-term care. Each requires PSWs and nurses. Financial disparity between sectors of the health care system leads to the needless movement of staff who understandably are looking for greater and more stable income. This cannibalization of one sector's workforce for another's does nothing to improve the lives of those needing care.

To ensure sufficient staffing for all sectors, the income disparity across the health care sector must be addressed. The Commission recommends that direct-care staff be provided with wages and benefits that are better aligned to those provided within the sector and with those provided in public hospitals.

An unregulated health profession

> [N]ot anyone can just be a PSW. … [T]hey are not servants. They are not maids. Not anyone can walk in and know how to use a Hoyer lift and know exactly how to do a proper bathing technique. It is a skilled profession.
>
> –Ian DaSilva, Human Resources Director, Ontario Personal Support Workers Association and Canadian Support Workers Association

Despite comprising the largest staffing category in long-term care homes and providing vital services to vulnerable Ontarians – many of whom cannot express a complaint about how they are treated by the staff caring for them – PSWs, unlike their registered nursing staff colleagues, are unregulated. In fact, the Commission was told that PSWs are the largest unregulated workforce in Ontario. The Commission heard that being an unregulated workforce has contributed to the lack of recognition of the important role PSWs play in the provision of long-term care, which in turn adds to the recruitment and retention issues facing the sector.

Attempts have been made to create a registry of qualified and trained PSWs in Ontario, with the most recent being a prototype built by the Michener Institute at the University Health Network. Although this registry was pilot-tested, the Commission was told that it is "currently in a bit of limbo" due to COVID-19.

The Commission heard that the government had explored a registry model as opposed to the elaborate and expensive nature of a regulatory college structure. However, creating a registry will not fully address the problem of having unregulated PSWs. In fact, a regulator would be required to oversee and operate the registry.

What would ameliorate this situation is linking PSWs, at least initially and after appropriate consultation, to an established regulator in the health care field. This practice would make PSWs "members" of an established health care service regulator, thus granting them "professional" status in the eyes of the public and other health care professionals.

While regulating personal support workers will not solve the staffing problems discussed in this report, it will enable personal support workers to better and more safely serve long-term care home residents. The Ministry of Health and Ministry of Long-Term Care should ensure basic requirements are in place to support the regulation of personal support workers and consider that initial regulation could be provided by an established health care regulator.

A lack of accurate hours-of-care data

As noted earlier in this chapter, the needs of long-term care residents have increased over the last few decades. Yet the hours of daily care that each resident receives have not seen a commensurate increase. The arrival of COVID-19 exacerbated this problem, leading to a situation in which already overworked staff were overwhelmed, and residents paid the price.

In December 2020, the provincial government committed to increasing the daily amount of direct care provided by registered nurses, registered practical nurses and personal support workers to four hours per day per resident, echoing an unfulfilled promise made by the previous government. In its commitment – and as noted above – the government reported that the actual amount of care per resident, on average, is currently two hours and 45 minutes per day. During its investigation, the Commission reviewed various calculations of the daily care rate. It was apparent that the data being used were inconsistent and differed depending on the source. The Commission was advised that the data collected by the province did not reflect actual hours of care provided but, instead, the scheduled hours of care. Staffing shortages, holidays and sick days were not factored into the calculation, which led to an over-counting of actual care hours. In addition, care-hour data are consistently presented as an *average*. This does not mean that all residents in all homes receive the same amount of care. The presentation of staffing data as an average is misleading; the danger lies in the extremes, where insufficient care is being provided. Dr. Arthur Sweetman, an economist who worked on the 2020 Long-Term Care Staffing Study commissioned in response to Justice Gillese's recommendation, made this point:

> [W]hen you start talking about what's happening in the average home, you miss the real challenge, which is identifying … the poor performing homes and then helping those poor performing homes.

Dr. Sweetman told the Commission that, for his study, he sought out the 20 to 30 per cent of homes that provided the most and least hours of care. Looking at these extremes, he felt, would provide a better understanding of what was happening across the sector. He wanted to not only understand the hours of care being provided in the "average" home, but also in those at either end of the spectrum. However, that information was not made available to Dr. Sweetman. He noted that this lack of available data presents a challenge in understanding a system that he describes as having "tremendous diversity."

It is indisputable that the average level of care in long-term care homes is currently and has long been inadequate. In some homes and for some residents who receive less than the average of two hours and 45 minutes of care a day, the situation is even

worse. By adopting the care standard of four hours per day per resident, the government has acknowledged this reality.

Dr. Sweetman pointed out that insisting on accurate data would assist in identifying homes that have chronic staffing issues or provide an inadequate level of care. Targeting these homes for improvement, whether in a pandemic or not, would assist in promoting the well-being and safety of residents.

A lack of relevant training

The *Long-Term Care Homes Act, 2007*, includes the vague requirement that licensees are obligated to ensure that all staff of a home have the "proper skills and qualifications to perform their duties" and possess the qualifications provided for in the regulations. Even so, the Commission heard that the expertise of staff does not always suit the specific needs of the residents. For example, physicians who work in long-term care settings as Medical Directors are not required to have geriatric skills or end-of-life training. As a result, many long-term care homes operate with Medical Directors who may not appreciate the full scope of the residents' needs.

As another example, the July 2020 Staffing Study identified gaps between the training that PSWs received at the various colleges and universities and the skills their jobs in long-term care homes required. Regulation 79/10 under the *Long-Term Care Homes Act, 2007*, requires that the PSWs working in long-term care homes successfully complete a PSW program that meets the standards set out by the Ministry of Training, Colleges and Universities and has at least 600 hours of combined in-class instruction and practical experience. Community colleges, private career colleges and school boards provide programs for PSWs. There is no standardized curriculum across these various institutions to ensure that training in all required areas has been provided. Consequently, there is often a knowledge gap once the PSW enters the long-term care home. The government should establish and implement standardized minimum training and education requirements for all PSW training programs.

The Commission also heard that staff in many homes, although well-intentioned, are not properly trained in infection prevention and control practices. Many homes in fact suffer from a significant lack of expertise, despite regulatory requirements to have an IPAC coordinator on staff. After the SARS outbreak, the Ontario and federal governments commissioned reports by the Honourable Justice Archie Campbell, Dr. David Walker and Dr. David Naylor to provide an understanding of why Ontario fared poorly during SARS and what might be done to prevent a similar occurrence in the future (see chapter 2 for more details on these reports and their findings). IPAC was a main focus of those reports. Justice Campbell made it clear that IPAC, along with the provision of safe food and water, is a first priority for Ontario's public health system; in his report,

he noted that the quick spread of disease requires immediate attention to preserve health and save lives. Dr. Walker noted that the lack of proper infection control measures during SARS demonstrated how quickly the health care system could be brought to its knees. Both Dr. Walker and Dr. Naylor emphasized the need to improve infection control safeguards at the provincial and local level. In April 2004, Dr. Walker recommended that there be one infection control practitioner per 250 acute and long-term beds, and that the province work toward one practitioner for every 120 residents in long-term care by 2007.

Much of what Dr. Walker recommended was implemented in hospitals, which left them well protected when COVID-19 hit. Long-term care, however, largely did not implement those recommendations. There was no requirement in long-term care other than to assign a designated infection control lead who was to have "education and experience in IPAC practices," yet there was no specific IPAC training or accreditation mandated.

In 2012, the Provincial Infectious Diseases Advisory Committee on Infection Prevention and Control (PIDAC) – a multidisciplinary committee of health care professionals that advises Public Health Ontario on the prevention and control of health care–associated infections – recommended that all health care settings "have access to a certified [infection control professional] or trained individuals to implement the IPAC program and resources that are proportional to the size, sophistication, case mix and estimated risk of the populations served by the health care setting." PIDAC further recommended that for long-term care settings, this ratio should be one infection control professional per 150 to 200 beds, depending on acuity levels.

Despite these warnings and recommendations, most long-term care homes did not have access to someone with basic knowledge of effective IPAC practices when COVID-19 hit, let alone a properly trained infection control professional.

Regular turnover of front-line staff, especially PSWs, exacerbated this problem.

The designation of an IPAC lead in a home was in large measure window dressing – a title without the necessary expertise or support to back it up. The Commission heard that training is generally inadequate and often involves watching a video. Instead of a fully trained IPAC specialist, the IPAC lead of a home is often a designation provided to an otherwise busy nurse who has not been sufficiently trained in infection prevention and control supervision.

Considering that long-term care homes experience regular influenza outbreaks, the failure to ensure the presence of adequately trained IPAC leads in homes is a problem that ought to have been corrected long ago. Proper IPAC leadership ensures that all staff are properly trained and that proper IPAC practices are followed. This also applies to agency staff hired by homes, who the Commission was told are often poorly trained

in IPAC practices. During the COVID-19 pandemic, the inadequate level of IPAC knowledge and practices was a frequent observation of the military and the hospitals who came to the aid of homes in crisis.

The Commission learned that long-term care homes in countries with a strong and pre-existing emphasis on IPAC fared better than those in Ontario. In Hong Kong, for example, where SARS devastated long-term care homes, there has been a strong emphasis on IPAC training and practices in the years since. This emphasis is one reason why Hong Kong's long-term care homes performed much better than those in Ontario during COVID-19.

Need for Urgent Action

The issues explored in the section above – including a lack of full-time employment, lack of wage parity, heavy workloads, and a challenging working environment and culture – in no way comprise an exhaustive list of the factors contributing to the staffing shortages in the long-term care sector. Nevertheless, they do paint a clear picture of the difficulties at hand.

Recruiting and retaining staff is a significant challenge. The requirement of four hours of direct daily resident care and the government's promise to add 15,000 beds in the next four to five years (discussed further later in this chapter) will require the hiring of an additional 25,000 to 30,000 personal support workers by 2024–25. If tens of thousands of additional beds are also added in the next two decades – as is needed – the increase will require tens of thousands of additional PSWs, nurses and other staff to care for the expected number of residents.

Staffing matters.

Every moment that passes without addressing these chronic staffing issues is a moment wasted, and wasted time costs lives.

The time to act is now.

More staff needed

Information received by the Commission demonstrated that how well a home fared during the COVID-19 pandemic was directly associated with its staffing. The Canadian Institute for Health Information found that homes with a higher ratio of nursing staff to residents were less likely to experience a COVID-19 outbreak (the term "nursing staff" included registered nurses, nurse practitioners, registered practical nurses and PSWs). CIHI also found that the risk of infection and the mortality rate in the first wave were greater in homes that were short-staffed at least once during that period; the same

increases were found in homes that used agency staff for at least seven days in any one month of the first wave.

Dr. Sweetman told the Commission that an indicator of strong performance in a home during an outbreak is the experience of its nurses (i.e., the number of years a home's nurses have worked in the province). While it is not necessary that every nurse or staff member be highly experienced, homes with experienced "clinical leadership" performed well in outbreak scenarios, including during the COVID-19 pandemic.

The significant staffing problems identified prior to the arrival of COVID-19 – problems that adversely affected the ability of the homes to protect residents from the virus – will continue to plague long-term care homes if not resolved fully, effectively and promptly.

To meet its commitment of four hours of direct daily care, the province announced in December 2020 that it would be investing up to $1.9 billion annually by 2024–25 to create more than 27,000 new positions for PSWs, registered nurses and registered practical nurses in long-term care. In February 2021, the province announced efforts to attract and train 8,200 new PSWs for Ontario's health care sectors (including long-term care). This is a good start, but it is just a start. Much more needs to be done to genuinely meet the current and inevitable demand.

Better ratios and skill mix required

It is not only the total number of staff providing care to residents that is relevant – staffing expertise needs to reflect the diversity of residents' care requirements. The existing legislation does not mandate the ratio of staff to residents that each home should employ or the skill mix of staff that each home should have (i.e., how many PSWs vs. registered nurses vs. registered practical nurses). These details are left to the individual homes to determine.

The 2020 Long-Term Care Staffing Study declined to suggest a staffing mix for the newly recommended four hours of care per resident per day, and the government has yet to indicate what its planned staffing mix will be. The Commission interviewed many well-informed stakeholders about suggested staffing mixes, including the Registered Nurses' Association of Ontario. The RNAO's recommended formula consists of 20 per cent registered nurse (or 0.8 hours), 25 per cent registered practical nurse (or 1 hour), and 55 per cent PSW (or 2.2 hours). The Ontario Nurses' Association recommends the same formula.

Considering the acuity level of the residents, particularly the continuing decline of mental cognition, it is clear to the Commission that more registered nursing staff are required in the long-term care sector and that the RNAO recommendation is a reasonable mix. The Commission also recognizes that the appropriate staffing mix may

differ from home to home, depending on the needs of the residents. The RNAO's recommendation reflects the increasingly complex level of care that residents need. If followed, it would ensure that an adequate number of staff, with a proper mix of training, skills and knowledge, would be on hand to provide safe, quality care to residents.

The Commission also heard about the need for nurse practitioners in long-term care. As will be discussed further in chapter 4, nurse practitioners have extensive training and may perform some of the same functions that a doctor performs. But the reality is that nurse practitioners have not been embraced in the sector to the degree that they should be. As it stands, there are only 60 to 70 nurse practitioners currently working in Ontario's long-term care sector. At just 0.6 per cent, the current ratio of nurse practitioners to residents in long-term care facilities is insufficient. The government and the long-term care sector need to recognize the important contribution and impact that nurse practitioners have on the quality of care in long-term care homes.

The Ontario Nurses' Association and the Registered Nurses' Association of Ontario recommend, and this Commission accepts, that the ratio for nurse practitioners in long-term care facilities be set at a minimum of one full-time nurse practitioner for every 120 residents.

It is also apparent that the services provided by allied health professionals play a vital role in extending the lives of the residents and ensuring quality of life while in long-term care. As set out in the 2020 Long-Term Care Staffing Study, access to these professionals increases residents' strength and mobility, reduces trips and falls, improves sleep quality, and promotes resident independence and quality of life. An investment to increase the involvement of allied health professionals (including dietitians, speech language pathologists and audiologists, physiotherapists, occupational therapists, recreation therapists, social workers, and others) in long-term care is necessary in order to ameliorate resident health and quality of life.

In addition to the newly recommended four hours of care per day per resident to be provided by registered nurses, registered practical nurses and personal support workers, the government has also committed to increase the average care provided by allied health professionals from the current 30 minutes per resident per day to 36 minutes per resident per day by 2022–23. This is not enough. To ensure that residents receive the necessary physical, emotional, social and spiritual care from this group, the average care provided by allied health professionals should be increased to 60 minutes per resident per day. While this will require a significant financial investment, failure to enact this change will deprive long-term care residents of this critical care. The Commission stresses that this does not need to be the subject of yet another staffing study. Action is required now to provide residents with the care and quality of life that they deserve.

Faster implementation of four-hour care standard

While the government has committed to four hours of care per resident per day, it is important to note that this threshold will not be reached until 2024–25. This staged implementation of the new care standards is too slow. The four hours have been recommended based on the *current* needs of residents. The staged approach likely means that the vast majority of current residents will have passed before the four hours of daily care is fully implemented. It is also worth noting that if the acuity of long-term care residents continues to increase, it is likely that more daily hours of care will be required by the time final implementation of the four-hour standard occurs.

The Commission recognizes that reaching the four hours of care per day per resident will not be possible if the underlying causes of the pre-existing and long-standing staffing issues are not addressed. Even if the government realizes its commitment to meet the future demand for long-term care beds over the coming decades (discussed later in this chapter), no improvement will result without adequate staffing to care for the residents. It is not just more beds or more care hours that are needed; there must also be sufficient – and sufficiently trained – staff to provide proper care to the residents in those beds.

Leadership of Homes: Unclear Roles and Responsibilities

While there are clearly challenges at the staffing level in long-term care homes, it is also true that home leadership is instrumental in creating and maintaining supportive and functional work environments that provide quality of care and support resident quality of life. It is vital that management responds to concerns expressed by residents, their families and loved ones, and staff, and engages in continuous improvement in quality of care and resident quality of life.

In its second set of interim recommendations (see appendix A), the Commission underlined the importance of in-home leadership in addressing workplace culture and setting the tone and direction for home performance. This is important at all times and becomes even more crucial in times of crisis. The quality of in-home leadership pre-COVID-19 is an important factor that influenced how long-term care homes fared during the pandemic.

The legislation governing long-term care homes mandates the presence of skilled, trained professionals to act in various capacities. They are the ones who are to ensure that the residents are properly cared for, kept safe and that their quality of life is maintained.

The Medical Director

The Regulation under the *Long-Term Care Homes Act, 2007*, does not define ongoing training requirements for the Medical Director in key areas responsive to resident needs, including IPAC, geriatric medicine, caring for patients with dementia and other cognitive dysfunction, the appropriate use of antipsychotic medication, palliative and end-of-life care, and in leadership and crisis management. The Regulation should be amended to require the Medical Director to have this additional ongoing training.

The Commission heard about the important role of the Medical Director in long-term care homes. In fact, the Canadian Institute for Health Information told the Commission that it found that the consistent physical presence of a Medical Director in a home was associated with better COVID-19 outcomes, with homes in which the Medical Director was present less than one day per week during the first wave having a higher risk of outbreak severity and resident mortality.

The Commission met with and heard about Medical Directors who were well-trained and devoted to the care of their residents. They were well-equipped to deal with a crisis.

However, the Commission also heard that some Medical Directors did not have training in geriatric medicine, palliative care, treating dementia, or IPAC. They did not have the requisite leadership training or training in crisis management.

If there had been a formal system of oversight, these shortcomings could have been identified and ameliorated, thereby improving the outcomes for long-term care residents.

The Ministry of Long-Term Care and the Ministry of Health should work with the College of Physicians and Surgeons and the Ontario Medical Association to create a system of formal oversight for long-term care home Medical Directors, similar to the Medical Advisory Committee model for physicians with hospital privileges. This oversight should include a review and assessment of the candidate's expertise in the care needs of the long-term care home resident population (including IPAC, geriatric medicine, caring for patients with dementia and other cognitive dysfunction, the appropriate use of antipsychotic medication, and end-of-life care), and in leadership and crisis management.

The IPAC Coordinator

This investigation has highlighted the importance of the role of the IPAC coordinator. This is a vital role in the home. As mentioned earlier, the Commission heard that in many homes prior to COVID-19 this role was not considered to be important and was

treated as an add-on to an existing full-time job. In fact, many of the designated IPAC coordinators did not have IPAC education, training or certification. This would prove to be a significant problem. When the pandemic hit, there was an absence of information, protocols and practices relating to IPAC in the homes; in some, there was not even a basic understanding of the importance and proper use of personal protective equipment (PPE).

It is the Commission's recommendation that the regulation under the *Long-Term Care Homes Act, 2007*, be amended to require the licensee to designate one registered nurse per 120 beds as the home's IPAC practitioner(s); this role would oversee, implement and maintain the home's IPAC program. The regulation should set out specific minimum IPAC education, training and certification requirements that the practitioner must keep current. The IPAC practitioner role should be a dedicated, full-time position that reports directly to the Director of Nursing and Personal Care. The regulation should also require that staff IPAC training be conducted in consultation with the local IPAC specialist (e.g., located at the hospital partner or public health unit).

Emergency Plans and IPAC Requirements

Part V of the *Long-Term Care Homes Act, 2007*, also addresses the IPAC and emergency planning provisions that long-term care homes are required to implement. The accountability and responsibility for these plans and actions fall to the in-home leadership team.

According to Dr. Jennie Johnstone, Medical Director of Infection Prevention and Control at Sinai Health, prior to the pandemic a culture of swabbing and testing did not exist in long-term care homes unless a number of residents presented with respiratory illness. She told the Commission that long-term care homes were given five swabs each for the flu season and the guidance was that once an influenza or respiratory virus outbreak was declared, the long-term care home should not continue to test. Instead, it was to be assumed that symptomatic residents had the respiratory illness.

While long-term care homes are required to report outbreaks of communicable diseases, there is no legislative or regulatory requirement for them to report to anyone on the general state of their IPAC preparedness. The Commission has neither heard nor seen any evidence of such reporting. The Commission also did not hear evidence that regular audits of IPAC preparedness were conducted in the homes before the pandemic. While the Commission heard that some public health units, such as York Region and Peel Region, were proactive in conducting IPAC and environmental audits of homes prior to the pandemic, this was not mandated and the Commission heard no evidence suggesting it was the norm.

There was a general lack of IPAC preparedness in long-term care homes when the province declared a state of emergency in March 2020. The inferior IPAC practices, the lack of knowledge among staff regarding how to contain an infectious disease, and the failure by provincial authorities and in-home management to ensure overall regulatory compliance meant that the homes were primed for the COVID-19 virus to enter and then spread like wildfire.

There needs to be accountability. The board of directors of the licensee (under the signature of the chair of the board or the applicable equivalent) should publicly certify annually to the Ministry that appropriate audits have been done of the home's IPAC practices and pandemic plan, including the sufficiency of the homes' pandemic stockpile of personal protective equipment and testing of the pandemic plan. This will provide a level of security that the home leadership acknowledges and is accountable for ensuring a safe environment for residents and staff. As will be seen below, this level of accountability is lacking in the current system.

Ministry Oversight and Enforcement: Weak and Ineffective

The Commission heard evidence that the province's oversight and enforcement of regulatory compliance has been ineffective, especially in areas that could have made a difference in how long-term care homes responded to the pandemic. It is necessary to have strong government regulatory oversight and enforcement in a government-funded sector responsible for taking care of seniors who are unable to live independently.

The Ministry of Long-Term Care performs a policy, funding and inspections/compliance role for the long-term care sector. Questions have been raised about the effectiveness of the province's oversight and inspections system, which is supposed to protect and advance the safety and security of the vulnerable population who reside in long-term care homes.

Reduction in Resident Quality Inspections

In 2013, the Ministry of Health and Long-Term Care recognized that comprehensive inspections would help identify systemic issues in homes. As a result, the Ministry committed to completing an annual Resident Quality Inspection (RQI) in every home by the end of 2014 and each following year. Approximately 100 inspectors were hired over two years to support this effort, bringing the total number of inspectors to 180 by 2015. This number has remained largely the same over the last five years, along with funding for 188 full-time equivalent long-term care inspector positions as of November 2020. Nearly all of the province's 626 long-term care homes received an RQI in 2015, 2016 and 2017.

In 2018, in order to clear a backlog of almost 3,000 complaint and critical incident inspections, the Ministry introduced a risk-based inspection and enforcement program. Long-term care homes deemed high-risk were to receive more thorough annual inspections, although the intention was to inspect all homes each year. In 2018, however, only 329 long-term care homes received an RQI. That number dropped to 27 homes in 2019.

This almost total elimination of RQIs, which are intended to provide a holistic review of operations in the long-term care homes, left the Ministry of Long-Term Care with a very limited picture of the state of long-term care homes, and virtually no idea of a home's IPAC and emergency preparedness when the pandemic began. This was a mistake, as RQIs are the only resident-focused inspections that include a review of IPAC.

This issue was raised by the Commission in its second set of interim recommendations to the Minister (see appendix A).

Focus on Complaints and Critical Incidents

In 2019, 97 per cent of the inspections completed by the Ministry were reactive (i.e., in response to complaints, critical incidents, follow-ups and Director Order follow-ups), and of these, there were only 28 complaints and 26 critical incident inspections related to IPAC and emergency preparedness. The Commission also heard that in most cases, homes are aware of when inspections will take place.

In addition, the 2018 changes to the inspection process described above specifically mandated that inspectors were to "stay focused" on the complaint or critical incident that brought them to the home unless the inspector witnessed a "level 4 problem" that placed the residents at immediate jeopardy or risk. As such, significant violations might exist in a home at the time of a critical inspection yet might not result in any notice of correction. Once the critical inspection was "completed," there would be no further inspection for the year. This may explain why hospitals and the military found homes in varying states of disarray and uncleanliness that appeared to pre-date COVID-19. The Commission heard that one hospital spent almost $500,000 to deep-clean a single home.

The complaint- and critical incident–driven approach to inspections provides a false sense of assurance, as homes with low or no complaints do not necessarily reflect low risk or high compliance. There are multiple reasons why a complaint about a home may not be received, including a lack of family or advocates speaking out on behalf of residents who cannot do so for themselves. This approach also places the onus on staff, families, residents, caregivers and the general public to be familiar with the regulations and to identify and report violations. It needs to be changed.

Lack of Enforcement

Prior to the pandemic, there was a lack of enforcement and lack of follow-up to verify compliance with orders issued by the Ministry. In 2019, the two most common actions resulting from an inspection were a Written Notification and a Voluntary Plan of Correction. Neither require mandatory follow-up by the Ministry or verification by the long-term care home to demonstrate compliance.

The Ministry does have a more effective tool to ensure compliance, but it is, unfortunately, rarely used. Director Orders allow the Director of the Ministry of Long-Term Care Inspections Branch to issue escalating sanctions to a home for non-compliance. Director Orders can range from a written notice to a cessation of admissions, the imposing of mandatory management orders and financial sanctions, and licence revocation. Director Orders clearly have the potential to enforce; however, they appear to be used only in extreme circumstances, with just 21 issued in the 20 months between January 2019 and August 2020.

The evidence before the Commission is that fines or prosecution penalties for failure to comply with orders under the *Long-Term Care Homes Act, 2007*, are rarely applied as a form of corrective action, which may explain the lack of urgency demonstrated by long-term care operators to achieve compliance.

It is evident from this approach taken by the Ministry that licensees have little reason to fear repercussions for non-compliance. It is unlikely that non-compliance will be discovered since inspections are limited. Further, when non-compliance is discovered and an inspector takes action, there is generally no follow-up to determine if the home has achieved compliance. In the rare event that an order is issued, there are few, if any, consequences for breaching the *Act* or its regulation. The licensees have little to fear, as the province is unlikely to shut them down due to the dire lack of beds and the growing demand for long-term care in the province.

A method to increase accountability and compliance in the inspection regime is needed, such as requiring accountability through a home's insurer, who can require compliance as a condition of coverage. The Ministry of Long-Term Care must recognize that insurers of long-term care homes are a natural partner in any compliance and enforcement regime.

Heavy Regulatory Burden on Non-Priority Issues

The Ministry has faced criticism for the excessive regulatory and administrative burden placed on homes. Critics have commented that homes are expected to report on many aspects of their operations and that such obligations detract from the care they are able to provide to residents.

Long-term care staff and some operators and associations have told the Commission that this situation has created a culture focused on adherence to rules and over-reporting but not necessarily relating to the priorities most relevant to residents' health, safety and well-being. Multiple witnesses spoke about the demands of over-reporting, which was common prior to the pandemic and became untenable once COVID-19 struck.

The necessity for government regulatory oversight over a sector that is government-funded and responsible for the care of the province's most dependent seniors is undeniable. Home operators must be held accountable. However, long-term care operators, staff, residents and families have all suggested to the Commission that a regulatory focus on the right issues and compliance support for homes, quality improvement and resident care, and resident and family satisfaction would be an improvement over the current approach.

Accreditation

In Ontario, accreditation is voluntary for long-term care homes. Homes that choose to seek it must do so from one of the two Ministry of Long-Term Care–approved accreditation bodies: Accreditation Canada or CARF International (Commission on Accreditation of Rehabilitation Facilities), a U.S.-based accreditation body. The Ministry provides an incentive of an additional $0.36 per bed per day for accredited homes. As of the end of 2020, 84 per cent of long-term care homes in Ontario were accredited.

This accreditation process does not appear to have identified the long-standing issues this Commission has heard about in many of the homes. Furthermore, issues identified during the accreditation process are not disclosed to anyone other than the home operator.

An independent mandatory transparent accreditation process for all homes that does not depend for its funding on the homes it is accrediting must be instituted.

The Ontario government should participate in current and future efforts to implement standards and best practices for long-term care across the country.

Flagging Homes At Risk

As noted in the Commission's second set of interim recommendations (see appendix A), the current six clinical indicators tracked in the long-term care home performance report – such as the percentage of residents who fell, experienced pain or were physically restrained – are a good first step in advancing transparency and flagging issues in homes. However, this data, while valuable, does not provide other important

insights into the quality of care received by residents and their experience in the home, nor is it being utilized to its fullest extent.

The Ministry of Health collects and analyzes system data for both the Ministry of Health and the Ministry of Long-Term Care. It has access to a range of data sources and possesses the expertise to use that data to produce dashboards, analyses, indicators, forecasts, performance measures and situational analyses. Data on long-term care residents include their cognitive status, payment status, food intake and medical status. The following key metrics were measured pre-COVID-19 to determine how a home was performing:

- inspection reports and the complaints process;
- routine monitoring of transfers to hospitals and falls;
- information (quarterly or annual) on high-level staffing; and
- other more static data, such as the number and nature of homes (age, size, etc.), financial and health human resources, and the number of people on the waitlist.

However, information received by the Commission indicated that quality, real-time data are not gathered and widely distributed in a timely manner to flag issues and bring them to the attention of those who need to know and could protect the residents.

In addition, some of the data generated through the ongoing governance, management and accreditation of long-term care homes are only available locally for decision-making. This information is often not captured by the government or shared among ministries, public health units and homes in a manner that allows it to be used to gain insights about the system and, more importantly, to raise red flags and identify risks. Had this information been utilized and shared among these entities, it might have alerted the regulators to issues before the pandemic that could have been rectified and, in turn, better prepared homes to manage when the pandemic hit. This siloed and non-transparent system failed to protect the residents and must be abandoned.

Data gaps in three important areas were identified to the Commission. The Ministry did not know the status of PPE supplies in homes, the adequacy of staffing levels or the status of IPAC practices. The lack of information in these areas proved to be critical once the pandemic struck.

In addition, since they are an unregulated workforce, information on PSWs is generally limited and of poor quality. In light of the central role that PSWs play in the long-term care sector, this is a significant knowledge gap. Furthermore, the experiences of long-term care residents, their family caregivers and staff are not systematically collected for ongoing performance reporting, making it difficult to reliably measure whether care

is meeting the needs of residents and their families, what the levels of staff engagement are, and how experiences have changed over time.

Better data and better reporting by the province are needed. Such a reporting system is possible. The Canadian Institute for Health Information, for example, publicly reports on home-level quality of care using nine quality indicators. The Commission heard that every long-term care home resident in Ontario has an annual assessment, as well as shorter quarterly assessments. This information forms the basis of the Continuing Care Reporting System. The nine quality indicators that CIHI reports on are derived from this quarterly clinical information. The indicators measure quality of care in numerous domains of health and well-being, including pressure ulcers, use of physical restraints, incidents of falls, antipsychotics use, mood worsening, experience of pain, pain worsening, and improved or worsened physical functioning. For each home, CIHI determines if the home is in the bottom 20 per cent on any quality indicator. This information is then made publicly available on CIHI's website. The availability of such metrics supplies information about the care being provided at homes that is accessible by families, residents, staff, home leadership, and the general public. Based on this information, the relative performance of different homes, as well as the performance of a home over time, can be assessed and used to identify risk to the residents. In line with this, CIHI reported to the Commission that those homes that performed more poorly on its publicly reported quality indicators were more likely to have a COVID-19 outbreak.

The performance of each long-term care home should be assessed by key performance indicators designed to accurately measure resident quality of care and quality of life. The homes should be required to provide annual reports, which should be accessible to the public.

Long-Term Care in the Broader Health Care System: No Seat at the Table

The staffing and management challenges outlined above certainly represent a major hurdle to providing top-quality care to Ontario's long-term care residents, as does the lack of effective oversight. However, it is important to note that long-term care staff and management should not be working in a vacuum.

In speaking with the Commission about infection prevention and control issues within long-term care homes, Dr. Allison McGeer, an infectious disease consultant at Sinai Health System, identified a key problem around IPAC training. She advised that prior to 2003, hospitals often assisted homes with infection prevention and control. In the aftermath of SARS, however, long-term care homes were required to have IPAC expertise on staff. As a result, homes no longer connected with the hospital and its IPAC experts. By the time COVID-19 hit, some homes were effectively estranged from

their local hospitals, and the hospitals did not consider themselves responsible for IPAC in long-term care homes.

This split was unfortunate, and indicative of what would become a wider isolation of long-term care within the broader health care system. Prior to COVID-19, there was no system in place to facilitate this type of integration, despite the fact that interaction between the long-term care sector and the broader health care system is essential. Ontario Health, public health units and hospitals play important roles in supporting long-term care homes to protect and care for their residents in public health emergencies.

Nevertheless, many long-term care homes did not have pre-existing or formal relationships with local health care partners, despite the increasing acute medical needs of residents. Where these connections did exist, they tended to be informal, *ad hoc* arrangements.

Hospital–long-term care home relationships, for example, generally only existed in those cases where a hospital is an owner-operator of a long-term care facility (e.g., Hôpital Montfort in Ottawa) or where a hospital had engaged with a long-term care home to manage a previous crisis. Some homes had ongoing informal relationships with their local hospital, but they were the exception rather than the rule.

This represents a missed opportunity, as hospitals are equipped with the expertise, training, equipment and, in some cases, the extra staffing needed to quickly address and contain the spread of infectious disease in a long-term care home.

In the early part of COVID-19's first wave, homes without a pre-existing hospital relationship did not initially reach out for assistance with IPAC expertise until they were already in crisis. By the time this outreach occurred, COVID-19 was out of control and residents were infected; 30 per cent of those residents died.

The onset of the COVID-19 pandemic did not initially change this siloed approach to long-term care. Without formal integration of long-term care homes into the wider health care community, it was not clear where long-term care homes could turn for help at the outset of the pandemic and who was responsible for responding to key issues in the homes during the pandemic.

The Ontario government is already providing funding to support the creation of Ontario Health Teams (OHTs) across the province. OHTs will bring together health care providers and organizations to work collaboratively as a coordinated team to provide a continuum of care for patients across providers.

The government should fast-track the implementation of a coordinated governance structure and enhanced funding model to strengthen and accelerate development

of Ontario Health Teams and ensure that local/regional Ontario Health Teams are implemented in such a manner that a coordinated continuum of care includes all long-term care homes. (Ontario Health Teams will be discussed in greater detail in chapter 4 and appendix B.)

Inadequate Funding for Long-Term Care

> [R]esidents are older, more medically complex than those living in many other congregate care settings, living often in crowded conditions, and the pandemic highlighted very long-standing issues that we have had to prevent, identify, contain and manage outbreaks, such as understaffing and underfunding ...
>
> –Lisa Levin, CEO, AdvantAge Ontario

As demonstrated throughout this chapter, there are numerous and complex challenges when it comes to ensuring that Ontario's most vulnerable citizens receive the quality care they so richly deserve. The province failed to address these long-standing and well-known issues in the decades prior to COVID-19 and failed to properly fund this vital health care sector.

In 2020–21, the provincial long-term care budget was $6.96 billion, 96 per cent of which was for daily operations, with the remaining 4 per cent for development projects and minor capital expenditures. Despite the fact that the province spends billions of dollars every year on this sector, the Commission heard repeatedly and from a variety of stakeholders that long-term care is chronically underfunded.

Public spending on long-term care in Ontario is lower than the average spent by developed countries.

Long-term care funding comes from a combination of provincial government funding and resident co-payments, with a government subsidy available for residents who demonstrate financial hardship and are unable to remit the full co-payment amount.

In order to understand the challenges the sector faces in this area, it is necessary to examine how the funding of long-term care homes works.

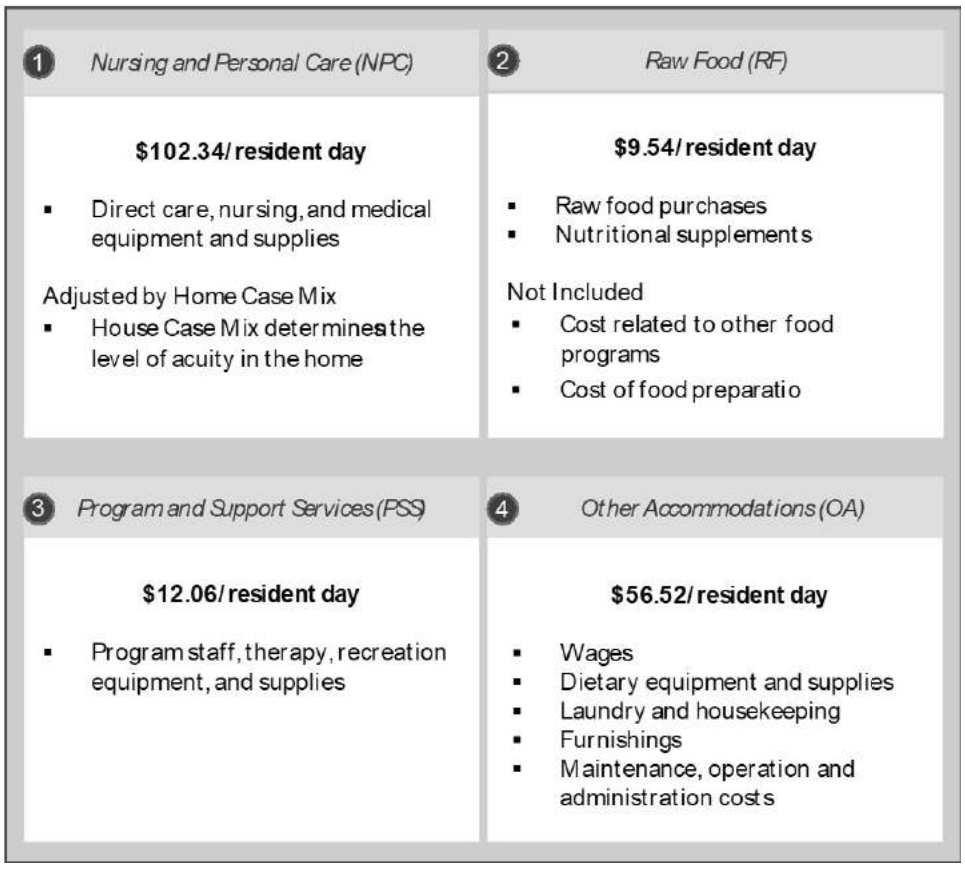
Level-of-Care Envelopes

The budget for resident care and accommodation is divided into four main funding envelopes – known as "level-of-care" envelopes. These cover a range of expenses, from staffing and medical equipment to food and housekeeping.

As of April 1, 2020, the level-of-care envelopes provide $184.96 per day for each long-term care resident (see Figure 1). In 2019, rather than increasing the funding of the four individual envelopes described in Figure 1, the government introduced a global per

diem of $4.50 per resident, giving homes the flexibility to allocate these funds to the envelopes as they see fit. The only restriction is that the allocation of global per diem funds to the Other Accommodations envelope is capped at $1.44 per resident per day (or 32 per cent of the global per diem).

Figure 1



The largest funding envelope is Nursing and Personal Care, which comprises 55 per cent of the per diem. It is adjusted annually to the individual home's occupancy level and to the acuity of the home's residents. Acuity of residents is measured by the Case Mix Index, or CMI – a measure of the complexity of medical needs of residents in the home.

With the Nursing and Personal Care, Raw Food, and Program and Support Services envelopes, funding that is not spent by the end of the fiscal year must be returned to the Ministry; this is not the case with the funds in the Other Accommodations envelope. The funding model does, however, allow for some flexibility in transferring surplus funds from certain envelopes to others.

It is important to note that the Other Accommodations envelope is used to pay for overhead, non-care staff, administration, servicing of debt and return to investors.

As such, for-profit homes may only take profit from the Other Accommodations envelope, not from the envelopes that directly fund the care of residents. The Commission was told that the funding in the Other Accommodations envelope largely comes from co-payments by residents. Specifically, the co-payment is remitted to the province by the resident, which in turn remits the bulk of the co-pay back to the home in the Other Accommodations envelope.

Supplementary Funding

In addition to the funding envelopes, a number of supplementary funding streams are available to long-term care homes. Supplementary funding is used for basic care and accommodation, specialized supports, capital and other initiatives. Supplementary funding streams include Behavioural Supports Ontario, Behavioural Specialized Units, equipment to aid in the prevention of falls and injury, and specified clinical education for staff. Any unused funds from the supplementary funding streams must be returned to the Ministry.

Use of Funding Envelopes

Homes are incentivized to spend all of the funding they receive through the envelopes. As discussed above, with the exception of the Other Accommodations funding, any unspent amounts must be returned to the Ministry. This encourages homes to use the funding within the stipulated categories. However, the Commission heard that the current government funding is still not adequate to fully cover the costs of caring for residents.

Topping Up

In certain circumstances, not-for profit homes and municipal homes have “topped-up” the care funding provided by the province. Not-for-profit homes seek grants or fundraise to access additional funds. In addition, their not-for-profit status means they do not pay income tax, which for-profit homes must pay. Municipal homes have a similar income tax advantage, as they do not pay municipal taxes. Certain municipalities also provide additional funding to support the care of the residents. The differences in how various homes top up funding results in significant variability in actual per-resident care funding, and likely in resident experiences, between homes.

Some municipalities use their municipal tax revenue to supplement the care of residents. For example, the Commission heard that in 2016, municipal governments collectively contributed $350 million over and above the provincial funding subsidy, not including capital expenditures (or approximately $21,600 per bed of additional funding).

One example of such a municipality is York Region, which pays 46.6 per cent of the total cost of care, whereas the provincial subsidy only pays 39.5 per cent, with residents' fees and service charges making up the remainder. While some of the additional funds municipal homes receive go toward increased employee salaries, much of the excess goes to care. This demonstrates that some municipalities clearly believe the province underfunds the cost of care. York Region, for example, uses part of its additional funding to top up the provincial Raw Food envelope by an additional $1.50 per resident per day in its two long-term care homes so that residents receive more fresh food, juices, better cuts of meat, and the like. The Commission heard that other municipalities similarly top up funding, although to varying levels.

With additional funding invested in care by some municipalities and not-for profits, there is clearly an inequity between homes as to the amount of money available to care for a resident. With the extensive delays due to the waitlist, those seeking placement are often compelled to take the first home offered. As a result, whether a resident enters a home that has additional funding to invest in care, such as the ones operated by York Region, is a matter of chance.

It is inequitable that chance should dictate the amount of money available to care for a resident in a provincial system of long-term care.

The State of Long-Term Care Infrastructure: Old and Overcrowded

> I don't think we can minimize the impact of these multi-bedrooms and the crowding with the 3 and 4 residents in the same room, the sharing of the washroom. This clearly drives transmission; it drives it during a pandemic. It also drives a bunch of these antibiotic resistant organisms, *C. difficile* and things like these, outside of pandemics but people are less focused on it during those interpandemic periods.
>
> –Dr. Kevin Katz, Medical Director of Infection Prevention and Control, North York General Hospital

As noted above, covering the cost of care in homes is an ongoing and serious challenge to the sector's ability to properly care for its residents. Equally challenging is the need to fund infrastructure projects that will allow long-term care homes to keep pace with changing needs and demands for care.

The Commission heard evidence from a variety of sources suggesting that these infrastructure projects are long overdue.

The Ministry of Long-Term Care advised the Commission that as of September 2020, a total of 31,399 beds still in use had been built to outdated design standards. Most of these older beds exist in for-profit homes. It is clear that these old beds need to be replaced or redeveloped to current design standards.

The physical design of older long-term care homes, many of which are built to design standards from the 1970s, can create challenges for providing quality care for residents, especially in reducing the spread of infection. For example, ward-style accommodations – in which three or four people share a room, and as many as eight share a washroom – can make it difficult to implement proper social distancing, deep-cleaning, and other infection prevention and control practices such as isolating and cohorting (or grouping) sick residents. The Commission heard that the space afforded to residents in newer home designs is greater than that in older homes. And unlike older design standards, updated standards introduced in 2015 require a washroom in all resident bedrooms.

It is worth noting that this issue regarding ward rooms is not the same across the country. Other provinces have fewer shared rooms. In British Columbia, for example, 88 per cent of long-term care rooms are single occupancy. In Alberta and Newfoundland and Labrador, less than one per cent of beds are in wards. In Ontario, by contrast, almost 40 per cent of homes have multi-bed wards.

Some believe the continued existence of these older homes reflects the value the province places on seniors and its long-term care system. As Dr. McGeer noted, no one wants to live four to a room, but:

> we think it's perfectly normal that our older people with Alzheimer's share bathrooms with eight or ten strangers and have one shower room for 30 people and live in a four-bed room with no space for ... visitors or anything else.

The failure to redevelop these older homes contributed to the inability of some homes to contain the spread of COVID-19. Moving forward, the province must address this issue by developing a better system for building and operating long-term care homes.

Building and Operating Long-Term Care Homes

One reason for the sorry state of the province's long-term care infrastructure is that throughout the decades prior to the COVID-19 pandemic, the government was slow or unable to attract long-term care stakeholders to deliver additional supply and upgrade their facilities.

Owners of long-term care homes are responsible for covering the upfront costs of development projects, with many owners accessing loans from banks or other sources. Some not-for-profits use the Infrastructure Ontario lending program, and some hospital-run long-term care homes use the Ontario Financing Authority.

The main source of financial support that the Ministry of Long-Term Care provides for long-term care development projects is through the 25-year Construction Funding Subsidy (CFS). The subsidy is paid to the long-term care home owner once the

development project is successfully completed in accordance with all conditions of the Development Agreement with the Ministry.

The Ministry also provides one-time funding opportunities, such as a $250,000 Planning Grant for not-for-profit and municipal owners to support project planning, once they sign a Development Agreement with the Ministry.

Owners use the CFS along with other funding sources, including revenue from the additional payment by residents in preferred accommodation (i.e., semi-private and private rooms), to finance redevelopment and development of long-term care beds.

In 2017–18, the then Ministry of Health and Long-Term Care allocated $151.5 million to the long-term care sector that was used mostly for the Construction Funding Subsidy for long-term care homes. In May 2019, the Ministry's Long-Term Care Homes Division reported that the Ministry had invested more than $1.8 billion of CFS funding into long-term care infrastructure projects over the past decade.

As of December 2019, however, only 177 beds were under construction, despite 7,889 beds having been approved for development.

In 2018, the Ministry of Health and Long-Term Care determined that there was an unwillingness to build long-term care homes because the return offered by the province via the Other Accommodations funding envelope was insufficient to attract private investors. As a result, the province increased funding levels. Past programs failed to acknowledge the diversity in property costs across the province; an acre of land in Toronto, for example, is vastly more expensive than in northern portions of the province. The new model was designed to recognize and address this disparity, as few new homes were being built in the heart of the province's more expensive urban centres. The government also sought to assist by permitting access to provincial surplus land.

Also, in 2019, certain financial incentives were implemented to assist not-for-profit operators, which usually do not have ready access to capital and must rely on fundraising to raise sufficient funds, which can then be leveraged by bank financing or some similar sources of debt.

The for-profit sector has ready access to capital provided the economic return is attractive and commensurate with the risk. Currently, the bulk of the payment for the capital is paid over the life of the licence, which is generally 25 to 30 years for new builds. The government also provides funding to cover a portion of the capital cost, payable as a top-up to the daily bed rate.

According to the province, the cost to build a new bed is generally considered to be the same as the cost to redevelop an existing bed. In 2017, it was estimated that the cost

to build a new long-term care bed ranged from $289,000 to $536,000. The present value of the province's contribution to the development or redevelopment of a bed ranges from $137,316 in rural Ontario to $174,195 in large urban areas. Assuming a construction cost of $350,000 per bed in a large urban area, with contributions from the province of $174,195 over 25 years, it follows that the province pays approximately half of the cost of a new long-term care bed. The rest of the funds must be found elsewhere.

The cost of building enough beds to handle the current and upcoming demand will be a real challenge for the government. To meet the current need to replace the expiring licences and to accommodate the current waitlist at the estimated cost of $350,000 per bed, the capital cost required will be approximately $19.8 billion.

By some accounts, in the next 20 years, Ontario will need to create between 96,000 and 115,000 additional beds to accommodate the province's increasing aged population. If this is so, the cost will exceed $33.6 billion in current dollars, or $1.68 billion a year for 20 years.

This does not take into account existing beds that require redevelopment. As discussed above, there are currently more than 31,000 beds in Ontario that were built to older design standards (i.e., classified as B, C or Upgraded D beds). At the approximate redevelopment cost of $350,000 per bed, an additional $10.9 billion in funding will be required to upgrade these beds.

Delayed and Prolonged Licensing Approval Process

The current government has committed to building 15,000 new beds by 2023–24 and upgrading 23,000 existing beds by 2028. Despite the government's commitment, the Commission was told that it takes two years to receive approval of a licensing application and then an additional two and a half years to construct the beds. The Commission heard from one long-term care home operator that it has made numerous applications over the years to redevelop its homes that did not move forward. This operator told the Commission that it currently has 22 pending applications before the government for redevelopment projects. The Commission also heard that another operator has had an application pending since 2017 but is facing zoning issues at the provincial and municipal level that are blocking redevelopment.

The need for multiple approvals at multiple stages creates a lengthy, costly approval process. The approximately five years that pass between concept and resident-ready beds means that the province is playing catch-up and is forever in a growing bed deficit.

Even if 15,000 new beds are built, the challenges with increasing demand for long-term care beds and an ever-growing waitlist will remain. In addition to a new funding model,

the province needs a streamlined and expedited approvals process for creating new beds.

A New Way Forward: Separating Construction from Care

This chapter has provided an overview of a long-term care system rife with challenges. Many of these issues have existed in the sector for decades. However, these challenges will be magnified considerably with the aging demographic and the future challenges around ensuring that people age at home safely and, as necessary, age safely in long-term care homes. In order to meet this challenge, the government will need to engage in a process that is both financially prudent and ensures residents are taken care of in a safe and healthy manner. As has been demonstrated here, building new beds must be a key component of this process.

Between 2011 and 2018, only 611 net new long-term care beds were built, though municipal and not-for-profit homes did redevelop some facilities. Over the same period, the waitlist for long-term care beds grew by 78 per cent. Complicating the issue is the fact that the licences for 26,500 beds will expire by 2025. In 2019, the province introduced programs to construct 15,000 new beds and redevelop an additional 15,000 beds to modern standards by 2025 (this was subsequently increased to 23,000 redeveloped beds).

The Commission retained Morrison Park Advisors (MPA) to advise it on the status of the for-profit long-term care sector. MPA confirmed that the long-term care business is considered a steady but low-return investment. The profit is made not on the care side but on the “hoteling” of the residents (i.e., on providing accommodations for the residents, including room and board). MPA advised the Commission that there are significant risks involved in operating a long-term care home, and that these risks must be considered when looking at the rate of return on investment.

MPA further advised that the use of private capital for a public service is not a new concept and is in fact commonplace in Ontario. The utility business, for example, has long used private investment capital to build and operate electricity generation, transmission and distribution, overseen by a regulatory body independent of government. The independent nature of the regulator, in part, ensures decisions are made without political interference.

In Ontario, the province has used Infrastructure Ontario to craft a host of innovative solutions that allow public infrastructure to be built with private funds. The province has privately funded hospitals, courthouses and light rail systems, to mention just a few. Each model is slightly different, but all involve the construction of infrastructure that is paid for up front by private investors who receive the return of their capital with profit

over time, whereas the activity for which the infrastructure was built, such as operating the courts or providing care in a hospital, is carried out by others.

The long-term care model appears to be an outlier, in that the provision of private capital for the infrastructure is combined with the provision of care; that is, long-term care owners finance the build and provide hoteling services while also providing care to residents. In essence, the companies do not make profit on the care portion; they provide the care as a complete net neutral activity for the government in return for making a profit on the infrastructure and hoteling of the residents. For many, it can be difficult to understand how investment vehicles such as real estate investment trusts can be responsible to their investors and, at the same time, for the care of residents. Indeed, REITs contract out this fundamental care task despite being legally responsible for it.

It is difficult to see how one can build a culture of excellence in care when care is only a means to profit on the infrastructure and hoteling.

As noted, COVID-19 has seriously undermined the reputation of for-profit homes. The Commission has repeatedly heard about the distrust of the private sector when it comes to providing care. A new model is needed to reset the balance – a model that will attract investment into the sector while also restoring Ontarians' faith that the care of our elderly is a priority.

Capital funding is clearly needed to meet the current and future demand for more long-term care beds. As demonstrated earlier in this chapter, the investment required to build new beds and redevelop old beds is considerable. Government must decide how to fund this urgent multi-billion dollar need for tens of thousands of additional and redeveloped beds. By some estimates, in two decades more than twice as many beds will need to be built than exist today; over this same time period, almost all of the current home licences will expire.

Now is the time to revisit the business of long-term care.

There is no reason that the accommodation and care of residents need to be handled by the same entity. The current model in which profit-seeking entities receive a profit for the infrastructure and hoteling as well as providing for the care of residents as an "add-on" does not create the right incentives.

The government should separate the construction of long-term care facilities from the care provided in those facilities, recognizing that those skilled at the former may not be appropriate for the latter. For example, construction of long-term care homes would continue to be open to the private sector based on design standards set by the province. In a manner similar to that employed in the hospital sector, the province would

then fund annual payments for an agreed-upon number of years sufficient to ensure that the developers recover their investment and an agreed-upon rate of return. This procurement strategy also would allow the province to require that upon the conclusion of this period, the province, not the developer, would own the long-term care facility and the land on which it is built.

Developers who participate in this program would earn an appropriate return rate that is commensurate with the reduced level of risk of not being responsible for the care of the residents. The developers would have no role in the care provided in the long-term care home. This reform would permit the private sector to satisfy the demand for long-term care facilities by accessing the capital required to construct the facilities; simultaneously, it would ensure that residents receive care from a provider whose sole focus is that care.

After construction, managing the long-term care home would fall to not-for-profit operators or private operators who are mission-driven rather than motivated by dividends. The province would, subject to negotiation, pay operators in much the same way that it does now, but with an improved funding envelope for care.

In addition, not-for-profit homes currently face a major barrier to development, which is that they lack expertise in capital development. This lack of expertise leads to difficulty accessing financing, resulting in fewer successful applications to construct new beds. As a first step toward encouraging the continued participation of not-for-profit organizations in the sector, the province must urgently implement a streamlined, expedited approvals process for creating redeveloped and new long-term care beds that accommodates the participation of existing and new not-for-profit and municipal licensees.

Given the current and projected demand for long-term care beds, a new model of building homes, providing more beds and delivering care is an urgent necessity. The sooner this can be implemented, the better protected Ontario’s most vulnerable will be in the future.

A Note on Insurance

Throughout its investigation, the Commission heard that the long-term care sector is having difficulty finding affordable insurance. Insurance broker Marsh Canada reported that the insurance market for long-term care has been tightening for years and that the lawsuits arising out of COVID-19 have made it difficult for homes to obtain liability and director and officer insurance. It is possible that some homes will not be able to obtain insurance at all. The loss of insurance will leave homes unable to cover residents’ liability claims. This loss may also impede the ability of some homes to attract financing and qualified directors. Such instability in the industry will create additional risk for

residents. Marsh Canada provided several examples of industry-wide solutions. The Ministry should recognize that the concerns of the insurance industry are important. If insurance companies were to withdraw from the sector, it would have a significant negative impact on the construction and operation of long-term care homes. The government has a role to play to ensure that homes are able to obtain necessary insurance and should consult with long-term care licensees and the insurance industry to determine what additional solutions are needed.

Conclusion

Notwithstanding the legislative requirement that long-term care homes are to be a “safe, comfortable, home-like environment” that support “a high quality of life for all residents,” this was not the case in all homes in the years leading up to the pandemic. As has been detailed throughout this chapter, the long-term care system in Ontario was at a tipping point well before COVID-19 came along. Homes were often overcrowded and understaffed; had outdated infrastructure, untrained leaders, and minimal IPAC knowledge; were unsupported by the rest of the health care system; and – as will be explored in chapter 2 – lacked a plan for dealing with a pandemic that experts believed was inevitable.

In a war against an infectious and potent virus, these deficiencies were the foundation of a devastating defeat.

Voices from the Front Line

“In the end, the long-term care home relied on many of these family members coming in so frequently to ease the burden on their staff in caring for residents. We have six members on our Family Council who come in every day of the year to feed either their wives or husbands or a parent. That’s every meal, every bath, and every important meeting. They wash their clothes because the home loses their loved ones’ clothes frequently. And they’ve been doing this for years.

–Harold Curwain, family member of long-term care resident

“Most nights, the RPNs are doing 64 residents to give them meds which is impossible when you have – you may have three at end of life on one side, or you have the behaviours on the other. How one RPN can do that is impossible.”

–Long-term care staff member

“PSWs need to be regulated, licensed, and trained. More ... training and skills dealing with responsive behaviors are required like dementia, depression, bipolar, mental illness, the use of PPE, all of that.”

–Family member of long-term care resident

“The model of care needs [to] change, and, most importantly, the respect and the treatment of seniors and their care providers, the PSWs, the nurses, need to change. A remake of long-term care. Not warehousing people but meeting needs at various stages of life with dignity.”

–Family member of long-term care resident

“We have to be better prepared. We owe it to these residents. We shouldn’t have lost as many residents as we did, and we shouldn’t have lost a co-worker that came to work every day, would not go off. She had existing health problems and would not go off work because she needed to be there to help take care of the residents.”

–Long-term care staff member

Chapter 2: Ontario's Pandemic Preparedness

> [W]e know now that new microbial threats like SARS have happened and can happen again. However, there is no longer any excuse for governments and hospitals to be caught off guard and no longer any excuse for health workers not to have available the maximum level of protection through appropriate equipment and training.
>
> –The Honourable Justice Archie Campbell, SARS Commission Final Report

Like many jurisdictions, Ontario was unprepared for the COVID-19 pandemic. However, this need not have been the case. As discussed briefly in chapter 1, Ontario was forced to contend with Severe Acute Respiratory Syndrome (SARS) – another deadly coronavirus – in 2003, and it suffered disproportionately compared to other provinces. In the wake of the outbreak, the Ontario and Canadian governments commissioned several studies that highlighted the failings of both the provincial and national health and emergency response systems when it came to preparing for a deadly virus.

Excellent recommendations came out of those studies and, for a time, Ontario paid attention to them. The province strengthened its defences and prepared the health care sector to respond to a pandemic. Outbreaks of H1N1 and Ebola in 2009 and 2014–16, respectively, were grim reminders of the threat a disease outbreak could pose.

Despite these stark reminders, Ontario lost the will to make pandemic preparedness a priority. By 2017, the Auditor General was warning the government of major weaknesses in the province's emergency management programs that could make Ontario vulnerable to a large-scale emergency. Ontario's current Chief Medical Officer of Health, Dr. David Williams, told the Commission that when the province is not in the middle of a public health emergency, pandemic preparedness policies often fall by the wayside in favour of more immediate concerns: "It is hard to keep [pandemic preparedness] always at the front table because the tyranny of the urgent always pushes things aside[.]"

This is exactly what happened in the years leading up to the COVID-19 pandemic. As this chapter will demonstrate, the Ministry of Health did not take sufficient steps to fulfill its legislative obligation to have a plan in place to address the eventuality of a pandemic. As a result, the province had no up-to-date, cohesive pandemic plan in 2020. Ontario's most current plan was primarily designed to address an influenza pandemic and had not been updated since 2013. Subsequent government attempts to expand the scope of the plan beyond influenza had stalled prior to the onset of COVID-19. Compounding this issue, responsible ministries failed to conduct simulations or drills of the 2013 pandemic influenza plan. In particular, there were no drills focused on long-term care, where some of the most vulnerable Ontarians live.

Furthermore, by the time COVID-19 hit Ontario, the majority of the province's stockpile of emergency health supplies, amassed after SARS, had expired without being replaced. Ontario's Auditor General warned in 2017 that 80 per cent of the stockpile was expired. By the end of 2019, 90 per cent of the stockpile – including surgical and N95 masks – had expired and was in the process of being destroyed, even though the risks the stockpile was meant to address had not vanished. Instead of taking immediate action in 2017, when it became clear that most of the stockpile was expired, successive governments spent three years deliberating on various policy options for replenishment.

In the years following SARS, Ontario received additional specific warnings that improvements were needed in governmental or administrative areas relevant to pandemic preparedness. The province was warned that it needed to identify isolation sites before another pandemic hit and also improve its laboratory network; it failed to do either. Chronic underfunding of Public Health Ontario (PHO) also hampered the agency's ability to carry out parts of its mandate.

All of this contributed to a fatal lack of preparedness when the deadly virus struck long-term care homes.

COVID-19 may have arrived unexpectedly in 2020, but it was entirely predictable that a deadly pathogen would sweep the world at some point. It was also predictable that a pandemic could disproportionately impact vulnerable Ontarians in long-term care. Ontario had numerous opportunities to build the lifeboats that would have buoyed the province and its long-term care sector during the storm of a potential pandemic. These opportunities were squandered, and instead of facing the storm from a position of strength, the province found itself building lifeboats after the downpour had already begun.

Warnings Ignored

The spread of infectious respiratory diseases is not a new phenomenon. Tuberculosis, a contagious disease that infects the lungs and is primarily spread through the air, was one of the leading causes of death in the late 19th and early 20th centuries and continues to disproportionately impact some populations in Canada. The 1918 influenza pandemic – to which COVID-19 has been compared because of similarities in transmission patterns – began during the spring of 1918 and infected a third of the world's population. The disease spread primarily in two waves, in the spring and fall of 1918, and is estimated to have killed between 50 million and 100 million people.

Infectious disease outbreaks were not mere historical footnotes in Ontario. In 2003, the province was one of the epicentres of the SARS outbreak. The 2009 H1N1 pandemic and the 2014–16 Ebola threat followed soon after, providing ample further warning of the dangers associated with a disease outbreak in Ontario.

SARS Sounds the Bell

> If we do not learn from SARS and we do not make the government fix the problems that remain we will pay a terrible price in the next pandemic.
>
> –The Honourable Justice Archie Campbell, SARS Commission Final Report

Initially emerging in China in November 2002, SARS spread across the world within several weeks. Like COVID-19, SARS was caused by a novel coronavirus, and there was no vaccine or timely test available for it.

The SARS outbreak challenged Ontario's health care system and overran several key hospitals in Toronto. By the time the virus was contained, more than 300 people in Ontario had been infected and 44 had lost their lives. The heroic efforts of health care workers spared the province from a more deadly catastrophe.

In Ontario, SARS was primarily managed with isolation and infection control in hospitals. Given the focus placed on managing and treating the disease in hospital settings and the fact that those infected with SARS are most infectious when their symptoms are most life-threatening, health care workers were at increased risk for contracting and spreading the disease. More than 100 health care workers in Canada became ill from the virus and three died.

The SARS outbreak should have warned successive provincial governments of the importance of preparing for a pandemic.

Three investigations were convened in 2003 to assess and report on the federal and provincial response to SARS:

1. **The National Advisory Committee on SARS and Public Health** was established by the federal Minister of Health to provide a "third party assessment of current public health efforts and lessons learned for ongoing and future infectious disease control." The committee's final report, "the Naylor Report," was published in October 2003.

2. **The Expert Panel on SARS and Infectious Disease Control** was established by Ontario's Ministry of Health and Long-Term Care to "identify the key lessons learned from [the SARS outbreak] and to provide practical, focused, and forward-looking recommendations regarding the management and control of infectious diseases and the capacity of Ontario to handle public health emergencies in the future." The panel published an interim report in December 2003 before publishing its final report, the "Walker Report," in April 2004.

3. **The SARS Commission** was established by Ontario's Minister of Health and Long-Term Care and led by the Honourable Justice Archie Campbell to investigate how the virus came to Ontario, how it spread and how the province

responded to the outbreak. The Commission published its first interim report in April 2004, its second interim report in April 2005 and its final report – the "SARS Commission Report" – in December 2006.

Each of these reports warned of deficiencies in pandemic preparedness and emergency medical supply stockpiles at both the national and provincial level. They also noted major problems with regards to health sector staffing and health facility infection prevention and control (IPAC). Taken together, these reports were prophetic in warning that the province's best chance at battling a pandemic was to be properly prepared ahead of time. Many of the public health system issues experienced during the SARS outbreak and foreshadowed in these reports arose again, with dire consequences for long-term care, during the COVID-19 outbreak.

Reading these reports in light of COVID-19, it is striking to note how the lessons of SARS were not learned, and how the same mistakes were repeated. A deeper exploration of the reports' findings and recommendations brings into stark focus the multiple warnings that successive governments disregarded.

Findings on lack of preparedness

All three reports found that the SARS outbreak revealed a significant lack of pandemic preparedness in Ontario and in Canada as a whole. Each pointed out systemic failures within Ontario's health emergency response system and called for strengthened leadership, coordination, surveillance and risk-reduction measures. Had these failures been properly resolved and these warnings fully heeded, Ontario's long-term care sector would have been better prepared than it was at the onset of the COVID-19 pandemic.

The Naylor Report noted that Ontario would not have been able to withstand two simultaneous outbreaks the size of the SARS outbreak. Consequently, the report called for strengthened surveillance programs by federal, provincial and territorial governments. It also recommended the development of clear protocols for leadership and coordination of future research to identify, characterize, respond to, monitor and learn from new pandemics.

The Walker Report found that the SARS outbreak "exposed a general lack of preparedness for managing health emergencies" and emphasized that improvements to the province's capacity to address health emergencies would be a "down payment on the future." The report identified tools required to respond to infectious disease outbreaks, including the implementation of a real-time comprehensive surveillance framework. Finally, the report called on the Ontario government to work with federal and municipal governments to promote "cross-training opportunities between public health, acute care, long-term care and other sectors." As revealed during the COVID-19 pandemic, many of these links, particularly with regards to acute care, were only forged after the pandemic had begun.

Meanwhile, in the SARS Commission Report, Justice Campbell stated that the outbreak revealed a “systemic province-wide inadequacy of preparedness.” The Commission also flagged that long-term care facilities were at particular risk for disease outbreak, detailing the impact of Legionnaires’ disease on the Seven Oaks Home for the Aged in Toronto in 2005. The Commission concluded that the Legionnaires’ outbreak, which resulted in the death of 23 residents, “showed the bad side of Ontario’s response to SARS systemic problems that remain unfixed.”

Tragically, these problems would remain largely unfixed in Ontario’s long-term care sector leading up to the COVID-19 pandemic.

Findings on lack of infection prevention and control

All three reports found weaknesses in provincial and federal infection prevention and control practices. The Naylor Report noted “a massive shortfall in the number of infection control practitioners necessary to provide optimum infection control in the hospital sector.” It also called attention to the insufficient liaisons between hospitals and public health units regarding infection control practices. (Public health units are administrative regions within Ontario through which the delivery of local public health services is organized. The role of public health units is discussed further in appendix B.)

The Walker Report found that a lack of basic infection control techniques extended to all health care facilities in the province – including long-term care facilities – as well as health care education programs. The report also recommended that efforts be made to ensure that more IPAC specialists were available to service the long-term care sector.

Justice Campbell echoed this sentiment when he stated that the SARS outbreak revealed the “inadequacy of infection control programs to protect patients and visitors to health facilities.”

Findings on staffing shortages

The reports also noted severe staffing deficiencies within the federal and provincial health care sectors. The Naylor Report stated that public health human resources across the country were deficient and argued that SARS should be viewed as a warning for institutions that provided health care training to better prepare for future disruptions. The report further warned that the lack of trained public health practitioners could hinder efforts to improve Canada’s public health infrastructure.

The SARS Commission Report included interviews with Ontario nurses noting critical nursing shortages during the SARS outbreak and stating that wages paid to health services providers during an outbreak must be proportionate to the risk the providers take on. Other nurses quoted in the report detailed how staffing shortages required nurses to work in multiple locations, which in turn contributed to these nurses becoming infected with SARS. Justice Campbell also reported that the Ontario Nurses’

Association surveyed their members after the outbreak and found that almost two-thirds felt their health had been compromised during the SARS outbreak. Echoes of this complaint were heard again as COVID-19 ravaged Ontario's long-term care homes.

The Walker Report noted a similar deficiency in health human resources, finding that "Ontario needs an increased number of professionals, as well as educational and career opportunities, in public health." The report also highlighted the growing trend in Ontario's health care sector of health workers being hired on a part-time basis instead of a full-time basis and warned about the risks inherent in this approach. The prescience of these warnings with regards to the staffing issues that would manifest during the COVID-19 pandemic is striking:

> SARS shed a spotlight upon a problem that has existed in the health professions … the use of a high proportion of staff that is employed casually, rather than on a full-time or "regular part-time" basis. Full-time and "regular part-time" work usually involves a relatively fixed schedule and an agreed number of hours, while "casualization" involves the systematic replacement of full-time and part-time staff with staff employed on an ad hoc basis. As stated in one submission to the Panel, "Move towards a much higher ratio of full-time, permanent staff. Part-time/casual staff work at multiple sites, and may contribute to the spread of disease."
>
> The Panel heard that the problem of casualization *is most severe in the long-term care* [emphasis added] … but remains a concern across all segments of health care. Those employed on a casual basis tend to work at multiple sites, raising the specter of healthcare workers transmitting a disease.
>
> […]
>
> In addition, the Panel was told that the rule of working at one facility only, a rule imposed during SARS, meant that a number of institutions that had high rates of casualization lost much of their staff. The flip side to this was that staff working casually found their hours slashed by the "one facility" rule. We heard that it is only feasible to limit staff to one facility during an infectious disease outbreak when full-time employment of healthcare workers is maximized. Until that comes to pass, "The focus should be on limiting risk rather than limiting employment."
>
> […]
>
> Ultimately, the Panel has concluded that reducing the rate of casualization, regardless of the theoretical impact this may have on infection control, is instrumental in improving the continuity of care of patients, improving workplace satisfaction and loyalty, and building cohesion and core capacity back into the system.

As will be discussed in chapter 3, very little progress was made on reducing the rate of casualization in Ontario's long-term care sector before the COVID-19 pandemic. Part-time staff working in multiple long-term care homes also played a role in the spread of COVID-19 between homes.

Emphasis on the importance of stockpiling medical supplies

The three reports also emphasized the importance of maintaining a provincial stockpile of medical supplies to allow for health care workers to contain an outbreak effectively. The SARS Commission Report stated that the outbreak "emphasized the need to have

sufficient quantities of medical supplies, secure supply chains and the means to distribute the supplies." The Walker Report similarly found that SARS "revealed clear provincial and national weaknesses around both production and distribution of emergency supplies."

The Naylor Report noted that, during the outbreak, personal protective equipment (PPE) was sometimes unavailable to front-line workers and at other times suboptimal. Making matters worse, some of this unavailable equipment was in fact mandated for use by government directives, putting health care workers in the frustrating position of not being able to adhere to directives through no fault of their own. The report recommended that provincial governments ensure that plans were created to provide medical supplies to health care workers outside the hospital sector.

Summary

As mentioned earlier, SARS was primarily transmitted in Ontario's hospitals and mostly affected hospital patients and health care workers rather than those in long-term care. However, in places such as Hong Kong, SARS did affect long-term care as well. Hong Kong's long-term care homes weathered COVID-19 largely due to the lessons learned during SARS – in particular, the importance of infection prevention and control.

A different situation played out in Ontario. Because the SARS outbreak here mostly occurred in hospitals, the province responded to the warnings issued by the Naylor, Walker and SARS Commission reports by preparing Ontario's hospitals to manage a future pandemic. These preparations were mainly successful, as hospital infection prevention and control measures had improved greatly by the time of the COVID-19 pandemic.

It is important to note, however, that the reports did not limit their warnings to hospital preparedness. Each report expressed urgent concerns that the province *as a whole* was systemically unprepared for the next pandemic – in some cases mentioning specific dangers facing the long-term care sector. Unfortunately, the lessons of SARS were not sufficiently taken up in Ontario's long-term care sector, and many long-term care residents and their families paid a terrible price.

H1N1: A Familiar Refrain

> Simply put, we know beyond a shadow of doubt that at some point there will be another pandemic, or another emerging infectious disease event like SARS, that will require a provincial response.
>
> –Dr. Arlene King, Ontario Chief Medical Officer of Health, 2010

In 2009, just six years after the SARS outbreak, the H1N1 pandemic again reminded Ontario of the unpredictability of virus severity and the need to identify and proactively protect populations at heightened risk (in the case of H1N1, more than half of all the confirmed cases in Ontario were under 20 years of age, and the highest number of

those were between the ages of 10 and 14). A familiar set of themes and warnings emerged from this influenza pandemic: the province cannot let its guard down; more challenges lie ahead. Public health experts and leaders stressed that it was necessary to stay ahead of emerging threats – and to not wait for catastrophe to strike to address problems exposed in previous pandemics and epidemics.

While public health experts in Canada acknowledged that public health and health care systems were largely able to perform under the strain caused by the H1N1 pandemic, they also warned that complacency in pandemic responses would have dire consequences in the future.

Dr. Arlene King, Ontario's Chief Medical Officer of Health (CMOH) during the H1N1 pandemic, warned that there would soon be another influenza pandemic or emerging infectious disease to address. In her 2010 report *The H1N1 Pandemic—How Ontario Fared: A Report by Ontario's Chief Medical Officer of Health,* she found that while reported rates of death and hospitalization in the province were low compared to the rest of Canada, Ontario did not emerge from the H1N1 pandemic unscathed. A total of 128 people succumbed to the virus and more than 1,800 were hospitalized.

Although Dr. King did not specifically refer to the long-term care sector, she did outline applicable measures to protect vulnerable populations "the next time around." Among these was ironing out issues with the province's immunization program to ensure vaccinations would be available to meet demand.

A similar caution surfaced at the 2010 public health workshop titled *The First Influenza Pandemic of the 21st Century: Canada's Response, Lessons Learned, and Challenges Ahead*, which involved public health administrators, decision-makers and infectious disease modellers from across the country. Citing the logistical barriers to timely vaccine distribution faced by provinces and territories, a 2011 study summarizing the workshop's findings reiterated the need for improved capacity in the face of emerging infectious disease threats:

> Future emerging infectious diseases are likely to bring far greater challenges than those imposed by the 2009 H1N1 pandemic. Canada must address these challenges and enhance its capacity for emergency responses by integrating modelling, surveillance, planning and decision-making.

The H1N1 influenza again served to warn Ontario that it must remain vigilant and prepared for a major public health emergency. Again, much of the advice would be ignored.

Global Warnings Escalate

The warnings did not end with H1N1. In 2014, two health care workers in Texas contracted Ebola, a highly contagious and deadly virus. The prospect of an Ebola outbreak in Canada put Ontario's health system on high alert. Thankfully, the province was spared. At the conclusion of the Ebola scare in 2016, Ontario embarked on a

revision of its approach to addressing disease threats. As explained below, that revision was not completed in the years between Ebola and COVID-19 (i.e., 2016–20), leaving the province with an incomplete plan for fighting the world's deadliest pandemic of the past century.

Following the Ebola outbreak in the United States, President Barack Obama warned of a future deadly airborne virus and called for investment in infrastructure to identify, isolate and respond quickly to disease. This warning was reinforced when the United States Department of Health and Human Services identified pandemic infectious diseases as a security threat to national public health in its 2019–2022 National Health Security Strategy. The strategy highlighted the importance of addressing the needs of at-risk individuals, including older adults, when planning for health security threats.

Meanwhile, on the international stage, disease outbreak had been a global concern for years. According to the World Health Organization (WHO), there were 1,483 epidemic events in 172 countries between 2011 and 2018. These included diseases such as Ebola, Zika and yellow fever. Many of the diseases shared similar characteristics: they spread fast, had a severe or fatal impact, and were difficult to contain.

Finally, just months before the emergence of COVID-19, the Global Preparedness Monitoring Board – an independent monitoring and advocacy body co-convened by the WHO and the World Bank – stated that the world was at acute risk for devastating regional or global disease epidemics or pandemics and that the chances of one of these events occurring were increasing. The annual report released in September 2019 described how high-impact respiratory pathogens, which spread through respiratory droplets and can infect large numbers of people in little time, posed significant global risks. Once again, the message was clear: the threat of a rapidly moving deadly respiratory pathogen pandemic was high; countries must prepare for the worst. A similar warning was published by Johns Hopkins University.

Summary

In the wake of SARS, H1N1 and Ebola, numerous experts warned that a new, even more severe pandemic was on the horizon. One of the key lessons from these experiences – and a message repeated many times by various sources between the SARS outbreak and the arrival of COVID-19 in Ontario – was the importance of preparedness.

The experts' warnings became reality in early 2020. A new virus, initially identified in Wuhan, China, spread across the world, claiming the lives of millions and infecting millions more. Ontario had been warned – and having lived through and experienced losses during previous outbreaks, the province should have hardened its resolve to be prepared. Instead, the initial improvements made were fleeting, and system-wide preparedness gave way to other government priorities. Rather than Ontario internalizing this important issue, the earlier warnings never graduated from short-term memory.

Given the lessons learned during previous pandemics and the warnings of pandemics to come, why was Ontario's long-term care home system not better prepared for COVID-19? The answer lies in part with the province's failure to sufficiently acknowledge the likelihood of a major pandemic. As will be seen below, however, Ontario also failed to respond to specific warnings and recommendations to take measures that would have left the province better equipped to manage such a pandemic.

Had preparedness been prioritized, the arrival of COVID-19 and its deadly impacts on Ontario's long-term care populations would have been more closely monitored and met with greater agility and decisive action.

The challenge going forward is to ensure that preparedness shifts from being an ideal that can be shunted aside in favour of other priorities to becoming part of the province's DNA.

Ontario's Failure to Act

As discussed above, SARS, H1N1 and Ebola had provided Ontario with ample warning regarding the threat of a pandemic and the need to prepare. Preparation for an emergency requires conscious action and sustained focus. Unfortunately, government focus on preparedness waxed and waned as successive health emergencies came and went. As a result, early preparedness efforts were wasted, important warnings and recommendations were ignored, and crucial actions were not taken. Key recommendations from the SARS Commission Report, Walker Report and Naylor Report were either not fully implemented or not implemented at all. Some of Ontario's long-term care residents would pay the steepest price for their governments' failure to devote sufficient attention to preparedness.

A Promising Start, Squandered

In 2006 and 2007, heeding the warnings of SARS and recognizing that a viral pandemic posed a risk, Ontario's Ministry of Health and Long-Term Care requisitioned $170 million for pandemic preparedness initiatives, including $84 million earmarked for personal protective equipment. During the 2006–07 fiscal year, Ontario spent $83 million on outbreak management–related expenditures. Government preparedness initiatives during this time included:

- creating a government stockpile of personal protective equipment;
- drafting detailed pandemic response plans;
- creating the Provincial Infectious Diseases Advisory Committee (PIDAC) to advise on infection prevention, surveillance and control;
- creating 14 Regional Infection Control Networks (RICNs) to coordinate infection control across health care facilities;

- creating a triage tool to decide who receives critical care during a pandemic;
- creating the Ontario Agency for Health Protection and Promotion to provide the province with laboratory and epidemiological services to help translate the latest health research into practical advice; and
- creating the Ministry of Health and Long-Term Care Emergency Management Unit.

It was a promising start, and some of these initiatives did in fact carry through to 2020. The Ministry's Emergency Management Unit has continued its work and is now called the Health System Emergency Management Branch. The Provincial Infectious Diseases Advisory Committee continues to advise Public Health Ontario on preventing and controlling health care–associated infections.

However, as will be discussed in greater detail below, many of these early efforts were squandered for lack of attention. The Ontario Agency for Health Protection and Promotion, for example, became Public Health Ontario in 2011, and its operations were hampered by underfunding beginning in 2013. The Regional Infection Control Networks also ran into difficulties. The Commission heard that, by 2011, the small size of the RICNs was causing operational challenges. As a result, they were integrated into Public Health Ontario in 2011 and eventually reorganized into seven Regional IPAC Support Teams. The Commission was also told that before the consolidation, a sentiment had been developing among local public health units that the Regional Infection Control Network funding would have been used more effectively if provided to the public health units.

In addition, provincial focus on both the PPE stockpile and detailed pandemic response plans was fickle. In 2007 and 2008, soon after creation of the PPE stockpile, all unspent funds remaining from the initial $170 million allocation were rescinded. In 2010, regular funding for the stockpile ceased. After that point, specific procurements were made to prepare the stockpile for emerging threats such as Ebola, but there was no comprehensive stockpile funding or management plan in place. The absence of such a plan caused life cycle management of the stockpile to become "challenging and/or non-existent." By 2019, 90 per cent of the stockpile was expired.

As for the pandemic plan, it was updated in 2013 in response to the H1N1 pandemic but then left dormant in the years leading up to the COVID-19 pandemic. The plan did not provide guidance on how to manage a pandemic in the long-term care sector and, as will be discussed below, was lacking in several other respects. Efforts to improve upon the plan stalled, and the plan that was in place was never drilled or simulated.

Meanwhile, other important recommendations from the SARS Commission that would have helped Ontario improve its capacity to withstand future health-related emergencies were not implemented. Notably, the SARS Commission recommended that:

- Ontario's primary public health legislation – the *Health Protection and Promotion Act* (*HPPA*) – be amended to ensure that "emergency planning, preparedness, mitigation, management, recovery, coordination and public health risk communication at the provincial level be put under the direct authority of the Chief Medical Officer of Health ..." This amendment was never made. As will be discussed below, in the lead-up to the COVID-19 pandemic, it was not always clear which government entities were in charge of maintaining the province's pandemic plans and personal protective equipment stockpile.
- The *HPPA* be amended to provide whistleblower protection to health care workers. This amendment was never made.
- Ontario's emergency legislation be amended to require that the province's emergency plans include compensation packages for "those who suffer an unfair burden of personal cost by reason of their cooperation with public health measures like quarantine." The Walker Report also noted that it was important to provide compensation to those who are unable to work and at risk of losing income due to being ill or quarantined during a health crisis. As discussed in chapter 3, Ontario did not have such a support plan in place in advance of the COVID-19 pandemic.

As Ontario's focus on pandemic preparedness wavered, it continued to receive warnings that specific action needed to be taken in order to ensure the province was fit to handle the next public health emergency. These warnings – like so many that had come before them – went largely unheeded. The province failed to take the steps necessary to protect its citizens, including those living in long-term care.

Failure to Follow the Precautionary Principle

Before assessing Ontario's emergency preparedness and response, it is important to examine the precautionary principle. Put simply, the principle stipulates that "we cannot wait for scientific certainty before we take reasonable steps to reduce risk." During a March 2020 press briefing providing an update on the global spread of COVID-19, Dr. Mike Ryan, Executive Director of the World Health Organization Health Emergencies Programme, put it this way: "Speed trumps perfection […] the greatest error is not to move." The principle often comes into play when deciding which kind of personal protective equipment should be used to respond to a contagious virus.

Justice Campbell referred to the precautionary principle as "[p]erhaps the most important lesson of SARS" and recommended that it:

> be expressly adopted as a guiding principle throughout Ontario's health, public health and worker safety systems by way of policy statement, by explicit reference in all relevant operational standards and directions, and by way of inclusion, through preamble, statement of principle, or otherwise, in the *Occupational Health and Safety Act*, the *Health Protection and Promotion Act*, and all relevant health statutes and regulations.

This recommendation has not been fully implemented. The *HPPA* was amended to require Ontario's Chief Medical Officer of Health to consider the precautionary principle, but this requirement only applies in very limited circumstances. The Chief Medical Officer of Health is only obliged to consider the principle when:

- They are of the opinion that an infectious or communicable disease outbreak exists or might exist; and
- They are issuing a directive specifically related to worker health and safety in the use of any protective clothing, equipment or device.

There are no other provisions in the *HPPA* requiring the Chief Medical Officer of Health or any other public health official to consider the precautionary principle. Similarly, the *Occupational Health and Safety Act*, which sets out the rights and duties of employers and employees in provincially regulated workplaces, references precaution in the context of employers' duties to protect employees but does not adopt the precautionary principle as a general guiding principle.

The *Ontario Public Health Standards,* which set out the basic requirements for the delivery of public services across Ontario, do not refer to the precautionary principle. The *Occupational Health and Safety Act* and the Ontario Public Health Standards are discussed further in appendix B.

It is clear that the principle has not been adopted as a guiding principle throughout Ontario's health, public health and worker safety systems, as was recommended by the SARS Commission.

As will be discussed in chapter 3, there were several other ways in which Ontario's response to the COVID-19 pandemic did not adhere to the precautionary principle.

Failure to Prepare for the Unexpected

In 2006, Cabinet was briefed on the likelihood and risk of a future pandemic. This briefing proved to be prophetic, as the government recognized that a pandemic influenza or another unknown virus was overdue:

> Public Health experts around the world are forecasting that an influenza pandemic is statistically overdue, and that if the source is not the avian influenza virus currently circulating, which has the potential to evolve into a strain that could cause a pandemic in humans, it will be another *as yet unknown virus*. [emphasis added]

The briefing's recognition that a pandemic might be caused by a novel virus reflects the SARS Commission's finding that:

> the next big outbreak might be caused by something completely different, totally new and entirely unexpected … One major lesson from SARS is that we must prepare not only for potential looming threats like H5N1, but also for the unexpected.

Similarly, a federal pandemic guidance document developed following the 2009 H1N1 outbreak recognized that a pandemic (in this case, an influenza pandemic) could come at any time, from anywhere:

> Some of the major unknown areas about the next pandemic are the following:
>
> - When the next pandemic will occur—although historically pandemics have occurred three to four times per century, there is no predictable interval. It should not be assumed that the 2009 pandemic has provided a respite during which preparedness efforts can be relaxed.
> - Where it will emerge—while most seasonal influenza strains emerge in East/Southeast Asia, the same is not true for pandemic influenza; the 2009 pandemic emerged in Mexico. An influenza pandemic could emerge anywhere in the world, and there may be very little lead time before Canada is extensively involved.
> - What the nature of spread will be—pandemics often first arrive outside the usual influenza season (e.g., in late spring or summer) and typically have more than one wave of infection. However, this is not true in all circumstances or in all areas. A small first wave is often followed by a larger second wave, but the relative size of pandemic waves may vary. The speed of spread may also vary – pandemic waves can be intense or more spread-out over time. An intense wave would put more stress on the health care system.
> - What its characteristics will be—the basic characteristics of the next pandemic virus are unknown, including its antigenic type (e.g., H2, H5, H7), its transmissibility and virulence, and the age groups and clinical groups most affected.
> - What its impact will be—the last four pandemics demonstrated that population impact can vary from low to high and is not the same in all populations or settings. It is important to consider all possibilities and make plans adaptable for different circumstances. This will help ensure that the response is proportional to the evolution of the pandemic in any specific community.
> - What effect interventions will have—typical seasonal influenza interventions are expected to be effective during the pandemic. However, the novel virus could be resistant to antiviral medications and/or pandemic vaccine production could be delayed or unsuccessful. The extent of vaccine uptake and adoption of public health measures is also unknown. Furthermore, interventions could have unintended consequences.

Finally, the World Health Organization also recognized the dangers posed to global public health due to an outbreak caused by a novel virus. Since 2015, the WHO has released an annual list of up to 10 “blueprint priority diseases” that require immediate attention from public health officials based on their epidemic potential or a global lack of available medical countermeasures. Diseases such as SARS and Ebola have been included in various versions of the list. In 2018, however, a new disease was added: Disease X, an unidentified disease coming from an undetermined source. After making this addition to the list, WHO representatives stated, “Disease X represents the knowledge that a serious international epidemic could be caused by a pathogen currently unknown to cause human disease.”

Ontario was thoroughly warned to prepare for a pandemic caused by an unknown, new virus. As will be seen, sufficient preparations did not take place.

Failures in Pandemic Planning

> SARS has ... taught the healthcare system a great deal about vulnerability, preparedness, and the need for far greater emergency planning within the sector if future risks of greater magnitude are to be effectively managed.
>
> – 2003 Interim Report of the Expert Panel on SARS and Infectious Disease Control

The SARS outbreak in 2003 made it clear that Ontario needed to prepare broadly and plan thoroughly for future pandemics caused by unexpected viruses. That did not happen. Instead, Ontario spent a decade relying on an influenza-oriented pandemic response plan that had not been updated since 2013, was never tested, and did not protect the vulnerable Ontarians in long-term care.

Ontario's failure to act more promptly to improve its preparedness – and to protect those living in long-term care – is all the more confounding when considered in light of the 2017 Auditor General's Report. The report clearly warned that the province was not prepared for an emergency, and that its emergency plans needed to be updated and simulated. Like so many others, these warnings would be ignored by the province.

In order to understand the province's failure to adequately plan for a future pandemic, and the consequences of that failure, it is worth exploring various aspects of the planning process in more detail.

Confusion over responsibilities for emergency planning

The *Emergency Management and Civil Protection Act* is the provincial legislation that addresses general emergency management in Ontario. The overarching provincial plan for emergencies, called the Provincial Emergency Response Plan, is the responsibility of the Solicitor General, through the Office of the Fire Marshal and Emergency Management.

Because emergencies may arise in an array of circumstances, certain ministries are required by Order in Council to prepare their own plans to address emergencies in their area of responsibility. For example, the Ministry of Natural Resources is to plan for forest fires, while the Ministry of Health and Long-Term Care (as it was known at the time) is responsible for emergencies arising from "human health, disease and epidemics." Representatives from the Solicitor General confirmed to the Commission that this responsibility would include leading the response to a pandemic such as COVID-19.

After the Ministry of Health and Long-Term Care was separated into two ministries in 2019, the Provincial Emergency Response Plan required both of the new ministries to have a plan, noting that "[Ministry of Health/Ministry of Long-Term Care] plans detail how responsibilities are met and describe how the ministries manage human health emergencies ...." The plan also directed the two ministries to coordinate "the health system with partners including: […] Long-term care facilities."

Minister of Health Christine Elliott acknowledged to the Commission that she has the ultimate responsibility to ensure that the province has a plan in place to address a health crisis. The Chief Medical Officer of Health told the Commission that he has the principal responsibility to ensure the pandemic plans are in place and updated and indicated that he sits on various provincial, territorial and federal committees that meet for that purpose. Undoubtedly, this should be a key function for the province's senior public health officer and should be a priority for the Minister. (For more information on the roles of the Chief Medical Officer of Health and the Minister of Health, see appendix B.) In this instance, however, as explored below, neither ensured that a comprehensive plan was in place.

Furthermore, there was no clarity as to what role the Ministry of Long-Term Care was to play in pandemic preparation.

The Deputy Solicitor General, whose Ministry is responsible for maintaining the Provincial Emergency Response Plan, told the Commission that all pandemic planning was the responsibility of the Ministry of Health.

The Minister of Health acknowledged her responsibility in this area but said that the Ministry of Long-Term Care had responsibility for planning with regards to long-term care. Minister of Long-Term Care Dr. Merrilee Fullerton told the Commission that her Ministry was to be integrated into the Ministry of Health's planning process. However, the Ministry of Long-Term Care's initial Deputy Minister told the Commission that she was not briefed on the emergency response to a pandemic when she arrived at the new ministry and that emergency response was not a priority issue for the Ministry in the months leading up to the COVID-19 pandemic. When COVID-19 fully took hold, the Ministry of Long-Term Care had no pandemic plan. It also made no outreach efforts to coordinate the emergency response within long-term care homes (although homes were required to have their own plan).

Furthermore, the Minister of Long-Term Care told the Commission that she was not aware of what the provincial plan to respond to an outbreak was.

There needs to be more clarity as to the respective roles of the Ministries of Health and of Long-Term Care regarding emergency planning – especially emergency planning with respect to long-term care. The two ministries must ensure that roles and responsibilities are clear and that those at the top not only know those roles but enforce them. They must also ensure that the safety of long-term care residents is reflected in any provincial emergency plan.

Existing pandemic plans insufficient

The Commission initially had difficulty determining which plans the province relied on when the COVID-19 pandemic began. Testimony from various government representatives was contradictory on what plan was being used to address the

COVID-19 pandemic. The Chief Medical Officer of Health provided answers inconsistent with those of the responsible Ministry of Health bureaucrats.

Ultimately, however, the province seems to have at the very least referred to two plans during the pandemic: the Ontario Health Plan for an Influenza Pandemic (OHPIP), which was published in 2004 and most recently updated in 2013, and the 2013 Ministry of Health and Long-Term Care Emergency Response Plan. Not only were these plans not updated, but both also lacked important elements that would have left the province better prepared for COVID-19.

The Ontario Health Plan for an Influenza Pandemic focused primarily on preparing for a major influenza outbreak, as the name suggests. It assumed that "[t]he pandemic virus behaves like seasonal influenza viruses in significant ways, including the incubation period, period of communicability and methods of transmission."

The SARS-Cov-2 virus, which causes COVID-19, does not behave like the influenza virus. As a result, treating it like an influenza virus is not an effective approach.

The OHPIP also included limited discussion of several items that could have helped the province better respond to a novel viral threat, including:

- increasing laboratory testing capacity, speed and reliability;
- managing contact-tracing capacity;
- broadening the range and efficacy of virus screening;
- balancing competing priorities, such as preserving acute- and intensive-care capacity;
- embracing the use of virtual care; and
- adopting modern communication tools such as videoconferencing.

Neither the Ontario Health Plan for an Influenza Pandemic nor the Ministry Emergency Response Plan contained a comprehensive communications strategy. Section 6.2 of the Ministry Emergency Response Plan was titled "Crisis Emergency and Risk Communications Response Guide." However, the content in this section was noted as "under development."

The Ontario Health Plan for an Influenza Pandemic guidance on pandemic communications only addressed communications between the Ministry of Health and Long-Term Care and health sector stakeholders, stating that other communications, such as media conferences, were "not described in this chapter as it is beyond the scope of health sector communications." The need for effective public communications protocols during a pandemic, nevertheless, was not new to the province at this point. In 2004, the Interim Walker Report had stated:

> To effectively deal with infectious disease outbreaks and health emergencies, the province needs to provide credible, timely, and as much as possible, evidence-based information to the general public, healthcare providers and the system as a whole.

As demonstrated by the insufficient communications guidance in the Ministry's two health emergency plans, Ontario only partly implemented this recommendation in the years following SARS. As will be discussed in chapter 3, families of long-term care residents experienced severe communications difficulties in trying to obtain information about the health status of their loved ones. Meanwhile, long-term care homes were often left confused by frequent and uncoordinated communications and guidelines published by provincial and local public health officials.

The Commission also heard from an expert in bioethics, Dr. Jennifer Gibson, who served on a government bioethics advisory committee during the COVID-19 pandemic. Dr. Gibson stated that while the Ontario Health Plan for an Influenza Pandemic contained some technical information that could help the provincial government manage a pandemic, the plan was silent as to the core ethical values that should underlie the government's decision-making processes during a public health emergency. She noted that explicitly publishing these core values is an important factor in building the public's trust in its government's pandemic response. Dr. Gibson also told the Commission that such a framework was included in the 2008 version of the OHPIP but was removed from the 2013 version, which is the version still in effect today.

Finally, as will be discussed in greater detail below, the OHPIP did not contain any specific guidance on how to manage a pandemic in the context of the long-term care sector.

The Commission was also told of a number of other documents that the government referred to in responding to the COVID-19 pandemic. These documents, however, were either specific to certain diseases such as Middle Eastern Respiratory Syndrome or never made public. For example, in August 2014, the Ministry of Health and Long-Term Care drafted a document providing guidance on how health system stakeholders should respond to emerging, novel respiratory infections. Yet representatives from the Ministry of Health confirmed to the Commission that this document was considered "internal" and that health sector stakeholders were never told that it was to be used in the case of an outbreak.

While the province's preparations for an influenza pandemic did indirectly yield some guidance for responding to the COVID-19 pandemic, this does not make up for Ontario's failure to follow Justice Campbell's advice and create a comprehensive response plan for a pandemic caused by a novel virus.

Scant information provided for long-term care homes

The 2013 Ontario Health Plan for an Influenza Pandemic – which was the province's operative pandemic plan at the time of the COVID-19 outbreak – did not contain specific guidance for how to manage a potential pandemic in the context of the long-term care sector, aside from requiring homes to report outbreaks to the Ministry of Health and Long-Term Care.

Previous versions of the plan, published in 2007 and 2008, contained an entire chapter dedicated to the topic, but that chapter was removed in the 2013 edition. This is a stark demonstration of how pandemic management in the long-term care sector was not integrated into the province's overall pandemic response structure.

By comparison, the federal government's 2018 influenza pandemic plan included long-term care homes in its simulations of how pandemics of varying severity might affect the country's health care system. It included a warning that long-term care services might not be well connected to regional and local pandemic planning processes, creating issues for the delivery of health care in homes during a pandemic. The federal plan also emphasized that long-term care services could not be ignored in pandemic plans and responses:

> Though often overlooked in pandemic planning, their [other health care services including long-term care] functioning is critical to achieving the pandemic objectives […] These organizations must be involved in pandemic planning and encouraged to have business continuity plans in place so that they can continue to provide their services to some of the most vulnerable patients in the community with minimal interruption during a pandemic.

While the 2018 federal pandemic plan addressed concerns over long-term care much more effectively than its provincial equivalent in Ontario, it is important to note that previous iterations of the federal pandemic playbook went into greater depth on the potential implications of a pandemic for long-term care facilities.

The 2011 Canadian Pandemic Influenza Plan for the Health Sector – as the playbook was then called – devoted an entire subsection to recommendations for infection prevention and control activities in long-term care settings. The section explained that, given experiences with seasonal influenza, "it is likely that the residents of [long-term care facilities] will be vulnerable to severe complications should they acquire influenza caused by the pandemic strain." It also pointed to the different ways the virus could be brought into homes:

> Since LTC facilities are relatively closed communities, visitors, HCWs [health care workers], and residents who have been on trips/visits into the community, or residents newly admitted from the community are frequently the point of entry of the influenza virus into LTC facilities.

As chapter 3 will demonstrate, several of these predictions were realized in long-term care homes during the COVID-19 pandemic.

Pandemic plans not updated

As noted above, in the years following the SARS outbreak, Ontario's Ministry of Health and Long-Term Care created the general Ministry Emergency Response Plan and the Ontario Health Plan for an Influenza Pandemic. Ontario's Emergency Management Office (EMO) also drafted two plans relevant to a potential pandemic: the Provincial Emergency Response Plan, which is used to coordinate the overall provincial response to any type of emergency, and the Provincial Co-ordination Plan for Influenza

Pandemic, which was developed to manage the broader societal aspects of influenza pandemics beyond the health system.

In 2007, Ontario's Auditor General recommended that the province's pandemic response plans be reviewed regularly and updated as needed. The EMO's Emergency Response Plan was updated in 2008, but its Provincial Co-ordination Plan for Influenza Pandemic from 2006 was not. In 2009, the Ministry of Health and Long-Term Care reported that it had updated the Ontario Health Plan for an Influenza Pandemic and that the Ministry Emergency Response Plan was under review. Both were updated again in 2013, but neither has been updated since. An update to the Emergency Management Office's response plan was completed in 2019 but had not been translated into French or coded for accessibility by the time the COVID-19 pandemic struck.

By the end of 2019, important elements of the Ministry of Health's plans that were publicly available were out of date. For example, the Ministry of Health and Long-Term Care's Emergency Response Plan's description of the Chief Medical Officer of Health's roles and responsibilities did not take into account the fact that, in 2018, the Chief Medical Officer of Health was assigned additional responsibilities as Assistant Deputy Minister for the Ministry of Health's Public Health Group. Furthermore, neither plan accounted for the role of the newly created Ontario Health or the recent division of the Ministry of Health and Long-Term Care into two ministries. (For more information on the roles and responsibilities of the Chief Medical Officer of Health, Minister of Health and Ontario Health, see appendix B.)

Ministry of Health representatives told the Commission that, at the onset of the pandemic, the Ministry was still in the process of determining what role the newly separated Ministry of Long-Term Care would play in a potential pandemic response. Various individuals involved in the province's long-term care sector also told the Commission that the Ministry of Long-Term Care was ill-prepared in the early days of the pandemic.

Since the Ministry of Health's emergency and pandemic response plans were not updated at the beginning of the COVID-19 pandemic, the government could not fully rely on them. Instead, these plans were used simply as guidance documents while a new COVID-19 response structure was set up.

The Chief Medical Officer of Health told the Commission that it was his responsibility to update Ontario's pandemic plan and that the plan was updated "[a]s necessary and as needed for an influenza pandemic." He also acknowledged that the Ontario Health Plan for an Influenza Pandemic had not been updated since 2013. Given the deficiencies in the plan identified above – especially the fact that the OHPIP did not contain specific guidance for outbreak management in long-term care – and the fact that Ontario's Auditor General had recommended regular reviews and updates to the pandemic plan as needed, the plans should have been updated and the roles and responsibilities of the Ministry of Long-Term Care clarified.

As a result of its failure to update its own pandemic plan, Ontario was forced to allocate time and resources early in the COVID-19 outbreak toward installing a response structure. It is impossible to build a structure to respond to a pandemic and effectively respond to a pandemic at the same time.

Broader preparedness plans not completed

Following the 2014–16 Ebola outbreak, it became clear that Ontario's overall emergency preparedness suffered from key weaknesses. Indeed, Ontario's Chief Medical Officer of Health told the Commission that, after the Ebola scare, it was apparent that the province needed to be prepared for all potential infectious disease threats – not just influenza. A 2016 government presentation on Ontario's infectious disease preparedness noted that "[r]ecent emergency responses to emerging infectious disease threats have raised concerns regarding health system readiness." Clearly, a new approach to Ontario's pandemic planning was required.

As a result, in 2016, Ontario began working on a new all-purpose model for preparedness. The "Ready and Resilient Health System" was intended to shift Ontario's approach to emergency preparedness from maintaining individual plans responding to specific events to maintaining a single plan that could be used to respond to all potential hazards. It would "meet the challenges of future infectious disease threats" and broaden the province's pandemic preparedness beyond the Ontario Health Plan for an Influenza Pandemic. The 2016 document embodying the first stage of this process, called the "Ebola Step-Down Plan," defined an "infectious disease threat" as any infectious disease of public health importance that might spread provincially, nationally or internationally; cause significant illness; pose a risk to health care workers and vulnerable populations; and be difficult to prevent and treat. It should be noted that the Ontario government web page housing the Ebola Step-Down Plan is marked with a label stating: "[t]his document was published under a previous government." This label is unnecessary. The distribution of information that could help protect the safety of the people of Ontario should not be subject to partisan considerations.

The present government also identified the challenges of a fragmented approach to preparedness. An August 2018 policy paper indicated that the province's existing approach to managing "disruptions" had resulted in:

- **Inconsistent levels of readiness across the system**

  A lack of consistent expectations across Ontario's health sectors has created varied levels of readiness. Roles, responsibilities, and core processes vary significantly from region to region and disruption to disruption depending on which sector and which hazard is being addressed. This limits the ability for long-term planning and capacity building and results in a need to redefine roles and responsibilities during a disruption.

- **Lack of strong networks to support readiness and response**

  Health emergency preparedness networks have inconsistent levels of involvement in the management of disruptions throughout Ontario. The complexity of the provincial health system makes it difficult to develop and sustain existing connections. This impacts the system's ability to perform and respond in moments of crisis when strong formal and informal networks are crucial.

- **Inconsistent awareness of risk**

  Across the province, "risk" is understood differently within various health entities. The lack of a common framework that maintains and integrates information for situational awareness limits the opportunities for early intervention and results in an inconsistent approach to risk assessment.

- **Lack of comprehensive resource management**

  The lack of a guiding resource management framework results in issues of availability, access, maintenance and sustainability of resources and supplies. While many resources and supplies exist (e.g., the provincial stockpile), there is inconsistency between their availability, how they are or aren't used during an incident, and the manner in which those resources and supplies are purchased, maintained, recycled or disposed.

- **Inconsistent approach to training**

  Approaches to education and learning are inconsistent across the province and health workers do not always feel confident that they have the right information to act safely. This results in ad-hoc training opportunities, lack of trust, and the inability to ensure system readiness.

The same report noted that the province's approach to emergency management continued to focus on known hazards and was limited in its ability to address unforeseen hazards in the future:

> While hazard-specific planning increases the system's ability to effectively respond to some hazards, it limits the ability to transfer lessons learned to other hazards and make timely system adjustments. This perpetuates the need to plan for each hazard individually. However, planning for each hazard or incident individually is not sustainable given an increasing diversity of hazards and since every hazard has the potential to affect the health of Ontarians and the health system.

A Ministry of Health and Long-Term Care slide deck from the same year indicated concerns that the province's preparedness plans "[did] not address the complex nature of disruptions and their ability to manifest unexpectedly."

These concerns were magnified by the fact that Ontario was also undergoing wholesale changes to its health system generally at this time. These included structural changes to Ontario's health care system delivery model, such as the creation of Ontario Health Teams (discussed in more detail in chapter 4 and appendix B), and proposed financial cutbacks to programs and agencies such as Public Health Ontario. An internal government document indicated that these changes made the installation of the Ready and Resilient Health System all the more necessary:

- This multi-year transformation, particularly the transition of 20 provincial agencies, including the LHINs [local health integration networks], to Ontario Health (OH), will be associated with a shift in system responsibilities, as well as with potential gaps in health human resources and organizational knowledge.
- This indicates an increasing need for on-going collaborative planning to reduce vulnerabilities to hazards, so patients continue to receive health services during an emergency or disruption.
- However, in the absence of a unifying [emergency management] framework, the current patchwork of fragmented approaches limits the overall health system readiness and its ability to successfully support the health system transformation.

Despite four years of policy work by public servants, the Ready and Resilient Health System was not implemented by the time COVID-19 struck the province.

When asked why the plan remained unfinished four years after work on it began, neither Deputy Minister of Health Helen Angus nor the Minister herself could provide a specific answer.

Meanwhile, when Commission counsel asked the Chief Medical Officer of Health whether it was possible that the Ready and Resilient Health System remained unfinished because completing it was not a governmental priority during a time in which the province was not faced with a public health emergency, he agreed.

Regardless of the reason, the fact remains that the Ready and Resilient Health System was not ready for use at the beginning of the COVID-19 pandemic. As a result, Ontario did not have an up-to-date, tested or thorough pandemic plan on which to rely. As will be discussed in chapter 3, this severely hampered the province's response to the spread of COVID-19 in Ontario's long-term care facilities.

Pandemic plan simulations and practice runs not undertaken

The SARS Commission's final report emphasized the importance of running training exercises to bolster the province's preparedness for future outbreaks. Many individuals interviewed by the Commission also noted that simulations and drills are a crucial part of emergency preparedness.

For example, Jonathan Suk of the European Centre for Disease Prevention and Control told the Commission about the importance of "simulation exercises, drills, table top exercises to test and see how well your plans work in practice and to try to identify gaps." James Scongack, Executive Vice-President of Corporate Affairs & Operational Services at Bruce Power responsible for emergency preparedness, discussed the importance of drills that consider the emergency environment, including communication to stakeholders and the public. He explained that it is critical to drill the plans so that when a crisis does hit, everyone knows what to do. Similarly, Dr. Terry Lum, Head of the Department of Social Work and Social Administration at the University of Hong Kong, told the Commission that infectious disease control simulations have been a

regular practice in Hong Kong's long-term care facilities since 2004. He noted as an example that one of the benefits of these drills was that, when the COVID-19 pandemic began, long-term care staff were already well aware of how to dilute cleaning products in the homes to create disinfectant.

Drills and exercises can reveal deficiencies in emergency plans and provide an opportunity to bolster the plans accordingly. Given the province's experience with SARS, H1N1 and Ebola, exercises and drills that involved regular reviews of Ontario's pandemic plans would have provided ample direction on what was needed to face a future pandemic.

The importance of these exercises was also brought to the province's attention in 2007 by Ontario's Auditor General, who recommended that the Ministry of Health and Long-Term Care periodically conduct simulation exercises to test and confirm its response plans' effectiveness. The Ministry did initially conduct some exercises, but the drills did not continue in the years that followed.

In 2017, the Auditor General's Report noted that, between 2012 and 2016, the Ministry of Health and Long-Term Care had conducted one basic emergency simulation per year regarding continuity of government operations and had not conducted any simulations of specific emergencies, including pandemics. Once again, the need for these exercises was not indelibly embedded in the government's regular operations.

In 2019, a new version of the Ontario Emergency Management Office's Provincial Emergency Response Plan reaffirmed that "every minister is responsible for conducting emergency management training programs and exercises to ensure the readiness of Crown employees and other persons to act under their respective ministry emergency plans."

In 2020, the Auditor General conducted a follow-up on her 2017 report. It revealed that the Ministry of Health and Long-Term Care had not conducted any tests of the Ontario Health Plan for an Influenza Pandemic or the Ministry's Emergency Response Plan in the previous three years. The Auditor General also found that the Emergency Management Office had not run any exercises regarding the Provincial Emergency Response Plan or the Provincial Co-ordination Plan for Influenza Pandemic.

Representatives from the Ministry of Health confirmed to the Commission that no general pandemic exercises or pandemic exercises related to long-term care facilities were conducted by the Ministry between 2013 and 2020. The Ministry of Long-Term Care also failed to conduct a planning exercise that would help prepare for a pandemic and address the challenges the already-taxed long-term care sector might experience.

Many of the issues confronted during the pandemic could and should have been simulated in advance. For example, there was no plan to deal with staffing shortages when workers refused to come to work because they were sick, feared catching COVID-19 because of the lack of personal protective equipment, or had to take care of a sick

loved one or children home from school. The loss of staff in an already understaffed sector was an obvious danger, yet there was no plan for surge capacity in the workforce.

A group of registered dietitians who work in long-term care homes also advised the Commission that the COVID-19 pandemic, which exacerbated pre-existing staffing shortages, caused many residents to suffer from malnutrition and dehydration, sometimes with fatal consequences. They noted that, had the province involved them in efforts to plan for how a pandemic might affect long-term care facilities, much of this suffering could have been avoided.

Similarly, there was a delay in addressing the issue of staff working in multiple homes (discussed further in chapter 3) while policy issues around labour concerns were addressed. This was not, however, a new issue. The Walker Report had identified the problem of long-term care staff working in more than one home, thereby possibly spreading a disease or virus.

It should be noted here that, at the time of writing, the Ontario government has not made the Walker Report in its entirety available online. Currently, only the introduction to the report is available on the government's website and, as with the Ebola Step-Down Plan, the passage appears with a label: "This document was published under a previous government." It is difficult to see how the report's prescient and important recommendations could be implemented if the report is not readily accessible in full. Furthermore, it is not helpful or necessary to label reports of this nature as the product of a previous government. Pandemic preparedness is not a partisan issue and should not be branded as such.

Limited guidance offered to long-term care outside of pandemic plan

Outside of the Ontario Health Plan for an Influenza Pandemic, the Ontario government did provide some limited written guidance to long-term care homes on managing respiratory infections. A November 2018 guideline document on controlling respiratory infection outbreaks in long-term care homes acknowledged that coronaviruses are among the most common viruses causing respiratory infection outbreaks in long-term care settings. The vast majority of the document, however, was concerned with "[t]he specific management of influenza outbreaks." The document's only guidance for responding to the outbreak of a novel virus was to state that "[d]uring an outbreak caused by new, emerging pathogens … [Long-Term Care homes] should follow recommendations developed specific to that emerging pathogen."

As with Ontario's 2013 influenza pandemic plan, the 2018 guideline document contained some information that was useful in responding to the COVID-19 pandemic. For example, it included recommendations regarding infection prevention and control measures; personal protective equipment for staff, visitors and residents;

communications with families and loved ones; transferring residents to hospitals where necessary; and isolating residents.

Nonetheless, the fact remains that this information was primarily oriented toward managing influenza and did not provide comprehensive guidance on managing a novel virus outbreak. This was confirmed by the Manager of Infectious Diseases Policy & Programs for the Office of the Chief Medical Officer of Health during an interview with the Commission. The manager told the Commission that the 2018 guidance document for responding to respiratory outbreaks in long-term care homes was "specifically geared for influenza when a staff or a resident could be vaccinated or receive [antiviral medication] to prevent and reduce transmission." When the COVID-19 pandemic began, vaccines were unavailable and antiviral treatments were of no use.

The manager was also asked whether the province ever contemplated planning for a viral outbreak in long-term care for which there was no vaccine or antiviral treatment available. In response, she did not refer to any such plan and told the Commission that, as a result of COVID-19, the province had learned important lessons on managing viral outbreaks that did not respond to vaccines or antiviral treatment.

Ontario did not need to wait for the COVID-19 pandemic to erupt before learning the lesson that the long-term care sector needed guidance on how to manage novel virus outbreaks that were not treatable with antiviral medication or a vaccine. As has been noted several times in this chapter, Ontario received numerous warnings from multiple expert sources that a novel viral outbreak was a viable threat. If these warnings had been properly heeded, the province would have provided the long-term care sector with crucial guidance on how to address these threats before the pandemic began to devastate its homes.

Summary

Maintaining thorough, up-to-date and tested pandemic plans is a crucial investment that must be made now to ensure proper preparedness in the future and the effective protection of Ontario's long-term care residents. The federal government's pandemic plan echoes this notion, stating that provincial governments are responsible for ensuring that pandemic plans are developed, tested and periodically updated.

Any resources and money spent on creating a pandemic plan in advance will pale in comparison to the amount a province will have to spend if it finds itself without an effective plan when a pandemic erupts. The onset of a pandemic is not the time to be updating existing plans or building new ones. When a public health emergency strikes, all focus must be on executing the plans already in place.

Tragically, when the COVID-19 pandemic emerged, Ontario did not have a comprehensive preparedness plan. Rather, it had a series of mostly dated plans that, at best, offered a partial response to a pandemic on the scale of COVID-19. These short-of-the-mark plans also compromised the province's ability to limit the effect of the

pandemic on the long-term care sector. The piecemeal nature of the province's pandemic planning was succinctly summed up by the Minister of Health when she was asked which of Ontario's pandemic planning documents would be applicable to a pandemic such as COVID-19:

> Well, there were a number of documents that were referred to, I know that, but there was no one plan that dealt with a pandemic of this nature … It wasn't written down in one document.

It is telling that the individual who served as Public Health Ontario's Chief Health Protection Officer at the beginning of the pandemic told the Commission that it was not clear to her which plan the Ontario government was using to build its pandemic response structure. Indeed, she indicated that Public Health Ontario and the Ministry of Health were relying on two different documents. Unfortunately, as the pandemic proceeded, it was never made clear to her what plan was being used by the Ministry of Health. If the person responsible for pandemic preparedness at Public Health Ontario was unaware of the pandemic plan, it is understandable that many in the wider health sector and the public at large would also be confused as to the province's planned pandemic response.

When a pandemic strikes, Ontario's response plan must be up to date, tested, thorough, clear and located in a single document. Given the province's failure to have such a plan in place, confusion was inevitable. Moreover, the failure to have a proper plan in place on the eve of the pandemic compromised the province's ability to devote attention and resources to the spread of the virus in long-term care.

Failure to Maintain a Personal Protective Equipment Stockpile

> Measures resulting from advance planning require resources of people and equipment. Examples are surge capacity for human resources and medical equipment, such as N95 respirators, gloves, gowns, visors and other protective equipment, and a secure source of supply and an effective logistical system to distribute them.
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> […]
>
> SARS not only underlined the importance of having an effective emergency management structure, it also emphasized the need to have sufficient quantities of medical supplies, secure supply chains and the means to distribute the supplies.
>
> –The Honourable Justice Archie Campbell, SARS Commission Final Report

Justice Campbell understood that Ontario's ability to protect its citizens during a pandemic depends on having necessary medical supplies available in an emergency. For a time, the government also recognized that a provincial stockpile was a central part of provincial preparedness. In 2006, the province acquired a stockpile of emergency health supplies, including personal protective equipment. This initial enthusiasm, however, was not maintained, and the stockpile was never completely funded. Furthermore, additions to the stockpile were episodic in that they responded to the most recent health threats of the day instead of being planned as part of a comprehensive

management strategy. By the onset of the COVID-19 pandemic, the vast majority of the stockpile was expired and had not been replaced. This issue was compounded by the fact that many long-term care facilities also did not maintain a substantial PPE stockpile of their own. These two problems combined to contribute to the desperate shortage of personal protective equipment in many of the province's long-term care homes.

The cost of a stockpile, the price of a pandemic

In the 2006 Cabinet submission requesting $170 million for outbreak management initiatives – including $84 million for the creation of a stockpile – it was explained that an influenza pandemic would take a terrible toll on both lives and the economy in Ontario. It was predicted that even a moderate pandemic would kill 18,000 people and have an economic impact of between $3 billion and $10 billion.

In the end, the cost of maintaining emergency supplies predicted in 2006 was dwarfed by the economic impact that COVID-19 had on this province. The COVID-19 pandemic has not been as deadly as the influenza pandemic predicted in 2006; it has, however, proven much more costly. Since the emergence of COVID-19, Ontario's gross domestic product (GDP) has fallen an estimated 5 per cent from 2019 to 2020 (or about $45 billion) according to Ontario government representatives. Before the pandemic, Ontario anticipated the provincial GDP would rise 3.3 per cent from 2019 to 2020 (or $29 billion). The difference between the anticipated GDP increase and the decline caused by COVID-19 has resulted in an approximately $74 billion additional cost between what was predicted and what occurred. (At the time these figures were provided to the Commission, they were not final, as the COVID-19 pandemic was ongoing and the year-end numbers for 2020–21 were not yet finalized.)

Ontario's Minister of Finance further advised that, as of the end of January 2021, provincial spending from the 2019–20 fiscal year to 2020–21 was up $25 billion due to the pandemic (this $25 billion does not include Ontario's share of federal spending and does not take into consideration planned cutbacks that were delayed due to this pandemic). In its 2021 budget, the province allocated $1.4 billion to be spent on personal protective equipment for health care and other sectors – a far cry from the original $84 million estimate for PPE requested in 2006.

Investing in a stockpile provides the province with a crucial defence against the dangers of a pandemic in several ways. First, it provides protection to the citizenry in the face of a health hazard. Second, it ensures that supplies are available when the global community is all seeking the same products at the same time and supply chains are stretched. Third, without sufficient PPE, front-line health workers – including those who work in long-term care – will not feel safe and may not come to work. As it happened, Ontario's lack of PPE resulted in all of these dangers coming to pass.

When COVID-19 struck Ontario, most of the province's stockpile of emergency supplies had expired and was in the midst of being destroyed. Indeed, 80 per cent of the

stockpile had expired by 2017. Successive governments failed to take action to replace these supplies. Instead, they conducted a three-year policy review to assess how best to acquire and store a future stockpile. Ontario was still in the midst of this study – with no clear plan or end date set for the replacement of stockpile supplies – at the onset of the COVID-19 pandemic. By the end of 2019, 90 per cent of the stockpile was expired and was in the process of being destroyed. The supplies that remained were primarily meant to address an Ebola outbreak.

In order to understand how this occurred, it is necessary to look back at the initial establishment of the stockpile and the successive decisions that resulted in its depletion prior to the emergence of COVID-19 – when an adequate stockpile was so desperately needed.

Provincial stockpile established

In January 2006, the Ministry of Health and Long-Term Care requested funding for the creation of a personal protective equipment stockpile, stating that there was "global concern regarding the readiness to respond to a potential influenza pandemic in humans." The submission noted that "Public Health experts around the world are forecasting that an influenza pandemic is statistically overdue … It is predicted that more than one third of the world's population may fall ill during the course of a new pandemic influenza event."

The funding request was prescient, predicting what eventually occurred in 2020, when civil servants attempted to source personal protective equipment in a time of crisis:

> The key issue that all jurisdictions will face as they begin to prepare for an influenza pandemic is the lack of surge capacity for essential supplies and equipment to protect healthcare workers and their patients. This is a serious problem during a pandemic, but also well before one begins as countries initiate stockpiling campaigns and are forced to compete for scarce supplies. Further, many key items are produced in, or require components produced in, Asian countries which, according to experts, may be among the first hit by an influenza pandemic
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> […]
>
> Without appropriate personal protective equipment, Ontario's health care workers may be placed unnecessarily at risk. Health care workers may refuse to work without adequate personal protective equipment. The level of care that can be provided to citizens during a pandemic could be compromised.

The 2006 funding and procurement request also noted that domestic production of many types of personal protective equipment that the stockpile needed to fight a pandemic, such as masks, gloves and gowns, was limited. Given the lack of local production capacity, the need for a stockpile was readily apparent and the dangers of failing to maintain such a stockpile were clear. If a pandemic struck, the province would be forced to seek desperately needed supplies in a crowded market where supplies were minimal and price gouging rampant. As noted here and elsewhere, this is precisely what happened during the COVID-19 pandemic.

The PPE stockpile was created later in 2006. Its formal purpose was to contain enough equipment to "supply the health system for four weeks of the response to a moderate influenza pandemic." The 2006 funding submission for the stockpile specifically contemplated the needs of the long-term care sector, recognizing that the population would likely have more significant infection rates during a pandemic.

The original intention of the stockpile, however, appears to have been misunderstood by key government officials. In presentations to the Commission, Ministry of Health and Cabinet Office representatives described the stockpile as a "top-up" or "backstop" that was supposed to complement health facilities' individual PPE supplies. It was neither of these things. The stockpile was intended to be an indispensable life-saving necessity in the event of a pandemic. In addition, the Chief Medical Officer of Health told the Commission that the PPE in the stockpile was not meant to be provided to long-term care facilities but was rather intended for smaller primary care providers that did not have sufficient access to supply chains. This directly contradicts the purpose of the stockpile as stated in the government documents that led to its creation.

Underfunded, understocked and allowed to expire

Within a year of the stockpile's creation, issues surrounding its administration began to emerge. In 2007, Ontario's Auditor General reported that only 60 per cent of the required PPE quantity was stockpiled and that the supply of N95 respirators was limited.

When the Auditor General followed up on the status of the stockpile two years later, the Ministry of Health and Long-Term Care had obtained almost all the required medical supplies and equipment, including N95 respirators, and expected to have all required items stockpiled by fall 2009.

Ministry of Health representatives told the Commission that, at some point between 2007 and 2008, all funds from the $170 million originally allocated for pandemic preparedness measures that had not yet been spent were rescinded and reallocated to other government initiatives. By 2010, the government stopped providing consistent funding for the stockpile. After consistent funding was halted, supplies were only added to the stockpile via individual procurement requests made in response to specific events and health crises.

Furthermore, the stockpile was never cycled, for example, by distributing older items to health care suppliers before expiry so that the stockpile remained "fresh." Instead, the stockpile was "static"; in the absence of an emergency situation, PPE sat in the stockpile unused until it expired. The Chief Medical Officer of Health told the Commission that it is preferable to have the contents of a public health emergency stockpile rotated instead of having the contents remain static.

A 2019 internal government report reviewing the history of the stockpile concluded that the 2010 decision to change the stockpile's funding from "consistent" funding to "point-in-time" funding "limited opportunities to find efficiencies in the life-cycle management

of the stockpile" and "impact[ed] the ability to pursue potential cost saving arrangements via a comprehensive stockpile management strategy." The analysis also noted that, as a result of the funding model, "life cycle management of the stockpile has … been challenging and/or non-existent."

Problems regarding the stockpile's supply levels would re-emerge later in the 2010s. The Ministry of Health and Long-Term Care's original funding request to Cabinet detailed precisely how many units of various kinds of personal protective equipment would be required to manage an influenza pandemic that affected 35 per cent of Ontario's general population and 50 per cent of its long-term care residents. These volumes had been calculated by an expert working group. Dr. Jennie Johnstone, Medical Director of Infection Prevention and Control at Sinai Health, told the Commission that the projected mask quantities in 2006 for the long-term care sector would have been sufficient to respond to COVID-19.

The table below compares the original amount of certain PPE types requested by the Ministry of Health and Long-Term Care in 2006 to the actual stockpile amounts as of October 30, 2013:

PPE Type	**Recommended Amount (2006)**	**Actual Amount (October 30, 2013)**
Surgical masks	94,000,000	36,545,000
Examination gloves	42,000,000	40,450,000
Disposable gowns	25,000,000	24,822,000
Safety glasses	13,000,000	1,274,000
Disinfecting wipes	134,000,000	3,260,815

In July 2019, the Ministry of Health warned Ontario's Treasury Board and Cabinet that "[m]ost of the ministry's supply and equipment stockpile is expired." The Chief Medical Officer of Health told the Commission that he also advocated for the stockpile to be replenished, though he noted that his primary concern was ensuring that the stockpile's supply of antivirals was increased.

As noted above, by the end of 2019, 90 per cent of the stockpile was expired and the government was undertaking organized efforts to destroy the expired equipment. However, there does not appear to have been any corresponding action taken by the government to replenish the supplies.

Bob Bell, who served as Ontario's Deputy Minister of Health between June 2014 and June 2018, told the Commission that, between 2017 and 2018, N95 masks were among the supplies that were discarded. He noted that destroying these masks was "not a smart decision" because the only defective element of the expired masks were the elastics and that the masks themselves could still be used.

Representatives from the Ministry of Health told the Commission that they could not recall any formal policy being put in place or procurement requests being made to

replenish supplies of expired products that had been destroyed prior to the COVID-19 pandemic. These representatives also told the Commission that the government had acknowledged the need to replenish the stockpile and that policy research was underway to determine how best to do so.

The Minister of Health was also aware of the destruction of the stockpile supplies; in 2019, she participated in a meeting with the Treasury Board to discuss the cost of warehousing and destroying the expired stockpile. The Minister told the Commission that she knew the stockpile was being destroyed and was aware that research regarding the stockpile was underway and that replenishment was being studied alongside potential plans for a new centralized provincial procurement process.

The Minister also told the Commission that, after she learned of the destruction of the stockpile supplies, she expected that the stockpile would be replenished. This turned out not to be the case.

Ministry of Health representatives told the Commission that research on potential stockpile replenishment policies was ongoing from 2016 to the end of 2019 but was paused once the COVID-19 pandemic began. With the research dragging on, no one thought to seek the replenishment of the stockpile.

Indecision on other fronts prior to the pandemic also contributed to the scarcity of PPE. In the years before the pandemic, nobody within the government ensured that there were contracts in place with PPE suppliers at pre-arranged prices. Instead, once the pandemic began, the province was subjected to the vagaries of the open market, where supplies were tight and prices exorbitant. A representative from Sienna Senior Living told the Commission that, once the pandemic started, the price of PPE increased tenfold.

Further, the Ministry confirmed to the Commission that no legislation, regulation or formal policy requiring the provincial government to maintain a PPE stockpile was ever put in place.

The keeper of the stockpile

Within the provincial government, the Minister of Health is responsible for ensuring that supplies are available to respond to a health crisis. However, unlike the Minister's oversight of Ontario's pandemic plans – which is clearly indicated in an Order in Council – the position with direct responsibility for the stockpile was often in flux. The stockpile is overseen by an Assistant Deputy Minister (ADM), but the specific ADM assigned responsibility for the stockpile has changed over the years. Between 2018 and 2020, the role was assigned to the Chief Medical Officer of Health, who also held an Assistant Deputy Minister position within the Ministry of Health. During this time, the Chief Medical Officer of Health had oversight of the stockpile, but only because the responsibility was tied to his Assistant Deputy Minister position, not his position as Chief Medical Officer of Health.

The Commission heard that responsibility for the stockpile was formally tied to an Assistant Deputy Minister and not the Chief Medical Officer of Health because the stockpile required purchases and procurement. This is an inadequate explanation as to why the Chief Medical Officer of Health – who told the Commission that he has the principal responsibility to ensure pandemic plans are in place and updated – did not have control of the emergency stockpile that was needed to implement those plans.

Given the importance of the PPE stockpile to the province's pandemic response in the long-term care sector, the person responsible for the province's pandemic plans must also be responsible, in the future, for the stockpile. This responsibility must fall within the purview of the Chief Medical Officer of Health, not an Assistant Deputy Minister.

Furthermore, the Chief Medical Officer of Health should be required to report to the legislature each year on all matters relevant to the stockpile. There must also be a mechanism in place that provides the Chief Medical Officer of Health with the prerogative to identify the resources and the funding levels needed to ensure that the stockpile functions effectively.

Insufficient stockpiles in many long-term care homes

Within the long-term care sector, the supply of personal protective equipment in many homes was also insufficient. This shortage compounded the perilous situation created by the lack of supplies in the provincial stockpile. When COVID-19 outbreaks began in Ontario's long-term care homes, many homes were short on PPE, putting staff at risk and causing them to fear coming to work.

The Ontario Health Plan for an Influenza Pandemic suggested that health care facilities maintain their own four-week supply of PPE. Representatives from the Ministry of Health told the Commission that this suggestion was intended to include long-term care homes. However, Ministry representatives also told the Commission that health care facilities maintaining their own supply was merely a recommendation and was not mandated by legislation. Furthermore, while the Ministry encouraged health organizations to maintain their own stockpiles, an internal government document from 2013 noted that the Ministry "never provided funding or support" for these stockpiles. The Commission heard that such funding and support was also not forthcoming for long-term care facilities between 2013 and the onset of the COVID-19 pandemic. This was unfortunate, as neither the province nor many long-term care homes had sufficient supplies when COVID-19 struck.

While some long-term care homes had sufficient PPE on hand, many did not have four weeks of personal protective equipment stockpiled in the years following the SARS outbreak. In 2007, 80 per cent of the province's public health units reported to the Auditor General that more than half of the long-term care homes in their jurisdiction did not have a sufficient PPE stockpile. The Auditor General opined that the low numbers were caused in part by the Ministry of Health and Long-Term Care's failure to ensure

that health care facilities were aware of the PPE stockpiling recommendations in the pandemic influenza plan. In the 13 years that followed, there was little progress on this front.

By the onset of the COVID-19 pandemic, the state of long-term care home stockpiles had not improved. Representatives from Sienna Senior Living told the Commission that, in January 2020, its homes had close to one week's worth of PPE stockpiled. Early in the pandemic, AdvantAge Ontario, an association of not-for-profit long-term care, housing and services for seniors, sent a PPE supply survey to its members. Nearly half of the respondents indicated that they were understocked with regards to PPE.

Furthermore, in March 2020, Ontario Health surveyed 44 Toronto long-term care homes on their supply levels of N95 respirators, surgical masks, face shields, eye goggles, gowns, gloves, wipes and sanitizers. For each type of equipment, at least half of the homes surveyed had less than a four-week supply. While some long-term care homes told the Commission that they were well stocked with PPE at the onset of the pandemic, the Commission also heard from many homes, residents and staff that PPE was lacking as the pandemic began.

Summary

Despite being warned for years about the state of the personal protective equipment stockpile, and despite being fully cognizant of the importance of PPE during a pandemic, by 2019 Ontario's PPE stockpile had languished beyond the point of uselessness. On the eve of the COVID-19 pandemic, Ontario did not have a stockpile and was not prepared to manage a surge in demand for essential medical supplies. As noted above, the province's lack of PPE was compounded by additional shortages within long-term care homes themselves. Without a stockpile, many homes relied on "just-in-time" inventory practices that depend on sufficient supply being delivered through the ordinary supply chain. When that supply chain was disrupted, many long-term care homes did not have enough appropriate PPE available to staff.

These personal protective equipment shortages were another significant factor affecting the Ontario government's ability to respond with the urgency required for COVID-19 and its effects on the long-term care sector.

Failure to Identify Alternative Quarantine and Isolation Sites

In describing the horrors of the SARS outbreak, Justice Campbell recounted how, as the crisis mounted, Toronto's hospitals ran out of facilities to isolate and treat health care workers who had contracted the virus. Furthermore, as there were no pre-determined alternative isolation sites, the only somewhat viable option available on short notice was a hundred-year-old tuberculosis treatment facility that had been decommissioned in 2001. The facility did not meet the then current standards for treating respiratory diseases and "could not provide optimal conditions for safely treating

SARS patients." While the 14 health care workers cared for in the facility eventually recovered, one staff member working at the facility and her husband contracted SARS and died soon after.

This experience – a clear indication of the importance of alternative quarantine and isolation sites – failed to motivate the province to act. By the onset of the COVID-19 pandemic, the Ministries of Health and Long-Term Care still had not identified alternative isolation sites. In the months that followed, these sites would be sorely needed by long-term care homes.

Despite the abovementioned incident during the SARS outbreak, the 2007 Auditor General's Report noted that the Ministry of Health and Long-Term Care still had not formally identified alternative quarantine or isolation sites to be used in the event of a future pandemic. The report recommended that the Ministry ensure that public health units identify quarantine sites and confirm that the sites were properly equipped for use when needed.

In its 2009 response to the Auditor General's recommendation, the Ministry indicated that the Ontario Agency for Health Protection and Promotion (now Public Health Ontario) had been created that year and had advised the Ministry that while quarantine sites could be required for outbreaks of unknown diseases, they were not needed for an influenza outbreak. The Ministry also noted the agency had recommended that:

1. non-hospital treatment sites be considered for symptomatic people who do not need hospital care but do not have access to home isolation;

2. location, capacity, equipment, supply and staffing criteria be developed for the sites; and

3. a template agreement be created for public health units to use to negotiate procurement of the sites from their owners.

Finally, the Ministry indicated to the Auditor General that it needed time to assess the Ontario Agency for Health Protection and Promotion's recommendations.

The Commission did not receive any evidence indicating that the Ministry of Long-Term Care or its predecessor, the Ministry of Health and Long-Term Care, took steps to identify alternative isolation or quarantine sites for long-term care homes between 2009 and the COVID-19 pandemic. Instead, the Ministry advised the Commission by letter that, under the *Long-Term Care Homes Act, 2007*, it was the responsibility of individual homes to have emergency plans in place to evacuate or relocate residents when necessary. The Ministry stated that it conducted inspections to ensure that homes had emergency plans in place, but explained "[t]here are no proactive inspections that

require a review of emergency plans"; inspections only took place after an emergency had hit.

Government materials discussing pandemic response strategies in the first wave of COVID-19 raised the prospect of decanting (moving long-term care residents to another location), but no concrete plans were formed. The Minister of Long-Term Care told the Commission that she raised the possibility of decanting long-term care residents at a meeting with the province's pandemic response leaders in April 2020, but "we couldn't get it done in the first wave."

By contrast, the Commission heard that, at the beginning of the pandemic, the Hong Kong government had already designated facilities such as community centres and hostels as "quarantine centres." Long-term care residents who tested positive for the virus were sent to the hospital. Residents who came into contact with these individuals were sent to a quarantine centre for monitoring.

The Commission heard from medical experts that the more crowded a long-term care home became, the higher COVID-19 case numbers and mortality rates climbed. These experts also told the Commission that maintaining temporary spaces to house long-term care residents can effectively control severe COVID-19 outbreaks in already overcrowded long-term care homes.

Some large health care partners did manage to successfully use temporary isolation spaces to contain the spread of COVID-19 in long-term care homes. The Windsor Regional Hospital, for example, successfully created a temporary treatment facility in a local college sports complex to house long-term care residents who had tested positive for COVID-19 and to help local long-term care homes bring their COVID-19 outbreaks under control.

While the Windsor Regional Hospital was undoubtedly resourceful in creating its field hospital, the successful creation of alternative isolation facilities should not have had to rely solely on the resourcefulness of local leaders. Eventually, late into the second wave, the Ministry arranged for an alternate decanting facility in the Greater Toronto Area.

Ontario should have been able to facilitate this process earlier by adhering to the Auditor General's recommendation and ensuring that isolation sites for long-term care facilities were identified and prepared in advance of the pandemic. The province's failure to do so represents a missed opportunity to contain the virus's impact on long-term care residents.

Failure to Adequately Fund Public Health Ontario

The creation of a public health agency such as Public Health Ontario was one of the most prominent recommendations of the SARS Commission Report. The report was

also careful to note, however, that any improvements to the province's public health system must be accompanied by sufficient funding:

> To arm the public health system with more powers and duties without the necessary resources is to mislead the public and to leave Ontario vulnerable to outbreaks like SARS.

Unfortunately, starting in 2013, the agency's funding was held flat for eight years, even as its costs rose. In depriving the agency of funding, the province hampered Public Health Ontario's ability to provide Ontario's long-term care sector with critical response services once the COVID-19 pandemic began. (PHO's roles and responsibilities are discussed further in appendix B.)

Public Health Ontario's base funding to cover operational expenses for the 2013–14 fiscal year was $148 million. This number did not increase in the years leading up to the COVID-19 pandemic, despite the fact that demands for agency resources such as laboratory testing were increasing year over year. Public Health Ontario staff reiterated this sentiment to the Commission, noting that the organization is "chronically underfunded."

In 2017, Public Health Ontario expressed concern regarding its funding in its annual business plan, noting that its highest organizational risk was a "[l]ack of sustainable funding to continue … to comprehensively respond to emerging public health threats." In particular, Public Health Ontario noted that the lack of funding would force it to reduce its staff and reallocate funds from other public health programs in order to satisfy increasing demand for its laboratory services. While the government did announce that it would undertake efforts to modernize and streamline Public Health Ontario in 2019, this project was not accompanied by an increase in funding.

As a result of the lack of funding, Public Health Ontario was forced to make cutbacks to simply address the impacts of inflation. The Commission was also told that the lack of funding hampered the agency's ability to repair aging infrastructure and update its laboratory technology.

Most notably, however, the failure to provide Public Health Ontario with additional funding required the agency to reduce its labour force, cutting 130 full-time-equivalent positions, including lab workers and epidemiologists, between 2014 and 2020. In December 2019, PHO reported that it had saved $13 million attributable to a reduction of 110 full-time employees. The plan going forward was to discontinue 53 vacant full-time employee positions and lay off another 33 full-time employees. Between fall 2019 and the end of 2020, at least 10 individuals in senior management positions left Public Health Ontario.

Furthermore, the agency's infection prevention and control specialists, who formally operated in a standalone Public Health Ontario infection prevention and control division, were merged in January 2020 with PHO's communicable diseases division. The Commission heard that this merger severely impacted the morale of the IPAC team. Ten senior IPAC specialists departed the agency between March and November 2020.

A former Public Health Ontario staff member told the Commission that budget concerns prevented PHO from replacing IPAC specialists who left the agency.

In 2019–20, Public Health Ontario was advised that its budget was to be reduced by 9 per cent, which further exacerbated the budgetary pressure. The agency faced a $25 million budget gap for 2020–21. Further budget cuts were expected, with an anticipated 18 per cent reduction by 2022–23.

During the pandemic, Public Health Ontario helped assess and improve infection prevention and control and to respond to the crisis with its expertise. However, a former PHO staff member told the Commission that budget cuts caused the agency's IPAC specialists to play a less prominent role in supporting long-term care during the pandemic than they otherwise might have. The agency had long been neglected, and the prospect of more cuts doubtless caused talented staff to seek opportunities elsewhere at a time when the province needed all hands on deck.

Failure to Address Recommendations for Laboratory Sector Reform

In addition to its recommendations around public health funding, the SARS Commission Report also touched on the importance of ensuring that Ontario had sufficient laboratory facilities in place before the onset of a pandemic:

> The capacity of a laboratory system to respond to an outbreak of infectious disease must pre-exist any future outbreak because it is impossible to create it during an outbreak.[…] Laboratory capacity is like the rest of public health; its importance is not appreciated, nor the impact of its inadequacies felt until there is an outbreak and then it is too late.

In the years leading up to the COVID-19 pandemic, the government received several warnings about the state of its laboratory network, particularly the fragmented nature of its management and funding. Many of these recommendations were ignored.

In 2015, the Ministry of Health and Long-Term Care convened an expert panel to report on the province's community laboratory network. The report recommended that the Ministry of Health and Long-Term Care establish a focal point for oversight and leadership of all the province's laboratories. In 2017, Ontario's Auditor General followed up on the Ministry's progress on this recommendation. She noted that while the Ministry had established a branch to oversee the province's community laboratories, no efforts had been made to consolidate oversight of these laboratories with the other laboratories operating in the province. These included Public Health Ontario, hospital and physician in-office laboratories, all of which operated in silos and were maintained under different governance and accountability structures.

The 2017 Auditor General Report also identified additional issues caused by the province's fragmented management of its laboratory network. Particularly, the report found that:

- hospitals were reducing the number of tests they performed and sending tests they did not perform to Public Health Ontario labs or private labs;
- in certain instances, test-result turnaround times could have been reduced by having hospitals perform tests that were being carried out by Public Health Ontario; and
- private labs had the capacity to run more tests but were being prevented from doing so by the Ministry of Health and Long-Term Care.

The Auditor General recommended that the Ministry implement a system to track the province's Public Health Ontario, hospital and private laboratories; determine which types of tests were best performed by each type of laboratory; and adjust funding accordingly. When the Auditor General followed up on these recommendations in 2019, she found that little progress had been made.

By the onset of the COVID-19 pandemic, Ontario had failed to create an interconnected laboratory network that would have allowed public, hospital and private labs to work together to address a pandemic. As the Minister of Health noted in her diary in May 2020: "when Covid-19 started Ontario did not have a well-connected lab system, to deal with a pandemic or other health situation requiring large numbers of tests." The Minister went on to note that this was one of the reasons that Alberta was able "to jump ahead of Ontario and other provinces in terms of the number of tests." An internal government document discussing the Ministry of Health's response to the COVID-19 pandemic also noted that a lack of laboratory capacity impeded the Ministry's response and that "the existing [laboratory] system led to Ontario initially lagging in its ability to test and process tests."

Steps to create such a network only began in March 2020 – after the COVID-19 pandemic had overwhelmed the province's laboratory system. As will be discussed in chapter 3, long-term care homes faced numerous difficulties securing broad testing and prompt test results during the COVID-19 pandemic. Some homes were forced to use private labs with slow test-turnaround times because testing at partner hospitals was unavailable. Other homes described test results taking between four and seven days to be returned, with some results being lost.

Further adding to these delays was the fact that many homes were forced to rely on outdated technology to receive test results. Some homes received results by fax one at a time with individual cover letters while others received results by conventional mail. Furthermore, according to the Deputy Minister of Long-Term Care, as of February 2020, approximately one-third of the province's long-term care homes did not have access to the province's online laboratory test results network.

Had the SARS Commission recommendations regarding laboratory infrastructure and the systemic reviews recommended in 2015 and 2017 been acted on promptly, Ontario may very well have had an efficient centralized laboratory system ready to respond to the surge in testing demand caused by a pandemic – particularly the urgent need for

prompt testing in long-term care homes. Instead, Ontario's laboratory system was plagued by delays and backlogs. Delayed test results made it difficult, if not impossible, for long-term care homes to effectively identify and isolate residents who had contracted COVID-19.

Conclusion

> Ontario … slept through many wake-up calls. Again and again the systemic flaws were pointed out, again and again the very problems that emerged during SARS were predicted, again and again the warnings were ignored.
>
> The Ontario government has a clear choice. If it has the necessary political will, it can make the financial investment and the long-term commitment to reform that is required to bring our public health protection against infectious disease up to a reasonable standard. If it lacks the necessary political will, it can tinker with the system, make a token investment, and then wait for the death, sickness, suffering, and economic disaster that will come with the next outbreak of disease.
>
> The strength of the government's political will can be measured in the months ahead by its actions and its long-term commitments.
>
> –The Honourable Justice Archie Campbell, SARS Commission Final Report

It is chilling that the passage above – published more than 13 years ago – remains applicable today.

In the years between the SARS outbreak and the COVID-19 pandemic, successive Ontario provincial governments watched the H1N1 pandemic and Ebola scare come and go without making necessary tangible improvements to Ontario's pandemic preparedness. Successive provincial governments failed to make the requisite financial investments and long-term commitments that would have left the province in a better position to manage a pandemic caused by a novel virus. The political will to provide meaningful protection to the citizens of Ontario was absent. The province's most vulnerable – its long-term care residents – suffered the most as a result.

As stated at the outset of this chapter, the fact that COVID-19 was caused by a novel virus does not excuse the state of Ontario's pandemic preparedness on the eve of the pandemic. Fundamental elements of preparedness were missing. The province's pandemic plans were out of date, untested and insufficient. Ontario's personal protective equipment stockpile had been allowed to expire unused. Calls from expert and government bodies to identify alternative isolation sites and reform the province's laboratory sector before the next pandemic hit were ignored. Years of underfunding left Public Health Ontario understaffed and hamstrung.

No government could have been fully prepared to specifically manage the COVID-19 pandemic, particularly in the challenging context of the long-term care sector. However, time and time again since the SARS outbreak in 2003, health experts and other public bodies implored several Ontario governments to take action that without doubt would have left the province in a much better position to do so. Unfortunately for the residents

of long-term care homes, the unstinting will of these experts and public bodies to ensure that the province was prepared for a pandemic consistently fell prey to other priorities.

It is a pattern that needs to end now.

If SARS was a precursor to COVID-19, it is frightening to think what may come next. Ontario needs to consciously and consistently prepare to protect its most vulnerable residents. It needs sustained political leadership, and a sharp focus on being ready for whatever pandemic comes next.

Voices from the Front Line

"... where is the Ministry, Public Health, and the home in ensuring that monitoring of these homes is sufficient, and that preparation for pandemics or other emergency issues arise[?]"

–Family member of long-term care resident

"... a crisis occurs with any outbreak. It could be a flu. It could be a war. It could be a physical disaster. But to see not just long-term care but the whole country in such a status of unpreparedness for this crisis really, really leaves me very concerned."

–Family member of long-term care resident

"...during the first few weeks of the outbreak, the directives for the PPE were all over the place. Every day, every minute of the day, it was changing. It was wear a mask one day and don't wear a mask the next. It was wear a gown and mask for your whole shift in and out of all the rooms, and it was don't do that. It was ... all over the place. Everything we learned about donning and doffing was basically thrown out the window."

–Long-term care staff member

"How many PSWs, how many healthcare workers have to give up their lives because we can't get it together? I don't think we have to be – we shouldn't have to die in order to do our jobs. So there has to be a workable, workable isolation plan."

–Long-term care staff member

"Other changes that should have been better implemented would be things coming down from government ... because apparently a lot of these rules are coming down from the government. They seem to occur on a Friday and around 4 p.m. And when we try to ask questions by our managers, we get told 'oh, well, it could wait until Monday.' And we're getting told to follow these directions when we have questions for the weekend. So ... we don't know if we're doing it right, if we're doing it wrong, or what."

–Long-term care staff member

Chapter 3: The COVID-19 Crisis in Long-Term Care

When the first cases of COVID-19 arrived in Ontario in early March 2020, the long-term care sector was not ready for a pandemic. The long-standing, systemic weaknesses in the sector discussed earlier in this report were on stark display as homes with limited staff, training and resources struggled to cope with outbreaks that spread with frightening speed.

This pre-existing vulnerability was made worse by a lack of provincial preparedness. As noted in chapter 2, the province had not planned for or drilled this type of scenario, despite clear warnings that a pandemic could be expected. This hampered the province's response, particularly in its long-term care homes.

These weaknesses had very real – and tragic – consequences. Before exploring how COVID-19 took hold in Ontario and the key factors that influenced the virus's spread in long-term care, this chapter will begin with a close look at two homes that experienced those consequences. While the experiences described below are taken from two homes in particular, they are not unique; many other long-term care homes and their staff, families and loved ones shared similar stories with the Commission.

The failure to prepare for a pandemic and the weakened state of long-term care cost lives and caused immeasurable hardship and pain to long-term care residents and staff. Their pain and suffering, along with that of their families and loved ones, must not be ignored – and the situation that caused that pain and suffering must not be allowed to happen again.

Wildfire: The Spread of COVID-19

On April 3, 2020, a positive COVID-19 test was reported to Dr. Robert Kyle, Durham Region's Medical Officer of Health. The test came from a staff member at Orchard Villa; a 233-bed long-term care home located in Pickering. Six days later, on April 9, the first resident case was reported. Over the coming weeks, COVID-19 would spread like wildfire among residents and staff.

On the evening of April 12, the switchboard at Lakeridge Health – the local hospital – received an unusual call: it was Orchard Villa, requesting support due to reduced staffing levels and a deteriorating situation. On April 13, Dr. Kyle notified the Ministry of Long-Term Care (MLTC) Inspection Branch about the outbreak. Between April 13

and April 17, Dr. Kyle met with Lakeridge Health, the Ministry of Health (MOH) and Orchard Villa to review the situation.

Even though the pandemic was weeks old, Dr. Kyle remarked that the MLTC Inspection Branch was “basically missing from action and invisible to us.” On April 17, with the situation worsening, Dr. Kyle and Lakeridge Health deployed an infection prevention and control (IPAC) team to Orchard Villa to conduct an assessment. By April 19, 80 per cent of the staff were infected and 98 residents had tested positive. Sixteen residents were already dead.

Urgent action was required. On April 19, without any clear precedent, Dr. Kyle reviewed the powers available to him under the *Health Protection and Promotion Act (HPPA)* and offered to use them to stabilize the situation. Section 29.2 of the *HPPA*, drafted in the wake of the 2003 outbreak of Severe Acute Respiratory Syndrome (SARS), gave local medical officers of health the power to order a hospital to take actions to respond to an outbreak.

Dr. Kyle and Lakeridge Health were aware that this action would be the first of its kind during the COVID-19 crisis – the first time the *HPPA*’s power would be used to place a hospital in control of a long-term care home. They also knew that a s. 29.2 order is appealable and that getting it wrong could well involve a protracted legal fight.

As a result, Dr. Kyle and Lakeridge consulted legal counsel to consider s. 29.2 and prepare an order that would allow the hospital to assume management of the home. They also checked in with the Ministry of Health’s counsel. Orchard Villa cooperated with the process, ensuring there would be no distracting appeals. All the same, Dr. Kyle was, as he put it to the Commission, “flying a bit blind.” Nevertheless, he knew action had to be taken.

Dr. Kyle served an order pursuant to s. 29.2 of the *Health Protection and Promotion Act* on April 21, and the Lakeridge team arrived at Orchard Villa the next day. The Commission heard that the team found problems as soon as they walked through the door. The appropriate signage was not present. Staff had a poor understanding of the proper use of personal protective equipment (PPE); the team leader described “very shocking visuals of multiple masks, multiple gowns, gloves being worn sort of at all times, sort of everything one should not do with PPE.”

Staffing was so low that those on duty could not keep the home clean. Garbage was everywhere and nothing seemed to have been wiped down. To stabilize the situation, the home required a deep-clean – costing just shy of $500,000.

Orchard Villa is a “C” type building – one of the oldest types of homes in the province. Inside, its various rooms and common areas were interconnected. When the Lakeridge team arrived, all of the internal doors were open and residents were wandering freely

about the home, increasing the risk that the virus would spread between the well and unwell. It was evident, according to Lakeridge, that the residents were unable to properly protect themselves with masks.

Staffing levels had collapsed to approximately 20 to 25 per cent of the normal complement. Staff who were COVID-positive – including the designated IPAC coordinator – were isolating at home. Others refused to work out of fear for their own safety and that of their families. Those who remained did what they could under the circumstances, despite being emotionally exhausted and overwhelmed.

With no provincial plan in place to handle such a situation in multiple homes, the government contemplated asking for military assistance. The possibility of military intervention had been on the table as early as mid-April, yet the first shift of Canadian Armed Forces personnel did not begin work at Orchard Villa until April 28. As the province worked out the logistics with the military, more residents died. During the first wave of the COVID-19 pandemic, 70 people died in Orchard Villa.

Though Orchard Villa was particularly hard-hit by COVID-19, it was not alone in its challenges. Racing to keep up with the virus during the first wave, the province was still refining its response structure throughout April – as COVID-19 raged through long-term care. Because of its lack of preparation, the province was chasing the virus rather than heading it off.

During the late spring, homes – working with hospitals, local public health units (PHUs), Public Health Ontario and the province – managed to get outbreaks under control. Over the summer there was a lull in the storm.

It did not last.

The province's preparations did not protect residents from the second wave. In fact, the second wave was worse.

The Second Wave

On November 23, 2020, after a staff member tested positive, a COVID-19 outbreak was declared at Sunnycrest Nursing Home in Whitby. The test had been administered on November 18, but the results had taken nearly a week to come back. Whitby is also located in Durham Region and so, once again, Lakeridge Health and Dr. Kyle were pressed into action.

In anticipation of the expected second wave, the Ministry of Long-Term Care had prepared and distributed a self-assessment survey to all long-term care homes. Sunnycrest had filled one out and returned it to the Ontario Health East Region, as requested. During the summer, Ontario Health East Region prepared a report for the

Ministry identifying Sunnycrest as among the homes in Durham at highest risk of being unprepared for a second wave. Unfortunately, neither Lakeridge Health nor Dr. Kyle nor the Ministry's own Inspection Branch was given the survey result or Ontario Health's opinion. Neither Lakeridge nor Dr. Kyle was asked to take action as a result of the survey.

By the time the second wave began, the Ministry had developed a process for addressing homes in crisis. Using the provisions of the *Long-Term Care Homes Act*, *2007,* the province issued either mandatory management orders or voluntary management agreements that allowed hospitals to manage homes in uncontrolled outbreaks. Lakeridge Health entered Sunnycrest on November 27 in response to a call for support. The team was on site every day until December 3, at which point it took charge of the home pursuant to a voluntary management agreement.

Lakeridge witnessed similar problems at Sunnycrest as it had found at Orchard Villa months before. The Lakeridge team told the Commission that insufficient screening practices were in place at the door when they arrived, conducted by an administrative assistant who was not protected by appropriate PPE. Staff were not clear on what PPE to wear or how to properly put it on or take it off. Overall, the Lakeridge team said that PPE was in short supply and basic IPAC protocols were not in place. The Commission heard that there was no "line list" showing which residents were positive and which were not, making it difficult to identify and separate sick and healthy residents. There was no one in charge of infection prevention and control – the home's IPAC lead had become ill and was off work. Lakeridge had to bring in equipment to monitor resident vital signs, as there was no such functioning equipment at the home. Infrared thermometers were also brought in, as there were no working thermometers on site.

As had been the case at Orchard Villa, staff numbers collapsed as the virus raged. So few staff were on hand that Lakeridge's team stepped in to help distribute medication. In order to bolster staffing, the Red Cross was also called in.

As at Orchard Villa, the disease spread quickly at Sunnycrest. Seven days after the outbreak was declared, there were 80 positive cases among residents and staff. Many of those infections occurred during the five-day delay between the initial staff member's positive test on November 18 and the result of that test arriving on November 23. Faster turnaround on that test could have saved lives.

Twenty-nine Sunnycrest residents died. One of these residents, Violet "Lorraine" Anderson, suffered from dementia, but she recognized her loved ones, could walk unaided and was capable of taking care of her own personal needs. When her daughter visited on November 21, wearing full PPE, Mrs. Anderson was in good spirits. Five days later, Mrs. Anderson tested positive. Four days after that, her family was notified that she would likely pass within days. But Mrs. Anderson was a fighter. Five times during

December she rallied from the brink of death. The virus robbed Mrs. Anderson of her ability to communicate through video, her ability to recognize her family, and her ability to understand what was happening to her. She could not speak. To avoid confusing and distressing her, and after speaking with medical staff on site, her family made the heart-wrenching decision to stop calling her. They were not present in the room, on the phone or on video when Mrs. Anderson passed. She died alone in her room on December 30, 2020.

Too many Ontarians had similar experiences. By March 14, 2021, Ontario long-term care home residents accounted for 54 per cent (3,881) of the province's total 7,162 COVID-19 deaths since the start of the pandemic, despite long-term care residents representing only about 0.5 per cent of Ontarians. In April 2020, the peak of the first wave, Ontario experienced 28 per cent more deaths in long-term care than expected, compared with previous years.

The Commission heard from the families of many who died at Sunnycrest, Orchard Villa and other homes. They spoke of their terrible losses and their anguish over the way their loved ones died – all too often alone and in distressing conditions. This Commission is grateful to the families, staff and residents who courageously shared their often-harrowing experiences. This province must not forget the difficult lessons that were learned at their expense.

The Epicentre: COVID-19 Takes Hold in Long-Term Care

Long-term care quickly became the epicentre of Ontario's fight against COVID-19.

Durham Public Health declared the province's first COVID-19 outbreak in long-term care on March 16, 2020. On March 18, a respiratory outbreak was declared in a long-term care home in Bobcaygeon, and by March 20, three residents of that home had tested positive for COVID-19. Within two days, 11 other homes were in outbreak, and by mid-April, there were widespread outbreaks in long-term care homes across Ontario, with the highest concentrations in Toronto, Ottawa, Peel Region and the Greater Toronto Area.

More than one-third of all Ontario long-term care homes experienced an outbreak with at least one resident case in the first wave (March 2020 to August 31, 2020). And yet, the hard lessons learned during that time were not heeded; 2,066 long-term care residents died between September 1, 2020, and March 14, 2021 (the second wave), a figure that eclipses the first wave death toll of 1,815.

Data presented to the Commission by the Ministry of Health indicate that homes built to older design standards have fared worse in the pandemic (see chapter 1 for a more detailed discussion of these standards). In the Ministry of Health's model, older design

standards are associated with the extent of an outbreak and the number of resident deaths. In other words, homes built at a time when older design standards were in place and that have not been upgraded were at increased risk for larger, more deadly outbreaks. These older homes must be replaced or upgraded.

To be clear, not all homes fared badly during the pandemic. COVID-19's deadly toll was not spread evenly across the province's long-term care homes. One study found that during the most intense period of the first wave, between March and May 2020, 86 per cent of infections occurred in just 10 per cent (or 63) of the province's homes. A survey conducted by the Commission and analyzed by the Canadian Institute of Health Information (CIHI) found that from March 2020 to the end of June in the same year, 5 per cent of all homes accounted for almost half of all resident cases of COVID-19 and just over half of all resident deaths due to the disease. The Commission heard of several homes where leaders showed initiative and took decisive preventive measures early; several of these examples will be discussed below and in chapter 4 of this report.

The Commission also found that the province and many long-term care homes failed to act quickly and in a precautionary manner to take measures to prevent, isolate and contain the spread of COVID-19. The province's lack of planning and preparedness – a pattern repeated by successive governments – delayed the implementation of key protective measures.

Slow, Late and Reactive: The Early Provincial Response

In a crisis, fast, informed and decisive action is necessary to avert tragedy. Speed and adherence to the precautionary principle are essential. As discussed in chapter 2, these were lessons from the SARS outbreak in 2003, and other health emergencies that preceded and followed it. In his 1997 report on Canada's tainted blood crisis, for example, the Honourable Justice Horace Krever described the precautionary principle as follows:

> Where there is reasonable evidence of an impending threat to public health, it is inappropriate to require proof of causation beyond a reasonable doubt before taking steps to avert the threat.

In 2004, the Honourable Justice Archie Campbell repeated this warning in his report on SARS, noting that the precautionary principle has particular application in cases when an infectious disease is at large. Since pathogens like a coronavirus move rapidly and spread quickly if not contained, the need for immediate infection prevention and control action is paramount.

And yet, despite these early and pointed warnings, the Ontario government's response to the emergence of a novel coronavirus in early 2020 was slow, uncoordinated and

lacked urgency. The government's emergency response system proved inadequate to protect staff and residents in Ontario's long-term care homes from COVID-19.

Rather than following the precautionary principle, the government maintained for too long that COVID-19 posed a low risk to Ontarians. In spite of known risks to vulnerable populations, the province failed to prioritize long-term care *before* the disease had already gained a fatal foothold in homes.

The lack of provincial preparedness was compounded by the lack of preparedness on the part of many individual homes. Long-term care home staff told the Commission how unprepared they felt they were to deal with this pandemic:

> I think that we had a lot of time to plan, and then all of a sudden, when it hit us, we didn't know what we were doing. We were kind of running around trying to – you know, things were changing every single day. Directions from Public Health could change hourly. We had ... a lot of community services that came in to help out, and we had a lot of redeployed staff.
>
> ~
>
> Definitely should have had a plan in place. We knew for months that this could possibly come into our home and we had no direction. Very poor leadership from our superiors. Asking questions to our management team and getting three different answers and no one knowing what to do. Again, way too many people in offices not actually doing hands-on work and coming down to the units and actually experiencing and offering to help feed, offering to do front-line care, but following us around with clipboards. Like, that's not helping us.

Provincial failures were not the only problem. Long-term care homes are responsible for the care and safety of their vulnerable residents, but many were wholly unprepared to discharge that duty when COVID-19 came.

Miscalculations and missed opportunities

> During a pandemic, quickly applying definitive actions to prevent the introduction and spread of a novel infection based on rapidly emerging evidence is key.
>
> –Dr. Samir Sinha, Director of Geriatrics, Sinai Health

At the beginning of 2020, government officials were paying attention to the emergence of a potential new health threat. On January 3, 2020, Dr. David Williams, Ontario's Chief Medical Officer of Health (CMOH), advised the province's local medical officers of health that he was "actively monitoring" the cluster of undiagnosed viral pneumonia cases reported in Wuhan, China, though he advised that the risk to Ontarians was "very low."

Ministry of Health representatives initially acknowledged the need to prepare, noting the need to expedite certain "readiness activities," including infection prevention and control. A few days later, Dr. Barbara Yaffe, the Ontario Associate Chief Medical Officer

of Health (ACMOH), told local medical officers of health that the risk to Canadians was still considered very low, but recommended that officers "begin to look at your processes should this situation escalate and to work closely with your hospitals to ensure readiness."

Long-term care was not prioritized in the early government response. Instead, the focus was on hospitals, despite early reports warning that it was not only hospitals that were at risk but also long-term care and other congregate settings. When preparing a letter of recommended precautions to health care workers, the Office of the CMOH and the Ministry of Health discussed whether settings such as long-term care homes should be included. Ultimately, they limited the recommendations to hospitals.

On January 23, 2020, Dr. Yaffe sent a letter to health system partners recommending that *acute care setting* health care workers exercise additional precautions, including those geared to airborne diseases, when dealing with "risk of exposure to a confirmed case, presumptive confirmed case, probable case or person under investigation ... and/or the patient's environment." Guidance for other settings (such as long-term care) were noted as under review. Dr. Yaffe reiterated that the risk to Ontarians remained low.

The first COVID-19 case in Ontario, also the first in Canada, was confirmed two days later on January 25, 2020. In a news release reporting this case, Minister of Health Christine Elliott stated that "the province is prepared to actively identify, prevent and control the spread of this serious infectious disease in Ontario." The Minister's confidence would prove to be misplaced.

By late January, there was mounting evidence of the risks to the elderly and those with comorbidities. There was also evidence that:

- COVID-19 shares symptoms with other viral infections, making it difficult to distinguish from other illnesses; and
- elderly and immunosuppressed individuals may present with atypical symptoms.

Ministry of Health general guidance documents issued at this time recognized these risks.

On January 27, 2020, as more reports of confirmed COVID-19 cases in North America surfaced, the Ontario Long-Term Care Association (OLTCA) reached out to the Ministry of Health with its concerns about the province's pandemic preparedness and the risks to long-term care facilities. In an email to the Ministry's Emergency Operations Centre dated January 27, 2020, the OLTCA outlined several issues about the emerging virus that needed to be addressed as soon as possible. Among these were the need for direction on visitor and staff screening, concerns over the mobility of staff who work in multiple health care settings, the difficulties facilities were experiencing accessing

personal protective equipment supplies, and worries regarding how the anticipated demand for hospital beds would impact the flow of patients into long-term care beds.

The Ontario Nurses' Association (ONA) met with the Minister of Health on January 28, 2020. They inquired about the province's plan to address COVID-19 and asked how long-term care would be protected along with home care and hospitals. Beverly Mathers, Chief Executive Officer of the ONA, told the Commission:

> [...] one of the reasons too why we advocate for the precautionary principle is because it helps minimize spread. So in terms of the directives themselves, we want to start out by saying that the long-term care direction came far too late ... [We] were meeting with the Ministry of Health even in January of this year and asked them how they were planning for COVID in Ontario. And while we recognized that Minister Elliott is not the Minister of Long-Term Care, we did meet with her in January, and we were talking to her about the health care system as a whole. We asked her questions about how they were going to protect long-term care, as well as home care and hospitals. We have rarely met with the Ministry of Long-Term Care.

The ONA did meet with the Minister of Long-Term Care, Dr. Merrilee Fullerton, in February. Ms. Mathers told the Commission that Dr. Fullerton and her staff did not have responses to the ONA's questions about the readiness of long-term care:

> ... during that meeting, when we raised issues of COVID with her, [she], as well as her staff, were unprepared and didn't have responses to our questions about the readiness of long-term care to protect against COVID.

Anthony Dale, President and CEO of the Ontario Hospital Association, echoed the concern that the long-term care sector was an afterthought in the provincial pandemic response:

> I think it is fair to say that right from the very beginning long-term care has been treated separately from the rest of the health care system when it comes to the coordination of the pandemic response. Right from the very time when the Ministry established a stakeholder relations table comprised of a very wide range of health provider organizations, the two long-term care associations were not present. They hadn't been invited, and it took weeks for that to be rectified.

By the end of January, Chinese health officials had found that COVID-19 symptoms appeared within two to 14 days after exposure, and that people without symptoms could be infectious during that period, signalling the possibility of asymptomatic transmission. If a disease can be spread by a person with no symptoms, it is possible for infected individuals to make others sick unknowingly. In public health guidance released on January 30, 2020, the Australian government's Health Protection Principal Committee cited international evidence, including a cluster of cases in Germany, that suggested asymptomatic transmission. They believed "a highly precautionary approach" should be taken. These findings were provided to Ontario's Chief Medical Officer of Health by email on January 31, 2020.

The Ministry of Health's first official guidance to the long-term care sector, which came on January 31, 2020, did not impart a sense of urgency or concern and did not suggest the possibility of asymptomatic or community transmission. Instead, it insisted that "the overall risk to the community remains low."

Standing in stark contrast to the mild messaging to long-term care, the Ministry of Health issued clear guidance to acute care settings the same day. The Ministry articulated the risk of asymptomatic cases in acute care settings by travellers from Hubei Province in China and provided specific guidance to monitor for that risk. In not providing the same important information to the long-term care sector, the Ministry placed long-term care staff and residents at a heightened risk.

Further, the province's focus on people with travel history as transmitters had the effect of downplaying the potential for staff and visitors to bring COVID-19 into homes. This is apparent in a Minister of Health Meeting Note ahead of a February 12, 2020, meeting requested by the Ontario Nurses' Association to discuss "the precautions in long-term care homes with respect to the novel coronavirus." The following was a key message for the Minister's reference in discussions on the novel coronavirus:

> The risk to LTC homes is low since residents can be screened during the admission and re-admission process and it is unlikely that LTC home residents will have travel history to China.

News of an outbreak on the *Diamond Princess* cruise ship in early February 2020 provided early evidence of asymptomatic spread and the risk of rapid infection in congregate settings. Along with others who appeared before the Commission, Dr. Allison McGeer, an expert in infection control and a professor at the Dalla Lana School of Public Health and Institute for Pandemics at the University of Toronto, noted that "as soon as we saw the *Diamond Princess* outbreak, [...] you knew that we were going to have trouble with nursing homes ..." Despite this clear evidence of trouble on the horizon, the province failed to recognize the increased risk to vulnerable long-term care residents.

By mid-February 2020, COVID-19 outbreaks had been linked to other congregate settings, including churches and prisons in South Korea. Researchers from China were reporting that case fatality increased markedly with age and pre-existing health conditions, and noted the risk of transmission between health care providers and patients in care settings.

Minister Fullerton, who practised medicine for more than 30 years prior to entering politics, told the Commission that she had concerns about asymptomatic spread of COVID-19 as early as February 5, 2020. Unfortunately, the Chief Medical Officer of Health did not share her concern. Dr. Williams told the Commission that "the evidence wasn't there for that." He did not act as if asymptomatic spread might be occurring and

did not issue directives on that basis. He stated that he maintained this view until the summer.

This approach was not consistent with the precautionary principle, which states that action should not wait for scientific certainty. It is unfortunate that Minister Fullerton's view did not prevail. She deferred to the expertise of the province's CMOH.

By March, there was ample evidence that long-term care was at risk. On February 27, the Chief Medical Officer of Health chaired a meeting that included representatives from Public Health Ontario, the Ontario Hospital Association, physicians, and Ministry of Health personnel at which "[m]ost expert attendees agreed that the widespread incidence of COVID-19 is imminent and essentially inevitable."

Dr. David Fisman, epidemiologist and professor at the Dalla Lana School of Public Health and Institute for Pandemics at the University of Toronto, described the state of affairs in March as follows:

> I think we knew quite a bit. We knew that SARS coronavirus-2 infection had a very high case fatality in older individuals, and we already knew at that point that it had a propensity to cause outbreaks in care settings.
>
> We had seen from February already in China that case fatality increased markedly with age. We knew that the virus almost seemed to target care settings. The initial recognition of community transmission in both Washington State and British Columbia was associated with high mortality outbreaks in long-term care.
>
> We had had warnings from other countries, and we already knew that long-term care facilities were very vulnerable to outbreaks in communicable diseases. We see this frequently with influenza and other diseases.

Throughout this early period of the pandemic, the Ministry of Long-Term Care continued to be sidelined. In early March, Minister Fullerton herself insisted the MLTC must be part of communications to its own sector:

> Just wondering why MOH is issuing/reissuing the guidelines without the MLTC? I understand MOH is the lead but MLTC must be part of this communication to our own sector.

Discussing this email with the Commission, the Minister noted the importance of the involvement of long-term care in the larger government response:

> So I understand in a crisis, you can't have multiple leaders because the communication gets garbled. And so I understood the necessity of having the Ministry of Health as the lead, but I believe very strongly that ... the trust in our ministry would be put at risk if we weren't able to communicate with our sector.

The Ontario Hospital Association observed that the separation of the Ministry of Long-Term Care from the Ministry of Health just the year before caused "kind of silos and barriers to integrated thinking for the response" and that, as a result, long-term care was

not ready to respond to the pandemic. This negative perception regarding the separation of the two ministries was shared by other stakeholders who spoke to the Commission.

Throughout much of the early part of the pandemic, the Ministry of Long-Term Care appeared to be a poor cousin to the Ministry of Health. On March 31, 2020, Blair Hains, Chief of Staff to Minister Fullerton, was again fighting to be heard – in this case, on the need for PPE. He wrote to the Deputy Minister:

> ... can we please use all channels. I will do so with my colleagues to ensure that long-term-care is recognized as an equal partner with hospitals, especially as it relates to PPE. The part on p. 7 is particularly frustrating which says that PPE has been deployed to hospitals and correctional facilities. This was done with LTC partners on the line. We are too often the forgotten partner.

As noted above, much of the focus at this stage of the crisis was on hospitals, primarily because hospital capacity was a significant concern. Like long-term care, hospitals have limited "slack" in their system; the concern was that they would be overwhelmed or perhaps, as had happened during the SARS outbreak, become ground zero for the pandemic. And so, while long-term care struggled to be heard, the hospitals engaged in extensive preparations.

In March and April, as hospitals were preparing for an influx of COVID-19-related intakes, temporary emergency licences were granted to quickly create additional bed capacity and facilitate the subsequent transfer of patients from hospitals to long-term care homes. A total of 97 spaces were created in 69 long-term care homes, and roughly 2,200 patients were discharged to long-term care homes or retirement homes from March to early May.

Even after outbreaks started in long-term care, the Ministry of Health and Ministry of Long-Term Care continued to prioritize a perceived "urgent need to free up public hospital beds" and preserve hospital capacity for a surge. On March 23, 2020, the deputy ministers of the two Ministries directed that all local health integration networks (LHINs) exercise their powers to promote the "expeditious movement" of all hospital patients waiting for placement in a long-term care home out of the hospital and into long-term care.

These decisions effectively reduced the space available in long-term care homes for isolation of COVID-positive residents, contributing to the potential spread of the disease. At the same time, personal protective equipment and other supplies were being redirected to hospitals, and long-term care homes were being told to conserve their supplies. Not surprisingly, long-term care homes were overloaded as a result of this single-minded focus on preserving acute-care facilities. There were other repercussions as well. Long-term care operators were told not to send long-term care patients to hospitals. The Commission also heard that hospitals refused to take patients from

long-term care homes. In addition, an investigative report by the *Ottawa Citizen* revealed that the vast majority of long-term care home residents who have died since the pandemic began did not go to the hospital.

According to the article:

> As of mid-May, 13 per cent of long-term care home residents over the age of 70 with COVID-19 were treated in hospital, compared with 36 per cent of the same age group who live in communities.

Dr. Nathan Stall, a geriatrician at Mount Sinai Hospital and Research Fellow in the University of Toronto's Departments of Medicine and Health Policy, Management and Evaluation, looked into this issue. He found that the number of community-dwelling people who were hospitalized prior to death was relatively constant throughout the pandemic; as of October 28, 2020, the figure sat between 75.9 and 88.8 per cent. However, only around 15.5 per cent of long-term care residents who passed away in March and April were transferred to hospitals. This number ranged from 26.9 per cent to 41.2 per cent between May and October.

A recent study by CIHI echoed these findings. The study found that there were 30 per cent fewer Ontario long-term care residents transferred to hospital for care during the first wave of the pandemic as compared with the same period in 2019. Residents were also far less likely to receive hospital treatment for COVID-19 compared to either the general population or even the elderly living at home.

In speaking to the Commission, Dr. Stall commented on the harmful impact of this failure to transfer residents to hospitals:

> I think this is important because that very well may have contributed to the large concentration of death we saw in the first wave, and people were not being transferred to hospital who not only may have benefited from medical care that may have saved their life, but also people were not being transferred for just basic care when homes were in crisis, and people aren't being transferred for palliative care to help them die with dignity during the first wave when homes were totally overwhelmed.

This was a tragic and untenable situation. Many groups believe that the focus on hospitals led to long-term care residents suffering at a disproportionate rate than others in society. The Ontario Council of Hospital Unions, the Advocacy Centre for the Elderly and the Ontario Health Coalition have filed a human rights complaint on that basis.

A critical blind spot: community spread

In March 2020, the province maintained that community spread (cases that could not be traced to contact or travel history) was not occurring. A March 8 news release from the province stated that: "At this time, the virus is not circulating locally. However, given the

global circumstances, Ontario is actively working with city and health partners to plan for the potential of local spread."

The province continued to suggest that the risk of transmission of COVID-19 in Ontario remained low and was related to travel. On March 10, this messaging was included in the briefing notes prepared for the Minister of Health ahead of her address to the Ontario legislature, despite emerging evidence of non-travel related cases of COVID-19. On that same day, the province's 37th confirmed case of COVID-19 was an individual who had not travelled internationally. The individual had travelled to Toronto from Sudbury for an international mineral and mining conference held from March 1 to 4, with more than 23,000 people from 132 countries in attendance. The province did not immediately classify this case as evidence of community spread.

On March 12, Minister Fullerton was expected to participate in a video about COVID-19. She was sufficiently concerned about the spread of COVID-19 that her notes indicate that she "refused to say the risk is low." Once again, her appreciation of the risk was more heightened than is reflected in the public communications of the Chief Medical Officer of Health and other provincial health experts. When speaking with the Commission, she explained:

> Well, in terms of my thinking at the time, I was very concerned about doing a video that would show or tell people that the risk was low, even though that was what health experts and the health leaders in Canada were saying I did not want to make a video indicating that.

Notwithstanding the inaction of provincial health officials, local public health authorities began raising concerns and calling for precautionary measures in their jurisdictions. At a news conference on March 15, Dr. Vera Etches, Ottawa's medical officer of health, said:

> We do assume that the coronavirus, COVID-19, is circulating in Ottawa, that there is local community transmission of the virus […] That means we will benefit from more social distancing between people and cancelling events of all sizes.

On March 16, the Office of the Premier issued a statement acknowledging the "growing evidence of community spread." On the same date, Ontario's Associate Chief Medical Officer of Health cautiously noted that with the near-doubling of new cases in a few days "we really cannot definitively rule out community transmission."

However, Dr. Yaffe later muddied the waters, telling *The Globe and Mail* on March 24 that it was not clear that community transmission was a problem in the province. She further suggested that local health officials just had not been able to properly connect new cases to international travel.

Inconsistent communications about the existence of community spread and the level of risk in the province had significant implications for long-term care.

The Minister of Long-term Care described to the Commission how the limited recognition of community spread, combined with insufficient staff testing, was a critical blind spot in countering the entry of COVID-19 into long-term care homes in the first wave:

> [...] we had to have some understanding of what was in the community as well. And I believe our limited testing early on did not identify the level of community spread that was there. So I believe that the staff were bringing it in unknowingly […] [Long-term care staff] were doing heroic work, but the problem was [the virus] was in the community and it was coming into the homes.

Without a clear acknowledgement that COVID-19 was (or could be) transmitted locally, including asymptomatically, efforts to mitigate the risk of all possible sources of the virus coming into homes stagnated during a critical window of time.

This lack of action to acknowledge and contain community spread had devastating consequences for long-term care homes. In fact, the Ministry of Health's own data now demonstrates that the rates of COVID-19 in the community surrounding a long-term care home are associated with an increased risk of an outbreak occurring within the home, as well as the severity of the home's outbreak and number of resident deaths.

Worldwide devastation ignored

> This wasn't just foreseeable, it was foreseen. We saw it coming in Italy. We saw it coming in Spain, let alone what was happening in Asia. And we knew that people in long-term facilities would be left without the care they need.
>
> –Laura Tamblyn Watts, President and CEO, CanAge

Before the first outbreak of COVID-19 in an Ontario long-term care home was declared on March 16, 2020, there were multiple global examples of COVID-19's impact on the elderly and the long-term care sector.

- **Italy:** Long-term care homes in Italy were the "first residential institutions in the western world that had to deal with the pandemic." As of March 11, the country had 12,462 confirmed cases and 827 deaths; the mean age of those who died was 81 years.
- **Spain:** By the week of March 15, 65 per cent of the COVID-19 deaths in Spain were people 80 years old or older. That same week, as the virus ravaged many of the country's 5,417 long-term care facilities, the Spanish government announced that it would assume control of senior-care facilities from privately-owned companies.
- **South Korea:** Reports of clusters of COVID-19 infections in South Korea's congregate spaces – including group homes for the disabled, convalescent hospitals and long-term care facilities – began to emerge in February 2020.

By March 10, more than 200 cases were reported in the country's senior-care facilities. South Korea adopted a widespread testing approach that enabled the government to identify where outbreaks were situated and contain them. In turn, the country was able to keep mortality rates low.

- **Washington State:** In late February, media reported on an outbreak at a nursing home facility in Kirkland, Washington. On March 18, the Centers for Disease Control and Prevention published a report on the spread of COVID-19 in a long-term care facility in Washington State between February 27 and March 9. The report indicated that 81 residents, 34 staff members and 14 visitors were infected, and 23 individuals died.
- **British Columbia:** The province reported the first long-term care facility outbreak in Canada on March 7, 2020 – two residents and one health care worker had tested positive. The next day, one of the residents died. In the following two weeks, another seven residents died and 36 residents and 18 staff were infected. The average resident age was 87 years old. On March 21, The Globe and Mail published an investigative report that characterized long-term care homes as "the form of housing in Canada that appears the most vulnerable in this global pandemic." By the end of the month, staff and resident COVID-19 cases were reported in 19 long-term care facilities in and around Vancouver.

At the local level in Ontario, some leaders were paying attention. On March 3, 2020, while news of the Washington and BC long-term care outbreaks was emerging, Dr. Monir Taha, associate medical officer of health with Ottawa Public Health, wrote an email to the Ministry of Health Emergency Operations Centre and Public Health Ontario representatives asking whether surveillance testing for COVID-19 should be implemented for long-term care:

> Would it be time now, in the interest of widening the net and given the vulnerability to severe COVID-19 disease of LTCF [long-term care facility] and other institutional residents, when investigating reported LTCF/institutional respiratory outbreaks, that COVID-19 is automatically added to the testing panel? Or, as a second choice, if the regular panel is negative, then to automatically add COVID-19 testing?
>
> What about automatic testing of LTCF/institutional residents admitted to hospital with respiratory illness? Or, again, if regular panel is negative?

Dr. Taha was told that there were no plans to start long-term care surveillance testing at that time but that "as things evolve this may change." Dr. Taha persisted and responded by email on March 8, 2020: "I would encourage, however, that surveillance of the LTCF sector be made a priority after seeing, already, the lessons from Washington state and Vancouver."

The Outbreaks Begin

Like SARS before it, COVID-19 once again illustrates that combating an invasive, silent killer such as a novel coronavirus necessitates speed and the application of the precautionary principle. As the discussion above demonstrates, Ontario was slow to take the risks seriously, delayed in its acknowledgement of asymptomatic and community transmission, and unwilling to heed warnings from other jurisdictions. Given that response, it was only a matter of time before outbreaks in the province's long-term care homes took hold.

As noted above, Ontario's first long-term care outbreak was declared on March 16, 2020, with the first recorded death on March 23. By April 11, there were 140 deaths, and 11 days later – on April 22 – there were 516 deaths. In the first wave of the pandemic, 30 per cent of infected residents died. From late March to late April, some 1,073 residents were either dead or destined to die. Such is the exponential spread of a disease like COVID-19. If precautions are not taken immediately, death ensues.

On March 20, after COVID-19 had already crashed into the long-term care sector, Assistant Deputy Minister of Long-Term Care Brian Pollard issued a memo to the long-term care sector announcing amendments to the *Long-Term Care Homes Act* regulation to assist with staffing shortages. Two days later, the Chief Medical Officer of Health issued his first directive aimed specifically at the sector. Called "Directive #3," it would be the subject of numerous and at times confusing amendments over the course of the pandemic. Unlike an earlier directive that had been issued to hospitals (Directive #1), Directive #3 did not require long-term care home staff to take any sort of PPE precautions when dealing with suspected or confirmed COVID-19 cases.

Other jurisdictions dealt with the emerging crisis in a different way. British Columbia, for example, took precautionary steps more quickly than Ontario. In part, its ability to respond nimbly was the result of better overall preparedness. British Columbia had updated its pandemic plan in February 2020, ensuring that emergency response roles and responsibilities were current. This stands in stark contrast to Ontario, where the provincial influenza pandemic plan had not been updated since 2013.

Further, British Columbia began offering infection prevention and control support (in the form of "SWAT teams") to its long-term care homes on March 7; this was a crucial resource that Ontario did not begin offering until more than a month later. British Columbia also recommended universal masking in its long-term care homes on March 25, while Ontario did not order universal masking until two weeks later.

Initiatives in the absence of provincial leadership

> Threats to public health may arise suddenly and without warning, overwhelming the capacity of a local health unit and local medical officer of health. It is essential in such cases that central resources and leadership be deployed immediately not only to assist the local unit but also to guard against the spread of disease to the rest of the province.
>
> –Justice Campbell, SARS Commission Final Report

As British Columbia's example demonstrates, Ontario could have been more proactive in the early months of 2020 to address potential risks for elderly populations. Notably, the Chief Medical Officer of Health failed to issue directives to ensure a consistent response to COVID-19 in long-term care homes. While Dr. Williams did issue a few directives, he failed to issue any to local boards of health or medical officers of health, on the basis that it was the local entities' role to enact measures appropriate for their regions. This resulted in a lack of consistency in regional COVID-19 response. For many homes and long-term care staff, it was difficult to determine who was in charge at the provincial level and what advice they should be following.

Dr. Rhonda Collins, member of the Board of Directors of the Ontario Long-Term Care Clinicians – a not-for-profit organization providing advocacy, education and membership to clinicians working in long-term care – noted that Medical Directors in the homes were receiving conflicting messages from public health units:

> We saw, within the Public Health Units, that the messaging we were receiving with regard to IPAC practices, cohorting, isolating, testing was variable across the 34 different health units, and there is still a little bit of a lack of understanding of what transpires in long-term care within some of our stakeholder partners that include hospitals and Public Health.

In the face of this confusion and lack of direction, however, some local public health units and long-term care homes took matters into their own hands. Dr. Kieran Moore, the local medical officer of health and CEO at Kingston, Frontenac, Lennox and Addington Public Health, told the Commission that the region's public health unit started taking proactive precautionary measures in January:

> [W]hen we saw how COVID was spreading in Wuhan and how the elderly were getting affected in January, we set up strategies to protect our vulnerable, to protect our facilities – because we were watching in Wuhan how the virus was spreading. And we set up strategies to protect our correctional facilities, our long-term care facilities, our retirement homes, and minimize the community rate of infection. And that was always our goal, to have a low rate of infection in our community. And that required a very robust strategy, not just an LTC strategy. But we knew if we kept our population rate low, we would protect all our vulnerable populations.

Dr. Moore and his team monitored the outbreak in Washington State and the long-term care outbreak in Vancouver. By March 10, 2020, Dr. Moore's team had established a

protocol to visit, inspect and audit all long-term care facilities in their public health unit, supervised by the IPAC nurse at the unit – a person who was already dedicated to working with long-term care and retirement homes. When restaurants and bars were closed by the province, Dr. Moore repurposed the public health unit's food safety inspectors to conduct infection prevention and control inspections in long-term care.

Dr. Moore met with the Medical Directors of the homes on a weekly basis to keep them apprised of the directives and local epidemiology. The public health unit held weekly coordination meetings with the acute care sector and hospital incident management system. When a worker in one long-term care home contracted COVID-19, the public health unit helped the facility swab around 100 individuals in the home for COVID-19 tests.

Dr. Moore instituted an early lockdown on March 17, restricting visitors and requiring active screening of staff and any visitors in long-term care.

In his presentation to the Commission, Dr. Moore emphasized the importance of the strong pre-existing relationship his public health unit had with their long-term care homes:

> So I know all the medical directors. We know the nurse managers, the nurse practitioners. We've worked with them longitudinally. And really, if you're going to have success, you have to have pre-existing partnerships.

The importance of pre-existing relationships between public health units and long-term care homes was echoed by others who presented to the Commission, and is discussed further in chapters 1 and 4 of this report.

York Region and its two municipal homes were also on high alert in early 2020, thanks to proactive municipal and public health leadership. When asked by the Commission about what prompted the region to start preparing for COVID-19 in January 2020, Lisa Gonsalves, General Manager of Paramedic and Seniors Services, responded as follows:

> ... we hear what's happening. And so we were getting information through Public Health, and ... Public Health had opened their health emergency operating centre on the third week of January.
>
> So we were already getting information, so we were taking that back to the long-term care management team. And we were starting to pull up our plans, look at our PPE supply; mask fit testing started as well. So that really was the real impetus as well as Dr. Meunier [Medical Director, Paramedic and Seniors Services], and she was watching everything.
>
> And so she was, at the same time, also telling us, "people, we need to meet. We need to talk about this. It's coming." So that was the real trigger.

York Region proactively put in place many preventative measures ahead of provincial directives. In a presentation on January 22, 2020, Dr. Catherine Meunier, the Medical

Director of York Region's two municipal homes, told the homes' teams that she could "see that something was coming on and that we needed to prepare." She had been monitoring the situation in China and elsewhere, as well as the first cases in British Columbia and Washington State. As she put it:

> I kind of made it my mission to try and be proactive and be at the forefront of the information that I was providing to York Region so that I could be ahead of the game and prepare the whole team because it was obvious that it was going to come. And I think at the beginning, the long-term care sector did not really grasp the COVID threat to the long-term care facility as it was more of an interpretation that, you know, we're used to managing outbreaks. ... But if you really looked at what was going on, it was quite obvious that we were going to be running into issues.

Dr. Meunier even contacted the Medical Director of the first long-term care home that went into outbreak in British Columbia, as well as the director of the home in outbreak in Washington State, in an effort to understand what could be done to contain outbreaks. In so doing, she identified key challenges to containing COVID-19: staffing issues, availability of testing, and clear communication.

As a result of these proactive steps, York Region implemented preventative measures in advance of provincial directives, including a "single employer" policy for its staff that came weeks before the equivalent provincial mandate. The staffing challenge that this would create in other long-term care homes (discussed later in this chapter) was not as severe for York Region, as it was able to redeploy other municipal staff to these homes as well as hire agency staff who were also restricted by the single employer rule. The two long-term care homes operated by York Region suffered no outbreaks in the first wave.

Another example of local-level initiative can be found by looking at early actions taken at Mariann Home in Richmond Hill. On January 20, 2020, home staff members who were in China visiting family contacted the home's CEO, Bernard Boreland, to ask if he could order personal protective equipment to be sent to them in China. This unusual request prompted Mr. Boreland to gather further information about PPE supplies and the situation in China, which, in turn, led him to begin preparing the home for the worst:

> On January the 20th is when I had some staff overseas, and they had contacted me asking ... if I could order some PPE supplies for them, surgical masks, and send to them. Obviously, that was an alarm to me because all of our supplies come from China. So after that call, I got on the phone with Viki [Scott, labour relations and occupational health and safety at Mariann Home] to see what she was hearing in – going on in the industry, as well as I made some calls to my suppliers in February.
>
> And that's when they told me that we could expect a shortage of PPE supplies in March and April. So we continued to order the necessary supplies that we needed.
>
> We also restricted the PPEs in January. Once I realized what was going on in the industry, we started treating all of our PPEs like narcotics, so they were all locked up. I converted a ... dining

> room that I had in the basement into our pandemic room. So we converted that room into the storage holding area.
>
> […]
>
> In January, we also got all of our pandemic plans in order. The dietary department ensured that she had three months of paper supply in place. We also introduced – or created a pandemic menu for the residents just in case we were to go down in staff or if we had any supply issues. So all of that was developed in January and February.

Mariann Home's approach was consistently precautionary throughout the pandemic. The home required its staff to quarantine before returning to work despite unclear Ministry guidance on this issue. It also cohorted its staff to particular units in the home early on and adopted a "single site" staff policy before it was mandated by the province. Mr. Boreland described to the Commission the lengths he went to ensure families stayed informed of what was occurring inside the home. Referring to the day the facility was locked to all visitors, he noted:

> I spent, I think, five hours, and I personally called every POA [Power of Attorney] to let them know what was going on and why we had to lock the facility as it was a Ministry mandate […] All the communication is from me. So, we developed that relationship with them. They trust us, and they know that we'll go above and beyond to keep their loved ones safe ...

In Toronto, the management team of Belmont House remembered well the lessons of the SARS epidemic. In February, noting the concerning signs worldwide, the home's leadership reviewed their pandemic plan, began verifying their PPE supplies and ensured that their staff was trained in IPAC protocols. Maria Elias, CEO of Belmont House, told the Commission:

> So we monitored the world and Canadian situation, and we determined very early on that the signs were all there for a pandemic and that we really needed to prepare. We looked at what we did here at Belmont during SARS. I've been here at Belmont for 20 years, a lot of members of my management team have been here for many, many years, and we recall what we went through during SARS, and we thought, here we go again. We better start thinking. And we looked at our pandemic plan, we assessed our staffing, our food, infection control, our PPE inventory, and we started looking at preparing for what we felt was the inevitable.

Like Mariann Home, Belmont House acted proactively, instituting universal masking in early March (about a month before the provincial masking mandate), communicating actively with families of residents, conducting regular in-home meetings, and conducting regular cleaning. Belmont House's experience also shows the value of a well-informed and proactive management team.

The precautionary approaches taken by local health leaders and home management teams should have prompted similar early precautionary approaches by the Ontario government. They did not.

Building the Lifeboat during the Storm: The Scramble to Respond

> [E]mergency management […] fundamentally is about bringing together the right people who have clear direction and are empowered to execute clear, concise decisions, and they are also empowered to not only execute but to, what we call in nuclear, check and adjust and don't trust but verify, and re-verify and re-verify, check, adjust, re-verify […] So when we think about emergency management, we think about that.
>
> –James Scongack, Executive Vice President, Corporate Affairs & Operational Services, Bruce Power

In the wake of the SARS outbreak, the interim report of the Ontario Expert Panel on SARS and Infectious Disease Control – also known as the Interim Walker Report – observed that Ontario's response to the health emergency was hampered by the need to create response structures on the fly. The same issues manifested themselves in the response to the COVID-19 pandemic. The authors of the Interim Walker Report could easily have been talking about 2020, not 2003, when they wrote:

> Without some of the necessary scaffolding and structures in place at the Ministry to respond in a highly coordinated manner to a communicable disease emergency, the province essentially had to develop the plan on a day-to-day basis (a problem compounded by the nature of the disease). At the same time, the Ministry had to work on constructing some of the very basic tools and vehicles to communicate, to analyze, receive, and disseminate the evolving science of the disease.
>
> In the words of OSSAC [the Ontario SARS Scientific Advisory Committee], we "built the boat while at sea in the middle of a storm."
>
> The overall result of attempting to create structures and processes at the Ministry level, in the midst of an outbreak that had soon escalated into an international news event, was an ongoing lack of clarity over roles and responsibilities among governments, agencies, and institutions. Lines of authority, reporting, and communication were all unclear.

Without a clear plan – and with the time for early and preventative action in the rear-view mirror – the province was forced to create its COVID-19 response structure in real time. Further, as discussed throughout this report and explained in appendix B, in early 2020 Ontario's health system was adjusting to significant changes proposed or implemented in 2019. The creation of Ontario Health and the separation of the Ministry of Health and Long-Term Care into two Ministries had not been accounted for in emergency planning. The province's announced reduction of funding to public health – including the cuts to and reorganization of Public Health Ontario – further left the health system lacking clarity on how the different pieces of the system would work together in response to a health emergency. Given the changes over the previous year, the roles of each Ministry, Ontario Health and the public health system in responding to the COVID-19 pandemic were not always clear. In particular, the removal of the long-term care portfolio from the Minister of Health appeared to contribute to the sidelining of the sector in the early Ministry of Health response.

This confusion over roles, combined with the general lack of preparation, created a response structure with significant redundancy and unclear lines of authority and accountability. This, in turn, led to confusing communications with, and delayed prioritization of, long-term care.

After SARS, Justice Campbell considered who should be in charge during a health emergency. After much consideration, he recommended that the Chief Medical Officer of Health be in charge of "medical decisions, medical advice and public communication," and that the Commissioner of Emergency Management be in charge of all other matters. He urged that the lines of authority be clear at the outset. While the 2013 influenza plan and the 2019 provincial emergency plan appear to create that structure, the reality is that the province created a new structure that morphed into an elaborate process in which neither the CMOH nor the Commissioner had clear authority.

Command Table confusion

The Ministry of Health did not establish a formal structure to guide its response to the pandemic until February 28, 2020 – a month after the first confirmed case in Canada.

However, the resulting Health Command Table, initially chaired by the Deputy Minister of Health, did not, in fact, command. It was only advisory, providing recommendations to existing decision-makers, including the Premier, Ministers and the Cabinet. The Health Command Table was supported by other tables of stakeholders and experts.

Missing from this early health response structure was a table devoted to long-term care, even though the Command Table acknowledged on February 28 that "the population health impacts [of COVID] will be greatest in the elderly and among those with comorbidities." A long-term care table would not be created until April 1– by which time homes were already in outbreak. There was a failure to prioritize long-term care, despite ample evidence and warning that long-term care would be disproportionately impacted by this disease.

As the first wave of COVID-19 began to sweep through long-term care homes, the province was still improvising its response structure. In mid to late March 2020, the province engaged McKinsey & Company, a management consulting firm, to help organize a government-wide response. McKinsey did not provide a final suggested response structure to the government until April 24. By mid-April, more than 127 homes were in outbreak.

In its report, McKinsey highlighted the importance of pushing decisions down to the lowest appropriate level to empower a broader group of leaders and avoid roadblocks. The firm proposed the establishment of a "Nerve Centre" – a coordinating committee to

orchestrate the response across the government, make decisions and eliminate any roadblocks to action. Later called the “Central Coordination Table,” this nerve centre was co-chaired by the Secretary of Cabinet and the Premier’s Chief of Staff. The existing Health Command Table and its sub-tables now reported to this new Central Coordination Table.

Notwithstanding the recommendation from Justice Campbell’s SARS Commission Final Report that the Chief Medical Officer of Health lead medical decision-making, it was not always clear who was in charge on this front. Dr. Williams, the CMOH, issued directives only after consultation with the Deputy Minister of Health and the Command Table. The result was delayed action when compared to a situation in which the CMOH holds a true leadership role, using discretion as required to issue orders.

In addition, as described below, key public health decisions were not made by the CMOH. Dr. Shelley Deeks, then Chief Health Protection Officer of Public Health Ontario, told the Commission that the public health experts involved in the extensive health response table structure – from both Public Health Ontario and the Office of the CMOH – were not always asked for input on public health issues or measures.

Key positions were also assigned to others, and not the CMOH. For example, in late August 2020, Chief Coroner Dr. Dirk Huyer was appointed as the Coordinator of the Provincial Outbreak Response.

In fall 2020, the Secretary of Cabinet undertook a review of the larger province-wide Central Coordination Table structure. By this time, it was clear that even the name of the Health Command Table was, in the words of Alison Blair, Associate Deputy Minister of Health, “quite a source of confusion for people” as the Table only provided advice to the Minister of Health; it did not “command.” As part of this review, the Health Command Table was renamed the “Health Coordination Table” – not to be confused with the “Central Coordination Table.”

At the same time, yet another Table was added to the response structure – the “MOH/MLTC Ministers Pandemic Response Leadership Table.” This Table was intended to make “decisions on the implementation of health response strategies, policies and programs approved by the government.” Despite this mandate, no decisions were made at this Table.

The Commission heard that there was poor coordination and communication between the tables; that the membership of certain tables was lacking in long-term care expertise; and that there was confusion even among table members about who was doing what, how they could contribute, and who was making decisions.

Dr. Kevin Smith, chair of the province’s Incident Management System (IMS) Table and President and CEO of the University Health Network, remarked:

> ... at the highest level, I guess most of us came into this thinking that there was a clearer and more robust chain of command as is enshrined in legislation that starts with the Public Health Agency of Canada and its leadership, medical leadership back to the provincial chief medical officers of each of the provinces, and in most provinces that have divisional responsibilities like Ontario where there are 34 chief medical [officers] of health based around municipal regions that, in times of a pandemic, there would be a more clear and action-oriented chain of command. And that has not been the experience I saw at IMS. I often saw jurisdictional issues.

The same message was repeated by others; that is, the leadership and command structure that existed was not suited to quick response. Something more efficient and emergency-oriented was needed.

Delayed response on rapid deployment

> Most of [the homes] that have received management orders were inexplicably late and only happened after scores of residents and staff were infected and deaths were mounting. As such, the new regulation under the emergency act and the use of those powers was an improvement, but in operation it remains too little, too late and inconsistently applied.
>
> –Ontario Health Coalition

At the same time it was creating its new response structure, the province was also trying to determine what legislation allowed emergency support to homes. This led to delays in offering assistance when it was needed most. The resulting frustration is evident in an email from a senior Ministry of Long-Term Care staff member to Deputy Minister Richard Steele on March 25, 2020, regarding a home in outbreak:

> I would like to discuss Pinehurst at the top of our call. It is 100% unacceptable that we are seen as doing nothing (or being unable to doing [sic]) anything to help.

Section 156 of the *Long-Term Care Homes Act, 2007*, allows the Ministry of Long-Term Care to direct a home to retain a party of the Ministry's choice to manage the home. However, it appears that by May 7, Ministry staff had concluded that s. 156 did not give sufficient authority to rapidly replace management of a home during an outbreak. The Minister's Cabinet speaking notes dated May 8 note that:

> While the Long-Term Care Homes Act, 2007 permits the issuing of mandatory management orders in very limited circumstances, the existing provisions do not specifically contemplate or support the rapid deployment of alternative management in the context of a COVID-19 outbreak.

As a result, on May 12, 2020, Cabinet made an order under the *Emergency Management and Civil Protection Act* to allow mandatory management orders in cases where at least one resident or staff member has tested positive for COVID-19. Referring to these management orders, Minister of Health Christine Elliott wrote in her notebook on May 13 about the internal frustration over the delay by the Ministry of Long-Term Care in "allowing hospitals now working in long-term care homes, to assume management of the homes that had little or no management staff available or were

unable to comply with provincial public health requirements." Minister Elliott noted that "at MOH we were relieved to hear of this Order, having been advised by many hospital CEO's about the terrible situation they were seeing in some of the LTC homes" and that "we had been urging the Minister of LTC to take this step and finally the Order was issued."

Even so, the first mandatory management orders were not issued until May 25, 2020, when two local hospitals were appointed to temporarily manage two long-term care homes for 90 days. Between May 25 and December 2020, seven long-term care homes were placed under management orders with local hospitals.

These orders came too late.

Making it work at the local level

With the Ministry of Long-Term Care unsure of its powers to issue mandatory management orders, public health units and hospitals stepped up to the plate, recognizing they could not leave homes without the help that was so desperately needed. They knew they had tools they could use, but were also aware that they could not simply descend upon a home and take it over.

Searching for a way to give hospitals authority to intervene to protect long-term care residents, local medical officers of health turned to Section 29.2 of the *Health Protection and Promotion Act*, which was drafted in response to the SARS outbreak. It provides medical officers of health with authority to compel hospitals and other institutions, including long-term care homes, to take action in response to an outbreak of a communicable disease.

As described in the case studies at the beginning of this chapter, the first s. 29.2 order was issued by Dr. Robert Kyle to Orchard Villa. Subsequently, other local medical officers of health issued s. 29.2 orders allowing hospitals to temporarily take over the management of homes and stabilize them.

Eventually, the Ministry of Long-Term Care used its statutory authority to issue mandatory or voluntary management orders that permitted hospitals to manage homes.

This delay in arriving at a suitable solution never should have occurred. Proper provincial preparation – even in January, February or March – should have revealed that such a solution might be necessary. Instead, local officials were left scrambling to find their own solutions to the growing problem of COVID-19 outbreaks in their region's long-term care homes.

Calling in the Army

As homes in outbreak began to spiral out of control in April, staffing largely collapsed. There were insufficient resources in the homes, agencies or hospitals to stabilize the increasingly dire situation. With nowhere left to turn, the province began to consider requesting military assistance. On April 17, 2020, Minister Fullerton wrote in her notebook: “Military plan needed, get them in within 24-48 hours ... Homes spiral down quickly.”

However, the military would not begin its first shifts in long-term care for another 12 days. The logistics of requesting and deploying took time. This delay – like others before it – was tragic for those trapped in homes with uncontrolled outbreaks. By the time Canadian Armed Forces (CAF) arrived at the homes identified as most in need of attention, they found deplorable conditions. Describing the experience in one home, one member reported:

> Large concern with the timing of arrival. It was noted by ACCT [augmented civilian care team] that 26 residents died due to dehydration prior to the arrival of the CAF team due to the lack of staff to care for them. They died when all they need was “water and a wipe down.”

In another home, the military noted:

> The ACCT described that when they first arrived at the LTCF there was “feces and vomit on floors and on the walls.” One ACCT member discovered that two of the residents had dried feces under their fingernails for a prolonged period of time.
>
> The ACCT Team reported that there had been resident deaths due to dehydration and malnourishment. The ACCT stated that in their time there, the LTCF management is non-existent and that they should be onsite daily but are not. The ACCT did note that the condition of the residents has improved dramatically since the CAF Teams arrival.

The military made specific observations with respect to the homes it supported, which included:

- ineffective communication between administrative personnel and staff;
- poor IPAC and PPE practices;
- lack of cleanliness in some areas of homes;
- inadequate supplies;
- inadequate nutrition and feeding provided to residents;
- reliance on agency staff where available, without ensuring staff were trained in the relevant clinical skills to provide care; and
- inadequate cohorting, as well as movement of staff between units without donning/doffing PPE or washing hands between patients.

The military provided reports that shocked many with descriptions of what they had seen in the homes. The reports noted that staff were overwhelmed in the circumstances and "struggling to maintain fundamental standards of care which, in some cases, expose[d] patients to elevated risks."

On the Ground in Long-Term Care: Who's in Charge?

It is clear that the delayed provincial response to the COVID-19 pandemic led to an increasingly dire situation in Ontario's long-term care homes. Directions, guidance, information and advice for homes came from a variety of sources involved in the pandemic response, including the Ministry of Health and Ministry of Long-Term Care, the public health units, and the local health integration networks. The work to understand and implement this messaging was compounded by the sheer volume of these communications, their complexity, and the fact that different regions reached different interpretations.

From the outset, homes struggled with this lack of clear leadership from the province. York Region's General Manager of Paramedic and Senior Services received 470 documents from the province between the beginning of the pandemic in late March 2020 and the end of January 2021, each of which required review and operationalization. Many were confusing and required interpretation. This sentiment was succinctly explained by Belmont House's Maria Elias, who said:

> What I think is important to note is that overall, we need clearer messaging in the early days, but even now it's very confusing. Who's in charge? We have Ontario Health, we have Toronto LHIN, Ministry of Health, Ministry of Long-Term Care, they all have their own communications and we get directives from different bodies. We get the same documents coming from these different branches of government, and it becomes very confusing and overwhelming, all these documents and communications from these various sources within one government. So one source of information, and clear message, and identifying who does what would be very helpful.

The volume and complexity of the communications about the pandemic response to long-term care exacerbated the challenges the homes faced.

The importance of leadership, communication

Similarly, at the home level it is clear that those homes with strong, present, well-trained leaders in the roles of Administrator, Medical Director, and Director of Nursing and Personal Care fared better and were better able to care for their residents and families. The Canadian Armed Forces and the hospitals that intervened in a number of homes during the first wave singled out inadequate leadership in their interim and final reports as a key contributor to the severity of the outbreaks.

Some long-term care homes had well-qualified, full-time, on-site and strong leaders paying attention to all aspects of resident care, including planning for issues that could affect resident safety and well-being. The Commission found that the key components of good leadership were consistent regardless of a home's size, location or ownership type. It further found that good leadership could not be narrowly equated with the absence of COVID-19 in long-term care homes, but rather with how well leaders planned, responded and mobilized their teams in a time of crisis.

The Commission consistently heard about the difference made by leaders who were always thinking one step ahead. Early actions included drawing on institutional knowledge and experience, such as that gained during the SARS epidemic, and reviewing and implementing pandemic plans upon hearing about COVID-19.

As discussed in chapter 4, a common theme among these leaders was ensuring that staff's efforts and sacrifices were acknowledged, and that constant messages of support and compassion were communicated in moments of extreme fatigue, stress and grief. Leaders came up with innovative ways to try to decrease the burden experienced by staff, including grocery and product-buying programs for staff to minimize possible exposure to the virus in the community.

Leadership does not operate in a vacuum. Lack of experience and skills in crisis management can impair the ability of leadership to act quickly when it counts.

Medical leadership, for example, varied significantly between homes. Some Medical Directors and attending physicians were actively engaged and on site daily during the pandemic, while others refused to enter homes or provided only virtual advice.

The doctors who stayed away did so for a number of reasons. In some cases, home Administrators asked them not to come due to concerns over bringing COVID-19 into the facility; in other cases, the doctors were grappling with their own fears of contracting COVID-19 and infecting others. Still others lacked formal IPAC training or access to PPE. Regardless of the reason, the outcome in most homes was the same: sick residents did not receive access to timely medical treatment and dignified end-of-life care.

One staff member shared these thoughts with the Commission:

> I left the other day and I came home and I said, It is like a war zone. I have no idea what's going on. Very, very mixed messaging and I feel horrible because my background is health and safety, I should know this, right? … We should know what we're doing by now. We're in a mess.

In some cases, a lack of clarity as to what needed to be done was made worse by the homes' own failure to communicate effectively with their staff:

> ... [the] mixed messaging that goes on within all of this pandemic is just, you know, really a – a symptom of a bigger problem. You know, the level of dismissal and bureaucracy that ultimately affects the residents we look after is unsurmounted.
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> ~
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> [W]e're given direction that was ever changing, very confusing, and at best, minimal. And that was right from the start. You know, asking questions about some of the directives that were coming down from long-term care even with the management team, we were told that they were communicating with us as a courtesy. A courtesy. Imagine.
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> ~
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> Communication of the update, of the pandemic situation update, of our outbreak situation. There's none. Okay? We heard it over the news. That's where we get our communication.

Families also suffered from these failures in communication. Many were unable to get updates on whether their loved ones were still alive. Over the course of its investigation, the Commission heard from numerous families. One family spokesperson noted:

> There was no communication. It was impossible to get updates on my mom. We were sick with worry and rightly so 'cause she passed ... We need to be with our families when they're dying, when they're sick. They need us. When they're in isolation, they get depressed. They have no one to talk to. There's no one checking on them.

The Commission heard of multiple instances where even residents within the home had no information on what was happening, including whether any fellow residents had passed away or how long lockdown measures would stay in place. As one resident explained:

> [W]e don't know when someone has died or anything. We know when we find out a couple of days later, and I think what we know ... and we all like living here ... but as I say, communication is bad. That's the one thing. It's really bad.

It is clear to the Commission that poor communication with staff, residents and families amplifies feelings of isolation and helplessness in a crisis. Worse, it makes a coordinated response to a crisis much more difficult to achieve.

Summary

Early warnings of the risk to the elderly and congregate settings should have prompted quick precautionary action by the province to protect long-term care homes. The warnings did not. As a result, vulnerable long-term care residents and their caregivers were left wide open to the death, suffering and loss that ensued.

Disaster: How COVID-19 Was Able to Spread

In order to establish how the COVID-19 crisis got so bad, so quickly, the balance of this chapter will explore the key factors that contributed to the horror that unfolded in Ontario's long-term care homes.

"We Have a Problem": The Scramble for PPE

As discussed in chapter 2, by the beginning of 2020 most COVID-19–appropriate personal protective equipment in the provincial stockpile was expired or had been destroyed. What remained had been purchased to protect against Ebola.

The situation that had been predicted by the government in 2006 – when funding for the creation of a stockpile was originally requested – was playing out in real time: COVID-19's rapid spread had increased demand and put ordinary supply chains under strain. Prices increased tenfold or more as PPE was in demand worldwide. Compounding the problem, there was very limited domestic supply. As had been noted in 2006, much of the PPE production still occurred in China. As the Auditor General had warned in her 2007 Report, most long-term care homes did not have sufficient inventory of their own.

The situation was aptly summarized by the Chief Medical Officer of Health, who wrote the following in his notes of a March 10, 2020, meeting discussing PPE: "Supply – being honest – we have a problem."

Efforts to source PPE

Ontario's Chief Medical Officer of Health, who was responsible for the stockpile, told the Commission he was surprised to discover that a great deal of personal protection equipment is made in China. Dr. Williams "assumed that our companies that supplied us made it onshore." It was not until the second or third week of February that he identified this "as a big problem."

As the person responsible for the stockpile, the Chief Medical Officer of Health should have known this basic fact. Indeed, the 2006 submission to Cabinet requisitioning stockpile funding highlighted the reality that Canada had no domestic suppliers and that a pandemic was likely to originate in Asia, where the suppliers resided. Even a modest amount of pandemic preparedness would have revealed this weakness. Compounding the situation created by the destruction of the stockpile, there were no pre-existing contracts for the supply of PPE that would have set prices at reasonable levels and secured a ready supply of product.

When COVID-19 hit, Ontario was on its own in the global scramble for PPE.

With the cupboard bare and no domestic production available, Ministry of Health personnel began working feverishly to source whatever PPE they could. In an internal briefing dated January 28, 2020, the Ministry of Health noted that it was beginning an urgent, non-competitive procurement process for PPE, given that the province's supply was limited.

By early February, supply chain pressures were already appearing. A February 8 briefing on PPE supplies noted:

> The CDC [US Centers for Disease Control and Prevention] and other public health experts are suggesting the health systems around the world need to be ready for a pandemic in the event that global containment measures do not work.
>
> […]
>
> Manufacturers are prioritizing global regions experiencing an outbreak. ... and, therefore, those areas that are most in need of PPE. Manufacturers will not support provincial procurement of PPE at this time given global pressures on supply chain.

Without an established supply chain and contracts, Ministry of Health personnel worked to create a system on the fly and to fill the supply gaps as best they could.

Initially, long-term care homes' requests for PPE were directed to the Ministry Emergency Operations Centre's email address or hotline for coordination and prioritization. The first distribution to a long-term care home in response to such a request was made on March 19, 2020. Even as late as March 27, the Ministry was still working to establish an approach to handle requests for PPE and to refine the logistics structure. The first proactive weekly allocation of PPE did not occur until April 11, at which point weekly allocation and reporting began, soon after universal masking was mandated (discussed further below).

Minister of Health Christine Elliott's notebook revealed just how chaotic PPE sourcing became. She describes a shady world in which global supply is so tight and demand so great that the unscrupulous try to take advantage. On the night of April 2, 2020, Minister Elliott received a call advising her that 30 million 3M N95 masks might be available from a broker in the United States. She jumped on the opportunity and convened an emergency teleconference with the Treasury Board of Cabinet. The board approved $280 million for this potential purchase, based on the "basic" cost for a mask, due to intense international competition. The money was paid into an escrow account at a law firm. Minister Elliott described to the Commission having to "literally chase [the masks] around the world because they didn't appear." The broker had initially represented that they were in the United States, then the U.K., then Singapore – only to finally refer the province back to the

U.S. headquarters of 3M. When the province contacted 3M, the company said it knew nothing of this proposed transaction.

The masks never did appear. The province was able to recover the money from the escrow account.

Limited supply in long-term care homes

Given the PPE shortage and the absence of a provincial stockpile, the province advised health care organizations, including long-term care homes, to implement "supply stewardship" – that is, to "ration your supply." At the outset, long-term care homes were on their own; they needed to access their own supply chains and could not depend on a provincial backstop.

Joe La Marca, York Region's Director, Health Protection, described the region's efforts to send PPE to homes that were rapidly discovering how quickly supplies were used up in a pandemic situation:

> There were a number of homes early on that were in dire situations, and either it is because they didn't recognize their burn rate in PPE – so they may have called us and said we are fine, but then it wasn't until they were in outbreak that they realized, Oh my, I didn't have enough ... [W]e filled that gap ... we gave them gloves, we gave them masks, and we gave them sort of wipes and gowns ... depending on the size of the home, to get them through that first 48 hours ...

Shortages of PPE and the directive to carefully conserve what little they had left many staff concerned for their own safety as they cared for their residents. AdvantAge Ontario, an association of not-for-profit long-term care, housing and services for seniors, described to the Commission its attempts to find PPE in a crisis:

> [W]e had calls out for volunteer groups to make cloth masks. We were investigating and purchasing equipment to resterilize masks. We were ... working with community groups, local businesses, organizations, you know, trying to solidify PPE supplies as best as possible, because we knew it was such an important strategy in preventing COVID.
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> […]
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> [S]ome of the early directives talked about how often you could use a mask before you have to change it, which was conservation mode which really made the staff very nervous.

According to the Assistant Deputy Minister of Health responsible for data analytics, prior to the first wave of COVID-19, the Ministry did not track PPE supplies in long-term care homes. As a result, it was not aware of the supply status.

The province directed Ontario Health to survey health care organizations, including long-term care homes, about their PPE supplies. The survey response rate was weaker in long-term care than it was in other sectors.

As early as January 26, 2020, the Ontario Long-Term Care Association advised the province that some of its members were not able to fill orders for N95 masks. On March 15, the association identified PPE shortages as one of the top issues in the long-term care sector. Some homes were afraid to report shortages to the Ministry of Long-Term Care (their regulator) due to fear of being found in non-compliance. On March 16, the Ministry of Long-Term Care identified PPE supply for the long-term care sector as an emerging need.

Representatives of the Ontario Personal Support Workers Association and Canadian Support Workers Association described their desperate attempts to find ways to protect their members:

> We literally had PSWs, we were recommending them, because of the shortage of PPE, they were putting garbage bags on. We were telling them how to put on garbage bags. We were showing them how to make face masks out of big pop bottles, plastic pop bottles.

Even by April, when the Control Table – which was established to coordinate oversight, access and distribution of PPE – began proactively dispatching PPE, supplies were still lower than ideal. In 2006, in the wake of SARS, it was recommended that the provincial pandemic stockpile have a four-week supply of 94 million surgical masks (23.5 million per week, or 3.3 million per day) ready to be shipped out to health care settings in need. On April 2, 2020, the provincial inventory was 1.9 million.

Going to war unprotected: the impact on staff

The shortage of personal protective equipment in long-term care homes left staff confused and afraid for their own safety. As a result, staffing levels suffered as the fear of being unprotected caused staff to stay home. This was an outcome foreseen in 2006, when Cabinet was warned that "[h]ealth care workers may refuse to [come to] work without adequate personal protective equipment."

One staff member told the Commission about the stress associated with working without enough PPE:

> We kept telling them over and over we needed more PPE. There [were] four residents per room. We had to use one gown per room and hang it on the back of the door. And then they eventually let us have four gowns per room ... per day, but we had to hang them on the back of the door side by side. It was mentally and physically draining.

Other staff members described an apparent lack of PPE precautions in some homes, due to late recognition by home management of the threat posed by the new disease:

> At the beginning, we didn't have an abundance amount of PPE either. Our management was telling us we didn't need it. We didn't have any COVID in the building, so just carry on.

~

> When it first happened, we asked them for masks, and they said that we didn't need them, that it wasn't in our home. We told them about residents that were getting ill, and they told us, don't worry about it. Just do our job. And then when it came down to it that it started to spread like wildfire through our home, we had no direction on how to deal with any resident with COVID.
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> People had some respiratory issues, but we were told, it's not COVID. And then when we realized – they didn't give us PPE or anything, so when we realized the COVID is there, I, myself, contracted the COVID, and I was sick like a dog. I was so sick. I couldn't breathe at a certain time, having wheezes, and I was afraid I was going to lose my life.

In some cases, staff who felt under-protected were put in the awful position of being forced to choose between their own safety and that of their families and the safety of the residents they cared for. One staff member told the Commission of such an experience and the guilt associated with it:

> I worked on a COVID-positive unit. I ended up walking out the one day from work. At the start of my shift, several staff members and I went to our DOC [Director of Care]. We begged her for N95s, and she said, "no, you will not be getting them. They are for hospital workers, not for us." And at this point, there was so much fear and anxiety. And I have a family I have to protect, too, and I feel very guilty about what I did. And the next day, the DOC had us – made us come in her office. And she showed me all the PPE that she locked up, and she told me that none of us would be getting any of it.

Despite their fears, many staff members continued to show up on the front lines to care for long-term care residents. As one staff member described it, they suited up and went to war:

> I was scared. But I still have to work. It's like you're going to a war. You know you get bullets. You will get bullets on you. But you still have to step out there in the field and shoot. That's how I felt.

Universal masking comes too late

Unfortunately for long-term care residents, the province waited too long to introduce a universal masking mandate.

By March 9, 2020, Public Health Ontario considered it a possibility that COVID-19 could be spread by asymptomatic people. A representative from the Office of the Chief Medical Officer of Health confirmed that this possibility, though not a scientific certainty, would have invoked the precautionary principle in his mind.

On March 18, Ottawa Public Health's Dr. Taha wrote to Dr. Williams urging the adoption of universal masking, despite the ongoing PPE shortage. In Dr. Taha's view, the evidence was sufficient that asymptomatic spread was happening – and universal masking was urgently required. Dr. Taha's warning is worth reproducing in full:

Dear David,

With the focus on HCWs [i.e. Healthcare Workers] who have travelled, the following is not receiving the immediate attention it needs.

• The evidence is now sufficient that there are more asymptomatic infections than symptomatic infections,

• and that asymptomatic infections likely cause more new infections than symptomatic infections do.

• This strongly suggests that when community transmission is evident or can reasonably be assumed to be occurring (e.g., on the basis of low cumulative case doubling times),

• then there is a strong risk that infected HCWs who have not travelled and who are asymptomatic could be actively working in healthcare facilities.

• Therefore when community transmission is evident or can be assumed, all HCWs should be assumed to be posing potential risk to other HCWs and to patients,

• and therefore that all HCWs should wear surgical masks from the time they enter the facility to the time that they leave.

I know there is a shortage of PPE, but that has to be solved.

I also know that there will be arguments that there isn't evidence for effectiveness of the above recommendation, but I would turn that around and say the onus is now to provide evidence that the above recommendation (i.e., all HCWs should wear masks at all times at work to prevent asymptomatic spread to patients and other HCWs) will not work and is not indicated, and in the absence of such evidence, proceed with the recommendation.

There are other implications of the importance of asymptomatic transmission, but the above is an urgent priority.

Thank you for all your hard work. Times are tough and decisions have to be made that would make anyone wish for more evidence.

Dr. Taha was not alone in his belief that universal masking should be mandatory. The Toronto hospital system IPAC specialists met informally on Sunday, March 22 and determined that universal masking was appropriate. The downtown Toronto hospitals were in the enviable position of having sufficient PPE supplies. They instituted universal masking on March 24, using a directive that had been prepared over that weekend. The Toronto Region Long-Term Care Table did the same on March 29. As noted above, some long-term care homes also decided to adopt universal masking, on their own initiative, in March. Unfortunately, the province did not act with similar speed.

On April 2, the day before the first COVID-19 positive staff case at Orchard Villa was reported, Deputy Minister of Long-Term Care Richard Steele raised the issue

of universal masking with Dr. Williams, asking him to consider broader PPE use even though the province might not be “in a position” to recommend usage at all times:

> Should we in fact be considering broader use of PPE by staff, in particular broader use of surgical masks? As discussed yesterday, if we are not in a position to recommend usage at all times, is there a risk-based approach to extend usage beyond current direction?

Dr. Williams did not mandate universal masking in long-term care until April 8.

The Commission heard from Dr. Jennie Johnstone, Medical Director of Infection Prevention and Control at Sinai Health, that the two-week period between March 24 and April 8 was a critical time during which COVID-19 escalated and many homes began to experience outbreaks. Discussing the Toronto hospitals’ move to universal masking, Dr. Johnstone emphasized the importance of quick action:

> Every day counted. It was a 24-hour cycle and ... things changed minute by minute. And I mean, if you think about ... hospital corporations, we don't normally implement a huge program practice change in 12 hours. I mean, this was – we decided on March 22nd, Sunday night, and I had a conversation with our CEO and executive team Monday morning and we rolled it out that day. So that pace is not a pace that we normally have in normal times.

When asked by the Commission if the hospitals had made the decision because they understood time was of the essence, she responded, “Correct.” Furthermore, she explained why the two-week delay was so significant:

> I believe that this would have been very significant in the context of long-term care. That delay came at a time where COVID-19 in the community started to escalate, and I think in retrospect many of the homes started to go into outbreak sort of that end of March timeline.

A representative from the Office of the Chief Medical Officer of Health explained the delay in instituting universal masking by noting that prior to April 8 there was no evidence that masking was effective in preventing transmission by a sick person. It appears to this Commission, however, that the evidence was sufficient to take a precautionary approach by the third week of March.

Toronto Region’s early experience with universal masking demonstrated that a precautionary approach also requires pragmatic considerations. Implementing universal masking requires that long-term care home operators know the number of masks consistently used each day. The needs of each home can then be determined based on current PPE supplies and those required.

It is reasonable to ask whether the significant shortage of PPE at the time played a role in the decision to wait until April 8 to implement universal masking – given that such a mandate would clearly lead to higher PPE usage. Indeed, as noted above, it seems likely that the delay was necessitated, at least in part, by the lack of PPE supply.

Revera, a large long-term care operator, reported that it was not until April 13 that same-day PPE supplies could be obtained. Revera noted that, by this time, 97 per cent of all the infections it experienced in the first wave had occurred. Revera's views are consistent with Dr. Johnstone's observations that the failure to act earlier on masking coincided with COVID-19 taking hold in long-term care.

No Line of Defence: IPAC Deficiencies

> Preparedness, training, equipment, relevant protocols matter. In fact, that is all we have when faced with new threats.
>
> –Dr. Penny Sutcliffe, Medical Officer of Health, Sudbury & Districts

Personal protective equipment is of little value if you do not know how to use it.

Proper PPE use is just one of a series of infection prevention and control practices that are critical to protect long-term care residents and staff from viral transmission.

As discussed in chapters 1 and 2 of this report, many of Ontario's long-term care homes lacked adequate IPAC knowledge and expertise when the pandemic hit. While the long-term care sector has experience with outbreaks of infectious respiratory illnesses such as influenza, many long-term care homes did not have the resources, knowledge or experience to implement effective IPAC practices. Without this basic line of defence, outbreaks within long-term care homes were inevitable.

Along with a lack of PPE and a lack of institutional knowledge regarding infection prevention and control, homes struggled with various other IPAC best practices:

1. **Surveillance:** without the ability to quickly detect the virus through testing, it is difficult to contain it. This is complicated by the possibility of asymptomatic spread by individuals who have no idea they are ill (discussed further below).
2. **Infrastructure restrictions:** with four people to a room in many homes and, in some cases, eight people sharing a bathroom, it is difficult to prevent spread. Many homes did not have places to isolate sick patients or to cohort the well from the unwell.
3. **Staff shortages:** the fewer people on the ground, the more difficult it is to take appropriate action, including basic practices such as surface cleaning.

Long-term care staff described these challenges to the Commission:

> Infection control. How can you do infection control with four people in a room? We know what needs to be done, but we cannot physically do it. There's no plan. There was absolutely no plan for infection control when this hit. Blew me away.

~

> I mean, the majority of the staff in the building, nursing, dietary, housekeeping, laundry, didn't even have the required [fit] tests to be able to know what mask was appropriate in our home. And those that you say did the [fit] test, we were told that the N95 mask could be used twice, maybe three times, four, who knows, possibly five. It's so unacceptable.

IPAC specialists from hospitals and public health units were called into homes to perform IPAC assessments and advise on appropriate control measures.

North York General Hospital, for example, assembled a team of approximately 11 health care practitioners, including two physicians, a nurse practitioner and eight registered nurses with seniors' care experience from their Emergency Department. The team provided a comprehensive basket of supports, including IPAC expertise, testing, outbreak management, training, education and medical support. During the first wave of the pandemic, North York General performed 64 IPAC assessments and hundreds of IPAC training sessions, administered 5,600 tests through its mobile units, and supplied countless hours of front-line staff, environmental staff and medical care.

These local efforts had been taking place since March 2020, but the province was still catching up. Although the Ministry of Health was aware of the "underdeveloped" state of IPAC in long-term care homes, it took until April 10 for the MOH to propose the creation of "IPAC mobile teams" to address the issue. Around the same time, Ministry of Long-Term Care officials were seeking the names of IPAC specialists and expressing concern that the availability of outside IPAC expertise was becoming limited.

It was not until April 24, 2020, that a Minister's Directive was issued to require all long-term care operators to allow entry and cooperate with all "required staff," including hospital personnel and IPAC teams. It appears that provincially coordinated IPAC SWAT teams were then deployed in late April or early May 2020.

It is difficult to train a home's staff on proper IPAC procedures in the middle of a pandemic. It takes time and consistency to create good habits. Joe La Marca, York Region's Director, Health Protection, described it this way:

> One of the things that we learned early on is that we would go in to do an assessment, but it was a point in time. So then when you left, it was very difficult, sometimes, for that home to continue with some of those IPAC, I'll just say knowledge, and so, that is where we either had to augment that with sending additional staff to … get more education there, and then that became the development of the IPAC Extenders. It sort of filled that gap between ... when we were doing the assessment to ... when we would leave that home to go into the next outbreak – because we were having outbreaks everywhere. You wanted that continuity or champions sort of to make sure that the home was following some of those recommendations, especially around donning and doffing and the proper use of PPE.

Dr. Vera Etches, Ottawa's medical officer of health, said much the same thing:

> And our learnings and our observations were that the training is one piece, but it really requires ongoing oversight and ongoing reinforcement. That means leadership and IPAC supervision really needs to be there seven days a week if not 24/7.

Moving forward, IPAC practices must be proactively and rigorously maintained so that outbreaks can be contained or prevented.

Resident cohorting

Another important IPAC best practice is cohorting – the ability to separate and group sick and healthy residents and staff. While the province expected homes to be able to cohort, it did not provide the appropriate instruction for doing so. As a result, staff at many long-term care homes had little or no knowledge of how to effectively cohort. In some cases, cohorting efforts went from being an important IPAC tool to actually spreading COVID-19 over a wider population.

As of March 30, 2020, Directive #3 required both staff and residents to be cohorted into groups of "well and unwell." The document did not contain instructions on how to cohort, nor did the Ministry provide any such guidance. Unfortunately, with asymptomatic spread, it was not always possible to determine who was well and who unwell. By the time Directive #3 was issued there was sufficient concern about asymptomatic spread to have triggered the precautionary principle. Following that principle would have required Directive #3 to provide specific guidance as to how the homes were to address this reality.

The Directive referenced a 2018 document from the Provincial Infectious Diseases Advisory Committee on IPAC best practices. However, this document also did not provide instructions on how to properly and safely cohort residents and staff, let alone offer advice on how to do so in a facility that is at or near capacity.

Moreover, some researchers described cohorting for the purpose of infection control as a novel concept for most long-term care homes. It is not surprising, then, that staff did not have the experience to do so properly. Notwithstanding multiple amendments to Directive #3 and this general lack of knowledge in the long-term care sector, the Directive never did provide guidance on how to cope with the fact that some infected with COVID-19 might be asymptomatic but still capable of spreading the disease.

In an attempt to follow the guidance to cohort, homes tried to group symptomatic residents together and asymptomatic residents together. The difficulty was that

pre-symptomatic and asymptomatic residents who had been exposed to COVID-19 were often carrying and spreading the virus.

Dr. Dylan Kain, an infectious disease physician at Sinai Health, conducted a retrospective study that demonstrated how one home had tried to cohort as instructed by the Directive. Not recognizing the asymptomatic nature of the disease, the home was unwittingly cohorting infected (but asymptomatic) residents with unexposed residents, and thereby inadvertently spreading COVID-19 from room to room. This did not have to happen. Early on in the pandemic, Hong Kong had learned about the risk of asymptomatic spread. Hong Kong's long-term care homes had many people sharing rooms. If a resident was diagnosed with COVID-19, the diagnosed resident was cohorted with other diagnosed residents. At the same time, the exposed residents were cohorted with other exposed residents. In that way, unexposed residents were not put at further risk.

In late May 2020, the province eventually moved to fill the knowledge gap by offering webinars on PPE use and appropriate cohorting practices. By then, the first wave had already ravaged long-term care homes, and more than 1,450 residents had died.

Nowhere to go: decanting

Where homes cannot properly isolate sick residents, an alternative is to transfer the residents to another facility, such as a hospital or a field hospital.

Despite evidence that a decanting strategy for long-term care homes could prevent infection, the province failed to adopt such a strategy in the first wave of the pandemic. The first province-led initiative was announced in late December 2020.

There was no direction from the Ministry of Long-Term Care or the Ministry of Health to approve decanting facilities during the first wave. And without an initiative by government or others in the health sector, individual long-term care homes simply did not have the resources required to provide individual decanting facilities. In contrast, the Commission heard from Dr. Terry Lum of the University of Hong Kong that, in Hong Kong, decanting facilities were used by the government to isolate exposed residents for 14 days to ensure they could not inadvertently spread the disease to others. Those who were positive were moved into isolation wards in hospitals. This did not happen in Ontario.

In some parts of the province, however, initiative was taken to set up alternate facilities to allow for decanting. In March 2020, the Windsor Regional Hospital coordinated with Lieutenant Colonel Andy Stewart, a retired member of the Canadian Armed Forces, to identify appropriate spaces for a field hospital. Ultimately, the Sportsplex at St. Clair

College was selected, and within 17 days the field hospital was up and running, with capacity for 100 patients.

The Commission, in its second set of interim recommendations, suggested that the Ministries look to Windsor Regional Hospital's successful field hospital as a model for how alternative health care spaces can be created quickly in a crisis.

In January 2021, the province opened its first Specialized Care Centre in Etobicoke to service Toronto. The centre creates capacity by allowing homes that are at high risk for COVID-19 to decant their residents to the facility. At the time of writing, it was able to provide up to 90 spaces for residents, though it initially opened with 30 available beds. The Toronto Grace Health Centre, a hospital that specializes in care of seniors, provides care in the centre.

In explaining why it took so long to create the Specialized Care Centre, Minister Fullerton cited advice from the Bioethics Table as well as concerns over the rights of the residents. She noted that there are also infrastructure and staffing challenges that must be addressed. Alternative spaces such as hotels or field hospitals require health human resources, which include an operations team and a command team. To be effective, this system also relies heavily on hospital workers to step in and assist. In speaking with the Commission, the Chief Medical Officer of Health noted that "We have facilities, but you haven't got the staff."

All of these considerations could have and should have been dealt with in pandemic preparedness plans. When COVID-19 hit, some 10 months passed before a decision was made to implement a decanting facility. By any measure, this was far too long. Minister Fullerton told the Commission that the government will be receiving a report on the success of the Specialized Care Centre. That report should be made public.

Inspections Branch absent for first wave

As discussed in chapter 1, in the years prior to the pandemic, Resident Quality Inspections had been almost totally eliminated. Had more robust inspections taken place, the IPAC deficiencies within homes might have been addressed earlier.

Inspectors began working remotely on March 16, 2020, the same day that the first outbreak was reported in long-term care. Instead of on-site visits, inspectors were assigned to call long-term care homes to check in, manage incoming complaints, triage high-risk issues and establish ongoing communication.

The effectiveness of this new approach is questionable. Correspondence from the Ontario Public Service Employees Union representative on the Ministry's Employee Relations Committee dated March 30, 2020, suggests that homes had little time to respond to remote inspector inquiries as they struggled to cope with outbreaks and

direct care responsibilities. Some inspectors were demoralized, confused and frustrated as instructions changed in a matter of days. The on-the-ground situation was described as follows:

> Many Inspectors are so confused with the different information coming out. Some feel the process is too difficult and confusing to even understand on a day-to-day basis.
>
> There have been homes that have pushed back at the Inspector as they said they are already in an outbreak (not necessarily COVID) and these calls cause them extra work and time that they do not have. They are already working 16 hours a day to try to keep up.
>
> Several Inspectors said it would be nice to be asked for input before rolling out policy and procedures.
>
> Many homes are upset with the calls and thusly the callers. One home told the Inspector they don't have one spare minute in a week to spend talking with an Inspector. They already are required to notify so many people with all the same information.
>
> One Inspector said it is hard that we cannot help them. They are so busy to try to talk with us also. Under the circumstances, morale is not at its best.

The sense that the Inspections Branch did not have clear direction for its COVID-19 response in March 2020 is also reflected in an email from the Director of the Inspections Branch to inspectors on March 27:

> The uncertainty and sheer pace at which our day-to-day environment and work environment have been changing is very difficult to keep up with and sometimes even simply understand. I want you to know that I have felt frustrated and at times helpless in not being able to provide you all with timely direction and advice on how to proceed with our duties. Please hang in there and understand that the management team and I are doing our very best to provide you with the right direction to keep moving forward with our very important work.

By April 29, with COVID-19 still raging in the homes, a checklist was finally provided to inspectors to do IPAC assessments in homes. This kind of detailed, IPAC-specific guidance was not available prior to the pandemic. Had it been, it might have alerted the Ministry of Long-Term Care to pre-pandemic IPAC deficiencies.

However, as with the staff situation in long-term care homes, there was no "surge capacity or surge resources" available to rapidly deploy inspectors into the homes. Prior to the pandemic and during the first wave, the inspectorate did not have sufficient funding for the number of inspector positions it had; it would not be until November 2020 that the inspectorate would receive further funding to increase its full-time complement of inspectors.

Everything Stops: The Staffing Collapse

Of all the challenges long-term care faced during the COVID-19 pandemic, one of the greatest has been the lack of staff. At the end of the day, it is the staff who make a home function. They care for the residents extensively and, in many cases, intimately – helping them eat, take their medication, bathe, dress and attend to their toileting. Without the staff, everything stops.

The Canadian Institute for Health Information, relying on the results of a survey of long-term care homes conducted by the Commission, reported that long-term care homes with a greater number of nursing staff (which included registered nurses, nurse practitioners, registered practical nurses and personal support workers) per resident were less likely to experience a COVID-19 outbreak during the first wave of the pandemic. CIHI also found that the severity of an outbreak and the resident mortality rate in a home during the first wave were greater in homes that were 25 per cent short on PSWs at least once during this time.

CIHI concluded that:

- "The health workforce is vital for pandemic response, including the ability to scale-up safely"; and
- "Staffing may be the strongest infection prevention and control practice within homes."

The province had for many years known about the staffing crisis in long-term care. As described in chapters 1 and 2, the sector has faced long-standing challenges with staff recruitment and retention. The Commission was told repeatedly by long-term care advocacy associations, sector experts, unions, long-term care homes and current long-term care staff that the staffing crisis that predated the pandemic was a key factor in the death and destruction that tore through Ontario's long-term care homes.

When the pandemic hit, staff were asked to care for vulnerable residents in overwhelming – and at times horrific – conditions. The Commission heard from long-term care staff, unions and other stakeholders about the day-to-day struggles faced by personal support workers, nurses and other staff tasked with protecting residents.

As COVID-19 spread through the system, home Administrators began to see unprecedented staffing shortages. Multiple factors were identified as causes for staff not coming to work during the pandemic. These included:

- staff becoming ill with the virus;
- self-isolation requirements after travel;

- child care responsibilities; and
- fear of contracting the virus and infecting others, including children and immunocompromised family members.

With news reports circulating about the infectious nature of COVID-19 and the vulnerability of older populations and those with pre-existing health conditions, fear quickly spread among staff in long-term care homes. When news of long-term care staff succumbing to the virus emerged in April, staff confidence was further depleted and anxiety reached a fever pitch. As noted above, PPE shortages only sharpened their fears.

Unprecedented shortages

> It got to the point where there were days there [were] only two people in the entire building to take care of everybody, and one day two PSWs showed up for the day shift, and they both had fevers, but they were allowed to stay, because if they left, there was literally nobody to care for anybody.
>
> –Long-term care staff member

The staffing shortage in some homes was so severe during outbreaks that in at least one case, management and staff brought in whoever could help, including their own family members. Marcia Barry, counsel for the Ontario Nurses' Association, described to the Commission the lengths one registered practical nurse went to in order to get more help in a long-term care home in Ottawa. There, 53 residents and 29 staff eventually ended up testing positive:

> […] one of the RPNs one day brought in her 18-year-old son and her father, who were both hired on the spot, and they were put to work partially as PSWs, partially as housekeeping, kind of doing whatever they could in the home to help […] Unfortunately that meant none of these new hires had any experience in health care, and they were provided with no training or orientation, particularly around infection control and PPE. And unfortunately [...] both she and her two family members eventually contracted the virus.

The failures surrounding infection prevention and control were more pronounced due to the use of inexperienced and agency staff. Despite statutory direction requiring mandatory IPAC education, it is evident that many homes had insufficient education in this area pre-COVID-19. Without the necessary skill set, staff were left in the dark about proper protocols, while rapid staff turnover due to the pandemic left little time or resources to train incoming staff. Without this training, both remaining and incoming staff placed themselves and those they were in contact with at great risk.

Staff teams assumed a high degree of responsibility when an outbreak struck in a long-term care home. Meals still needed to be prepared and delivered to residents, and facilities needed to be cleaned and sanitized from top to bottom – especially rooms that housed COVID-positive residents. The pandemic brought the often under-appreciated

work and dedication of cooks, dietary aides and housekeeping staff to the forefront. A COVID-positive case or absence of staff in these areas could quickly bring a home to the brink of collapse. This situation also illustrated the necessity of providing IPAC training and proper PPE for all staff, regardless of their role.

Long-term care staff are dedicated and worked in extraordinarily difficult circumstances throughout the pandemic. In many cases, theirs was the last face that a long-term care resident saw before they died. Staff cared for residents even though they knew they were putting themselves and their families at risk by doing so. There is no question that these risks were real. As of April 25, 2021, 6,924 staff had been infected with COVID-19; sadly, 11 died. The tragedy that played out in the province's long-term care homes reached beyond residents to also include the families and loved ones of the diligent staff who suffered through and died of COVID-19. Their dedication and professionalism should not be forgotten.

Unmanageable workloads, dangerously low ratios

From September 12 to October 4, 2020, the Ontario Nurses' Association conducted a survey of ONA members working in long-term care homes about their experiences during the pandemic since March 2020. In data the ONA called "disturbing," 43 per cent of respondents reported that since March 2020 they had not had a registered nurse in the home at all times. Additionally, 11 per cent reported that their home failed to meet this standard more than four times in a month.

The chronically low levels of staffing described in earlier chapters of this report were exacerbated by the pandemic, with staff workloads often doubling, tripling or even quadrupling under unmanageable conditions. This was coupled with an increase in areas of responsibilities, such as contacting families, assessing residents multiple times throughout the day, administering medications, providing palliative care and attending to the bodies of recently deceased residents. These circumstances inevitably meant that residents did not receive the appropriate level of care they needed and deserved. In addition, back-to-back shifts and supporting residents with dementia and other responsive behaviours increased demands in homes that were already critically short of staff.

Unmanageable workloads and disproportionate staffing ratios were made worse by visitor restrictions placed on family members and loved ones, who before the pandemic had often acted as essential caregivers to residents.

The Commission repeatedly heard that the inadequate numbers of staff had a direct impact on staff's ability to practise effective IPAC and to meet the basic needs of residents, including hydration, nutrition, hygiene and human interaction. Apart from fatalities due to COVID-19, residents died as a result of neglect due to staff shortages.

For example, the Commission was told that malnutrition and dehydration occurred due to a lack of available staff to tend to resident needs. As a result of these conditions, some residents spent their final hours in complete isolation and ultimately died alone.

A devastating impact

The Commission heard many stories of staff who went beyond the call of duty to support residents, families and colleagues during the pandemic. Sacrifices included working multiple shifts and not seeing their own families and loved ones for weeks or months on end. As one long-term care staff member noted:

> You cry coming into work. You cry during work. You cry after work. You're vomiting in locker rooms. You try to hold it together before going home to your loved ones, if that's an option with this COVID, as most of us do isolate from them. PTSD is on a rise on our front lines. Guilt weighs heavy. We are very compassionate, caring people. I am risking my life to save someone's mother or father while isolated from my own. Stress is unbearable.

Staff were often the only people with residents when they died. They were then required to perform after-death procedures. Such procedures are usually conducted by coroners or funeral home attendants, but they were directed not to enter homes in early April. The procedures staff had to perform included putting deceased residents they had cared for in body bags, tagging their bodies with the necessary identification and transferring them on stretchers to a waiting hearse. Staff described to the Commission being ill-equipped to perform these procedures with the dignity and care deserved and PPE required:

> The most difficult and hard time, and I can't forget, and I am traumatized. When the resident died, and no one's family beside them. And we, including myself, I wrap, I wrap the dead body in a plastic bag, in the black bag and push them out in our home. That is the most devastating in my life I experience. And I know I am not protected that time.

Whether they witnessed the suffering and anguish of residents they just did not have time to get to or the undignified deaths of those whom they loved and cared for, front-line staff described extreme feelings of personal and professional helplessness, guilt and regret.

> We went from heroes to zeros. […] We had five PSWs for 58 residents. And this gentleman was dying. And we tried the best we could to get into that room and spend as much time as we could doing care […] but unfortunately he still died alone. We weren't there when he died […] [O]nce a resident passes, you're expected to pull yourself together and heaven forbid you should be emotionally attached to this person and move on to the next task at hand with just, you know, a snap. [...] You become the substitute families. They know our voices, they know our touch, and that's important. And I believe it's inhumane not to be able to spend any extra time with a dying person or somebody that's lonely or has an issue.

Non-nursing staff saw their roles turned on their head. Recreational activities for residents disappeared in lockdown and staff were reassigned to other duties. The Commission heard that the loss of activities that supported the physical, mental and emotional stimulation of residents not only had significant impacts on their overall health and well-being but also affected the morale of staff who had once prepared and led programming with care and pride.

As one long-term care recreational worker described in a written submission to the Commission, the enjoyment of interactive games or movie nights was replaced with the despair of holding iPads so families could say their goodbyes to loved ones:

> As a recreation staff, I would don my PPE and sit bedside a resident [with] my iPad to facilitate a "good-bye" call […] For one resident, I sat at bedside after he died with the iPad because the family wanted to see him one more time. So, I watched and listened as his wife and adult children spoke of their love and silently wept under my mask and face shield.

As a result of these traumatic experiences, many staff continue to deal with mental health issues, including depression and increased anxiety, without assistance. Many are grieving alone as they struggle to come to terms with what they witnessed, all while continuing to work at the homes where the tragedies took place.

The staff who soldiered on during the pandemic and bear the scars must not be forgotten. Long-term care home licensees should make counselling services available to the residents and staff living and working in long-term care during the pandemic. The licensees should bear the cost of this counselling, and no portion of that cost should be passed on to residents or staff.

Give and Take: Delayed Staff Restrictions and Support

While staffing levels were critically low during the pandemic, staff were also a potential means by which COVID-19 could enter a home. Two policies to address these competing concerns – the direction to limit staff to working in one home and the decision to provide pandemic pay to staff, were both slow in coming.

The single-site order

During the early months of the pandemic, evidence suggested that COVID-19 outbreaks in long-term care settings were occurring because staff who worked part-time at more than one home were unwittingly carrying the virus from site to site. The recommended solution was to have workers limit themselves to one home.

However, as with the universal masking requirement discussed above, the province was slow to act, in part because it failed to prepare for this predicted concern and then conducted a policy review when action was required. There is undoubtedly a downside

to restricting workers to one site, thus exacerbating a staffing crisis that existed prior to the pandemic; the result, inevitably, is a more constrained workforce.

In remarks to Cabinet on April 14, 2020 – while seeking an emergency order to restrict staff to a single home – Minister Fullerton acknowledged the likelihood of asymptomatic spread via staff and also addressed the reasons why so many staff needed to work in more than one place:

> The evidence is increasingly clear that many outbreaks are the result of asymptomatic staff unknowingly introducing the virus into homes. We know that a considerable number of long-term care staff work part-time, often in more than one job – at another long-term care home, a retirement home, or elsewhere – to create full time employment.

Minister Fullerton's remarks should not have come as a surprise. The province had been aware of the risk to residents posed by staff working in multiple long-term care homes years before COVID-19. As described in chapter 2, the issue was raised by Dr. David Walker in early 2004, in the final report of the Expert Panel on SARS and Infectious Disease Control. In April 2020, Dr. Williams acknowledged to the media that:

> From the beginning, we had concerns about employees who work at multiple sites. We had experienced this problem back in SARS and a bit in our H1N1 issue a few years back […] And we knew this was a continuing problem.

As Chief Medical Officer of Health, Dr. Williams has the power to issue mandatory directives backed by legislated sanctions under the *Health Protection and Promotion Act*. Rather than use that power in the early days of the pandemic, however, Dr. Williams asked staff to work in only one home. In a memo to long-term care operators dated March 19, 2020, he wrote:

> Health workers who work in multiple locations should identify themselves to their managers and develop an individualized plan to manage their employment across these settings over the course of the pandemic. In some high-risk settings, it may be possible to coordinate arrangements for staff to only work in one institution.

It was explained to the Commission that the CMOH often starts with warning letters before escalating to the use of more coercive powers. The Commission acknowledges that this process may be suitable for "peace time," but in a public health emergency such as the COVID-19 pandemic swift mandatory action is required. The memo did not have the anticipated impact.

The memo's recommendation was elevated to a directive on March 22, 2020. Directive #3 provided that long-term care homes should immediately, and "wherever possible,"

> work with employees to limit the number of different work locations that employees are working to minimize risk to patients of exposure to COVID-19.

The inclusion of the language “wherever possible” was self-defeating, as it resulted in the Directive being no more than a suggestion. It was not mandatory, and therefore it was not universally followed.

It soon became apparent that the Directive was not strong enough. In speaking with the Commission, the Chief Medical Officer of Health stated that his powers did not allow him to issue a stronger directive – one that would have compelled employers to prohibit workers from working at more than one site. Given that this entire scenario was predicted by Dr. Walker 16 years before COVID-19 arrived in Ontario, the debate over the extent of the CMOH’s powers could have been dealt with well in advance of the pandemic. Nonetheless, in late March 2020, the Office of the CMOH and Ministry personnel began to discuss how to make the Directive stronger. It was thought that an emergency order by Cabinet could strengthen the message. Before such an order could be recommended, however, policy analysis had to take place, including labour considerations. All of this took time – time in which asymptomatic employees inadvertently spread COVID-19 by working – as the Minister of Long-Term Care acknowledged.

By April 8, 2020, nothing was ready for Cabinet. The Secretary of the Cabinet Office reached out to the Ministry of Long-Term Care with an urgent request to strengthen the language used in Directive #3. As was explained in the request: “The goal is to have more direction … than encouragement.” However, it took another six days – until April 14 – to issue the single-site order. Compliance was not required until April 22.

As mentioned earlier, the majority of those who died in the first wave of the pandemic did so or were infected between March 22 and April 22. Whatever impact the “single-site order” eventually had, it came far too late for far too many. A pandemic is no time to debate the relative powers of the CMOH and Cabinet, nor is it a time to do policy work that could easily have been done well in advance – if only Dr. Walker’s warning had been heeded.

In addition, at the time the single-site order was issued, it was not complemented by any supporting measures that would have avoided the negative impacts on staffing levels. There was no requirement that a part-time employee be given full-time hours, for example, although many homes did convert part-time employees to full-time. There was no compensation provided to part-time employees who lost hours because they could only work at one home. There was nothing preventing those employees working a second job outside of health care, where they might contract COVID-19 and again inadvertently bring it to a home. Agency staff could still work at more than one home. All of these examples were known gaps in the single-site decision. The largest concern was that many part-time workers would just leave the industry. It is not clear how many

did, but the single-site order is nevertheless often considered to have disrupted an already fragile workforce.

It is also worth noting that not all provinces or jurisdictions were as slow to act. British Columbia ordered long-term care staff to work at a single site much earlier than Ontario, implementing its policy on March 26, 2020. The framework included making all long-term care workers full-time at a single site and also boosted hourly wages for long-term care workers. The Ontario Nurses' Association also highlighted these differences between the British Columbia and Ontario approaches in its presentation to the Commission.

Even within Ontario, some homes and regions took a different approach. As noted above, York Region (which operates two municipal homes) and Mariann Home implemented single-site, single-employer rules for their staff well in advance of the provincial emergency order taking effect. In the case of York Region, this was done on March 25, 2020; for Mariann Home, in early April.

Pandemic pay

On April 25, 2020, some two months into the pandemic, the Ontario government announced temporary pandemic pay (in effect from April 24 to August 13, 2020) for front-line health care workers across multiple sectors: hospitals, retirement homes, long-term care homes and other congregate settings.

The Commission heard that the province announced additional pandemic pay for PSWs on October 1, 2020, and released specific details of such pay on November 30, 2020. On January 13, 2021, some 29 per cent of homes reported that they still had not begun paying their PSWs the additional funds designed to "stabilize the workforce."

Pandemic pay had several objectives:

- to provide additional support and relief to front-line workers;
- to encourage staff to continue working;
- to attract prospective employees; and
- to help maintain safe staffing levels and the operation of critical front-line workers.

The wage increase was a much-needed measure.

Despite more resident and staff infections and more resident deaths occurring in the second wave, the pandemic pay received by PSWs was less than that obtained in the first wave (i.e., reduced to $3 per hour in the second wave compared to $4 per hour plus a lump sum bonus of $1,000 for those staff who worked 100 hours or more in a

designated four-week period in the first wave). Staffing shortages continued to be a problem throughout the first and second waves of the pandemic.

Sick pay

Sick pay for workers has been widely touted by politicians, physicians and academics as an important administrative control to encourage workers to stay home when sick.

Sick pay in Ontario has fluctuated over the years. Beginning in January 2018, the *Employment Standards Act* provided 10 days of unpaid leave. The *Act* was later amended to mandate a total of two days of sick pay and eight days of unpaid leave. In 2019, the current government amended the *Employment Standards Act* to remove mandatory sick days for employees; to date, nothing has been implemented to reinstate sick pay.

As discussed throughout this report, a significant number of workers in the long-term care sector are employed part-time, on a casual basis, and without benefits such as paid sick leave. As the pandemic took hold, these workers had no legislative safety net that would have allowed them to take time off work without losing wages.

A 2019 review by *BioMed Central Public Health* – a peer-reviewed journal that considers articles on the epidemiology of disease and the understanding of public health – found that the prevalence of workers who continued to work while infectiously ill ranged from 35 to 97 per cent. A Public Health Ontario document noted that several studies had reported that workers continued to work while ill because they would not get paid while on leave.

Public Health Ontario was well aware of the issues around the absence of paid sick leave in the early stages of the pandemic. The issue had been brought to the government's attention well before the first wave of COVID-19 hit the province.

On February 4, 2020, a group of 179 concerned physicians released an open letter to the government. In it, they discussed several issues they had deemed problematic with Ontario's labour landscape. The physicians noted that the province's legislative scheme did not encourage workers to follow doctors' recommendations and to stay at home when ill – not without forgoing their wages. Workers affected included those in long-term care facilities. The physicians provided the following evidence for their findings:

> The medical literature consistently states that employees with no sick leave are more likely to go to work and expose others to infection. Additionally, research shows that workers have no choice but to send their children to school sick because they cannot afford to take unpaid time off or afford

> childcare. A lack of paid sick days results in children and adults transmitting infections at school and work, exacerbating contagion throughout the province.

The physicians stated that paid sick days were a vital measure to decrease the spread of illness, and they called for the Ontario government to reinstate 10 days of flexible personal emergency leave, seven of which would be paid.

During the first and second waves of the pandemic, the province did not provide paid sick days for long-term care workers. As this report is being finalized, the province is reconsidering this issue. The Commission accepts that efforts to support staff so that they do not – for financial reasons – attend work while sick will further protect the residents of long-term care homes going forward.

Making a Bad Situation Worse: Visitor Restrictions

To stem the viral tide in long-term care homes, the province restricted visitors from entering. While decision-makers were well-intentioned on this front, it appears they did not fully appreciate the essential caregiving role that visitors, particularly family members, play. When visitation rights were limited, residents suffered.

Early inconsistencies

Visitor restrictions were introduced on March 13, 2020, when the Ministry of Long-Term Care issued "guidance" to homes. In order to reduce the probability of disease spread, visits were restricted to essential visitors only. The term "essential visitors" was defined as "those who have a resident who is dying or very ill." This language – particularly the term "very ill" in the context of highly compromised residents – was confusing for staff and families.

As noted above, the Chief Medical Officer of Health released the first iteration of Directive #3 on March 22, 2020. The Directive recommended that visits between residents and family members take place outside. The "essential visitor" policy issued by the Ministry of Long-Term Care and the "outside visits" policy in Directive #3 created confusion among stakeholders and friction within the government itself due to the apparent conflict between the ability to visit as an "essential visitor," on the one hand, and to visit outdoors, on the other. Ministry of Long-Term Care staff expressed displeasure with the Directive internally and noted that the number of families who would seek to visit their loved ones outdoors could create a "logistical nightmare."

On March 30, 2020, the Chief Medical Officer of Health issued the second iteration of Directive #3. This version generally aligned the CMOH's visitor policy with that of the Ministry of Long-Term Care. From April 2020 to June 2020, CMOH and the Ministry

collaborated on efforts to expand the visitor policy to include essential visitors and caregivers.

Impacts of visitor restrictions

Under the version of Directive #3 issued on March 30, 2020, visits were again restricted to essential visitors; all other visitors were barred from entry. The definition of “essential visitors” now included “a person visiting a very ill or palliative resident.” Absent a loved one being very ill or near death, no family members or private caregivers were allowed into homes; visits could only be conducted over the phone, via video chats or through windows.

As noted above, it was not clear what constituted a “very ill” resident; given the acuity of many long-term care patients, this definition could include a wide range of conditions. Eventually, the determination of who was “very ill” was left to the physicians and clinical staff at the home. Even so, the Commission heard that the directive to allow visits for palliative patients was not always followed, and some residents died without family members present.

Many of those who spoke with the Commission understood the need to restrict visitors early on in the pandemic but felt more was needed to support residents’ psychological and emotional needs.

Without the assistance of caregivers or family visitors, resident well-being plummeted. Many residents’ mental and physical well-being depended on family and friends. Prior to the outbreak of COVID-19, family members made daily visits to help with feedings, dressing, toileting and companionship. This support ended when the restricted visitor policy took effect in March 2020. As mentioned above, the loss of assistance from these family members also put an added burden on staff, who had relied on family members to share some of the load in assisting in daily care activities.

Residents spoke to the Commission about the ways in which the visitor restrictions and room confinement affected them:

> The impact of this pandemic is as if our whole world stopped and a reality nightmare has set in.
>
> ~
>
> … it hit that we really are isolated, and a lot of our other residents were saying it is just like being in prison, except that prisoners are treated better.
>
> ~
>
> I also enjoyed going out two to three times a week for lectures, outings with my kids, activities with the home. All that stopped all at once, and I was all alone.
>
> ~

> I find it very isolating. We're not allowed out of our rooms, so we don't get to see our friends anymore ... spend all day in my room by myself. Me and my TV.

The policy had a particularly devastating effect on residents suffering with dementia or complex medical conditions.

Worsening the impact, many residents of homes were confined to their rooms, in many cases without access to visitors or recreational programs.

The province's COVID-19 Science Advisory Table reported that many long-term care home residents experienced symptoms of what is known as "confinement syndrome." The term is typically used in medical literature to describe the intense anxiety and sensory deprivation experienced by persons placed in solitary confinement. The impacts of confinement syndrome are wide ranging, and can include changes in the following areas:

- **Physical health and well-being:** acute deterioration in chronic conditions, dehydration, malnutrition, inadequate pain management and pressure ulcers.
- **Mental health and cognition:** loneliness, anxiety, mood disorders, depression and other mental health issues including a reduced sense of purpose, post-traumatic stress disorder and/or suicidal ideation, substance use, cognitive changes including delirium, and responsive behaviours.
- **Functional status:** reduced mobility, fall risk, bladder and/or bowel incontinence, and loss of functional abilities.

With staff numbers at historic lows, extensive use of agency staff who did not know the residents, and family members unable to advocate for residents, the quality of care in long-term care homes also decreased. The Commission heard accounts of medications not being dispensed on time or not administered to the right resident:

> [t]here [were] medication mixups because we did not have regular staff available who know our characteristics, who know our medications and the needs that we have. Twice I had medication mixups. Had I not been alert and aware of what was happening, it would have been painful. It would have hurt emotionally, physically.
>
> ~
>
> You know, residents were getting medication that wasn't prescribed to them, or we would come in and find our mother-in-law, and she would hand over these pills. And some of the pills were hers; some of them were not.

Once family members were permitted to visit again, the relief of finally gaining access was often fleeting. Many families expressed shock and sadness at the rapid decline in their loved one's cognitive and physical functions. They reported increasing levels of depression and noted how, in some cases, once vibrant and alert residents had lost hope and were totally unresponsive. The Commission also heard that it was often

difficult for family members to re-engage with residents as no physical contact was allowed and masks tended to obscure one's identity and voice.

One family member described the quiet desperation that many residents experienced:

> The inside of the residence became silent. Residents could no longer go from one area to another. There were no longer any visitors, and my mother was resigned to simply wait beside her phone in case one of her children would call her.

As the months progressed, the rules on visitation continued to evolve. Outside visits were allowed, followed by inside visits, and then visits based on the community's designation under the provincial lockdown framework. The ever-changing rules caused continued confusion and frustration for family and residents. Dr. Vivian Stamatopolous, an associate teaching professor, told the Commission:

> So then they had ... different rules based on the colour scheme. And it was just a nightmare trying to navigate this with families, because ... the information was always confusing, ever changing, families didn't know what was happening.

The residents' and families' fears and frustrations were real – and the shifting directives regarding visitation made the situation even harder.

Bottleneck: Screening, Testing and Lab Capacity

As discussed in chapter 2, Ontario's laboratory system entered the COVID-19 pandemic unprepared. The Commission heard from several long-term care homes and hospitals that the delay in processing and reporting test results affected their ability to contain the scope of COVID-19 outbreaks in their homes. Test results often took seven to 10 days to be received, with some results being lost. By the time homes received the test results, the disease had already spread; without the results, it was difficult to identify and isolate infected residents.

Dr. Joel Kennedy, Division Head, Hospitalist Medicine at Lakeridge Health, explained to the Commission that when test results are delayed a ripple effect is set into motion. Not only does the delay prevent containment of the disease but, in turn, it also strains the wider health system by leading to a higher number of transfers from long-term care homes to hospitals.

Recognizing that it was not going to get enough testing done by public health labs alone, the province moved to a combination of Public Health Ontario labs, hospital labs and private labs. But Ontario had more restrictions on what lab testing could be done. The focus was on hospitals, so there was limited testing available for long-term care facilities.

On January 25, 2020, Public Health Ontario identified the first case of COVID-19 in the province, using the testing protocol it had established earlier that month for the then "unknown pathogen" emerging out of China. Despite being the first province to conduct its own COVID-19 testing, Ontario got off to a slow start. By February 26, public health labs had tested only 629 samples. Long-term care residents, staff and visitors were not considered a priority at this time, with international travellers being the primary focus of testing efforts.

Lab capacity and the establishment of assessment centres across the province began to ramp up at the end of March 2020. According to Public Health Ontario, 49,227 COVID-19 tests were completed between March 1 and March 29, which is equivalent to 1,697 tests per day over this period. On March 24, Ontario Health warned that the existing provincial capacity for COVID-19 testing did not match the anticipated demand, resulting in wait times of up to four to six days in some centres. It also noted that the true demand for testing was anticipated to be much higher than current public health policy permitted.

The Commission heard that the jurisdictions that were successful at COVID-19 testing during the first wave of the pandemic had an integrated lab system already in place to coordinate testing. Ontario was not one of these jurisdictions. It was not until late March 2020 that a formal Provincial Diagnostic Network was developed to oversee and coordinate testing between participating laboratories. By this time, COVID-19 was already devastating long-term care homes across the province.

The number of tests being processed increased to 5,500 per day by mid-April and 10,000 per day by the end of that month, but that was still only half of the daily testing goal set by the Provincial Diagnostic Network.

Delays in reporting test results

As the demand for tests continued to outpace lab capacity and the Provincial Diagnostic Network continued to fall short of its testing targets, delays in providing test results to long-term care residents and staff resulted. For homes in outbreak, this was catastrophic – and it had a direct and disastrous effect on the spread of the virus within the homes. Had Ontario been prepared with a strategy to ramp up laboratory capacity to a level sufficient to respond to a pandemic situation, the outcome for many homes would likely have been different.

These problems persisted into the second wave. The Commission heard of one home, for example, that declared an outbreak on November 23, 2020; on November 28, it was still waiting to receive test results for 47 staff and 33 residents.

A representative from AdvantAge Ontario spoke to the Commission on the issue of delayed test results:

> We also had a home that was in outbreak because a staff member had COVID, and then a resident had COVID, and they did testing. They didn't get results back from everyone until eight days, and then there were two tests that were missing, ... so they called. They thought to call, and they found out a couple of days later that one of those tests was positive.
>
> So that had been like ten days where there was someone who was positive in their home and, you know, they didn't know.

Outdated technology and lack of swabs

The Commission heard that many homes lacked the technology to access Public Health Ontario's Online Laboratory Information System (OLIS), meaning they were not able to receive test results electronically. Instead, they were left to rely on outdated technology.

The Deputy Minister of Long-Term Care advised that OLIS, which provides electronic receipt of lab results, was still being rolled out in long-term care at the time of the pandemic, despite having been in place for almost 30 years and a standard feature of most health care settings. For some homes, this meant that test results were sent by fax, sometimes in a stack for staff at the home to sort through, and in some cases with only the case numbers and no patient names. Test results were delivered to other homes through the mail.

The slow delivery of test results often made it impossible for management to make informed and speedy decisions regarding the need to isolate residents and/or staff in order to contain the potential spread of infection.

A lack of testing supplies further exacerbated the delays in testing. At the start of the pandemic, long-term care homes did not have enough swabs to ensure sufficient testing. Typically, homes would only maintain a small supply of swabs to test for respiratory illnesses, such as influenza.

The Commission heard that when the pandemic was declared in March, Ontario was running low on the swabs needed to perform nasopharyngeal sample collection and the reagents required to perform the tests. Public Health Ontario also faced a shortage of the technicians and testing equipment needed to test the flood of samples being received. Together, this resulted in a backlog of tests and stalled the reporting of results to long-term care homes.

Advice ignored: an overwhelmed system

In light of the challenges with testing and lab capacity in the first wave of the pandemic, and at the request of the Health Command Table, the government established the

Testing Strategy Expert Panel on April 5 to assist with informing the provincial testing policy.

In early May 2020, the Testing Panel warned that the province did not have enough tests to “test everyone.” As a result, panel Co-Chair Dr. Jennie Johnstone suggested that widespread asymptomatic testing was not a sustainable public health strategy and should not be pursued. Dr. Johnstone’s Co-Chair, Dr. Vanessa Allen from Public Health Ontario, agreed.

Despite this advice, the government announced the Protecting Ontarians through Enhanced Testing plan on May 29, with the goal of expanding asymptomatic surveillance testing across the province for “anyone who wanted a test.” This testing became available as of May 24. As of that date, the provincial daily testing capacity was said to be only 24,522. Clearly, the province was not going to be able to test everyone who wanted a test and analyze the results.

Ontario’s lab capacity was already strained. The province had introduced a suite of surveillance testing policies by this time, including for long-term care staff, residents and visitors. Where the delivery of positive test results was delayed, long-term care homes were losing days of response time.

By July 6, 2020, the Testing Panel recommended to the Chief Medical Officer of Health that the province limit asymptomatic testing in low-prevalence, low-risk populations. It repeated this recommendation on August 18, 2020, noting that “low value asymptomatic testing is not recommended in a low prevalence setting” and that asymptomatic testing should only be used where it adds “high value.”

Once again, the advice was disregarded.

This was not the only time that the view of scientists did not prevail. On November 13, 2020, the province announced a new plan to respond to the rise of community spread, which had been identified as one of the biggest risk factors and predictors of a home being infected with COVID-19. The province’s announcement ushered in a colour-coded lockdown system. The more prevalent COVID-19 was in the community, the greater the need for vigilance.

To determine the appropriate levels of concern, Public Health Ontario was asked to provide advice about epidemiologic thresholds that could be used to drive decision-making about public health measures.

In September, Public Health Ontario recommended that the highest category of restrictions (grey, or “lockdown,” in the province’s colour-coded system) be used when cases were greater than 25 per 100,000 population per week.

In October, the Public Health Measures Table, a sub-table of experts established to provide advice on public health measures to combat COVID-19, was advised that the threshold for the highest category of restrictions should be 40 cases per 100,000 per week.

That advice was not only agreed upon by the Public Health Measures Table but also by Dr. Williams. Despite this advice, the province announced a threshold of 100 cases per 100,000 population per week. This announced threshold was *four times higher* than the one recommended by Public Health Ontario and was alarming to many in the scientific community.

For several days, there was silence from the scientific community about the announcement. On November 11, 2020, however, Dr. Shelley Deeks – then Public Health Ontario's Chief Health Protection Officer – broke that silence and told the press that the government was acting contrary to the advice given by the scientists. Dr. Deeks recognized that science and public health play only a part in the political decision to shut down society, but she believed that advice should be transparent and publicly available. Dr. Williams agreed with the rejected scientific advice but said nothing publicly on the subject, leaving it to Dr. Deeks to release the information. Following her statement, the province reconsidered its position and adopted the recommended 40 per 100,000 threshold.

Dr. Williams advised the Commission that he thought confidentiality restrictions constrained him since he gave this advice to Cabinet. Dr. Williams had the authority to make the advice public. As the chief health officer to the province, his primary responsibility is the health of Ontarians.

Both the SARS Report and Walker Report recommended that the Chief Medical Officer of Health be independent, with the authority and the duty to communicate with the public whenever he or she sees fit. Any doubts about the source, timing or motives of public health information damages public confidence.

Advice during a pandemic should be made in a transparent and public way. In a health emergency, the public has the right to know the advice given on such an important matter, directly from their chief medical officer. It should not have been left to Dr. Deeks to communicate that advice.

While the Chief Medical Officer of Health has a legislated duty to deliver an annual report on the state of public health in Ontario to the legislature, there is no duty to report on other public health matters to the public. He only has *permission* to report on other public health matters to the public or any other person he may consider appropriate.

The recommendations of the SARS Report to provide "visible safeguards to ensure the independence of the CMOH" have only been partially addressed in amendments to the

Ontario legislation. The SARS recommendations should be fully implemented, and the CMOH should be required to report directly to the public where he or she believes it would be in the public interest to do so.

Slow adopting of rapid tests

Rapid COVID-19 tests were approved by Health Canada and made available to Ontario's long-term care homes in fall 2020 through procurement by the federal government.

Pilot testing in Ontario's long-term care homes started in late November 2020. On-site testing requires significant operational and staff resources for the home. For most homes, dedicating two to three staff members to operate the testing was simply not feasible. Despite this, in late January 2021, the Ministry directed homes to scale up the use of rapid antigen testing of asymptomatic persons.

Integration into the broader health sector could ensure that long-term care homes have capable and ready partners to promptly employ testing to protect their residents in the case of infectious disease outbreaks. Even though the Commission heard that the Ministry had begun consultations with community labs and pharmacies to address the human resource challenges in homes related to administering rapid testing, these arrangements were not in place to protect residents during the second wave.

Fall Preparedness and the Second Wave

By late May 2020, COVID-19 seemed to be receding. On May 20, there were approximately 2,458 resident cases and 1,564 staff cases in long-term care homes; by June 20 those numbers had fallen to approximately 241 resident cases and 347 staff cases. While this lull provided residents, families and staff a moment of reprieve, a second wave was not only predictable but also historically inevitable.

The summer of 2020 was the time to prepare for the second wave, which was anticipated to hit in the fall, following the pattern seen in the 1918 influenza pandemic. With the lessons learned from the first wave and a summer to fortify long-term care, it was reasonable to anticipate that the second wave would be less punishing than first. That was not the case.

The second wave – September 1, 2020, to March 14, 2021 – had more long-term care deaths than the first. This higher number of deaths came despite the COVID-19 mortality rate of long-term care residents dropping from approximately 33 per cent to 21 per cent between the two waves.

It is difficult to assess exactly why the second wave was more deadly than the first. As more data are analyzed, it will undoubtedly lead to a better understanding of why Ontario did not fare better in the second wave, despite having months to prepare. However, this will bring little comfort to the families and loved ones of the long-term care residents who lost their lives to COVID-19 during this time.

In building a fall preparedness plan for the second wave, the Ministry of Long-Term Care looked for lessons in both the successes of the first wave and in what could have been done better. In doing so, the Ministry heard from key partners – including hospitals, public health, other ministries, and long-term care sector groups. The Ministry then identified three main areas of focus for second-wave preparation: partnerships with hospitals, infection prevention and control, and staffing. The Ministry also asked homes to complete a preparedness assessment so they could gauge their own level of preparedness and identify gaps in these three "key" areas.

To "avoid a repeat of the tragedies" in the long-term care sector, the government committed almost $540 million in new investments as part of its fall preparedness plan to support incremental costs of staffing, protective equipment and other prevention measures.

Yet despite the self-assessment tool and the commitment of half a billion dollars to protect long-term care residents, there was nevertheless a "repeat of the tragedies" in the second wave.

Self-Assessments: Completed and Forgotten

As part of its fall preparedness efforts, the Ministry of Long-Term Care designed a self-assessment for homes that addressed issues such as partnerships, IPAC and staffing. The homes were asked to rate themselves on a number of these preparedness indicators.

The results of the self-assessments were provided to the appropriate Ontario Health regional office, which then provided an assessment to the Ministry regarding the status of homes in its region. Notwithstanding the self-assessments, the Commission heard that there was no Ministry follow-up with the homes.

In addition, the self-assessments were not provided to the local public health unit, the partnered hospital or even the Ministry's inspectors. Even in cases where the Ontario Health regional office identified a home as being of concern, it appears that nothing was done with this information. The Commission heard about a home that the Ontario Health regional office had identified as a concern for the second wave, but that information was not shared with the paired hospital, local health unit or Ministry inspectors.

The second-wave outbreak in that home resulted in close to 80 resident and staff cases, with about 30 per cent of the residents dying of COVID-19.

The Commission heard that the Ministry did not evaluate the effectiveness of the self-assessment; however, the devastating COVID-19 outcomes in the second wave indicate that many homes were not, in fact, prepared.

Partnering Homes with Hospitals: Too Little, Too Late

Prior to the first wave of the pandemic – and as noted in chapter 1 – many long-term care homes did not have pre-existing or formal relationships with local health care partners, despite the increasing acute medical needs of residents. Where these connections did exist, they tended to be informal, *ad hoc* arrangements.

As the pandemic spread, hospitals were called upon to assist homes in crisis, and public health units had to innovate to ensure homes in crisis received help. However, these partnerships were only addressed on a regional and *ad hoc* basis.

In late April 2020, the government established a Long-Term Care Incident Management System Committee sub-table under the Health Command Table, which endeavoured to coordinate support to the long-term care sector. Building off successes such as those in Durham Region (described earlier in this chapter), a Minister's Directive was issued on April 24, 2020, requiring homes to accept the assistance of hospitals when offered. While this approach provided much needed assistance to many homes in the first wave, there were still no formal arrangements.

The system generally worked well to address homes in crisis, since hospitals managed these homes. However, once hospitals handed oversight of management back to the homes, there was concern that the problems that had given rise to the crises were not resolved.

For example, in the case of IPAC, much of the province's expertise resides in hospitals, public health units and Public Health Ontario. In advance of the second wave, Public Health Ontario prepared additional IPAC material, but there is no clear understanding of how many homes used that material or how effective it was in changing the culture in long-term care.

As Dr. McGeer advised the Commission, "it is not possible to change the behaviour of 75,000 staff members who, generally speaking, have deeply inadequate training and education in a four-month period." The partnering of long-term care homes with hospitals through the Minister's Directive was a short-term solution that helped homes weather the storm of the first wave, but it did not prepare homes to fend for themselves in subsequent waves.

As part of second-wave preparation, the Ministry, through the Ontario Health regions, sought to formalize arrangements by pairing each home with a hospital. The plan was to ensure that health care partners knew what might be expected of them in the second wave so they could ensure the proper resources were available.

Using this partnership model, the Ministry created a hub-and-spoke system through which hospitals would assist homes with IPAC. However, Dr. Johnstone advised the Commission that this was not implemented until November 2020, and that the delay meant there was no time for the hospitals to have a meaningful impact on creating an infection prevention and control culture before the second wave hit.

IPAC: Lack of Transparency on Sufficiency and Use of Funding

Included in the province's "key investments" of the almost $540 million that it committed to protecting long-term care residents was $20 million to hire trained IPAC specialists and $10 million for IPAC training of new and existing staff. Detailed data as to how this money was spent during the second wave was not available to the Commission.

The Commission is aware, however, that an IPAC specialist is paid an annual salary of approximately $120,000, with benefits. The $20 million earmarked for the hiring of IPAC specialists would only provide $30,000 per home. Experts contrasted this program with the one implemented in Quebec, where IPAC teams were placed in each home before the second wave. As to how the IPAC training amounts were spent by homes, this too was unclear at the time the Commission's investigation concluded. The Commission heard about one home in which, even during a second-wave outbreak, the IPAC lead had not taken even a four-hour video course.

The government also allocated $61.4 million for IPAC minor capital improvements to homes – including such measures as the installation of plastic barriers and other physical distancing barriers – and $40 million in funds to compensate homes impacted by the changes in occupancy numbers due to the restrictions imposed on three- and four-bed rooms. Money was also allocated to allow homes to pay for additional staff, to compensate homes for the government-imposed deferral of resident co-payment increases, and to provide temporary pandemic pay. Again, at the time the Commission's investigation concluded, it was not clear how all of this money was spent by homes.

In its report to Treasury Board seeking the allocation of the $540 million to prepare for the second wave of the pandemic, the Ministry noted that "the proposed investments may be insufficient to cover all costs, depending on the spread, duration, and progression of the outbreak."

As no analysis was made available to the Commission to account for how this money was spent, it is not clear if the funding was adequate or what impact, if any, it had on keeping long-term care residents and staff safe during the second wave.

What is known is that a report on spending during the first wave demonstrated that provincial funding did not cover all the costs of COVID-19. In a report to Treasury Board, the Ministry noted that a total of $110 million was allocated for prevention and containment funding and the sector spent $196 million. It is not clear if a similar shortfall in second-wave funding existed, and if it did, if such a shortfall put residents at risk.

Staffing: No Comprehensive Plan

The third major area that was addressed as part of the province's preparedness efforts for the second wave was staffing. As noted in chapter 1 of this report and earlier in this chapter, existing staffing shortages were exacerbated during the first wave as the single-site directive reduced the number of available workers and fatigue caused staff to leave the long-term care sector. The provincial plan to assist staffing largely consisted of allowing homes to access money to augment staffing supports. At the end of February 2021, the province announced that it was investing more than $115 million to train up to 8,200 new personal support workers. This move came too late to help homes through the second wave.

The lack of a comprehensive hiring plan during Ontario's second wave exasperated advocates such as Doris Grinspun, Chief Executive Officer of the Registered Nurses' Association of Ontario, who told the Commission:

> And the tragedy is that nothing happened in the summer because there was, again, no directive from the government here is the funding, hire people. So nothing happened in the summer. And we are very concerned that we will be again in the same predicament that we were before.

There was also a renewed role for inspectors in the second wave. After not releasing any new funding for inspectors through the first wave, the government moved in November 2020 to hire 27 new inspectors to address COVID-19 issues. The Commission was told that it takes eight to nine months to fully train an inspector. Given this timeframe, those newly hired inspectors would have been of limited use during the second wave.

The Commission heard that the shortage of inspectors resulted in some homes in outbreak not being inspected at all. In fact, data from the Office of the Chief Medical Officer of Health show that 71 per cent of outbreaks that occurred in long-term care homes between August 21, 2020, and September 21, 2020, were repeat outbreaks. Sixty-one per cent of these homes involved multiple cases within a single home, suggesting transmission of the virus within the home. In one case, a home had four

outbreaks with no inspections, with 156 resident cases, 82 staff cases and 14 resident deaths. When asked why no comprehensive inspection of the home was done, the Ministry of Long-Term Care's Manager of Compliance Inspection said it was because, in part, he did not have resources to send inspectors.

Summary

The analysis of what happened in the second wave of the COVID-19 pandemic will continue. To facilitate this important research, the government must provide transparent and detailed data both in aggregate and at the home level as to how the hundreds of millions of dollars of pandemic funding was spent. In this way, researchers will be able to use this data to search for answers that might better protect Ontario's long-term care residents in the future.

Conclusion

The long-standing weaknesses in the long-term care sector figured prominently in the death and devastation COVID-19 inflicted on residents, their loved ones and the staff who care for them. So too did the lack of advance planning for such a crisis. The failure of successive governments to properly plan for a pandemic led to a lack of personal protective equipment, a cumbersome response structure, and slow government reaction time. This was compounded by critical and early failures to adhere to the precautionary principle. Precautions with respect to asymptomatic spread, masking guidance and limiting staff work in multiple homes should all have been taken sooner. The same is true of interventions in homes.

The homes and regions that acted early and proactively to take precautions fared better throughout the pandemic. Their examples demonstrate what could have been done, and what must be done in the future. The Commission heard about many promising practices that assisted in reducing the spread of COVID-19 and improving the lives of residents – some of which will be described in more detail in chapter 4. We must consider adopting these practices; our parents, grandparents and the older residents of our province deserve nothing less.

As it should have done following the SARS outbreak in 2003, the province must now accept that there will be another pandemic; it is not a matter of if but when. Ontario must resolve to be ready, and thereby ensure that its long-term care homes are ready as well.

Voices from the Front Line

“Mom was confined to her room for eight weeks straight because, every week, another resident – another worker would test positive … So, my mom, who’s extremely social, was confined to her room. What do you do 24-hours a day, 7-days a week looking at the walls?”

–Family member of long-term care resident

“Like, you can’t cut off access. The loved ones are desperate to see you. You’re desperate to see them. You need to find a way to – to let us go in and help. Right? We’re happy to get tested. We’re happy to use full PPE. And we’re going to take some of the burden off the PSWs that were there.”

–Family member of long-term care resident

“The management team were nowhere to be found. They’re just staying in their office, not coming out, not helping to feed. Not helping. Not giving any proper directives. It was just so, I mean, chaotic and a mess. …But they chose – in a fight or flight situation, they chose the flight and left the staff with no safety and no security, no PPE. They had to be reported for them to bring proper PPE to give to the staff. People were getting sick. It was so sad.”

–Long-term care staff member

“They are tested. They come in negative. Why can’t we hug them? Why can’t we touch them, even hold their hands? We have to keep distance. They – they have no – they have – had the test that prove that they are negative, so why can’t they touch us, even just for five minutes?”

–Long-term care resident

“My dear husband does not understand what COVID is, what this pandemic is. We tried to explain to him, but he doesn’t understand. He can’t grasp the impact it has on us, on our family. His family is no longer visiting him, neither his wife, so he is experiencing isolation, fear. He feels sorrow. He has to live in his room. He is amputated of both legs, so most time he is in his bed alone in his room.”

–Family member of long-term care resident

Chapter 4: Best Practices and Promising Ideas

Investigating the cause of so many deaths and infections in long-term care homes required this Commission to shine a spotlight on the failures that contributed to this tragedy. Nevertheless, the Commission also saw examples of strong leadership and practices that helped to prevent or mitigate the spread of COVID-19 in many of the province's long-term care homes. This chapter will highlight these examples. The Commission also heard about promising innovations that, if implemented, could help safeguard the health of older Ontarians and improve their quality of life. These are discussed below.

As touched on in earlier chapters of this report, Ontario is facing a growing demand for care and services for its older population. Seniors are the province's fastest-growing demographic. The projected increase of older Ontarians by 2041, particularly those aged 75 and older, will, according to one report, put "unprecedented pressure on long-term and healthcare services in Ontario." It is urgent that the government address the needs of this population.

Those who bore the brunt of the pandemic deserve a response that recognizes their dignity and worth. It is the duty of the province's elected leaders and those who oversee the delivery of care to Ontario's most vulnerable to make changes that will allow them to live safely, with dignity, and to have their autonomy and wishes supported. The practices and innovations discussed below demonstrate that there is no need to "start from scratch" on this front. Across the province, there are already good practices being carried out by strong leaders, and there are projects in various stages of development that would go a long way toward supporting the safety and dignity of the province's seniors.

The Value of Strong, Accountable Leadership

As noted in earlier chapters of this report, most long-term care residents have some form of cognitive impairment along with a number of other chronic health conditions. They cannot live on their own or even be supported in their homes. They require round-the-clock care that meets both their medical and personal care needs and that can support them in their activities of daily living. Both the fundamental principle of the *Long-Term Care Homes Act, 2007*, and the *Residents' Bill of Rights* incorporated into the *Act* require this care to be delivered with dignity. In particular, the *Bill of Rights* requires that

residents have the right not to be neglected by the licensee or staff, to be properly sheltered, fed, groomed and cared for, and to live in a safe and clean environment.

The pandemic further exposed known weaknesses that rendered homes unable to provide service in accordance with the fundamental principle and the *Residents' Bill of Rights*. The Commission heard from many staff who struggled to support residents but ultimately were overburdened; they were, in the end, outnumbered by residents who required a high level of care to begin with and were now ill and dying. Staff reported feeling guilty and ashamed. Families and loved ones reported feeling constantly stressed and worried about the care their loved one was receiving and frustrated by the lack of clear communication from the homes.

The Commission received data concerning all of Ontario's 626 long-term care homes; it did not, however, hear detailed information about the experiences in each one. It is important to note that the majority of homes did not experience severe outbreaks. Although much of what the Commission has heard during its investigation is related to the causes and consequences of severe outbreaks, the Commission also learned about homes, both in Ontario and elsewhere, that had existing plans or processes in place that enabled them to respond both early and decisively to prevent or minimize the spread of COVID-19. In addition, the Commission learned about managers who were able to support staff and ensure that families were kept informed.

The Commission also heard how the actions of others in the health system – most notably, local public health units and hospitals – supported homes to either prevent or help contain the spread of COVID-19. Some of these partnerships were formed during the pandemic, while others were pre-existing relationships that enabled partners to respond quickly with assistance for struggling long-term care homes.

In the Commission's view, the proof of an effective response does not lie simply in whether or not there was an outbreak; there were factors beyond anyone's control that contributed to the spread of COVID-19 in a home. Some of the examples discussed below involve homes that did, in fact, suffer outbreaks. However, all of the examples involve leaders who were proactive and held themselves accountable for the outcomes in the long-term care homes they work in or support. These leaders include Administrators, Directors of Care and Medical Directors in long-term care homes. Throughout the investigation, the Commission has also seen examples of physicians and staff working in local public health units, and doctors and nurses working in hospitals providing leadership and support to long-term care homes. These leaders:

- had a sense of urgency early in the pandemic;
- acted decisively;
- effectively directed, mobilized and supported their staff;

- developed and implemented creative solutions;
- leveraged relationships both within and outside their own organizations to respond to the crisis;
- demonstrated emotional intelligence and empathy in their interactions with residents, staff and families; and
- held themselves accountable for managing the pandemic in the long-term care homes they worked in or for supporting the long-term care homes in their communities.

The following sections will explore the ways in which these leaders were able to make a difference in some of the province's long-term care homes.

Supporting Staff

In presentations from long-term care staff, the Commission learned the importance of support from the management team. Again and again, the Commission heard that lack of support had a direct impact on staff morale. Staff appreciated managers who helped with care tasks during the pandemic and ensured that staff were kept informed at all times.

There is broad consensus across the long-term care community that staffing is a critical – if not the *most* critical – challenge facing the sector. As has been revealed throughout this report, staffing issues in long-term care homes are long-standing and pervasive.

The Commission cannot overstate how critical it is to improve working conditions in long-term care homes. These homes cannot function without a cadre of well-paid, well-trained and engaged staff who are supported in their work. As noted earlier in this report, increasing the number of full-time staff positions is also critical to improving conditions. Not only will better conditions improve the recruitment and retention of staff, but they may also improve a home's ability to prevent an outbreak of infection. The authors of a recent U.K. study published in *The Lancet* surveyed 5,126 long-term care homes in England. They found a connection between staff working conditions and the odds of an outbreak. Factors that were associated with an increased risk of outbreak included:

- frequent employment of agency nurses;
- lower staffing ratios;
- staff working in multiple locations; and
- failure to cohort staff with either infected or uninfected residents.

Similarly, a study prepared for the Commission by the Canadian Institute for Health Information (CIHI) found a correlation between:

- a higher ratio of nursing staff to residents and a reduced likelihood of an outbreak; and
- a shortage of personal support workers or a reliance on PSWs from agencies and increased severity of outbreaks and higher resident mortality rates.

During the course of its hearings, the Commission heard about practices undertaken in some long-term care homes that improved working conditions and boosted morale during the pandemic. These examples (set out below) demonstrate that leaders can help minimize the impact on staff through creativity and flexibility in the midst of a crisis. They also speak to an issue that came up repeatedly during the Commission's meetings with long-term care staff; namely, a lack of support and appreciation. As one staff member told the Commission:

> COVID has pretty much made working in long-term care impossible. The staff are suffering. There is constant directive changes. No communication from managers. We have more responsibility. We are not getting any holidays or vacation time. Constantly working short. And this all leads to increased stress, zero teamwork, and really – like, our morale is so low ...

Whether a home did poorly or well at preventing or containing an outbreak, staff spoke about how pre-existing staff challenges worsened during the pandemic, principally as a result of the single-site restriction (see chapter 3). The Commission learned of several measures that homes took to address the staff shortages during this time. They included:

- offering part-time staff full-time hours to encourage them to choose that home as their single employer;
- hiring private caregivers already working for residents as nursing aides;
- hiring family members as staff on short-term contracts; and
- topping up staff pay by an additional $2 over and above the pandemic pay offered by the government.

The management in homes that were able to prevent or contain the spread of COVID-19 also appeared to understand the difficult circumstances staff were experiencing. In addition to hiring extra staff and topping up wages, these management teams provided other methods of support. These included:

- Redeploying staff, including the executive team, to support the care staff. One chief executive officer described how redeployed staff, including himself and other members of the executive team, pitched in to help with care:

  > We've been up on the floors, wiping floors down, serving residents, so it's all hands on deck and we managed to get over 20 of our staff ... to work on the floors with residents, to set up iPads to do the virtual connections with their families.

- Communicating regularly with staff over a variety of channels including email, memoranda, meetings and town halls.
- Walking around the home to provide emotional support to staff.
- Where feasible, permitting employees who were at a greater risk from COVID-19 to work from home and offering paid leave if they could not do their job remotely.
- Providing the option of taking a leave of absence without pay if employees feared contracting COVID-19 because of potential implications for their families – as well as providing assistance with applying for the Canada Emergency Response Benefit.
- Covering the accommodation costs for staff living apart from their families because of the need to protect their families and residents from the risk of COVID-19.
- Providing staff who commuted to work on public transit with additional personal protective equipment (PPE).
- Offering staff the opportunity to purchase groceries through the home's food supplier so they were not required to go into a supermarket.
- Introducing an Employee Assistance Plan for staff to help deal with the stress and burnout from working during the pandemic.
- Creating opportunities to show appreciation for the hard work staff was doing, including, for example, the creation of a "Hero Board" to post thank-you letters from residents and families, and supplying special staff meals.

Though these may seem like insignificant gestures, the Commission heard from many staff members that such gestures mattered. At the other end of the spectrum, the Commission heard from one staff member who contracted COVID-19. She became gravely ill. She was upset because she received no support from her employer during her illness.

These examples do not represent a solution to the long-standing staffing crisis in long-term care homes. They are shared here to demonstrate that effective leadership practices in a crisis – including an awareness of staff challenges and a commitment to doing all that is possible to improve working conditions – protect staff from illness and support them emotionally.

Being Prepared

The Commission's investigation revealed examples of the devastating consequences that flowed from a lack of preparation. However, the Commission also heard about instances of advance planning and quick action that may have helped to prevent or mitigate an outbreak.

Having a pre-existing pandemic plan

It is clear from Ontario's experience with Severe Acute Respiratory Syndrome (SARS) and the experience of many long-term care homes in the first and second waves of the COVID-19 pandemic that an effective response requires an effective plan.

The Commission has concluded that many of those responsible for Ontario's long-term care homes failed to apply this lesson from the SARS outbreak in 2003.

Having an up-to-date pandemic plan before an outbreak enables a home to quickly understand what steps management and staff need to take to prevent or control spread. The presence of such a plan avoids the need to build one "on the fly," after an outbreak has already begun. The value of having a current and clearly communicated plan can be seen in the example of Hong Kong's experience with the pandemic, as well as in a few exemplary long-term care homes in Ontario that managed to prevent the spread of COVID-19.

In 2003, Hong Kong experienced a severe outbreak of SARS that devastated the city's nursing homes. The Commission met with Dr. Terry Lum, Head of the Department of Social Work and Social Administration at the University of Hong Kong. Dr. Lum had recently completed a study examining the impact of the long-term care policy implemented after SARS and its contribution to Hong Kong's success in preventing an outbreak of COVID-19 in its nursing homes. Hong Kong had no outbreaks until June, and quickly addressed those it had over the summer. In a presentation to Provincial Geriatrics Leadership Ontario after the release of his paper, Dr. Lum noted that, as of September 23, 2020, 16 nursing homes (2 per cent) had had an outbreak, 105 residents had been infected and 30 had died.

After the SARS outbreak, the Hong Kong government developed and published "Guidelines on the Prevention of Communicable Diseases in Residential Care Homes for the Elderly." Long-term care homes in Hong Kong are expected to follow these guidelines. Homes must also have a government-trained Infection Prevention and Control (IPAC) Officer on staff to coordinate IPAC procedures in the home in accordance with the guidelines. This includes training staff in infection control, disinfecting practices and the use of personal protective equipment. IPAC officers are charged with conducting an annual IPAC drill.

The Commission's investigation found that some homes in Ontario were prepared for COVID-19 – either because they had learned the necessary lessons from SARS or because they began planning as soon as they heard about the new virus, or both. The Commission met with the CEO of a home in Toronto that had a pandemic plan in place; she referred to this as being "required" following SARS. The plan covered IPAC practices such as isolating, cohorting, limiting staff to one floor, and the proper use of

personal protective equipment. Both she and other CEOs the Commission met with monitored the progress of the virus as it emerged from China, understood that it was a threat to residents, and began preparing before the first case was reported in Ontario. In their actions, these leaders demonstrated an adherence to the precautionary principle, the fundamental lesson identified by the Honourable Justice Archie Campbell and the SARS Commission and discussed throughout this report. As Maria Elias, CEO of long-term care home Belmont House, stated:

> We looked at what we did here at Belmont during SARS. I've been here at Belmont for 20 years, a lot of members of my management team have been here for many, many years, and we recall what we went through during SARS, and we thought, here we go again. We better start thinking.

Ensuring robust infection prevention and control

> I feel like if we had more conversations beforehand about infection control practices and had the health and safety meetings to prepare us for the pandemic and in general – before we actually got hit, you know – and talked about it, and then once we were in the midst of it, I think that if we were having weekly health and safety meetings to discuss, like, okay, this is the situation of the home today, this is what we are going to do going forward, I think that would have made a difference.
>
> –Long-term care nurse

Being prepared for the pandemic meant knowing that robust infection prevention and control practices were a key safeguard against the introduction and spread of COVID-19 in a long-term care home. The Commission heard from several sources about the weak IPAC practices in many of the homes that experienced a severe outbreak. In the Commission's first set of interim recommendations, the importance of having IPAC expertise within long-term care homes was highlighted. In homes that did manage to prevent an outbreak, management took some or all of the following measures to ensure that their residents were protected from infection:

- Assessed the home's supply of personal protective equipment regularly, both before and during the pandemic. For example, for the last 10 years, Mariann Home, a not-for-profit home in Richmond Hill, has ordered additional nursing and PPE supplies with their surplus funds at the end of each year. In December 2019, management ordered personal protective equipment, including N95 masks, surgical masks, isolation gowns, wipes and gloves. Mariann Home also ensured they had the correct size masks for their employees. The home has had a N95 mask-fit program in place for the last eight years. Two designated, trained employees conduct the testing.
- Implemented a universal masking policy in advance of the government's policy.
- Adopted a single-employer rule before the government mandated it and offered full-time work to part-time employees until the conclusion of the pandemic.

- Assigned staff to one unit in the home.
- Had a plan to separate sick residents from those who were well.
- Trained staff on the proper use of personal protective equipment and regularly monitored its use by staff.
- Convened regular meetings of the management team and of the home's Occupational Health and Safety Committee to ensure decisions were made quickly and communicated in a timely way.
- Repurposed space in the home to create isolation rooms in the event of an outbreak, or used facilities outside the home to isolate sick residents. For example, in Hong Kong, where conditions in most long-term care homes are crowded, the government took over recreational facilities and used them as isolation facilities for residents who had been in contact with an infected individual.
- Implemented a 14-day isolation rule for staff returning from vacation.
- Frequently checked residents' temperatures.
- Increased cleaning of the home.

In addition to learning about the actions that home leadership took to address IPAC concerns, the Commission also heard about outside health organizations that, upon learning of the developing crisis in long-term care homes, stepped in to provide support and leadership on IPAC and other matters. Examples of this support included:

- Regular communication between a local public health unit and the long-term care homes in the unit. In Peterborough, Dr. Rosana Salvaterra, the local medical officer of health, hosted a weekly teleconference between a local public health unit and the long-term care homes in the area. During these calls, the unit shared information with the homes and reviewed their pandemic and contingency plans. As Dr. Salvaterra noted:

  > So that work began in January, and we anticipated that the sector would be vulnerable given what we were seeing from internationally and the fact that people over the age of 70 were experiencing higher-case fatality rates, greater levels of morbidity. We identified that this sector, both the institutionalised but also the community independent older adults were going to be more vulnerable, and we flagged that for our community.

- The redeployment of public health inspectors from areas such as restaurants to long-term care homes, and the creation of an evidence-based checklist based on IPAC expertise, which every inspector reviewed with the long-term care home.
- The creation by hospitals or a group of health care providers across a region of SWAT or "Strike" teams comprising health care practitioners. These teams would go into long-term care homes and provide a range of assistance including with testing, outbreak management, training, education and clinical support.

Communicating with Families and Loved Ones

Many residents and families told the Commission that they faced difficulties when homes were in lockdown. The residents described loneliness and isolation. The families described anxiety and stress over not being kept informed about what was happening in the home and the status of their loved one. The Commission heard heart-rending stories about families who were not contacted when their loved one was dying and found out about the death only after the fact.

It may indeed have been challenging to communicate regularly with families while managing the COVID-19 crisis. Nevertheless, some homes found ways to keep families informed. As noted in chapter 3, when the Ministry of Long-Term Care ordered the lockdown of long-term care homes, the CEO of one home took it upon himself to call everyone who acted as a power of attorney for a resident to inform them personally about the lockdown. Other efforts at communication included:

- Holding weekly teleconferences with families.
- Hosting a townhall for families.
- Hiring family members to address the staffing shortage. Although this decision was meant to address staffing issues, it yielded an additional benefit: the family staff members became a source of constant communication for other families, through regular phone calls.

Fostering Relationships with Other Health Partners

Over the course of the Commission's investigation, a common theme emerged: many of the long-term care homes that were able to prevent or effectively manage an outbreak cited their ability to access support and services from other health care providers – such as hospitals and local public health units – as critical to their success. Long-term care homes largely operate as islands of care set apart from the broader health care system. The pandemic revealed the problems inherent in that situation. As one CEO noted, COVID-19 has identified the need to place the long-term care sector within the broader health system.

During meetings, the Commissioners learned of pre-existing relationships between long-term care homes and local public health units that facilitated the homes' ability to access IPAC expertise. Some local medical officers of health convened committees to share knowledge about managing the spread of disease.

Some public health units ensured communication and provided support when it was sought by homes. Others took a more proactive stance. For example, Dr. Kieran Moore – Medical Officer of Health for Kingston, Frontenac, Lennox and Addington – told the

Commission that his ongoing collaborations and good partnerships with long-term care homes enabled him to act quickly to assist the homes in his unit. Dr. Moore reported that he had worked with long-term care homes for years on prevention and infection management. Although he worked collaboratively with long-term care homes, he indicated that he was prepared to use his enforcement powers under the *Health Protection and Promotion Act* in order to secure compliance. On December 10, 2020, Dr. Moore issued a Class Order under section 22 of the *Health Protection and Promotion Act* to enforce requirements for owners and operators of home and community care organizations. The goal was to ensure stronger IPAC practices and to institute mandatory surveillance testing of staff working in community and home care settings. Dr. Moore believes that his office and the powers he is able to exercise under the *Act* both enable and require him to take a leadership role:

> I have always considered that to be a key role of Public Health ...You are the lead, and you tell the acute care sector what you want of them and the LTC and retirement homes. Leadership isn't always embraced, but I do think it's foundational to our practice …

The Commission also learned of hospitals that reached out to long-term care homes to provide support both before and during the pandemic. For example, the management team at Kensington Health – a Toronto health care organization that provides several health services, including long-term care and hospice care – credited its ability to respond to the pandemic in part to its pre-existing relationship with Women's College Hospital. Two years ago, the hospital reached out to Kensington Health to offer resources, primarily through virtual care. After the pandemic began, Women's College became a critical source of aid, assisting with PPE, ensuring robust IPAC practices and providing additional staffing.

Ontario Health Teams

At present, Ontario is taking steps to help foster better coordination of services through the creation of Ontario Health Teams (OHTs). OHTs will deliver all care needs for their patients and make direct connections to the type of care that patients need in order to ensure smooth transitions. An OHT could provide a number of services, including:

- primary care;
- hospital care;
- home and community care;
- palliative care;
- residential long-term care; and
- mental health and addictions care.

Amy Olmstead, the acting executive lead of the Ontario Health Teams, noted that the Ontario Health Teams initiative is meant to provide an integrated approach to care:

> We have many providers across multiple care sectors leading to potential gaps, duplication, lack of coordination, and over-reliance on hospitals and an under-reliance on primary care, not enough attention to self-management and preventative healthcare and financial incentives that are not aligned and reinforce that siloed experience of the health system ... what we've seen in other jurisdictions is a move towards integrate[d] and accountable care systems ...

The legislation governing Ontario Health Teams is the *Connecting Care Act, 2019*, which establishes the teams as a new model of health care organization, funding and delivery. Groups of organizations wishing to become an OHT must submit an application for approval. At the time of writing, there were 42 Ontario Health Teams.

The vision for OHTs is that they will enter, eventually, into accountability agreements and receive an integrated funding envelope from Ontario Health, the agency that oversees the initiative. There are, however, preliminary Ontario Health Team governance arrangements and funding to support collaboration efforts. The idea is to allow the OHTs to grow into partnerships that are capable of providing a full continuum of care and of being responsible for the health outcomes of the entire population that they serve. In contrast to local health integration networks, which previously administered and oversaw health care, Ontario Health Teams will be administered by the service providers themselves and overseen by Ontario Health. (Ontario Health Teams and local health integration networks are discussed further in appendix B.)

Ontario Health Teams are in an early stage of development. As the pandemic progressed, some members of Ontario Health Teams provided assistance to long-term care homes that were part of the team even though they were not accountable for long-term care homes during the pandemic.

Examples of Ontario Health Team partners aiding long-term care homes during the pandemic include:

- collaboration between partners to share hospital learnings about infection prevention and control with long-term care homes, which proved essential when responding to COVID-19;
- creating and mobilizing volunteer emergency response teams to support long-term care homes in need of staffing support;
- establishing local COVID-19 tables to bring together and strengthen relationships across sectors, including long-term care;
- collaborating across sectors to develop evacuation plans to support the rapid and safe transfer of patients in the event of a large-scale outbreak in long-term care homes;

- establishing regional warehouses to coordinate the supply of personal protective equipment across sectors, including long-term care;
- providing support to ascertain critical staffing needs and access to necessary supports and associated training for long-term care staff;
- expediting the implementation of virtual care initiatives for long-term care (and other sectors);
- transitioning to virtual and phone appointments for those discharged from the Emergency Department or inpatient units, and referrals from the community (general practitioner) and long-term homes; and
- transitioning hospital Emergency Department visits to virtual visits for patients from long-term care homes who present with certain conditions.

Michael Garron Hospital in Toronto is part of an Ontario Health Team and worked with several long-term care homes in its catchment area. Dr. Jeff Powis, Medical Director of Infection Prevention and Control at Michael Garron, described the impact the hospital's focus on the broader community had in his approach to the pandemic:

> [O]ur vision was to build health and build community. And so we wanted to do the right thing for our community. And that at times led to challenging decisions where we had to weigh what was right for our hospital versus what was right for our community. Often those things aligned, but we needed to ensure what we did was the right thing for the community ... as an infection prevention and control expert, whose major focus before this was on the space inside my four walls, that gave me the power and motivation to actually start thinking about my community as my focus.

The staff at Michael Garron Hospital leveraged the pre-existing relationship between its Nurse-Led Outreach Team and long-term care homes to foster a relationship of trust, collaboration and support with the homes. Through this relationship-building, the hospital was able to identify gaps in personal protective equipment availability and IPAC knowledge and expertise. Their support to the long-term care homes included going into the homes themselves. According to Philip Anthony, the hospital's COVID-19 Outreach Lead: "[y]ou can't do IPAC from 50,000 feet. You can't coordinate it through a Zoom call or by over the phone. You must be present because over and over again, we heard 'Yeah, everything's fine; everything's fine.'"

Through perseverance and patience, the hospital was able to help the homes without a management agreement. Hospital staff reported that the homes they worked with were better prepared for the second wave.

The work carried out by the staff at Michael Garron Hospital in partnership with long-term care homes shows how the goals of the Ontario Health Team model, including the coordination of service providers, and the development of relationships of trust, collaboration and support can make a difference in the time of a crisis.

North York General Hospital, also a member of an Ontario Health Team, pointed to its OHT network as being vital to the help it has provided to long-term care homes throughout the pandemic. The hospital support included the creation of the SWAT team mentioned above.

The experience of the COVID-19 pandemic has shown the value of partnerships and collaboration in providing support to long-term care homes. As a result of the Ontario Health Teams' work during the pandemic, the OHT implementation plan was refined to include amendments to the application process. Applicants are now encouraged to engage public health and congregate care settings (including long-term care homes), support regional responses to COVID-19, and deliver the entire continuum of care for their patient populations.

Summary

Much of what the Commission heard during this investigation focused on the pre-existing challenges in the long-term care sector that enabled a tragedy to unfold in a number of homes. Many of these challenges continue to exist. However, the examples discussed above clearly demonstrate that good practices and leaders who understand their role and accountabilities can be found in this sector. As the system moves forward in addressing challenges, it can learn from these excellent examples. The investigation has also revealed the value of partnerships and collaborations among different health care providers. These collaborations must be fostered, and the government should proceed with a sense of urgency in getting them up and running. Given the experience of long-term care homes during the pandemic, it is vital that these homes be integrated into the broader health system. Being part of an Ontario Health Team should not be optional for long-term care homes.

Emerging Practices and Innovative Ideas

During its investigation, the Commission heard about emerging practices, projects and models that could help to improve the health and quality of life of older Ontarians. The Commission was told about these ideas by a wide range of stakeholders including academics, advocacy groups, and leaders in the long-term care industry, as well as residents, families and staff. It is clear that there are many individuals and groups who are committed to improving the lives of Ontario's seniors. Some of the emerging practices and innovations that were shared with the Commission are included below.

Nurse Practitioners in Long-Term Care Homes

Nurse practitioners (NPs) are advanced practice nurses who have extensive experience and graduate-level education. NPs working in long-term care homes are able to assess, diagnose and treat residents living with chronic conditions; deal with episodic acute challenges; and prescribe drugs as well as other treatments. They also mentor staff and engage with residents and family for care planning and decision-making.

The importance of nurse practitioners to the long-term care sector has been discussed earlier in this report. Currently, they are connected to homes in two different ways. First, some are part of Nurse-Led Outreach Teams. The purpose of these teams is to build capacity in long-term care homes by providing clinical support and education to staff and enhanced standards of assessment for residents. Another goal of these teams is to minimize the transfer of residents to hospital by providing care in the long-term care home.

The Commission learned that Nurse-Led Outreach Teams provided on-the-ground support during the COVID-19 crisis, including education around transmission, how to prevent spread, how to isolate and cohort, and how to properly use personal protective equipment.

Second, several nurse practitioners act as Attending NPs in long-term care homes. The government launched the Attending Nurse Practitioner Program in 2014. At the time, the commitment was to employ 75 NPs in publicly funded long-term care homes. To date, 60 of these positions are filled. Attending NPs provide training and coaching for the nursing staff, direct resident support, family communications, clinical management, and palliative and end-of-life care. They can also provide medical assistance in dying.

The Long-Term Care Staffing Study that the government carried out following the Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System (the Gillese Inquiry), and which was released in summer 2020, spoke approvingly of the use of nurse practitioners in long-term care homes:

> Some long-term care homes have implemented a NP model to support clinical leadership in long-term care homes. A NP augments the clinical leadership present in a home and may provide an effective link with the Medical Director who is typically less physically present in the home, especially when the NP has expertise in geriatric medicine. NPs support education and coaching of the clinical team as well as providing direct care. They can also assist with medication management, reduction in polypharmacy, and have been associated with the reduction in need to transfer residents to hospital, reducing hospital costs and improving the resident experience. We recommend the ministry move forward with phase three of the Attending Nurse Practitioners Program in long-term care homes and consider opportunities for further expansion.

The Commission heard that long-term care homes with nurse practitioners were able to manage the pandemic better than homes that did not employ them. A doctor who treated residents in long-term care during the pandemic spoke of the value of having nurse practitioners provide core care:

> There were a number of facilities that had nurse practitioners on site, and ... they're excellent. They don't have a large number of people that they follow. They focus on them. They do spend a lot of time at the bedside. And they're just as capable of doing the core care ... that these patients require as a physician would be. And it really helps you deliver on this really important point that I'm trying to convey, which is boots on the ground.

A recent study conducted by Dr. Katherine McGilton, a senior scientist at the University Health Network, along with a number of her colleagues, examined the role and responsibilities of nurse practitioners during the pandemic. The study found that NPs improved the care of residents during the pandemic in four ways:

1. Containing the spread of COVID-19 by acting as a conduit between management and staff to communicate and implement the evolving COVID-19 recommendations, and by providing training and coaching on the appropriate use of personal protective equipment.
2. By independently providing – for homes with limited or no on-site access to a Medical Director – clinical care to critically ill residents; by working on advance care planning; and by discussing goals of care and ensuring appropriate end-of-life care. One nurse practitioner interviewed in the study stated: "I was evaluating every single resident. And the doctors stopped coming in, so I was essentially their eyes and ears. As soon as I saw someone starting [to] declin[e], I would call the families, start having the comfort care discussion, asking about what level of care we are doing."
3. By providing support to staff and families.
4. By acting as the link between different health care providers. Nurse practitioners collaborate with long-term care homes and acute care on creating policies, strategies and algorithms to establish links between the long-term care homes, acute care hospitals and Emergency Departments. The study states: "NPs described developing unique solutions with LTCH managers and external partners and many NPs expressed hope in maintaining these relationships post pandemic."

There are significant benefits to having a nurse practitioner in long-term care homes. The Ontario Nurses' Association, the Registered Nurses' Association of Ontario, and the Nurse Practitioners' Association of Ontario all spoke in favour of expanding the Attending Nurse Practitioner Program. Both the Ontario Nurses' Association and the Registered Nurses' Association of Ontario were of the view that the appropriate ratio would be one nurse practitioner for every 120 residents. The Commission adopts this

ratio and urges that the presence of nurse practitioners in long-term care homes be expanded.

Improved Palliative and End-of-Life Care

The Commission heard that the average length of stay for a resident in long-term care is two years, and most remain there until the end of life. Even though it is evident that palliative and end-of-life care should be essential in long-term care homes, the Commission heard that the provision of these aspects of care is, in many homes, inadequate. The pandemic revealed the weaknesses of the palliative and end-of-life care provided in a number of homes. The Commission heard about many residents who died frightened, alone and in pain. A robust palliative and end-of-life care program could have helped avoid this tragic situation.

The Commission heard that it was challenging, pre-pandemic, to provide good-quality palliative and end-of-life care in long-term care homes. Dr. Amit Arya, a palliative care specialist, noted:

> Many of these residents would benefit from a palliative care approach, really, at the beginning, which doesn't mean end-of-life care, but it means integrating sort of a focus on symptom management and having early and frequent goals of care discussions with the resident, along with their substitute decision-maker, which is usually their family or family members.

In its submission to the Commission, Hospice Palliative Care Ontario (HPCO) cited a 2018 report from the Canadian Institute for Health Information. That report, "Access to Palliative Care in Canada," found that among residents who died in long-term care in 2016 and 2017, only 6 per cent were recorded as having received palliative care in the last year of life. The report noted that many of the remaining 94 per cent likely did receive care that was palliative, despite it not being recorded, simply because most long-term care facilities consider end-of-life care to be a vital part of their practice. The report identified some barriers to palliative care delivery, including the lack of multidisciplinary skills, knowledge and assessment, and the lack of tools required to provide specialized palliative care services.

In its presentation to the Commission, the Advocacy Centre for the Elderly provided greater detail regarding the state of palliative care in long-term care homes and its impact during the pandemic:

> Long-term care homes don't do palliative care well. They don't have ... doctors in the homes. They're not nimble enough, they don't have access to the kind of medications. They don't do IVs, generally. ... People were being kept in the home, and were subject to a lot of pain and suffering at the end of their lives which should not have occurred.

The Ontario Palliative Care Network developed the Palliative Care Health Services Delivery Framework to improve access to end-of-life care in the community, including

in long-term care. In its submission, HPCO noted that, notwithstanding the existence of this framework, there was a "disconnect between policies and practice on the ground." This became painfully obvious during the pandemic, as was noted in the report submitted to the provincial government by the Canadian Armed Forces after they were called in to assist homes in crisis. One palliative care doctor described it as a "humanitarian disaster." Nurses, physicians and long-term care Administrators echoed these sentiments in HPCO-hosted forums.

HPCO further noted that "while improved access to palliative care may not have had an impact on the death rate from COVID-19, dying without appropriate pain and symptom management deprived them of comfort and quality of life in their final days."

Kensington Health provides both long-term care and hospice services. Representatives talked with the Commission about the value of the support they receive from their hospice team to provide good palliative and end-of-life care to the residents in their long-term care home:

> We're fortunate because we have palliative care physicians next door at our hospice. Our doctors can phone a physician and say, "I'm having issues with a complex person in end of life. Can you help." They may come over, have a look at the person, recommend some different types of medications and make it [a] much more comfortable end of life for those folks that are dying.

In addition to receiving support from its hospice, Kensington Health works closely with the palliative care doctors at Princess Margaret Hospital.

The Commission also heard that greater integration with community-based palliative care teams, and a designated on-site palliative care lead, would improve palliative and end-of-life care in long-term care homes. For example, the Ottawa and Champlain Regional Palliative Care Team, which comprises 13 nurse practitioners and advanced practice nurses, supports palliative and end-of-life care in the community and in long-term care homes. One doctor described this team's work as making a "night-and-day difference" in providing palliative and end-of-life care.

As noted, many long-term care residents are very ill and spend the remainder of their lives in their long-term care home. For these reasons, it is imperative that homes develop the capacity and expertise to deliver excellent palliative and end-of-life care.

Person-Centred Models of Care

> It is possible to operate a home that meets the medical needs of vulnerable adults while also enabling them to flourish and reach their potential no matter what stage in life.
>
> –Moira Welsh, journalist and author

The Commission heard from several groups that have been advocating for models of care associated with the "culture change" movement. This movement promotes person-

centred or resident-focused care. Models of care associated with the culture change movement are guided by a number of principles. For example:

- Care is directed by the needs of the resident to the greatest degree possible.
- Units are small (10 to 15 residents) and feel like a home rather than an institution.
- Meals are prepared in the units, and residents have access to the kitchen and assist with meal preparation.
- Routines in the home are organized to foster close relationships between staff, residents and family. This requires having dedicated staff within each unit.
- Staff are empowered so that they can respond appropriately to residents' needs.
- The organizational structure is flat, with participatory management systems encouraged.
- Processes are put in place to enable continuous assessment and quality improvement.

In 2019, the City of Toronto asked Dr. Pat Armstrong to analyze the models associated with the culture change movement. Dr. Armstrong is a professor at York University and the principal investigator of the Reimagining Long-Term Residential Care project, which launched in 2011 and has produced numerous publications relating to long-term care in Canada and other countries. Dr. Armstrong and her team looked at such culture change models as the Butterfly Home, Green House, Wellspring, and Eden Alternative.

Though the team identified methodological challenges in assessing these models of care, they noted that, overall, the research provides support for the ability of culture change models to influence the quality of life and care. This finding was based on the use of measures such as staff turnover and work absences, and on improvement in standard care indicators such as the presence of pressure ulcers. Dr. Armstrong and her team concluded that the evidence supports a "strategy to learn from all the models, adapting promising practices to specific homes and their populations."

Moira Welsh, an investigative journalist with *The Toronto Star*, was invited to meet with the Commissioners. Ms. Welsh has reported extensively on long-term care in the province and is the author of *Happily Ever Older: Revolutionary Approaches to Long-Term Care*. Regarding models that focus on person-centred care, Ms. Welsh observed:

> These ideas have a shared DNA, mostly focused on kindness, which is unique – what is unique and very interesting is the way that each home does it differently and what is telling is the need to stay on it with focus. The leaders I met are constantly working to uphold their philosophies so the home doesn't slip back into old ways.

The Commission heard considerable detail about the development of Butterfly Homes in Ontario from Jill Knowlton, Chief Operating Officer of Primacare Living Solutions (a private, for-profit long-term care home provider), and Mary Connell, a registered nurse

and dementia advisor for the Region of Peel. Both Peel Region and Primacare Living Solutions have transitioned traditional long-term care homes into Butterfly Homes.

This transformation involves both a change to the layout of the home and a change-management exercise to help staff and management transition to resident-focused care.

The Butterfly Model, developed by Dr. David Sheard, is premised on the belief that "for people experiencing dementia, feelings matter most, that emotional intelligence is the core competency" and that "people living with a dementia can thrive well in a nurturing environment where those living and working together know how to 'be' person centered together."

Impact of person-centred care models on residents

Ms. Knowlton and Ms. Connell told the Commission that they have observed many benefits to residents who reside in their Butterfly Homes. These include:

- reduction in pain;
- reduction in the use of antipsychotic medication use by greater than 50 per cent;
- dramatic reduction in responsive behaviours (they reported no responsive behaviours);
- increased social engagement;
- no weight loss and no use of nutritional supplements; and
- increased family satisfaction.

Ms. Knowlton and Ms. Connell's observations are consistent with a study of two Butterfly Homes in Alberta and research into the Green House, another person-centred care model. The research into both of these models reveal residents had an improved quality of life. The research also found improved satisfaction from the residents' families.

With respect to infection prevention and control, Ms. Knowlton noted:

> Residents are dedicated as part of the family to their households, and staff are part of that family ... [E]ven within the home, they are not moved ... And so we don't just look at staff as a pair of hands to shift over here when we're short or move over here. You are part of that family, and you stay in that family. And under IPAC, what's a term that we know? We know the term "cohort." What is a cohort? Cohort is your family, is your household ... So staff is dedicated to the household or the cohort. The ability to close off households ... you can compartmentalize ... You've got a small group of staff and residents. That's not being spread and moved throughout the home.

Ms. Knowlton and Ms. Connell advised that, at the time of their presentation, there were only two cases of COVID-19 in their homes and no deaths. This is in line with recent research showing a lower incidence of and mortality from COVID-19 in Green House and other small nursing home models.

Impact of person-centred care models on staff

Models that encompass the tenets of the culture change movement contain within them several features that are meant to support greater employee engagement, including:

- fostering close relationships between staff, residents and families (this requires reducing staff turnover and assigning staff to one group of residents);
- empowering staff so they can respond appropriately to residents' needs; and
- embracing collaborative decision-making, which requires less hierarchy, participatory management and giving staff such as personal support workers some decision-making authority.

The Commission was told that staff in the Butterfly Homes operated by Primacare and Peel Region are able to provide better care to residents because they use a universal-care-provider approach. Ms. Knowlton described this as an approach in which "dietary aides, housekeepers, recreation, physio aides, PSWs, nurses are all considered part of the home action team and all have equal weight on that team ... So we actually exceed a 1 [staff] to 5 [residents] ratio."

Ms. Knowlton and Ms. Connell spoke about how this shift in approach encourages staff to view themselves as part of a household and a family. This model has led to decreased absenteeism, staff injury and turnover in the Butterfly Homes they have developed.

Cost and implementation challenges of the Butterfly Model

Ms. Knowlton advised that she is able to run a Butterfly Home at no additional cost. Her assertion is consistent with a study, carried out in 2011, that concluded that while the capital cost of developing a smaller and resident-focused Green House is higher than traditionally designed nursing homes, the cost of operating this type of home is nonetheless similar.

Ms. Knowlton and Ms. Connell advised that implementing the Butterfly Model involved a robust change in management strategy that required "buy-in" from everyone involved – especially from leadership. As Ms. Welsh noted in her presentation, the retirement and long-term care homes and communities she visited when writing her book exist because they "had motivated leaders, and without that personal motivation, change is unlikely to succeed." These observations are in line with the conclusions of a 2013 U.S. study examining the characteristics of homes that implement a culture change model. The study noted that the implementation requires significant investment, vision and stable and competent leadership.

Infrastructure Design That Improves Infection Control and Quality of Life

> With community-spread viruses, where you get into most trouble with transmission are congregate living settings, okay? Places where you crowd people together, where they have a lot of contact with each other … in crowded living settings, you not only get more transmission, but you get the potential for amplification that you don't see in other settings where people go home, are separated.
>
> –Dr. Allison McGeer, infectious disease consultant, Sinai Health System

The infrastructure and layout of a long-term care home is an important factor in preventing the spread of infection. The Commission met with Dr. Nathan Stall, a geriatrician at Mount Sinai Hospital in Toronto. One of the issues he addressed was the relationship between a home's infrastructure and the spread of COVID-19.

In a study completed in August 2020, Dr. Stall and his colleagues found that highly crowded homes had a significantly increased risk of COVID-19 incidents and mortality.

As detailed elsewhere in this report, the Commission heard that older design standards, which allowed for ward-style rooms with three or four beds and shared bathrooms, were associated with an increased spread of COVID-19 within homes in outbreak and, as a result, more COVID-related resident deaths.

While the approach taken by Hong Kong, described above, proves that it was possible to contain the spread of COVID-19 even in crowded homes, other innovative design ideas may achieve the same result and improve quality of life.

The Commission met with Dr. Diana Anderson – a geriatric specialist and architect – and Ansar Ahmed, an engineer. Dr. Anderson is currently a fellow in geriatric neurology at the VA Boston Health Care System. Both Dr. Anderson and Mr. Ahmed are principals at Jacobs, a technical professional services firm. Dr. Anderson and Mr. Ahmed spoke about the importance of design and the built environment as an element of care. They pointed to research showing that planning and architecture are key determinants of health. They advocate for "empathic" design, which focuses the design processes from the perspective of the end-user.

Jacobs recently convened a roundtable with academics, service providers, health system leaders, clinicians and designers to consider responses to a number of challenging issues related to delivering care in long-term care homes. The resulting submission to the government states:

> The built environment is an instrumental therapeutic component of the healthcare experience; while architecture appears passive, in reality it has a strong active dimension as it can inhibit or promote certain behaviours which strongly influence the overall healthcare experience.

> While infectious outbreaks are known to occur in these settings with medically complex residents and frequent staff throughout, transforming LTC homes into more clinical and institutional environments is likely a reactive approach to the current pandemic and we urge caution in this area. Alternatively, a proactive framework is recommended whereby the focus is to make these environments more resilient overall, ensuring they do not lose the limited characteristics of home, while also strengthening their ability to manage emergency preparedness.

Dr. Anderson noted that the "built environment" can handle infection control through the segregation and decentralization of space, by controlling the flow of people through the space, and by making sure that staff can be segregated: "Staff flow is different from patient flow is different from caregiver flow. Those are all design problems that we can sort out."

Other elements of design – such as windows, acoustics, lighting and where a room is located on the floor – can also improve health outcomes, as can germ-killing surface materials (e.g., copper alloy).

In a recent article, Dr. Anderson and a number of her colleagues pointed to evidence that homes employing a person-centred care model – with self-contained units, a smaller number of residents, single rooms and dedicated staff – may improve infection control and quality of life for residents and staff. They tied the risk of COVID-19 spread to the number of staff and visitors accessing a single building, staff movement between multiple residents' rooms, and singular high-traffic communal areas such as dining rooms or living spaces. A recent study specifically examined the performance of smaller nursing homes such as the Green House and Butterfly models during COVID-19. The study found that these models had fewer COVID-19 cases and deaths.

Effective long-term care design does not look at the building in isolation. Rather, the environment around the building is equally important and includes the following design considerations:

- Access to transitional space, such as porches, alcoves and seating, which allows a view of the streetscape. As Dr. Anderson noted in her presentation: "So this idea of companionship [is] facilitated by this material context, the places and porches. The concept of the porch is something that I think we've lost over the years. Allowing the elderly to touch the world beyond. I think that's a powerful concept."
- Space to exercise, access to nature, and exposure to sun and fresh air. These are important both to infection control and quality of life: "The outdoors can boost beneficial vitamin D for residents and provide an environment that is inhospitable to pathogens through reduced moisture, UV light and the diluting effects of fresh air and air movement."
- Proximity of the home to a person's home community.
- The integration of the home with health and social care, and emergency services.

- Design that promotes walkability and activity to promote safe exercise and socialization.

Schlegel Villages is a family-owned mission-driven for-profit company that builds and operates long-term care and retirement homes. Its model is an example of integrating long-term care homes with outdoor space and the broader community, including access to medical and community services.

James Schlegel, Chief Executive Officer of Schlegel Villages, met with the Commission. He described the village main street and town square design that is part of their model as the "social spine" of the village. The design also incorporates outdoor patios and landscaping to encourage people to spend time outdoors. The square is the central gathering place, and it helps to connect the residents of the village and the people in the surrounding community:

> So it's very much a social model designed to … encourage socialization, social connectedness of our residents. We find that ... the biggest deficit that our residents have when they come to us is disengagement with life. ... So this design is really intended to reconnect, reengage our residents in life and create opportunities for them to meet new friends, to learn new things, to contribute, to pursue their passions, all those things that make life worth living for. We happen to also provide a lot of care which supports people ... in pursuing that objective, so very much a social model.
>
> ... it's also very much a hub model. ... So we incorporate things like our health centres right on to our main street ... satellite family health teams whose physicians provide a medical service to our residents, but they also have typically all ages practices. So young mom and her kids can come to the doctor's office. They happen to come to the local retirement home, and they happen to wait on main street to see the doctor, and they might bump into a resident and strike up a conversation. But it's ... a way of not only providing medical services that are more effective, we think, for our residents, but also brings the community into our village and connects our residents with the outside community.

The Commission heard from many sources that it would be a mistake for the government to respond to the demand for long-term care by building more of the same types of homes that currently dominate the sector. In his recent book, *Neglected No More: The Urgent Need to Improve the Lives of Canada's Elders in the Wake of a Pandemic*, André Picard echoed what the Commission heard from many sources:

> What needs to replace many of our large decrepit institutions are smaller, more home-like facilities that are built to the needs of residents. ... Dragging the infrastructure and architecture into the twenty-first century won't happen quickly, and it won't be cheap, but it is essential. In the interim, we can reorganize to make existing facilities more user-friendly; with some effort, we can still provide pretty good care in big old buildings. ... As we upgrade and replace long-term care homes, the following elements must all become standard: private or semi-private rooms and bathrooms, homey communal spaces, ready access to the outdoors, air conditioning, non-slip floors, laundry and cleaning services, and in-house food. As well, nursing homes should be an integral part of the community, not hidden away.

The innovations in person-centred care and infrastructure design described above are examples of emerging ideas that can improve the health and safety of residents and their quality of life. As the province moves to address the demand for beds in long-term care homes, it should create incentives so that those who develop and build these homes incorporate innovative care and design models that will improve infection control and quality of life.

Summary

In the final report of the Gillese Inquiry, the Honourable Justice Eileen E. Gillese observed a commitment to innovation in the long-term care sector:

> ... many stakeholders in the LTC system have been actively pursuing innovations and new technologies to support excellence in the delivery of resident care. This is important because innovation and technology have the potential to save time and costs, reduce human error, lead to improved resident outcomes, and provide oversight.

The information the Commission has heard from a wide variety of stakeholders confirms Justice Gillese's view that there are emerging practices and innovations that can address the problems plaguing long-term care. The pandemic has made it abundantly clear that those in charge of long-term care homes in this province can wait no longer to make these improvements. It is time for the government to leverage the creativity and innovation that already exists in the sector to ensure that residents in long-term care homes can live safely and with dignity.

Expanding Home Care Options

> The high concentration of fatalities coupled with isolation among residents has led some to call for [reimagining] elder-care homes, while others have argued for abolishing these facilities and instead investing in community-based alternatives. These two opposing viewpoints represent a false dichotomy in the care of older adults. Improving long-term care in a post-pandemic world will require increased investment in community-based care while also changing the nature and scale of elder-care homes.
>
> –David C. Grabowski, "The Future of Long-Term Care Requires Investment in Both Facility- and Home-Based Services"

Many older Ontarians and their families require a level of care that can only be delivered in a long-term care home. However, the Commission has also learned that a significant number of individuals who currently live in long-term care homes or are in an Alternative Level of Care (ALC) bed in a hospital, awaiting placement in a long-term care home, could be cared for at home with the right supports.

During its investigation, the Commission heard that older Ontarians living in their own homes were safer during the pandemic; significantly fewer of them were exposed to or

died from COVID-19. However, home care is a limited option for those who do not have the means to pay for it privately.

The provision of home care is governed by the *Home Care and Community Services Act, 1994*, as well as by contracts that local health integration networks have entered into with service providers such as Bayshore Healthcare, Saint Elizabeth (SE) Health and Victorian Order of Nurses (VON) Canada. (As of the time of writing, the government was transitioning the responsibilities held by the local health integration networks to Ontario Health. This transition is discussed in greater detail in appendix B.) People receiving care at home may have significant and complex health needs. However, the capacity to deliver these services is limited as a result of the limited government spending on home care. It is worth noting that Canada has one of the lowest levels of spending on home care among countries belonging to the Organisation for Economic Co-operation and Development. Canada spends $6 on long-term care homes for every $1 spent on home care. By contrast, countries that are known for high life satisfaction among seniors spend more on home than institutional care.

What follows here is a discussion of existing home care practices in Ontario and options for expanding them. The Commission is not suggesting that home care is a panacea to the problems plaguing the long-term care sector. The majority of residents in long-term care homes need to be there, and it is imperative that the province improves the care they receive. There is, however, a place for properly resourced and supported care, in the spectrum of supports and services, for those residents who could live at home but cannot due to the inadequacies of the current home care system.

There are several factors that support a greater investment in home care.

Aging at Home Is Desirable, Feasible and Safer for Many

The vast majority of Canadians want to age at home. In a report entitled “Ageing Well,” the COVID-19 Health Policy Working Group at the School of Policy Studies, Queen’s University, pointed to a survey that outlined the biggest reasons that older Ontarians want to age in place. They included convenience of location, emotional attachment, and feelings of safety and independence.

In addition, according to a recent analysis by the Canadian Institute for Health Information of data from 2018–19, about one in nine newly admitted residents in long-term care homes potentially could have been cared for at home. These people may end up in long-term care simply because they cannot afford adequate home care.

The Commission also heard that people were at greater risk of infection if they lived in a congregate setting. Accordingly, people were safer in their homes during the pandemic. In its submission to the Commission, the Home Care 2020 group comprised of

Bayshore Healthcare, Saint Elizabeth Health and VON Canada cited data from Ontario Public Health indicating that the infection rates of home care workers were very low (0.01–0.2 per cent) compared to the infection rate of staff in long-term care homes (30 per cent).

Home and Community Services Are Flexible and Adaptable

The authors of the "Ageing Well" report noted that seniors require four primary types of support. The current home-care model prioritizes care to address physical and mental limitations, while the other three supports – for housing, lifestyle and social needs – are not adequately addressed.

During its investigation, the Commission learned about several existing and proposed models for the care of the elderly in their homes and their communities that provide all four types of primary support.

For example, the Commission heard about Naturally Occurring Retirement Communities, or NORCs. A NORC is a housing development that is not specifically planned for older people but, over time, becomes inhabited primarily by older people. NORCs located in supportive neighbourhoods, and with access to integrated services, have been successful in allowing older people to age in place for a longer time. One of the NORCs featured in the "Ageing Well" report is the Oasis Community in Kingston. A group of older adults living in one building in the city established Oasis after successfully lobbying the regional government to provide annual funds for a number of supportive services to the building's residents. It is described in the report as follows:

> Oasis serves about 60 seniors who live independently, with some supports in place such as catered and communal meals three times a week, exercise programs, social events, on-site support workers, movies and art classes, skill sharing, and projects to support the broader community. An on-site coordinator supports Oasis programs and helps members navigate community supports to meet changing needs and abilities. According to a case study report by the University Health Network, residents have testified that "the program has been instrumental in helping manage their own personal chronic illness, as well as providing invaluable support for caregivers managing their loved one with dementia." In fact, the 12 original Oasis residents eligible for an LTC-home refused to enter these homes and stayed in Oasis as a direct result of the program's benefits to their health and lives.

The Commission also met with Mathieu Fleury, an Ottawa city councillor who spoke about two models of support for groups of community-living older Ontarians. Ottawa Community Housing hosts a provincial program called "Aging in Place" in several of its seniors' apartment buildings. The program coordinates a number of supports including homemaking services, transportation, nursing visits, personal care and crisis intervention.

Councillor Fleury also referred to the Carlington Health Hub, a development that received funds from the City of Ottawa to build affordable housing with integrated health and social supports for older adults. According to the architects who designed it, the Carlington Health Hub will provide:

> Affordable rental housing for seniors, [which] includes 42 independent living rental apartment suites on the upper three floors of the new building. Amenity features provided in the building are communal laundry room lounges, brightly-lit wide stairwells to encourage stair use, a roof-top patio with community garden plots, a community room for large gatherings and walking paths around the property with ample trees and benches. This phase of the project is now complete.
>
> The next phase of the project includes the relocation of the CCHC [Carlington Community Health Centre] medical clinic to the ground floor of the addition, with an interior connection to the existing facility. This also includes the renovation of the existing building for other community health care programs.

The Commission also received a submission from the University Health Network OpenLab. The lab brings together clinicians, patients, researchers, designers and policymakers to develop solutions to health and social issues. In its submission, entitled *Vertical Aging: The Future of Aging in Place in Urban Canada*, OpenLab has developed two to three potential innovations that can "unlock the potential of NORCs." These innovations include:

- **Digital Neighbour Network:** a peer-to-peer platform that expands informal supports for seniors.
- **Connected Care Hub:** a hybrid model of on-site and virtual supports to deliver place-based services, augmented by virtual technology and telehealth services.
- **Social Spaces:** retrofitting of high-rise buildings to encourage more social engagement.

There is no shortage of creativity and innovation that the government can draw on in addressing the challenges in the province's long-term care sector. As the province begins the work of fixing its long-term care homes, it should also explore programs and services not only in jurisdictions in Canada but also internationally.

For example, time and again the Commission was directed to Denmark as a leader in care of the elderly. Since the 1970s, Denmark has focused on prioritizing the independence of seniors and does not institutionalize old age. Denmark provides "reablement" programs, which have been described as "teaching people the skills to stay at home or addressing the things that ... may mitigate their progression of frailty or ageing." Reablement services range from physical therapy following surgery to teaching an individual how to cook more nutritious meals. Danish municipalities also carry out free annual home visits for individuals over 75 to assess frailty or risk of frailty to determine who may benefit from a reablement program. Denmark has seen a decline in the use of institutional nursing homes over the last 30 years.

The Canadian Frailty Network – a research network that collaborates with industry, health care, academic, non-governmental organizations and private partners to improve the care of older adults living with frailty – led a contingent that directly observed Denmark's approach to caring for this vulnerable population. In an article describing the contingent's findings, the authors concluded:

> Aging populations are a global phenomenon, and there are many people, care systems and nations working to address the care challenges posed by aging. It makes sense for Canada to learn from others. The visit to Denmark was one attempt to inform care changes in Canada. Correspondingly, there are many local innovations in Canada from which we can learn and that may be scaled to a provincial or national level. Most importantly, for knowledge to improve the lives of older people living with frailty, *it must be implemented into practice*. (emphasis added)

Home Care Is Cost-Effective

The Commission heard that home care is much less expensive than long-term care. The "Ageing Well" report cites research that put the cost of institutional care in 2014 at $60,200, while the cost of formal home care was $18,000.

The care services required to ensure better support at home will no doubt require additional investment, but it may continue to be more cost-effective than placing people who could be cared for at home in a long-term care home instead.

A member of the Ageing Well group compared the Oasis Community described above to a similarly situated apartment building without the services Oasis provides. She found that those who lived in the Oasis-supported building required 50 per cent less home care service and that there was a median delay of admission into a long-term care home of one year.

Improving Home and Community Care

Seniors with financial resources can usually put together the housing and support services required to enable them to age at home. Those with modest means, however, do not have adequate access to these services. A further complication is that limited funding has resulted in a rationing of services and long waitlists to receive them. This unfortunate situation can drive those with limited means to the waitlist for admission to long-term care homes. In addition, the current model of home care does not address the breadth and diversity of the needs of older Ontarians, which further drives admission to long-term care homes.

The Commission has heard that home care providers are calling for a modification in how these services are paid for. Home Care 2020 advocated for a relational funding model that moves "from per-visit funding to fund bundles of services that encompass a range of nursing and personal support services, provided over a period of time."

An example of this type of model has been proposed by SE Health, which is currently working in partnership with other home care leaders, clinicians, point-of-care staff, patients and families to codesign “life-care” packages that would provide access to more than 65 different types of services anchored by home care.

The challenges around home care in Ontario go beyond funding. In a report titled “Ageism is Killing Older Adults,” Seniors for Social Action Ontario describes the lack of home and community-based care in this way:

> Historically government has not responded to older people’s calls to be able to stay home should they develop health problems or disabilities. The province’s home care system continues to be an underfunded shambles of poorly coordinated and unreliable care with a laughably small number of home care hours available to those who need assistance. It has never been an alternative to being placed in an institution.

The Commission believes that there is a role for a robust home care program in supporting seniors and keeping them safe in the community. As discussed above, there are a number of benefits to home care, as well as sound economic reasons for investing in it. Remaining at home is also what many people want. It is important to note, however, that improving access to home care is not a replacement for the work required to improve long-term care homes. Even though one out of nine residents living in long-term care homes could remain in their homes with the right supports, the remaining eight need the level of care provided in a long-term care home. As noted above, long-term care and home care are not mutually exclusive; rather, there needs to be an array of options that provide the right services at the right time, and a better ability for all system actors to work together to ensure seamless transitions.

Conclusion

The conclusion of the report on Denmark discussed above echoes what the Commission heard from many who made presentations or prepared written submissions: it is time to stop studying the problems with long-term care and begin implementing comprehensive change. As André Picard noted in his book:

> Since the advent of medicare, there have been at least 150 inquiries, parliamentary hearings, task forces and commissioned reports on the sad state of long-term care, home care and eldercare, not to mention media exposés, academic work and cris de coeur from families. And yet very few of the recommendations ever get implemented. The result is neglect by institutional indifference ... for which elders have paid a heavy price, before and during the pandemic. ... The most pointed message to take from the carnage wrought by the pandemic is that we need to stop wringing our hands and start implementing reforms in earnest.

The information in this chapter indicates that there exists among stakeholders in the long-term care system the leadership, creativity and capacity to innovate. It is well past

time for the government and other leaders in the system to build on these pillars. It is time to tackle the challenges that exist in delivering care to older Ontarians, and to commit to keeping them safe and improving their quality of life.

Chapter 5: Recommendations

> The best time to change course to address better the wellbeing of seniors was many years ago. The second-best time is right now.
>
> –Ageing Well

This Commission was struck by the province to address the government's "need for an expedited process to review the spread of COVID-19 in Ontario's long-term care homes."

In response to the severe crisis in long-term care, the Commission released two sets of interim recommendations over the course of its investigation. The first set, released on October 23, 2020, focused on the urgent need for additional long-term care home staff, increased direct resident care, and a strengthening of health sector support and collaboration for long-term care homes. The second set, released on December 4, 2020, addressed three further factors to reduce risk and enhance resident quality of care: effective leadership and accountability, the expansion and improvement of performance indicators, and the reintroduction of comprehensive annual inspections and improvement of enforcement. The interim recommendations are included in this report as appendix A.

The Commission's final recommendations build on and supplement the matters identified in its interim recommendations to address significant shortcomings in the long-term care system. As discussed in the first three chapters of this report, these shortcomings have plagued the sector for years. When COVID-19 hit Ontario, they exacerbated the pandemic's terrible impact on the vulnerable long-term care resident population and on those who care for them.

The sector's future must be grounded in respect, dignity, compassion and kindness for the people who live and work in long-term care.

Some of the Commissioners' recommendations have been included in previous chapters of this report, but all final recommendations are set out here in full. These recommendations may require additional funding, legislative or regulatory amendments, and will certainly require consideration of other supporting actions by government actors and long-term care homes. To the extent that more is needed to implement or support these recommendations, the Commission expects those supports to be provided as necessary.

Pandemic Preparedness

To ensure that residents are not exposed to unnecessary risks stemming from the spread of infectious diseases, the recommendations that follow seek to address shortcomings in pandemic preparedness on the part of the province and long-term care homes. Pandemic preparedness is a crucial part of safeguarding against such devastation ever happening again.

Precautionary Principle

In 1997, the report of the Commission of Inquiry on the Blood System in Canada described the precautionary principle as follows:

> Where there is reasonable evidence of an impending threat to public health, it is inappropriate to require proof of causation beyond a reasonable doubt before taking steps to avert the threat.

In 2006, the final report of the Independent Commission to Investigate the Introduction and Spread of Severe Acute Respiratory Syndrome (SARS) summarized this principle by stating that "reasonable action to reduce risk should not await scientific certainty."

1. All pandemic plans in the province of Ontario that affect the long-term care sector's pandemic response must be guided by a proper appreciation and application of the precautionary principle.

2. This Commission repeats the SARS Commission Report's recommendation that the precautionary principle should "be expressly adopted as a guiding principle throughout Ontario's health, public and worker safety systems." The COVID-19 crisis in long-term care homes has proven that the precautionary principle must also be expressly adopted as a guiding principle in Ontario's long-term care home system. This should be done by way of policy statement, by explicit reference in all relevant operational standards, directions, protocols and guidelines, and by way of inclusion (through preamble or otherwise) in relevant long-term care home and public health statutes including the *Long-Term Care Homes Act, 2007*, *(LTCHA)* and the *Health Protection and Promotion Act.* Specifically, Ontario Regulation 79/10 should be amended to require that the precautionary principle guide each long-term care home's infection prevention and control (IPAC) program, outbreak management system and written plan for responding to infectious disease outbreaks.

3. The pandemic response should be consistent with available scientific evidence and public health expert advice including from the Chief Medical Officer of Health and Public Health Ontario. Where long-term care homes, public health officials, health care providers, government officials, or anyone involved in

directing the response of any of those entities departs from the evidence and/or public health expert advice in response to a public health threat, a clear and public explanation should be provided for the departure.

4. The government should amend the *Health Protection and Promotion Act* to clarify that the Chief Medical Officer of Health has the authority to issue any comment, including public comment, without prior authorization.

Pandemic Plans

Ontario was not prepared to protect long-term care residents and staff in the event of an infectious disease pandemic, despite clear warnings from experts, public servants and the Auditor General in the years before COVID-19. Existing plans were out of date and untested, leaving homes more vulnerable to outbreaks than they ought to have been.

Pandemic planning is most effective when it is completed and tested before a public health emergency hits. The following recommendations prepare the province's long-term care sector for the next public health emergency.

Long-term care homes

The long-term care sector must respond to the lessons learned in this pandemic in order to prepare an effective response to future public health threats. These recommendations introduce specific pandemic plan requirements for long-term care homes.

5. The province must amend Ontario Regulation 79/10 to provide specific requirements for long-term care homes' mandatory written infectious disease outbreak plans. These requirements must include that the plan:

    a. State the precautionary principle ("reasonable action to reduce risk should not await scientific certainty") and explicitly require that the principle guide the plan's execution;

    b. Clearly identify who is responsible for coordinating the home's outbreak response;

    c. Require regular, proactive, timely communication with residents and their families and loved ones, substitute decision-makers, essential caregivers, and any person designated by the resident or substitute decision-maker:

i. At the outset of any infectious disease outbreak;

ii. During an outbreak, including proactive updates regarding the status of the home in general and the health status of individual residents;

iii. Whenever new management is introduced; and

iv. In response to requests for information.

d. Make provision for safe, in-person access to residents by essential caregivers;

e. Provide for the facilitation of regular remote visits between residents and their families and loved ones during an outbreak;

f. Include a strategy for predicting and responding to staffing shortages to ensure that the home is not left with a staffing crisis. This strategy should rely on resources available to the home through health care partners or Ontario Health Teams and minimize reliance on agency staff. This strategy should not only take into account the replacement of sick or absent staff members but also the increased care needs of residents during an outbreak. At the home level, redundancy should be built into the duties of key staff members such that if a key staff member is absent from the home during an outbreak due to illness, self-isolation or other factors, that critical role is not lost;

g. Include a system that ensures the home maintains its pandemic stockpile of personal protective equipment (PPE) and other necessary items (discussed below) with sufficient supply to respond during an infectious disease outbreak;

h. Include a plan to group residents to avoid the transmission of infectious disease (“cohorting”) with appropriate staffing for each cohort, and also include a plan for moving some residents to another site or sites (“decanting”) if cohorting measures are deemed unlikely to contain an outbreak. Agreements should be put in place in advance with the home’s health care partners to facilitate the cohorting and decanting plans, and those agreements should be reviewed and tested annually and updated as needed;

i. Require the long-term care home to:

    i. Continually assess and provide timely and complete information to the public health unit regarding the need for cohorting or decanting (where cohorting measures are unlikely to contain an outbreak); and

    ii. Consult and coordinate with the public health unit on appropriate cohorting and decanting measures to implement.

j. In the event that residents are confined to their rooms to minimize the spread of infectious disease, require the Medical Director to continually assess the impact of such confinement on the quality of care and quality of life of the residents and work with relevant health partners to make appropriate adjustments as necessary; and

k. Require annual drilling and testing of the home's plan for responding to infectious disease outbreaks. The long-term care home's health partners, including but not limited to the public health unit and Ontario Health Team, should participate in the annual drills and tests. The results of the drills and tests should be reported to the Ministry of Long-Term Care and the public health unit as part of the compliance and inspection regime discussed below.

6. Long-term care home licensees should be required to post the home's infectious disease outbreak plan and any related plans to the home's website, and make this information publicly available in other formats as requested. The licensees should also post online and make available in other formats contact information for the home's Administrator and, in the case of homes owned by corporations, a contact person at the corporate level.

Provincial government

Long-term care homes cannot effectively plan for infectious disease outbreaks if provincial pandemic plans are not in place. These recommendations focus on the provincial planning required to protect residents and front-line staff.

7. The province must clearly define the respective roles of the Ministry of Health and the Ministry of Long-Term Care in addressing health emergencies, especially emergency planning with respect to long-term care, and update Order in Council 1157/2009 accordingly. The province must also ensure that the safety of long-term care residents is reflected in any provincial emergency plan.

8. The government must ensure that comprehensive pandemic plans anticipating various scenarios are developed, updated, tested, drilled and communicated at all levels (provincial, regional, municipal and in each long-term care home). The plans must include clearly defined and delineated roles and responsibilities and identify a clear and direct chain of command. In particular, the Ministry of Health and the Ministry of Long-Term Care must finalize a comprehensive all-hazards plan for the health care sector, including provisions for the long-term care sector. This plan must be made available to the public. The Chief Medical Officer of Health should be responsible for this plan and should report on it annually to the legislature.

9. Pandemic preparation and response in the province's long-term care sector should be explicitly provided for in provincial, regional and local pandemic plans. Long-term care home licensees, management, front-line staff, residents and their loved ones should be consulted regarding the pandemic plan provisions affecting long-term care. The province must ensure that the pandemic plan provisions regarding long-term care:

    a. Include a strategy to address critical staff shortages in long-term care homes, including identifying where surge capacity or other resources may be required and deploying critical staff to long-term care homes in the event of staff shortages;

    b. Ensure that staff are supported so that they do not – for financial reasons – attend work while sick;

    c. Require timely on-site inspections of long-term care homes focused on ensuring that long-term care homes are properly implementing appropriate, proactive IPAC measures. This plan should prioritize homes at high risk of outbreak based on available information. This plan should include a scheme for supporting and supplementing the IPAC expertise available to the home through the IPAC Practitioner role discussed in more detail in Recommendation #24;

    d. Ensure that any surge in pandemic-related hospitalizations does not result in:

        i. Shifting patients to already overburdened, under-resourced and understaffed long-term care homes; and

        ii. The failure to transfer long-term care residents to hospital for care where necessary.

e. Include arrangements to move long-term care residents to other facilities to avoid the spread of infectious disease if directed by the local medical officer of health or the Chief Medical Officer of Health;

f. Ensure the coordination and prioritization of all information, directives and guidance documents sent to the long-term care sector by all government sources during an emergency. A user-friendly, central repository of all such documents should be maintained in such a way that it is clear what information, directives and guidance documents are the most current so homes can easily identify the most up-to-date information and know what is required of them. When revised directives or guidance documents are issued, these should include a blackline version that highlights the changes.

10. The government's pandemic plans must include strategies to ensure laboratory surge capacity sufficient to respond to a variety of challenges, both in terms of volume of testing and duration of increased laboratory demand. The laboratory surge capacity strategy should prioritize long-term care in accessing effective testing and timely, efficient reporting of testing results. This includes ensuring long-term care homes have the technological capacity to receive electronic medical test results.

11. The pandemic plans must include all provincial laboratory assets whether they are public or private, and all such assets should be advised of the terms of the plans that apply to them. The pandemic plans should ensure that the Ontario laboratory system is connected and coordinated, and that laboratories and long-term care homes are interconnected.

12. The priority assigned for access to vaccinations for residents, staff and essential caregivers must recognize and take into account the vulnerability of long-term care home residents in a pandemic.

13. Where reliable, clinically accepted rapid testing for a virus or other pathogen causing infectious disease outbreaks is available, the government should ensure that every long-term care home in the province is provided on a priority basis with the appropriate tools, equipment and support necessary to facilitate rapid testing of residents, staff, management and visitors.

14. The province's pandemic plans must include a strategy for ensuring that funeral home staff and staff from the coroner's office may safely complete their usual duties for the respectful disposition of deceased long-term care home residents during an infectious disease outbreak using appropriate precautionary

measures, including appropriate infection prevention and control practices. It must not fall to nurses, personal support workers (PSWs) or other staff employed by long-term care homes to perform duties normally performed by funeral service providers or the coroner for deceased residents (including the transfer of deceased residents into body bags).

15. To ensure that the provincial pandemic plans are ready to be activated on short notice, they must be reviewed, assessed and drilled annually. The province should set out a testing strategy that involves a review of the pandemic plans and full simulations that engage all key stakeholders involved in implementing the plan. The drill exercise results should be disseminated to the key stakeholder participants for review to improve the pandemic plans. The plans must also be updated promptly.

16. As part of its pandemic planning, the province should ensure that there is a central procurement process for personal protective equipment and other necessary supplies that provides clarity about purchasing and supply chain legislation, policies and best practices. Whenever possible, this process should place emphasis on maintaining within the province of Ontario a capacity to manufacture PPE. The procurement process should include pre-existing agreements to ensure necessary resources are available at pre-established prices and quantities.

Provincial Pandemic Stockpile

As part of its planning for surge capacity in an emergency, the province must maintain a provincial pandemic stockpile including personal protective equipment and other necessary supplies.

Given the importance of the stockpile to the province's pandemic response in long-term care and the broader health care sector, the person responsible for the province's pandemic plans must also be clearly responsible, in the future, for the stockpile.

17. The Chief Medical Officer of Health must be responsible for the province's pandemic stockpile.

18. This responsibility must include ensuring that the provincial stockpile contains sufficient supply to allow the government to respond appropriately to needs that may arise from long-term care homes in the case of a pandemic.

19. The government should provide the funding required to:

    a. Ensure that the provincial pandemic stockpile has sufficient supply to support a provincial response to current and anticipated needs and public health threats, including known and novel infectious diseases. The stockpile should contain appropriate supplies to support long-term care homes as needed during any infectious disease outbreak, including a pandemic. Long-term care homes should be given priority access to supplies from the provincial stockpile; and

    b. Actively manage the provincial pandemic stockpile to avoid the expiration of stockpile supplies before they can be used.

20. The Chief Medical Officer of Health must report to the legislature each year as part of the annual report required in the *Health Protection and Promotion Act* on all matters relevant to the stockpile.

21. The province should make any legislative amendments necessary to designate the Chief Medical Officer of Health as responsible for the management of the stockpile in accordance with the recommendations set out above.

Addressing the Aftermath of COVID-19 for Residents and Staff

As discussed repeatedly throughout this report, the COVID-19 pandemic has had a significant and lasting impact on the emotional and psychological well-being of staff and residents in long-term care.

22. Long-term care home licensees should make counselling services available to the residents and staff living and working in long-term care during the pandemic. Long-term care home licensees should bear the cost of this counselling, and no portion of that cost should be passed on to residents or staff.

Infection Prevention and Control

Infection prevention and control is essential to combating an infectious disease. Failures to standardize and prioritize IPAC best practices in long-term care left many homes unprepared to effectively combat COVID-19, with devastating results. As repeatedly discussed in this report, effective IPAC practices require focused attention and resources at all times.

23. All long-term care homes in the province must be held to the same IPAC standards. These standards, which should include requirements for a pandemic stockpile, should be set, published and regularly reviewed and updated by Public Health Ontario.

24. To ensure that long-term care homes have meaningful access to IPAC expertise, Ontario Regulation 79/10 should be amended to:

    a. Require the licensee to appoint one full-time, dedicated registered nurse per 120 beds as the home's IPAC Practitioner(s). This role, which replaces that of the staff IPAC coordinator currently required, should report directly to the Director of Nursing and Personal Care;

    b. Set out specific minimum IPAC education, training and certification requirements that the IPAC Practitioner must keep current. The IPAC Practitioners in long-term care homes should be trained and supported by IPAC specialists from the local hospital or public health unit as appropriate; and

    c. Require the IPAC Practitioner to take on the duties formerly assigned to the staff IPAC coordinator and to oversee, implement and maintain the home's infection prevention and control program and required staff IPAC training in consultation with the local IPAC specialist.

25. The Ministry of Long-Term Care and Ministry of Health should amend the *Institutional/Facility Outbreak Management Protocol, 2018*, to explicitly provide for the involvement of local hospitals to support long-term care homes in their IPAC practices, up to and including a related management agreement if and as necessary, along with any other legislative amendments necessary to facilitate the IPAC program.

26. Ontario Regulation 79/10 should be amended to require the licensee to:

    a. Ensure that the members of the home's interdisciplinary IPAC team, already required under the regulation, reflect the home's staff complement, including representatives from the nursing, personal support worker, environmental cleaning, food service and administrative staff. The home's IPAC Practitioner should be the lead of the interdisciplinary IPAC team;

b. Ensure that the home's infection prevention and control program is consistent with the standards, best practices and key principles established by Public Health Ontario;

c. Ensure that its long-term care home(s) maintain a stockpile of personal protective equipment and other necessary supplies under the supervision of the home's IPAC Practitioner. The stockpile should be readily accessible and replenished regularly to ensure that supplies are used before they expire;

d. Require the IPAC Practitioner to ensure that personal protective equipment is also available to all staff and visitors as appropriate; and

e. Ensure staff receive IPAC training, delivered by the home's IPAC Practitioner(s), at the following minimum intervals:

    i. At the commencement of their employment with the long-term care home;

    ii. Annually;

    iii. Whenever there is a change to IPAC policies or practices; and

    iv. At the outset of and during any infectious disease outbreak in the long-term care home.

Strengthen Health Care System Integration

Many long-term care homes did not have established relationships with the broader health care system, particularly hospitals, prior to the COVID-19 pandemic. While such partnerships could have benefited residents and staff prior to the pandemic, they became crucial when homes in outbreak suddenly and desperately needed skilled assistance from health care professionals. *Ad hoc* partnerships were formed as long-term care homes went into crisis. The success of those partnerships demonstrates the need for strengthening the integration of long-term care into the province's health care system.

27. The government should fast-track the implementation of a coordinated governance structure and enhanced funding model to strengthen and accelerate the development of Ontario Health Teams.

28. The Ministry of Health and Ontario Health must work with the Ministry of Long-Term Care as local/regional Ontario Health Teams are implemented to ensure a coordinated continuum of care that includes all long-term care homes.

Improve Resident-Focused Care and Quality of Life

The people who live in long-term care homes are loved by their families, friends and the people who care for them. Most of these residents suffer from cognitive impairment and/or chronic health conditions and therefore require around the clock clinical care and assistance with activities of daily living. The fundamental principle of the *Long-Term Care Homes Act, 2007,* requires homes to be operated so residents "may live with dignity and in security, safety and comfort and have their physical, psychological, social, spiritual and cultural needs adequately met." This requirement should be obvious to all involved in caring for this vulnerable population. The recommendations that follow are meant to ensure that residents receive the care promised to them in the *LTCHA*.

Residents' Rights

As discussed in chapter 1 of this report, due to the long-standing issues plaguing the sector prior to the pandemic, many long-term care residents were not getting the care they needed and deserved. As discussed in chapter 3, when COVID-19 entered the homes, many residents were subject to isolation and decreasing levels of care in an environment charged with fear and uncertainty. This situation should never be forgotten and never be repeated.

29. The government should amend the fundamental principle in section 1 of the *Long-Term Care Homes Act, 2007*, to explicitly acknowledge that long-term care residents have complex physical and mental health needs, including cognitive impairments, and to promise that licensees will ensure that residents' complex care needs are met.

30. The Ministry of Long-Term Care should amend Ontario Regulation 79/10 to include a presumption against prohibiting all visitors to long-term care homes experiencing an outbreak because of the negative effects of isolation on the quality of life and health of long-term care residents. Any changes to visiting rules during an infectious disease outbreak must seek to place the minimum possible restrictions on visits to long-term care residents.

31. In order to avoid the separation of residents from their families and loved ones in future infectious disease outbreaks, the province should amend Ontario Regulation 79/10 to recognize the role of "essential caregiver" (individuals "designated by the resident and/or their substitute decision-maker ... to provide

direct care to the resident"). Essential caregivers may be family, loved ones or people hired to provide care to the resident. Basic IPAC training, including the appropriate use of personal protective equipment, should be required in order to qualify as an essential caregiver. The training should be mandated for all essential caregivers at least annually and at the onset of any infectious disease outbreak. The amendment should ensure that essential caregivers who have complied with these training requirements are allowed to enter the home.

32. Licensees must ensure that their home maintains an up-to-date contact list for all persons, including essential caregivers, designated by the resident and/or their substitute decision-maker. Management of each home should delegate a member of the management team to coordinate regular communication with families and loved ones about key activities and issues in the home. Long-term care homes licensees, operators and their directors must be held accountable for ensuring that the home communicates proactively and regularly with residents' chosen contacts.

33. In order to enable residents' families and loved ones to monitor and contribute to resident care, long-term care homes must permit video monitoring technology to be set up and used in an appropriate manner at the request of any resident, their "substitute decision-maker[s], if any, and any other persons designated by the resident or substitute decision-maker."

34. Long-term care residents require social and other connections both inside and beyond the long-term care home. In order to ensure this need is consistently met, the province should make the following legislative amendments:

    a. The *Residents' Bill of Rights* should be amended to include the right to the technology required to permit residents to "communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference"; and

    b. Ontario Regulation 79/10 to the *Long-Term Care Homes Act, 2007*, regarding residents' rights, care and services should be amended to require long-term care licensees to provide reliable Wi-Fi and consistent, frequent access to technology, such as computer tablets and smartphones, to facilitate residents' remote visits with those outside of the home.

35. Physicians providing care to long-term care home residents must be required to physically attend when needed and within 24 hours of the request for care.

36. Long-term care home licensees must ensure that residents are provided with appropriate palliative and end-of-life care. To that end:

    a. Long-term care home licensees must ensure that their homes always have ready access to skilled clinicians with the training to provide palliative and end-of-life care in the long-term care home whenever appropriate; and

    b. The Ministry of Long-Term Care must, after consulting with palliative care and other relevant experts, require long-term care homes to implement best practices for end-of-life care.

Diversity and Inclusion

Long-term care home residents reflect the diversity of Ontario's population. The Ministry of Long-Term Care, long-term care home licensees, management and staff must respect and support this diversity in the care and services provided to long-term care residents.

37. The *Residents' Bill of Rights* should be amended to align more closely with the prohibited grounds of discrimination in the *Ontario Human Rights Code*.

38. The *Residents' Bill of Rights* provides that residents have the right to have their lifestyle choices respected. Residents also have the right to reasonable assistance from the licensee to pursue their interests and live to their potential. Consistent with these rights, licensees must recognize and respect residents' social, cultural, religious, spiritual, and other histories and choices. For example, long-term care home licensees should be required to:

    a. Recognize and respect 2S-LGBTQ+ spousal relationships and chosen/non-biological family relationships generally and in any rules or policies regarding visitation and the provision of essential care to 2S-LGBTQ+ residents; and

    b. Ensure that residents are provided with culturally and linguistically specific care, including but not limited to traditional foods; activities and opportunities for socializing in the resident's first language; culturally specific activities; observation of holidays; and religious and spiritual practices and services.

French-Language Services

Francophone residents must receive care and services that are culturally and linguistically appropriate.

39. To protect the rights of Francophone residents in long-term care, the Ministry of Long-Term Care should:

    a. Design and implement a provincial strategy to increase French-language long-term care services and increase the number of French-language beds through the prioritization of designations under the *French Language Services Act,* and cultural designations under section 173 of Ontario Regulation 79/10; and

    b. Adopt a clear definition of "Francophone beds" that excludes long-term care homes that have not demonstrated their capacity to provide services in French.

Address the Human Resources Challenges

As described in chapters 1 and 3 of this report, long-standing human resources problems in long-term care complicated efforts to manage COVID-19 outbreaks in homes. These problems include staff shortages, insufficient skill mix, and lack of training and education opportunities for staff. The following recommendations address the human resources issues that exacerbated the devastating effects of COVID-19 in long-term care homes.

Urgent Need for Skilled Staff

The Commission heard overwhelming evidence that the long-term care sector was plagued with a two-pronged staffing problem prior to the pandemic. There was an overall shortage of staff – particularly direct care staff – and the staffing mix was inadequate to meet residents' increasingly complex health care needs.

These problems quickly escalated to a crisis once COVID-19 entered long-term care homes. As with so many aspects of this pandemic, residents and front-line staff experienced the most severe consequences of this failure to resolve the staffing crisis.

The staffing situation in long-term care is untenable. Immediate steps must be taken to address it.

Accelerate Long-Term Care Staffing Plan implementation

40. The government must fast-track the implementation of Ontario's Long-Term Care Staffing Plan (2021–2025) (the "Staffing Plan") to help address the urgent need for skilled staff in long-term care homes across the province, with amendments as necessary to incorporate the recommendations below.

41. The government must, with the assistance of key stakeholders (including residents, families and loved ones, and front-line staff), immediately identify specific and measurable targets that clearly track the government's Staffing Plan implementation progress. It should also develop a way of measuring the success of the Staffing Plan as it impacts resident care and quality of life, as well as outcomes for staff.

42. To enhance accountability and increase transparency in the implementation of the Staffing Plan, the government should:

    a. Require long-term care licensees to provide regular public reports on the progress of each of their long-term care homes in meeting the Staffing Plan targets discussed in Recommendation #44;

    b. Instruct Ministry of Long-Term Care inspectors to audit these reports as part of the inspection process; and

    c. Provide public reports, including information from the individual home reports, measuring the rate and success of the sector's implementation of the Staffing Plan. The government should post its progress reports on the Ministry of Long-Term Care website in a manner that makes them easy to find and review.

43. The government must implement its Staffing Plan in a manner that does not undermine the delivery of home care services.

Increase number of skilled staff

44. The government should implement the Staffing Plan's increase in "hours of direct hands-on care provided by nurses and personal support workers, to an average of four hours per day per resident" on an urgent basis. In order to meet the target of four hours of direct nursing and personal support worker care, the number of those staff per resident should be increased, and their workload should be changed so they can spend more time providing direct care to each resident. The starting point for the target staffing mix for the four hours of direct

care should be as follows, with adjustment made to reflect the needs of the residents in the home:

a. 20 per cent registered nurses;

b. 25 per cent registered practical nurses; and

c. 55 per cent personal support workers.

45. The government should ensure that its recruitment measures result in a skilled staffing mix that meets the increasing mental health and complex care needs of the long-term care resident population. In particular, recruitment should focus on ensuring appropriate care by registered practical nurses, registered nurses, nurse practitioners and personal support workers. Recruitment should seek to increase the skill level in long-term care homes. Resident Support Aide hours should not be counted in the target average of four hours of direct care per resident.

46. Nurse practitioners are underutilized in long-term care. The role of nurse practitioners in long-term care should be expanded to better utilize their skills, and more nurse practitioners should be hired to meet the needs of the province's long-term care residents. The Ontario Nurses' Association and the Registered Nurses' Association of Ontario recommend, and this Commission accepts, that the proper ratio for nurse practitioners in long-term care facilities be set at a minimum of one full-time nurse practitioner for every 120 residents. The government should increase the number of nurse practitioners working in long-term care and target this nurse practitioner-to-resident ratio while ensuring that any resulting adjustments to the staffing mix described above provide the same or more skilled direct care to residents.

47. Further to the French-Language Services recommendations above, the recruitment efforts of the Ministry of Long-Term Care and long-term care home licensees and management should include targeted efforts to attract and retain Francophone registered practical nurses, registered nurses, nurse practitioners and personal support workers.

48. The target increase for resident access to allied health professionals in the Staffing Plan is insufficient given their importance in improving resident quality of care and quality of life. The government's target average care per day per resident provided by allied health professionals – including dieticians, speech language pathologists and audiologists, physiotherapists, occupational

therapists, recreation therapists, social workers, and others – should be increased from 36 minutes (the target set in the Staffing Plan) to 60 minutes.

Retain and Attract Staff

The working conditions and organizational culture in long-term care homes must be improved in order to better attract, recruit, develop and retain staff.

Improve working conditions and compensation

49. The Ministry of Long-Term Care must insist that licensees make changes in working conditions that lead to less reliance on agency and part-time staffing, and provide funding adequate to support these changes, which must include:

    a. Creating more full-time direct care positions. A target of 70 per cent full-time positions for nursing and personal support worker staff should be set for each long-term care home; and

    b. Reviewing agreements with direct care staff and making adjustments to better align their wages and benefits within the sector and with those provided in public hospitals.

50. Long-term care home licensees must recruit home management that have the leadership skills and capacity to lead and to create a respectful and inclusive workplace. In order to improve staff morale, licensees must create a workplace culture that is compassionate and values-based.

Support enhanced education, training and development

51. The government's implementation of the Staffing Plan should prioritize "[s]upporting continued development and professional growth for long-term care staff" to retain skilled, experienced and dedicated workers. Consistent with the recommendations made by the Honourable Justice Eileen E. Gillese as part of her Public Inquiry on the Safety and Security of Residents in the Long-Term Care Homes System, this training should be completed during regular work hours and staff should be paid for the time spent in training. This training should prioritize:

    a. Geriatric care;

    b. Skills and practices for effectively caring for residents with dementia and related illnesses in the long-term care home setting;

c. Comprehensive and meaningful training on palliative and end-of-life care in long-term care; and

d. IPAC training (discussed in more detail above).

52. The province must amend Ontario Regulation 79/10 to define ongoing training requirements for long-term care health care professionals, including the Medical Director, in key areas responsive to resident needs. These areas include IPAC, geriatric medicine, caring for patients with dementia and other cognitive dysfunction, the appropriate use of antipsychotic medication, palliative and end-of-life care, and leadership development and crisis management. Further to these requirements, and consistent with Justice Gillese's recommendations, Ontario Regulation 79/10 should be amended to eliminate the training exemptions provided in section 222(1) and (3).

Regulate personal support workers

While regulating personal support workers will not solve the staffing problems discussed in this report, it will enable personal support workers to serve long-term care home residents better and more safely.

53. The Ministry of Health and Ministry of Long-Term Care should ensure basic requirements are in place to support the regulation of personal support workers and consider that initial regulation could be provided by an established health care regulator.

54. The government should, with the assistance of relevant stakeholders, establish and implement standardized minimum training and education requirements for personal support workers.

Enhance Oversight of Medical Director

55. The Ministry of Long-Term Care and the Ministry of Health must work with the College of Physicians and Surgeons and the Ontario Medical Association to create a system of formal oversight for long-term care home Medical Directors, similar to the Medical Advisory Committee model for physicians with hospital privileges. This oversight should include a review and assessment of the candidate's expertise in the care needs of the long-term care home resident population (including IPAC, geriatric medicine, caring for patients with dementia and other cognitive dysfunction, the appropriate use of antipsychotic medication, and end-of-life care), and in leadership and crisis management.

Funding

As detailed below, the province's long-term care funding must be increased and reoriented to enable the sector to effectively meet the care demands of residents, those waiting to be placed in care, and the substantial projected increase in demand for long-term care capacity.

Operational Funding: Increased Investment in Care

The current government funding for nursing and personal care is inadequate. The following recommendations therefore assume that the government will increase operational funding to meet resident needs and focus on how to allocate that funding more effectively.

56. The overall funding for nursing and personal care must meet the overall health needs of the residents in the homes. The current approach, which uses the Case Mix Index to divide the fixed pot of funding among homes based on their relative need, is insufficient. The Case Mix Index should be used only as a measure of need to guide the overall funding for nursing and personal care. The level of nursing and personal care funding should increase to reflect this overall need.

57. In addition to the recommendation above, the Commission endorses implementing Justice Gillese's recommendation to "encourage, recognize, and financially reward long-term care homes that have demonstrated improvements in the wellness and quality of life of their residents." Improved resident outcomes should be specific and measurable (such as overall resident, family/loved ones and staff experience; appropriate use of anti-psychotic drugs as compared to other homes; maintaining weight; fewer infections).

58. The Ministry of Long-Term Care should actively promote and provide funding for homes transitioning to recognized alternate, person-centred models of care. Examples of these models are discussed in chapter 4 of this report.

59. It is important to give elderly people choices regarding the care they receive and enable them to age at home, where possible. For that reason, the government should increase funding to home care services, including innovative models of delivering home care, and to community-based supports for seniors.

Long-Term Care Home Development

As noted in chapter 1 of this report, the province will need to create 55,000 more long-term care beds by 2033 just to maintain the current waiting list. The Commission also

heard that Ontario will need to create between 96,000 and 115,000 more beds by 2041 to keep up with the growing demand for long-term care home placements. These numbers do not take into account existing beds that require redevelopment.

Since 2018, the province has updated the Long-Term Care Home Development Program through an Enhanced Funding Model; it has also created the Accelerated Build Pilot Program. While these programs have generated some new developments, they do not address the long waiting list or the forecasted increasing demand for long-term care beds. They also fail to resolve the challenges that not-for-profit providers have in accessing capital, resulting in fewer successful applications from not-for-profit providers to construct new beds.

Now is the time to revisit the business of long-term care.

While the Commission heard repeatedly that COVID-19 has seriously undermined the reputation of for-profit homes in the long-term care sector, the multi-billions of dollars required for tens of thousands of new and redeveloped beds must be addressed, and it is difficult to see how this can be done without private capital funding. That does not, however, mean the status quo has to remain.

As noted in chapter 1, a different approach to the construction and operation of long-term care homes is needed to meet current and future demand. The Commission recognizes that the government, in meeting the current and projected need, must engage in a process that is financially prudent, ensures that residents receive proper care, and encourages innovation to achieve continuous quality improvement.

The government should separate the construction of long-term care facilities from the care provided in those facilities. This model is consistent with the province's Accelerated Build Pilot Program for long-term care. Such a model is already employed in hospitals in Ontario, where the construction and ownership of the facilities is separate from the provision of care.

For example, construction of long-term care homes would continue to be open to the private sector so that the capital required to construct the facilities could still be accessed. The province would pay to use the facility as a long-term care home, thereby providing a return to the investors who put up the capital to build. The province would license not-for-profit operators or for-profit operators who are mission-driven rather than dividend-driven to manage the long-term care home. The province would provide sufficient funds for operations in a manner consistent with the way it currently provides operational funding.

Finally, home design has an impact on resident quality of life and quality of care. In an infectious disease outbreak, these impacts are heightened, particularly in

homes with ward-style accommodations and shared washrooms, which can make it difficult to implement infection prevention and control measures. While rooms with three or four beds are being phased out, further changes are required.

60. As outlined above, and in more detail in chapter 1, the government must urgently implement a model for building and redeveloping long-term care facilities to ensure that quality long-term care capacity is created to meet the province's current and projected demand for beds. This model should separate construction of the home from its operation. Persons skilled at the former may not be appropriate for the latter.

61. The model for building and redeveloping long-term care facilities must also include appropriate incentives to:

    a. Create smaller, self-contained units within existing and new homes;

    b. Build smaller group homes to expand choices as part of a continuum of care for seniors; and

    c. Integrate homes into the broader health and social services community.

62. The province should provide additional support and incentives for applications from organizations that prioritize the availability of culturally and linguistically specific care to meet the needs of ethnically diverse residents.

63. The province must urgently implement a streamlined, expedited approvals process for creating redeveloped and new long-term care beds that accommodates the participation of existing and new not-for-profit and municipal licensees. The province should also insist that municipal governments streamline their municipal approval process for long-term care home development.

64. The Ministry must review and update the *Long-Term Care Home Design Manual, 2015*, as soon as possible to respond to long-standing infrastructure needs. The design standards must facilitate the implementation of infection prevention and control best practices. The updates to the *Design Manual* should include:

    a. Sufficient space to allow for the effective cohorting of residents in the case of an infectious disease outbreak;

b. Design solutions to facilitate the effective provision of palliative care; and

c. Updated heating, ventilation and air-conditioning systems. Improvements to ventilation systems in existing homes should be made on an urgent basis to bring them up to the revised standard and ensure regular maintenance.

65. The licensing requirements under the *Long-Term Care Homes Act, 2007*, should be updated to reflect compliance with the changes to the *Design Manual*.

Increase Accountability and Transparency in Long-Term Care

Quality resident care depends on quality leadership and accountability at all levels. The province's compliance oversight and enforcement must hold licensees accountable for the safe and respectful care required by the *Long-Term Care Homes Act, 2007*. Licensees and home management lead and oversee long-term care home staff, and their decisions directly impact the lives of residents and those who care for them. When leadership at any level falters, those who work in and depend on the system pay the price.

Leadership, accountability and oversight were, to a significant degree, lacking in the system and in many homes before COVID-19 hit. These shortfalls contributed to the fear, uncertainty, and deteriorating levels of resident care and quality of life visited upon residents, their loved ones and front-line staff during the pandemic.

Residents, their families and loved ones, and the public are entitled to understand how long-term care homes are funded, governed and operated, and how well they are performing. Accountability and transparency are required at all levels of the long-term care sector. These recommendations bolster long-term care leadership, accountability and oversight to better protect residents and staff.

66. The Ministry of Long-Term Care must require long-term care home licensees to publicly post:

a. Current information about the individuals with decision-making authority at the owner/licensee level, including their names, contact details and annual compensation, along with relevant organizational charts for the licensee and any company retained to manage the long-term care home;

b. The Long-Term Care Home Service Accountability Agreement between the local health integration network/Ontario Health and the long-term care home licensee, and the Direct Funding Agreements between the Ministry of Long-Term Care and the long-term care home licensee; and

c. The most recent audited Long-Term Care Home Annual Report.

Public Performance Indicators and Standards

67. The six clinical indicators tracked in the Health Quality Ontario long-term care home performance reports are a good first step in advancing transparency and flagging issues in homes. However, long-term care homes should monitor and report publicly on additional indicators to provide important information to residents, families and the general public. These additional indicators – the nature and collection of which should be standardized across the long-term care sector – should include family and staff experience, Medical Director engagement, staffing indicators such as direct care staffing mix, and direct care staff-to-resident ratios.

68. Long-term care home licensees should be required to provide public reports on these key performance indicators at least annually. These reports, which should be posted to long-term care homes' websites, should be accessible and easy to understand for members of the public. In addition to providing current information, this public reporting should track the performance of individual homes over time as measured by the key performance indicators. These reports should be reviewed and audited as part of the comprehensive inspection regime discussed below.

69. Long-term care homes currently supply data about residents to the Canadian Institute for Health Information (CIHI) using the Continuing Care Reporting System. The system provides a hindsight view of aspects of resident life and care. CIHI has implemented a new assessment standard (interRAI-LTCF) and reporting system (the Integrated interRAI Reporting System, or IRRS) in other jurisdictions that permits near-real-time collection of resident data, significantly improving timely data access in crisis situations. The government should consult with CIHI and long-term care stakeholders and then create a transition plan to introduce the new assessment and reporting system in Ontario. The transition plan should be completed within six months of the first consultation with CIHI and should include a plan for timely implementation, including public progress reports posted to the Ministry of Long-Term Care website.

70. The Ministry of Health should work with the Ministry of Long-Term Care to collect and analyze data on the long-term care workforce to determine current staffing profiles, achievement of staffing targets, and support HR planning and strategies at the provincial and home level.

71. An independent accreditation process is needed. This accreditation process must not depend for its funding on the organizations it is accrediting. This process must be provided for all homes.

72. The Ontario government should participate in current and future efforts to implement standards and best practices for long-term care across the country.

Comprehensive and Transparent Compliance and Enforcement

The long-term care inspection and enforcement regime did not adequately address long-standing compliance issues before or during the pandemic. The province must insist that the Ministry of Long-Term Care, the Ministry of Labour, Training and Skills Development, and the public health units coordinate their work to facilitate comprehensive and effective inspections. While inspections should provide opportunity for improvement, serious and repeated breaches must be met with serious consequences. The well-being and safety of the residents requires no less.

Compliance

73. To support long-term care homes in their compliance and quality improvement efforts, the Ministry of Long-Term Care should establish a dedicated ministry compliance support unit as recommended by Justice Gillese in the Long-Term Care Homes public inquiry. The compliance unit should encourage and assist with compliance training tools, compliance coaching, sharing best practices, and tracking and reporting on improvements.

74. The Ministry should recognize that the concerns of the insurance industry are important. If insurance companies were to withdraw from the sector, it would have a significant negative impact on the construction and operation of long-term care homes. The government has a role to play to ensure that homes are able to obtain necessary insurance and should consult with long-term care licensees and the insurance industry to determine what additional solutions are needed.

Inspections

75. The Ministry of Long-Term Care should develop a coordinated, comprehensive long-term care home inspection regime involving the Ministry of Labour,

Training and Skills Development and the public health units. The inspection regime must ensure that residents enjoy the quality of life and receive the quality of care promised in the fundamental principle in the *Long-Term Care Homes Act, 2007*, and that a safe and healthy workplace is created for staff. The inspection regime must gather information from residents, their families and loved ones, and front-line staff. The Ministries and the public health units must promptly share the resulting data, findings and compliance enforcement steps with each other to ensure that the government's regulation of long-term care homes is consistent, coordinated and complete.

76. The inspections conducted pursuant to the long-term care homes inspection regime should be unannounced. The long-term care homes inspection regime must include:

    a. Annual comprehensive Resident Quality Inspections (RQIs) conducted by the Ministry of Long-Term Care. The continuous quality improvement report results should be reviewed and audited as part of the RQIs;

    b. Annual inspection of the IPAC program, including compliance with the requirements of the *Long-Term Care Homes Act, 2007*, and Ontario Regulation 79/10; the adequacy of the home's IPAC program and related training; and assessment of the sufficiency of the home's IPAC supplies and stockpiles, to be conducted by the public health unit. This inspection should include consultation with the relevant IPAC partners. To facilitate these inspections, the government should amend the Ontario Public Health Standards and related protocols and guidelines. This includes amending the *IPAC Protocol 2019* to identify long-term care homes as a third category of settings subject to inspection by the public health unit at least once every 12 months for adherence to IPAC practices, with consequential amendments to the other IPAC protocols;

    c. The board of directors of the licensee, under the signature of the chair of the board (or the applicable equivalent), should publicly certify annually to the Ministry of Long-Term Care that the licensee has completed appropriate audits of the home's IPAC program and pandemic plan, including the sufficiency of the home's pandemic stockpile and testing of the plan; and

    d. Targeted inspections responsive to complaints, critical incidents and trends identified in the data generated from the inspection regime

should continue to be conducted by the relevant Ministry or public health unit, with the assistance of other authorities where appropriate. The Ministry of Long-Term Care should consult with long-term care home staff, residents, and their families and loved ones about how to provide meaningful whistleblower protection to ensure timely reporting of concerns about the operation of long-term care homes and treatment of their residents.

77. The government must provide the funding necessary to implement the comprehensive inspection regime. This funding must include ensuring that there are enough inspectors to conduct the required inspections, and that those inspectors are provided with the education and training required to conduct the inspections effectively.

Enforcement

The province's long-term care home compliance enforcement efforts must improve to protect residents' safety and well-being.

78. The results of the inspections conducted by the Ministry of Long-Term Care, the Ministry of Labour, Training and Skills Development, and public health units should form the basis for a clear and consistently applied enforcement regime. The enforcement regime should include:

    a. Proportionate and escalating consequences for non-compliance. Repeated findings of non-compliance must be met with consequences of increasing severity up to and including measures such as mandatory management orders and the transfer of the long-term care home owner's operating licence; and

    b. A centralized public reporting system that provides meaningful current information about each home's compliance and enforcement status, including:

        i. The dates of the most recent inspections and information about the cause and outcome of the inspections, including the findings made and how they were resolved or remedied;

        ii. Current enforcement orders and unresolved inspection findings, including the status of any enforcement or remediation action and any enforcement or remediation deadlines; and

iii. Relevant historical data (e.g., historical inspection findings and enforcement orders with information about how those findings were resolved or remedied).

Health Protection and Promotion Act Investigations

This investigation was conducted under the *Health Protection and Promotion Act,* which authorizes investigations into "the causes of disease and mortality in any part of Ontario." The tools available to the Commission allowed it to work quickly and efficiently. However, there is room for improvement. The following recommendations should assist future investigations into the causes of disease and/or mortality in Ontario.

79. The government must review the additional provisions of the *Public Inquiries Act* and consider incorporating such other provisions that may assist the investigators in conducting section 78 *Health Protection and Promotion Act* investigations. Any such amendments must maintain the ability to ensure investigations are done expeditiously with maximum flexibility.

80. On more than one occasion the Commission was reminded about the importance of whistleblower protections. It therefore recommends strengthening the protections offered in the context of *Health Protection and Promotion Act* investigations.

81. The government must take steps to ensure the timely and orderly production of documents for future investigations.

Ensure Public Access to Public Health Reports

From time to time, Ontario governments study matters of public health. The resulting reports are matters of public interest and safety and are, by their nature, non-partisan.

82. To ensure that public health reports remain available for future reference and use, all such reports should be carefully publicly archived and readily available on the internet. In addition, other public health interest documents, such as Ontario's 2016 Ebola Step-Down Plan, should not be labelled as the product of a previous government.

83. The Minister of Long-Term Care told the Commission that the government will be receiving a report on the success of the decanting facility referred to as the Specialized Care Centre. That report should be made public.

84. The government should ensure that Commission websites and reports remain readily accessible online indefinitely.

Responding to the Commission's Report

The devastation that was visited upon long-term care residents and those who care for them must never be repeated. Immediate and sustained action to resolve and improve the issues the pandemic uncovered must be taken. The Commission therefore recommends that:

85. The Ministry of Long-Term Care should, on the first and third anniversaries of the release of this report, table in the legislature a report describing for the benefit of the stakeholders and the public the extent to which it has implemented this Commission's recommendations.

Ontario's Long-Term Care COVID-19 Commission

The Honourable Frank N. Marrocco, Chair
Angela Coke, Commissioner
Dr. Jack Kitts, Commissioner

Commission ontarienne d'enquête sur la COVID-19 dans les foyers de soins de longue durée

L'honorable Frank N. Marrocco, président
Angela Coke, commissaire
Dr Jack Kitts, commissaire

Dear Minister Fullerton:

"Devastating, emotional"... "lonely, depressed"... "muzzled, trapped"...
"broken-spirited, boredom"... "terror awakened"

- Words used by LTC residents and Board Members, Ontario Association of Residents' Councils, to describe their lived experiences during the first wave of COVID-19.

Many witnesses have shared heart-wrenching accounts of their experiences during the first wave of the pandemic that resulted in tragic loss of life, suffering and devastating impacts on residents, families and staff. We have heard that long-term care (LTC) homes were forgotten in the initial provincial plans to control the spread of COVID-19 until residents started dying, and pleas that this not be repeated when this crisis is over. We have also heard many opinions on why 45% of LTC homes did not experience an outbreak. We will continue to gather valuable information that will inform our final recommendations to protect residents and staff of LTC homes in the future.

What we do know so far is that, at the end of April 2020 in the first wave of the pandemic, 55% of all LTC homes experienced COVID-19 outbreaks, and 75% of all COVID-related deaths in the province were in long-term care. Some common characteristics among the most impacted homes were: location in communities with high infection rates; insufficient leadership capacity; pre-existing and COVID-related staffing shortages; and a lack of strong infection prevention and control measures, including difficulty cohorting and isolating positive residents, often because of limitations of the physical environment.

We are sending this letter today because the second wave is upon us and, given the continuing urgency of the situation and high risks in long-term care homes, our Commission is making some early recommendations that focus on staffing, collaborative relationships, and infection prevention and control (IPAC). Based on the information we have gathered to date, we feel confident in providing these early recommendations now, consistent with the precautionary principle, instead of waiting for more certainty as the pandemic continues to grow.

These early recommendations do not represent our final word or the full range of findings and recommendations on the issues we were commissioned to investigate. We are continuing our investigation, and plan to submit our final report to the government by April 30, 2021.

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Increase Staffing

"So since at least 2001, numerous reports have been written confirming what staff who work in long-term care have known, that long-term care is grossly inadequate, their staffing, and given the acuity and care needs of the residents which has grown year over year."

- Beverly Mathers, CEO, Ontario Nurses Association

All witnesses agreed that residents of LTC homes in 2020 are a much frailer group than residents were ten or twenty years ago; 81% of residents have some type of cognitive impairment, and often residents have advanced and ongoing medical conditions. For that reason, the quality of care and quality of life for long-term care residents depend on an adequate supply and mix of skilled and qualified staff available to meet their clinical, recreational, social and daily living needs.

We have heard repeatedly and consistently about critical staffing shortages pre-COVID and the reasons for long-standing recruitment and retention challenges in long-term care homes. The staffing challenges have been well documented with numerous reports on the subject. Covid-19 exposed these challenges in stark terms. Similarly, those previous reports as well as witness testimony have commented on how improving the employment environment for workers can enhance the ability to attract people willing to work in the LTC sector and ultimately improve the quality of resident care. We recognize the ministry is providing funding to increase staffing as part of the fall COVID-19 Long-Term Care Preparedness Plan, including a temporary wage enhancement for personal support workers (PSW) to March 2021. In addition, **we recommend the following**:

1. In addition to increasing the supply of PSWs, ensure that LTC staff recruitment efforts address the requirement for an appropriate staff mix to meet the increasing acuity and complex care needs of residents.

2. While all witnesses agreed on the need for staffing flexibility given the 24/7 nature of homes' operations, more full-time positions must be created to ensure staffing stability and retention, and resident continuity of care.

3. Beyond these initial steps, identify the permanent investments required to develop and implement a comprehensive human resources strategy that addresses the full range of staffing issues in the sector. The ministry's Long-Term Care Staffing Study, released in July 2020, identifies the best path forward. Further "study" of the Study is not necessary. What is required is the Study's timely implementation.

4. Consistent with that study, the Commission recommends a minimum daily average of four hours of direct care per resident. The government needs to increase permanent funding for more nurses and support staff, to enable homes to increase their staff to resident ratio, and provide more hours of care, based on residents' needs.

5. Given the essential role of families and caregivers in supporting not just physical care needs but the psycho-social well-being of residents, we reinforce the calls from residents, families and caregivers to ensure that families and caregivers have ongoing, safe and managed access to long-term care residents.

Strengthen Healthcare Sector Relationships and Collaboration

"We know the nurse managers, the nurse practitioners. We've worked with them longitudinally. And really, if you're going to have success, you have to have pre-existing partnerships."

- Dr. Kieran Moore, Medical Officer of Health and CEO of KFL&A Public Health

We learned that communities with pre-existing relationships between LTC homes and healthcare partners were better able to mobilize resources and support homes experiencing outbreak. We have heard from numerous witnesses that early interventions and support, from public health units and hospitals, were successful in preventing outbreaks, and in homes where outbreaks have occurred, they succeeded in bringing them under control. This was accomplished through onsite leadership in the homes, effective IPAC training, effective testing and screening to prevent transmission from the community into the homes, and early intervention to identify COVID-positive residents who then could be cohorted to avoid further spread. We believe that by working together with local healthcare partners, LTC homes can mitigate the impact of a second wave surge.

While hospitals may have less capacity than they did in the first wave, they are still the logical source of local, on-the-ground medical and IPAC expertise and resources to support long term-care homes in crisis, along with support from local public health units.

We recommend that:

1. In the short term, where there are LTC homes that are likely to have difficulties (whether based on past experience, high infection rates in the surrounding communities or other data), a collaboration model should be mandated immediately. These relationships between LTC homes, local hospitals and public health units must be based on trust, collaboration and respect on all sides for the expertise all parties bring to the priority of ensuring the health, safety and well-being of residents.

2. Your ministry work with the Ministry of Health to formalize these relationships proactively. There is no need to wait until an outbreak has occurred before a local hospital assists or is compelled to assist a LTC home. Clearly defined supports and surge capacity for each LTC home must be in place and quickly mobilized when an emergency situation arises.

Improve Infection Prevention and Control (IPAC) Measures

"..during the initial wave, we really saw the relevance and necessity to have dedicated IPAC support for long-term care homes across the province.."

- Jane Sinclair, Chair, AdvantAge Ontario

We have heard repeatedly that adherence to evidence-based IPAC measures is essential to avoid transmission from the surrounding community into the home and to prevent COVID-19 spread to both staff and residents in the home. We heard that in many cases, it was unclear who was accountable for compliance with IPAC measures, including having sufficient supply and adequate training for staff. We understand that in many older LTC homes, the physical infrastructure is a barrier to safe IPAC practices such as cohorting COVID-positive patients. We are aware of system-wide challenges with testing, surveillance and contact tracing, which are necessary to reduce outbreaks.

Continuing to strengthen IPAC measures is critical to protect residents, staff, visiting families and caregivers from outbreaks. In this regard, **we recommend the following**:

1. Ensure every LTC home has a dedicated IPAC lead who can monitor, evaluate and ensure compliance with proper protocols; support and provide basic training for all staff, and access the local IPAC centre of expertise, as required.

2. Enhance LTC ministry resources and capacity to provide compliance support immediately. In the short term, inspection staff from your ministry and others who can be trained, as well as from the local Public Health Unit, should be sent into homes to conduct timely, focused inspections to ensure homes are properly implementing proactive IPAC measures, and are responding effectively to their assessment results. These inspections should prioritize visits to homes based on the same risk measures as those used for our first recommendation under Relationships and Collaboration section above.

3. Given long-term care residents are a highly vulnerable population and to date have suffered the highest COVID-19 death rates, provide highest priority access to testing and quick turn-around of results for residents and staff. The government should also prioritize LTC homes for point of care and less invasive tests as they become available.

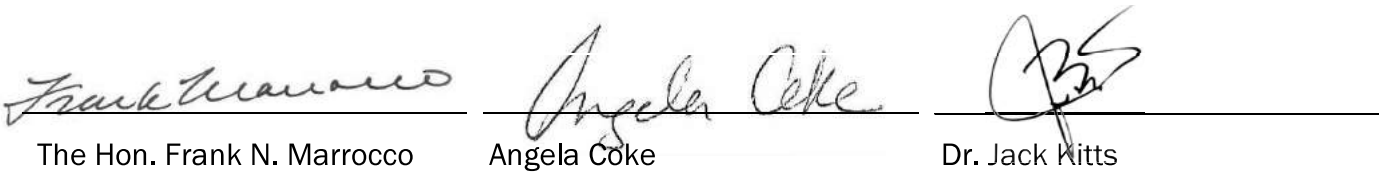
4. Residents who are COVID-positive, especially in older homes, should be given the option to transfer to alternate settings to avoid further transmission of the virus and to help them recover. Given that many LTC homes cannot effectively cohort and isolate because of physical infrastructure limitations, each home should work with its hospital, public health partners and others to put plans in place to quickly decant residents to other facilities, if it is appropriate and safe to do so. The plan should identify these facilities in advance.

As you know, the Commission was announced on July 29, 2020 with a mandate to investigate among other things, why COVID-19 had such a devastating impact on residents, their families and staff of long-term care homes in Ontario. The investigation will determine the adequacy of measures taken by the province and other parties to prevent, isolate and contain the spread, and provide recommendations on how to better protect the residents and staff in our LTC homes in the future. The work of our Commission differs from traditional commissions where inquiries and recommendations are made after the crisis has occurred. We are conducting our work during the COVID-19 pandemic, and as a second wave of infections is occurring in the province, including in long-term care homes.

As part of the investigation phase to date, we have met with more than 200 individuals from almost 50 groups, including experts, associations, unions, long-term care home operators, residents, families and government officials. Our website identifies those who have appeared before the Commission to date and includes presentation slides and transcripts (www.ltccommission-commissionsld.ca). We have also received numerous written submissions to date from individuals and associations interested in contributing to the work of the Commission.

Based on our ongoing investigation, our final report will provide an account of what happened in the first wave of the pandemic and provide a broad range of recommendations that deal with pre-COVID systemic challenges and factors that contributed to the tragedy in long-term care homes.

We look forward to receiving your responses to our early recommendations and your appearance before the Commission as we continue our investigation.



The Hon. Frank N. Marrocco	Angela Coke	Dr. Jack Kitts
Chair	Commissioner	Commissioner

cc. Hon. Christine Elliott, Deputy Premier and Minister of Health

Ontario's Long-Term Care COVID-19 Commission

The Honourable Frank N. Marrocco, Chair
Angela Coke, Commissioner
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Commission ontarienne d'enquête sur la COVID-19 dans les foyers de soins de longue durée

L'honorable Frank N. Marrocco, président
Angela Coke, commissaire
Dr Jack Kitts, commissaire

December 4, 2020

Dear Minister Fullerton:

As is apparent, the province is in the midst of a second wave of the COVID-19 pandemic and residents in LTC homes continue to be at increased risk. Since the release of our interim letter and recommendations on October 23rd, over 100 homes are experiencing an outbreak and more than 300 residents have died.

This is our second interim letter with recommendations. It focuses on quality of resident care because of the continued vulnerability of LTC homes and further information based on evidence we have received since our first interim letter.

We are aware that there are many factors that increase the risk of this virus entering LTC homes and causing widespread infections and death. For example, we have heard that the prevalence and transmission of the virus in the community is a strong predictor of spread into LTC homes. However, some factors which may be effective in reducing risk and enhancing the quality of care for residents in LTC homes can be addressed in the short term. These factors include:

1. Effective leadership and accountability
2. Using performance indicators to assess each home's readiness to prevent and manage COVID-19 outbreaks, and
3. Focused inspections to assess compliance with measures known to reduce the impact of the virus.

1. Leadership and accountability in LTC homes

The fundamental principle defined in the *Long-Term Care Homes Act* states that "A home is primarily the home of its residents and is to be operated so that it is a place where they may live with dignity and in security, safety, and comfort and have their physical, psychological, social, spiritual and cultural needs adequately met." Effective leadership and accountability at all levels of the LTC sector are required to ensure that residents and staff live and work in an environment defined by this fundamental principle. In the coming months the Commission will continue to review leadership at all levels and its impact on resident care and staffing in LTC homes. For this interim letter we will focus on in-home leadership as a priority.

We learned from wave 1 that on-site leadership matters. We heard that homes where leaders were visible and provided clarity around staff roles and responsibilities fared better than those where leadership was less engaged. Homes with effective leaders were better prepared, had less outbreaks, and better contained outbreaks when they occurred.

The Canadian Armed Forces' (CAF) interim and final reports on their observations in the LTC homes to which they were assigned in Ontario clearly identified poor leadership communication to staff, poor onboarding of new staff, inappropriate levels of supervision and concerns about the clinical skills and quality of care of residents as main contributors to the crises in those homes. The CAF interim report indicates that the LTC homes' management acknowledge that they need to improve.

On the other hand, we heard testimony that the leadership team of a not-for-profit home in Toronto, a location with high community spread, demonstrated leadership in preparing for, and managing through, the pandemic. The management team proactively monitored world events and the Canadian situation in early February to prepare for possible impacts. Senior management meetings were held to activate and review pandemic plans, based on their SARS experience. In early February, their assessment included reviewing staffing, food, IPAC and PPE supplies and the implementation of mandatory mask wearing, prior to the government direction. Regular leadership communication with staff and families (CEO walkabouts, etc.) was standard practice. This proactive and hands-on approach resulted in the home having zero resident COVID-19 positive cases in the first wave and zero cases so far in wave 2.

We have also heard there was confusion around who was responsible for maintaining resident quality of care in LTC homes during the pandemic. It was unclear to whom the responsibility fell in the LTC home's leadership team of the Executive Director, Director of Nursing and Personal Care and Medical Director and that these leaders were not always accessible or on-site. We have also received evidence about the education, training and financial resources that those leaders require to effectively assume and carry out their duties.

Experience demonstrates that effective leadership often requires difficult decisions. Cohorting, isolating and decanting are examples of the hard and timely decisions that leaders in LTC homes must make in the midst of an outbreak.

Since 40% of LTC homes have multi-bed wards in which the disease spreads rapidly and which have limited ability to cohort and isolate on-site, leaders in these homes need to work with their local healthcare partners, residents and families to develop contingency plans to decant residents, if necessary. The experience of the Windsor Regional Hospital and the Heron Terrace LTC home is instructive to illustrate how decisive leadership, planning and execution can be combined in a singular effort to save residents' lives when a home is experiencing a severe outbreak.

"It became obvious that Heron Terrace couldn't sustain their operations, even with some staffing support from home and community services, and discussions started rather rapidly about decanting the residents, for safety concerns."

David Musyj, President and CEO, Windsor Regional Hospital

This is consistent with our earlier recommendation that residents who are COVID-positive, especially in older homes, be given the option to transfer to alternate settings to avoid further transmission of the virus and to help them recover.

The on-site quality of care leader in each home should be required to work with their hospital, public health partners and others to put plans in place to quickly decant residents to other facilities, where necessary. The plan should identify these facilities in advance.

We have also heard that LTC homes in Ontario and in other jurisdictions (e.g. Hong Kong since 2004) where there was a trained, dedicated and designated staff person responsible for infection prevention and control were better able to prevent and/or control the spread of the virus.

"..the Government require(s) all nursing home(s) to have one staff, usually a nurse, to be designated as an infectious disease control officer in the nursing home."

Professor Terry Lum, University of Hong Kong and interRAI

While the LTCHA regulation requires that each home have an IPAC Program Coordinator and progress has been made to improve access to IPAC expertise through the IPAC Centres of Expertise since our October recommendations, more still needs to be done in the individual homes.

We recommend that until the pandemic is over, you require that:

- **There is a clear lead for the quality of care** amongst the leadership team of the Executive Director, Director of Nursing and Personal Care and Medical Director in each LTC home. This individual must be on-site each day in a full-time position and be held accountable for resident quality of care and the Province provide the financial resources necessary to effectively support the lead for quality of care in carrying out their role and responsibilities.

2. Performance Indicators

The current six clinical indicators tracked in the LTC home performance reports, such as the percentage of residents who fell, experienced pain or were physically restrained, are a good first step in advancing transparency and flagging issues in homes. While valuable, this data does not provide other important insight on the quality of care received by residents and their experience in the home. Furthermore, the most recent figures are based on 2018/19 data and housed on a separate online platform from home inspection reports.

From a quality of care perspective, homes should monitor and report on other indicators that would provide additional important information to residents, families and the general public and against which homes can be assessed.

Indicators in areas such as staffing (e.g. staffing mix, ratio of residents to staff and ratio of residents to staff with clinical expertise, level of staff engagement, etc.), PPE supplies and resident and family satisfaction with care at the home should be monitored and publicly reported.

We understand that monitoring and compliance with public health practices, PPE, IPAC and staffing have taken on recent importance because of the pandemic and are not routinely monitored as other metrics. The responsibility and accountability for overseeing this task should fall to the home's on-site quality of care leader.

We therefore recommend that immediate action be taken to:

- **Include performance metrics such as resident and family satisfaction, staff engagement, staffing levels, and supply of PPE in the LTC home performance reports.**

- **Publicly post the home performance reports** in a single and centralized location so that the public and other homes can assess and compare homes to one another. This information should be updated more frequently and be presented with inspections

status of each home in a user-friendly manner so that the public can search and access a comprehensive picture of each home's performance.

3. Inspections

Questions and concerns have been raised about the effectiveness of the Province's oversight and inspections system, whose primary focus is to protect the vulnerable people in LTC homes.

Based on testimony before the Commission, information shared by government officials and research conducted by the Commission, several issues have surfaced that the Commission believes require urgent attention. These include the decision in fall 2018 to discontinue Resident Quality Inspections (RQIs) in all long-term care homes, the apparent lack of consistency in enforcement and the siloed approach to inspections by the MLTC, Ministry of Labour, Training and Skills Development (MLTSD) and Public Health inspectors.

a) The discontinuance of annual Resident Quality Inspections (RQIs)

In 2013, the MOHLTC recognized that comprehensive inspections would help identify systemic issues in homes and committed to completing an RQI in every home by the end of 2014 and each following year. Nearly all 626 LTC homes received RQIs in 2015, 2016 and 2017.

In addition, approximately 100 inspectors were hired over two years to support this effort, bringing the total up to 180 by 2015. We note that this number has remained largely the same over the last five years with 175 LTC inspectors currently working in the Long-Term Care Quality Inspections Program (LQIP).

In response to the Auditor General's 2015 recommendation "to prioritize comprehensive inspections based on LTC homes' complaints and critical incidents and other risk factors" in order to clear a backlog of almost 3,000 complaint and critical incident inspections, the Ministry introduced a risk-based approach to inspection and enforcement.

LTC homes deemed high risk were to receive more thorough annual inspections, although all homes were still to be inspected every year. In 2018, 329 LTC homes received an RQI. However, that number dropped to 27 homes in 2019.

This reduction in RQIs which are intended to provide a holistic review of operations in the homes left the Ministry with an incomplete picture of the state of Infection Prevention and Control (IPAC) and emergency preparedness.

This is a key gap as RQIs are the only resident-focused inspections that must include a review of IPAC. By their nature, a complaint about day-to-day issues in a home is very unlikely to identify problems with equipment and processes that would be used in an emergency.

Importantly, we have found no indications that proactive RQIs were initiated by the MLTC when COVID-19 outbreaks began globally. From March 1 to October 15, 2020, only 11 LTC homes received a proactive inspection.

We recommend that the Ministry:

- **Reintroduce annual Resident Quality Inspections for all LTC homes and require all reactive inspections occurring during the pandemic to include an IPAC Program review.** This will ensure that all LTC homes receive an IPAC protocol review and assessment and that possible violations are identified whenever there is a MLTC inspection in the home during the pandemic.

- **Request appropriate funding in the upcoming 2021 provincial Budget to hire and train a new cadre of inspectors to implement the annual RQIs on each LTC home in the system.** These resources are important to address the current need as well as the anticipated demand that will be created with the additional new beds that will be coming on stream in the next two to five years.

b) Enforcement

In addition to the discontinuance of RQIs, we are concerned about the apparent lack of enforcement and follow-up verification of compliance with Orders issued by the ministry.

In 2019, the two most common enforcement actions were Written Notification and Voluntary Plan of Correction. Neither require mandatory follow-up or verification from the LTC home to illustrate compliance with the requirement under the Long-Term Care Homes Act (LTCHA).

From 2018 to 2020, Plan of Care has consistently been identified as the top area of non-compliance identified from complaint inspections. This illustrates the high volume of complaints that must have been made about a resident's Plan of Care. It is interesting to note that IPAC issues rarely made it into the list of the top ten areas of non-compliance identified from complaint inspections, showing that it was rarely a focus of any inspections.

Director Orders (DOs), seem only to be applied in extreme circumstances. There were only 21 issued between January 2019 and August 2020.

Also, it appears that fines or prosecution penalties for failure to comply with orders under the LTCHA are rarely applied as a form of corrective action, which may feed into the lack of urgency illustrated by LTC operators to come into compliance.

We recommend that the Ministry:

- **Improve enforcement by prioritizing timely responses to non-compliance** with IPAC and Plan of Care orders.

c) Coordination of Inspections

Finally, there appears to be an absence of a cohesive approach to inspections completed by the MLTC, MLTSD and Public Health Units.

This has likely occurred because inspectors from all three organizations tend to carry out their duties independently. If issues arise during inspections that are outside their respective mandates, they may inform or consult their counterparts but there is no clear or widely used protocol for information exchange or follow-up.

This disjointed approach to inspections proved extremely detrimental for IPAC in LTC homes. With the near elimination of RQIs and minimal inspections initiated by IPAC complaints or critical incidents, MLTC inspections provided little help in proactively identifying and addressing gaps in

infection control inside homes. MLTSD inspections were centered on occupational health and safety standards, such as access to PPE, but only as they related to staff, not residents. Public health agencies provided guidance on IPAC best practices but in some cases did not appear to have sufficient resources or capacity to support hands-on application in the home.

We therefore recommend the following immediate steps be taken to:

- **Eliminate the siloed approach to MLTSD, Public Health and MLTC inspections through cross training, the establishment of a centralized system of report sharing, and inspector teams to address specific cross-cutting issues.** Information sharing on intersecting legislative requirements, such as IPAC, would ensure the consistent communication and application of standards and cross training would enable inspectors from all three organizations to be dispatched to support homes in emergency situations.

Conclusion

As indicated in our previous letter that contained our first interim recommendations, unlike other Public Inquiries, our Commission's work is being conducted during the COVID-19 pandemic, and as a second wave of infections is occurring in the province, including in long-term care homes.

As with our first set of interim recommendations, this is not our last word on the issues raised in this letter.

Based on our ongoing investigation, our final report will provide an account of what happened throughout the pandemic and provide a broad range of recommendations that deal with pre-COVID systemic challenges and factors that contributed to the tragedy in long-term care homes.

The Hon. Frank N. Marrocco Chair	Angela Coke Commissioner	Dr. Jack Kitts Commissioner

cc. Hon. Christine Elliott, Deputy Premier and Minister of Health

Appendix B: Long-Term Care and Emergency Response in Ontario

In order to assess the impact of COVID-19 on Ontario's long-term care system, it is helpful to understand the roles and responsibilities of those involved in the response to the pandemic in the province's long-term care homes.

Within long-term care homes, home licensees, management and staff all have their own roles and responsibilities with regards to the general operation of homes and protecting homes from infectious disease outbreaks.

Meanwhile, Ontario's health care, public health and emergency response systems are extremely complex. At the provincial level, these systems are managed by ministries such as the Ministry of Health and Ministry of Long-Term Care with support from government agencies such as Public Health Ontario (PHO). In addition to their general powers and responsibilities, many of these entities have additional powers and responsibilities that are engaged during a public health–related emergency.

At the regional level, public health units (PHUs) are responsible for the delivery of *public* health services to the general population. Prior to April 1, 2021, local health integration networks (LHINs) planned, funded and administered certain *individual* health services for those in Ontario's local communities. These included overseeing the admissions and placement processes for long-term care homes.

Adding to this complexity is the fact that, at the onset of the COVID-19 pandemic, two key components of the province's health sector were undergoing major overhauls. In June 2019, the Ministry of Health and Long-Term Care was divided into two separate ministries: the Ministry of Health and the Ministry of Long-Term Care. Furthermore, many of the roles and responsibilities held by the local health integration networks were being moved into a new health agency called Ontario Health.

On April 1, 2021, Ontario announced that most of the planning and funding functions of the local health integration networks would be transferred to Ontario Health (discussed in more detail below). LHINs, now called Home and Community Care Support Services, maintained their oversight of long-term care homes admissions and placement. Unless otherwise indicated, information on local health integration networks and Ontario Health in this appendix is current to March 31, 2021.

This appendix will begin by describing the leadership structures within long-term care homes. It will then describe the roles and responsibilities of those who lead Ontario's

public health and health care sectors and emergency services systems. Finally, relevant legislation and guidelines will be briefly discussed, all with the purpose of understanding the impact these actors had on the response to the COVID-19 pandemic within long-term care homes.

Long-Term Care

Long-term care homes provide residents with care 24 hours a day, seven days a week. This includes professional health services, personal care support such as bathing and feeding, and services such as meals and housekeeping. Residents of these homes have complex health care needs and, as such, homes maintain various leadership positions to ensure that all relevant legislative and regulatory requirements for long-term care facilities are met. These roles and responsibilities are discussed below.

Long-Term Care Home Licensee

The licensee is the entity that is provided with formal government approval to operate a long-term care facility. Entities eligible to be licensees include for-profit corporations, not-for-profit corporations, municipalities and First Nations.

Licensees are subject to a number of requirements detailed in the *Long-Term Care Homes Act, 2007 (LTCHA)*, and its associated regulation (detailed below). The primary licensee responsibility is to "ensure that the home is a safe and secure environment for its residents." Ministry of Long-Term Care representatives told the Commission that, among other things, this responsibility requires licensees to ensure residents' safety from a pandemic.

Under the *LTCHA*, licensees must provide residents with several key services including medical services, nursing and personal support services, dietary and hydration services, and restorative care. With regards to health services, licensees must ensure that either a physician or registered nurse:

- conducts a physical examination of each resident upon admission;
- conducts an annual physical examination of each resident every year after admission and produces a written report of the findings of the examination;
- attends regularly at the home to provide services, including assessments; and
- participates in the provision of after-hours and on-call coverage.

Subject to certain exceptions detailed below, licensees must ensure that before staff begin working in a long-term care home they receive training in, among other things, infection prevention and control (IPAC). This training must include education in hand hygiene, infection transmission, cleaning and disinfection practices, and use of personal

protective equipment (PPE). Licensees must also ensure that staff are trained on how to clean and sanitize equipment that they use as part of their work.

In the event of an emergency or unforeseen circumstance that prevents training from occurring before the staff member starts work, licensees can provide IPAC training within one week after the staff member begins work.

Licensees must also ensure that staff who have direct contact with residents receive training in additional areas including caring for residents with dementia, managing aggressive or difficult behaviours, and providing palliative care.

Subject to certain exceptions, licensees must ensure that staff are retrained in the above-noted areas once a year.

The licensee is not required to provide this training to staff who work at a home as contract workers or staff who work at a home under contract between the licensee and an employment agency. The licensee is still required, however, to provide these staff with information on infection prevention and control before they begin working at the home.

In addition to placing obligations on licensees, the *Long-Term Care Homes Act, 2007*, also assigns responsibilities to three management positions: the Administrator, the Director of Nursing and Personal Care, and the Medical Director.

Administrator

The Administrator is the individual who is in charge of a given long-term care facility and responsible for its day-to-day management. The number of hours per week that an Administrator spends working in a home is dictated by the number of beds in the home.

Generally, Administrators must have between two and three years of post-secondary education, three years' experience working in a managerial capacity, and demonstrated leadership and communication skills. Administrators are also required to complete a specific course on long-term care homes administration before they can be hired. These requirements do not apply to individuals who have previous experience working as an Administrator in a long-term care facility.

Aside from their responsibility for the general management of homes, Administrators do not have many explicit responsibilities in relevant legislation or regulations. However, in practice, they often deal with staffing and personnel issues, manage complaints regarding the homes' operations, and maintain relationships with external stakeholders.

Director of Nursing and Personal Care

Every long-term care home must employ a Director of Nursing and Personal Care (Director of Nursing). The Director of Nursing is responsible for directing and supervising the homes' nursing and personal care staff and their services. All Directors of Nursing must be registered nurses with at least one year of experience working in long-term care and three years' experience working in a managerial or supervisory capacity. These requirements do not apply to individuals who have previous experience working as Director of Nursing in a long-term care facility.

As with the Administrator, the number of hours that the Director of Nursing must spend working on site in their long-term care home depends on the number of beds in the home.

Typically, the responsibilities of a Director of Nursing include hiring and scheduling nursing staff and personal support workers (PSWs), responding to nursing-related complaints, and reporting and investigating critical incidents.

Medical Director

The *Long-Term Care Homes Act, 2007*, also requires every long-term care facility to have a Medical Director. The Medical Director must be a physician and is generally responsible for advising the licensee on matters relating to medical care in the home.

The Medical Director's specific responsibilities include:

- developing, implementing, monitoring and evaluating medical services in the home;
- advising on clinical policies and procedures, where appropriate;
- communicating care expectations to attending physicians and registered nurses;
- addressing issues relating to resident care, after-hours coverage and on-call coverage; and
- participating in interdisciplinary committees and quality improvement activities.

Aside from the requirement that the director be a physician, the legislation does not require specific training or credentials for an individual to work as a Medical Director. In fact, Medical Directors are exempt from training requirements under the *LTCHA* in areas including caring for residents with dementia, managing difficult or aggressive behaviour, and providing palliative care. This exemption also applies in specified circumstances to physicians and certain registered nurses who work in long-term care homes.

Nursing and Personal Support Services

All long-term care homes must maintain organized programs that provide nursing and personal support services required to meet the needs of the home's residents. To this end, homes must ensure that there is a written staffing plan for both their nursing and personal support services programs. The plan must:

- provide for a staffing mix that is consistent with the residents' assessed care and safety needs;
- set out the organization and scheduling of staff shifts;
- promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident;
- include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the nursing staff, cannot come to work; and
- be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The legislation does not provide specific detail as to what constitutes an appropriate staffing mix.

Homes are also required by the *Long-Term Care Act, 2007*, to limit their use of temporary, casual or agency staff.

Nursing

All homes must have at least one registered nurse on premises at all times. Aside from a narrow set of exceptional circumstances, the nurse on premises must be both an employee of the home and a working member of the home's nursing staff. The Administrator or Director of Nursing cannot serve as the nurse on premises.

Given that nurses who work for nursing agencies are not employees of the home, they are generally not permitted to serve as the nurse on premises at a long-term care home. There are certain exceptional circumstances, however, in which an agency nurse is permitted to serve as the nurse on premises.

Personal support workers

Personal support workers play a crucial role in the daily care of residents. They are responsible for assisting residents with all activities of daily living and personal hygiene, such as bathing, dressing and toileting; helping residents get to and from various locations in the home; assisting residents with their meals; and charting all non-nursing and non-medical aspects of the residents' daily living.

There are currently no uniform training requirements for PSWs in long-term care homes. While the *Long-Term Care Homes Act, 2007*, regulation states that every person hired by a licensee to work as a PSW must have completed a personal support worker training program approved by Ontario's Ministry of Training, Colleges and Universities, there are many exceptions to this rule. In certain cases, individuals can be hired as PSWs in long-term care homes without PSW training as long as, in the opinion of the home's leadership, they have the skills required to work as a personal support worker.

For example, licensees can hire an individual who has a "diploma or certificate granted in another jurisdiction" to work as a PSW as long as:

- the individual provides proof of graduation to the licensee;
- the program involved at least 600 hours of education and practical experience time; and
- the individual "has a set of skills that in the reasonable opinion of the licensee, is equivalent to those that the licensee would expect of a person who has completed [an Ontario PSW training program]."

The regulation does not provide any additional detail as to what kind of diploma or certificate would qualify for this exception.

Infection Prevention and Control Coordinator

Every licensee is required to ensure that their home has an infection prevention and control program (discussed further below). The licensee must also designate one of the home's staff members as the home's IPAC program coordinator. The coordinator must have education and experience in IPAC practices such as infectious diseases, cleaning and disinfection, data collection and trend analysis, reporting protocols, and outbreak management. The legislation does not specify, however, specific training or credentials that the coordinator must hold.

While specific legislative responsibilities are not assigned to the coordinator, Government of Ontario long-term care guidance documents indicate that the coordinator's activities can include:

- receiving reports on potential infection outbreaks in long-term care homes;
- carrying out infectious disease surveillance in homes and analyzing the resulting data;
- consulting with public health units on potential outbreaks in long-term care homes and providing PHUs with information on infected individuals;
- serving as a member of a home's outbreak management team; and
- coordinating a home's response to an outbreak and ensuring that outbreak control measures are in place and enforced.

All licensees are also required to maintain an organized program for housekeeping. This program must include procedures for cleaning and disinfecting resident care equipment, supplies and devices, and contact surfaces. The *LTCHA* regulation requires that the IPAC coordinator be involved in selecting the disinfectant used to carry out the cleaning program.

Residents' and Family Councils

The *Long-Term Care Homes Act, 2007*, contemplates two groups that can play a role in advocating for the rights of residents within homes: Residents' Councils and Family Councils. Licensees must cooperate and meet with Residents' and Family Councils when asked and consult with the Councils at least once every three months on the operation of the home. Licensees cannot attend Residents' Council or Family Council meetings unless invited. Licensees must also seek the advice of the Residents' Council and Family Council when developing, carrying out and acting on the results of resident and family satisfaction surveys. These surveys must be conducted at least once a year. Finally, licensees cannot interfere with or prevent either of the two Councils from carrying out their duties.

Residents' Councils

All long-term care homes must have a Residents' Council. Only residents of the home are permitted to be members of the Council. All long-term care residents have the right to participate in Residents' Councils and raise concerns regarding the operation of their home to their Residents' Councils without interference or fear of coercion, discrimination or reprisal. Residents' Councils have the power to, among other things:

- advise residents of their legal rights and obligations as well as the legal rights and obligations of the licensee;
- attempt to resolve disputes between licensees and residents;
- advise the licensee of any concerns or recommendations the Council has about the operation of the home;
- review documents related to Ministry of Long-Term Care inspections of the home and financial statements related to the home;
- report recommendations and concerns regarding the home's operation to the licensee or Ministry; and
- review the home's menus and food provision plans.

When the Residents' Council raises a concern or recommendation with the licensee, the licensee must respond to the Council in writing within 10 days.

Family Councils

Long-term care homes are permitted but not required to create Family Councils. Any family member of any resident of a home can ask the licensee to create a Family Council and the licensee must do so within 30 days. If a home does not have a Family Council, the licensee must regularly advise residents' families of their right to request the establishment of a Council. Approximately 80 per cent of Ontario's long-term care homes have Family Councils.

Any family member or person of importance to a resident (including friends and substitute decision-makers) is entitled to be a Family Council member. Individuals involved in the operations or management of the home as well as staff members cannot be members of the Family Council, even if they also have loved ones who are residents at the home. Every long-term care home resident has the right to raise concerns or recommendations regarding the operation of their long-term care home to the home's Family Council without fear of coercion, discrimination or reprisal.

Among other things, Family Councils have the power to:

- provide assistance, information and advice to residents, family members of residents and persons of importance to residents;
- advise residents, family members of residents and persons of importance to residents respecting the legal rights and obligations of residents and the licensee;
- attempt to resolve disputes between licensees and residents;
- review documents related to Ministry of Long-Term Care inspections of the home and financial statements related to the home; and
- report recommendations and concerns regarding the home's operation to the licensee or the Ministry.

When the Family Council raises a concern or recommendation with the licensee, the licensee must respond in writing within 10 days.

Government Oversight of Long-Term Care Homes

Public bodies at the provincial, regional and local levels also play important roles in overseeing the province's long-term care homes. This oversight system is quite complex and was in a state of flux at the onset of the COVID-19 pandemic.

Overview

Ontario's Ministry of Long-Term Care has primary responsibility for the province's long-term care sector, including long-term care licensing, inspections, funding and policy.

Prior to June 2019, long-term care in Ontario was overseen by the Ministry of Health and Long-Term Care. In June 2019, this Ministry was divided into two separate entities: the Ministry of Health and the Ministry of Long-Term Care. Following this split, the Ministry of Long-Term Care took over responsibilities for certain elements of the long-term care system while continuing to share others with the Ministry of Health. While the two entities had been separated for more than six months by the time COVID-19 emerged, they had yet to fully disentangle and delineate their respective responsibilities, including responsibilities central to the Ministries' emergency response. As discussed in chapters 2 and 3, there was confusion between the newly separated Ministry of Health and the Ministry of Long-Term Care as to the roles each Ministry should play in responding to the COVID-19 pandemic.

Furthermore, after the two Ministries were separated, the Ministry of Long-Term Care did not have a formal relationship with the Chief Medical Officer of Health (CMOH) and Public Health Ontario, both of which played an important role in the province's response to the COVID-19 pandemic and will be described further below.

Long-term care homes are also inspected by Ontario's Ministry of Labour, Training and Skills Development, whose responsibility is to ensure that long-term care facilities are safe work environments for staff.

The public health system too plays a significant role in the province's long-term care sector and involves shared authority and accountability at the provincial and local levels. The primary actors within this system are the Ministry of Health, the Chief Medical Officer of Health, Public Health Ontario, local public health units, local boards of health and local medical officers of health.

A closer look at the roles and responsibilities of the entities that control Ontario's health system helps provide a better understanding of how the system works as a whole.

Ministry of Health

Ontario's Ministry of Health is in charge of administering the province's health care system. The Minister of Health is responsible for, among other things, advising the government concerning the health of the people of Ontario, overseeing and promoting the health and well-being of the people of Ontario, and developing, coordinating and

maintaining “a balanced and integrated system” of hospitals, laboratories, ambulances and other health facilities in the province. The Ministry also plays a crucial role in the delivery of public health services and the management of province-wide public health emergencies, which will be discussed further below.

Ministry of Long-Term Care

As of February 2020, the Ministry of Long-Term Care’s core functions included licensing, inspections, policymaking and funding.

All long-term care homes must be licensed by the government in order to operate. The Ministry of Long-Term Care determines whether long-term care homes, including those owned and operated by First Nations and municipalities, should be granted licences to operate in accordance with a set of factors described in the *Long-Term Care Homes Act, 2007*.

The Ministry oversees the operation of the province’s long-term care homes and is responsible for promoting long-term care residents’ rights and quality of life. As part of this oversight, the Ministry employs inspectors to monitor licensees’ compliance with the legislative requirements of the *Long-Term Care Homes Act, 2007*.

Under the *LTCHA*, the Ministry of Long-Term Care must inspect long-term care homes at least once a year. As discussed in chapter 1, in 2018, the Ministry scaled back proactive inspections that reviewed the entirety of the homes’ operations; instead, it shifted its focus to reactive inspections responding to complaints and critical incidents and inspections of homes that were deemed to be “high risk.”

The Ministry of Long-Term Care provides funding to all of the province’s long-term care homes and is also tasked with developing policies on matters including long-term care home staffing, funding, redevelopment and construction. Decisions related to how many beds are built, how care is provided or how much must be spent on food all rest with the Ministry. Ultimately, of course, significant decisions including how many beds are built and whether beds are available for all persons needing long-term care are political in nature. As described in chapters 1 and 3, more than 38,000 people are waiting for long-term care beds in Ontario.

Finally, the Ministry of Long-Term Care also shares certain divisions with the Ministry of Health, including its Capacity Planning and Analytics Division and its Health Services Information and Information Technology Division.

Ministry of Labour, Training and Skills Development

The primary goal of the Ministry of Labour, Training and Skills Development is to promote workplace health and safety and prevent injuries and illnesses. The Ministry develops occupational health and safety policies for workplaces regulated by the Ontario government and enforces the *Occupational Health and Safety Act (OHSA)*, which, among other things, sets out the duties of employers and workers, delineates workers' rights, provides for workplace inspections, and prohibits employer reprisals against workers.

Regarding long-term care, the Ministry also enforces the *Health Care and Residential Facilities Regulation*, which applies to all workers in long-term care homes. The regulation addresses matters including safe working conditions and the use of personal protective equipment by staff. It also lists the duties of employers and supervisors (such as the duty to take every reasonable precaution to protect workers and the duty to advise workers of workplace hazards), and workers' duties (such as the duty to operate equipment safely and report workplace hazards to their employer). Finally, the regulation sets out workers' rights, including the right to be informed of workplace hazards and the right to refuse unsafe work.

The Ministry's interactions with workplaces – including long-term care facilities – can consist of visits to workplaces to offer compliance consultations, proactive investigations to review compliance with the *OHSA*, or workplace investigations in response to incidents such as complaints, injuries, staff refusals to work or fatalities. Ministry inspectors have the power to issue orders and initiate prosecutions.

Provincial Public Health System

Public health focuses on the health of the population as a whole. There are three primary actors in Ontario's public health system at the provincial level: the Minister of Health, the Chief Medical Officer of Health and Public Health Ontario.

Minister of Health

The Minister of Health is responsible for administering the province's core public health statute: the *Health Protection and Promotion Act (HPPA),* described in further detail below. Among other things, the *HPPA* provides for the organization and delivery of public health programs and services in Ontario.

The Minister of Health plays an important role in guiding the operations of Ontario's local public health system. Pursuant to the *HPPA*, the Minister publishes the Ontario

Public Health Standards, which set out the responsibilities of Ontario's boards of health (see below). The Minister funds local boards of health through agreements that require the boards to deliver public health services within their regions.

The Minister also has the power to determine which diseases are included on Ontario's list of reportable diseases and which diseases constitute communicable diseases. Diseases caused by novel coronaviruses were added to Ontario's list of reportable diseases, and were designated as communicable, on January 22, 2020.

Once a disease is designated as communicable, Ontario's local medical officers of health can issue orders requiring health care facilities to take certain measures to control the spread of the diseases. If there is a risk of a communicable disease outbreak, the Minister of Health can also take control of property for use as an isolation facility.

The Minister of Health must approve the appointment and dismissal of all local medical officers of health and can establish, maintain and direct public health laboratories.

Chief Medical Officer of Health

The Chief Medical Officer of Health is Ontario's senior public health official. By law, the CMOH must be a physician of at least five years' standing with specialist credentials in public health and preventive medicine.

The Chief Medical Officer of Health's primary role is to be the lead physician for public health in the province of Ontario. The *HPPA* requires the CMOH to stay informed of occupational and environmental health matters in Ontario and deliver an annual report on the state of public health to the provincial legislature. The CMOH must provide the report to the Minister of Health 30 days before it is provided to the legislature, though the Minister cannot edit or censor the report. The CMOH may also release other reports related to public health as appropriate and can speak with the media independently of the Ministry.

The *HPPA* grants the Chief Medical Officer of Health broad powers. When the CMOH believes that there is a risk to the health of any person in Ontario, they may take any action they consider necessary to eliminate or decrease that risk. This includes issuing directives to any health care provider (including long-term care homes) requiring them to undertake specified medical precautions and procedures to protect the health of persons anywhere in Ontario.

Notably, under the *HPPA,* the Chief Medical Officer of Health is only authorized to issue directives to individuals who work as health care providers. However, the *HPPA* authorizes local medical officers of health to issue directives to any individual, whether they are a health care provider or not. The *HPPA* also allows the CMOH to exercise the

powers of a local medical officer of health. While this arguably means that the CMOH can also issue directives to any individual, the legislation is unclear on this point. This became an issue during the COVID-19 pandemic when the government sought to limit personal support workers, who are not classified as health care workers, from working at more than one long-term care home.

When the Chief Medical Officer of Health is of the opinion that there is an imminent risk of a pandemic or other public health emergency, they can also issue directives to boards of health or medical officers of health requiring that they adopt or implement policies or measures regarding:

- infectious diseases;
- health hazards;
- public health preparedness; and
- a matter prescribed in a regulation made by the Minister of Health.

The *HPPA* requires the Chief Medical Officer of Health to consider the precautionary principle when issuing directives that relate to worker health and safety in the use of any protective clothing, equipment or device in the context of an actual or suspected infectious or communicable disease. As discussed elsewhere in this report, the precautionary principle stipulates that:

> Where there is reasonable evidence of an impending threat to public health, it is inappropriate to require proof of causation beyond a reasonable doubt before taking steps to avert the threat.

The Chief Medical Officer of Health also serves as an Assistant Deputy Minister within the Ministry of Health and, in that role, reports to the Deputy Minister of Health.

The Minister of Health sets the budget for the Chief Medical Officer of Health's office. Aside from the specific powers described above, there is no legislation describing the general roles and responsibilities of the CMOH, the accountability relationship between the CMOH and the Minister of Health, or whose view takes precedence when the CMOH disagrees with the Minister of Health on matters of public health.

Following the division of the Ministry of Long-Term Care and the Ministry of Health, the Chief Medical Officer of Health retained a formal reporting relationship with the Ministry of Health but not with the Ministry of Long-Term Care. Ontario's current Chief Medical Officer of Health, Dr. David Williams, told the Commission that, after the Ministry of Long-Term Care was separated from the Ministry of Health, the role of the CMOH with the Ministry of Long-Term Care consisted mostly of consulting and providing advice.

Public Health Ontario

Public Health Ontario is a government agency mandated to, among other things, provide scientific and technical advice and support to public health officials at the provincial and local levels. The agency was established in 2008 and was one of the primary recommendations of the SARS Commission Final Report. PHO's responsibilities include operating Ontario's Public Health Laboratories, conducting infectious disease surveillance, collecting and analyzing epidemiological data, and generally conducting public health research. Public Health Ontario does not have any powers to oversee or intervene in the provision of public health services in Ontario. Its mandate remains limited to providing advice and support and operating laboratory facilities.

The Chief Medical Officer of Health serves as a member of Public Health Ontario's Strategic Planning Committee but does not have any operational control over the agency. Public Health Ontario provides the Chief Medical Officer of Health with advice and guidance on which the CMOH may rely to make public health decisions within their mandate.

Public Health Ontario receives its funding from the Ministry of Health and must submit an annual report to the Ministry describing its activities. PHO's strategic objectives must be included in its annual business plan and are subject to the Minister of Health's approval.

Public Health Ontario is also party to a memorandum of understanding with the now defunct Ministry of Health and Long-Term Care. The memorandum sets out the accountability relationship between the two entities and expectations with regards to PHO's operations. The memorandum currently applies to the relationship between PHO and the Ministry of Health but does not govern PHO's relationship with the Ministry of Long-Term Care. At present, there is no formal accountability relationship between Public Health Ontario and the Ministry of Long-Term Care.

As discussed elsewhere in this report, the province did not always seek Public Health Ontario's input when formulating its pandemic response. In other instances, the province solicited Public Health Ontario's advice but then did not follow the advice.

Prior to the COVID-19 pandemic, Public Health Ontario provided materials, including training modules and guidance documents, to long-term care facilities to assist them in developing their infection prevention and control programs.

Local Public Health

Public health at the local level in Ontario is comprised of three primary entities: public health units, boards of health and local medical officers of health. Public health units deliver crucial public health information and programming to their communities. They have been described as “the front line of protection against infectious disease.” Each PHU is governed by a board of health. Local medical officers of health are appointed by boards of health, report directly to the board and are responsible for ensuring that all legislatively required public health programming is provided to the residents of their respective public health units.

Public health units

The province is divided into 34 geographic areas known as public health units. The term “public health unit” is also sometimes used to refer collectively to the board of health, medical officer of health and relevant staff.

Public health units provide healthy living and disease prevention information and programs to Ontario’s communities at the local level. Among other things, they are responsible for monitoring food safety in long-term care homes.

Public health units also monitor infection prevention and control in long-term care homes in some ways, but these services are generally only provided in response to IPAC-related complaints received from homes. All PHUs must maintain a 24/7 on-call system for receiving and responding to reports or complaints regarding infection prevention and control practices in local facilities, including reports of confirmed and suspected outbreaks of infectious diseases of public health significance in long-term care homes.

Where appropriate, public health units are required to respond to such reports by conducting an inspection. After these inspections are conducted, public health units must:

- determine if a health hazard exists;
- determine whether there was non-compliance with infection prevention and control practices;
- determine the adequacy of IPAC measures and recommend measures to address identified risks; and
- take action to decrease the effect of, or eliminate, identified health hazards.

This action “may include a number of educational, procedural, and re-inspection measures to effect the necessary correction, up to and including the issuance of an order under the *HPPA* or the issuance of fines under applicable legislation.” Public health units must also publish summary reports of inspection results on their websites.

Boards of health

Each of Ontario’s 34 public health units is governed by a board of health. Boards of health oversee the implementation of the public health units’ infection prevention and control initiatives in long-term care homes.

The board of health’s role is oriented toward high-level stewardship of local public health programming and services and is less concerned with day-to-day service and program delivery. Boards of health hire medical service providers, including public health nurses, as necessary to carry out their responsibilities for the provision of public health services. Boards of health also set the budget and determine service priorities for their public health unit.

Boards of health operate independently of the government, but they remain accountable to the province as they are required to provide services in accordance with accountability agreements with the Ministry of Health and the Ontario Public Health Standards (discussed below), which the Ministry of Health issues. Boards of health are required to comply with the Ontario Public Health Standards and the *HPPA* in order to receive funding. The Ministry of Health may inspect boards of health for compliance with the *HPPA*, the Ontario Public Health Standards and other relevant regulations and, where necessary, direct and enforce compliance.

Every board of health uses one of three kinds of governance structure. The majority are established as corporations under the *HPPA*. Most of the members of these boards are appointed by the municipalities served by the board, while the rest are appointed by Order in Council. A small number of the province’s boards of health are established under legislation that applies to specific municipalities. Membership of these boards consists either of the municipal council itself or a group of individuals appointed by the municipality. The cities of Hamilton and Ottawa make use of the former structure, while the City of Toronto uses the latter. Finally, a small number of Ontario’s boards of health are embedded within regional municipal governments, with the regional council itself acting as the board of health. The regions of Durham and Peel use this structure.

Local medical officers of health

Each board of health must appoint a full-time local medical officer of health who is a physician with specialist credentials in public health and preventive medicine. The local

medical officer of health reports directly to the board of health, and is responsible to the board of health for management of the public health programs and services within the public health unit. All individuals hired by a board of health to deliver public health services are responsible to the local medical officer of health.

Where a complaint is made to a board of health or local medical officer of health that a health hazard related to occupational or environmental health exists, the local medical officer of health is required to notify the government ministry with primary responsibility in the matter (e.g., the Ministry of Labour, Training and Skills Development) and, in consultation with that Ministry, investigate the complaint to determine whether the health hazard exists or does not exist.

Local medical officers of health can issue orders requiring individuals to take or to refrain from taking any action regarding a communicable disease when they, on reasonable and probable grounds, are of the opinion that:

1. a communicable disease or outbreak exists or may exist or that there is an immediate risk of an outbreak of a communicable disease;
2. the disease presents a health risk to individuals within their public health unit; and
3. the order is necessary to decrease or eliminate the risk.

The local medical officer of health can issue these orders to individuals or classes of people, such as all individuals living in long-term care homes. Local medical officers of health also have the power to issue orders requiring entire health facilities such as hospitals or long-term care homes to take actions to manage, monitor, investigate and respond to an outbreak of a communicable disease at the hospital or institution. A number of these orders were issued during the COVID-19 pandemic.

Health facilities – including long-term care homes – within a given public health unit are required to report instances of communicable diseases within their facilities to the local medical officer of health, who in turn is required to report this information to the Ministry of Health and Public Health Ontario.

Local Health Integration Networks

Between 2007 and 2019, the Ontario government sought to make the provision of health services at the regional level more efficient through the creation of 14 local health integration networks. In 2019, however, the government began a process to eliminate LHINs and transition their responsibilities – along with the responsibilities of several other provincial health agencies – to a new body called Ontario Health.

Prior to April 1, 2021, local health integration networks were non-profit Crown agencies funded by the Ministry of Health. LHINs planned, funded and integrated certain

individual health services in Ontario's local communities. With regards to long-term care homes, LHINs were responsible for determining eligibility for admission to homes and assisting applicants with placement-related application processes. LHINs also administered the provision of certain professional therapy and nursing services to long-term care homes.

Local health integration networks did not directly provide health services to patients nor did they control the provision of health services to patients on a day-to-day basis. Rather, LHINs signed contracts with health care providers (Service Accountability Agreements) under which the health care professionals agreed to provide certain services within their regions in exchange for funding from LHINs. Local health integration networks provided funding to long-term care homes through these agreements.

As of July 2019, and as noted above, there were 14 local health integration networks in the province allocated to separate geographic regions. In November 2019, the Ontario government announced that it would begin a process to eliminate the LHINs. Soon after, the government announced that the local health integration networks would be collapsed into five "Ontario Health Interim and Transitional Regions" as the networks' responsibilities would be shifted to Ontario Health (described in further detail below). Government press releases noted that local health integration networks would maintain their responsibility for overseeing long-term care home admissions for the time being, with an eye toward eventually transitioning all of the LHINs' responsibilities to Ontario Health and the newly created Ontario Health Teams (also described below). On March 18, 2020, the province announced that the decommissioning of the local health integration networks would be suspended while the province responded to the COVID-19 pandemic.

On March 17, 2021, Ontario announced that the decommissioning of the local health integrations networks had resumed and that the health system planning and funding functions of the LHINs would be transferred to Ontario Health. Meanwhile, LHINs were to be renamed Home and Community Care Support Services and retain their oversight of long-term care home placement services. The province noted that Home and Community Care Support Services would likely maintain control of long-term care placement services over the next few years before the services were eventually transferred to Ontario Health and other health service providers. These changes took effect on April 1, 2021.

Ontario Health and Ontario Health Teams

Ontario Health is a government health agency created in April 2019 with a mandate to connect and coordinate services across Ontario's health system. Among other things,

Ontario Health currently exercises the health system planning and funding functions that used to belong to the local health integration networks. A 13-person board of directors governs Ontario Health. The agency's relationship with the Ministry of Health is primarily governed by a memorandum of understanding that defines both parties' roles and the relationship, mutual expectations and accountability between Ontario Health's board of directors and chief executive officer and the Ministry of Health.

The transition of oversight of relevant health services from local health integration networks to Ontario Health is still in progress. Once complete, the agency will carry out roles that were formerly the responsibility of several separate health entities in Ontario, including local health integration networks.

Ontario Health is also responsible for oversight of Ontario Health Teams. Ontario Health Teams are coordinated teams of local health care providers that are responsible for providing integrated and comprehensive care to individuals within defined geographic regions of the province. Ontario Health Teams can comprise many different health service providers including primary and secondary care, hospitals, health promotion and disease prevention services, laboratory and diagnostic services, palliative care, residential care in long-term care homes, and long-term care home placement services.

A primary difference between Ontario Health Teams and local health integration networks is that LHINs administered and oversaw the provision of health services but were not responsible for the actual provision of those services. Ontario Health Teams, however, are primarily composed of professionals and entities, such as family doctors and hospitals, that provide direct care to patients. The implementation of the Ontario Health Teams program began in fall 2019 and is ongoing. As of November 2020, service provider participation in an Ontario Health Team was voluntary, and some but not all Ontario Health Teams included long-term care homes within the team's region.

Ontario's Roles and Responsibilities during a Public Health Emergency

When a public health emergency strikes, some of Ontario's government organizations and leaders gain additional powers, roles and responsibilities.

The *Emergency Management and Civil Protection Act (EMCPA)* (discussed further below) establishes Ontario's emergency management framework, defining the authority and responsibilities of provincial ministries, municipalities and individuals (such as the Premier and Commissioner of Emergency Management).

Certain ministries have been assigned lead responsibilities for certain types of emergencies. The Ministry of the Solicitor General, for example, must plan for “any emergency that requires the coordination of provincial emergency management.”

Premier and Lieutenant Governor in Council

The Premier has the power to declare and terminate emergencies under the *Emergency Management and Civil Protection Act.* In an emergency situation, the Premier may also exercise any power or perform any duty conferred upon a minister or an employee of the Crown. Once an emergency has been declared, the Premier or their delegate is required to report regularly to the public with regards to the status of the state of emergency. With the advice of Cabinet, the Lieutenant Governor also has the power to declare provincial emergencies or confirm emergency declarations made by the Premier.

During an emergency, the Lieutenant Governor, with the advice of Cabinet, has the capacity to make orders to, among other things, implement emergency plans, regulate or prohibit travel, evacuate individuals from specific areas, establish new care facilities and close public or private spaces. The authority to make these orders can be delegated to other provincial ministers or the Commissioner of Emergency Management (discussed below).

Emergency Management Ontario

Emergency Management Ontario (EMO) is a department of the Ministry of the Solicitor General with a mandate to monitor, coordinate and assist in the development and implementation of provincial emergency management programs. During states of emergency, EMO is also responsible for coordinating the province’s response efforts with Canada’s federal government.

EMO is led by the Commissioner of Emergency Management and the Chief of Emergency Management.

The Commissioner of Emergency Management’s role is to provide advice and guidance to the Premier and Cabinet during declared emergencies; oversee the coordination of public safety initiatives across the Ontario government; and make emergency orders as delegated to them during a provincial emergency. The position is currently filled by Ontario’s Deputy Solicitor General, Community Safety.

Meanwhile, the Chief of Emergency Management is specifically responsible for leading Emergency Management Ontario when an emergency situation arises and for implementing EMO’s emergency response plans.

Emergency Management Ontario is also charged with operating the Provincial Emergency Operation Centre (PEOC). The PEOC's central purpose is to coordinate emergency response activities between municipal, provincial and federal governments as well as non-governmental organizations and any other relevant entities.

In the SARS Commission Second Interim Report, the Honourable Justice Archie Campbell recommended that lines of authority be clear in future public health emergencies. He stated that the Chief Medical Officer of Health should oversee medical decisions, medical advice and communications regarding health risks, while the Commissioner of Emergency Management should be in charge of all other matters. Unfortunately, this is not what occurred during the COVID-19 pandemic, as neither the CMOH nor the Commissioner of Emergency Management had clear lines of authority within the province's pandemic response system.

Furthermore, while the PEOC was seemingly activated during Ontario's response to COVID-19, it was just one of the many government entities involved in the province's complex pandemic response structure.

Ministry of Health

The Ministry of Health is responsible for leading the province's response to public health emergencies including pandemics.

The Health System Emergency Management Branch in the Ministry of Health helps the health sector in general respond to public health emergencies. The branch also develops the Ministry's emergency readiness plans, helps health sector actors plan for emergencies, and directs, as necessary, health sector emergency response and recovery. Finally, the branch also works to ensure continuity of critical Ministry services during an emergency.

Until August 31, 2020, the Health System Emergency Management Branch reported to the Chief Medical Officer of Health. As of August 31, 2020, it reports to the Assistant Deputy Minister of Pandemic Response and Public Health Modernization.

The Health System Emergency Management Branch includes the Ministry Emergency Operations Centre (MEOC), which the Ministry can activate in response to an emergency. The MEOC, described by government representatives as the Ministry's operational "nerve centre," is tasked with coordinating and operationalizing the Ministry of Health's response to a public health emergency.

During the COVID-19 pandemic, the MEOC issued guidance documents whose purpose was to complement and provide more detail on directives the Chief Medical Officer of Health had issued. Ministry of Health representatives told the Commission that one of the MEOC's responsibilities was to support alignment and consistency

across the COVID-19 guidance documents issued by the province. As discussed in chapter 3, however, local public health officials and long-term care home Administrators told the Commission that the province issued an overwhelming number of guidance documents during the pandemic, some of which were inconsistent with one another.

Ministry of Long-Term Care

Under the *Long-Term Care Homes Act, 2007*, the Minister of Long-Term Care has the power to issue mandatory operational or policy directives to all of the province's long-term care homes when they consider it to be in the public interest to do so. One such directive was issued during the COVID-19 pandemic, requiring homes to accept assistance from hospitals when provided.

At the onset of the COVID-19 pandemic, the Ministry of Long-Term Care had only recently become a standalone ministry and, consequently, aside from the legislative power stated above, its role in preparing for and responding to a public health emergency was not clear.

Ministry of Labour, Training and Skills Development

The Ministry of Labour, Training and Skills Development is required by Order in Council to continue its oversight of provincial workplaces, including long-term care homes, during a state of emergency. The Ministry also receives and responds to reports of infectious disease outbreaks from public health units, long-term care homes and other provincial workplaces. In the event of an outbreak, the Ministry is to ensure that workplace safety requirements are being met at the outbreak site.

Chief Medical Officer of Health

The *Health Protection and Promotion Act* does not assign specific roles or responsibilities to the Chief Medical Officer of Health with regards to public health emergencies or pandemics.

The Ministry of Health's Emergency Response Plan, however, states that "[a]n Executive Lead may lead the [Ministry's] response to an emergency ... The [Chief Medical Officer of Health] typically plays this role for emergencies that fall under the [Ministry's] responsibility of 'human health, disease and epidemics' and for health system emergencies focused on Ontario's public health units ... "

As discussed above, when the CMOH believes that an immediate risk to the health of persons anywhere in Ontario exists or may exist, they may issue a directive to any health care provider or health care entity regarding precautions and procedures to be

followed to protect the health of persons anywhere in Ontario. A number of these directives were issued during the COVID-19 pandemic, including a directive requiring long-term care homes to ensure that staff and visitors wear personal protective equipment at all times while inside a home.

During a public health emergency or outbreak situation, the Chief Medical Officer of Health also has the power to issue directives to Public Health Ontario to provide scientific advice, technical advice or operational support to any person or entity, which would include long-term care homes.

Public Health Ontario

In a public health emergency or outbreak situation, Public Health Ontario's general mandate is to:

1. provide the Ontario government with scientific and technical advice;
2. provide surveillance and epidemiological data and analysis in support of pandemic response;
3. conduct research relevant to the pandemic; and
4. provide field support.

Public Health Ontario also operates public health laboratories that perform infectious disease testing.

Public Health Units, Boards of Health and Local Medical Officers of Health

In the event of a pandemic, public health units are generally responsible for overseeing local surveillance strategies, immunization and other relevant public health measures. Public health units also participate in coordinating local care and treatment during a pandemic.

When it comes to outbreak management in long-term care facilities, the role of public health units is primarily one of assistance rather than direct management. Public health units are to help homes prepare for outbreaks by educating them on outbreak management, helping them review and revise their infection prevention and control policies and outbreak plans, and providing recommendations for outbreak preventions, protection and management. Long-term care facilities can also request that a public health unit consult or inspect the adequacy of their IPAC programs at any time.

Boards of health are responsible for developing and maintaining written policies and procedures in preparation for responding to infectious disease outbreaks in institutional and facility settings. The boards are also responsible for helping individual facilities develop their own plans.

For their part, local medical officers of health maintain the ability to issue the orders and directives described above during a public health emergency. They also have the ability to declare a facility to be in an outbreak, though individual facilities can also make this declaration on their own. However, only the local medical officer of health has the final authority to determine whether an outbreak in a facility is over. Neither the *HPPA* nor the Ontario Public Health Standards and relevant guidelines explicitly require the local medical officer of health to take on a leadership role with regards to public health emergency preparedness, management or recovery.

Local Health Integration Networks, Ontario Health and Ontario Health Teams

Before the COVID-19 pandemic, the role of the province's local health integration networks during a pandemic emergency was not entirely clear. The most recent version of the Ministry of Health and Long-Term Care's Emergency Response Plan – published in 2013 – stated that LHINs were responsible for ensuring that the health services funded under their structure could continue to be delivered during public health emergencies. Ontario's most recent influenza pandemic plan – also published in 2013 – stated that local health integration networks were responsible for liaising between the health service providers in their jurisdiction and the Ministry of Health and Long-Term Care. It further assigned LHINs the responsibility of participating in the coordination of local care and treatment, a duty allocated to public health units as well. The plan also noted, however, that "[o]ther LHIN roles during an influenza pandemic are currently under development" and that, in the next version of the influenza pandemic plan, the Ministry of Health and Long-Term Care would "continue to clarify the role of LHINs in influenza pandemic response." As discussed in chapter 2 of this report, a "next version" of the pandemic plan was never developed.

As of November 2020, the Ontario Health Teams program was still in the early stages of development and the provincial government did not yet mandate individual teams to provide direct assistance to long-term care homes in emergencies such as a pandemic. Ministry of Health representatives told the Commission that the Ontario Health Teams initiative was not sufficiently advanced during the first or second wave of the pandemic to allow the Ministry to endow the teams with the power to give binding directions to their constituent health care providers. In some instances, however, Ontario Health Teams have been able to mobilize resources and create relationships that have allowed them to assist long-term care homes during the COVID-19 pandemic with infection prevention and control advice, personal protective equipment acquisition, staffing support, and virtual care. A further discussion of these cases can be found in chapter 4 of this report.

Legislation, Standards, Protocols and Guidelines

Ontario's public health, long-term care and emergency response systems are governed by several key laws, regulations, standards, protocols and guidelines.

The *Health Protection and Promotion Act*

The *Health Protection and Promotion Act* is Ontario's primary public health statute. It provides legislative authority for the organization and delivery of public health programs and services in Ontario, and initiatives to prevent the spread of disease and promote and protect the health of the people of Ontario. The *HPPA* sets out a list of mandatory public health programs and services to be delivered across the province. These include "[c]ontrol of infectious diseases and diseases of public health significance, including provision of immunization services to children and adults." The *HPPA* also defines the roles and responsibilities of local boards of health and local medical officers of health. Finally, the legislation is the source of the powers held by local medical officers of health and the Chief Medical Officer of Health to issue orders to help decrease or eliminate the risk to Ontarians' health presented by communicable diseases.

Ontario Public Health Standards, Protocols and Guidelines

The Ontario Public Health Standards, published by the Ministry of Health, detail certain public health programs and services that boards of health are required to deliver. The Ministry of Health also publishes guidelines and protocols regarding infection prevention and control, infectious disease outbreak management, and control of respiratory infection outbreaks in long-term care homes. These documents elaborate on the responsibilities of the boards of health as set out in the Standards.

The Emergency Management and Civil Protection Act

The *Emergency Management and Civil Protection Act* establishes the provincial and municipal framework to prepare for and respond to emergencies, including those caused by "a disease or other health risk." Ontario's Solicitor General is responsible for administering the *EMCPA*. The *EMCPA* requires Ontario's ministries to create emergency plans to govern the provision of necessary ministry services during an emergency.

In Ontario, a state of emergency is declared under the *Emergency Management and Civil Protection Act* by the Premier or the Lieutenant Governor with the advice of Cabinet. Once an emergency is declared, specified government officials gain the ability

to issue a broad range of orders, including prohibitions on travel or movement, the closure of public or private places, and the restriction of service provision. An initial declaration of a state of emergency can last for up to 14 days and can only be renewed once by the Lieutenant Governor with the advice of Cabinet for 14 additional days. After this point, additional extensions must be approved by a majority of the Ontario legislature.

The declaration of a state of emergency does not affect any of the powers provided to the Chief Medical Officer of Health, local medical officers of health or the Minister of Health under the *Health Promotion and Protection Act*. If there is any conflict between an order issued by any of these individuals and an order made under the *EMCPA*, the *EMPCA* order prevails.

The Long-Term Care Homes Act

Ontario's *Long-Term Care Homes Act, 2007*, sets a framework for the delivery of care services from long-term care homes to their residents. The *LTCHA* requires every long-term care home to implement an infection prevention and control program. The *LTCHA* states that each home's IPAC program is to include infection monitoring and infection prevention measures and must comply with the requirements stated in the *LTCHA* regulation.

The *LTCHA* regulation states that licensees must ensure that:

- IPAC programs are implemented in the home by an interdisciplinary team that meets regularly and invites the local medical officer of health to its meetings.
- IPAC programs are evaluated and updated at least annually.
- All staff participate in the implementation of the IPAC program and monitor and record signs of infection on every shift. Licensees must also ensure that these records are analyzed regularly to detect infection trends.
- As part of the IPAC program, an outbreak management system is implemented to detect, manage and control infectious disease outbreaks. The outbreak management plan must also include defined staff responsibilities, reporting protocols based on requirements of the *Health Promotion and Protection Act*, communication plans, and protocols for receiving and responding to health alerts.
- A hand hygiene program is included in the IPAC program.

As discussed elsewhere in this report, some long-term care homes in Ontario failed to abide by the IPAC program requirements in the *LTCHA* regulation.

Legislation and Order in Council Not Updated to Reflect New Ministries

It should be noted that many of the important pieces of legislation mentioned above were not updated after the Ministry of Health and Long-Term Care was partitioned in July 2019. Consequently, all references to "the Minister" and said Minister's responsibilities in the *Health Protection and Promotion Act* and the *Long-Term Care Homes Act, 2007*, technically refer to the Minister of Health and Long-Term Care – a position that no longer exists within a Ministry that no longer exists.

The Commission could not locate any publicly available government documents indicating which of the responsibilities described in these laws were assigned to the Minister of Health and which to the Minister of Long-Term Care. These two acts are crucial to the oversight of long-term care homes and the protection of their residents. It is critical that information regarding ministerial responsibility for the enforcement and implementation of these laws be apparent and accessible to members of the public and those who work within the long-term care sector. When the province created a standalone Ministry of Health and a separate Ministry of Long-Term Care, it should have updated relevant legislation accordingly to clarify the new Ministers' roles and responsibilities.

Furthermore, the provincial Order in Council that assigns emergency planning responsibilities to various ministries assigns responsibility for "human health, disease and epidemics; health services during an emergency" to the defunct Ministry of Health and Long-Term Care, making it unclear what specific roles the new Ministry of Health and Ministry of Long-Term Care should play in a pandemic. Confusion between the two ministries as to their respective roles in pandemic preparedness was apparent during the COVID-19 crisis.

Conclusion

In the months leading up to the COVID-19 pandemic, Ontario's complicated health and public health systems were in a state of flux. The primary ministry responsible for the health and long-term care sectors had been divided into two. The networks through which the provision of local health services was overseen and administered were undergoing a significant reorganization. Meanwhile, as discussed in chapter 1, within the province's long-term care homes, deep-seated issues were festering, weakening the ability of homes to manage a potential pandemic.

Once the COVID-19 pandemic began, it severely tested the actors, bodies, legislation and regulatory regimes that oversee and administer Ontario's health sector, public

health system, emergency response system and long-term care homes. As discussed throughout this report, the ability of these institutions to protect the province's long-term care homes would, in many respects, prove to be lacking.

Appendix C: An Investigation into an Ongoing Crisis

This Commission was called on July 29, 2020, to investigate how and why COVID-19 spread in long-term care homes, what was done to prevent the spread, and the impact of existing features of the long-term care system on the spread. Like the SARS Commission launched in 2003 and led by the Honourable Justice Archie Campbell, Ontario's Long-Term Care COVID-19 Commission was created pursuant to section 78 of the *Health Protection and Promotion Act (HPPA)*, which allows the Minister of Health to call for an investigation into "the causes of any disease or mortality in any part of Ontario."

This investigation has been different and perhaps even unprecedented in many ways. It involved investigating a severe and evolving health crisis as it was still underway. The Commission had to complete its investigation and prepare its report within nine months, a significantly short time when compared to recent commissions struck under the *HPPA* and public inquiry legislation to investigate matters of public health. Furthermore, the Commission conducted its investigation entirely remotely.

The Commission

The Commission conducted its investigation in accordance with the *Health Protection and Promotion Act*, the Terms of Reference, and its own Guiding Principles.

Section 78 of the Health Protection and Promotion Act

Under section 78 of the *Health Protection and Promotion Act* anyone can be appointed to investigate the causes of diseases and mortality in Ontario (an *HPPA* investigation). The investigative power is vital to meeting one of the essential purposes of the *HPPA*: the prevention of the spread of disease and the protection of health. The importance of this power to investigate was critical during the COVID-19 pandemic given the dire situation facing long-term care. This Commission was called upon to investigate and make recommendations during the course of the health emergency with the hope that those recommendations would not only prevent the continued spread of COVID-19 in long-term care but also provide longer-term solutions.

The *HPPA* provides that only section 33 of the *Public Inquiries Act (PIA)* applies to the investigation. Section 33 sets out certain investigative powers and procedures, though other sections of the *PIA* contain a broader set of tools and procedures suitable to a more formal hearing. The legislature wisely limited the complexity of *HPPA*

investigations so as to ensure that they take place expeditiously and with flexibility, as would be expected where an investigation is attempting to address an ongoing public health hazard. Section 33 provides the investigators with the power to summons witnesses and documents, which facilitates the investigative process. The investigation is not a trial or even an inquiry. It is an inquisitorial process intended to allow the investigators to assess the causes of the disease and mortality and make recommendations so that steps may be taken to protect the health and lives of Ontarians.

However, during the course of this investigation, it became apparent that additional powers and protections in the *Public Inquiries Act* would have been of assistance in expediting this investigation. For example, section 19 of the *PIA* allows the government to produce privileged documents to an inquiry without waiving privilege. This section does not apply to *HPPA* investigations. Unfortunately, considerable time was spent addressing this issue within this Commission, which distracted from the Commission's real work. Other sections in the *PIA* should also be considered for inclusion in section 78, such as sections 18 (no intimidation by employer), 22 (protection against compulsion) and 23 (protection from action). Furthermore, consideration should also be given to ensuring that investigators may hear from people confidentially. The Commission heard from staff and residents who feared speaking publicly. As discussed below, this necessitated an amendment to the Terms of Reference. The extraordinary circumstances in which section 78 is used requires the government to ensure that the investigators have all the tools needed to act expeditiously and independently. The government should review all of the provisions of the *PIA* and consider applying any that might be helpful to *HPPA* investigations.

Terms of Reference

The Commission's Terms of Reference (see appendix C.2) as drafted by the government required the Commission to investigate and consider:

1. how the state of Ontario's long-term care homes system before the COVID-19 pandemic contributed to the spread of COVID-19 within long-term care homes, and how residents, staff, volunteers, visitors, family members and others were impacted;

2. the adequacy of the measures taken by the provincial government, long-term care homes and others to prevent and contain the spread of COVID-19 within long-term care homes;

3. the impact of, among other things, physical infrastructure, staffing approaches, labour relations and clinical oversight on the spread of COVID-19 in long-term care homes;

4. current government initiatives and reforms in the long-term care homes system; and

5. all other matters that the Commissioners considered necessary to both assess the cause of the spread of COVID-19 within long-term care homes and further areas that should be the subject of future action by government to help prevent the future spread of disease in long-term care homes.

The Terms of Reference specifically require the Commissioners to conduct the investigation without making any findings of fact with respect to civil or criminal responsibility of any person or organization.

The Terms of Reference permitted the Commissioners to use any existing records or reports relevant to its mandate, including the 2019 final report and recommendations from the Honourable Justice Eileen E. Gillese's Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System.

The Terms of Reference required that the Commission's report be completed by April 30, 2021, and permitted the Commission to release interim reports setting out any information or recommendations that the Commissioners felt the government should consider before the final report was published.

The Commission released two sets of interim recommendations in order to communicate as soon as possible key recommendations that, if acted upon, would assist in preventing the spread of COVID-19 and protecting the health of the residents in long-term care homes (see appendix A). The interim recommendations, which were provided to the Minister of Long-Term Care and published on the Commission's website on October 23, 2020, and December 4, 2020, are discussed further below.

The Commissioners heard that long-term care staff and residents did not feel comfortable coming forward as they feared for the safety of the residents and also for their jobs. The Commission therefore sought and obtained amendments to the Terms of Reference to clarify the Commission's power to deal with information related to the investigation, including receiving information confidentially, anonymizing the sources of information received confidentially, and otherwise maintaining the confidentiality of such information.

The Terms of Reference require that "The Commissioners shall take into account any current government initiatives and reforms in the long-term care homes system, including responses to COVID-19 and any work underway in response to the Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System in making any recommendations." The government has not advised the Commission of all of its ongoing initiatives and reforms. For example, the government has indicated that it is currently reviewing whether personal support workers should be either part of

a registry system or a regulated profession, or should remain unregulated; however, it declined to share its current analysis of this issue, even though the subject has been a matter of much discussion before the Commission (see chapters 1 and 5).

Guiding Principles

At the outset of the Commission, the Commissioners articulated five Guiding Principles (see appendix c.3) for their investigation:

1. **Independence:** The Commission operates independently of the government. Its independence is essential to uncovering the facts, conducting an objective analysis of the issues and developing recommendations.
2. **Thoroughness:** The Commission will conduct a comprehensive investigation to ensure that the questions set out in its Terms of Reference are explored and answered.
3. **Inclusiveness:** The Commission will ensure that it obtains information from the full spectrum of individuals and organizations who have information relevant to determining the factors that led to the outbreak in long-term care homes, and to developing strategies to prevent future outbreaks.
4. **Timeliness:** The Commission is working as the entire health care system continues to address the pandemic. In addition to making recommendations to assist the government in planning for future pandemics, the Commissioners will aim to make recommendations to prevent the further spread of disease during this pandemic.
5. **Flexibility:** To support a thorough, inclusive and timely investigation, the Commission will use a broad range of investigatory methods.

This Commission used all of these Guiding Principles to develop a process that would permit it to explore and investigate in a way that was consistent with its Terms of Reference. This process is described below.

The Commissioners, Commission Counsel and the Secretariat

The Commission was led by three Commissioners. The Commissioners directed the investigation and presided over public meetings that were transcribed, with the transcripts posted on the Commission's website, and over certain confidential meetings. The Commissioners were supported in their work by Commission Counsel and the Secretariat to the Commission. The Secretariat was composed primarily of seconded Ontario Public Service staff. Commission Counsel provided legal advice to the Commissioners and, together with the Secretariat staff, assisted in the Commission's investigation.

The Commissioners, Commission Counsel and the Secretariat brought various perspectives from both the public and private sectors. The Commission's team included members with expertise in health care, long-term care and legal sectors, as well as civil servants with significant public policy experience.

The Commission Website

The Commission's website provided the public with information both in English and French about the Commission's investigation, including the Commission's mandate, Terms of Reference, Guiding Principles, Commissioners, Commission Counsel and Secretariat staff. The website was fully compliant with the requirements of the *Accessibility for Ontarians with Disabilities Act, 2005*.

Updates on the Commission's progress were posted to the website along with transcripts of public meetings with the Commissioners. Many of the Commission's witnesses had slide decks to assist when they were presenting; these were also posted to the Commission's website to ensure that readers could understand the discussion in the transcript.

In addition, specific pages of the website were created to solicit observations and insights from long-term care home residents and their loved ones, long-term care homes staff, and management. Those who wished to could provide a written submission to a dedicated email address, leave a message on a monitored toll-free phone line, or participate in facilitated group meetings with Commissioners. Members of the general public could also leave a message or make written submissions to the Commission.

Guidelines for written submissions posted to the website provided suggested issues and questions to assist those preparing submissions to the Commission. The website notified those making written submissions that, while their submissions would not be posted on the Commission's website, the Commissioners might refer to those submissions in an interim or final report. Following the amendments to the Terms of Reference, the Commission permitted individuals to provide information on a confidential basis. The website advised that the general themes expressed in information provided confidentially might be discussed without attribution in the Commission's interim or final reports. The website also noted that if information provided confidentially identified an immediate risk to an individual or individuals' health and safety, the Commission might take steps to ensure that this information was shared with organizations that could address the risk.

Organizations whose members were interested in the Commission's work were also asked to provide a link to the Commission's website on their own website to make it easy for that organization's members to follow the Commission's progress.

Investigating in the Midst of a Pandemic

Commissions are often called in the aftermath of terrible disasters. Few, if any, have been called while the disaster rages. This Commission was called to investigate the cause and spread of death due to a disease that gripped the province and long-term care throughout the tenure of the Commission's work. Conducting an investigation in the midst of a crisis poses additional challenges.

The Supreme Court of Canada has stated that Commissions of Inquiry are "often convened, in the wake of public shock, horror, disillusionment, or scepticism, in order to uncover 'the truth.'" The Court has also stated that Commissions are charged with investigating tragedies in order to "help to prevent a recurrence of such tragedies in the future[.]"

Investigating the response to a novel ongoing public health threat required a different approach than that taken by most Commissions, since the information and situation evolved as the investigation was proceeding. The number and severity of outbreaks within long-term care facilities were constantly changing, as was the common understanding of the nature and transmission of COVID-19. Having the benefit of timely information, the Commission released two sets of interim recommendations to assist in preventing the spread of COVID-19 and protecting the health of the residents and staff in long-term care homes (see appendix A).

Interim Recommendations

The Commission's first set of recommendations was released and sent to the Minister of Long-Term Care on October 23, 2020, amidst the pandemic's second wave. The recommendations focused on staffing, collaborative relationships between long-term care homes and health care partners, and infection prevention and control (IPAC).

As the second wave of the pandemic worsened, the Commission released a second set of interim recommendations on December 4, 2020. These recommendations focused on increasing the quality of resident care by improving leadership and accountability within long-term care homes. The recommendations included expanding and improving performance indicators to enhance resident quality of care. This set of recommendations also addressed issues regarding long-term care home inspections carried out by the Ministry of Long-Term Care, the Ministry of Labour, Training and Skills Development, and local public health units.

The Commission's Investigation Process

The Commissioners had the power by summons to require any person to provide documents and information. The Commission used summonses where required and at the request of individuals and document custodians.

The Interviews

The Commission engaged with a variety of individuals who had information relevant to the Terms of Reference, including:

- **Long-term care home residents and their loved ones:** The Commission met with residents and loved ones as well as Residents' Councils and Family Councils from many long-term care homes from different areas throughout the province. Meetings were conducted in English, and where Francophones were participating, live interpretation was used.
- **Long-term care home staff:** The Commissioners met with staff, staff associations and unions from across the province to hear about their experiences in long-term care before and during the pandemic.
- **Operators of long-term care homes:** The Commission heard from for-profit, not-for-profit, and municipally owned homes throughout the province and their representative organizations.
- **Other health care professionals from Ontario, and other provinces and countries:** These individuals provided the Commission with information about approaches that helped and could help reduce the spread of COVID-19 in long-term care homes during the pandemic, and that could have helped in the years prior.
- **Former and current government representatives**, including representatives from the Ministry of Health, Ministry of Long-Term Care, Ministry of the Solicitor General, Public Health Ontario, Ontario Health, Ministry of Labour, Training and Skills Development, and Cabinet Office, as well as medical officers of health. These individuals provided information about the province's approach to long-term care generally and its response to COVID-19 in long-term care homes.
- **Associations and advocacy groups:** The Commission sought information from associations and advocacy groups representing the interests of various stakeholders including personal support workers, pharmacists, registered nurses, allied health professionals (including audiologists, speech pathologists and dietitians), hospitals and long-term care homes. The Commission spoke with groups representing the province's senior citizens generally and was particularly interested to meet with groups specifically devoted to seniors belonging to

various minority or marginalized groups including Francophone, 2S-LGBTQ+, Indigenous, and those living in or using homeless shelters.

- **Experts and researchers in a variety of fields:** These individuals shared their knowledge, insights and findings in such areas as economics, data analytics, sociology, HVAC, architecture and design, social work, occupational health and safety, health education, medicine, infectious diseases, and geriatrics.

The Commissioners interviewed more than 700 individuals, some of whom appeared more than once, during the course of more than 170 formal sessions. There are more than 15,000 pages of transcripts of these meetings. All individuals interviewed had an opportunity to review and correct the transcripts of the interviews before they were posted to the website, and to provide any additional information.

In addition, the Commission held more than 20 confidential interviews, including with staff and other individuals concerned about reprisals.

Group Meetings with Impacted Individuals and Commissioners

Meetings with impacted individuals have been an important part of previous commissions where individuals have experienced trauma. Hearing first-hand from those who have suffered is an important part of the investigation; it also provides an opportunity for individual healing through the sharing of experience and loss.

This Commission made every effort to hear, in either official language, from as many residents, family and staff as possible. Given that the pandemic required the meetings to be held virtually, additional consideration had to be given to the design of the sessions since they would normally be held in person.

Impacted individuals numbered in the thousands, so efforts were made to maximize the number of participants. The Commission was mindful of issues in long-term care homes fighting outbreaks and where residents needed assistance to participate. Addressing the accessibility, design and confidentiality needs of vulnerable populations allowed for long-term care residents and staff to participate. The Commission reached out to the Ontario Association of Residents' Councils, Family Councils Ontario and a number of regional family council organizations to help advertise the meetings and to get advice about the needs of residents and families. The Commission also worked with unions representing staff in homes to ensure that staff felt safe in sharing their difficult experiences with the Commissioners in a group setting.

These meetings were beneficial for the Commission because they brought discussions of policy to life – or, perhaps more appropriately, they brought life to discussions of policy.

Finally, the transcripts of these public meetings are on the website and form – for future generations – an oral historical record of what happened to the people in long-term care homes during this pandemic.

Written Submissions

The Commission sought written submissions from stakeholders and members of the public as part of its investigation. The Commission received and considered in its investigation some 300 written submissions from long-term care residents and their families, from long-term care home staff, from long-term care home management, from the general public, and from a variety of others including academics, researchers, advocacy groups and non-profit organizations.

Preliminary Interviews

Commission Counsel and Secretariat staff conducted preliminary interviews to identify those to attend before the Commissioners. In addition, Commission Counsel interviewed people who did not appear before the Commission but who nonetheless provided useful information and background.

Public Access to Meetings with the Commissioners

The Commission published transcripts of the formal Commissioners' meetings to the Commission website to ensure that the public had access to all information it was able to share.

The final reports of other Commissions have highlighted the importance of providing public access to the means, methods and objectives of the Commission where matters of public interest are under investigation; doing so helps instill confidence in the public that the process is moving forward appropriately. In the final report of the Walkerton Inquiry, the Honourable Justice Dennis R. O'Connor noted that providing the public with access to the evidence helps keep the public informed of a Commission of Inquiry's progress in real time, and allows the public to formulate their own opinions about what the Commissioners are being told. The Supreme Court of Canada has also stated that conducting these sorts of investigations in full view of the public can "serve as a type of healing therapy for a community shocked and angered by a tragedy."

In light of the urgency of the situation and consistent with the Terms of Reference requirement that the investigation not impede ongoing efforts to isolate and contain COVID-19, Commission meetings were conducted remotely on a secure virtual platform. When conducting interviews, multiple individuals from the same organization

were often interviewed simultaneously to maximize the investigation's efficiency and to ensure the most accurate information possible.

Confidential Interviews with Commission Staff

The Commission also relied on confidential meetings where necessary, following the precedent set by Justice Campbell's investigation into the introduction and spread of SARS. The SARS Commission conducted more than 600 confidential interviews over three years and held only six days of public hearings. In his report, Justice Campbell stated that using confidential interviews was necessary to obtain the frank, in-depth testimony required for the Commission to consider all issues and make appropriate findings and recommendations. In certain instances, that proved true for this Commission as well.

This Commission repeatedly heard that people were afraid to publicly provide information to assist in the investigation. Staff working in long-term care homes feared reprisal against themselves, while people with loved ones still living in long-term care homes feared reprisal against those residents. In order to address these concerns and protect the privacy of these individuals, Commission staff conducted confidential interviews where appropriate.

The Commission also heard from family members who were concerned about legal action if they spoke negatively about the homes. The Commission arranged for duty counsel to advise individual participants if requested.

It is important that individuals feel safe giving information to investigatory bodies such as this. On more than one occasion the Commission was reminded about the importance of whistleblower protections and has therefore recommended strengthening the protections offered in the context of *HPPA* investigations.

Survey of the Province's Long-Term Care Homes

To fill gaps in existing reports and documents, and to have real-time information to inform its recommendations, the Commission conducted a survey of the province's 626 long-term care homes. This mandatory survey sought information about a number of issues including staffing, infrastructure, infection prevention and control practices, and leadership in the homes.

This survey data was used to report to the Commission on factors that contributed to the spread of COVID-19 in the province's long-term care homes in the first wave of the pandemic.

Documentary Disclosure

In addition to the steps described above, the Commission also sought and obtained documents from relevant individuals and entities, including government ministries and agencies.

Difficulties Obtaining Necessary Government Information

The Terms of Reference mandated this Commission to investigate the adequacy of measures taken by the government and others to prevent, isolate and contain the spread of COVID-19 in long-term care homes. This necessitated a review and analysis of the government's contemporaneous records about the measures taken to prepare for the pandemic (prevention) and regarding the adequacy of the government's efforts to respond (isolate and contain the spread of the virus).

The Cabinet – well aware of the extraordinarily short time in which the Commission was required to complete its work – directed its ministries by Order in Council to cooperate with the Commission. When it was clear that, despite the Order in Council and the April 30 deadline, timely production of records would not be forthcoming, a summons to produce documents was issued in October. The government produced documents episodically through to early December. Government counsel advised the Commission early in its investigation that hundreds of thousands of documents would be produced. By early December, only a fraction of this amount had been produced. The failure to produce documents in a timely fashion was a specified reason why the Commissioners sought an extension of the deadline, which was denied.

The Chief Medical Officer of Health, Minister of Health and Minister of Long-Term Care were scheduled to appear before the Commission during the last week of February 2021. Ten days before they were to testify, the government produced an additional 211,000 documents. Furthermore, notes were produced on the eve of each of their attendances before the Commission. This type of late production does not assist the process and negatively affects the appearance of the process. While the Commission is confident that this very late disclosure has not undermined its recommendations, the government nonetheless must take steps to ensure future Commissions are not faced with the same late and obstructive disclosure issues.

Other Operational Challenges of the Short Timeline

Important elements of the Commission's work to ensure public participation and public transparency were challenging given the short timeframe for investigating and reporting.

Specifically, as noted, the Commission took its obligations to Francophone Ontarians very seriously, actively offering services in French for all residents, family and staff, and providing French and English versions of all its communications with the public on its website.

Despite the compressed timeframe, the Commission placed priority on ensuring that individuals were able to speak to the Commission in both English and French. Additional time to deliver the report would have afforded an opportunity to provide simultaneous interpretation for meetings with persons whose first language was other than French or English, which is important given the general recognition that people with dementia and other cognitive issues tend to lose facility in their second language. It would have also afforded long-term care staff and loved ones of long-term care residents the opportunity to express themselves more comfortably and effectively in another language. The Commission heard from some individuals that language issues contributed to additional isolation for non-English first-language speakers. Had the Commission had more time, it would have ensured that the voices of those individuals could be heard through participation in additional group sessions with residents, staff and families using simultaneous translation.

In considering the time that Commissions need to conduct an investigation and deliver a final report, governments must consider more carefully the issues that must be attended to in conducting such work.

Existing Reports

The Commission's Terms of Reference required the Commissioners to review and consider any existing records or reports relevant to the Commission's mandate where practicable and appropriate, and permitted reliance on such reports instead of requiring the authors to attend before the Commission through interviews or otherwise.

Ontario has commissioned some very helpful reports. However, some were not easily accessible. For example, Dr. David Walker's report on SARS could not be located on the government website. This seminal work was of great value to this Commission, and should be accessible to all Ontarians. It is recommended that all reports of significance on public health be made easily accessible to the public on the internet.

Conclusion

It has been an honour to serve on this Commission. Although we were confronted with extraordinary circumstances in conducting our investigation, thanks to the efforts of many, we were able to meet the challenge.

We were entrusted with the obligation to fully investigate what happened to cause the excessive sickness and deaths in long-term care homes and to make recommendations to prevent such a tragedy in the future.

Through our interviews we were also entrusted with the experiences of the residents who survived, and the experiences of family members and staff who suffered significant trauma as the first and second waves of COVID-19 swept through Ontario's long-term care homes. Instead of thanking the surviving residents, residents' family members and staff for reliving these painful events, the Commission respectfully suggests that we finally do now what many have urged be done in the past; namely, that we listen to what they told us and do what so obviously needs to be done.

Stay at home except for essential travel and follow the restrictions and public health measures.

Ontario

Ontario

Order in Council 1058/2020

On the recommendation of the undersigned, the Lieutenant Governor of Ontario, by and with the advice and concurrence of the Executive Council of Ontario, orders that:

Whereas the Minister of Long-Term Care will appoint the Honourable Justice Frank Marrocco, Chair, Angela Coke and Dr. Jack Kitts as Commissioners to investigate the recent spread of Covid-19 within long-term care homes pursuant to section 78 of the *Health Protection and Promotion Act*;

Whereas clause 56(1)(b) of the *Judges Act* (Canada) provides that a Judge may act as a Commissioner where authorized to do so by the Lieutenant Governor in Council of a Province;

Whereas the Minister of Long-Term Care has provided the Commissioners with a Terms of Reference for the investigation;

And whereas it is desirable to support the investigation and to mandate full co-operation with the Commissioners by all Government ministries and agencies;

Honourable Justice Frank Marrocco is hereby authorized to act as a Commissioner pursuant to his appointment by the Minister of Long-Term Care to undertake an investigation under section 78 of the *Health Protection and Promotion Act*;

All Government ministries and agencies, and their employees, shall assist the Commissioners to the fullest extent in order that they may carry out the investigation; and

All Government ministries and agencies shall respect the independence of the investigation.

Premier and President of the Council

Approved and Ordered: July 22, 2020

Published: August 6, 2020

Terms of Reference

Ontario's Long-Term Care COVID-19 Commission

MANDATE

1. Having regard to s. 78 of the *Health Protection and Promotion Act*, the Commissioners shall investigate and provide a report of findings and recommendations respecting:

   (a) how the pre-COVID-19 state of the long-term care homes system, including the relationship to other aspects of the health care system, contributed to the COVID-19 virus spread within long-term care homes and how residents, staff, volunteers, visitors, family members and others were impacted;

   (b) the adequacy of measures taken by parties, including the province, long-term care homes and other parties, to prevent, isolate and contain the spread of COVID-19, including the adequacy of existing legislative and regulatory provisions, policies, practices and specifications on infection prevention and control of infectious diseases in long-term care homes;

   (c) the impact of existing physical infrastructure, staffing approaches, labour relations, clinical oversight and other features of the long-term care system on the spread of COVID-19 in the long-term care homes;

   (d) all other relevant matters that the Commissioners consider necessary to investigate the cause of the spread of COVID-19 within long-term care homes;

   (e) in considering the current government initiatives and reforms in the long-term care homes system, any further areas that should be the subject matter of future action by government to help prevent the future spread of disease in long-term care homes.

2. The Commissioners shall ensure that the investigation be conducted in a manner that does not impede ongoing efforts to isolate and contain COVID-19.

3. The Commissioners shall conduct the investigation faithfully, honestly and impartially in accordance with these terms of reference, and shall ensure that the investigation

is conducted effectively, expeditiously, and in accordance with the principle of proportionality.

4. The Commissioners shall conduct the investigation and make the report without expressing any conclusion or recommendation regarding the civil or criminal responsibility of any person or organization. The Commissioners shall further ensure that the conduct of the investigation does not in any way interfere or conflict with any ongoing criminal, civil or other legal proceedings or investigation, and without making any findings of fact with respect to civil or criminal responsibility of any person or organization.

5. The Commissioners shall, as much as practicable and appropriate, refer to and rely on the matters set out in section 33 of the *Public Inquiries Act, 2009*. In particular, the Commissioners may request and review and consider any existing records or reports relevant to the mandate, including the Final Report and Recommendations from the Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System dated July 30, 2019, and other medical, professional and business records. Further, the Commissioners may consider such reports and records in lieu of requiring persons to provide evidence and documents to the Commissioners through interviews or otherwise.

6. The Commissioners shall take into account any current government initiatives and reforms in the long-term care homes system, including responses to COVID-19 and any work underway in response to the Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System in making any recommendations.

7. The Commissioners shall hold such public and private (in person or virtual, as appropriate) meetings as they deem advisable in the course of investigation.

8. In accordance with section 33 of the *Public Inquiries Act, 2009*, the Commissioners may by summons require any person to give evidence or produce in evidence such documents and things as the Commissioners may specify that is relevant to the investigation in order to fulfill their mandate in a timely manner.

9. The Commissioners, through the support Secretariat, shall be provided with such resources as are required, and may request the retention of lawyers, experts, research and other staff as the Commissioners deem appropriate and may request the acquisition of external research.

10. Upon completion of their investigation, the Commissioners shall deliver their final report containing their findings, conclusions and recommendations to the Minister of

Long-Term Care who shall make such report available to the public as soon as practicable after receiving it.

11. The Commissioners shall conclude the investigation and deliver a final report to the Minister of Long-Term Care no later than April 30, 2021. The Commissioners may provide an interim report setting out any information or recommendations they believe should be considered by the government prior to the submission of their final report.

12. The Commissioners shall also ensure that the final report is delivered in both English and French at the same time; however, if, in the opinion of the Commissioners, the health and safety of the public would not be served by delaying the delivery of the report and only one language version is ready, the Commissioners may deliver the report in only one language. If the report is delivered in only one language, the other language version shall be delivered as soon as possible.

13. The Commissioners shall ensure that the final report is prepared in a form appropriate for release to the public, pursuant to the *Freedom of Information and Protection of Privacy Act*, the *Personal Health Information Protection Act, 2004* and other applicable legislation. In so far as practicable, the Commissioners shall work to maintain and ensure the confidentiality of personal information and personal health information.

14. The Commissioners shall ensure that the investigation is conducted in a manner consistent with the limits of the constitutional jurisdiction of the Province of Ontario.

15. The Commissioners shall act in accordance with the Terms of Reference, which may be amended by the Minister of Long-Term Care as required.

16. In the event that the Commissioners are unable to carry out any individual term of the mandate, the remainder of these provisions shall continue to operate, it being the intention of the Minister of Long-Term Care that the provisions operate independently.

AUTHORITY AND APPOINTMENT OF COMMISSIONERS

The Commissioners will be appointed by the Minister of Long-Term Care under section 78 of the *Health Protection and Promotion Act* and in accordance with directives outlined in Treasury Board/Management Board of Cabinet's *Agencies and Appointment Directive*.

This process will include meeting eligibility criteria and completing personal and conflict of interest disclosures and a police record check.

The Commissioners will be tasked with acting in the interest of Ontario and will need to demonstrate impartiality.

The appointment as a Commissioner does not confer the status of a public servant under the *Public Service of Ontario Act, 2006*. Further, as an appointee, the Commissioners are not, and shall not be deemed to be an employee, agent or partner of Her Majesty the Queen in right of Ontario or the Ministry of Long-Term Care for any purpose, except as set out in the paragraphs below regarding Access and Privacy.

The Commissioners shall comply with the Treasury Board/Management Board of Cabinet's *Agencies and Appointment Directive* and all other applicable government directives.

The Commissioners will be collectively referred to as "Ontario's Long-Term Care COVID-19 Commission."

TERM OF APPOINTMENT

Each appointment is at pleasure and will be for a term not exceeding May 31, 2021, unless the appointment is revoked, or the Commissioner terminates his or her participation by providing 30 days' prior written notice.

REIMBURSEMENT AND REMUNERATION

The Commissioners will be compensated with a *per diem* as set out in the Order in Council approved by the Lieutenant Governor in Council.

The Commissioners will be reimbursed for eligible expenses in accordance with Treasury Board/Management Board of Cabinet's *Travel, Meals and Hospitality Directive*.

COMMISSION APPOINTEES

Chair:

One Commissioner will be designated to act as a Chair and will:

- Set the direction of the Commission's investigation and may make recommendations to the Minister of Long-Term Care on amendments to the Terms of Reference;
- Determine the structure and staffing needs of the Commission in order to fulfil its mandate and make recommendations to the Executive Lead – subject to applicable guidelines and directives;
- Liaise between the Commission and the Minister of Long-Term Care;
- Ensure the fulfillment of the Commission's mandate without prejudice; and,
- Be the public face of the Commission and be the official person of record for the Commission.

Commissioners

The other Commissioner(s) will:

- Be representatives of the Commission that may preside over hearings and interviews;
- Be a strategic advisor to the Chair and the government;
- Fulfil the mandate of the Commission without prejudice; and,
- Be responsible for the duties of the Chair if he is unable to fulfil those duties.

SECRETARIAT STAFF

The Commission will be supported by a secretariat of approximately 12 FTEs to provide a variety of support functions including administration, communications, research, project management and legal services.

The Ontario Public Service will provide an Executive Lead who will oversee the secretariat. The Executive Lead will be responsible for staffing the secretariat and ensuring the Commissioners are supported in their mandate. This secretariat will be housed within the Ministry of the Attorney General.

BUDGET

The Commission will have an operating budget to support activities related to their mandate. The Commission may recommend to the Executive Lead such counsel, staff, or expertise or other services as the Commission considers necessary in the performance of their duties, subject to the operating budget, and applicable directives and guidelines, including those pertaining to the retention of outside counsel.

CONFLICT OF INTEREST

Each Commissioner is required to fulfill the duties of his or her appointment in a professional, ethical and competent manner and avoid any real or perceived conflict of interest. In particular, and without limiting the generality of the foregoing obligations, each Commissioner shall:

1. not use or attempt to use his or her appointment to benefit himself or herself or any person or entity;
2. not participate in or attempt to influence decision-making as an appointee if he or she could benefit from the decision;
3. not accept a gift that could influence, or that could be seen to influence, the appointee in carrying out the duties of the appointment;
4. not use or disclose any confidential information, either during or after the appointment, obtained as a result of his or her appointment for any purpose unrelated to the duties of the appointment, except if required to do so by law or authorized to do so by the Minister of Long-Term Care;
5. not use government premises, equipment or supplies for purposes unrelated to his or her appointment;
6. comply with all applicable government directives; and
7. comply with such additional requirements, if any, established by the Minister of Long-Term Care.

For the purposes of the above “confidential information” means information that is not available to the public.

CONFIDENTIALITY

During the term of the appointment and after its termination or expiration each Commissioner shall hold in confidence and treat as confidential all Confidential Information where “Confidential Information” is defined as all data and information in oral, written, graphic, photographic, recorded or other form acquired or prepared by or for each Commissioner pursuant to this appointment, regardless of whether it is identified as confidential. Further each Commissioner shall:

(a) use Confidential Information only as required for their participation as a Commissioner;

(b) maintain all Confidential Information separate and apart from all other records and databases in a physically secure location;

(c) not disclose, directly or indirectly, to any person or entity any Confidential Information without the prior written authorization of the Ministry of Long-Term Care at its sole discretion;

(d) take all reasonable precautions to protect the Confidential Information from any unauthorized use, access and disclosure, and loss; and

(e) provide any Confidential Information in possession of each Commissioner or under their custody and control to the Ministry of Long-Term Care on demand and at the termination or expiration of the appointment, with no copy or portion kept in any form or on any media.

All Confidential Information shall be and remain the sole property of the Ministry of Long-Term Care.

ACCESS AND PRIVACY

All Confidential Information, including hand written notes, e-mail, and voicemail relating to work pursuant to the appointment as a Commissioner is subject to the provisions of the *Freedom of Information and Protection of Privacy Act* and/or the *Personal Health Information Protection Act, 2004* and may be subject to disclosure in accordance with these Acts. For the purposes of sections 17 and 37(2) of the *Personal Health Information Protection Act, 2004*, the Commissioners are an agent as defined in that Act.

Terms of Reference

Ontario's Long-Term Care COVID-19 Commission

MANDATE

1. Having regard to s. 78 of the *Health Protection and Promotion Act*, the Commissioners shall investigate and provide a report of findings and recommendations respecting:

   (a) how the pre-COVID-19 state of the long-term care homes system, including the relationship to other aspects of the health care system, contributed to the COVID-19 virus spread within long-term care homes and how residents, staff, volunteers, visitors, family members and others were impacted;

   (b) the adequacy of measures taken by parties, including the province, long-term care homes and other parties, to prevent, isolate and contain the spread of COVID-19, including the adequacy of existing legislative and regulatory provisions, policies, practices and specifications on infection prevention and control of infectious diseases in long-term care homes;

   (c) the impact of existing physical infrastructure, staffing approaches, labour relations, clinical oversight and other features of the long-term care system on the spread of COVID-19 in the long-term care homes;

   (d) all other relevant matters that the Commissioners consider necessary to investigate the cause of the spread of COVID-19 within long-term care homes;

   (e) in considering the current government initiatives and reforms in the long-term care homes system, any further areas that should be the subject matter of future action by government to help prevent the future spread of disease in long-term care homes.

2. The Commissioners shall ensure that the investigation be conducted in a manner that does not impede ongoing efforts to isolate and contain COVID-19.

3. The Commissioners shall conduct the investigation faithfully, honestly and impartially in accordance with these terms of reference, and shall ensure that the investigation is conducted effectively, expeditiously, and in accordance with the principle of proportionality.

4. The Commissioners shall conduct the investigation and make the report without expressing any conclusion or recommendation regarding the civil or criminal responsibility of any person or organization. The Commissioners shall further ensure that the conduct of the investigation does not in any way interfere or conflict with any ongoing criminal, civil or other legal proceedings or investigation, and without making any findings of fact with respect to civil or criminal responsibility of any person or organization.

5. The Commissioners shall, as much as practicable and appropriate, refer to and rely on the matters set out in section 33 of the *Public Inquiries Act, 2009*. In particular, the Commissioners may request and review and consider any existing records or reports relevant to the mandate, including the Final Report and Recommendations from the Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System dated July 30, 2019, and other medical, professional and business records. Further, the Commissioners may consider such reports and records in lieu of requiring persons to provide evidence and documents to the Commissioners through interviews or otherwise.

6. The Commissioners shall take into account any current government initiatives and reforms in the long-term care homes system, including responses to COVID-19 and any work underway in response to the Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System in making any recommendations.

7. The Commissioners shall hold such public and private (in person or virtual, as appropriate) meetings as they deem advisable in the course of investigation.

8. In accordance with section 33 of the *Public Inquiries Act, 2009*, the Commissioners may by summons require any person to give evidence or produce in evidence such documents and things as the Commissioners may specify that is relevant to the investigation in order to fulfill their mandate in a timely manner.

9. The Commissioners, through the support Secretariat, shall be provided with such resources as are required, and may request the retention of lawyers, experts, research and other staff as the Commissioners deem appropriate and may request the acquisition of external research.

10. Upon completion of their investigation, the Commissioners shall deliver their final report containing their findings, conclusions and recommendations to the Minister of Long-Term Care who shall make such report available to the public as soon as practicable after receiving it.

11. The Commissioners shall conclude the investigation and deliver a final report to the Minister of Long-Term Care no later than April 30, 2021. The Commissioners may provide an interim report setting out any information or recommendations they believe should be considered by the government prior to the submission of their final report.

12. The Commissioners shall also ensure that the final report is delivered in both English and French at the same time; however, if, in the opinion of the Commissioners, the health and safety of the public would not be served by delaying the delivery of the report and only one language version is ready, the Commissioners may deliver the report in only one language. If the report is delivered in only one language, the other language version shall be delivered as soon as possible.

13. The Commissioners shall ensure that the final report is prepared in a form appropriate for release to the public, pursuant to the *Freedom of Information and Protection of Privacy Act*, the *Personal Health Information Protection Act, 2004* and other applicable legislation. In so far as practicable, the Commissioners shall work to maintain and ensure the confidentiality of personal information and personal health information.

14. The Commissioners shall ensure that the investigation is conducted in a manner consistent with the limits of the constitutional jurisdiction of the Province of Ontario.

15. The Commissioners shall act in accordance with the Terms of Reference, which may be amended by the Minister of Long-Term Care as required.

16. In the event that the Commissioners are unable to carry out any individual term of the mandate, the remainder of these provisions shall continue to operate, it being the intention of the Minister of Long-Term Care that the provisions operate independently.

AUTHORITY AND APPOINTMENT OF COMMISSIONERS

The Commissioners will be appointed by the Minister of Long-Term Care under section 78 of the *Health Protection and Promotion Act* and in accordance with directives outlined in Treasury Board/Management Board of Cabinet's *Agencies and Appointment Directive*.

This process will include meeting eligibility criteria and completing personal and conflict of interest disclosures and a police record check.

The Commissioners will be tasked with acting in the interest of Ontario and will need to demonstrate impartiality.

The appointment as a Commissioner does not confer the status of a public servant under the *Public Service of Ontario Act, 2006*. Further, as an appointee, the Commissioners are not, and shall not be deemed to be an employee, agent or partner of Her Majesty the Queen in right of Ontario or the Ministry of Long-Term Care.

The Commissioners shall comply with the Treasury Board/Management Board of Cabinet's *Agencies and Appointment Directive* and all other applicable government directives.

The Commissioners will be collectively referred to as "Ontario's Long-Term Care COVID-19 Commission."

TERM OF APPOINTMENT

Each appointment is at pleasure and will be for a term not exceeding May 31, 2021, unless the appointment is revoked, or the Commissioner terminates his or her participation by providing 30 days' prior written notice.

REIMBURSEMENT AND REMUNERATION

The Commissioners will be compensated with a *per diem* as set out in the Order in Council approved by the Lieutenant Governor in Council.

The Commissioners will be reimbursed for eligible expenses in accordance with Treasury Board/Management Board of Cabinet's *Travel, Meals and Hospitality Directive*.

COMMISSION APPOINTEES

Chair:

One Commissioner will be designated to act as a Chair and will:

- Set the direction of the Commission's investigation and may make recommendations to the Minister of Long-Term Care on amendments to the Terms of Reference;
- Determine the structure and staffing needs of the Commission in order to fulfil its mandate and make recommendations to the Executive Lead – subject to applicable guidelines and directives;
- Liaise between the Commission and the Minister of Long-Term Care;

- Ensure the fulfillment of the Commission's mandate without prejudice; and,
- Be the public face of the Commission and be the official person of record for the Commission.

Commissioners

The other Commissioner(s) will:

- Be representatives of the Commission that may preside over hearings and interviews;
- Be a strategic advisor to the Chair and the government;
- Fulfil the mandate of the Commission without prejudice; and,
- Be responsible for the duties of the Chair if he is unable to fulfil those duties.

SECRETARIAT STAFF

The Commission will be supported by a secretariat of approximately 12 FTEs to provide a variety of support functions including administration, communications, research, project management and legal services.

The Ontario Public Service will provide an Executive Lead who will oversee the secretariat. The Executive Lead will be responsible for staffing the secretariat and ensuring the Commissioners are supported in their mandate. This secretariat will be housed within the Ministry of the Attorney General.

BUDGET

The Commission will have an operating budget to support activities related to their mandate. The Commission may recommend to the Executive Lead such counsel, staff, or expertise or other services as the Commission considers necessary in the performance of their duties, subject to the operating budget, and applicable directives and guidelines, including those pertaining to the retention of outside counsel.

CONFLICT OF INTEREST

Each Commissioner is required to fulfill the duties of his or her appointment in a professional, ethical and competent manner and avoid any real or perceived conflict of interest. In particular, and without limiting the generality of the foregoing obligations, each Commissioner shall:

1. not use or attempt to use his or her appointment to benefit himself or herself or any person or entity;
2. not participate in or attempt to influence decision-making as an appointee if he or she could benefit from the decision;
3. not accept a gift that could influence, or that could be seen to influence, the appointee in carrying out the duties of the appointment;
4. not use or disclose any confidential information, either during or after the appointment, obtained as a result of his or her appointment for any purpose unrelated to the duties of the appointment, except if required to do so by law or authorized to do so by the Minister of Long-Term Care;
5. not use government premises, equipment or supplies for purposes unrelated to his or her appointment;
6. comply with all applicable government directives; and
7. comply with such additional requirements, if any, established by the Minister of Long-Term Care.

For the purposes of the above “confidential information” means information that is not available to the public.

CONFIDENTIALITY AND RECORDS

Records of the Government of Ontario

Any disclosure of records by the Government of Ontario to the Commission, either voluntarily or in response to a request or summons, is not intended to waive any confidentiality, privilege or immunity that may exist over those records whether or not the government has specifically asserted the confidentiality, privilege or immunity.

Subject to any order made by the Lieutenant Governor in Council respecting the records of the Executive Council or any agreement entered into between the Commissioners and the Government of Ontario:

1. the Commissioners shall hold in confidence and treat as confidential all information provided by the Government of Ontario that is identified at the time of disclosure or subsequent to disclosure as subject to a legal confidentiality, privilege or immunity;
2. the Commissioners shall take all reasonable measure to avoid the disclosure, directly or indirectly, of such information without the further consent of the Government of Ontario.

Records Provided by Parties Other than the Government of Ontario

The Commissioners may in their sole discretion determine what information provided by parties other than the Government of Ontario shall be maintained as confidential and may enter into agreements or undertakings to maintain such confidence and otherwise regulate the maintenance and use of that information.

Maintenance of Records

The records of the Commission during the course of its work are to be maintained within the custody and control of the Commission and are not considered to be the records of the Ministry of Long-Term Care.

At the conclusion of the investigation, subject to the confidentiality provisions above, all records and information supplied to or obtained by the Commissioners shall be transferred to Archives Ontario for the purposes of archiving in accordance with the *Archives and Recordkeeping Act, 2006*.

October 2020
This version of the Terms of Reference amends and replaces any previous version

Long Term Care COVID-19 Commission

Guiding Principles

The Long-Term Care Commission was established to investigate how and why COVID-19 spread in long-term care homes, what was done to prevent it and the impact of key elements of the existing system on the spread of the disease. The Commission will also make recommendations aimed at preventing future outbreaks in long-term care homes.

The Commission was established under section 78 of the *Health Protection and Promotion Act*, which authorizes investigations respecting the causes of disease and mortality.

The Commissioners' investigation will be guided by the following principles:

Independence

The Commission operates independently of government. Its independence is essential to uncovering the facts, conducting an objective analysis of the issues and developing recommendations.

Thoroughness

The Commission will conduct a comprehensive investigation to ensure that the questions set out in its terms of reference are explored and answered.

Inclusiveness

The Commission will ensure that it obtains information from the full spectrum of individuals and organizations who have information relevant to determining the factors which led to the outbreak in LTC homes, and to developing strategies to prevent future outbreaks.

Timeliness

The Commission is working as the entire health care system continues to address the pandemic and prepares for a possible second wave of COVID-19. In addition to making recommendations to assist the government in planning for future pandemics, the

Commissioners will aim to make recommendations to prevent the further spread of disease during this pandemic.

Flexibility

To support a thorough, inclusive and timely investigation, the Commission will use a broad range of investigatory methods.

Ontario's Long-Term Care COVID-19 Commission

The Honourable Frank N. Marrocco, Chair
Angela Coke, Commissioner
Dr. Jack Kitts, Commissioner

Commission ontarienne d'enquête sur la COVID-19 dans les foyers de soins de longue durée

L'honorable Frank N. Marrocco, président
Angela Coke, commissaire
Dr Jack Kitts, commissaire

December 9, 2020

The Honorable Merrilee Fullerton
Ministry of Long-Term Care
400 University Avenue, 6th Floor
Toronto, ON M5G 1S5

Dear Minister Fullerton:

The Terms of Reference for the *Long-Term Care Covid-19 Commission* require that we investigate and report the causes of the spread of COVID-19 in the Province's long-term care homes and deliver our final report no later than April 30, 2021. We understand the rationale for completing the report as soon as possible. We are however, writing to inform you that we will not have completed the investigation in time to deliver our report by the intended date.

The Commission's investigation so far has included over 70 meetings with government representatives, stakeholders, and experts, generating over 5,880 pages of public transcripts. We have delivered two interim reports including interim recommendations.

However, as wave 2 continues to spread in the community and LTC homes, we continue to gather new information and gain valuable insights into the spread of COVID-19 in LTC homes. This will better inform our findings and recommendations in our final report.

Notwithstanding the work to date, the Commission continues to encounter significant delays in obtaining government information central to the Commission's investigation. Most documents responsive to the Commission's document summonses and requests remain outstanding. To meet its obligation to address the questions outlined in the Terms of Reference, the Commission will require additional information about the measures taken to prevent, isolate and contain the spread of COVID-19 in the province's long-term care homes before and through the second wave.

24th Floor 700 Bay Street
Toronto ON M5G 1Z6
email *Info@LTCcommission-CommissionSLD.ca*
ltccommission-commissionsld.ca/

700, rue Bay, 24e étage
Toronto (Ontario) M5G 1Z6
Courriel *Info@LTCcommission-CommissionSLD.ca*
ltccommission-commissionsld.ca/fr/index.html

In light of the ongoing pandemic, the Commission's outstanding requests for information, and the volume of data that the Commission anticipates receiving, we are writing to request an extension to the deadline for the Commission's final report to December 31, 2021. Our ability to deliver the final report by this date will require the province's full cooperation, promised in the July 22, 2020 Order-in-Council.

The Hon. Frank N. Marrocco Chair	Angela Coke Commissioner	Dr. Jack Kitts Commissioner

cc. Hon. Christine Elliott, Deputy Premier and Minister of Health

Ministry of
Long-Term Care

Office of the Minister

400 University Avenue, 6th Floor
Toronto ON M7A 1N3

Ministère des
Soins de longue durée

Bureau du ministre

400, avenue University, 6e étage
Toronto ON M7A 1N3

December 23, 2020

The Honourable Frank N. Marrocco
Chair Commissioner
Angela Coke, Commissioner
Dr. Jack Kitts, Commissioner
Ontario's Long-Term Care COVID-19 Commission
24th Floor, 700 Bay Street
Toronto ON M5G 1Z6

Dear Chair Commissioner Marrocco and Commissioners Coke and Kitts:

Thank you for your letter of December 9 requesting an extension of the Commission's mandate.

In establishing the Commission under the *Health Protection and Promotion Act*, the Premier, the Minister of Health, and I highlighted the need for an expedited process to review the spread of COVID-19 in Ontario's long-term care homes. Our main goal was to establish an independent but agile review process to make timely recommendations that could both support the government's ongoing work managing COVID-19 and preventing the spread of disease in those homes, as well as informing the Government's priority focus on addressing long standing challenges in the sector. In this respect, I am pleased that the Commission has been able to deliver interim recommendations on October 23 and December 4.

The urgency of our situation has not changed. In fact, as Ontario deals with this next wave of COVID-19 throughout the province, the duration of which is unknown, the need for timely and focused advice is even more acute. The government has had to take aggressive and decisive action to deal with this situation, and we will continue to make COVID-19 and Ontario's long-term care system a central focus of our ongoing policy agenda. We have already made announcements about significant investments in long-term care, and your recommendations will inform our decisions to ensure those investments result in meaningful and concrete changes.

It is for these reasons that I must request that the Commissioners remain focused on the reporting deadline of April 30, 2021, as indicated in your Terms of Reference.

I appreciate the independence of the Commission in deciding how best to fulfill its Terms of Reference. At the same time, we would respectfully request that you consider prioritizing recommendations that would best support government decisions you believe are needed now. If you are of the view that there are matters that fall within your terms of reference that warrant further examination by government beyond April 30, 2021, I invite you to highlight those matters in your recommendations.

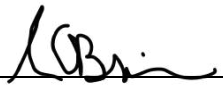
I want to assure you of the ongoing cooperation of the government as you complete your work. An organization as large as the Ontario Public Service can create a considerable volume of records and I note that government staff continue to be engaged full-time in responding to the evolving COVID-19 pandemic. I have asked staff to continue to work with the Commission to ensure you receive the documents you require to fulfill your mandate in as timely a manner as possible.

We look forward to receiving the Commission's final report and recommendations by April 30, 2021. Keeping Ontarians safe—particularly our most vulnerable—continues to be the top priority of our government.

Sincerely,

Dr. Merrilee Fullerton
Minister of Long-Term Care

This is **Exhibit "I"** referred to in the Affidavit of **Jane E. Meadus**, affirmed this 11 day of April, 2023, in accordance with O. Reg 431/20, Administering Oath or Declaration Remotely.



A Commissioner for taking Affidavits etc.(*or as may be*) (pursuant to O. Reg 431/20)

Amanda Marie O'Brien, a Commissioner etc. Province of Ontario, for Goldblatt Partners LLP, Barristers & Solicitors
Expires November 15, 2024

Long-Term Care Homes

The Long-Term Care Quality Inspection Program for Ontario

December 7, 2010
Presentation to the Ontario Nurses Association

Ministry of Health and Long-Term Care

Ontario LTC Home Quality Agenda

2010	• LTCHA enforce July 1 • Introduction of the new inspection process
2009	• First LTC Public Report Card • Residents First Program
2008	• Key Risk Indicator Development • Beginning of Compliance Transformation
2007	Development of the LTCHA
2005	Beginning of RAI-MDS 2.0 Implementation

Ministry of Health and Long-Term Care

Compliance Transformation

Why change now?

We are transforming the inspection process to:

- Align with the new *Long-Term Care Homes Act, 2007* (LTCHA) legislation and regulations
- Ensure that the residents in LTC homes continue to be protected and cared for, and their dignity and rights respected.
- Assure the public that our first priority is the care and safety of residents.
- Build a new evidence-based and resident centred inspection process.

We are transforming the inspection process to:
Align with requirements of the new Long-Term Care Homes Act, 2007 (LTCHA) legislation and regulation which was proclaimed on July 1, 2010.
Ensure that the residents in LTC homes continue to be protected and cared for, and their dignity and rights respected.
Assure the public that our first priority is the care and safety of residents.
Build a new evidence-based and resident centred inspection process that
improves objectivity, consistency and effective decision making
enhances the ability to identify and mitigate risks
engages residents and families directly and has focus on resident quality of life and quality of care

Performance Improvement & Compliance Branch (PICB)

- Established in 2007
- 75 inspectors
- 55 Nursing, 13 Dietary and 7 Environmental Inspectors
- 5 Service Area Offices: Toronto, Hamilton, Ottawa, London, Sudbury
- Types of inspections: annual, complaint, critical incident, follow up and other

The focus of today's presentation is the annual inspection.

Inspection Redesign - Interjurisdictional Review

Conducted across Canada, Australia, England and United States

Review Criteria

- Aligns with LTCHA and key risk areas
- Resident-centred
- Focused on the delivery of quality care
- Transparent, objective, consistent and fair

Findings

- Ontario is more advanced than other Canadian jurisdictions with the US generally ahead.
- Over a period of 15 years, the US Center for Medicare and Medicaid Services (CMS) funded research into the effectiveness of state inspections which resulted in the development of the "**Quality Indicator Survey**" (QIS). Survey developed by the University of Colorado was rolled out to ~10 states as of March 2010 with intent to go nation-wide

In consultation with Dr. Kramer – QIS process. QIS used successfully in the US, similar long-term care home requirements as Ontario

Characteristics and Benefits of QIS

- Resident-centred process:
  - Residents are surveyed first, then documentation reviewed
  - Residents and families feel heard and valued
- Extensive research by clinical experts to identify the quality of life, quality of care and screening indicators required in the inspection process to identify potential presence of non-compliance
- Resident responses and care outcomes guide the inspection process. Evidence-based approach means results are much less subject to interpretation
- Improved objectivity and consistency of quality of care/quality of life problem identification through a structured information gathering process
- Greater automation facilitates better organization of inspection findings and enhanced documentation
- Also targets inspection resources on homes with the largest number of quality concerns for improved risk management and resource deployment

Comprehensive
Structured approach requires inspectors to examine all regulations, not targeted only selected deficiencies while missing the big picture
Structured Approach
Systematic observations and questions are comparable across sites and replicable
Providers could use the tool to reliably assess and improve quality on an ongoing basis
Alignment with Risk Indicators Identified in Fall 2008
All 26 RAI risk indicators
All Trigger and Sentinel events except: medication misappropriation, verified complaints leading to non-compliance and leadership turnover

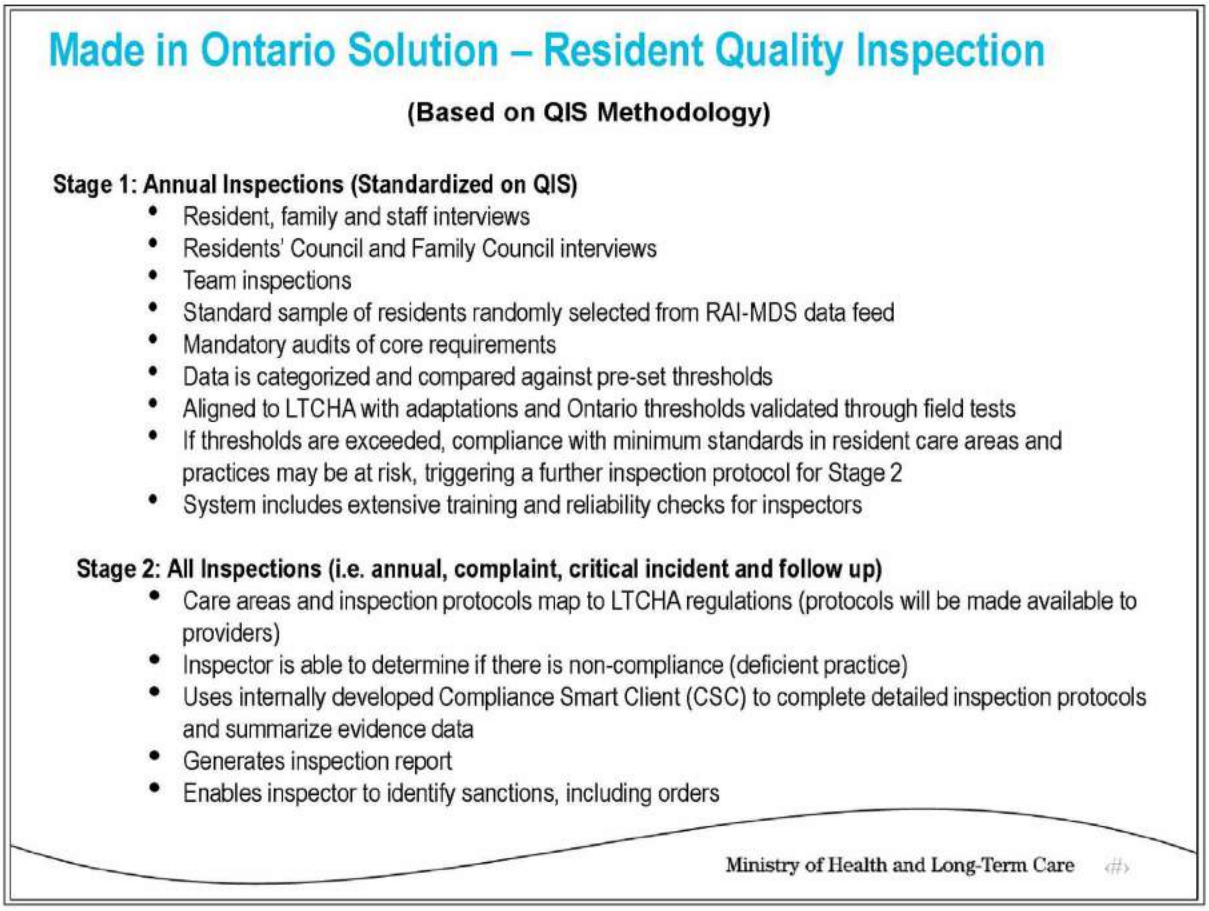
Enhanced Documentation
Information collected throughout the process is collated by computer
Should be more defensible because of rates and structured findings

Adapting QIS to Ontario Annual Inspection

- Tendered a Request for Proposal and Nursing Home Quality (NHQ) was the successful vendor
- Adaption of the QIS: methodology, thresholds, policies, procedures, education and technology to be Ontario specific
- Extensive testing, analysis and revision of the QIS program to align with other Ontario inspection, investigation and enforcement ministries, the LTCHA, regulations, other associated agreements and key risk indicators
- Teams of inspectors and experts from NHQ tested the QIS process and tools over 4 months in 12 volunteer LTC homes in Ontario
- Feedback was obtained from residents, families, front line care providers and ministry inspectors throughout the testing process

Ontario LTC Quality Inspection Program (LQIP)

An Inspection Program to ensure compliance with the Long-Term Care Homes Act, 2007



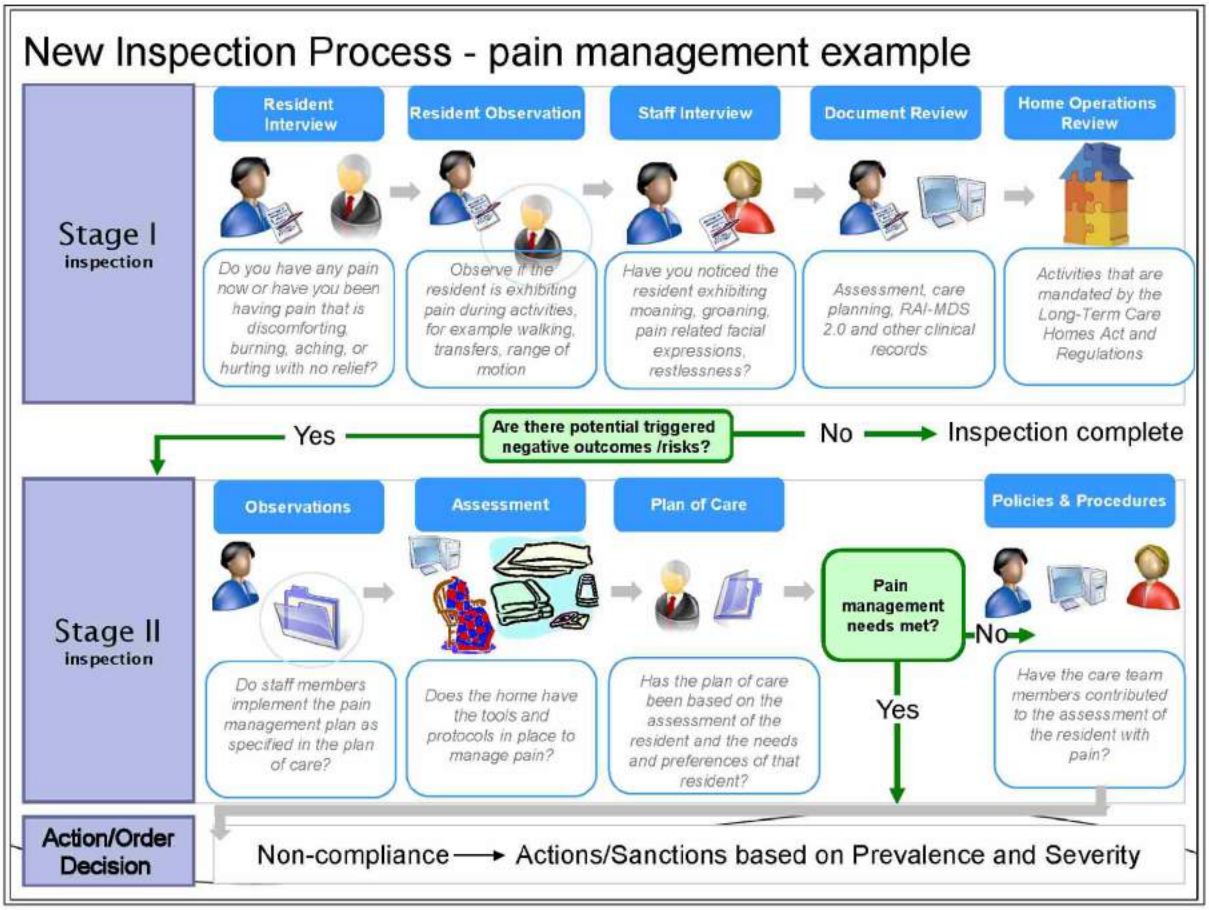
In consultation with Dr. Kramer – QIS process. QIS used successfully in the US, similar long-term care home requirements as Ontario

Stage 1 – Areas that may require further inspection

- **Abuse**
- Accidents
- Activities
- **ADL, ROM , Cleanliness and Grooming, Positioning**
- **Admission, Transfer and Discharge**
- Behavioural and Emotional Status
- Bowel and Bladder Function, use of Catheter
- Choices
- Communication and Sensory, Hearing and Vision
- **Dental Status and Services**
- **Dignity**
- Dining
- **Environment**
- Fecal Impaction
- Food Quality

***Questions for Family/SDM**

- Fecal Impaction
- Food Quality
- Hospitalization or Death
- Infections (non-UTI related)
- **Notification of Change**
- Nutrition, Hydration, Tube Feeding
- Pain Management
- **Participation in Care Plan**
- **Personal Funds**
- Physical Restraints
- Pressure Ulcers
- **Privacy**
- Psychoactive Medications
- Rehabilitation and Community Discharge
- Skin Conditions (non-pressure related)
- Social Services
- **Personal Property**

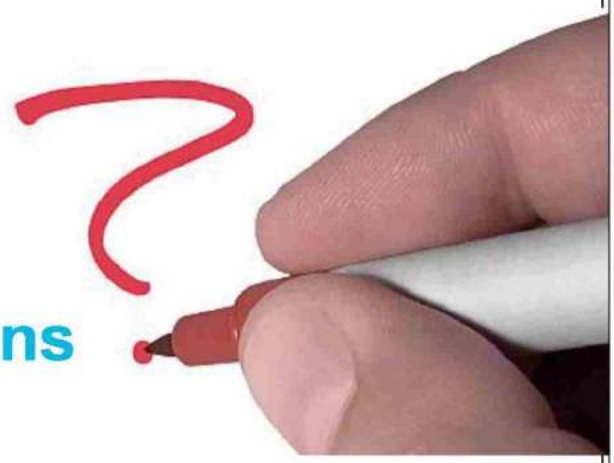

New Inspection Process - pain management example
Stage I
inspection
Resident Interview
Resident Observation
Staff Interview
Document Review
Home Operations Review
Do you have any pain now or have you been having pain that is discomforting, burning, aching, or hurting with no relief?
Observe if the resident is exhibiting pain during activities, for example walking, transfers, range of motion
Have you noticed the resident exhibiting moaning, groaning, pain related facial expressions, restlessness?
Assessment, care planning, RAI-MDS 2.0 and other clinical records
Activities that are mandated by the Long-Term Care Homes Act and Regulations
Yes
Are there potential triggered negative outcomes /risks?
No
Inspection complete
Stage II
inspection
Observations
Assessment
Plan of Care
Policies & Procedures
Pain management needs met?
No
Yes
Do staff members implement the pain management plan as specified in the plan of care?
Does the home have the tools and protocols in place to manage pain?
Has the plan of care been based on the assessment of the resident and the needs and preferences of that resident?
Have the care team members contributed to the assessment of the resident with pain?
Action/Order Decision
Non-compliance
Actions/Sanctions based on Prevalence and Severity

Supporting the Culture Shift

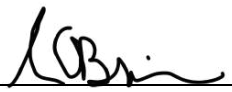
The new inspection model will support the Quality Agenda in LTC Homes in a number of ways:

- Inspections will refocus attention in homes on residents and their experience of care
- Provides consistent, structured and evidence-based approach
- More objective and predictable results encourage providers to focus on problem solving and continuous improvement. Prompts them to follow up and address resident and family concerns
- Detailed evidence provided by RQI to support non-compliance findings should reduce controversy and be less adversarial
- Ministry resources can be focused on homes demonstrating highest risk to residents
- RQI will provide rich data directly related to resident experience to identify trends, monitor and improve performance

Questions



This is **Exhibit "J"** referred to in the Affidavit of **Jane E. Meadus**, affirmed this 1 day of April, 2023, in accordance with O. Reg 431/20, Administering Oath or Declaration Remotely.



A Commissioner for taking Affidavits etc.(*or as may be*) (pursuant to O. Reg 431/20)

Amanda Marie O'Brien, a Commissioner etc.
Province of Ontario, for Goldblatt Partners LLP, Barristers & Solicitors
Expires November 15, 2024

Co-payment Waiver Program Winddown Key Messages and Q&As

Key Messages

- The co-payment waiver program for long-term care home residents admitted from hospitals was a temporary, pandemic-related measure to support hospital capacity at the peak of the third wave in spring 2021.
- To better reflect current circumstances, respond to progress that's been made, and promote fairness, we are ending the temporary co-payment waiver for new long-term care residents admitted from hospital as of December 15, 2021.
- Residents admitted to a long-term care home by December 14, 2021 who otherwise qualify for the co-payment waiver program will continue to have their fees waived until they are offered a spot in their first-choice home.
- Hospital patients will continue to be admitted as residents to long-term care homes as appropriate through applicable admissions processes.
- The province continues to monitor COVID-19 activity in the health and long-term care sectors and is proactively supporting them to ensure the appropriate measures are in place to keep staff, residents, patients and communities safe.

Q1. What is the co-payment waiver program?

A. The co-payment waiver program for long-term care home residents admitted from hospitals is a temporary, pandemic-related measure that was intended to support hospital capacity at the peak of the third wave in spring 2021. When a resident agrees to move to a long-term care home that is not their first-choice home the licensee is prohibited from charging the resident any amount for accommodation until they are offered a spot in their first-choice home. The ministry then funds the licensee for the loss of the co-payment.

Q2. Who is eligible to enroll in the co-payment waiver program?

A. The co-payment waiver applies to patients in "Alternate Level of Care" beds in hospitals who agree to move to a long-term care home that is not their preferred home when the hospital is experiencing severe capacity pressure during the pandemic. The waiver applies until the resident is offered a spot in their first-choice home, and they maintain their priority status on the waitlist of their preferred home in the meantime. This change was aimed at supporting the movement of ALC patients waiting for LTC homes when considering available placement opportunities in safe, appropriate homes and further enables temporary placements outside of hospitals while they wait for their preferred home.

Q3. When is the co-payment waiver program ending?

A. To better reflect current circumstances, respond to progress that's been made, and promote fairness, we are ending the temporary co-payment waiver for new long-term care residents admitted from hospital as of December 15, 2021.

Hospital patients will continue to be admitted as residents to long-term care homes as appropriate through applicable admissions processes.

Q4. Why is the co-payment program ending?

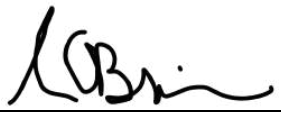
A. The province continues to monitor COVID-19 activity in the health and long-term care sectors and is proactively supporting them to ensure the appropriate measures are in place to keep staff, residents, patients and communities safe.

The critical hospital capacity pressures experienced in the third wave have abated while occupancy in long-term care homes has increased. To better reflect current circumstances, respond to progress that's been made, and promote fairness, we are ending the co-payment waiver program on December 15, 2021.

Q5. Will the co-payment waivers continue to apply to ALC patients already enrolled in the program?

A. Residents already admitted to a long-term care home from hospital by December 14, 2021 and who otherwise meet the eligibility criteria for the program will continue to have their fees waived until they have been offered a bed at their home of choice.

This is **Exhibit "K"** referred to in the Affidavit of **Jane E. Meadus**, affirmed this 11 day of April, 2023, in accordance with O. Reg 431/20, Administering Oath or Declaration Remotely.



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Amanda Marie O'Brien, a Commissioner etc.
Province of Ontario, for Goldblatt Partners LLP, Barristers & Solicitors
Expires November 15, 2024

Ministry of
Long-Term Care

Office of the Minister

400 University Avenue, 6th
Floor
Toronto ON M7A 1N3

Ministère des
Soins de longue durée

Bureau du ministre

400, avenue University, 6e étage
Toronto ON M7A 1N3

Ontario

October 26, 2021

Re: Proactive Inspections Program

Dear Long-Term Care Homes Licensees:

Our government has a plan to fix long-term care based on three pillars: staffing and care; accountability, enforcement and transparency; and building modern, safe, comfortable homes for seniors.

Ontario is investing $20 million in the recruitment and training of 193 new inspections staff and launching an improved annual **proactive inspections program** in long-term care homes. This major investment will bolster accountability, enforcement and transparency across the sector ensuring that every resident experiences the safest and best quality of life, and homes are held to account for the care they provide.

Over the next two years, a total of 156 long-term care home inspectors and 37 support staff will be recruited. This will mean a doubling of the current number of long-term care home inspectors. It will also give Ontario the most inspectors per long-term care home in Canada, with a ratio of one inspector per every two homes.

We have listened to the advice of the Long-Term Care COVID-19 Commission and the Auditor General — and are heeding the calls from residents, their families, the public and those working in the sector to fix the long-term care system. The implementation of the proactive inspections program addresses these concerns and allows Ministry inspectors to proactively visit each long-term care home every year, all the while continuing reactive inspections to promptly address complaints and critical incidents.

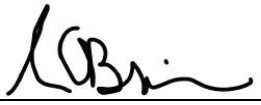
Sheila Bristo, the Assistant Deputy Minister of the Long-Term Care Operations Division, will provide more details to the sector on the nature of the new proactive inspections program and the implementation timelines.

I look forward to continuing to work with you as we build a 21st century long-term care system that is well-resourced, puts residents at the centre and is ready to welcome our most vulnerable, when and where they need it.

Sincerely,

Hon. Rod Phillips
Minister of Long-Term Care

This is **Exhibit "L"** referred to in the Affidavit of **Jane E. Meadus**, affirmed this 11 day of April, 2023, in accordance with O. Reg 431/20, Administering Oath or Declaration Remotely.



A Commissioner for taking Affidavits etc.(*or as may be*) (pursuant to O. Reg 431/20)

Amanda Marie O'Brien, a Commissioner etc. Province of Ontario, for Goldblatt Partners LLP, Barristers & Solicitors
Expires November 15, 2024

Ministry of Long-Term Care

Director
Long-Term Care Inspections Branch
Long-Term Care Operations Division

8th Floor, 438 University Ave.
Toronto ON M5G 2K8
Tel.: (416) 212-6707
Fax: (416) 327-7603

Ministère des Soins de longue durée

Directeur
Inspection de soins de longue durée
Division des opérations de soins de longue durée

438, avenue University, 8e étage
Toronto ON M5G 2K8
Téléphone: (416) 212-6707
Télécopieur: (416) 327-7603

Ontario

DATE: **August 18, 2022**

MEMORANDUM TO: Long-Term Care Home Licensees
Long-Term Care Home Administrators

FROM: Mike Moodie
Director
Long-Term Care Inspections Branch

RE: New Inspection Guides to Replace Inspection Protocols

I am pleased to share with you our *Fixing Long-Term Care Act, 2021* (FLTCA) Inspection Guides (IGs). These guides support a consistent delivery of inspection services across the province. We are committed to transparency in the inspection process and have posted these guides on LTChomes.net.

The IGs replace our 31 Long-Term Care Homes Act based Inspection Protocols (IPs). The IPs have been consolidated and revised into 23 FLTCA based IGs.

Inspection Guides

- Admissions, Absences and Discharge
- Continence Care
- Falls Prevention
- Food, Nutrition and Hydration
- Housekeeping, Laundry and Maintenance
- Infection Prevention and Control
- Medication Management
- Pain Management
- Palliative Care
- Prevention of Abuse and Neglect
- Quality Improvement
- Recreational and Social Activities
- Reporting and Complaints
- Resident Care and Support Services
- Resident Charges and Trust Accounts
- Resident Rights and Choices
- Resident and Family Councils
- Responsive Behaviour
- Restraints and PASD Management
- Safe and Secure Home
- Skin and Wound Care
- Staffing, Training and Care Standards
- Whistle-blower Protection and Retaliation

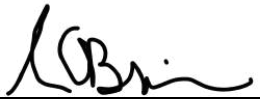
…2/

I encourage home administrators and staff to review these guides to increase awareness of the inspection process. The guides will help you understand what to expect an inspector might observe or engage upon during an inspection.

Sincerely,

Mike Moodie
Director
Long-Term Care Inspections Branch

This is **Exhibit "M"** referred to in the Affidavit of **Jane E. Meadus**, affirmed this 11 day of April, 2023, in accordance with O. Reg 431/20, Administering Oath or Declaration Remotely.



A Commissioner for taking Affidavits etc.(*or as may be*) (pursuant to O. Reg 431/20)

Amanda Marie O'Brien, a Commissioner etc. Province of Ontario, for Goldblatt Partners LLP, Barristers & Solicitors
Expires November 15, 2024

Proactive Compliance Inspections Webinar
November 3rd, 2021
Questions and Answers

Context

This Frequently Asked Questions (FAQ) Document will provide additional details and clarification on the new Proactive Compliance Inspections.

FAQs

Q1. Will this session be recorded and sent out?
Yes. A recording of the session has been made available on LTCHomes.net along with this FAQ document.

Q2. When should Homes expect proactive inspections to commence (after fall 2022)?
The new proactive inspections program launched in November 2021. Five per cent of homes (approximately 31 homes) will be inspected by spring 2022. With the additional inspectors, 100 per cent of long-term care homes will receive a proactive inspection by end of 2024, while the ministry continues to respond to critical incidents and complaints.

Q3. When will the checklist be available and sent to the LTC homes?
The Entrance Conference Checklist as well as the Quality Improvement and Required Programs Confirmation Checklist have been made available on LTCHomes.net with this FAQ document.

Q4. Are the proactive inspections replacing the RQI? Details seem similar to RQI process.
Yes, this new proactive inspection program is taking the place of the previous proactive Resident Quality Inspection (RQI). The program reflects what has been learned from the previous RQI as well as responds to the advice of the Long-Term Care COVID-19 Commission and the Auditor General — as well as calls from residents, their families, the public and those working in the sector for an effective enforcement regime that ensures residents are protected.

The proactive inspections program adds to the current risk-based program of responding to complaints and critical incidents. The proactive inspections program will assist the government and long-term care homes in identifying and resolving problems to improve the quality of care residents receive.

The program takes a resident-centred approach by allowing for more direct discussion with residents, to focus on their care needs as well as the home's program and services.

Q5. Many homes don't have Resident Council Presidents, and many have moved to a shared leadership model. Is the home to select a member or provide the list of members to the inspector to select the member they wish to speak with?
This matter can be discussed with the inspector during the entrance conference. The inspector will determine on a case by case basis the best approach to gathering information from the Residents' and Family Councils.

Q6. Will the inspectors be using the PHO IPAC assessment to review IPAC? There seems to be inconsistency between what the inspectors understand vs what PHO expects.
Inspectors will conduct an IPAC inspection that is developed specifically for enforcement of the *Long-Term Care Homes Act, 2007* (LTCHA 2007)/*Fixing Long-Term Care Act, 2021* (FLTC, 2021). The PHO IPAC assessment and the MLTC IPAC Inspection are in line with current CMOH guidance and aim to ensure that homes are taking the necessary precautions to prevent outbreaks and manage them should they occur. The LTCIB and local PHUs collaborate to ensure homes are implementing necessary precautions to prevent outbreaks and to manage outbreaks should they occur.

Q7. Will the Ministry take into consideration the ongoing human resource crisis in the province, which is the major contributor to non-compliance?
We recognize that staff in long-term care homes are the backbone of the sector and are essential to meeting the needs of our loved ones in long-term care. We also know more needs to be done to improve accountability, enforcement and transparency in the sector to rebuild public trust.

That's why we built the FLTCA, 2021 on three pillars: staffing and care; accountability, enforcement, and transparency; and building modern, safe, comfortable homes for seniors.

To support the first pillar, the government is investing up to $4.9 billion by 2025 – to increase average daily direct care for residents and hire more long-term care staff – to improve the quality of care residents receive, now and into the future.

Equally important is the second pillar—accountability, enforcement, and transparency. The Act provides for a number of new and improved progressive enforcement tools to encourage compliance and hold homes that don't comply to account. These changes will streamline the suite of enforcement tools available to inspectors. The Act and the new proactive inspections program respond to the advice of the Long-Term Care COVID-19 Commission and the Auditor General — as well as calls from residents, their families, the public and those working in the sector for an effective enforcement regime that ensures residents are protected and have a good quality of life.

Our top priority is to ensure that residents are safe and receive the quality of care they deserve. Under the Act, Proactive Inspections will continue to focus on residents' rights, infection prevention and control, plans of care, abuse and neglect, nutrition and hydration, medication management, policies and directives, and dining observations.

We know that the long-term care system in Ontario must be fixed. The new proactive inspections program and investments in long-term care staffing are key steps the government is taking to do so.

Q8. Will the inspectors be more involved within the home to help with gaps in practice? Especially if there is going to be 1 inspector for 2 homes. It would be great to have their involvement to really understand the process in the home, challenges and successes, and to be part of the solution rather than to come in to spot check which has not been very helpful in the past.
The FLTCA, 2021 introduces a new quality improvement element that would require long-term care homes to participate in a quality improvement initiative and enable the creation of a Long-Term Care Quality Centre to advance and share research on innovative and evidence-informed person-centred models of care.

The role of the inspector, as described in the FLTCA, 2021, is to conduct inspections that determine compliance with legislative requirements. The change in role from advisor to inspector took place when the LTCHA, 2007 was proclaimed into law in 2010. While the inspector's role will remain the same, the intent is for elements of that advisory function to be taken up by the Long-Term Care Quality Centre.

The proactive inspections program will assist both the ministry and long-term care homes in identifying and resolving problems to improve the quality of care provided to residents. The program takes a resident-centred approach by allowing for more direct discussion with residents, to focus on their care needs as well as the home's program and services. The results from proactive inspections will help the government determine where the sector can benefit from additional resources, including guidance material and best practices.

Q9. Please review the plan for hiring inspectors. Each SAO will hire one team so they can begin mid Nov?
Proactive inspections will initially be carried out by existing inspectors who will undergo training for this specific type of inspection. Eventually, more inspectors will be trained across the province as we build our capacity to carry out proactive, as well as reactive inspections. Part of this process will also include a review of the long-term care inspector program and function so that it aligns fully with the FLTCA, 2021.

To ensure long-term care resident safety, the government is providing an additional $72.3 million over three years to increase enforcement capacity including doubling the number of inspectors across the province by Fall of 2022. This doubling of inspections staff will make Ontario the leading province in Canada, with a ratio of one inspector for every two long-term care homes.

The government plans to hire just over half of the new staff by spring 2022, with the full complement on board by Fall of 2022.

Q10. Will there be any attention to improving the clarity and brevity of inspection reports?
In the Fall of 2020, as part of a regular process of evaluation and improvement, changes were made to the way inspectors write reports to make them clearer and more succinct (see LTCHomes.net post from September 8th, 2020 for details).

Further review of inspection reports will occur in conjunction with changes put forth in the new Act.

Q11. Are there any changes to the IPs being used by inspectors?
Currently, there are no changes to the Inspection Protocols (IPs) being used. In the event that new IPs are created, or changes are made to existing IPs to align with the FLTCA, 2021, the sector will be provided with updates.

Q12. Will inspectors be giving positive feedback to homes or only identify issues?
At this point, inspectors will continue to focus on compliance with legislation and ensuring that residents receive the quality of care they need and deserve.

Q13. Are there also opportunities for the inspectors to recognize the great work that is occurring in the homes? I worry that the workforce is already burnt out, struggling with the work ahead as we move on from the pandemic. There must be a way to move the culture away from blame, I am afraid this program will push more staff to leave the profession without positive reinforcement.
We recognize the challenges that healthcare workers face on a regular basis, and the extraordinary circumstances faced by staff in long-term care homes during the pandemic. We also recognize that a majority of homes in the province have a relatively high compliance rate with only minor issues being flagged by inspectors.

Staff in long-term care homes are the backbone of the sector and are essential to meeting the needs of our loved ones in long-term care. It's crucial that we recognize the tremendous work that they do every day and the challenges that they have faced throughout the pandemic in serving the needs of residents and their families. We also realize that more needs to be done to support staff in the long-term care sector.

That's why staffing and care is one of three key pillars of the government's FLTCA, 2021 and why we are investing up to $4.9 billion by 2025 to create more than 27,000 new positions for personal support workers, registered nurses and registered practical nurses. focuses on Additionally, the government continues to prioritize ongoing engagement with the sector, which is of critical importance, as we develop the regulations associated with the FLTCA, 2021.

With this being said inspectors play an important role in regulating the sector and holding homes to account when they are not meeting requirements set out in legislation. The proactive inspection program will assist both the ministry and long-term care homes in identifying and resolving problems to improve the quality of care provided to residents.

We are extremely grateful for the hard work and dedication of all long-term care staff working under challenging conditions to care for our most vulnerable during the pandemic. We will continue to work with homes across the province and our health sector partners to support staffing needs in long-term care homes, and to understand their unique challenges with staffing and how we can best work with them to address these challenges.

Q14. Will inspectors have the ability to support homes by connecting them with "high performers" if there are areas of struggle?
The role of the inspector, as described in the FLTCA, 2021, is to conduct inspections that determine compliance with legislative requirements. The change in role from advisor to inspector took place when the LTCHA, 2007 was proclaimed into law in 2010. While the inspector's role will remain the same, the intent is for elements of that advisory function to be taken up by the Long-Term Care Quality Centre.

Q15. The presentation didn't mention how you plan to work with Homes to proactively address and work with homes to mitigate gaps and challenges.
The proactive inspections program adds to the current risk-based program of responding to complaints and critical incidents. It will assist the government and long-term care homes in identifying and resolving problems to improve the quality of care residents receive.

The program takes a resident-centred approach by allowing for more direct discussion with residents, to focus on their care needs as well as the home's program and services. The results from proactive inspections will help the government determine where the sector can benefit from additional resources.

The results will also inform thorough and ongoing evaluation and continuous improvement of the program, which will include regular engagement with the sector.

Q16. Homes were utilizing the QIPS to assist with Quality Improvement plans in the home. This was stopped this past year due to COVID. Most homes have switched improvement programs to obviously improve IPAC. Will there be initiatives to assist homes to increase and update Quality Improvement programs?
The FLTCA, 2021 introduces a new quality improvement element that would require long-term care homes to participate in a quality improvement initiative and enable the creation of a Long-Term Care Quality Centre to advance and share research on innovative and evidence-informed person-centred models of care.

Q17. With so many challenges surrounding staffing shortages and COVID, it feels as though the ministry is ramping up inspections when LTC is at its worst and trying their best. Almost feels punitive. How will this assist LTC in their current struggling state when most are doing the very best that they can?
From the earliest stages through the latest wave of COVID-19, the government has taken decisive action to support all long-term care homes, staff and residents.

This includes allocating over $2 billion to help the sector respond and cope with the pandemic. These supports helped homes with operating pressures related to COVID-19, including infection prevention and control, personal protective equipment (PPE) supplies, and staffing.

As part of Ontario's long-term care staffing plan, the province is training and hiring a historic number of personal support workers (PSW), registered practical nurses (RPN) and registered nurses (RN).We are investing up to $4.9 billion by 2025 to create more than 27,000 new PSW, RN and RPN positions, which includes up to $270 million to help homes hire thousands of these positions by the end of this fiscal year.

The government has also committed to an investment of up to $540 million in Prevention and Containment Funding to support measures to stop the spread of the virus in long-term care homes. Some of the measures supported by this funding include increased staffing, the purchase of supplies/equipment, increased infection prevention and control, and any other incremental costs associated with preventing and containing the spread of COVID-19 in long-term care homes. staffing supports and the purchase of additional supplies and equipment.

Additionally, the FLTCA, 2021, introduces a new quality improvement element that requires long-term care homes to participate in a quality improvement initiative and enables the creation of a Long-Term Care Quality Centre to advance and share research on innovative and evidence-informed person-centred models of care.

We are working to fix long-term care while taking extraordinary measures to slow the spread of COVID-19 and protect our most vulnerable citizens. We will continue to build on these hard-fought gains by making transformative investments in our health and long-term care systems and workers. We are closely monitoring the evolving situation and will continue to work with homes across the province and our health sector partners to support long-term care homes.

Q18. For smaller homes are you still interviewing 40 residents?
Inspectors will interview a random number of residents during an inspection to assess the home's level of compliance. Interviewing 40 residents was part of the previous Resident Quality Inspection (RQI) methodology.

Q19. Do inspectors need to be registered nurses as we feel this does not help the shortage of nurses we are already experiencing?
Currently, it is a mandatory requirement in our hiring practices that all long-term care home inspectors must have one of the following professional designations: registered nurse, physiotherapist, or dietitian. These requirements are currently under review as part of the broader Fixing Long-Term Care Plan.

Q20. If care was provided to a resident and no harm or ill effect resulted and resident is happy will we still receive non-compliance if the care provided did not follow our home policy to the letter?
An inspector would make a determination after examining all of the relevant information available.

Q21. Will there be a public report and a licensee report?
Inspectors will create both a public and licensee version of the proactive compliance inspection reports.

Q22. What does regular engagement with the sector look like? It seems like there is a lot of engagement with "experts" that have never worked in LTC. How can we be more involved?
One of the primary means of engaging with long-term care home staff, administrators, and licensees will be through the post inspection surveys where homes will have a chance to share their feedback on the new methodology. The sector will also be represented at the Strategic Long-Term Care Advisory Table where the Proactive Inspections Program evaluation will be presented. Finally, presentations will be made to the long-term care associations as more inspections are carried out and the resulting data can be analyzed.

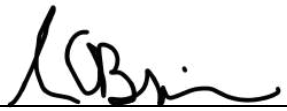
Q23. Will we receive memos as items become available on LTC.net? Is there any work being done on that site as it is not that user friendly and is difficult to navigate?

LTCHomes.net will continue to be the main avenue for communication between the ministry and licensees in the long-term care sector. We are noting the feedback on the site's usability and will look for opportunities in the future to improve the functionality and design of the site.

Q24. Please could you explain what is meant by Personal Support Services.

"Personal support services" means services to assist with the activities of daily living, including personal hygiene services, and includes supervision in carrying out those activities.

This is **Exhibit "N"** referred to in the Affidavit of **Jane E. Meadus**, affirmed this 11 day of April, 2023, in accordance with O. Reg 431/20, Administering Oath or Declaration Remotely.



A Commissioner for taking Affidavits etc.(*or as may be*) (pursuant to O. Reg 431/20)

Amanda Marie O'Brien, a Commissioner etc. Province of Ontario, for Goldblatt Partners LLP, Barristers & Solicitors
~~Expires November 15, 2024~~

From: Jane Meadus (ACE) <MeadusJ@lao.on.ca>
Sent: October 29, 2020 1:05 PM
To: Lewis, Wendy (MLTC) <Wendy.Lewis@ontario.ca>
Subject: Question re Eligibility criteria for long-term care homes

Wendy:

Hope that you are staying well during COVID. I understand you are acting Director? Tough job at the moment I'm sure.

I'm trying to find out whether the Ministry has policies on eligibility for long-term care, and specifically on when a person is too heavy care for long-term care and should be in chronic care/complex continuing care. The legislation and regulations talk about the low end – where they are not eligible if publicly funded community based services etc. are not sufficient – and the homecare legislation helps on that – but there is nothing in the legislation that says when care is too high for long-term care.

If there are policy or other documents which identify when a person would not be eligible for long-term care because their needs are too great, could you provide them to me?

Thanks

Jane

Jane E. Meadus
Barrister & Solicitor
Institutional Advocate

Advocacy Centre for the Elderly
2 Carlton Street, Suite 701
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Toll Free Number: 1-855-598-2656
Fax: (416) 598-7924
www.acelaw.ca

please notify the sender immediately by return e-mail and permanently delete the copy you have received. Thank you.

From: Lewis, Wendy (MLTC) [mailto:Wendy.Lewis@ontario.ca]
Sent: Tuesday, November 3, 2020 11:39 AM
To: Jane Meadus (ACE) <MeadusJ@lao.on.ca>
Subject: RE: Question re Eligibility criteria for long-term care homes

Hi Jane,

I shared your question with the folks in the policy and implementation branch and I have included their response below.

Thank you for your e-mail question regarding long-term care (LTC) home eligibility requirements.

As you know, Local Health Integration Networks (LHINs), as the designated placement co-ordinators under the *Long-Term Care Homes Act, 2007* (LTCHA), are responsible for determining eligibility for admission, providing applicants with information and assisting with the placement related application processes, prioritizing for admission, monitoring and managing waiting lists and authorizing long-stay and short-stay admissions into LTC homes.

The LHINs as placement co-ordinators are required to consider all publicly funded community-based services as part of the determination of eligibility for long-stay admission. LHINs also determine eligibility for and arrange home care services under the *Home Care and Community Services Act, 1994* when these services can support and meet the needs of a client at home.

LHINs in their role as placement co-ordinators for LTC home admission, and in their role in home and community care, may have documents that they use for the determination of LTC home eligibility. You may wish to contact the LHIN for further information.

The Ministry of Long-Term Care is not aware of any policy document used by the LHINs to help identify when a person would not be eligible for LTC home admission because their needs are considered too great.

If an applicant is determined ineligible for admission to a LTC home, the LHIN must suggest alternative services and make appropriate referrals on behalf of the applicant. The LHIN must also provide the applicant with a written notice outlining:

a) The determination of ineligibility,

b) The reasons for the determination of ineligibility, and

c) The applicant's right to apply to the Health Services Appeal and Review Board (Appeal Board) for a review of the determination.

If the LHIN determines an individual eligible for LTC home admission according to the eligibility criteria set out in the Regulation, a licensee of a LTC home must approve the admission unless:

- The LTC home lacks the physical facilities necessary to meet the applicant's care requirements; or
- The staff of the LTC home lack the nursing expertise necessary to meet the applicant's care requirements.

I hope this information is of assistance. Thank you for writing.

Take good care,

Wendy

Wendy Lewis, Senior Manager
Long-Term Care Inspections Branch
Long-Term Care Operations Division
159 Cedar St. Suite 403
Sudbury, ON P3E 6A5

This is **Exhibit "O"** referred to in the Affidavit of **Jane E. Meadus**, affirmed this 11 day of April, 2023, in accordance with O. Reg 431/20, Administering Oath or Declaration Remotely.

A Commissioner for taking Affidavits etc.(*or as may be*) (pursuant to O. Reg 431/20)

Amanda Marie O'Brien, a Commissioner etc.
Province of Ontario, for Goldblatt Partners LLP, Barristers & Solicitors
Expires November 15, 2024

Admissions to Long-Term Care Homes for Alternate Level of Care Patients from Public Hospitals

Field Guidance to Home and Community Care Support Services Placement Co-ordinators

Ontario

Table of Contents

Definitions

In this document:

- "**alternate level of care (ALC) patient**" refers to someone who occupies a bed in a hospital under the *Public Hospitals Act* and has been designated by an attending clinician in the hospital as requiring alternate level of care. This means, in the clinician's opinion, the person does not require the intensity of resources or services provided in the hospital care setting (FLTCA s. 60.1).
  - For the purposes of this document, "ALC patient":
    - also refers to their substitute decision maker, if any, when referring to consent and decision making, and
    - does not include patients who are currently in a transitional care unit based in the community and not designated as hospital premises under the *Public Hospitals Act*.

- "**first-choice home**" refers to the top ranked LTC home on the ALC applicant's LTC home choice list.

- "**long-term care home**" "**LTC home"** refers to a place that is licensed as a long-term care home under the *Fixing Long-Term Care Act, 2021* (FLTCA), and includes a municipal home, joint home or First Nations home approved under Part IX of the FLTCA, unless otherwise specified.

- "**placement co-ordinator selected home**" refers to an LTC home that the placement co-ordinator has chosen for the ALC patient, but the ALC patient has not consented to be on the waitlist at the time of LTC home selection.

- "**patient-selected home**" refers to one of the homes that the ALC patient chooses to be on the waiting list for at the time of LTC home selection.

- "**placement co-ordinators**" refer to placement co-ordinator as defined in subsection 51 (2) of the FLTCA.

1.0 Introduction

This document sets out guidance for Home and Community Care Support Services (HCCSS) placement co-ordinators to support the flow of eligible alternate level of care (ALC) patients from public hospitals to long-term care (LTC) homes, where LTC is under consideration as the most appropriate care setting. As managed in current practice however, Home First should be the preferred discharge destination before LTC is considered.

The intent of this guidance document is to be a resource for placement co-ordinators to implement recent changes to the placement of ALC patients based on the provisions set out in the *Fixing Long-Term Care Act, 2021* (FLTCA) and Ontario Regulation 246/22 (Regulation).

This document should be read in conjunction with the FLTCA and the Regulation and, in the case of any conflict or inconsistency between this document and the FLTCA and the Regulation, the provisions of the FLTCA and the Regulation prevail. This document does not constitute legal advice or interpretation. This document does not apply to admissions to settings other than LTC homes. Additionally, this document and the recent amendments to the FLTCA and Regulation do not apply to individuals seeking admission to Direct Access Beds, High Acuity Priority Access Beds, or beds in LTC homes set out in the Table to section 368 of the Regulation (the four First Nations LTC homes).

1.1 Consent

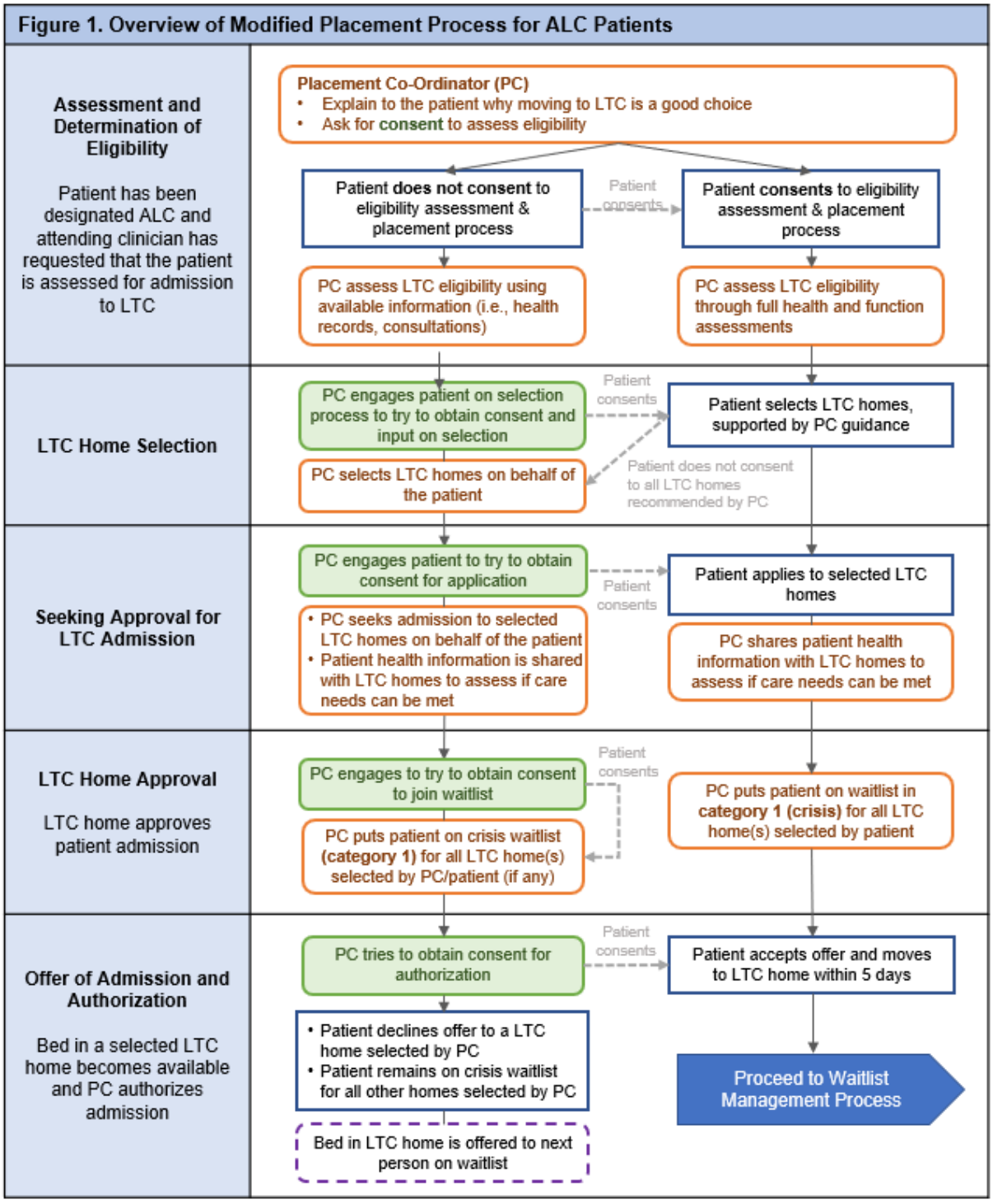
The LTC admissions process for ALC patients will continue to be grounded in an ongoing dialogue with ALC patients, their families, and caregiver(s) about a safe transition to LTC, striving to understand preferences and promote as much choice as possible throughout the entire process.

Where an ALC patient requiring LTC declines to participate in the admission process, these changes will allow that process and conversation to continue. Placement co-ordinators must continue to strive to engage the ALC patient to participate in the process and obtain consent whenever possible.

Legislative and regulatory changes have been made to enable the collection, use and disclosure of personal health information by and to placement co-ordinators for the purposes of determining LTC eligibility of ALC patients and determining admission of an ALC patient to a LTC home in circumstances where consent may not be provided. Details of the changes can be found in para. 5 of s. 60.1(3) of the FLTCA and ss.240.1(9) and (10) of the Regulation.

Please see figure 1 for an overview of the modified placement process and how it may vary, depending on consent from the ALC patient.

Figure 1. Overview of Modified Placement Process for ALC Patients



2.0 Initial Discussions with Hospital ALC Patient

Once it has been determined that a patient no longer needs treatment in a hospital setting, the determination of the most appropriate discharge destination should be an interdisciplinary and collaborative process amongst hospital staff including the discharge co-ordinator, the patient's health care providers and support services, such as HCCSS, and including the ALC patient, family and/or caregiver(s).

Following comprehensive assessments, the attending clinician or care team may request for the ALC patient's LTC eligibility to be determined. However, Home First should be explored as the preferred discharge destination before LTC is considered.

Placement co-ordinators must meet with ALC patients and facilitate initial discussions about exploring LTC. These discussions may take place virtually, over the phone, or in person and should include family and/or caregiver(s). If family and/or caregiver(s) cannot attend in-person, efforts should be made still to include them or ensure their involvement. These discussions should be a collaborative effort supported by both the placement co-ordinator and the hospital discharge team.

It should be explained to the patient why LTC might be a more suitable environment to meet their personal and medical care needs than the hospital. Rationale that could support this conversation may include:

- All LTC homes are required to meet the same standards of care, regardless of home type, ownership model, location, size, etc.
- LTC homes provide a home-like environment and can offer more recreational services and social supports.
- Some LTC homes are better able to provide culturally appropriate, religious and linguistic services, tailoring meals, daily practices and activities to meet these needs.

Ensure the patient's understanding of why the hospital is no longer an option to wait for further services, including the need to provide care for more acute and emergent patients.

If a transitional care unit, in the community and not designated as hospital premises, is under consideration for the ALC patient and they move to that transitional care unit, the ALC patient would not be eligible for the modified admissions process described in this guidance document.

It is important at this step that the hospital discharge team provides sufficient information regarding the implications of remaining in hospital after being discharged if it has not been provided earlier in their hospital stay. This information should continue to be readily available and understood throughout this process.

Every effort must be made to obtain consent from the ALC patient to explore moving to an LTC home, beginning with the assessment for LTC eligibility. If the ALC patient does not initially consent to starting the process to assess LTC eligibility, the placement co-ordinator must explain the next steps that will still be taken to perform the assessment (see s.240.1(5) of the Regulation and also section 3 for further details on determining eligibility) and to select LTC homes if the patient is determined to be eligible.

Throughout this process, the patient should be reminded:

- that they can provide consent at any time without having to start from the beginning, and
- of the implications of consenting or declining to consent during the process.

Placement co-ordinators must provide the patient with all necessary information about the LTC application and placement process, as per sections 49 to 54 and 60.1 of the FLTCA. The initial conversations with the ALC patient should also address choices available regarding accommodation types, payment responsibility, and available financial supports (for example, preferred accommodation top-up, basic accommodation rate reduction).

3.0 Determining Eligibility

3.1 Eligibility Criteria for LTC

The existing eligibility requirements, as set out in s.172 of the Regulation continue to apply for ALC patients.

In accordance with the existing Regulation, it is important to consider the availability of publicly-funded community-based services (including services that may be available on-reserve, for First Nations individuals) and other caregiving, support or companionship arrangements that could be made.

If these are sufficient to meet the individual's care needs, in any combination, the individual would not be determined eligible for LTC admission, as there is a more appropriate care setting or services outside of LTC that could support the patient in the community.

It is important that this LTC eligibility criteria is thoroughly considered by placement co-ordinators based on their knowledge of all available services and care settings, and their ability to utilize their network with the home and community care support services sector to ensure that the patient is directed to the most appropriate care.

If it is determined that the ALC patient is already or should be on the waitlist for other services that would be able to meet their care needs, they would not be eligible for LTC

placement, regardless of the date of availability of the services. The hospital discharge team may have already conducted an assessment for appropriate services. Placement co-ordinators are encouraged to confirm the appropriateness or completeness of these assessments and follow up if necessary.

- Examples of services to consider include adult day programs, community support services, and community-based developmental supports and services through Developmental Services Ontario.
    - ALC patients with developmental disabilities who may already be on a waitlist or should be on a waitlist for community-based services would likely not be eligible for LTC placement. The applicable Developmental Services Ontario office should be consulted to confirm if a request for community-based services has been made, to understand the status of any developmental services assessments and/or the need to conduct a reassessment, if required.
    - If the ALC patient has or may have a developmental disability but has not yet been connected to appropriate supports by the hospital discharge team, placement co-ordinators should raise this as a consideration for discharge and can connect directly with Developmental Services Ontario if necessary.
    - The joint Ministry of Long-Term Care and Ministry of Children, Community and Social Services' *Guidelines For Supporting Adults With A Developmental Disability When Applying To, Moving Into And Residing In A Long-Term Care Home* can provide supplemental information to guide decision-making.

3.2 Assessing Eligibility

In circumstances where the ALC patient does not consent to the assessments required to determine eligibility, placement co-ordinators must attempt to determine eligibility based on as much information as is available in the circumstances.

If the ALC patient does not consent to a health or functional assessment as defined under the FLTCA s.50(4), placement co-ordinators are able to assess eligibility through review of available hospital records and health records from the patient's primary care provider, home and community care provider, an application entity or a service agency defined under the *Services and Supports to Promote the Social Inclusion of Persons with Developmental Disabilities Act*, *2008* (SIPDDA).

- As per para. 5 s. 60.1(3) of the FLTCA and s. 240.1 (10) of the Regulation, regulatory changes have enabled the collection, use and disclosure of patient health information to placement co-ordinators.

To support a records-based assessment, consultations with the ALC patient's attending clinician, primary care provider, home and community care provider(s), and/or Developmental Services Ontario and service agency(ies), if available and applicable, are also strongly recommended.

- It will be important to ensure completion of the Health Assessment form by the attending clinician for a patient that is not consenting to an LTC assessment/application; a copy of this assessment should be included to support the LTC application.

If after conducting consultations and reviewing available patient records, there is still insufficient information to make an accurate determination of eligibility, the placement co-ordinator is encouraged to continue discussions with the ALC patient to consider the transition to LTC and obtain consent for the required assessments.

3.3 Determination of Ineligibility

If it is determined that the patient is not eligible for LTC, this should be communicated back to the hospital discharge team so the appropriate next steps can be taken. This process of determining the ALC patient's most appropriate discharge destination should be a collaborative effort supported appropriately by the patient's clinician(s), hospital discharge team and the HCCSS placement co-ordinator.

4.0 Homes Selected by the Placement Co-ordinator

4.1 Identifying LTC Homes for Selection

If an ALC patient is determined to be eligible for LTC without their consent, it is important to re-engage the ALC patient to communicate this decision and inform them of the next steps.

As it would occur with a regular LTC applicant, once the individual is determined to be eligible for LTC, the placement co-ordinator is to provide the ALC patient with information regarding relevant LTC waitlists and vacancies of the potential LTC homes under consideration, and how to obtain additional information about LTC homes.

If the ALC patient withholds consent to apply for LTC or to apply to additional LTC homes or to LTC homes to which admission would likely happen within a relatively short period of time (for example, they are currently on the waitlist for only 1-2 LTC homes with long waitlists), the placement co-ordinator should identify as many additional LTC homes that they feel would be appropriate matches for that individual based on their conditions and circumstances, class of accommodation and the proximity of the LTC home to the patient's homes, family/caregiver(s) or current hospital.

4.1.1 Required Considerations

The patient's conditions and circumstances

The LTC home(s) selected by the placement co-ordinator must be able to adequately meet the individual's care needs. This includes determining if the ALC patient has specialized care needs and whether there are resources/supports in place or that could be arranged to meet their needs upon admission to that LTC home (for example, additional resources for specialized care).

Specialized Care or Supports Required

- If specialized care or supports are required to enable placement of an ALC patient or a community applicant to an LTC home, or it is known that an LTC home under consideration does not have appropriate supports in place to meet the applicant's needs, the placement co-ordinator can help facilitate a discussion with the LTC home and Ontario Health to determine the availability of services and resources that could enable placement.
- Possible supports include the Local Priorities Fund for investments in specialized equipment (such as bariatric equipment) and services to support placements in particular local contexts, the Virtual Behavioural Medicine program for virtual inpatient neurobehavioural services, services from Behavioural Supports Ontario and the LTC High Intensity Needs Fund (HINF).
- For patients who are eligible for LTC but also have a developmental disability (as defined by eligibility criteria under the SIPDDA), consider the wraparound supports and services that may be required and how these will be provided within an LTC home setting. Placement co-ordinators will need to work with Developmental Services Ontario and the appropriate service agencies in such cases to understand supports and services that would be appropriate and required, and to ensure these wraparound supports are available to support the patient following admission to the LTC home.

Geographic proximity

The LTC home(s) selected by the placement co-ordinator must be within 70 kilometres (km) of a location of the patient's choosing, if input is provided, and more than one location can be used. Possible locations could include the first-choice LTC home, if available, the location of a caregiver or family member, or the current hospital. If the ALC patient does not provide a preferred location(s) from which to search, the patient's preferred location will be the patient's primary residence; or if the patient's primary residence is unknown, then the patient's preferred location will be the hospital in which they are located.

If the patient's preferred location(s) are in the North East or North West HCCSS, the LTC home(s) selected by the placement co-ordinator must be within a 150 km radius of the preferred location(s).

However, if in these regions there is no suitable LTC home in the applicable radius, or if there are extremely limited vacancies in the available homes within the geographic boundary, the next closest home or homes to the patient's preferred location(s) can be selected.

Within the 70 km or 150 km boundary, as applicable, efforts should be made to place the ALC patient as close as possible to their preferred location(s), subject to considerations regarding care needs and accommodation type.

Accommodation type

If a patient is open to admission to preferred accommodation, in addition to basic accommodation, suitable LTC homes with greater availability of preferred accommodations should be prioritized.

If a patient prefers admission to basic accommodation, suitable LTC homes with basic accommodation availability should be prioritized in conjunction with other considerations outlined above. However, as noted under section 240.3(6) of the Regulation, placement co-ordinators are authorized to place these patients in preferred accommodation. See Section 6: Preferred Accommodation Top-Up for further details.

If the patient does not select a class of accommodation, the default accommodation type selected by the placement co-ordinator must be basic.

4.1.2. Additional Considerations

Religious/ethnic/linguistic circumstances

Circumstances that may be unique to the patient, including religious, ethnic and linguistic factors, should be considered when selecting LTC homes in a balanced way, in conjunction with the other requirements set out in the Regulation (that is, care needs, geographic proximity, and accommodation type). Where these factors inform the selection of LTC homes, it is important for the placement co-ordinator to provide updated waitlist information to support realistic wait time expectations.

When considering LTC homes that are designated to serve specific religious, ethnic or linguistic populations, placement co-ordinators should avoid as much as possible matching ALC patients who do not match these designations or those who do not request these designations.

If an ALC patient would like to be placed in an LTC home of a specific religious, ethnic or linguistic origin, it may be advantageous to also consider homes that have a substantial population of residents who also identify such preferences, even though they may not be designated.

- For example, if an ALC patient is only able to communicate in French, according to their linguistic needs, placement co-ordinators should attempt to place them in a home that provides services in French. If the applicant also has religious beliefs but the home is not primarily engaged in serving the interests of persons of that religion, placement co-ordinators would need to work with the applicant to determine how these factors should be prioritized to support selection of homes.

Consideration should be given on best practices for working with ALC patients who identify as First Nations, Inuit or Métis on their options, especially if they have language barriers and/or are far from their support networks.

- Translators/Indigenous language speakers should be used where appropriate.
- Placement co-ordinators should also recognize the importance of prioritizing geographic proximity for Indigenous patients, given the history of relocation and potential traumatization associated with moving an individual far from their home community.
- Ensuring placements within LTC homes where Indigenous language supports are available may be necessary for some Indigenous patients.
- Consideration should be given to LTC homes that are able to provide access to Indigenous staff, Indigenous programming and/or where staff have undergone Indigenous cultural competency.
- Placement co-ordinators should be encouraged to request information regarding Indigenous programming from prospective LTC homes.

Ranking of choices

Placement co-ordinators can consider ranking the LTC homes that they have selected based on proximity to their preferred location. However, the ALC patient should be engaged to determine how homes should be ranked and how other circumstances, such as cultural or religious, should be prioritized.

- These discussions should also set realistic expectations regarding wait times for prioritized LTC homes. This is especially relevant for LTC homes that are primarily engaged in serving the interests of residents of a particular religion, ethnic origin or linguistic origin, which may also be in high demand.

Other

Placement co-ordinators are encouraged to select homes with idle beds or short waitlisted homes within their region and the appropriate geographic parameter,

wherever possible, which will likely have beds available in the immediate term to support patient flow.

There is no minimum or maximum number of LTC homes that a placement co-ordinator can select for an ALC patient. Acknowledging the variation in factors important in meeting the patient's needs, such as geographic limits or cultural circumstances, the number of appropriate LTC homes will also vary.

Placement co-ordinators are encouraged to review the selected LTC homes if there is a significant change in the patient's care needs or they have identified specific circumstances that would require a change (such as their preferred location).

Placement co-ordinators should continue to engage and inform the ALC patient throughout the selection process, while encouraging their participation and consent.

4.2 Seeking Admission Approval to an LTC Home Selected by a Placement Co-ordinator

Placement co-ordinators may share information with a long-term care home licensee to review and determine their approval or non-approval of the admission of the patient to an LTC home selected by the placement co-ordinator . Placement co-ordinators may share patient personal health information with LTC homes as early as possible in the process to support homes in determining if they have the facilities and expertise to be able to meet the care needs of the patient.

If an LTC home withholds the approval of an application, the placement co-ordinator should engage with the LTC home to explore reasons for the rejection and determine if there are opportunities to address barriers to admission. For example, if the reason for rejection was the lack of larger doorways to accommodate oversized beds, specialized supports through the Local Priority Fund could be considered (see section 4.1).

5.0 Waitlist Management

For all ALC patients, the placement co-ordinator will place the patient in category 1 (Crisis Category) of every LTC waiting list on which they are placed, until they can be admitted to a home selected by the patient (unless the patient would otherwise be placed in a higher-ranking category).

5.1 Reunification Priority Access Beds (RPABs)

If an ALC patient meets the criteria for a RPAB, their place on the applicable waitlist for a RPAB would be maintained even if the ALC patient is admitted to a home chosen by

the placement co-ordinator or the ALC patient consents to admission to a home chosen by the placement co-ordinator. The existing placement mechanisms and waitlist categorization continue to apply to support LTC applicants seeking reunification with spouses and partners.

In instances where two spouses are both in hospital waiting for an LTC placement, the placement coordinator must look for opportunities to place them in the same home. The placement coordinator must not authorize admission for either spouse unless there are available placements for both spouses in the same home, or the spouses have consented to separate admissions.

5.2 Strategies for Waitlist Management

Current waitlist management requirements which prioritize individuals within an LTC waitlist category in consideration of their care needs and need for admission continues to apply.

As per existing provisions in s. 200 of the Regulation, individuals with the highest need of admission should be given priority within the crisis waitlist category regardless of current location. Changes to an individual's condition or circumstances should also be considered when determining their level of priority within the waitlist category.

Placement co-ordinators are to take into consideration the urgency for ALC patients to be placed into an LTC home, while balancing the risk of hospitalization for community applicants if they are not placed in LTC imminently.

Where possible, consideration should be given to patients who have been waiting in the hospital as ALC the longest when prioritizing available beds for ALC patients. A regional approach that reflects local contexts in this prioritization strategy is recommended.

Placement co-ordinators are encouraged to conduct regular interviews with those on waitlists to ensure any changes in care needs (through updated assessments), preferences and readiness to be placed into LTC are captured accurately to allow for appropriate prioritization of individuals within waitlists.

6.0 Preferred Accommodation Top-Up

Funding for preferred accommodation top-up will be available to help facilitate placement of ALC patients to LTC homes where an ALC patient requests basic accommodation, but only preferred accommodation is available.

Placement co-ordinators may authorize the ALC patient's admission to preferred accommodation and work with the licensee of the LTC home where the ALC patient will

be placed to make the accommodation available as basic accommodation for the ALC patient.

Placement co-ordinators can direct the licensee to refer to the *COVID-19 Emergency Measures Funding Policy (COVID-19 Funding Policy)* and any related communications materials from the Ministry for information about the reimbursement process for the preferred accommodation top-up and the reporting requirements.

The maximum cost difference between preferred and basic accommodation will be reimbursed to the licensee by the Ministry of Long-Term Care (Ministry).

Before the placement co-ordinator authorizes the admission, they should provide information to the ALC patient and ensure their understanding about the change in their accommodation, how accommodation charges will work, and the conditions under which the preferred accommodation top-up would stop applying to them. Details provided should include, but are not limited to, the following:

- The maximum cost difference between preferred and basic accommodation, as stipulated by the *Bulletin to Residents of Long-Term Care Homes: Important News Regarding Long-Term Care Home Accommodations Charges*, will be reimbursed to the licensee by the Ministry.
- Once the ALC patient moves into the LTC home (now an LTC resident), the licensee will place them on the internal transfer list for basic accommodation based on the date of their admission, even if they do not explicitly request the transfer.
- During the period that the resident is eligible for the preferred accommodation top-up or once they are transferred to basic accommodation, if the resident is unable to afford the basic accommodation rate, they may be eligible to apply for the Long-Term Care Rate Reduction Program. Please refer to the Co-Pay Bulletin for the applicable rate.
- The Ministry will continue to pay the cost difference until the resident:
    a) transfers to basic accommodation; or
    b) refuses an offer to transfer to basic accommodation (internally or to another LTC home); or
    c) removes themselves from any other LTC home waitlists and would rather remain in preferred accommodation.

- In scenarios b and c above, the resident may be charged the applicable accommodation rate only if the resident signs an accommodation agreement.
- Additional details can be found in the *COVID-19 Emergency Measures Funding Policy* on the terms and conditions that apply to preferred accommodation top-up funding.

7.0 Offer of Admission to an LTC Home Selected by a Placement Co-ordinator

If admission has been authorized to an LTC home selected by the placement co-ordinator, it is important to notify the hospital that an LTC placement has been facilitated and if consent has or has not been provided by the patient or substitute decision-maker.

7.1 Continuing Conversation to Support Getting Consent

If an ALC patient refuses a bed offer in an LTC home that was selected by the placement co-ordinator, placement co-ordinators are encouraged to continue to engage the patient in conversation to explore their concerns or needs and how these can be addressed to get consent.

If a bed offer is refused, placement co-ordinators are encouraged to continue to work with the ALC patient to select other LTC homes where the patient may accept a bed. See section 7.2 for suggested rationale and strategies to support why a transition to LTC would be beneficial.

7.2 Following Refusal of Admission to LTC

If an ALC patient refuses a bed offer to a home selected by the placement co-ordinator, they will remain on all other LTC home waitlists that were selected by both the patient and the placement co-ordinator.

If an ALC patient refuses a bed offer, the discharge team for the hospital should be consulted for more specific information about actions they may take if an ALC patient who no longer requires treatment in the hospital and is eligible for LTC refuses a bed offer to an LTC home.

If the placement co-ordinator is made aware that the ALC patient refuses to move into the LTC home prior to the five days, they are able to offer the bed to the next person on the waitlist.

ALC patients are not precluded from seeking alternative care options after they are discharged from the hospital. Alternative care options may include seeking private care at home.

Please note that nothing in the FLTCA or Regulation allows for the physical transfer from a hospital to a long-term care home without the patient’s consent.

7.3 Timeline for Moving into the LTC Home After Accepting an Offer

Once an offer for LTC is accepted, the ALC patient has five days to move into the LTC home.

If the ALC patient does not move into the home before noon of the fifth day following the day on which they are informed of the offer, the placement co-ordinator may offer the bed to the next applicant on the waiting list, unless arrangements were made with the licensee for the patient to move at a later time on the fifth day.

7.4 Transportation to the LTC Home

ALC patients who are discharged from the hospital for admission to an LTC home are responsible for arranging and paying for their own transportation to the LTC home. Hospitals are not required to arrange, provide, or pay for transportation services for people who have been discharged from hospital.

In some cases, hospitals may be able to provide background and contact information to patients and their families about transportation options such as private patient transportation services, wheelchair transportation and stretcher transportation services for patients who must travel in a fully reclined position.

Where the ALC patient has no means to arrange or pay for transportation, the placement co-ordinator should consult with the hospital discharge team and Ontario Health about options and next steps.

8.0 Steps Following Initial Admission

8.1 Following Admission to a Placement Co-ordinator Selected Home

If an ALC patient consented to admission to an LTC home selected by the placement co-ordinator, following admission to the home, the placement co-ordinator must limit the number of remaining waitlists to five and should engage with the ALC patient (now LTC resident) to determine if they still wish transfer to a home from their list of patient-selected homes.

If the resident expresses within the first six months of admission that they wish to apply to another LTC home, the placement co-ordinator will maintain the category 1 (crisis) designation for those five waitlist choices.

At this time, the placement co-ordinator should share with the resident information about the length of the waiting list and approximate time to admission for their preferred home to support the resident in making an informed decision.

See the appendix for a process flow of waitlist management following admission.

8.1.1 If No Additional Home(s) are Selected by the Patient

If an ALC patient is admitted to a home selected by the placement co-ordinator and is not on the waiting list for any other home of their choice, the placement co-ordinator should determine if they wish to select other LTC homes for a future transfer.

The placement co-ordinator should also ensure that the resident understands that they would only qualify for the crisis waitlist category if they selected additional LTC homes within the first six months of admission.

If the resident does not select other homes for transfer within six months of their admission to their current LTC home, the placement co-ordinator may assume the resident's current LTC home has become a patient-selected home.

If the resident selects other LTC homes to apply within six months, the placement co-ordinator should then place them in the crisis category of the waitlist for all of homes they may select (up to five).

If the resident expresses a desire to transfer after the first six months of admission to the LTC home, the placement co-ordinator would then place them based on the normal transfer rules according to the Regulation for the LTC homes they have now selected.

8.2 Following Admission to a Patient-Selected Home

If an ALC patient is placed in an LTC home that was a patient-selected home but it is not their first-choice home, placement co-ordinators should engage with them to determine if they wish transfer to their first-choice home or another home from their list of patient-selected homes.

If the resident wishes to be transferred to another home from their list of patient-selected homes, including their first-choice home, the placement co-ordinator should then place the resident on the waiting list for their patient-selected home(s) in accordance with the waiting list prioritization scheme set out in Regulation. The resident would likely be placed into category 3A/4A "Others" of the waiting list for the home (unless the resident's circumstances warrant placement into a higher category).

At this time, the placement co-ordinator should share with the resident information about the length of the waiting list and approximate time to admission for their preferred home to support the resident in making an informed decision.

8.3 Conditions for Removal from Waiting List

If an ALC patient is admitted as a resident to a placement co-ordinator-selected LTC home, and the resident later refuses an offer of admission to one of the patient-selected

home, the placement co-ordinator is required to remove the resident from all waiting lists.

9.0 Process for Addressing Complaints

9.1 Documentation

To ensure that all components of the ALC-to-LTC transition process are clearly communicated to all relevant parties, including the ALC patient caregiver(s) or family, and other supporting providers, placement co-ordinators should ensure that all actions taken, progress made, and decisions are appropriately and clearly documented. This will support any future need for review, in case of complaints and/or disputes.

9.2 Patient Experience Manager, Client Experience Office and LTC Family Support and Action Line

Placement co-ordinators should communicate to hospital patients and their families the process for communicating their concerns or complaints regarding the service from HCCSS organizations. This may include sharing information about the Patient Experience Manager, Client Experience Office, Long-Term Care Family Support and Action Line (Action Line) and the option of speaking to an Independent Complaints Facilitator (ICF).

If an ALC patient or their family members have any concerns or complaints regarding the service from HCCSS organizations, they can contact the Patient Experience Manager or the Client Experience Office for HCCSS (where these are available) or they can contact the Action Line.

In addition to the Action Line, they also have the option of speaking to an ICF to discuss their concerns. ICFs are located throughout Ontario and are trained to listen to concerns from persons receiving service from LTC Homes and HCCSS organizations.

HCCSS organizations' clients who would like to reach the Action Line can call 1-866-876-7658. To work with an ICF, they would call the same number and then request to work with an ICF.

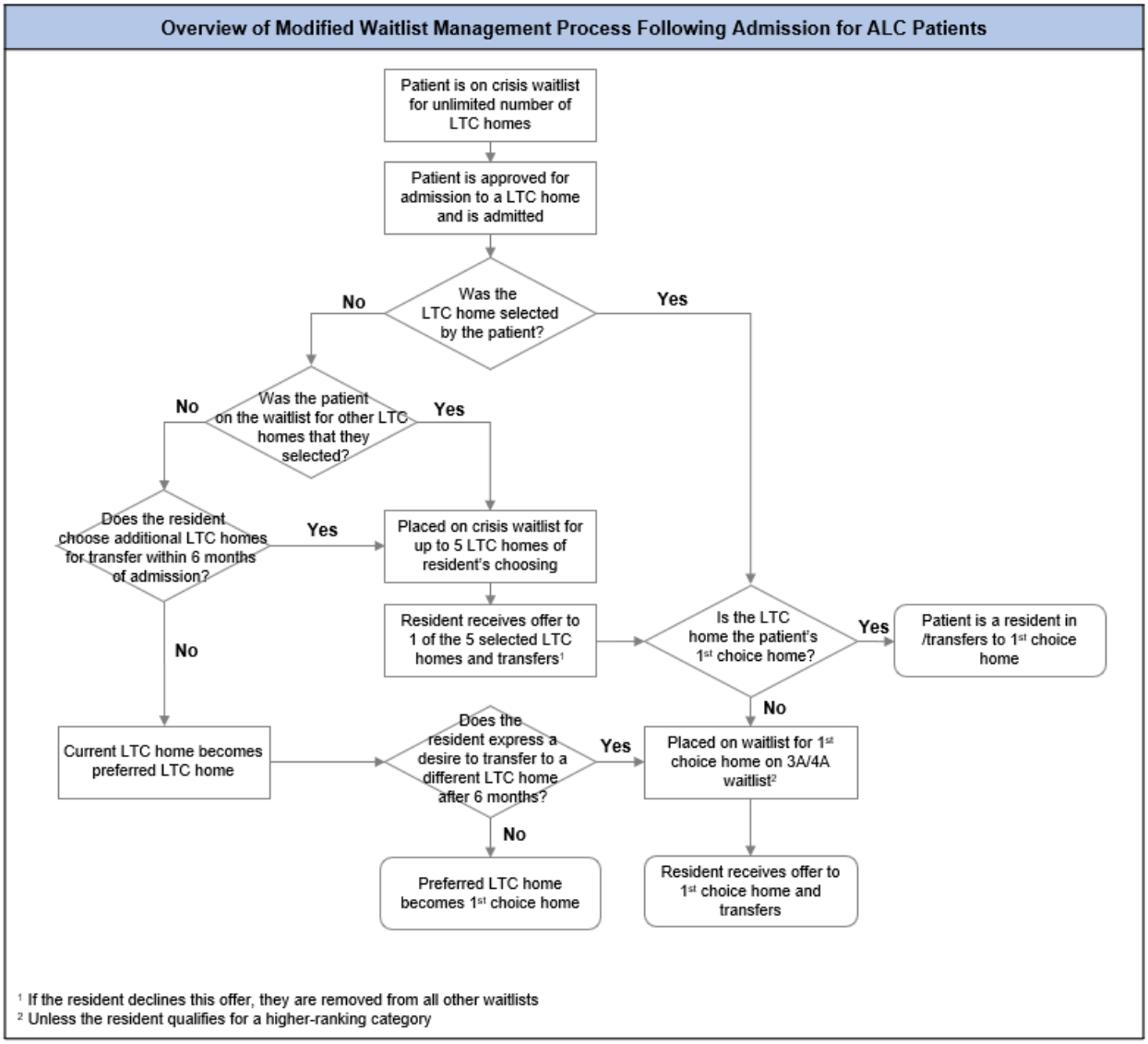
Placement co-ordinators are encouraged to offer to work with patients, applicants and family members to resolve their concerns before they are referred to the Action Line or an ICF.

9.3 Ombudsman Ontario and Patient Ombudsman

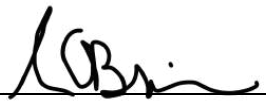
Patients and their families may be directed to the Office of The Ombudsman of Ontario in cases of unresolved complaints regarding the Ministry of Long-Term Care.

In cases of unresolved complaints about public hospitals, LTC homes, HCCSS organizations, patients and their families can be directed to the Patient Ombudsman's office.

Appendix


Overview of Modified Waitlist Management Process Following Admission for ALC Patients
Patient is on crisis waitlist for unlimited number of LTC homes
Patient is approved for admission to a LTC home and is admitted
Was the LTC home selected by the patient?
No
Yes
Was the patient on the waitlist for other LTC homes that they selected?
No
Yes
Does the resident choose additional LTC homes for transfer within 6 months of admission?
Yes
No
Placed on crisis waitlist for up to 5 LTC homes of resident's choosing
Resident receives offer to 1 of the 5 selected LTC homes and transfers[1]
Is the LTC home the patient's 1st choice home?
Yes
Patient is a resident in /transfers to 1st choice home
No
Current LTC home becomes preferred LTC home
Does the resident express a desire to transfer to a different LTC home after 6 months?
Yes
No
Placed on waitlist for 1st choice home on 3A/4A waitlist[2]
Preferred LTC home becomes 1st choice home
Resident receives offer to 1st choice home and transfers
[1] If the resident declines this offer, they are removed from all other waitlists
[2] Unless the resident qualifies for a higher-ranking category

This is **Exhibit "P"** referred to in the Affidavit of **Jane E. Meadus**, affirmed this 11 day of April, 2023, in accordance with O. Reg 431/20, Administering Oath or Declaration Remotely.



A Commissioner for taking Affidavits etc.(*or as may be*) (pursuant to O. Reg 431/20)

Amanda Marie O'Brien, a Commissioner etc. Province of Ontario, for Goldblatt Partners LLP, Barristers & Solicitors
~~Expires November 15, 2024~~

Fact Sheet – Bill 7: *More Beds, Better Care Act, 2022*

What is Bill 7?

Bill 7, the *More Beds, Better Care Act, 2022*, was passed by the Legislature and received Royal Assent on August 31, 2022, and takes effect on September 21, 2022. This legislation frees up hospital beds so that people waiting for surgeries can get them sooner; it eases pressures on crowded emergency departments by admitting patients sooner. It follows the lead of other provinces, who have had similar policies in place for decades.

A long-term care home is a more appropriate care environment for many patients as it provides a home-like environment where residents benefit from social activities like dining, recreation, and physical activity. Hospitals are not designed to meet an ALC patient's restorative, supportive or rehabilitative needs.

The legislation and supporting regulations come into force September 21, 2022.

What happened before Bill 7?

Without these proposed changes, thousands of Ontarians would continue to wait in hospitals for extended periods of time for their preferred choice in a long-term care home. This creates pressures for hospitals to manage emergency and surgical beds, and it means ALC patients were not benefiting from the services, activities and supports that are offered in a long-term care environment, such as social and physical activities, entertainment, group dining, and personal care. Studies show how crucial social interaction and daily routine can be to improve an individual's health.

Before Bill 7, if a patient was to transfer to a long-term care home that was not their preferred choice, they would lose their spot on the waiting list.

What is changing because of Bill 7?

A placement co-ordinator – working in consultation with the patient, their caregivers, the hospital clinical care team, long-term care homes and others – will assess an ALC patient's eligibility and admission to a long-term care home. These are decisions that clinicians already make with their patients every day.

Starting September 21, if there is no bed available in a long-term care home that is on the patient's preferred home list, the placement co-ordinator may authorize the patient's admission to a home where the patient can live while they continue to wait for a spot in one of their preferred homes. The patient would be placed in priority status on the wait list while they wait. This also would allow for the patient to receive those enriching services, activities and supports, such as social and physical activity, entertainment, and organized dining.

All patients are expected to leave the hospital when they have been discharged by their attending clinician. Starting November 20, 2022, hospitals would be required to charge discharged patients a standardized fee of $400 for every day that they remain in hospital after discharge, following a 24-hour period. This fee would be charged to any discharged patient who refuses to leave hospital.

Although Bill 7 would allow for certain steps in the eligibility determination and admission process to be taken without the consent of an ALC patient or their substitute decision-maker, it would not allow for a patient to be physically transferred to a long-term care home without consent.

How will this impact patients?

Where will patients be placed?

Placement co-ordinators would be expected to have ongoing conversations with patients, their family and caregivers, to explain and explore the benefits of long-term care. Placement co-ordinators would make reasonable efforts to seek the patient's consent at each stage of the placement process.

The process for admitting hospital ALC patients to a long-term care home involves an ongoing dialogue with patients, families and caregivers. When identifying possible homes, placement co-ordinators would strive to accommodate the patient's preferences, including distance from the patient's preferred location(s), travel for loved ones, and the patient's preferences based on ethnic, religious, spiritual, linguistic, familial and cultural factors.

Placement co-ordinators would select long-term care homes within a radius of 70 kilometres from the patient's preferred location. This parameter would be consistent across Ontario except in the areas within the boundaries of Home and Community Care Support Services North East and Home and Community Care Support Services North West, where the radius would be 150 kilometres. If there is no long-term care home or if there is limited vacancy within the applicable radius in the aforementioned regions, placement coordinators would select the next closest home(s) to the patient's preferred location(s).

Long-term care homes would be required to review the information respecting an ALC patient that is sent by the placement co-ordinator and to approve that patient's admission unless the home does not have the physical facilities or nursing expertise to meet the patient's care needs.

Once an offer to a long-term care home has been made, the patient would have five days to move in unless other arrangements have been made with the long-term care home, otherwise the bed could be offered to the next person on the waiting list.

A patient's choice of where they ultimately want to live would remain. Once admitted, the ALC patient would maintain priority status on the wait list for their preferred long-term care home(s). Once a bed becomes available at one of their preferred homes, they could choose to permanently move to that home, or they could choose to remain in the home they were originally placed in.

What will patients have to pay for?

The government pays in full the health care costs of long-term care. Residents contribute towards the cost of their meals and accommodation. The government provides rate reductions for those who cannot afford accommodation co-payments.

If an ALC patient has requested basic accommodation in long-term care and is moved to preferred accommodation in a home not of their choice, they will be charged only the basic rate.

Starting November 20, 2022, hospitals will charge a standardized daily fee of $400 to patients who no longer require hospital care, but who choose to remain in hospital after being discharged, including ALC patients who have been authorized for admission to a long-term care home. This fee would be charged every day that the discharged patient remains in the hospital after a 24-hour period. Where issues related to the implementation of these changes arise, patients, families and caregivers would be encouraged to connect with the hospital's patient relations office.

ALC Patient Journey

Long-Term Care

- Jane is admitted to the hospital to receive treatment.
- Jane's attending clinician determines she no longer requires hospital-level care and needs an alternate level of care. The attending clinician believes that long-term care might be suitable for Jane, and requests an assessment by a placement co-ordinator of Jane's eligibility for long-term care.
- A placement co-ordinator assesses Jane's eligibility to receive care in a long-term care home and her care needs and determines she is eligible.
- Jane applies for long-term care and is on a waitlist for her preferred homes with many other people. The placement coordinator talks to Jane about the benefits of waiting in a long-term care home rather than hospital while waiting for admission to one of her preferred homes.
- During the conversation, the placement coordinator also gathers as much information as possible about Jane's preferred location(s) and any religious, ethnic, and linguistic preferences that she has, in order to help select an appropriate home for her immediate care as she waits for admission into one of her preferred homes.
- The placement coordinator informs Jane about the home(s) they have identified that have a bed available and can meet her immediate care needs while she waits for admission into one of her preferred homes.
- Jane is authorized for admission into one of the homes selected by the placement coordinator.
- The hospital is informed about the authorization for admission into a home and advises Jane that she can now be discharged from the hospital, and that if she chooses to stay, she will be charged $400 per day, 24 hours after discharge.
- Jane agrees to transfer into the long-term care home selected by her placement coordinator while she remains on the wait list for her preferred homes, with priority status, and is discharged from the hospital.
- Jane moves her personal belongings into her room at the home. She adds her own decorative touches to the room, such as her favourite photos, art and plants.

- The staff at the home help Jane with activities of daily living like bathing and getting dressed, and Jane has access to the health services she needs, such as physical therapy or behavioural supports
- Home staff shares with Jane opportunities to participate in the social activities of the home, which could include various forms of entertainment, shared dining spaces and access to outdoor gardens.
- Once space is available at one of her preferred long-term care home(s), Jane is offered the option to stay where she is or to transfer to her preferred home.

Home Care

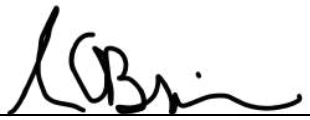
- Jane's attending clinician believes that either home care or a long-term care home might be suitable for Jane and issues an order for her discharge.
- Jane chooses to return home, while she remains on the wait list for her preferred long-term care home.
- Jane's local Home and Community Care Support Services care coordinator, working with her discharge planning team, determines her care plan at home to prepare for hospital discharge.
- Jane is discharged from hospital and Home and Community Care Support Services arranges regular visits from a personal support worker (PSW), who will help Jane bathe and get dressed, and from a physiotherapist, who will help Jane with daily exercises that help her heal.
- Home and Community Care Support Services also connects Jane's husband and caregiver, Dave, with an Adult Day Program, where his wife can spend the day enjoying various group activities, while getting any needed personal care during the day. This subsidized program offers transportation and meals, allowing Dave to take a break from his caregiving activities and run a few errands from time to time.
- Jane is delighted to watch television in the comfort of her own home with old friends again and arranges to have her hair done every month by a community hairdresser recommended by Home and Community Care Support Services.

No Option Selected

- Jane's attending clinician determines she no longer requires hospital-level care and believes that a long-term care home might be suitable for Jane and requests an assessment by a placement co-ordinator of Jane's eligibility for long-term care.
- The placement co-ordinator informs Jane about the home(s) they have identified that have a bed available and can meet her immediate care needs while she waits for admission into one of her preferred homes.
- Jane's attending clinician issues an order for her discharge. The hospital exercises its discretion to permit Jane to remain in the hospital for an additional 24 hours after the date set out in the discharge order in accordance with the discharge provisions under the *Public Hospitals Act*.

- The hospital discharge coordinator advises Jane that she can stay within hospital without charge for another 24 hours but, if she chooses to stay beyond that time, the hospital will be required to begin charging her a post-discharge fee of $400 per day.
- Jane chooses to stay in the hospital after her discharge date, and she begins to accrue daily charges. Jane, her family and caregivers remain in discussion with her hospital team to determine what the next steps would be.

This is **Exhibit "Q"** referred to in the Affidavit of **Jane E. Meadus**, affirmed this 11 day of April, 2023, in accordance with O. Reg 431/20, Administering Oath or Declaration Remotely.



A Commissioner for taking Affidavits etc.(*or as may be*) (pursuant to O. Reg 431/20)

Amanda Marie O'Brien, a Commissioner etc.
Province of Ontario, for Goldblatt Partners LLP, Barristers & Solicitors
Expires November 15, 2024

September 14, 2022

MEMORANDUM TO: Health System Partners

FROM: Nancy Matthews, Deputy Minister, Ministry of Long-Term Care
Alison Blair on behalf of Dr. Catherine Zahn, Deputy Minister, Ministry of Health
Matthew Anderson, President and CEO, Ontario Health

RE: **Bill 7 Implementation to Support Ontario's *Plan to Stay Open: Health System Stability and Recovery***

On August 18th, the government launched Ontario's Plan to Stay Open*: Health System Stability and Recovery.* This five-point action plan was developed to address Ontario's urgent need to stabilize the health and long-term care sectors and preserve our hospital capacity this fall/winter and into the future. As we look ahead, with the potential for a new wave of COVID-19 and other respiratory illnesses, our focus remains on ensuring patients, residents, clients, and communities continue to receive the care they need from our health system. This means ensuring Ontarians receive the right care in the right place.

Together with partners across the system, we have begun immediate steps to implement several key strategies from the plan. This includes operationalizing the *More Beds, Better Care Act, 2022* (the "Act", formerly Bill 7) (More Beds, Better Care Act, 2022, S.O. 2022, c. 16 - Bill 7 (ontario.ca)) that received Royal Assent on August 31, 2022. The Act is aimed at facilitating the admission of eligible patients, who are clinically determined as needing an Alternate Level of Care (ALC), into a long-term care home, while they wait for placement in a preferred home.

As we move forward with this implementation, we are grounded in a 'home-first' philosophy, ensuring that, whenever possible, patients arriving in a hospital are supported in returning to their home. However, where that is not possible and long-term care is determined to be the appropriate setting, we are committed to ensuring those patients are compassionately and respectfully supported as they transition to long-term care, where their health and personal care needs can be met and their independence, safety, and quality of life enhanced.

Effective September 21, 2022, the remaining provisions of the Act will come into force. In addition, changes to the regulations under the *Fixing Long-Term Care Act, 2021* (O. Reg. 484/22) and the *Public Hospitals Act* (O. Reg. 485/22, O. Reg. 486/22) will come into effect (see attached appendix for a summary of the regulations). These regulations will provide added clarity and specific requirements enabling and supporting the changes outlined in the legislation. The most significant change is the ability of Home and Community Care Support Services (HCCSS) placement coordinators, working collaboratively with hospitals and long-term care homes, to facilitate an eligible ALC patient's admission into a temporary long-term care home, while they wait for a preferred home.

All sectors should be aware of these changes as they support care to patients, families, caregivers, clients, and residents.

The following outlines some high-level information and specific direction where change is required to support this implementation:

Home and Community Care Support Services:

- A comprehensive Ministry of Long-Term Care field guidance document has been developed, in partnership with HCCSS and Ontario Health, to support HCCSS placement coordinators implement the new regulations (see attached). Consistent with current best practice, integrated care teams from the hospital and HCCSS should first review all options to have the patient return to their home.

- HCCSS placement coordinators must consider various factors, in consultation with the patient and family prior to authorizing admission to a long-term care home, including a patient's care needs, accommodation requested and distance from the patient's preferred location(s). They will also consider travel for loved ones, caregivers and religious, ethnic, and linguistic preferences.

- HCCSS placement coordinators will continually engage the patient, family, caregiver, or substitute decision-maker, making every effort to seek consent at each stage of the process. If not achieved, the placement coordinator will continue to move forward with the determination of eligibility and other admission processes, without consent, with the goal of finding a suitable temporary arrangement in a long-term care home while they wait for their preferred home.

- A patient's choice of where they ultimately want to live will remain. A patient will be placed in a priority status on the wait list for a preferred home while in a temporary arrangement in a long-term care home. Where applicable, their place on a waiting list for a reunification priority access bed, would also be maintained.

Long-Term Care Homes

- Long-term care homes are required to review the information sent by the placement coordinator and either approve or not approve the admission, related to the temporary arrangement, promptly and to admit an eligible patient. (In practice, this would ideally occur within less than five (5) days).

- In addition, long-term care homes should work proactively with HCCSS and their Ontario Health region to identify available specialized supports and services for patients that could enable admissions that would otherwise not be possible.

- As previously communicated by the Ministry of Long-Term Care, long-term care homes are expected to bring beds back online that are no longer needed for pandemic-related isolation purposes. This is critical to increase available capacity within long-term care homes across the province.

- Long-term care homes are authorized to collect, use and disclose an ALC patient's personal health information to enable the long-term care admissions process.

Hospitals

- The discharge of a patient from a hospital remains a clinical decision that is undertaken in consultation with the interdisciplinary care team that facilitates ongoing dialogue with the patient, family, caregiver, or substitute decision-maker.

- HCCSS placement coordinators should keep hospitals informed throughout the eligibility assessment and application process and notify the hospital if a temporary care arrangement has been facilitated and if consent has or has not been provided by the patient or substitute decision-maker.

- Hospital personnel, as appropriate, are authorized to collect, use and disclose personal health information in respect of ALC patients as they carry out the eligibility assessment process including in cases where, despite reasonable efforts, patient consent has not been obtained.

- Hospitals will continue to be required under the *Health Insurance Act* to charge the daily chronic care co-payment to ALC in-patients who are awaiting placement in a long-term care home, subject to any applicable reductions or exemptions.

- Effective November 20, 2022, hospitals will be required under the *Public Hospitals Act* regulations to charge a standardized daily fee of $400 to patients who no longer require hospital care, but who remain in hospital after being discharged, including ALC patients who have been authorized for admission to a long-term care home. This fee must be charged every day that the discharged patient remains in the hospital after a 24-hour period. In the case of a patient who will require care or supports in another setting after they are discharged from hospital (e.g., home care, long-term care, etc.), it is expected that members of the discharge planning team will coordinate regarding the timing of discharge to help ensure that, on the discharge date, any necessary arrangements are in place. Where issues related to the implementation of these changes arise, patients, families and caregivers should be encouraged to connect with the hospital's patient relations office.

Primary Health Care Providers

- Primary health care providers should familiarize themselves with the changes to support communication with patients, caregivers, and families, as appropriate.

- Primary health care providers, as defined in the regulation, are authorized to collect, use and disclose personal health information respecting ALC patients as they carry out the long-term care home eligibility assessment and placement process, including in cases where, despite reasonable efforts, patient consent has not been obtained.

Home and Community Care Service Providers

- Home and community care service providers should enhance efforts to support safe and timely transitions to home and other community settings.

- Service providers should familiarize themselves with the changes to support communication with patient, caregivers, and families, as appropriate.

- A service provider that was providing home and community care services to an ALC patient immediately before their admission to hospital is authorized to provide personal health information respecting that patient to a placement coordinator to assist the coordinator in carrying out the long-term care home eligibility assessment and placement process, including in cases where, despite reasonable efforts, patient consent has not been obtained.

As a system, we are requesting that you continue to work collaboratively through Ontario Health regional Access and Flow tables in support of a consistent and coordinated implementation approach across the province.

We understand the significant challenges ahead for our health system and know we can count on your ongoing collaboration. Our shared goal remains -- equitable access to quality care for all Ontarians by ensuring people receive the right care in the right place. Once again, thank you for your continued commitment and dedication to caring for millions of Ontarians each day.

If you have any questions or require further information, please contact the Ministry of Long-Term Care for changes under the *Fixing Long-Term Care Act, 2021* by email at LTC.Info@ontario.ca, and the Ministry of Health for changes under the *Public Hospitals Act* by email at CSU.MOH@ontario.ca.

Sincerely,

Nancy Matthews
Deputy Minister, Ministry of Long-Term Care

Alison Blair on behalf of Dr. Catherine Zahn
Deputy Minister, Ministry of Health

Matthew Anderson
President and CEO, Ontario Health

C: Dr. Kieran Moore, Chief Medical Officer of Health
Dr. Barbara Yaffe, Associate Chief Medical Officer of Health
Alison Blair, Associate Deputy Minister, Pandemic Response and Recovery, Ministry of Health
Melanie Fraser, Associate Deputy Minister, Health Services, Ministry of Health
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Peter Spencer, Director, Legal Services, Ministry of Health/Ministry of Long-Term Care
Tara Wilson, Director, Ministry of Health
Amy Olmstead, Executive Lead, Ministry of Health
Donna Kline, Chief Communications and Engagement Officer, Ontario Health
Anna Greenberg, Chief Regional Officer, Toronto & East, Ontario Health
Susan DeRyk, Chief Regional Officer, Central & West, Ontario Health
Brian Ktytor, Chief Regional Officer, North, Ontario Health
Michael Sherar, President and CEO, Public Health Ontario
Cynthia Martineau, CEO, Home and Community Care Support Services
Lisa Levin, Chief Executive Officer, AdvantAge Ontario
Donna Duncan, Chief Executive Officer, Ontario Long Term Care Association
Samantha Peck, Executive Director, Family Councils Ontario
Dee Tripp, Executive Director, Ontario Association of Residents Councils
Monika Turner, Director of Policy, Association of Municipalities of Ontario
Michael Jacek, Senior Advisor on Social and Health Policy, Association of Municipalities of Ontario
Chris Murray, City Manager, City of Toronto

ONTARIO HEALTH COALITION AND ADVOCACY CENTRE FOR THE ELDERLY

Applicants

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HIS MAJESTY THE KING IN RIGHT OF ONTARIO AS REPRESENTED BY THE ATTORNEY GENERAL OF ONTARIO, THE MINISTER OF HEALTH, and THE MINISTER OF LONG-TERM CARE

Respondents

Court File No.

ONTARIO
SUPERIOR COURT OF JUSTICE

Proceeding commenced in Toronto

AFFIDAVIT OF
JANE E. MEADUS
(Affirmed April 11, 2023)

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