Champlain Region Family Council Network (CRFCN)
Minutes of the Thirteenth Annual General Meeting

AGM CRFCN Keynote Speaker
Dr Jack Kitts, Commissioner,
Ontario's Long-Term Care COVID-19 Commission

Welcome and introduction provided by Grace Welch.

Dr. Kitts began his remarks by saying that we are at a crossroads in Ontario history where we can finally break the mold of studying what to do about long-term care and take action. We must all be advocates to keep reform present and on the "priority" agenda. He noted the many traumas and loss of life in long-term care during the pandemic and said that few if any others in our society had demonstrated the heroic spirit shown by staff and residents. We must support transformation and this tragedy must never happen again.

Dr. Kitts briefly described the setting up of the Commission with its mandate to investigate how and why Covid -19 spread in LTC and what was done to mitigate the spread. A 9-month time frame was given it to report. He identified the Commission's guiding principles as being independence from government; thoroughness; inclusiveness; timeliness; and flexibility.

The Commission met with 700 individuals and received 170 formal presentations and over 300 written submissions. 15,000 pages of transcripts can be found on the Commission's website. The Commission heard from residents, staff and loved ones of residents, operators of for-profit, not-for-profit, and municipal homes, current and former government officials from the Ministry of Health and the Ministry of Long-Term care, many advocacy groups, groups representing seniors and marginalized seniors including the homeless and LGBQT representatives. Evidence was also gathered from other Provinces and from abroad and from health groups and geriatricians.

Dr. Kitts said that the Commission took note of the letter from Rosemary Cavan, CRFCN Chair, dated September 14, 2020, and accepted the advice that the voices of families and residents should be heard. Family and resident voices -as many as possible - were heard in both French and English, as were the voices of staff, staff associations and unions. Family Councils Ontario and the Ontario Association of Residents Councils. Hearing powerful stories and thoughtful recommendations brought discussion of policies to life and life to policy discussions. The reports have been put on the Commission's website so that there is a written record of what happened in LTC during the pandemic.

The Commission conducted a survey of 626 LTC homes on a number of issues including staffing, infection control, leadership in the homes. The responses were used to inform Commissioners on what happened in LTC to make Covid spread so dramatically.

Dr. Kitts moved on to the Commission's recommendations. Although the Commission recognized that challenges in LTC have existed for at least a decade, the 85 recommendations are based on findings during the pandemic. Dr. Kitts identified and commented on the top 6 areas where adoption of the Commission's recommendations would make a difference.

Pandemic Planning and Preparedness

Across the sector at the provincial, regional, and municipal levels, pandemic plans were non-existent or not kept up to date. No actions were taken to conduct emergency planning drills or simulations. Some LTC homes did have a plan and a supply of PPE.

Staffing

During the pandemic there were too few staff to care for residents. Most homes did not have a full complement of staff. Staffing was a problem across the sector – in some homes up to 25% of the workforce (RNs, RPNs and PSWs) was missing. 80 to 85 % of LTC residents have cognitive impairment and approximately 70% have dementia. These needs must be recognized and cared for. The staff to patient ratio needs improvement. The acuity of residents suggests that staff should be more skilled. The Commission looked at the question of hours of care and recommended an increase from the current hours (less than 3) to at least 4 hrs of direct care per day. They suggested a template for the staff mix but felt that the individual homes were best suited to determine the appropriate mix of staff for their resident care. Education, training and development of staff and management are essential. Geriatric, psychiatric and infection control education, and training is needed as is training on the appropriate use of PPE. Nurse practitioners would be an important addition to staff. Long-term care should aim for the same ratio of Full time to Part time workers as is the case in hospitals – 70:30 percent.

Leadership and Accountability

Leadership is key to making things work. LTC homes need strong vision, mission and values statements and strategic plans to achieve their goals. Standards need to be set and outcomes measured. Leadership competencies need to include preparedness and staffing skills.

The Ontario Long Term Care Homes Act sets out in section 1 the "fundamental principle" that should govern care and be the foundation upon which the culture of the homes should be built. The Ontario Residents Bill of Rights describes what every LTC home in Ontario should aspire to provide. The question is "Who are the leaders essential for this to work?" LTC homes cannot do it without leadership and funding. Government cannot do it alone. The Ministry of LTC must be at the table along with owners and licensees, Boards of Directors and Management teams, Operators, Administrators and Executive Directors and Practitioners. Their roles/job descriptions must be aligned to achieve the promise of the fundamental principle. Leaders should undergo professional development to be effective leaders and training to develop leadership skills.

Accountability requires performance measurement – perhaps each home could adopt a standard based on overall resident experience? It requires setting targets and providing appropriate resources for leaders to do their jobs.

Compliance and Enforcement

Three types of inspections in LTC homes were felt to be taking place during the pandemic. The Ministry of Long-Term Care inspectors respond to complaints and critical incidents. In fact, the number of these incidents was far higher than the number of inspectors required to complete thorough inspections of the homes. The inspections became entirely focused on the incident and did not include proactive inspections. The Ministry

of Labour is responsible for inspection homes for workplace safety including responding to staff safety ncidents and ensuring compliance with staff safety protocols and procedures. The Public Health Agencies in the Province carry out inspections to determine if good housekeeping practices are followed and that food is safe. The Commission recommended that the inspectors from the 3 different ministries collaborate more and work together.

The Commission feels that greater public reporting is needed. There should be an escalating scale of consequences for non-compliance with Provincial standards culminating with a potential loss of licence.

Culture

A positive culture must be created to recruit and retain good staff for LTC. PSWs and other staff members often do not feel respected or valued. A culture of respect, kindness and compassion must be created for all residents and staff. This would be a natural lead-in to patient centered care. Staff who directly care for residents should decide what is best for residents and what kind of care plans they need.

Funding

Long-term care homes should be established much in the same way as hospitals: in a Public Private Partnership (PPP). The private sector designs, builds and finances (DBF) hospitals. The hospital manages the patient care and the government finances the hospital after it is built. The service provider for patient care should either be public sector like hospitals or mission driven organizations. The level of care in a home should not compete with profits and payments to shareholders.

New standards for home design and renovations are needed. Bedrooms should accommodate 1 or at most 2 residents at a time. Small, self-contained units are associated with better patient experiences. The province should support homes which provide cultural and linguistic care.

Dr. Kitts concluded his formal remarks by quoting from the Commission's Report. He said that the Commissionhad learned much from the witnesses who shared their stories, including one family member from the Eastern Region of Ontario.

The model of care must be changed and most importantly the respect and treatment of seniors and their care providers, the PSW's the nurses also must change. A remake of long- term care is needed not warehousing people, but meeting needs of people at various stages of life with dignity,

Dr Kitts closed by saying the LTC Commission hopes the report will take us a long way towards fulfilling this wish.

Following is the transcript of the questions and answer period following Dr Kitts presentation. Janet Luloff moderated the Q and A portion.

1. **Q:** Will the results of the staffing survey that was done by the LTC Commission be made public?
   A: Dr Kitts
   There is a staffing plan that was completed by the Ministry before the commission was created. It was submitted to the government in July. We received the staffing plan, went through it, and endorsed it as

a good plan. We added some recommendations to the plan. We {the LTC Commission} don't have a staffing survey except the one we did to ask to look for readiness in Wave 2. It was done in the fall, and we were asking if the staffing, IPAC (Infection Prevention and Control) PPE (Personal Protective Equipment) had been sorted out. It gave us a sense that most but not all homes were better prepared in in wave 2.

2. **Q:** Did the inspection process overall fail to identify the failures in the care of LTC residents and ensure the corrective action was taken, including severe monetary and or closure of homes? You described the fragmentation and the number of players involved in the inspection process. This question is about compliance action.
A: Dr Kitts
There was an insufficient number of inspectors to complete the volume of work they required. There was a shift a few years ago from proactive inspections of the entire home for quality and safety of resident care and compliance with regulations. There have been licenses revoked in the past but this step is rare. In most instances orders have been written but not escalated as quickly as one might expect. We felt that the tools are there to hold the home's leaders accountable, but the resources, particularly staffing were not sufficient to execute the inspections as well as they should. We recommended that the inspectors be given the resources to complete inspections well and hold leaders accountable. We also felt that by working with the Ministry of Labor and Training and Schools Development, the Public Health Units and the inspectors in Long term care there might be synergies and overlap that when addressed would enhance efficiencies and the quality of inspections.

3. **Q:** Should the regulation of PSW's be a priority in improving the LTC system?
A: Dr Kitts
We spent a lot of time on this. The short answer is yes. We all believe that PSW's should be regulated. We felt that when workers are in a position where the public trust is essential, the staff should be regulated. But we did not see this as a short-term fix in solving the PSW shortage and challenges. We felt that a register with a clear description of training, skills development and education PSW's would need, could be started immediately and would help address the shortages and other challenges the PSW's face today. It is a long answer to say yes, ultimately regulation needs to be implemented, but its not a short-term solution.

4. **Q:** In your comments, about the top 6 points, you mentioned culture. You elaborated a bit more in terms of the need for compassionate culture. It has been talked about so much, not just recently but for years and years. We know what is needed, its that transformation from something more institutional or traditional models of care to something that is more focussed on person-centred care. But how to get there? In your view, what is it going to take to do that transformation?
A: Dr Kitts
I have experience with culture change through my work at The Ottawa Hospital(TOH). It isn't easy and it takes longer than most people think but I believe we did it at the TOH. It took several years and it required the following. Effective leadership at the Board and Senior Leadership including Doctors and Nurses. It also required effective change management processes and procedures as well as frontline staff who engaged in the process and believed that the culture change would be better for patients and staff. We began with a patient-centred vision statement – "to provide each patient with the world-class care, exceptional service and compassion that we would want for a loved one". In essence we committed

to patient-centred care and we would be held accountable for ensuring our patients were treated as a loved one. The recipe is simple but it works. For the LTC homes, leadership is critical. Leaders must create a compelling vision, engage their staff and be held accountable for success. We heard from some homes that to change the culture you have to focus on resident or people-centred care. It is based on principles and actions needed to transform a culture. From my perspective those who succeeded, followed a similar process that I experienced at TOH. Leaders at all levels – owners/licensees, the senior management teams of the large chains, and on-site leaders of the individual homes have to engage, they have to focus on each and every resident in their home and measure whether they feel safe, are treated with dignity and are receiving the care that is promised in the fundamental principle. Each resident and every resident matters.

To measure whether the leadership and frontline staff are making progress in the culture change, standards or metrics must be developed, monitored and reported. The leaders must have the resources to meet the standards or goals. Perhaps, a good starting position is to pick a few (resident experience, staff engagement, quality of care and efficiency…

5. **Q:** In your view would Canada's Long-Term Care system be significantly improved through development of National Standards of care, increased federal funding and enforcement of those Standards by an agency independent of Government?

   A: Dr Kitts
   Yes. Standards are essential to measure progress in improving culture, quality of care etc. Funding is required but the funding must be associated with achieving agreed upon standards to ensure the money is achieving what it is meant to achieve. In most cased the funder monitors and evaluates whether the value for money (achieving pre-determined goals/standards) is acceptable and funding continues. What I believe is missing is transparency in performance. In other word, the evaluation of each home could be shared with the general public so that citizens can also evaluate whether the improvement in quality is reflective of the funding provided. I prefer the carrot to the stick and suggest that financial rewards could be given to homes achieving standards. Without standards to monitor and evaluate performance, there is no means to hold anyone accountabile.

6. **Q:** Where do residents and family councils fit into the framework of leadership and accountability and the development of quality policy.

   A: Dr Kitts
   That is a great question. The pendulum has swung in hospitals from when patients were not engaged in planning or policy development. Today, patients are involved in almost every aspect of a hospitals, strategy, policy development and care. At TOH we have patients sitting at frontline staff tables for virtually every service we profide. Patients are invaluable in helping us "get it right" when it comes to there care. They should be involved in every aspect of care where decisions are being made that impact them directly.

   I support having a residents / family members on various committees like IPAC (Infection Prevention and Control), palliative and end-of-life care, etc. I think their input is invaluable. They bring life to policies. They should be there. This reminds me of a saying I heard long ago – "nothing about me without me."

7. **Q:** Has the commission received a formal response from the Government to the report?

   A: Dr Kitts
   We did receive an acknowledgement to the report. We also received acknowledgement of our 2 interim reports. Some actions have been taken, and in my usual optimistic view, I do believe that Minister Fullerton is aware of the gravity of the problem and is committed to ensuring that her government does everything possible to correct problems that have existed for decades, and prevent such a tragedy from ever happening again. I believe some of the most pressing challenges include pandemcic preparedness, leadership and accountability, staffing, funding, and culture.

8. **Q:** The question is a double question and has to do with the Governments reactions, both to the interim recommendations and whether Ontario went far enough to implement those recommendations on staffing improved hours etc. In the same vein, the issue of LTC staffing, the Ontario Government made announcements for funding, you mentioned the one on nursing that just came out recently, but has this been done too late? Has Ontario's response come too late to have an ability for the LTC homes to attract and retain those employees and the other part is the improved hours and salary with respect to the earlier recommendations made by the commission?

   A: Dr Kitts
   I think the too late was in the 1st wave - loss of staff from fear, illness, uprotected, one site only etc. I think that between our interim recommendations and these recommendations, now is the time to act. To me the big question is does the clock start now on reforming the LTC sector and truly bringing it in to the health sector with hospitals and the expertise there. I have spoken to a lot of people involved from other hospitals and other health care providers and I think there is a momentum to get going. I do not know what LTC overall thinks about Ontario Health Teams, but that is another way where LTC is on the healthcare team, at the same table, influencing strategic decisions, and policy. The key players - Continuing Complex Care, Rehab Care, LTC, Home Care, Hospital Care, Public Health, Primary Care, all saying what is the best way forward is to collaborate and focus on patient or people-centred care.

   We have all heard many times that it's all about having the right patient, in the right place at the right time for the right care. I believe the only way you can achieve this is to have the right care providers in in the right room creating strategies, plans, policies etc. to ensure we focus on truly putting residents and patients at the forefront of what we do.

9. **Q:** The last question is about the need for clarity when it comes to guidance material coming from the Ministry. That guidance goes to LTC homes and then the LTC home has the challenge of interpreting it and in some cases that can have an impact on the ability for family to visit or be involved directly because the of the interpretation. Do you have any thoughts on that?

   A: Dr Kitts
   First of all, you are absolutely right. Having been the CEO of the Ottawa Hospital for the 1st wave, I do understand the need for clarity, but in fairness I also understand that when there is very little evidence, particularly scientific evidence available, those in charge of sending the messages may end up sending recommendations that may contradict previous ones as more evidence becomes available. I believe that the shortage of PPE early in wave 1, led to fear and confusion and may have contributed to "mixed

messages” about its use. In our report we make a recommendation that the precautionary principle has to be invoked under these circumstances.

I believe that if LTC homes, hospitals and others had the appropriate stores of PPE, it would have lessened the fear and anxiety created by the them feeling that they were not being protected to the extent they felt was necessary .

I also feel that some of the communications around care-givers and essential visitors had to be made prior to sound scientific evidence being available. Again, messages were updated as new evidence evolved.

In my experience with 3 pandemics and other tragic events, communication usually tops the list of issues to resolve and improve for next time. This pandemic will provide more lessons learned in preparation for the next one.

I want to end by telling you something I did not expect from the meetings that your group told the Commission we must do – meet personally with residents and their families in LTC homes.
I did not expect to hear that when a resident loses contact with their family, they quickly become depressed from isolation and loneliness – they lose the will to live. The impact on the family cannot be described in works. A decision made for all the right reasons at the time should not be repeated.

Closing Remarks:
Eleanor Ryan provided words of appreciation and gratitude for Dr Kitts presentation and the work of the LTC Commission.

Doreen Rocque provided closing remarks thanks all for attending the AGM and presentation by Dr. Kitts.

September 16, 2021