Long-Term Care COVID-19 Commission

Graham Webb, Jane Meadus, Alyssa Lane
on Wednesday, September 23, 2020

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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- Held Virtually via Zoom, with all participants attending remotely, on the 23rd day of September, 2020, 1:02 p.m. to 2:52 p.m.

BEFORE:

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

PRESENTERS:

Graham Webb, Executive Director, Advocacy Centre for the Elderly

Jane Meadus, Staff Lawyer and Institutional Advocate, Advocacy Centre for the Elderly

Alyssa Lane, Staff Lawyer and Institutional Advocate, Advocacy Centre for the Elderly

PARTICIPANTS:

Alison Drummond, Assistant Deputy Minister, Long-Term Care Commission Secretariat

Ida Bianchi, Counsel, Long-Term Care Commission Secretariat

Derek Lett, Policy Director, Long-Term Care Commission Secretariat

Lynn Mahoney, Counsel to the Ministry of Health and Long-Term Care

ALSO PRESENT:

Judith M. Caputo, Stenographer/Transcriptionist

COMMISSIONER MARROCCO: Ms. Meadus, good afternoon. I am Commissioner Frank Marrocco, Commissioner Angela Coke is on your screen and Commissioner Dr. Jack Kitts.

I take it, Mr. Webb, everybody is here now from your perspective?

MR. WEBB: Yes. We are all here and we're prepared to begin, if you wish.

COMMISSIONER MARROCCO: Well, thank you very much for coming, because this will be very informative for us and we're very much looking forward to what you have to say.

I think the best way for you to do this is to just start. We will ask questions as we go along, so don't think us rude if we're interrupting you with questions, because we think it's better that way than to trying to go back.

And secondly, around quarter after 2:00, I'll take a ten-minute break. So any time around there, if you think it's convenient to stop, just say so. We're ready when you are.

MR. WEBB: If I may begin then, just to say a few words about ourselves and our clinic.

I am Graham Webb, I am a lawyer here and the Executive Director of the Advocacy Centre

for the Elderly. I'm joined by my colleagues, Jane Meadus and Alyssa Lane, who are both lawyers and institutional advocates.

The Advocacy Centre for the Elderly is a specialty community legal clinic under the Legal Aid Services Act. It was established to provide a range of legal services to low-income seniors in Ontario. Legal services include individual and group client advice and representation; public legal education; community development; and law reform activities.

ACE was established in 1984, has been continuously operating since then. And it was the first legal clinic in Canada, with a specific mandate in expertise in legal issues of older adults.

ACE currently employs six lawyers, two paralegals, and an administrative coordinator, and two administrative assistants.

On average, we receive about 3,000 calls or more from older adults, families of older adults, health and social service providers and others every year.

About two-thirds of our intakes and our case files are in the area of health law. Most of

our telephone inquiries come from the Greater Toronto Area, with about 20 percent from other areas of Ontario. And we also receive calls from across Canada and around the world.

Our lawyers frequently present on all issues of elder law, including long-term care homes; retirement homes; consent and capacity law; elder abuse; to other lawyers; to healthcare professionals; to older adults and other groups.

And we have made many presentations at the local, provincial and national and international levels.

We have two institutional advocates who provide legal services to institutionalized persons, most specifically in long-term care homes and hospitals.

Jane Meadus has been our institutional advocate since 1995 and she's recognized as an expert in long-term care.

Alyssa Lane joined in 2019, when a second institutional advocate position was created. Now these positions are unique across Canada. We are not aware of any other lawyers in Canada who are dedicated full-time to the issue of institutionalized seniors. And I've often said

that I think personally the most important work that ACE does, including elder abuse, pensions and fire safety and so on, of all that work, I think the most important work that we do is in the area of long-term care homes, because it is the highest unmet need. There is very few other resources for older adults and their families to turn to when they need legal advice, legal representation, and general legal information in the area of Ontario long-term care homes.

With that, I'd like to turn our remarks over to the person who has been on the frontline of that service for 25 years this November, November 1995 she joined us, Jane Meadus.

MS. MEADUS: Thank you very much. I'm very glad to hear that you're going to be asking questions, and please do so. I think that's definitely the best way to go through this.

So we will be putting in some written submissions, because we do have a lot of information to provide to the Commission, and I'm sure that we will not get to all of it today. And in our written submissions, we'll also refer to documentation.

If there's any documents or anything

that we refer to that we don't have, or that you would like to have, please let me know and we can hopefully provide them or let you know where you can get them.

COMMISSIONER MARROCCO: That's very helpful, thank you. We would welcome the sort of tailored remarks and any papers or documents that you think would be useful for us to read. Don't feel hesitant about offering them, we'd be pleased to get them.

MS. MEADUS: Fair. And I've already sent Ida a couple of documents when we had our sort of informal conversation the other day. I sent a couple of things that I had referenced that she wasn't aware of.

So with that said, I just want to do a little bit of history. You all probably know this, but I'll talk a little bit about it.

So the history of long-term care in Ontario goes way back. When I started practicing law, there were the three different kinds of homes, there were charitable homes, municipal homes and rest homes, and then nursing homes.

At the time I started, they were actually under two different ministries. So the

nursing homes were under the long-term -- sorry, the Ministry of Health. And the other two were under COMSOC at the time.

So that was a time, the '90s were a time when they were bringing them together. They certainly focused on different populations, I think at the time, obviously, the charitable homes were focusing on their populations that had come out of different kind of linguistic, religious, ethnic groups, providing services.

Municipal homes, of course, came out of the poor homes. And nursing homes had originally been sort of the retirement homes of the '60s. So in the '60s, you saw a lot of newspaper reports about problems in the nursing homes, like we did prior in Ontario for retirement homes, prior to the Retirement Home Act legislation, so there's a lot of parallels there.

There were differences in the way they were funded, the oversight, there was a lot of differences certainly when I started. Certainly in the late '90s and then into the 2000s there was a remerging of the three types.

So by the time around the 2000s, if you lived in a long-term care home, you shouldn't have

known the difference whether you were in one or the other; they were more corporate. There was still the three different types of legislation at the time. And because of that, like the Nursing Homes Act was very detailed, whereas, the others were not.

So what really sort of governed the situation was the policy manuals. And Ms. Coke, I think, worked at the Ministry of Health at the time, so she may be familiar with the Long-Term Care Home Facilities Manual, which was a giant manual about this big, which contained a lot of the policies. And a lot of those policies did become regulation.

So we hear a lot about the complaint around it's highly regulated, there's hundreds of sections. When you look at the history, you can say, well, yeah, but a lot of those things were really still there, but they were policy under the old system prior to 2010.

So, you know, the industry will often complain about how highly regulated it was, starting in 2010. And in fact, most of those things were there by policy and they had to do them anyway beforehand.

We actually wrote a manual, and if you'd like, we can certainly send you a copy of that. We wrote a manual that went into three editions, this would have been prior to 2010. We have not had time, unfortunately, to write one since then.

But which sort of took the manual, took the legislation, and explained the system at the time. And I think that a lot of that is still relevant, given that there's a lot of that still continues until today. So we can certainly provide a copy of that, if you wish.

COMMISSIONER MARROCCO: That would be helpful.

MS. MEADUS: Okay. It was written for the lay person, so even though it discusses law -- you know, it's called "The Advocates Manual", and it really provides for the people advocating. And it talks about things like funding, and all of that, which can be quite complex. As I said, a lot of it hasn't changed a huge amount.

One of the big differences at the time, was the time they had compliance advisors. So their inspection process was done by compliance advisors. And the compliance advisors had a dual

role at the time.

First of all, they were generally assigned to specific homes. So, you know, Ms. Smith would be assigned to Shady Acres, and that was her home; and she had a dual role. So she inspected the home, but also advised the home on compliance issues. And this created a lot of issues.

We ran into a lot of problems, because if we made complaints against homes, we had inspectors -- sorry, compliance advisors who might have been with that home for many, many years, who had a relationship with the staff, and the directors and stuff, who would tell us, "oh, this is a perfect home. I don't know why you would complain about it, it's so wonderful".

So there was a lot of problems with that. There was a lot of subjectivity in that system. So even if a compliance advisor found something that was noncompliant, they did not have to actually make a finding. So they could come in and find something, but they wouldn't have to note it; they didn't have to report it, or anything like that. It was all subjective. And so there were a lot of problems inherent in that system.

So, you know, we came up until 2010 when we got the new legislation. And that legislation, the Long-Term Care Homes Act I think was unique from many pieces of legislation. In that the Ministry actually came to the stakeholders -- and I'm talking about the, you know, the different industry organizations, our office, Concerned Friends, which is an organization for advocates for people in long-term care. It pre-dated Family Council and OARC, so Concerned Friends has been around. Actually, they helped establish our office.

So, you know, met with them, OARC. Different people were there looking at what needed to be in the Long-Term Care Homes Act. So instead of what usually happens where the government drafts legislation, then gives it to you and you comment, we actually were all really part of the drafting of the Long-Term Care Homes Act.

So I always laugh when people say there's too many things in it, or in the regulations. Because, you know, there were very specific reasons for things being included in the legislation, based on the experience of all of the parties.

So I think that that is a very important thing to know, that this legislation was actually really in some ways a collaborative work. Now, the regulations were a little bit faster, we didn't have quite as much in it, because the government of the day was going into an election. And I think it wanted to get the Long-Term Care Homes Act put into place prior to the election.

So they sort of quickly drafted a lot of the regulations, and put them in place for July 1st, 2010. And some of that was not really ready at the time; and that included the inspection process. So the inspection process that we have now, was actually not implemented until sometime quite later.

Rate reductions weren't available at the time -- like the process wasn't in place yet per the legislation, so there were certain things that had to be delayed.

But it did replace the three pieces of legislation and made it very, very clear that, you know, it didn't matter who the owners were of the home, all the same rules and standards applied; and that, I think, was a really good thing.

So I'm going to talk a little bit about

inspections. Because we've heard, I think, a lot through COVID about the inspection process, and sort of what the, you know, issues around that. And we've heard the government make certain statements about it, and the opposition complaining, so I think it's important that we be able to talk a little bit about that.

So the inspection process that we have now was based on the U.S. system that was used for Medicaid and Medicare, the quality inspection system there. It was created out of the University of Denver, and I've been trying to find the name of the person, but I cannot just find it in my notes at the moment. And of course we're not at the office, so I don't have access to my stuff there.

But it was definitely something that was worked on for a very long time, it was contracted, you know, and it was to really ensure that the inspection process had been tested, and was rigorous, and inspecting what it needed to do.

At the time the government promised that there would be full resident quality inspections -- and those are the big full inspections that we see annually -- every year on every home. That is what was promised to us.

For the first couple of years, there were really only complaints and critical incident inspections and a few others, because they were still training and testing the system.

In this system, one of the differences between the old system was that the inspectors were required to cite non-compliances, and there were no advisors in the system. And this was a criticism, a criticism to which I agree, although, I don't think it's the role of the inspectors to do that assistance, I think it's the role of the -- or should be a different part of the Ministry, and I believe that was one of the Gillese Inquiry recommendations, that they do that. But it can't be -- the inspectors can't also be advising as they were in the other system.

Inspectors are now assigned randomly within geographic regions, but they're inspectors, not investigators, which means they don't have the ability to sort of weigh evidence. So they sort of have to have some kind of evidence in front of them. And a good example of that, where it creates a problem is around, for example, abuse issues.

So if a resident complains that they were abused, and the staff member says, "no, I

didn't do it". And there's no other kind of evidence -- even a bruising, or marks, or broken bones, you know, if they can't prove how it was done, they will not make a finding around there being abuse. And that's always been problematic in the system, because the residents see this as, you know, not being bullied; to the family, it's very problematic for the family.

So they're not investigators, they're inspectors. They have protocols based on the various topics and they've hopefully been given that by the Ministry.

In general, in a complaint or critical incidents inspection, they will use whatever protocol is applicable. In the resident quality inspections, they interview 40 residents, have other protocols to be used, and if something is triggered -- so, for example, during a inspection, a resident talks about abuse, then they would trigger that protocol.

So it really became clear quite quickly that there weren't enough inspectors, because these inspections were taking longer, and they were also getting complaints in critical incidents.

In and around 2013, they decided to

change the interpretation of the requirement under Section 143 of the Act that it be an annual inspection, from what would have been promised to us, which was the resident quality inspection, to being any inspection in a home. So if they went in and inspected on food, that was an inspection. That meant the home had been inspected and that met the criteria.

However, we were able to bring pressure on the government to live up to this promise, because it had promised it publicly. And in 2013 they hired 100 new inspectors to meet the needs.

In 2015 the Ministry of Health and Long-Term Care produced statistics through their statistical analysis team that showed the difference between what is found in sort of critical incident and complaint inspections, and what was found in resident quality inspections.

And they used to give us top ten lists at the time I was on the long-term care quality inspection advisory group, and they would bring us like the top ten. So what were the top ten issues that were found during a critical incident versus a complaint versus RQIs; and they were very different.

You know, they really said that we need all of those things, because you can't find -- what you find in a critical incident is going to be different from other things. And one of the very specific things was infection protocols. Because people generally don't complain about infection, whether or not you're complying with infection protocols; because they don't know. The residents don't know what they're supposed to be, families don't necessarily know what they're supposed to be. So they're not something that people will complain about, and they're generally not things that will come up in a critical incident report.

So that was one of the top once, and very relevant to today, where we're not having RQIs. As the system went on -- so we got our extra 100 people, they started to do the RQIs, they still couldn't meet it. So then the Ministry introduced sort of two levels of RQIs, one which was risk-focused; and the other was intense risk-focused.

The intense risk-focused is the one that we always saw before. Whereas, the risk-focused was a lesser one, had less protocols and only interviewed 20 residents.

With the change of government in -- whenever it was, 2018, I guess -- there was a change, and they stopped doing a lot of the RQIs.

My understanding is, in 2019 there was less than 10 out of over 600 homes that had RQIs. And this is really problematic, because complaints and critical incidents are after the fact. Something bad has happened, and they're inspecting on that.

The RQIs go in and they look at different things. For example, infection control, you know, nursing -- there's different things that they look at. And we're really missing a piece of the puzzle, and prevention as well. Because they can go in and they can see things -- for example, they're not doing infection protocols properly, or medication management is another big one, that they're not doing those things properly. But it may not have actually harmed anyone yet and they can prevent it.

But if they're not looking, they're coming in and doing an abuse inspection or something else, they're not looking at those protocols. And, therefore, we're really losing something in the system.

The other problem with relying on the critical incidents in the complaints is that complaint inspections rely on people complaining. There are certainly a cohort of people who complain more than others. It also relies on homes actually submitting critical incidents. And if you look at inspection reports, you'll see that very often what the findings are, are sort of examples around abuse. They may not be able to determine whether abuse occurred, but they can say that the home did not actually report abuse when they knew -- or an allegation of abuse, when they knew about it. So there's a lot of those sort of, the home didn't do the proper reporting.

While we all like to think that homes are all the same, I think we know that there are some homes that are able to meet standards more than others, and we've certainly seen that throughout the pandemic.

There are over 30,000 people on waiting lists in long-term care in Ontario. And because of that, homes have no trouble, in general, keeping their beds filled; especially in big cities. Hospitals put a huge amount of pressure -- and Alyssa and I spent a large part of our time

pre-pandemic, on hospitals trying to force people into homes they don't want to go into.

Homes that have very lengthy noncompliance lists, inspection reports that are very problematic, lots of problems, have no trouble filling the beds, because hospitals really put a lot of pressure on people.

And the people that tend to end up in those homes are often the people who don't have families. Because families will all -- you know, people who do have families, the families go in and say, "I'm not going to put my mom in there" and that's the end of it.

So they tend to be the most marginalized, incapable people; people who don't have someone to speak up for them. So they're not -- you know, so homes who have problematic, may actually have less complaints because the residents may be not capable, or may be fearful, and they may not complain. And they may not have the family or social structure to complain on their behalf.

And if that's the case, the homes may also be less likely to make, you know, make critical incident reports, because nobody is really complaining and nobody is looking at it.

So just because a home doesn't have a lot of complaints or critical incidents, doesn't mean that they're very good. It maybe means that there's nobody really watching.

MS. LANE: Yeah, and sort of speaking to that point as well. Especially in rural areas, we get a lot of calls from families who are fearful to complain, because as soon as they make the complaint, the home is going to know they made the complaint. And so, you know, if they're a business owner, their livelihood could be at risk. They're worried about reprisal for their family member now in that home.

And that was a big issue during COVID as well, is family members fearing complaining because their family member is stuck in this home, and they don't have access to them, they don't know what's going on in there. You know, is the family member in the home then going to be provided less care or poorer care, because they made a complaint against the home.

MS. MEADUS: So one of the things, so I was co-counsel with Susan Fraser for the Ontario Association of Residents' Councils at the Gillese Inquiry.

And one of the things we really saw at the Gillese Inquiry, which was really clear -- and I don't think this was specific to these homes, it just happened to be the homes that were on the stand -- was that they didn't really understand their reporting obligations. There was a huge lack of reporting of abuse and other issues.

They didn't understand a lot of things. The medical director didn't understand their role, they didn't understand the medication rules. So I think that this again was an issue around compliance.

And it's interesting that -- one of the sort of interesting things around the Wettlaufer case was that the home, Caressant Care in Woodstock which was the home where most of the murders had taken place, had just had an inspection -- and it wasn't the worst inspection report I've ever seen by a long shot -- just before she had come out and confessed.

Of course immediately as soon as she confessed, the Ministry was in there. And the list of non-compliances, when they really did a deep dive, was huge. And they eventually -- so from October until January, they sort of had a chance to fix it, they didn't. They had to cease submission,

and then they went under mandatory management, which I understand continues to this day, is that it is being managed by a third-party.

So even with RQI, whether we're getting to the depth of everything is really questionable. But certainly we're not doing RQIs, they're not looking at enough things in homes.

There's different levels of enforcement, as you know, in long-term care: Written notices; voluntary plans of correction; compliance orders; work orders; direct to work referrals; directors can order cease admission or mandatory management orders.

There's a lot of -- unfortunately, the system which we had hoped would really clean up the system, I'm not sure that it did. We get very frustrated reading reports. First of all, it's often very difficult to understand what happened in a compliance report.

Second of all, we find the overuse of written notices and voluntary plans of correction. So a written notice is just saying, you did something bad; don't do it again.

Voluntary plan of correction, the home is supposed to do a plan of correction. But the

Ministry does not review that plan; nor, do they go back and check to see if they have complied.

Compliance order, the home is given an order to comply. And the home is reinspected, but there's no timeframe for that. So it could be months and months later. And we also find that there's less compliance these days than there used to be. I don't believe that's because there's less problems. Things that we used to see as a compliance order, we're seeing as voluntary plan of correction now.

And I'll give you an example. And very often, the homes are given extended periods of time, so they don't comply and they extend it, and extend it. One I looked at recently, and I can't remember the home off the top of my head. But it was something like they had to fix the windows. It was like two years, it went on, and on, and on, and they didn't comply.

There is no specific fining system. There can be provincial offences. To my knowledge, there's never been a charge under this act. There was one around the time of change in the legislation and that was with respect to a whistle blowing situation.

So we really, you know, haven't seen the full -- you know, there's fines in the legislation, but it's been ten years and we haven't seen one, any provincial offences, despite some pretty egregious situations.

So I don't think that -- there's not much fear. I mean, homes will tell you, oh, they don't like to get non-compliances and compliance orders. But frankly, it doesn't change who gets in, it really doesn't change a lot. Cease admissions order do, and mandatory management orders do, but those are used very few and far between.

Whether there's one issue or multiple under a noncompliance, it's counted as one. So, for example, if they abuse one person or if they abuse 20 people, it's only counted as like one noncompliance. So you really have to often look at inspection reports to see, you know, what happened.

COMMISSIONER KITTS: Can I just ask a question?

MS. MEADUS: Sure.

COMMISSIONER KITTS: What role, if any, does the Ministry of Labour play in this?

MS. MEADUS: So the Ministry of Labour

inspects on the labour issues. So they would potentially go in and check whether or not staff are under proper working conditions. But it's not under the Long-Term Care Homes Act, it would be under the labour legislation.

COMMISSIONER KITTS: So they don't have any jurisdiction over staff safety, abuse?

MS. MEADUS: They do, but under the labour legislation. So I know that, for example, during COVID, they were -- they went in and were inspecting on whether or not people had access to PPE, for example.

So that would be under the Employment and Labour Legislation of Safety, for that. The Long-Term Care Homes Act is specifically with respect to the resident.

COMMISSIONER KITTS: Do you think Ministry of Labour should play a larger role?

MS. MEADUS: I think so. I think that there are a lot of labour issues. I think that there's a lot of poor conditions in long-term care for staff. And I think that they're coming in now under, you know, what is a dreadful situation.

And I think that's part of the problem is that, you know, when the pandemic hit, many of

the things that we saw, whether it was, you know, the Canadian Armed Forces report, whether it was the labour issues, they all existed before. It was just, you know, it was just expanded.

And I think that absolutely we think that the conditions for staff in long-term care are quite poor, and I think this is why we're having a lot of problems keeping staff. Why they have a really big problem getting staff of all type, whether it be nurses, whether it be PSWs, and physicians, medical directors.

Long-term care is sort of the poor cousin of the healthcare system. It is not seen as sexy as working in a hospital. And I know, Dr. Kitts, you used to be at a hospital. But, you know, it's not seen as a desirable place to work. And I think that's one of the things we have as a challenge, as a system, that we really need to change the perspective and not be looking at, well, since we can't cure these people, why bother? I think that's really a problem.

COMMISSIONER KITTS: Violence in the workplace brought labour into hospitals a few years ago, led a lot by the RNAO and ONA.

Violence in the workplace sounds -- for

lack of a better word -- rampant in long-term care, because of the high number of patients with dementia and other disorders.

So I'm surprised that Labour hasn't come in there, similar to hospitals, on staff safety.

MR. WEBB: Dr. Kitts, may I interject? I don't plan to say much this afternoon, but I would like to follow up on your comment.

In my view, I think long-term care homes are extremely intense and complicated environments, because they really have, at least a three-fold purpose.

In one sense, they are a place of employment for the employees who work there. Just like other people go to their place of work, this is a place where people from many different disciplines, caregiving, nutrition, maintenance, all kind of professionals and nonprofessionals go and work daily, 24-7.

The second thing is, it's a place of business. So the licensees, whether it's a municipal corporation, or a charitable institution, or a for-profit corporation; or, some blend where it's owned perhaps by a charitable corporation but

operated under a management contract to a private company, it is in some sense, a place of business for the licensee.

In fact, for years when we researched the law concerning long-term care homes, we found that almost all the litigation concerned the business aspects of long-term care homes; it has to do with licensing and financing, etcetera.

But most importantly -- and this is unlike hospitals which are also complex -- long-term care homes are also the home of the people who live there. Because a hospital is a place where someone goes, usually, for a temporary period of time -- there are exceptions of course -- but normally, people are visitors in hospitals.

But in long-term care homes, it's most important to remember that these are the homes of the persons who live there. And that in fact is the fundamental principle of the Long-Term Care Homes Act. And it really drives everything that we do at the Advocacy Centre for the Elderly as we regard this primarily as someone's home.

And, actually, we tend not to call long-term care home residents "patients". They are patients of a doctor, just as my mother when she

lived in her private apartment was a patient of her physician; but a resident of her apartment.

Now that she lives in a personal care home in Manitoba, she is a resident of the home. And we think of these as residents, and that perspective drives everything else that happens in the long-term care home.

Now many years ago, long-term care homes were called in Ontario, "long-term care facilities". This was the legal term they were called as long-term care facilities. Thankfully, they're no longer called long-term care facilities, they are appropriately called "long-term care homes", because that is the way we look at them.

So I just wanted to share that perspective with all of the Commissioners. Thank you.

COMMISSIONER KITTS: Thank you.

We've heard from others that the acuity of the residents has increased dramatically over the past several years and we've heard 70 percent plus have some form of dementia, and most of them have one or more chronic diseases. So I think the acuity going up may change the workforce and skill mix, and I think staff safety is still paramount in

that.

MS. MEADUS: I think that brings us to another topic, which I think is really important. I agree with you, I think that the acuity level, you know, I'm sure you've heard people used to drive up to these places with their cars and all of that. And, of course, I haven't had one client ever that had a car at a long-term care home, and that is not what happens.

I think there's been a number of things that have happened over the years, certainly that I've been here. And it's that the -- I think that the closing, or the redistribution of patients from chronic or complex care has been a big problem.

People who used to go to complex or chronic care, now go to long-term care. Most chronic care and complex care, in our opinion, has become more of a rehab facility and is really not truly complex anymore.

MS. LANE: It's a very short term, yeah.

MS. MEADUS: Yes, chronic care is no longer really a destination for people. We have a lot of problems where we have clients who, we believe, clearly cannot be managed in long-term

care. Their needs are far too high, and yet they are found to be eligible by the LHIN, because there's no upper level, and they're forced into long-term care where it's pretty clear they can't be managed.

Other things that have happened is, of course, the closure of mental health facilities without proper planning. As well as the lack of access for assistive, either -- subsidized retirement homes, you know, or assisted living.

So if you're poor, and you need some help, and you can't get enough at home through home care, you end up in long-term care. If you're rich, you end up in a retirement home. And a lot of the poorer people could be managed in long-term care, so they either ended up at home unsafe, or they end up in long-term care where they really shouldn't be, because we don't have a subsidized system, or not a lot of it out there.

We also have a lot of younger people who might have, for example, lived in what used to be the regional centres, for example. So it's not uncommon for people with developmental disabilities who are getting older to end up in them.

My youngest client right now is

27 years old. She resides in a long-term care home in Toronto, she is totally competent. I think I sent to Ida the links to some media that's been about her.

She grew up in the Crown Ward System, so she has no family, doesn't really have a support system. She was in an accident and suffered a partial paralysis and has gone in there. It is an incredibly inappropriate place for her. And both for her -- anyone younger, we have problems with.

I mean, we don't have problems with our client, we have problems with the homes. They just don't know how to manage people who are younger. They don't like to be told what to do.

So if a client says, I want to do this, this, and this, like you would in assistive living, the homes don't like that. They don't understand the kind of system that -- they don't understand their diseases; they don't understand how to manage people like that.

My client is trying to move. And one of the reasons that she's getting refused by other homes is because it's reported that she doesn't want to live with a bunch of old people. Well, yeah, she's 27. You know, I don't think that

that's an inappropriate thing to say. The problem is, she doesn't have any other options at the moment. So this is used against her.

So anybody with any kind of different kinds of diseases, if you have ALS or something like that, it's quite problematic trying to get people cared for in long-term care. And the system is very rigid at looking at things in a very specific way, and assuming that everybody is old, has dementia, is incapable, and that they're going to come and do things their way. And this creates a lot of problems in long-term care.

With respect to the, you know, issue we talked a little bit about -- sorry, go ahead.

COMMISSIONER COKE: So I'm just wanting to understand.

In terms of pre-COVID, what would be sort of the top concerns that you would hear from residents and families? The most consistent ones.

MS. MEADUS: I would say in long-term care would be lack of appropriate care. So it would depend on who's calling.

So for residents, it would be lack of appropriate care; poor treatment; not respecting their wishes; forcing medication; that type of

thing.

Family members, I would say it would be more around potential neglect or abuse of residents; lack of communication from long-term care homes. So not being contacted to give consent to treatment.

It's very common for us to get a call to say, "I've just discovered that my mother is on Risperidone --" for example, which is an antipsychotic "-- and have no idea, and mom's incapable."

And I ask them, "Who consented to the medication?"

And they said, "The doctor."

And I said, "No, doctors don't consent to medication."

But you know, this is a consistent issue we run into where medications are given, or treatments are given without consent.

And, again, coming in and finding people dirty with feces on them, not taken out of bed, not fed properly, through the whole gamut of sort of neglect and abuse issues, really.

MS. LANE: Also lots of issues with admissions. So homes denying applicants because of

a particular disability. So maybe they have an addiction to alcohol, and the home doesn't want a person who has an addiction. Maybe they have behaviours, the home doesn't want individuals who have behaviors. So we get a lot of complaints about homes denying people for illegal reasons.

MS. MEADUS: And, of course, these are part of our health system. And, generally, if you go to hospital and you have a broken hip, they don't say, "I'm sorry, I'm not going to give you treatment because you're an alcoholic."

Long-term care homes will very often say, "we're not going to take you because you're an alcoholic"; or, "you're young"; or, "you use an electric wheelchair". That's against the Human Rights Code, that's a common one and it's a big problem.

MR. WEBB: In response to Commissioner Coke's question, would it be appropriate to touch on the outcome of the Casa Verde Inquest and the lack of specialized units behaviour?

MS. MEADUS: I can talk a little bit about Casa Verde. Have you heard about the Casa Verde inquest at all?

COMMISSIONER COKE: No.

MS. MEADUS: Okay. The Casa Verde Inquest, which is actually known as the Elroubi Inquest, was the inquest into the deaths of two gentlemen at a long-term care home.

What happened was, a gentleman who had a history of abuse, although it was not properly noted in any of the documentation, was very quickly admitted into a long-term care home after he assaulted his wife.

He didn't speak English very well, he was admitted on a Saturday morning. And if you ever hear of homes -- I know hospitals always used to complain why people won't admit on the weekends -- so this is the reason why they don't admit on weekends, is because they don't have the staff.

This gentleman was admitted on a Saturday morning, basically taken by his family, dropped off, not told he was going to long-term care, and left. He spent the day asking to speak to his family, who of course didn't want to talk to him.

At approximately 7:00, 7:30 that night, the PSW came around with the evening snack, and came into his room which he shared, it was a four-bedroom. One of the roommates was in hospital

and he shared it with two other people. He had bludgeoned his two roommates to death, one with the back of a toilet seat, and one with a metal bar that he had ripped off of a tray, and he was across the hall trying to kill a third person.

All the nursing staff ran and hid in the nursing station. Luckily, the cleaner came to the rescue and actually pulled him off of the third person, or tried to.

The police arrived, said it was one of the worst scenes they had ever seen. Had a lot of trouble actually controlling this gentleman. He was arrested, found not criminally responsible and there was an inquest into these deaths.

One of the biggest things that came out of that was the lack of funding and the lack of specialized training in specialized units for people who have behavioral issues.

We see in long-term care, a lot of what they call "secure units". They might call them "behavioral units" in some cases, but they're usually what they call a "secure unit". That's usually where they try to put people who have either wandering, or behaviors. And, frankly, those two things actually don't mix. There's

people who wander, don't necessarily have behavioral issues, but they may be targets.

Those are not funded behavioral units; they don't have to have any special training, they're set up by the homes. We only have about six, I think, behavioral units in the province. For example, there's one in the Toronto area; there's one at Baycrest, one at Cummer Lodge and one at Sheridan.

I'm not sure about Ottawa. The City of Ottawa used to run one, I want to say at Armstrong, but I'm not sure. And it pulled out, because they said they weren't funded enough. Even the specialty unit was not funded enough. And so this has increased problems.

One of the things that happened during COVID, is that if there was a person on a unit that had tested positive for COVID, the home generally treated every person -- just assumed everybody on the unit had COVID, and allowed them to intermingle on these sort of behavioral units. So instead of trying to have strategies to cohort, or to keep them apart, they just presumed everybody already had it, without any evidence, and allowed them to comingle.

MR. WEBB: Justice Coke, in answer to your question. What goes through my mind is one of the most glaring deficiencies of the Long-Term Care Home System Ontario is the lack of sufficient behavioral specialized units.

One of the recommendations of the Casa Verde inquest was a recommendation that there be sufficient behavioral units in all parts of Ontario, that they are available throughout the Province without a waiting list.

You know, I spent 21 years as a staff litigation lawyer with ACE beginning in 1995. I acted in an inquest which was the longest inquest in Ontario history in 1995, in which we heard evidence that it's not that the long-term care home system does not know how to care for residents with behavioral issues; they do quite well. It's simply they lack resources to provide the behavioral supports they need to manage these issues.

And so this has been a longstanding issue that, you know, I say frequently, the jails are sometimes filled with people who come from long-term care homes; or should be in long-term care homes, because it's a health issue. But there's a long waiting list for behavioral units in

long-term care homes, but there's no waiting list for jail. And that's why we find demented prisoners in jails rather than in long-term care homes where they need healthcare.

And so this has been a longstanding issue. And in COVID you particularly find problems with persons with behavioral issues, because they can't follow instructions to self-isolate, for example. And we need more specialized care throughout the system, and this has been highlighted in COVID as well.

MS. MEADUS: And one of the things that has happened during COVID is that the directives say that residents are require to self-isolate when admitted.

And what does "self-isolation" mean? We have tried to get the Ministry to clarify that. Because what we have found happens, is that residents who have been accepted for long-term care and are on waiting lists, and come to the top of the list, but who are not deemed by the LHIN or the home to be able to follow instructions to self-isolate. So if you say, "stay in your room"; they wouldn't do it. They are being what they call "bypassed". So the home is not refusing them, but

they are not being admitted because they can't self-isolate.

Our opinion is that, first of all, that's contrary to the Human Rights Code, because they're not admitting people for a service based upon a disability. We've asked the Ministry to clarify this, because it is not being done in all LHINs, only in some.

Our opinion is that the person has to be isolated by themselves; that doesn't mean they have to personally be able to do that. If we have 70 percent of people going into long-term care who have some type of dementia; isn't that their bread and butter, and aren't they turning away the exact people who need to be there?

And we did receive a response from the Ministry which was unfortunately not very satisfactory. Although, I'm personally interpreting it as meaning that a home has to do the isolation; although, of course, it wasn't quite that clear the way they wrote it.

But this is another issue we've had during COVID is a lack of information from the Ministry, a lack of clarification. So they come out with directives or guidelines about things. We

ask questions like, what does this mean? Can you tell us? Can you explain it to us? And we don't get responses certainly in a timely manner and sometimes we don't get responses at all.

And this has been an issue, actually, in the last couple of years where there seems to have been a change in perspective from the Ministry and committees that we used to be on, where we used to be able to bring some of these issues and talk to them with the Ministry and with other groups have been disbanded, there's not -- we have not ever met with the Minister. We have never been contacted by the Minister, despite having been working in this area for many years and writing in the area.

We have occasion, like today, we did attend, Alyssa and I did attend something with the Ministry, where they were doing some outreach on something. But it has really been very clear that there has been a change in perspective in that sort of working with, certainly with our office and other offices, which I think has been unfortunate.

And, you know, during COVID that has been a real problem in trying to get responses to things.

COMMISSIONER KITTS: Can I just come back to your request for isolation.

What does "isolation" mean to you in a long-term care home, recognizing that, I think, a lot of rooms have four, three and two people in a room?

MS. MEADUS: Right.

COMMISSIONER KITTS: Is isolation a single person in a single room?

MS. MEADUS: So our understanding is that on admission, so a new resident who's being admission, that the homes are now to have rooms -- single rooms for those people, and they have to be isolated in those rooms.

It's very different than what happens once they're in, and cohorted. And that's, of course, been a problem in -- during the pandemic, that with four bedrooms, for example, that people were not being cohorted, because there wasn't room for them to be cohorted. And that, you know, we had people continuing -- you had one person with a curtain around them and, of course, that spread the disease.

I think what that also brought up was an issue around the planning and the pre-planning

was all to the hospitals. Even though we knew from looking at Europe, from looking at Washington, that we're the first places. And where it was really being hit hard was long-term care homes. There was really little planning on how to deal with long-term care homes; how to deal with these four bedrooms.

You know, stick a curtain around them, I'm not a medical person, but -- you know, we were seeing cruise ships, for example, where, you know, the cruise ship that was the Diamond Princess, was not allowed to dock, and how it was going through there, even though they were all in their rooms.

It never made sense to me to allow someone to stay in a room with vulnerable people, not send them to hospital and just keep them there and allow them to infect. If they didn't have room there, they should've been sent to hospitals. But hospitals don't want people from long-term care homes.

COMMISSIONER MARROCCO: If you were put on a timeline, when do you think it should have been obvious that there was a problem? Or going to be a problem with long-term care homes?

MS. MEADUS: Well, I can tell you that

I was interviewed by -- I want to say the Toronto Star, or The Citizen, I can't remember which now -- right at the very beginning. And I said it from the beginning.

COMMISSIONER MARROCCO: What do you mean by "the beginning"?

MS. MEADUS: So I would say the beginning of March. You know, around the time when we were starting to go in lockdown, I was contacted and I said, it is going to be a disaster in long-term care. I believe that was a quote on the front page of The Star at the time.

MS. LANE: What made it worse was there was this huge push, and even change in amendments to the legislation to say, get all of these ALC patients out of the hospital and into long-term care. And they made all these patients crisis, and pushed them into these homes as quickly as possible so that they would have the hospital beds.

And so now we're just adding more fuel to this fire that's already existing, right? More people now going into these homes that are getting sick.

COMMISSIONER MARROCCO: Did anybody say that?

MS. LANE: Well, that was the result. I think very much in part there was this push to get everybody out of the hospital, and also not allow them to go back to the hospital. Keep them in long-term care out of the hospital.

But the long-term care homes weren't -- a lot of them weren't able to handle the -- handle Corona Virus, and then you have these people with nowhere to put them, and nowhere to isolate them.

MS. MEADUS: You asked whether or not people were saying this; absolutely they were.

COMMISSIONER MARROCCO: I'm just trying to affix, you know, first of all, that I was concerned about, whether people articulated that. And I was just trying to get a sense of when, because then I have some sense of a timeline, you know.

MS. MEADUS: So I would say that from the middle of March until May, the main part of my job was media. I have not yet counted how many media appearances that I made during COVID, but I was probably doing four, five interviews per day, as were some colleagues of mine. And these were all issues that we were bringing into the media for sure.

As I said, we didn't have contact with the various government entities, the few attempts that I made didn't work. So, you know, I figured maybe if we did it in the front page of the Toronto Star, that maybe it would get into the ears of people. But I don't know that it was really listened to at the time.

So these were definitely things that were discussed, and those -- I meet regularly with a variety of associations with union people in different meetings, and these are things that we were all discussing and trying to get into meetings.

But, you know, we're not at the table. We're not at the pandemic table, we're not at long-term care tables. There's not that voice there. So it has been increasingly difficult. These are sort of things that we brought up at committee meetings when I used to do committees.

So, yes, we were saying them publicly and loudly and as much as we could. And hopefully it was getting -- but I don't know. As I said, I haven't spoken to the Ministers or the Chief Medical Officer of Health.

MR. WEBB: Commissioner Marrocco, I

think it's telling that --

COMMISSIONER MARROCCO: Commissioner Kitts had a question, so I'll come back to you in a minute, okay?

MR. WEBB: Yes, thank you.

COMMISSIONER KITTS: I just want to finish off with the concerns about isolation of positive patients. And you go back to the Diamond Princess, rightfully, that congregate settings, crowded areas are going to be a problem, and you saw it coming.

And so my question to you is, it seems like you aren't comfortable with the responses from the Ministry in terms of what they've done to mitigate Wave 2 from this outbreak, because you feel that they're still too crowded, and there isn't a way to isolate these residents?

MS. MEADUS: Yeah. I mean, we're certainly seeing obviously admissions to homes, they're not allowed to admit to three and four bedrooms. So if there is a new admission, the most that can go into a room is two.

Again, this is another one of those unclear areas. So in some areas homes are moving everybody out of those three and four bedrooms. So

there's actually no admissions to the homes, because they're doing it internally, so there's no open beds. As soon as somebody dies, they move people around so that they're only having two to a room. So there's no admissions, so it's creating another problem in the system.

My position is that I think that we don't have the ability in long-term care for the most part to do the proper cohorting and isolating that's necessary during the pandemic. And we're just going to see another wave of deaths unless it's corrected.

And I have to look to the hospital system, you know, we used to have -- and I really hate to say this -- but we used to have TV sanatoriums and stuff, places like that. And I really think that that may be something we have to do is having pandemic, you know, facilities. Whether it's a wing of a hospital or something.

Long-term care homes aren't set up, they're -- you know, especially the older ones -- and by the way, they were supposed to be redeveloping these beds since 2009. But with inaction, frankly, by the government, this has not happened. And there's a whole bunch of reasons I

can discuss at some other time with you, because I do think it's important.

But I just don't see the homes -- I mean, some of the homes through attrition have opened up a little, and I think they are leaving rooms open, and they are getting some funding to allow that, but I don't know that it's sufficient.

COMMISSIONER KITTS: So are you suggesting that there might be -- because Wave 2 is upon us and --

MS. MEADUS: Yes.

COMMISSIONER KITTS: -- you're not confident it's going to be mitigated very much better than Wave 1. Are you suggesting to put up facilities to cohort positive patients in a facility outside of the long-term care home; is that what you're saying?

MS. MEADUS: I think so. That's not my preference, I know people don't want to leave their homes, but I just don't see any other way to protect people. As soon as somebody has COVID positive, if they're a resident, they need not to be in those homes.

COMMISSIONER KITTS: Thank you.

MS. MEADUS: Yeah. That brings me --

MR. WEBB: Just a couple of comments.

COMMISSIONER MARROCCO: Go ahead, sorry I was going to come back to you.

MR. WEBB: Thank you.

First in answer to your question, Commissioner Kitts. I think it is actually, that is one of the answers is to cohort COVID patients outside the long-term care home.

Because if we come back to the fundamental principles, fundamentally long-term care homes are not hospitals or healthcare facilities. Fundamentally, they are a person's home, where older adults and other peoples live congregately with other people in their home as well.

And so, you know, as Ms. Meadus has said, these homes are not equipped to handle COVID. We have seen, sadly, situations where older adults were in long-term care homes with presumed COVID, and told they couldn't go to hospital; and the opposite should be true.

If the person has a highly contagious disease, it's not adequately equipped within the long-term care home, they should be moved to another healthcare facility that is equipped to

handle that.

Additionally, Commissioner Marrocco, you asked a question, which to me as a litigator, turns on the issue of foreseeability.

I think it's telling that when the Canadian Armed Forces reported on their experience in the long-term care homes they visited in Ontario, nothing that was revealed in their report was new or surprising to our staff.

You know, all of these problems are not new problems. They are old problems that are held up under a much more intense light. There's greater pressure brought to bear on the system through COVID than ever before. But the problems that are revealed, are problems that are long known to anyone who works in the system. They've been there at least for the past 25 years that Ms. Meadus and I have worked at the Advocacy Centre for the Elderly.

COMMISSIONER MARROCCO: You hit on it in a way. I'm asking the question, because I'm trying to get a sense of how foreseeable it was. I'm trying to make sure that I don't fall victim to hindsight, if you know what I mean.

MR. WEBB: Yes.

COMMISSIONER MARROCCO: And then I'm trying to place that in a timeline. Because once you know there's a pandemic, because the day before maybe you didn't know that there was going to be a pandemic, until somebody calls it "pandemic".

But then once you know that's going to be, and whether it's a declaration or whether it's the Diamond Princess back in January, that's why I'm asking the questions. I'm just trying to get a sense of that.

MR. WEBB: Certainly when we saw the first range of North American deaths in Washington State that were in an American nursing home, I think all of the alarm bells should have been ringing. Because anybody who has worked in the system would know, would necessarily know that if this highly contagious disease got into Ontario long-term care homes, that it would be disastrous.

MS. MEADUS: And I think that the planning problems come in two different ways. One is, I don't think that when they found out about the pandemic, that proper planning was taking place.

I think anybody looking, who's knowledgeable about long-term care -- you know,

we've heard the Minister say many times, "we were already in a staffing crisis." Well, that's not an excuse. You had to deal with that then. If there was a staffing crisis, how was she fixing it?

But there were a lot of issues and these kind of problems in long-term care, as I indicated before, and that's why I spent some time on that inspection process. Is that what we had in place really wasn't correcting the system.

And if you go back and look at the myriad of reports -- and when I was doing my little bit of research before this, I found a RNAO document which basically is a, just a list -- just a list of different reports, over the last 20 years or something, into long-term care. There is nothing about this.

Like all of the issues that we're talking about, and all the problems we had, a lot of them you couldn't fix in January or February. You couldn't build new homes, and get people out of four bedrooms, but we've been trying to do that since 2009 without a proper plan.

All the plan was, was, "here's some money." Homes weren't picking it up. Frankly, I don't know how they'd do it anyway. In the City of

Toronto where there was 7,000 beds that had to be redeveloped. Where do you put those 7,000 people when you were redeveloping? And the Ministry kept saying, "oh, it's not our problem."

And I think there is a lot of, "it's not our problem". We've seen it in some of the litigation in the defence documents of the Ministry where they've said, this isn't a system, we don't have responsibility.

And I know that is some litigation speak. But I think really, you know, we've seen year after year, there's been more and more things placed in between the government and long-term care, even though they fund and they inspect it.

I believe I had sent to Ida, a document from 1999, which was the -- an inquest into 25 deaths from the flu in a place called --

MR. WEBB: Central Park Lodge.

MS. MEADUS: Yes, thank you. Central Park Lodge. And I mean, you know, you read that and just swap it out and put it, you know, today and it was, you know, very similar kind of issues and problems.

So this is not something that crept up today, that was over 20 years ago.

MR. WEBB: Commissioner Kitts, you've touched on the issue of isolation and the lack of -- how do you put it? Resources, or the presence of crowding in long-term care homes. Just to tie this into the fact that these are long-term issues.

There has been a rebuild program in place for many years, and Ms. Meadus can speak to this, where I can't. But, essentially, it's long been the policy of the Government of Ontario to rebuild long-term care homes by 2025. And the current architectural standard would not have multiple beds in a single room. They rather would have one person in one room, perhaps with a shared bathroom is the basic accommodation.

And for one reason or another, Ms. Meadus could ably speak to, it now looks impossible to meet that goal. And this is due to a lack of central planning and organization of the rebuild program. I'll stop there and if Ms. Meadus could speak to it.

MS. MEADUS: I think we sort of covered I think most of it. We can certainly provide information about that.

I think this is probably a good time

for our break. You said you wanted to take a break.

COMMISSIONER MARROCCO: Yes, if it's convenient.

MS. MEADUS: Yes, I'm going on to another couple of topics.

COMMISSIONER MARROCCO: Before we do that, though, you mentioned the RNAO document.

MS. MEADUS: Yes.

COMMISSIONER MARROCCO: If you have it, it would be interesting to read it.

MS. MEADUS: Yes. I will send that along, for sure.

COMMISSIONER MARROCCO: All right. So we'll take ten minutes and back at 2:20.

-- RECESS TAKEN AT 2:10 --

-- UPON RESUMING AT 2:23 --

MS. MEADUS: Okay. So I have a couple of topics that I wanted to cover that could be -- you know, we could talk for days as you can imagine on all these subjects. We certainly have a lot of expertise, and we certainly can answer any questions you want to ask us after, if you want to meet again, we'd be pleased to do that.

There are two issues I would like to

speak to. One had to do with some of the directives. And specifically with reference to the Advance Care Planning documents, which was contained in Directive No. 3.

So starting on March 30th, the directive stated that -- so this would have been the second version of the directive. And one of the complaints, just sort of a general complaint you may hear throughout, is that there were a lot of directives, guidelines, all these different documents.

There really wasn't a central repository for these things and people really had trouble finding them. Probably the best was the Ontario Hospital Association, but they watched documents -- which I didn't understand since they were public -- but at least you knew what you were looking for. That was a problem, and then also the way things were interpreted.

You'd get the Chief Medical Officer saying something, maybe the Ministry saying something different, the home saying something different, and the local public health office saying yet another thing. So there was a lot of confusion.

So I think that communication piece overall, you know, from the government's perspective, was quite problematic. And then of course with long-term care, there were other issues around communication with residents and families, a lot of problems, which I know you've covered from other places.

So the directive said that homes were to review all Advance Directives. And that was on, like, I believe that was on page 5. So page 5 says that homes were to review all Advance Directives of all residents in long-term care homes.

We then had a guidance document dated April 15th. And that guidance document contained two recommendations with respect to that they call "Advanced -- with a 'D' -- Directives". It is actually "Advance Directives". The first one was to:

> "Review and summarize Advance Directives for all residents as part of community planning with local acute care facility and EMS."

And that was on page 5. And:

> "Communicate with local acute care hospitals regarding outbreak

including number of residents in the facility, and number who may potentially be transferred to hospital if ill, based on Advance Care Directives."

And that was on page 13 of that document.

The problem is that Ontario law does not recognize Advance Directives. When admitted to long-term care, most homes will provide some type of a document to the resident, or family, or substitute decisionmaker. It's often called a "Level of Care Form". If you want to see one, I can certainly send a document.

But I'm actually going to refer you guys to two studies that were done through our office, with some other people with the Law Commission, for a much bigger discussion on it; because we're just going to touch the surface here.

But these documents, generally, if you've never seen them, they usually have five different choices from, "I want everything done to me; take me to a hospital." To, "I don't want anything. I don't want to go to a hospital, I just want comfort measures."

So first of all, only capable individuals can sign any kind of -- or make any kind of future wishes; and that's what these documents really are. They are not consents at all under Our Healthcare Consent Act.

They are not consents, but only the person themselves can make wishes. A substitute decisionmaker has no authority to make wishes on behalf of an incapable person. So, you know, homes were being asked to do something that legally isn't proper. And a substitute decisionmaker can only consent to treatments that are being offered.

These documents -- and frankly, there's not five choices in life, so they're quite problematic from the get-go. They're often signed by substitutes, who don't have authority to sign them, because they're really a statement of wishes about future care. And they're made mandatory. So people are really forced to sign these documents.

They're not well understood, they're usually done out of context. Often it's done by whoever is doing the paperwork on admission. So you might get the bookkeeper asking you to sign these documents.

Even if the document was valid, so even

if a -- and I certainly have a couple of clients who are capable, who have signed them and made them very clear. And I tell them, they don't have to choose the five choices. They can make any choices they want. They can add, subtract, do something else, it doesn't matter.

Even where a capable person signs the document, of course if they continue to be capable, you don't look at the document, you talk to the person as to what they want at that time.

If a person is incapable, those documents do not speak to the health provider, they are not consents. They speak to the substitute, and it's up to the substitute to interpret them.

One of the problems with what was happening, despite -- first of all, you know, most of these documents are signed by either family. And families don't get to sign them, only substitutes under the Healthcare Consent Act, which may be a family member. But they're often signed by people with no authority, whatsoever.

Even if it was a document where the person knew what they were signing, understood, had their wishes known, it speaks to the substitute. And it would be up to the substitute to say,

"hey, does this wish apply to this situation?"

Of course, 99 percent of these documents were created when COVID wasn't a thing. So there was no way that it can be applicable to this situation, because it's a disease that didn't exist. So you can't make a future wish about something that didn't even exist.

What these documents -- what the purpose was, to count up the number of people who have said, "I want to be taken to hospital." And then those people who were substitutes who ticked they didn't want to be taken to hospital; "oh, we don't have to worry about them", and it's just the people who signed.

So they were trying to give numbers to the hospital, but the numbers were meaningless. Should have been meaningless, because we don't know. They weren't relevant, and we don't know what the decision would be at the time.

Pre-COVID, these have been something we've written about a lot, and that's why there's the two Law Commission papers that talk about them. We ran into situations like all the time with respect to these documents.

We advise our clients not to sign them,

since they're not valid documents. Public guardian and trustee as substitutes don't sign them. If they're the substitute decision maker and last resort, the reason they don't sign them is, they're not valid.

And they're often used as consent. So one of the choices, for example, is I don't want antibiotics. Theory is, if you have pneumonia, you don't have antibiotics, and you can slowly die and it's sort of a peaceful way to die.

Well, what happens if you have a UTI, or a tooth abscess. When you said, "I don't want antibiotics"; is that what you really meant? Usually it's not, but these things aren't explained.

We've also had many times where people have not been transported to hospital, or questioned transported to hospital because of these documents.

I had a client who was a non-verbal resident of a long-term care home. A family member came in to see her and discovered -- the family member happened to be a nurse, saw bruising on the leg and realized the person had a broken hip and was in a great deal of pain.

She immediately demanded they contact an ambulance. And they gave her trouble because they said, "Well, four years ago when you admitted your mother, you said no hospitalization."

And she said, "I meant when she was dying, not if she was in pain."

And they said, "Well, we just didn't call you because what was the point."

I've had homes call me where there was a resident who had some kind of a problem, and the administrator called and said, I have a resident, I don't know what to do. They have X, Y, Z, and we think they should probably go to the hospital. But two years ago when they were admitted, they signed this document and it said "no hospitalization".

The first question I asked is, "is the person competent?"

"Oh, yes, they are. They're sitting right here."

And I said, "well, you don't look at the document. What do they want to do?"

"Oh, they want to go to the hospital."

"Then why are you calling me?"

These documents shouldn't be used. It's clear whoever wrote the documents, the

directive and the guidelines did not understand that these are not consents. Couldn't possibly be applicable to the situation. There was no way to know whether people wanted family members to be sent to hospital.

I think we saw this throughout where people were calling us, we're hearing it in the media, they were not being sent to hospital? They were being told, "oh, you signed something, we're not sending you to hospital".

They're being told hospitals didn't want them. Even though hospitals denied saying that, but we know that because it happens all the time.

But to go to documents that aren't even legally valid, and should have never been signed in the first place is really problematic. And I think it created a situation were many people -- we were talking about sending people to hospital and getting them out of homes.

That didn't happen, because the homes simply looked at these documents as the Ministry told them to and said, "oh, this person said no hospitalization, so we're not even going to offer it."

I think that increased the number of people in long-term care who had COVID because it spread it. And I also think that people also got better treatment in hospital. That's not a slam on long-term care. They're not funded, we all know they don't have enough funding. They don't have enough expertise in infection control, and so seems that in many cases people who went to hospital seemed to have a better outcome. That does not mean they were intubated, and that's not what we were suggesting. But they do seem to have gotten better more than a lot of other people.

And even palliative care. Long-term care homes don't do palliative care well. They don't have -- as we know, they didn'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. And so 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.

Yes?

COMMISSIONER KITTS: Can I just ask the question about palliative care. And I guess not that common in hospitals, or not done well.

Do you think that --

MS. MEADUS: Long-term care.

COMMISSIONER KITTS: Sorry, in long-term care. It's kind of similar for hospitals, so...

Do you think that the ask might be that because this is their home, and you know, palliative care is mostly in the home and community. Instead of transferring to hospitals, would you think having palliative care specialists available 24-7, so that palliative care could happen in the long-term care home?

MS. MEADUS: Well, I think in non-COVID times, yes.

I understand that people want to stay in their home. And most people when asked whether they would prefer to die in their own home, and that includes in long-term care, they would say they would; they would want to die in their own home.

If the question was: Do you want to die in your own home, but you might be infecting other people? Because they don't have the ability to prevent that infection from spreading, because they don't have negative, you know, air and all

that sort of thing, I think that's a different question.

So again, I go back to the issue around, it depends on the ability to properly control that infection. Even, you know, at the best of times, I don't think we do that well in long-term care.

COMMISSIONER KITTS: In pre-COVID, is palliative care much better?

MS. MEADUS: No.

COMMISSIONER KITTS: So as a rule, palliative care needs to have a greater presence in long-term care?

MS. MEADUS: Yeah, and it makes no sense. There's a couple of things you would think they would be experts in.

One would be palliative care since the bulk of people who leave long-term care leave because they've died.

And yet we've known for many, many years, and there's been studies and there's been attempts, that palliative care is not well-managed in long-term care, and there's been a lot of complaints. Of course some homes do it well, but overall if you've talked to the hospice and

palliative care group, who I know he's been trying to contact you guys.

COMMISSIONER KITTS: Yeah.

MS. MEADUS: He'll tell you about how long-term care does not do palliative well.

COMMISSIONER KITTS: Yeah.

MS. MEADUS: The other area you would think they would do well in is infection control, because they're required by law to have certain infection control programs.

They have flu outbreaks and gastro outbreaks all the time, and people die. And so you would think this would be an area they're an absolute expert in, and as we found that's not the case. This was not a surprise to us, and we see this, you know, during flu outbreaks and things, and we shake our heads and we hear from our clients and families, telling us about the poor infection control systems; and lack of proper hand washing, and locking away PPE -- which is, by the way still going on. Homes are still locking away these things, there's no access to people. And misuse, not knowing how to use the PPE well.

It sort of boggles my mind that in a place where you've got congregate care, if a

contagious disease does get in, it does spread rapidly. It just boggles your mind that they're not experts in control.

COMMISSIONER KITTS: Thank you.

MS. MEADUS: Sorry. That's sort of what I have to say about the Advance Care issue. And that's an issue that we talk about a lot, and try to do a lot of education about.

But it's clearly not getting to the mark. We have a lot of issues around getting consent to treatment in the long-term care and how staff just don't understand consent to treatment, including Advance Care.

MS. LANE: Should we move to the detention issue?

MS. MEADUS: Yes. So the next one I'm going to talk about is the issue of the detention of 72,000 residents of long-term care homes.

So right from the beginning, the Directive No. 3 stated that residents were not allowed to leave long-term care homes.

That is continued until fairly recently. So at the present time, if a home is not in outbreak, residents are allowed to go out for short absences and potentially overnight absences

as well to visit family, but there's more stringent rules about that.

Just with respect to the rules around absences, visitors, all of that. I know the visitor stuff, you know, the family counsel will probably talk to you about that a lot.

Is that, again, this is an area where we have documents, we have the government coming out and saying things, but they're allowing the homes to make up their own rules. For example, around short absences, people are being told, you can go out on a short absence, but when you come back, you're in isolation for five days.

That's not what the directives say, that's not what the guidance documents say.

They're told that you have to book your absences. That's not what it says.

And so we continue to have this problem where the government is sort of putting up these guidance documents, but they're not actually enforcing what's going on.

So with respect to this detention issue, I guess the first thing you have to understand is that long-term care homes actually don't have any detention authority, they're not

like a psych facility. Even clients who are found incapable, there is no detention authority.

It's really questionable whether or not -- so under the Healthcare Consent Act, there is at present no detention authority. The Long-Term Care Homes Act does not have detention authority either.

There are sections in both of those pieces of legislation which would allow some type of detention, although, I don't think it would apply in this situation. But that they do have sections, but they have never been enacted, so they've been on the books, but never enacted.

So the only authority that long-term care homes have is under the common law in an emergency. So if someone is walking out on the street, going to get hit by a car, they can bring them back.

This is really problematic. I've been pushing since prior to the new legislation in 2010, to get this section, which would protect both the residents and the homes. The homes would know what the parameters were for detention, then the residents would know, and there would be an appeal process which of course you have to have if you're

being detained, there has to be an appeal process.

The government has not passed that, unfortunately. There's been no litigation on that, probably because in most cases where we have residents who are complaining about it, we usually get them undetained fairly quickly, non-COVID.

So sometimes homes have a policy, which is in one of the papers that I'll be sending the bibliography to you. It was another Law Commission report that we did.

We found that every home that we talked to, detained all residents. And if a resident wanted to be able to leave the home on their own, they had to prove that they had the ability to do that.

In fact, the law would be the exact opposite. Everyone is allowed out, unless the home provides proof that they should not be allowed out. That would be the way it should go.

So under the pandemic, what happened was, we had the directive. Now Directive No. 3 is under Section 77.7 of the Health Detection and Promotion Act, and it gives the Chief Medical Officer of Health the authority to issue directives to help practitioners. And it says

that:

"The proposed directives relate to health worker safety protective clothing equipment and advice."

The use of Directive 3 during this pandemic with respect to long-term care and its residents has been overly broad. It has put in sections that I believe are outside the authority of Section 77.7, and this includes both illegal detention, as well as the restrictions on visitors and absences from homes.

That section doesn't give the Chief Medical Officer of Health that kind of authority. If they want to detain, they have to use Section 22 of the Act. And that's what, for example, has been used by the Public Officer of Health in Toronto. That's what they use to say, if you've been exposed, or if you have it, you have to detain for two weeks. That's done under that section.

It is much more restrictive than what these directives have said, which is basically, "we don't care if your home has COVID or not, you can't go out".

So we basically illegally detained 72,000 people for almost six months, with no right

of review. The section doesn't comply with the charter. It's trying to download the rules onto the homes who don't have detention authority.

If they had done it under Section 22, it's much narrower and there would have been a right of review. I think that we can't continue with this. We all understand that almost 2,000 people died. We understand how rampant it became in the long-term care homes. But detaining 72,000 people basically in solitary confinement for six months is not, in my opinion, the proper way of managing this.

I think that there were other ways of doing this. And I think that the government has to really think about how they're going to do this moving forward, because I'm really afraid as we go into a second wave, they're going to do a lockdown again and not allow people out.

And COVID, obviously, had a devastating effect on long-term care homes, but so did detention of people. And the detention and inability to have family members who assisted, have family members visit, on people who have common issues, especially -- and frankly, those without cognitive issues, are even worse. You know, the

effect on their mental health has been absolutely horrendous. And I think this is an area that, you know, really they looked at and said, "we just won't let anybody out and that will protect it".

I guess they could have done that for the rest of society --

COMMISSIONER MARROCCO: Just a second. Commissioner Coke, did you want to ask a question?

COMMISSIONER COKE: Yes. You mentioned there's probably other ways they should have looked at. I'm just wanting to hear you elaborate on what you think they could have done instead.

MS. MEADUS: Well, I think there has to be more than, "we have a pandemic, we're going to lock everybody away". It's very different than what they did with the rest of society.

There were many places in Ontario that didn't even have COVID in the north and stuff. I think that -- I had residents who wanted to go out and were quite willing to do the same kind of precautions that you and I do when we go out, wear masks, use protection, do whatever is needed to do.

Staff are coming and going out of those homes all the time, and that's where the infections are coming in.

If somebody wants to go to somewhere else -- you know, you don't lose your rights just because you live in a long-term care home. And we have to figure out a better way than just detain everybody. We could have prevented it by detaining all of us, too. But we didn't do that.

COMMISSIONER MARROCCO: And I suppose one improvement implied in what you're saying is that you wouldn't have the same policy for Toronto as Kingston, if Kingston has no -- if there's a long-term care facility in Kingston, and Kingston has no cases, then you would be saying the residents there should be free to go out?

MS. MEADUS: Yeah, I think it's a balance. And I think we just -- you know, the system, the government just took away all of those rights of people thinking that was okay. And didn't really consider the fact that they didn't have the legal authority to do that.

Section 22 is much more prescriptive. And that they, you know, had no right of review, they just -- this wasn't -- I think at the beginning, you know, we all kind of went, "well, we're all doing our part". And I think long-term care residents wanted to do their part, too.

But as things went on -- you know, we all stayed home for the most part, I think. Many of us stayed home, unless we were essential workers, we tried to not go out unless we had to. That was not -- that same ability was not allowed for long-term care residents.

MR. WEBB: If I may interject to say non-charter compliant detention has been a longstanding concern of ours in long-term care homes. Because normally we see when someone is detained, there's usually a right of review in some manner.

And we've had detention of long-term care home residents with no prescribed legal standards and no right of review. And, of course, this is another situation where the intent sleight of COVID has just made that problem more abundantly clear.

COMMISSIONER MARROCCO: Could you bring judicial review?

MR. WEBB: I don't have an answer to that immediately at hand. I do know there has been some litigation concerning that, but I am not -- I don't have that fresh in mind, and I am not in a position to comment on it.

COMMISSIONER MARROCCO: All right. And --

MS. MEADUS: I just wanted to comment that I do believe that there are some -- certainly, you know, in non-COVID times, we have -- you have to deal with it sort of on a case by case basis, usually.

The clients that we've had, usually we can get out quite quickly. During COVID, access to people in long-term care, as you know, has been very difficult. Families aren't necessarily who might be substitutes and might assist with cases aren't particularly interested in it.

The couple of clients that I've had -- I had one client who we were going to pursue something and she got out anyway. So we weren't able to pursue it.

MR. WEBB: The type of review we would have in mind is something more akin to the Consenting Capacity Board, where somebody is detained, say, in the mental health factor, in that way they would have an easy and a fast way of review that would not have a lot of barriers to it.

MS. MEADUS: That's what's under the legislation written, but we don't have it right now.

COMMISSIONER MARROCCO: So is there anything else that you wanted to present?

MS. MEADUS: We have lots of other things, I'd say I have pages. But maybe I'll just open, if there's areas that we didn't cover and you think you'd like our perspective on.

COMMISSIONER MARROCCO: I asked my questions as we went along.

Any other questions?

COMMISSIONER COKE: No.

COMMISSIONER MARROCCO: It doesn't sound like it.

Well, to repeat what I said when I started. Thank you, this is very informative. We would be happy to receive -- we'll leave it to your discretion, but some things that we might find interesting, I mentioned the one document that I was interested in particularly. And I just will say, apart from saying thank you, as you may hear from us again.

MS. MEADUS: Anytime.

MR. WEBB: May we purchase a transcript of our submissions to help us?

COMMISSIONER MARROCCO: Of course. It should be ready within a day or so.

MR. WEBB: Thank you very much.

-- Meeting concluded at 2:50 p.m.

REPORTER'S CERTIFICATE

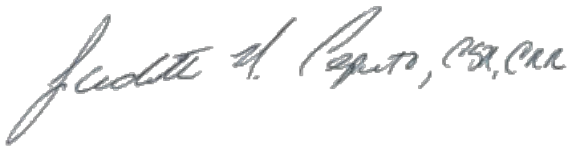
I, JUDITH M. CAPUTO, RPR, CSR, CRR, Certified Shorthand Reporter, certify;

That the foregoing proceedings were taken before me at the time and place therein set forth;

That all remarks made at the time were recorded stenographically by me and were thereafter transcribed;

That the foregoing is a true and correct transcript of my shorthand notes so taken.

Dated this 24th day of September, 2020.



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