Submission on behalf of CUPE Ontario
and the Ontario Council of Hospital Unions to

# Ontario's Long-Term Care COVID-19 Commission

February 16, 2021


## The Canadian Union of Public Employees

This brief is being submitted on behalf of the Canadian Union of Public Employees (CUPE) Ontario and the Ontario Council of Hospital Unions (OCHU). CUPE Ontario is the largest Union in the province with more than 280,000 members in virtually every community and every riding in Ontario. CUPE members provide front line services that help make Ontario a great place to live. CUPE members are employed in five basic sectors of our economy, delivering public services in: health care, including hospitals, long-term care and home care; municipalities, including ambulance services and libraries; school boards in both the separate and public systems in both French and English; social services; and post-secondary education. The Ontario Council of Hospital Unions is part of CUPE, representing 35,000 hospital workers including members in hospital-based long-term care homes.

Over 35,000 of CUPE's 280,000 members are long-term care workers who are employed in 65 public/municipal, 54 private non-profit, and 62 private for-profit homes across Ontario, from Kenora to Hawkesbury, Hearst to Windsor, and many more communities in-between. Our members are employed in diverse classifications including activity aides, cooks, dietary aides, health care aides/personal support workers, nurse aides, nurse practitioners, Resident Assessment Instrument (RAI) Coordinators, registered practical nurses, registered nurses, and housekeeping, laundry, and maintenance staff.

Many CUPE long-term care workers have been infected with COVID-19, and at least three of our members have died as a result. Members have worked on the front lines of the pandemic while simultaneously juggling child and elder care responsibilities due to day care, school, and elder care closures. They're suffering significant emotional, physical, and mental stress from working short, coping with high numbers of COVID-related resident deaths, and the fear of transmitting the virus to residents and co-workers, as well as their families and loved ones. These stressors will have long-lasting impacts on the health and well-being of our members for years to come.

Long-term care workers provide care that is integral to Ontario's health care system and essential to the seniors and people with disabilities who live in the homes where they are employed. Their work and sacrifices deserve our utmost respect, not just throughout the pandemic, but always.

## Introduction

The story of Ontario's long-term care system during the COVID-19 pandemic is one of failure. The provincial government's failure to connect how years of bad policy choices, care neglect and underfunding would sadly create the perfect conditions where more than 3,600 residents would die (to date) from the virus, will be an unfortunate legacy of Ontario's pandemic response.

It is also a story of a care system where residents and staff are left out to dry.

The government response to protecting residents and staff in long-term care homes during the pandemic was an afterthought.

Long-term care is highly regulated. The *Long-Term Care Homes Act*, its regulations and provincially issued Policy Manual outline in minute detail exactly how each facility is to operate. Unfortunately, the resources needed to achieve the lofty goals and requirements of the *Act* and *Regulations* are not provided – and have not historically been provided – by successive Ontario governments.

Enforcement of the *Act* and *Regulations* though regular inspections and a robust complaints and compliance mechanism are scattered at best, non-existent at worst.

The most measurable indicators of good quality care – such as staffing levels – are not regulated.

The gatekeepers – that is, the residents and staff who could sound the alarm – may be mute, face complex health needs, or part of a worker community that is silenced because of their race, their ethnicity, their age, and/or their gender. Sounding an alarm when one is in such a vulnerable situation, (reliant on the care or reliant on having a job) is extremely difficult. Outside advocates have not been heard because our society places so little value on the residents living in and the staff working in these homes. Focus always shifts to other priorities.

These issues are compounded for staff by the fear generated by a culture that relies heavily on disciplinary measures. Far too often staff fear being disciplined for not completing tasks due to short staffing, and where mistakes occur discipline is often imposed at the front-line level without considering the mitigating factors involved. In multiple instances members have gotten in trouble for simply explaining to a resident's family member that they were unable to complete a particular task because they were short-staffed.

This unique set of characteristics has resulted in a highly authoritarian, stratified structure for delivering long-term care to our elderly. There is a culture of fear. Blame for errors cascades downward to those staff at the lowest rungs of the organization. The lack of resources means that the pay and benefits are extremely low. Those who have options, leave.

The structural stresses and strains in this system that made the operation of long-term care facilities barely sustainable prior to the pandemic have broken apart over the last year. Even so, it was only when the military sounded the alarm after observing first-hand the wreckage in our care homes that the rest of Ontario sat up and took notice.

This submission on behalf of CUPE Ontario will focus primarily on the stories of our members who have been working in long-term care during the pandemic. We will provide policy context for some of their experiences, but we believe that it is important that the Commission hear directly from our members in their own words. Although they are the experts when it comes to long-term care, too often their views have been ignored. Throughout this submission you will find direct quotes from some of these members who collectively have over 200 years of experience working in the sector. All these stories are drawn from interviews conducted during the pandemic. CUPE has provided aliases for each of these members in order to protect them from retribution.

1. *Nancy:* Activationist (former PSW) for-profit nursing home
2. *Florence:* Activationist (former PSW) municipal nursing home
3. *Robin*: RPN, for-profit nursing home
4. *Kris:* RPN, for-profit nursing home
5. *Olga:* RPN, municipal home
6. *Cheryl*: PSW, for-profit nursing home
7. *Pam*: PSW, Municipal home
8. *Sarah*: Housekeeper, for-profit nursing home

## Background

Long-term care has evolved over the past two decades as successive governments dealt with the demographic challenges of an aging population, combined with the diminishment of extended family supports. More and more Ontarians are living well into their eighties and nineties. There is, consequently, a growing demand for geriatric health supports.

The expansion of the long-term care sector came at the expense of chronic care and continuing care hospital beds. Virtually all of the residents currently in Ontario long-term care homes today would have been housed in chronic or continuing care hospitals two decades ago.
Still, acuity levels in facilities continue to rise. The average age of a resident in Ontario LTC is 83. In 2019, sixty-four percent of residents in LTC homes had dementia which is fourteen percent higher than it was in 2009. The remaining residents have physical disabilities which necessitate their living in LTC. Over the past ten years from 2009 to 2019, the number of residents over age 85 is up 10% and dependence indicators for both cognitive impairment and functional immobility are also up significantly.[1]

Despite the fact that LTC homes are providing care that used to be standard in a hospital, long-term care homes are funded at about one third the rate of continuing care beds in hospitals.[2] Hospitals are more skilled at infection control and providing for complex needs. However, hospitals have been starved of bed capacity (per capita hospital beds in Ontario are the lowest in Canada) and there has been a concerted effort on the part of successive Ontario governments to transfer elderly Ontarians to long-term care homes rather than place them in continuing care hospitals.

[1] *2019 Auditor General of Ontario Annual Report,* Chapter 3, "Food and Nutrition in Long-term Care Homes" p. 296.
[2] Ontario Health Coalition*, Planning, Access, Levels of Care and Violence in Ontario's Long-Term Care*, January 2019, p. 5

## Staffing

The lack of staffing in long-term care homes has been a long-standing worry from CUPE members working in this sector. Over the past decade those concerns have grown to a crescendo. The staffing issues can be broken down into three categories:

a) The low wages and benefits.
b) The inability of facilities to retain staff.
c) The Workload/Acuity of the residents the staff are expected to care for.

## Pay and Benefits

There is a wide range of wage rates for CUPE members working in these homes. Long-term care workers in facilities run by large municipalities often make significantly more than the median. These employees have benefitted from pay equity laws and the fact that municipalities have a wide range of male dominated trades positions to compare with. Employees in not-for-profit charitable homes tend to be paid significantly less than municipal employees but still do a little better than employees in for-profit nursing homes. CUPE members in the for-profit nursing homes tend to have the worst wages and benefit packages. Unionized CUPE homes pay as little as $16.35 per hour for housekeeping aides, $18.39 per hour for PSWs or $23.87 for a Registered Practical Nurse.

Notwithstanding the wide range of wage rates, the majority of members working as PSWs or Aides make at or around $20 per hour. A significant and depressing number make less. Compared to Hospital rates, housekeepers, PSWs and RPNs in most long-term care homes make at least two to four dollars an hour less than their counterparts in Ontario Hospitals represented by CUPE.

The use of part-time staff is extremely high in long-term care. Although we do not have firm numbers, on average, full-time members comprise approximately 40% of the bargaining unit. Part-time and casual part-time staff would make up approximately 60% of the membership Because the rates of pay are so low, and because of the high prevalence of part-time and casual part-time staff, many employees in long-term care carry multiple jobs. Even full-time employees often will have a part-time job (or even another full-time job) to make ends-meet.

> *Honestly, we need a fair wage, a living wage. Honestly, most people are single mothers. I am, my two youngest are now 18 and 19. My youngest has a disability who I'm still supporting. He doesn't have an income. It's very difficult.*
>
> *I can't even move out of where I am, because it's too expensive. I'd like to but I can't. So, like I said, my daughter works in a grocery store. She's earning crappier money. We barely make it...but we have people [in the home] that have three jobs.*
>
> - ***Cheryl, PSW, for-profit home***

Benefits are also significantly lower in long-term care homes, especially when it comes to sick leave. Almost all full-time hospital employees are covered by the Hospitals of Ontario Disability Insurance Plan (HOODIP) which provides fifteen weeks of short-term disability at 100% of pay for full-time employees with four or more years of service and fifteen weeks of paid leave at a lower income replacement rate (between 66 2/3% to 90%) for those with less than four years of service. HOODIP also provides long-term disability insurance which is virtually non-existent in long-term care homes outside of a handful of municipal homes. In contrast full-time CUPE members in nursing homes usually receive between 10 to 18 paid sick days per year. Other Unions in this sector have negotiated Weekly Indemnity Plans which provide 66 2/3% income replacement for 17 weeks after a four-day unpaid waiting period.

Almost no CUPE part-time employees working in long-term care receive any paid sick leave or benefits. Part-time employees mostly receive a premium in lieu of benefits which provides an extra stipend on top of their wage rate to cover the loss of benefits. This has historically evolved based on employer's reluctance to fund benefit premium costs at the same level as for full-time workers.

Long-term care homes have a basic two-week three-shift schedule. Day shift is from around 7:00am to 3:00pm. Evening shift is from around 3:00pm to 11:00pm. Night shift is from 11:00pm to 7:00am. Full-time staff will work ten shifts of 7.5 hours every two weeks. Part-time staff who replace full-time staff will work 4 shifts of 7.5 hours every two weeks. The facility will hire additional part-time staff for short shifts (three or four hours) to deal with busier times of the day. Part-time and casual staff will also be allowed to pick up additional shifts to replace scheduled staff who are off sick, on vacation or some other leave of absence.

The use of twelve-hour shifts which is common among hospital nursing staff is not widespread in long-term care homes. The work is considered too physically challenging to make twelve-hour shifts a viable option. Notwithstanding that, as a result of severe staffing shortages during the pandemic many employers have imposed 12, and in some cases 16, hour shifts without regard to the Collective Agreement, relying on the powers granted to them by the province's emergency orders.

Employers also frequently rely on "doubles" where staff stay and continue working the next shift because someone else has called in sick or the shift can't otherwise be filled. This inevitably leads to a compounding problem where those staff burn out and get sick themselves, but people continue to stay and work double-shifts to ensure that residents can receive basic care. This practice was already common before COVID-19 and has become increasingly common as the pandemic drags on.

## Recruitment and Retention

The funding of long-term care homes means that staffing levels are kept at an absolute minimum. The physical nature of the work, combined with the low wages and demand for PSWs and RPNs in other health facilities, has resulted in there being significant shortages of staff.

Even prior to the pandemic, the ability of long-term care homes to recruit and retain staff was strained. Unionized long-term care workers are not allowed to strike and must proceed to arbitration to resolve renewal Collective Agreements. Since recruitment and retention is an issue that arbitrators must consider, CUPE has put forward numerous examples of recruitment and retention difficulties in these facilities. For example, at one for-profit nursing home, the Union found that the facility hired 48 new staff in the 18-month period between September 2016 and February 2018. Forty-eight staff was equivalent to one third of the entire staff complement. Of the forty-eight staff hired, only sixteen remained. The rest no longer worked for that facility. In another example, CUPE looked at turnover at a small chain and found that between 35% to 80% of the staff at each of these facilities over 2017 and 2018 had left.

Use of overtime is another indicator of staffing shortages. Overtime which is normally paid at 1.5x the normal hourly rate is only used when the facility is unable to get any part-time or casual staff to fill the shift. Again, even before the pandemic, overtime use was rampant in many long-term care homes to cover staffing shortages. Below is the Union's analysis at one for-profit facility in Eastern Ontario: [3]

| **OVERTIME HOURS IN 2017** | |
|---|---|
| **Department** | **Overtime hours** |
| PSW | 2827.50 |
| PROG | 138.50 |
| NUTR | 381.00 |
| HSK | 90.00 |
| LNDRY | 30.25 |
| **TOTAL:** | **3,467.25** |
| **OVERTIME HOURS IN 2018** | |
| PSW | 2,218.91 |
| PROG | 52.50 |
| NUTR | 287.50 |
| HSK | 15.00 |
| LNDRY | 31.00 |
| **TOTAL:** | **2,604.91** |

It is important to note that it is not automatic that a facility will offer overtime to replace someone who is on leave. Overtime is usually only offered when the facility is so short of staff that it cannot function safely with the numbers of staff reporting to work. Also, overtime is often only offered after temporary agencies are contacted and cannot fill the need.

[3] The Union does not represent Registered Practical Nurses at this facility so did not present the overtime hours for that job class.

To this day, even with the worst scourges of the pandemic, for-profit nursing home operators deny that they have recruitment and retention issues when faced with this data at arbitration hearings. Prior to the pandemic, arbitrators were unwilling to look at recruitment and retention issues. Even now arbitrators will not award wage rates in long-term care homes that are comparable to those in nearby hospitals.[4]

## Workloads, Acuity of the Residents and Workplace Culture

There are no margins when it comes to staffing in long-term care homes. The residents are frail. A large portion of residents have dementia and need care and time to manage their behaviours. Others need assistance in simple activities such as getting up, dressed and toileting. It is standard for PSWs to be assigned the care of ten to twelve residents per shift. They may have 90 minutes to wake, dress and bring every resident under their care to the dining room for breakfast. While doing this, they may have to help their fellow colleagues or seek help from them for two person transfers – whereby for safety reasons the resident needs two staff to transfer them from the bed to a wheelchair (or vice versa). If their colleague is busy, they may have to wait a while before someone will come to assist. This adds to their anxiety that they will not get their assigned tasks done. If they try to transfer the resident on their own, they will face discipline if they are caught because they have put the resident and themselves at risk. PSWs are supposed to regularly read their residents' charts and note updates in their care plan. They are also supposed to monitor and report behaviours and incidents to the Registered staff and note items on the flow charts. If they forget to report something, it can lead to discipline. *Everything* is timed. A staff member who rushes may face discipline from managers for not showing proper care to a resident. A staff member who takes too long may face discipline for not completing his or her tasks by the end of the shift.

If every shift is staffed and everything goes perfectly there may be just enough workers to give all the residents the minimum care that they need that day. However, things never go perfectly. There is always a resident who is in a bad mood and won't cooperate with the morning or evening ritual. There is always another who has a toileting accident, or still another who is feeling poorly. The staffing levels allow no margins for error, no margins even for the everyday normal things that will happen when you are dealing with groups of people living in a congregate setting. When the staff work short, even more things get missed and residents and staff risk getting hurt.

> *You don't have time to spend with them. You really don't have time to go every step of the way. You do the best you can, but you are still rushing them. Which if you're going to rush them it's going to be very hurtful to someone not meaning to, but you know, and it's the rushing that's the problem. They don't deserve to be rushed. And you make better money to put a car part together than you do looking after a person.*
>
> - ***Cheryl, PSW, for-profit home***

[4] Prior to the onset of the pandemic, the Ontario government passed Bill 124: "Protecting a Sustainable Public Sector for Future Generations Act, 2019" This legislation prohibits, unions, employers and arbitrators from raising compensation more than 1 percent in each of three years. This legislation applies to employees in charitable homes only but has made it difficult for unions to negotiate improvements to wages and working conditions across the sector during the pandemic.

The facilities are highly regulated. Every resident is supposed to have a care plan that is updated regularly. Acuity levels are monitored and measured through the flow sheets filled out by the PSWs and the Resident Assessment Instrument which is coordinated by a Registered staff member at the home. Incidents must be reported, and serious incidents must be reported to the Ministry of Long-Term Care. The Ministry may come in to investigate complaints and reported incidents. Ministry orders and inspection reports for each long-term care home are available publicly on the government of Ontario website. Serious incidents involving Registered Nursing staff must also be reported to the College of Nurses. If a nurse is disciplined, that is also publicly available on the College website.

> *"Everybody is scared. Scared to do something wrong. Fear that they are going to be reprimanded. Fear that they are going to forget to do something important like putting a safety device underneath a resident who is at risk for falls."*
>
> - ***Florence, PSW turned Activationist, Municipal home***

The high level of regulation combined with the sheer impossibility of meeting demand has, in many instances, created highly punitive work environments. PSWs and aides who are at the bottom rung of the ladder have it worst. Given the lack of proper staffing, there is always something that didn't get done that should have gotten done. The risk of discipline is high. LTC staff are given impossible jobs and are expected to do them perfectly or face discipline and censure. Added to this toxic culture is the racialized nature of many long-term care workplaces, where staff may be new Canadians, where English or French may be their second language and there is little appetite to speak out about the abuses.

The only thing that is not regulated in long-term care homes is the staffing levels.
The irony is that enforcement of the regulations is lax at the Ministerial level. The Ontario government cancelled annual inspections of long-term care homes in 2018.[5] Inspections and orders are complaints driven and Ministry of long-term care inspectors who enter the facility do not necessarily engage with staff even when staff are brave enough to take the risk of engaging with them.

## Health and Safety

The lack of adequate staffing, combined with residents with dementia, and a workplace culture where bottom rung staff are not valued or heard created serious health and safety issues for even prior to the pandemic.

A good example of how inadequate health and safety was prior to the pandemic is to look at the issue of violence in long-term care. It has been a constant concern of health care staff. There is resident-on-resident violence, there is resident-on-staff violence and there is – although rarely – staff-on-resident violence. Only staff-on-resident violence is taken seriously.

Resident care plans should provide for two staff to attend Residents who are aggressive. One person can distract, while the other performs the ADL's. This isn't possible with a shortage of staff. Blame for all forms of resident violence is laid squarely on the shoulders of the long-term care staff working with these residents as if they could have prevented it.

[5] Even when comprehensive annual inspections were commonplace, staff in for-profit homes have often alleged that the facility was notified in advance of the dates that the compliance officers would be conducting their inspections. The facility would ensure that there was an abundance of supplies for the inspection.

*"…when a resident will strike out, one of the questions will often be, "What did you do to make that resident strike at you?" That is one of the first questions that they ask, "What did you do?" Where it shouldn't be, what did you do, it should be, "What can we do to make this better? How are you in this moment to this person?" And trying to fix the problem, not try to blame the problem on somebody. I find that it's a lot of finger pointing. And management needs to be a lot more supportive of their staff…. Management needs to change the atmosphere by making it a more open environment instead of the atmosphere of fear of your manager."*

- ***Kris, RPN for-profit home***

Often, the staff have internalized this culture and blame themselves when residents lash out:

*"… It happens more than what's documented because staff are fearful of retaliation. They're also thinking, well, it's just the resident, I wasn't able to do this for the resident. So that's why they did that. And it's partially self blame, as well. It's [fear of] retribution and self blame. … And people will even make excuses for the residents. 'The resident has dementia, so they don't realize what they're doing.' Those types of excuses. 'They have this type of disease; they don't comprehend what they're doing.' And I've heard those excuses numerous times. More times than I can count."*

- ***Kris, RPN for-profit home***

## The Pandemic and Its Impact

The onset of the pandemic created a perfect storm in the long-term care sector. Workloads skyrocketed as staff were expected to do more. A proper staffing plan was never fleshed out either by the Ministry of Long-Term Care or by most long-term care homes.[6] Health and Safety protocols were slow to roll out, slow to be implemented and were not enforced until the home was in crisis and, in many cases, a hospital contingent was sent in. Most homes, but particularly the for-profit homes refused to spend money on PPE, staffing, or disinfectant. Staffing levels dropped as fear, illness and regulations all took their toll. As staffing shortages mounted and all health facilities were scrambling to operate, the homes paying the lowest wages, providing the most punitive working conditions saw the biggest exodus. For the most part the lower paid, for-profit facilities got hit hardest as employees moved to facilities with better working conditions.

If you had asked a small group of people with some background or direct experience in long-term care operations what would be the major fault lines in the long-term care sector during a pandemic and what government would have to do to keep residents and staff safe, you would have a better plan in a couple of hours than you got from the Ontario government over the months of the first wave. Staffing levels would have been front and centre. Staffing is key to screening, to being able to cohort presumptive or confirmed COVID positive residents. Providing staff with appropriate PPE that gave not only protection, but reassurance would also have been emphasized. As would providing livable pay and sick leave benefits reduce their anxieties about making ends meet while working at only one job at one facility.

[6] There were a few exceptions where the leadership in the long-term care facility was able to implement proper infection control systems in place and prevent outbreaks. Unfortunately, these facilities were in the minority.

The Ontario Government's response to potential staffing needs was all about imposing punitive measures against workers in this sector. Government orders and legislation gave widespread powers to employers to over-ride collective agreements, cancel vacations, change work schedules, hire workers who did not have the appropriate qualifications and prohibit any union grievances that may have been filed as a result of these actions.

Additionally, the government showed a shocking lack of concern about the health and safety of staff working in long-term care. Initially, the Ontario government and the Ontario Chief Medical Officer of Health ignored the findings of the Campbell Commission which investigated the failures of the SARS pandemic in 2003 and strongly recommended applying the precautionary principle with respect to the use of N95 masks. The Campbell Commission determined that where it is unclear that transmission is droplet or aerosol, the precautionary principle should be applied to treat transmission as aerosol. That the Ontario government decided to ignore this recommendation, had much to do with the shortages of PPE available,[7] but it did not help that the Minister of Health also decided to give the limited cache of N95 masks to police and ambulance workers before giving them to long-term care or hospital staff. Further, there was chaos and confusion as to whether CUPE members in long-term care had the right to demand and readily receive PPE while caring for residents.

Essentially, the government's response to the pandemic was to remove the few measures that long-term care workers had available to them which gave them some level of control over their lives and their work. This marginalized, silenced group of workers taking care of a marginalized group in society were thrust into a tornado where they had no control and no agency. The tragic impact of the Ontario government's approach is writ large in the military reports a few months later.

## The Single Site Rule:

It was not until April 14th that the Ontario government issued orders that restricted long-term care staff from working at more than one facility. This was more than a month after the World Health Organization declared that COVID-19 constituted a global pandemic and four weeks after the Ontario government declared a provincial state of emergency. The single-site rule was, and is, absolutely necessary to prevent the transmission of COVID-19 between homes. However, the rule had serious consequences and resulted in severe staffing shortages at many homes. Those consequences have not since been remedied.

Under the order, part-time staff, and even full-time staff who held more than one job, were forced to choose a facility and work only at one facility. Many chose based on pay and working conditions. Homes that paid less or had poor benefits lost more staff than those homes with better pay and benefits. Also, homes that had a higher proportion of part-time staff lost the most because full-time staff tended to stay with the facility that gave them full-time work.

> *"The part-timers definitely went to jobs with more money. We're situated near a hospital and then near a municipal home. So, we lose out because our maximum rate is lower than their starting rate."*
>
> - ***Cheryl, PSW for-profit home***

[7] The Ontario government also failed to keep an adequate stockpile of PPE in anticipation of a future pandemic which was also a key recommendation of the Campbell Commission.

*"Well, when the pandemic hit the staffing went down to crapshoot because people had to choose one job or another, [due to] the directives given by the government. And with where I work, for-profit, they like to do more with less. And obviously, the people were like, well, I'll go here because they're offering me full-time hours. Yeah, it's a little bit less [money], but the work is also less and less stressful there. So, I'm going to go there. We were left with very little staff in the home, and when it comes to part-time, there's not that many at all. So, I was working, since the pandemic, close to [about] 60 to 75% of the time I'm working by myself trying to do the job of two people. Before the pandemic, that was about 25% of the time."*

- ***Kris, RPN, for-profit home***

The fact that staff would gravitate to those facilities that provided them with the best pay and working conditions shouldn't have been a surprise for the Ontario government. In British Columbia, where the provincial government (almost three weeks earlier) also implemented a single site rule, long-term care staff were guaranteed more than full-time hours. Rates of pay were standardized upward, and benefits were guaranteed. Although staff were given an option to indicate which home they preferred to work at, employees were deployed to workplaces based on the need of the facility thus ensuring that all homes had some level of staffing.

Some Ontario LTC homes did offer full-time hours and benefits to part-time staff who chose to stay but not all homes made that offer and not all homes who offered full-time hours guaranteed it to all the staff that chose to stay. Ironically, in the midst of a staffing crisis, where some homes are desperate for staff, many part-time CUPE members have seen significant reductions in their income because they are not able to work at multiple homes and are not being called in to work full-time hours.

The Government's lack of foresight or interest in the impact of their decisions on long-term care employees is also highlighted by their decision to exempt staff working at temporary agencies and contractors from the single site rule. Employees working for these primarily for-profit agencies are allowed to move from home to home. Not only does this create a health hazard and negate the reason for the one-site rule, it also is patently unfair to health care workers who are restricted to working only at one facility.

*"And now we have agencies paying PSWs thirty-five dollars an hour to work in LTC. It doesn't do much for the morale of the regular staff who are making $15 less than them. They don't think they are being respected – more, the opposite - devalued and divided. Even how the government is dealing with pandemic pay is dividing the LTC workforce. It's just wrong.*

*If you are living on $20 and hour as regular LTC staff – and someone says here is $35 for a short time to work for an agency….but you may not get a fresh a mask, you may take that risk."*

- ***Robin, RPN, for-profit home.***

## COVID-19 Exhaustion

The Pandemic resulted in lower staffing levels and a dramatic increase in workload. There were (and are) additional protocols associated with donning and doffing PPE, additional procedures for presumptive or confirmed residents and there is additional cleaning and disinfection that should be done.

> *As part of COVID-19 prevention, RPNs have to do rounds to take resident's temperature twice in a shift. That's in addition to their other duties. 43 residents and 2 RPNs – this is not tenable. The problem is that when an RPN is off (on top these already short-staffed shifts) – then you have one 1 RPNs to 43 residents to give meds to and the fever rounds.*
>
> - ***Florence, PSW turned Activationist, municipal home***
>
> *I would have had maybe four residents out of 12 with it before I left. So, I didn't get the really bad part of it. I mean, yes you have to put them in their rooms, you have to feed them in their rooms, management just stepped in to help us feed them, most of them, not all of them. And then [physio, activation] and everyone got a room pretty much to look after, because you can't leave them alone to eat either. Even if they can feed themselves, you're not allowed to leave them with food in the room. You have to be there. It was a little bit trying because some managers don't realize that you don't just drop it off and walk away. So, then they go in and find out you're just sitting there staring at the food. I'm like, "Oh no no no. It doesn't work that way."*
>
> - ***Cheryl, PSW, for-profit home***
>
> *22 bathrooms, tub rooms, 60 residents, dining lounge, kitchenette and nursing station everyday. That's what I was doing March, April, May – then the hospital came – and we were taught different infection housekeeping techniques that took even more time – 32-35 rooms, gowning and ungowning for all these rooms each day. Impossible to keep it up and I got injured.*
>
> *It is impossible to keep up this level of cleaning and infection control with the staff we have.*
>
> *We need one extra staff in the laundry each time we have an outbreak. Housekeeping should have two people per floor – not one and a half. We are on our fifth outbreak no wonder people are burning out. When we are in outbreak the staff should be working just on one floor – not travelling to another floor to clean.*
>
> - ***Sarah, Housekeeping Aide, for-profit home***

Neither the Ontario government, nor many of the homes themselves had an effective strategy to recruit additional workers to the sector. The Ontario government changed the regulations to allow operators to utilize untrained staff in care roles, but this did not result in widespread hiring. The nature of the work, and the frailty of the residents involved does not easily lend itself to using staff who are not trained. PSW work is highly skilled. The shortages in PSWs prior to the pandemic were multiplied after March 2020.

Coming on to eleven months into the pandemic, and in the midst of a second wave, the staff burnout is real.

> *"This month (January 2021) I'm going to be working 17 days straight. Some of these may also spill over into double shifts. I'm thinking of this period as 'repeat and rinse'. I'm exhausted and so are my coworkers."*
>
> - ***Florence, PSW turned Activationist, for-profit home***

> *"Staffing is way down, and we are pulled in a million different directions. The whole workplace dynamic has changed. Everyone is on edge. We don't mingle. We barely talk. There is no camaraderie. It's very sad.*
>
> *COVID-19 exhaustion, that's what we are calling it.*
>
> *Everyday I think quietly to myself – "we've done well – none of our residents have died a COVID-19-related death." Then I think, "don't, don't jinx it".*
>
> *Because it does feel like it's a battle we are going to lose since we are so constantly short staffed. Below the usual levels before the pandemic hit. Now staff are getting sick. Others are lone parents who are homeschooling their children because the schools are closed in the provincial lockdown. We are dropping like flies."*
>
> - ***Nancy, PSW turned Activationist, for-profit home***

The Quebec government facing similar staffing issues implemented a plan to recruit and train 10,000 people to become PSWs starting in the summer of 2020. Those chosen had their tuition and expenses paid for by the government. Additionally, they were paid an hourly wage while in school and guaranteed work in a facility with a minimum base income on graduation.[8] Sixty-five thousand Quebec residents applied for the program and it no doubt has helped with the staffing shortages in that province.

There is no required training for housekeeping staff and long-term-care operators could have hired additional housekeeping aides to disinfect and clean, but many did not. In the for-profit homes this would have directly cut into their profit margins as savings from the accommodation envelope do not flow back to the government but can be taken as profit for the shareholders.

> *I still think that we aren't doing adequate infection cleaning. They have not expanded the housekeeping hours. Years ago, we used to have more housekeeping staff. But laundry and housekeeping hours have been cut back drastically. We need more housekeepers. Toilets aren't cleaned on a regular basis. There is only a bit of extra cleaning in the high touch areas.*
>
> - ***Nancy, PSW turned Activationist, for-profit home***

[8] There have been some issues with the pay guarantee which was slow to be paid out to the recruited staff. See "Quebec long-term care orderlies still waiting to be paid salary they were promised" *Global News*, November 6, 2020

Indeed, three of the largest chains operating in Ontario: Sienna, Extendicare and Chartwell, are reported to have paid out over 1.5 billion dollars in dividends during the height of the first wave of the pandemic.[9]

## Health and Safety, Infection Control and PPE

Throughout the COVID-19 pandemic, long-term care homes, and the healthcare sector more broadly, have suffered from a chronic shortage of personal protective equipment (PPE). In the long-term care sector, employers have consistently refused to provide CUPE members who work in homes with confirmed, presumed, or suspected cases of COVID-19, including front line workers who provide direct care to residents who test positive for COVID-19, with adequate and appropriate PPE, including N95 masks. Seven months into the pandemic, the International Council of Nurses reported that access to PPE remains a major concern for front line workers as Canadian long-term care homes still face "severe shortages of PPE."[10] Employer practices endangered the health and safety not only of a home's residents and workers, but every Ontario resident. If long-term care workers are not provided with the PPE they need to protect themselves against infection, they can unwittingly spread the virus among residents and other members of their community.

The Ontario government and the CMOH were very slow to roll out infection prevention and control protocols for long-term care homes. The WHO declared a world-wide pandemic on March 11th. Ontario declared a state of emergency on March 17th. It was not until March 22nd that the first iteration of Directive 3 dealing with protocols in long-term care was issued. The first version of Directive 3 was a mere three pages long with only two short paragraphs of precautions. Residents were prohibited from visiting family and friends outside the facility and operators were asked to discuss with their staff limiting their work locations. Directive 3 was updated again on March 30th to cover screening, protocols for when a resident of staff tested positive, and testing procedures. It was not until April 8th that Directive 3 was again amended to require universal masking of all staff. Today, Directive 3 is now 11 pages long and includes detailed requirements for dealing with outbreaks, admitting new residents and managing visitors.

In short, the Ontario government and the CMOH for Ontario took almost full month to implement even the most minimal IPAC procedures necessary to control the pandemic in long-term care homes. By that date, there had already been 69 outbreaks in long-term care, with 88 deaths and over 850 infected residents and staff.[11]

[9] "For-profit nursing homes have had far worse COVID-19 outcomes than public facilities — and three of the largest paid out $1.5 billion to shareholders" ***Toronto Star**, May 16, 2020.*

[10] International Council of Nurses, "Protecting Nurses from COVID-19 a Top Priority: A Survey of ICN's National Nursing Associations," September 14, 2020, https://www.icn.ch/system/files/documents/2020-09/Analysis_COVID-19%20survey%20feedback_14.09.2020.pdf.

[11] Public Health Ontario, ***Epidemiologic Summary January 15, 2020 to April 8, 2020,*** page 4

Measures directing how the use of PPE was to be applied came even later under Directive 5. Directive 5 was not first issued until March 30th and covered only the use of N95 masks by Registered Nurses. That directive was amended a day later to clarify that N95 mask were available *only* to Registered Nurses working in hospitals *and* who were members of the Ontario Nurses Association. It was not until April 10th that Directive 5 was again amended to apply to all health care staff in both hospitals and long-term care homes. It was not until October 8th, into the second wave that Directive 5 was finally amended to make clear, among other points, that anyone working within 2 metres of a confirmed or suspected COVID-19 case in a home in outbreak must be provided with an N95 on request. Even with this change many of our members still find themselves having to argue to access this basic right. Despite substantial evidence that COVID-19 is an airborne virus, the Province still refuses to accept this basic reality, and staff and residents pay the price.

Long-term care operators were also slow to react. As a result of the Campbell Commission, all long-term care homes are required by the provincial government to have pandemic plans which are to be rolled out in the event of a pandemic such as the SARS COVID19. It is unclear if many operators did indeed have such plans. CUPE requested pandemic plans from all our employers, almost none provided them to either the Union or even to the staff who would, ostensibly, be required to implement them.

> *"When I went to my DOC* (Director of Care) *and asked her, 'what protocols that you should be following to deal with COVID?' She looked at me like I actually had three heads. I said I had received an email from CUPE that says you should be telling us this stuff. So, she said, 'Well go ask them what it's about and let me know.'"*
>
> - ***Cheryl, PSW, for-profit home***

## Failure of Operators to follow protocols

Even with the directives in place, management in homes failed to properly implement the protocols, leading to outbreaks. Problems existed with respect to isolation practices, use of PPE and disinfecting.

> *It's the weirdest thing that even in a global pandemic – something that happens – what every 100 years, our employer is processing COVID in dollars and cents. Unbelievable. They say we are "spending too much on overtime, too much on PPE". Really – now is not the time to think about how much its costing to keep residents and staff alive…. these are lives, human beings. It's not always about the money.*
>
> - ***Pam, PSW, municipal home***

Initially, many managers failed to isolate presumptive residents and staff.

> *"The first guy who died before the [outbreak was declared in the first wave]. And I actually said to his RPN that he had COVID, but she said "no, he's okay." Anyway, he was sent to the hospital and he died of an aneurysm or something … pulmonary embolism which is a blood clot.*

*… the next one, the PSW had worked at [another home with an outbreak]. So, then they said okay, you got to choose a home, but they let them finish the week. And this during that week, she was sick at work. Her RPN knew that she was sick. But then the following week because she's now given up [her other job, at the home with the outbreak], they said that they give them extra hours at our place to make up for the fact that it's her other job…[but] that they had her doing [a lot of tasks] which means she's all over the building."*

- ***Cheryl, PSW, for-profit home***

Another complaint from many CUPE members was cleaning. Most feel that the cleaning protocols directed by the facilities are not sufficient to prevent transmission of the virus.

*We really need to be looking at staffing levels – and cleaning [protocols] in the dementia unit. [Years ago] we used to have cleaning that went right up to 11 o'clock at night. And we don't have that anymore. They cut that out. The dementia floor residents are in and out of everybody's rooms, they're wandering, they're touching things. We need that extra cleaning for those types of units. And maybe that will help and stop the spread of viruses.*

- ***Olga, RPN, municipal home***

*"We didn't even have the proper disinfectant cleaners to kill COVID-19 at first. That came months after when one of the area hospitals was brought in to help us deal with the outbreak. Can you imagine? We were given dust masks to wear at the beginning and didn't have the proper cleaning solutions. When I think about this, I think 'this is what it must be like walking into a war zone. What care in a war zone is like.'*

*"…(M)anagement contradicted everything the hospital infection staff were telling us were best practices.*

*By then we had dozens of residents die. We had not enough staff and cleaning chemicals that were not effective against COVID-19. It's like middle management just refused to accept that we needed both staff and chemicals to do infection control."*

- ***Sarah, Housekeeping Aide, for-profit home***

## Personal Protective Equipment

No issue was more contentious or raised as many concerns as how long-term care homes controlled and distributed personal protective equipment. Throughout the pandemic, several grievances have been filed by CUPE on the lack of appropriate PPE and other health and safety issues. The common thread across these grievances is employers refusing to provide N95 masks and other appropriate PPE to employees providing care to residents with confirmed, presumed, or suspected cases of COVID-19.

*"First wave hit us hard at the end of March.* (The Employer) *did not give us masks – any masks at all. We called the Ministry of Labour 11-12 times. Inspectors didn't come in because of COVID-19. They made recommendations but the employer did not follow through. They didn't want to give us anything. Eventually they gave us dust masks, not surgical masks, certainly not good N95.*

*I got infected with COVID-19 very early on – the beginning of April. So did other staff. One of our RPNs had a collapsed lung. 15-20 residents were infected then. That's when they finally started cohorting residents. They finally gave us dust masks… it was just horrible that we didn't get the PPE to protect us. Also, we were really short-staffed for a long-time then.*

*When residents started dying is when management took it seriously. Looking back, this is sad and disturbing."*

- ***Robin, RPN, for-profit facility***

*"At the very beginning of the pandemic access to enough personal protective equipment was very bad. In my work as an Activationist, I have to get really close with some of the residents. But when I asked for a face shield in addition to the surgical mask, to help residents make video calls to their families, I was told no."*

- ***Nancy, PSW turned Activationist, for-profit home***

Even after Directive 5 mandated that staff had the right to request and receive N95 masks staff had difficulty accessing appropriate levels of personal protective equipment.

*We can see that despite our best efforts on the front-line the virus spreads. We ask for the N95 masks each time that there is a suspected case… but in the first wave we weren't getting them. Even now we have to justify why are asking… but we don't we have a directive that says if ask for an N95 in a suspected case, we should get one. Why would we wait to know the resident has the virus? By then it's too late for the staff who are caring for the resident – they will all be infected.*

*They are still rationing disposable gowns. Doug Ford says call me if you don't have enough PPE, I say "Premier give me your number."*

- ***Nancy, PSW turned Activationist, for-profit home***

*Public health directed us that we did not need N95s to take care of COVID patients, that a visor and the surgical mask was fine. That it was enough protection.*

*We told them that there's not a chance in hell [that we would work without N95s]. I supported them as their Union person. And I said, 'Yeah, no, absolutely not.' Nobody goes in without an N95. If that's what they feel comfortable with. Would you rather have staff feeling comfortable, or would you rather they go home? You should go in and put your surgical mask on.*

- ***Olga, RPN, municipal home***

*When* (the outbreak) *first started, in one day we went through 500 gowns, so we got in trouble.*

*… And then N95s, "we don't need them." And then finally when it got really bad, they said, "Well, if you really want to, you can have them." But you had to go and get it, and keep it for as long as could, until it fell apart.*

*(on N95s) It wasn't offered, it wasn't – "make sure you wear one." It was only if you insist.*

- ***Cheryl, PSW for-profit home***

CUPE locals filed numerous grievances over the use or lack of use of PPE in long-term care. Since the enactment of Ontario Regulation 77/20, some employers in the long-term care sector have refused to meet with the union to hear or process grievances regardless of their content. This has significantly undermined the health and safety of employees and residents, as well as the legal rights of workers.

*"Staff are so careful. There was PPE but no access to the N95 masks that would given us more protection and more of a sense of security. And I said to the employer, "I'm not going to work unless I get an N95." Even after Directive 5 came out they did not give the N95 mask readily. And that's just wrong.*

*We shouldn't wait until there is a positive test from a resident. We need the N95 now when we ask for one. We can't get infected and spread it to other residents and we have families too. We could infect them."*

- ***Pam, PSW, municipal home***

In one of our locals, several grievances were filed after employees reported that the employer was providing expired N95 masks and inadequate PPE to workers providing direct care to COVID-19 positive residents. Employees were provided torn gowns that were loose fitting and did not cover their entire body. Because they were provided with improperly fitting PPE, employees resorted to taping their wrists and purchasing their own PPE to protect their health and safety.

At another local, grievances were filed after employees reported the employer refused to provide N95 masks for any reason, including to workers providing direct care to COVID-19 positive residents. The situation in the home deteriorated to such a great extent that the facility was placed under the management of the local hospital. Management from hospital also took the position that N95 masks are not required by workers unless aerosol generating medical procedures are taking place. While there has been dispute around the application of Directive #5, there is a broader question as to the intersection between the public health guidance and employer's responsibilities under the Occupational Health and Safety Act.

In yet another local, grievances were filed after employees reported the employer's failure to provide N95 masks to workers providing direct care to COVID-19 positive residents. The employer's policy is that N95 masks were not required unless an aerosol generating medical procedure is being performed.

More recently, at the outset of the second wave of the COVID-19 pandemic in Ontario, another CUPE local has experienced similar issues with respect to the provision of adequate and appropriate PPE, particularly N95 masks, as the home struggled with a significant outbreak. In this home, some classifications of workers have been provided with N95 masks, while other workers who provide direct care to COVID-19 positive residents have not.

Recently, the government of Quebec has ordered that all staff working in long-term care be equipped with N95 masks as the evidence is growing stronger that the virus can become aerosolized.[12]

## Trauma and Grief:

*"The military has PTSD, don't you think we might?"*

The cumulative effect of the pandemic has been devastating on CUPE members working in long-term care. It has taken a huge emotional and physical toll. Many of our members have come down with COVID-19. They have given it to family members. All are exhausted from the stresses of the job itself.

Most of our members have close emotional relationships with the residents in the homes. Their grief over their loss of residents is mixed with shame as if there was something more that that could have done. The culture in long-term care has been to blame the least powerful employees for the outcomes of the residents and even now many have internalized that culture.

> *We know how someone likes her hair combed and done. What food they eat how they like to sit to watch the birds. We care a lot about what happens to residents.*
>
> *I was thinking if one of these big outbreaks happens in my nursing home…with one of my residents, I don't know how I'm going to cope with that.*
>
> - ***Pam, PSW, municipal home***
>
> *In a lot of cases the residents are like your mother or grandmother getting infected or dying of COVID. Some died from not enough nourishment or liquids.*
>
> *Family members couldn't come into the home for weeks on end. We were the only people there for residents who were dying. This will have a lasting impact on all of us. Some staff will remember it but be able to move on. Others won't because it is devastating. There will be a lot of anguish and residue well after we are done with the pandemic.*
>
> - ***Robin, RPN, for-profit home***
>
> *"The media were out there watching us everyday because we were dealing with one of the biggest outbreaks locally. We had to walk past them to get into the building. When staff had to start cleaning and prepping the residents' bodies, taking them outside to be taken away by the funeral home transport the media were outside waiting and counting the body bags as we took them out. It was just horrible. It was just so demoralizing. We didn't need that everyday. We were inside. We knew what was happening to the residents. We didn't have enough staff before the pandemic to deal with their needs, now they were getting infected, needed more time to eat, bathe and some were dying, and staff were getting sick."*
>
> - ***Sarah, Housekeeping Aide, for-profit home***

[12] N95 face masks mandatory for Quebec health workers in COVID-19 hot zones, *Montreal Gazette, February 11, 2021*

Numerous members have expressed that they have been tremendously impacted by having been required to prepare and bag the bodies of deceased residents when funeral home staff were no longer able come into the homes. Members were provided no training or support, and in many cases any notice, before being told that they would be required to perform this task that they had never contemplated before. The act of having to prepare the body of a resident that they have provided care to many years haunts them to this day.

> *After they changed the rules and the funeral homes were no longer coming in the homes to take away the residents who died, we (the RPNs mostly) had to prepare and bag the bodies. We had never done this before. It was very traumatic, and we had never been trained. … there has to be hands-on training about how to do this and how to handle it emotionally.*
>
> - ***Pam, PSW, municipal home***

The lack of support from management has also led to feelings of helplessness and being under-valued. For example, facility operators and health officials seemed oblivious to the fact that staff in these homes felt incredibly vulnerable. They were risking their health, the health of their family to go to work. If they had, in return, been provided with the gold standard of PPE, i.e. an N95 mask, it would have provided significant reassurance for workers. It would also have signalled some indication that they were valued as workers and as people. The fact that their health and dignity was not considered by managers or the government is something that must change.

Many CUPE members recognize that they are going through something akin to PTSD. That the helplessness that they felt has long standing implications.

> *We're expected to go into work all the time to care for residents. When 99% of the time we're no longer caring for ourselves with self care, because we're trying to barricade ourselves from family, we're not seeing family. And we're trying to be there for residents, but we're falling apart ourselves. So how can we help our residents not fall apart when we're falling apart ourselves? We need better mental health components for that, because we're falling apart.*
>
> - ***Kris, RPN, for-profit home***

> *The healing circle was a good idea. But people don't want to be singled out the way she did it. Because they're thinking, "Oh, well, she thinks I have a problem." No, we need support to understand what we went through and get over this and try to heal and continue on. But it's just it's so nasty now.*
>
> - ***Cheryl, PSW, for-profit home***

Mental health supports are mostly non-existent in many long-term care homes. Some municipalities offer an Employee Assistance Plan (EAP) and some workplace benefit plans provide minimal counselling coverage for the full-time employees who have benefit coverage. A more comprehensive way to cover the PTSD and mental health issues faced by our members in long-term care would be through the Workplace Safety and Insurance Plan. Although PTSD is not often covered as a workplace accident or injury, there are specific workplaces and situations where PTSD is considered presumptively to be a work-place injury and covered by WSIB benefits. The Ontario government could presumptively clear long-term care and hospital employees who have had to work during this pandemic to qualify for WSIB coverage should they experience PTSD.

## Going Forward

Many CUPE members have expressed the view that large numbers of long-term care workers will abandon the sector once the pandemic is over. Major changes need to be made to retain existing staff, recruit new staff and to entice staff who have the left the field to return. Below are some recommendations, in addition to those made during CUPE's meeting with the Commission, that are necessary to rebuild a sector where people will want to work, and where residents can receive the care they deserve.

## Legislate and fund a four-hour care standard now

In November 2020 the Ontario government announced that they would move to regulate a minimum average of four-hours of hands-on care for residents in long-term care homes.

> *If we had the four hours of care [plus additional staff for housekeeping], the virus may never have come through into the building. Because we would have enough people to care for the residents. You'd have enough people to make sure that they kept her hands clean, you'd have enough people to make sure that they were well taken care of.*
>
> *You wouldn't have as many people that you would have to rush to take care of. You'd be able to pay attention to detail. You'd be able to keep their areas clean and tidy. You'd be able to make sure that they are well-fed and that they are well-hydrated throughout your shift. You wouldn't have these mental health issues with our clients that are missing so much, because you'd have time to spend with them.*
>
> - ***Olga, RPN, municipal home***

The four-hour standard is something for which our members have been advocating for decades. While the announcement is welcome, the timeline is woefully inadequate. The extra staff, and the funding required to hire them, were desperately needed before the pandemic – and are even more urgently needed now. The standard also must be legislated, and homes' compliance reported publicly to ensure accountability. Most importantly these changes need to be accompanied by sufficient funding to make them happen – and funding for homes must be tied to meeting the standard.

## Staff recruitment

The staffing crisis cannot be solved without a robust, province-wide plan to recruit and train thousands of new staff. Barriers to entry need to be removed with free tuition for training offered by public colleges. Recruitment plans must also be focused on all regions of the province to ensure that all homes have access trained and qualified pool of applicants to be able to draw from.

Integral to recruitment – particularly to enticing former staff to return – is a shift in the culture within the sector to one that respects the contributions of all members of the staff team. The relationships that staff from all departments build with residents must be valued, and the role that all classifications play in the provision of care must be acknowledged.

## Better wages and working conditions

Work in long-term care is difficult, physical and skilled yet the pay and benefits are dismally low. Staff frequently leave because they can make more working in coffee shops or retail outlets. For those that stay in the healthcare field they certainly make more working in hospitals which are facing their own staffing shortages. Significant improvements to wages and working conditions, including access to paid sick time, are essential to recruiting and retaining staff and improving the quality of resident care. This will require additional funding to allow for wages and working conditions in line with wages paid in hospitals.

## Presumptive legislation for PTSD

The pandemic has highlighted the trauma that staff have faced in this sector, but it is nothing new. Existing legislation that presumes that PTSD diagnosed in first responders is work-related should be extended to front-line healthcare workers – ensuring access to treatments and supports.

## Remove the profit motive

Profit has no place in healthcare. The pandemic has shown the outcomes in for-profit homes were significantly worse than those in non-profit and municipal homes. Profit has to come from somewhere which inevitably leads to choices to cut corners on things such as cleaning, investment in aging infrastructure and the provision of PPE – all of which have contributed to tragic outcomes throughout the pandemic.

At minimum there should be a moratorium on the issuance of any new licences to for-profit providers – and an acknowledgement that profit should have no place in the care for our seniors.

## Better enforcement mechanisms

Improvements must be made to ensure adequate inspections and enforcement take place – from the Ministry of Labour, Training and Skills Development in the case of health and safety and from the Ministry of Long-Term Care as it relates to resident care. These inspections should not be announced in advance. Essential to both of these processes is the inclusion of front-line staff, recognizing their experience and knowledge of the realities on the floor. Meaningful whistleblower legislation is absolutely necessary to protect front-line health care staff who bravely speak out about low staffing, inadequate care levels, abuse and health and safety infractions.

## Conclusion

This last year has brought unimaginable horrors that have been writ large in headlines and on our TV screens. The impact that COVID-19 has had on long-term care homes, their residents and staff is impossible to quantify. That said, none of this should have come as a surprise. These challenges may have been amplified by this pandemic, but they certainly existed long before. Our members have been sounding the alarm bells about the lack of staff and resources in the sector for years. If there is one silver-lining to what has occurred here it is that our society is now paying attention to problems that we have ignored for far too long.

It is impossible to tell the story of what happened in long-term care during COVID-19 without understanding the experiences of the members working on the frontlines. We want to thank the Commission for the opportunity to share these stories.

We are hopeful that your report will continue to shed light on these stark realities and offer tangible solutions to ensure that we can build a long-term care sector that provides proper care for its residents and respect for its staff. It will be incumbent on all of us to ensure that we never forget what has happened here – and that we collectively work to ensure it never happens again.

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