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I am the Scientific Director of the longitudinal *Translating Research in Elder Care* applied research program in LTC. My research focuses on quality of care, quality of life and quality of end of life for older adults living in LTC homes, and on LTC workforce quality of work life. I also focuses on moving research to action to support evidence informed policy decisions.

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Opening remarks

In Canada we are fortunate that we have the capacity to call upon the Canadian Armed Forces in crisis. We are thankful that they stepped up to provide care to frail, vulnerable older Canadians in nursing homes during the first wave of the pandemic – going into unfamiliar and besieged care settings, with unfamiliar charges in their care, with little time to prepare. We are grateful that they stabilized parts of the LTC system that had moved into deep crisis, preventing further suffering and unnecessary deaths not from COVID-19 but from the terrible conditions COVID19 was permitted to establish. We are grateful that they fulfilled their duty to report – that those stark and pointed reports riveted the attention of Canadians and our leaders on the unfolding catastrophe.

In Canada over 80% of country COVID deaths have been in LTC, far outpacing any other country in the world. How could this happen? Only by valuing older adults and in particular, older adults with dementia, less. Only by valuing nursing home care less than care in the hospitals and ICUs. Only by discriminating actively and passively against older adults with dementia who live in care homes

Nursing homes or LTC homes have their origins in 17th century Elizabethan poor law – when poor houses and alms houses were created. Why would that matter in the 21st century? Well Elizabethan poor law created the concept of the deserving poor and the undeserving poor whose needs could be ignored.

In this, our second Elizabethan age, amidst the COVID crisis, we see in full display (1) a mindset of discrimination against older adults and (2) the creation of the undeserving ill and needy who we deemed could live acceptably in conditions most of consider intolerable – in a sector profoundly underfunded, understaffed, unmodernized functioning in a patchwork system of regulation, inspection, oversight and accountability.

Some have argued that care homes and their vulnerable residents were used as a human shield to protect the health care system, government, and society. Dying to protect us.

We all knew early (if we were associated with LTC) that things in care homes were bad and could quickly become catastrophically worse – that attention and action favored the young and the hospitals, that decades of neglect and inattention – of managing on the *thinnest of razor edges* had created these conditions. Still when the military reports of COVID conditions in nursing homes came out, we gasped, we wept and for some a smouldering rage began.

I regret that our men and women of the armed services had to step in but I am grateful that they did. As a Canadian I am proud of their work.

For over half a century, reports of abuse, insufficient resources, neglect and so on in LTC have been produced by governments, organizations, unions, and the media. In the last 30 years alone, 80 Canadian reports have been produced at considerable cost, common themes have emerged (many focusing on the workforce and working conditions) and little was done – even when nearly 2 dozen seniors burned to death in Quebec or when Canada's most prolific serial killer emerged in Ontario nursing homes.

Our governments and our society at large have known or should have known what has been happening – for example, in the Royal Society of Canada report on *Restoring Trust: COVID-19 and the Future of LTC* we identified over 150 media reports in the last 10 years alone, in nursing homes in this country.

Experts, the public and the media have not been able to capture and hold enough attention for action. It took reports from our Military to spur action, and thank god those reports emerged but – we need to ask *why is that*? *and what happens beyond the duty to report?*

These military reports from Quebec and Ontario, while they did galvanize attention and action, are however unlikely create lasting impact on the Canadian LTC system because the root causes of the situation were not addressed.

At the heart of the LTC and workforce challenges (in addition to ageism) is undisguised sexism. Caring for the elderly in LTC is considered "just women's work" after all *how hard can it be to feed and toilet people – pretty much anybody can do it*. **This is of course patently false**. Caring for an increasingly complex population of the frail and vulnerable elderly is complex, demanding and skilled work. **It is honorable work**.

It is delivered by personal support workers of whom over 90% are older women, half of them immigrants. Paid the poorest of any workers in our health system, often without benefits or the security of a FT position, with poor preparation and little to no ongoing education. Treated as if they have little to offer beyond basic care and with insufficient support by a team of professionals. Our modern day workforce of the 17th century Elizabethan poor houses.

Before I end I want to speak briefly to issues of mental health among the military and civilian workers under COID conditions.

I am pleased to see support for the mental health and well-being of military personnel who were on a temporary assignment. We must turn to the mental health and well-being of the LTC staff who have no such support and who are not there temporarily.

Early prevalence estimates of moderate-to-severe symptoms of anxiety and/or PTSD among LTC workers are as high as 43%, with mild symptoms reaching 87% (Italy; Riello et al., 2020)

LTC staff in Spain working with COVID positive residents report high levels of secondary traumatic stress from work presssures, high exposure to suffering, lack of PPE, and minimal supervisor support (Blanco-Donoso, 2020).

In Ontario, health care workers have been disproportionately infected, making up nearly 20%of COVID cases by late July 2020, significantly more than the estimated global rate of 14% for health care workers.

The mental health issues experienced by personnel working on the front lines will not be gone by this Christmas, by Easter, or by next Christmas – many of them will linger for years and decades. But they will be less devastating if we act now to support personnel on the front lines in care homes and elsewhere, if we act to support families who have suffered and if we support the mental health needs of those older adults in care homes who *have* survived.

We do not need more commissions, or inquiries or reports. We do need a modern day equivalent of a **Marshall Plan** to accomplish a root and branch overhaul of the LTC system.

These places where we have placed and forgotten our elders – these are homes, not chronic hospitals or poor houses. Homes charged with delivering quality care – in the service of a good quality of life, a good end of life and a good death. Even with dementia these are achievable ends.

Conclusion

I want to thank the Standing Committee for inviting me to speak. But what now? is there a role for military beyond reporting? We are all, when we are our best selves, accountable for each other, how do we ensure action? I am grateful for the work and care of CAF members in LTC, but the LTC system into which we place our parents, siblings, spouses and long term companions has endured over 50 years of eroding funding and neglect, because of undisguised discrimination toward the old and toward women and the work of caregiving.

COVID-19 conditions in nursing homes have caused excess death, indescribable suffering and operationalized the deepest existential fear that many Canadians have – the fear of dying alone.

Just as Passchendaele has come to symbolize the senseless slaughter and unimaginable suffering of Canadians who served, COVID-19 in nursing homes has come to symbolize unnecessary death and senseless suffering among those who built Canadian society, among those who once served, whether in the armed services or in regular, everyday civilian life to make this one of the most desirable countries in the world in which to live.

If we do nothing, then once the vaccines are administered, once COVID-19 has passed, once our memories fade, once we can forget again about the deserving old in nursing homes, once new priorities take centre stage – nursing homes will return to pre COVID conditions, we will not have learned, and nothing will have changed – not really. Until the next event.

COVID-19 is a global tragedy but if we work together to address both our immediate needs and a truly rot and branch overhaul then the sacrifice (including the sacrifices of the CAF) will mean something. Something good and honorable.

A LTC home (a nursing home) is not a chronic hospital. It is a home and for most of its inhabitants it will be their last home. The older adults in these homes require both health (quality of care) and social (quality of life) care. They are old, half over the age of 85, frail, with many co-existing diseases; about 80% of them have dementia, itself an age related, life limiting disease. Their care has been and is increasingly complex and demanding.

Yet over half of Canadians surveyed say that they would rather die than go to a nursing home. How is it that we have let it come to this in Canada – a high income, high quality of life nation? How have we let 85% of Canada's COVID-19 deaths occur in nursing homes – the highest rate of any country in the world.

We have thus far failed in our duty to care for our most vulnerable citizens. With particular savagery in some places in Canada. We should each of us, stop and recall each day – that we, in the worst of the first pandemic wave in some parts of Canada, left old people to die in their own excrement, without water, without food, without human contact. Old, vulnerable Canadians. Somebody's parent or grandparent, husband or wife, brother or sister, friend or long time companion.

This is everyone's problem. Not just a problem in Ontario and Quebec. Every one of the some 1800 nursing homes in Canada is but one step away from an outbreak of COVID-19. Witness the tragedy unfolding in Campellton, New Brunswick. One physician with COVID-19 who gave it to one patient who then went to work in their nursing home, and gave it to 3 staff and 15 seniors, one of whom has died – so far. One step away, that is all any nursing home, in any province or territory is.

It is complacency and non-malevolent neglect; it is our attitudes toward the old and infirm; it is our attitudes toward the work of caregiving – the purview of women; it is our belief that anyone can care for an old person with dementia – these got us precisely where we are today. It is also our baffling belief that we could manage a system as complex as the LTC sector without decent data. Something more akin to using a Ouija board than an evidence informed approach. *In the 21st century*.

Blaming is not useful. The task now is to solve the immediate problems, and then turn sharply to the medium and longer term problems. Or this will assuredly happen again.

Not because we do not know what to do. I can cite 100 reports (literally) gathering dust on shelves. I can cite thousands of research papers, offering solutions to various of the many challenges. I can personally cite you over 10,000 interviews my own research team has done with direct care staff. They tell us they are under duress, inadequately prepared, that they miss and rush essential care – because there is not enough staff and not enough time.

What needs to happen?

1. We must ensure every LTC home in Canada is ready for the possibility of a second wave
2. We must continue to fix the worst of the workforce conditions: pay, benefits, working in multiple sites
3. We must ensure LTC homes have the equipment and resources to "test and trace" all residents and staff; to screen all workers and visitors; to screen all families; to ensure all have proper PPE and training in infection control
4. We must help women workers whose children are out of school and whose own aging parents may need care – with innovative strategies for child care and for respite
5. We must treat families like families – not visitors
6. We must assess the impact of "one-site work" policies to make sure there are no unintended consequences
7. We must ensure competent management and leadership in all LTC homes
8. We must figure out how to deploy available workers if a LTC home is crippled by staff who are sick themselves
9. We must have data – for heaven's sake – we need to get good data, so that we can manage the LTC sector properly

What does not need to happen?

1. Another commission, inquiry, report, study – I can point you to 80 reports in the last 30 years, done in Canada at an extremely conservative estimate of 24M that all say essentially the same thing we – point to the same solutions time after time
2. We must not favor acute care over LTC
3. We mustn't engage in unrealistic thinking – that this is easy and will not take resources. It is hard work and of course it will take resources, but it won't bankrupt the country
4. We cannot engage in endless acrimonious debates over federal vs. provincial jurisdictions

Do any of us believe that the old person lying in their own excrement, thirsty, in pain, alone and afraid as they died wondered whose *jurisdiction* it was to help?

Thank you.

Operation Laser – Canadian Armed Forces (CAF) in nursing homes

First some facts from the previous testimony (document review from Melissa)

- 729 personnel provided front line support in LTC facilities, 393 were women, you can link into the % of women who live and work in LTC.
- 55 members serving in LTC facilities got COVID, no hospitalizations were necessary.
- The leadership summarized the Report observations as "patient & staff safety considerations:
    - Noted all facilities were different
    - Some had non-adherence to policies related to infection control
    - Some had inadequate staff training and supplies
    - Some had deficiencies in infrastructure
    - Some had concerns over standards of care
- There is a CAF mental health program called "The Road to Mental Readiness" that helps personnel prepare for deployment. Apparently, there were services tailored to the specific needs of troops going into LTC. Social workers and Chaplains were made available during deployment. This program also offered Post Deployment services

Carole's Comments

It will be very important to be positive about the military response. The MP's were all effusive in their praise for their service in LTC, so

- Begin with stating how fortunate we are in Canada to have the CAF willing and able to serve the LTC homes in crisis. Express your gratitude also for them stepping up no only to provide assistant to the most vulnerable population during the pandemic but also in fulfilling their duty to report.
- For over half a century (50 years) reports of abuse, neglect and so on in LTC have been written, seen in media - governments and society have known or should have known what has been happening (here use the list of media articles) in nursing homes in this country.
- Experts and the media have not been able to get enough attention for action. It took reports from the Military to spur action, and thankfully they did but – as a society we need to ask why is that? and what happens beyond the duty to report?

Military Reports

- Described the circumstances they encountered, and did it well. They did have an impact in catalyzing action, however that action in the two provinces Quebec and Ontario may not have the lasting impact on the LTC system as the root causes were not included in such a report. Ageism and sexism discussion can go here. Value in a life lived …….
- Go into the RSC report and stress that more studies are not needed, action is needed, then the recommendations
- **Add in Eric's paper!**
- Come back to the military report summarizing the issues as patient and staff safety, but include Quality of life and work
- Then go into the sexism part and the interesting issues around women, value of women's work
- Say the military reports become much more powerful when they are considered within the health and social system context – they describe the effects of decades of ageism and sexism on those who live and work in LTC

Mental Health

- I think it is worth mentioning that you are pleased to see the support for the mental health and well-being of military personnel who were on a temporary assignment, then consider the mental health and well-being of the LTC staff who have no such support and who are not there temporarily.

    - Early prevalence estimates of moderate-to-severe symptoms of anxiety and/or PTSD among LTC workers are as high as 43%, with mild symptoms reaching 87% (Italy; Riello et al., 2020)
    - LTC staff in Spain working with COVID positive residents report high levels of secondary traumatic stress explained largely by social pressure from work, high exposure to suffer ing, lack of PPE, and minimal supervisor support (Blanco-Donoso, 2020).
    - In Ontario, HCWs have been disproportionately infected, making up nearly 20 percent of cases by late July 2020 which is a significantly higher rate than the estimated global rate for HCW infection at 14 percent.

- Preparing the CAF staff for deployment in LTC is important, and if you can help, offer to assist in the preparation if any future such deployments, this may help prepare the CAF staff for what they will be facing. You can

describe the systemic issues, describe the workforce and the resident population
- Make the point that this is a “home” not a hospital and the significant differences between the two – the link here is the mental health and well-being of residents and families and perhaps the information about the indirect Covid-19 related deaths (Washington Post article)

Conclusion
- In addition to thanking them for the invitation, ask what now? What is the role of CAF beyond reporting? We are all accountable for each other, how do we ensure action happens?
- You are so very grateful for the CAF members work and their support for LTC, but we have endured 50 years of eroding funding and neglect, due to ageism and sexism – how can we as a country move forward? These members have fresh eyes and first-hand experience, is that what it takes?