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STANDING COMMITTEE

ON

HEALTH

Tuesday, January 12, 2021

Via Video Conference

Long-term Care

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STANDING COMMITTEE ON HEALTH

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[Brendan Maguire replaced Keith Irving]
[Hon. Tony Ince replaced Hon. Margaret Miller]

In Attendance:

Judy Kavanagh
Legislative Committee Clerk

Gordon Hebb
Chief Legislative Counsel

WITNESSES

Department of Health and Wellness

Dr. Kevin Orrell, Deputy Minister
Vicki Elliott-Lopez, Senior Director, Continuing Care

Nova Scotia Health Authority

Susan Stevens, Senior Director, Continuing Care

Nova Scotia Government and General Employees Union

Jason MacLean, President
Lynette Johnson, Employee Relations Officer for Health Care

Nursing Homes of Nova Scotia Association

Michele Lowe, Managing Director

Canadian Union of Public Employees

Govind Rao, Atlantic Region Research Representative

Nova Scotia Nurses' Union

Janet Hazelton, President

Unifor

Linda MacNeil, Atlantic Regional Director

House of Assembly
Nova Scotia

HALIFAX, TUESDAY, JANUARY 12, 2021

STANDING COMMITTEE ON HEALTH

1:00 P.M.

CHAIR
Ben Jessome

VICE-CHAIR
Keith Irving

THE CHAIR: I call the meeting of the Health Committee to order on this Tuesday, January 12th. Folks, thank you all for your time this afternoon. My name is Ben Jessome, I'm the MLA for Hammonds Plains-Lucasville, and I'm going to be your Chair for the day.

Today we're going to hear from a variety of representatives from different organizations on the subject of long-term care. I'll allow the guests to introduce themselves in a moment here.

First, presenters and members, we should all make an effort to keep the videos on whenever possible just to ensure that we know you're there. Mr. Maguire is having some technical difficulties, so we'll cut him some slack this time around.

If you have your phone nearby or another device that might possibly interrupt the meeting, please make an effort to put that on silent or vibrate. If for some reason you need to communicate with myself or Legislative Counsel or legislative staff, I believe that you would have received the agenda with the phone numbers for their respective offices at the top.

At this point I think we'll just go ahead with some introductions from our members. We'll begin with our friends from the New Democratic Party with Ms. Leblanc.

[The committee members introduced themselves.]

THE CHAIR: Without further ado, I will move to our guests representing long-term care here in the province. Why don't we begin with Deputy Orrell?

DR. KEVIN ORRELL: Good afternoon, Mr. Chair and members of the committee. Thank you for the opportunity to join you today. I'm Kevin Orrell, Deputy Minister of Health and Wellness. I have with me from the department Vicki Elliott-Lopez, our Senior Executive Director of Continuing Care. I'll say a few words and then look forward to the discussion.

We all want to know our loved ones are getting the care they need and deserve from skilled professionals in a safe environment. Given our population and demographics, providing this care to all Nova Scotians who need it is no small feat. We need the physical places for people to live and we need skilled, compassionate people providing day-to-day care. This is why we have been acting on all of the recommendations from the expert advisory panel on long-term care and it is why we work with many partners across the long-term care and health care sectors, including those who are with us today.

Equally important is ensuring the support and safety of those working in long-term care. We continue to implement the Workplace Safety Action Plan and we are seeing positive results.

The first wave of the COVID-19 pandemic had a disproportionate impact on older Nova Scotians and on our long-term care sector specifically. The risk was highest in long-term care and we took early and aggressive action to keep COVID-19 out of our facilities. We made big changes very quickly. We acknowledged that this was difficult for staff and for volunteers, and for residents and families. I have no doubt that those measures saved many lives.

Advice continued to shift as we learned more about the virus and we adapted our response to meet the changing landscape. Health care staff and the unions that represent them worked with employers and government to meet the unique challenges we faced. I am proud to say that we faced them together. Health care workers stepped up and we thank them for the important work that they do. While we didn't always agree, we ultimately put differences aside to ensure Nova Scotians' needs were met.

Nova Scotia has fared generally well throughout the pandemic to date. It hasn't been easy, but we have shown our collective resolve in how we pulled together to keep one another safe. The pandemic has highlighted the need for urgent change in how we provide long-term care. We know there are staffing challenges in our facilities. We know we have

infrastructure that is aging quickly and we know we need more beds. It was an urgent call to action - one answered by government, the sector, staff, families, and communities.

Together, through the collaboration with our partners, we have created new rapid response teams to support providers in the event of an outbreak; opened new regional care unit sites to allow COVID-19-positive residents to recover away from others; started routine asymptomatic testing for staff, volunteers, and caregivers; developed a staff deployment model to meet the needs of in-house and publicly funded facilities; hired more staff, invested in capital, and provided more PPE for better infection prevention and control; and we have completed all of the IPAC and Northwood recommendations. We are proud of the work that we've done together to improve the quality of care and prepare for subsequent waves of COVID-19.

The challenges Nova Scotia faces in delivering long-term care are not unique, but others are looking to Nova Scotia for best practices. We continue to draw on the advice and expertise of our provincial experts, as well as others from around the globe. We will continue to listen to those experts, and to residents and families, and we will continue to work with our many partners, present company included, on new approaches and new models of care, ones that put residents and families first.

Together with our partners and stakeholders, we have accomplished a great deal and we should be proud of that. Thank you for the opportunity to join you here today, and I look forward to hearing from the other witnesses.

THE CHAIR: Thank you, deputy. Welcome, Ms. Elliott-Lopez. Let's move to Nova Scotia Health - Ms. Stevens, please.

SUSAN STEVENS: Good afternoon, everyone. I'm Susan Stevens, and I'm the Senior Director of Continuing Care with Nova Scotia Health Authority. I'm very pleased to be with you today to hear from you and to share information that I hope you and others will find helpful.

Every year, more than 40,000 Nova Scotians receive care, services, and support from Continuing Care. This includes a wide range of programs and services that help people live safely in a place they call home. Nova Scotia Health Authority is responsible for intake, assessment, placement, care coordination, and facilitation of these programs. We also deliver some home care nursing and long-term care services directly.

Today there are over 17,000 individuals across the province in our home care program. As we speak, many of them are receiving home support or nursing services in their homes, like a bath, help with meals, administration of medication, wound care, or a much-needed break for a devoted caregiver. Sometimes people need more care and support than can be provided at home, and long-term care is needed. Today, more than 7,400 Nova Scotians will receive care and support in a long-term care facility licensed and funded by the Department of Health and Wellness.

The pandemic has had a significant impact on the Continuing Care sector and on the individuals and families who rely on these programs and services. We are seeing challenges we have never faced before. It takes all of us working together to ensure people receive the care and support they need where and when they need it. I want to thank our partners, the Department of Health & Wellness, continuing care providers, unions, provider associations, our community-based organizations and their volunteers, as well as the individuals and families that we serve.

During wave one, we collaborated with the Department of Health & Wellness and long-term care providers, unions, and associations to help prevent spread and respond to the outbreaks in long-term care. We provided our support, our resources, and our expertise. We've incorporated the lessons learned from these experiences into our planning in our organization and across the health system. Our new knowledge and experiences are serving us well as we make our way through wave two.

We are grateful to the Department of Health and Wellness for the support and the resources to expand our Infection Prevention and Control program, our Occupational Health, Safety & Wellness program, and our emergency planning programs and services to better support our partners in long-term care. We've established Regional Care Units to provide centralized care for residents who test positive for COVID-19, and our deployment centres - originally set up to move staff around within Nova Scotia Health Authority to respond to the demands of the pandemic - have been resourced to provide support to nursing homes who have staffing shortages due to a COVID-19 outbreak.

We continue to work closely with the Department of Health and Wellness and providers to support access and flow across the health system. This at times has been very challenging, and I want to acknowledge our collective efforts which have enabled over 1,600 people to move into long-term care since March 2020.

We don't know what the coming months will bring, but I can assure the many families and individuals who depend on us - and all of you - that we will continue to work with our partners to support them, to problem solve, to find new and creative ways to provide the safe, competent and compassionate care that they need. Our IPAC program, our Occupational Health, Safety & Wellness program, and our recent partnership with the Department of Health and Wellness, Northwood, and a local business to establish a community transition unit here in Central Zone are just a few examples.

[1:15 p.m.]

The pandemic and other events over the past 10 months have challenged us in ways we never could have imagined. Health care workers in this province showed up for work every day and did what they do best: they provided kind, competent, and compassionate care. For that, I and so many others are grateful. I look forward to our discussion.

THE CHAIR: Thank you. Now on to the NSGEU. We are joined by Mr. Jason MacLean and Lynette Johnson.

JASON MACLEAN: Good afternoon and thank you for having us here. I'm Jason MacLean, President of the Nova Scotia Government and General Employees Union. With me is our Healthcare Acute and Community Servicing Coordinator, Lynette Johnson.

As President of NSGEU and Vice-President of the Nova Scotia Federation of Labour, I proudly represent thousands of people working in the Continuing Care sector.

Many work in long-term care facilities throughout this province. Just as the deputy minister said, the pandemic has exposed the weaknesses in the system. Interestingly enough, we actually represent none of the workers at the Northwood Halifax campus, but many of our members were forced to go to work there during the first wave of COVID-19, when the virus was ravaging through the facility.

What happened at Northwood was a tragedy, no doubt, but it was preventable. To be clear, the staff at Northwood are not to blame for what happened there. I believe the government is. For years, they have ignored cries of workers and the unions who represent them, trying to call attention to the crisis in the sector, all the while cutting long-term care budgets.

At the outset of this pandemic, we tried to raise critical concerns of front-line workers. Not only did the government ignore us, they accused us of fearmongering and hyperbole. Then 53 people passed away.

Systemic underfunding is the root cause of what was wrong with our long-term care sector. We have a government that has been fixated for eight years on balancing their budget at any cost. Now we can clearly see the true cost of what that balanced budget was.

In our report *Neglecting Northwood*, we clearly outlined the systemic problems that came to light during COVID-19, including the fact that management from Northwood approached this government for three consecutive years asking for funding to modernize their facility to make it safer for residents and staff. Those requests were denied. Make no mistake: what happened at Northwood could have happened at just about any long-term care facility in this province, and it still could.

Because we still face systemic issues that have been raised by workers in this sector for a very long time, band-aid solutions like providing bursaries and creating a new lower-pay position in the sector are not going to solve the problem. In short, we need more trained and qualified staff to work in this sector. They need to want to work in this sector.

The work that they do is hard work. It's physical. It's incredibly stressful and it's certainly not glamorous. They make approximately $18 per hour for their efforts. In some

communities, they need to work in multiple facilities to put together enough to make a living and support their families.

In other areas, they are so understaffed that they cannot get vacation or time off approved. The sector needs to be completely reformed so we can actually keep people in this occupation. In many ways, government reaction to long-term care through the pandemic was simply indicative of how abused the sector is in normal times. It is an afterthought.

Our seniors and our workers deserve much better. Long-term care and home care must be thought of as part of our overall public health care system. Our government needs to take full responsibility for what happened at Northwood and invest in reforming this system. If they truly want to ensure Nova Scotians are protected, they will have to do that.

Thank you for having us here today. I believe our members are the subject matter experts and we're always available to share and to make this sector safer and enjoyable for all.

THE CHAIR: Thank you, Mr. MacLean. Moving now to the Nursing Homes of Nova Scotia Association with Ms. Lowe.

MICHELE LOWE: Thank you for inviting me to present on behalf of 85 per cent of all the nursing homes in Nova Scotia that our association represents. In July 2020, our collective group launched a position paper called *Enough Talk*. I know that was part of the materials to read. The significance of the title cannot be lost on anyone in this sector. There have been numerous calls to action with research papers, ministerial reviews, advocacy reports all demanding investments in long-term care.

What that lack of investment has failed to do, COVID-19 has certainly exposed. Many administrators describe the system as teetering on the edge for years. We do not have the luxury of time. We know that in 8 to 10 years, we will see a significant surge in the need for long-term care beds, and less than that in terms of the specialized support that will be required for Nova Scotians who have been diagnosed with dementia.

There are five priority areas that we have identified within this report: creating a vision for long-term care in Nova Scotia; investing in our workforce; establishing a multi-year infrastructure plan; revising the existing funding models; and re-assessing the timelines of long-term care panel recommendations.

One of the key values of our association is to advocate for change, but also to show up with solutions. We strongly believe that we have strategies for each one of these key priorities that can support the transformative change that we need to see here in Nova Scotia. For example, we have partnered with Dalhousie University to explore the development of a long-term care administrator and leadership program to support new administrators entering our sector. This non-credit certificate program will help to support

the succession planning efforts that are already under way across the province, as many of our administrators are preparing for retirement within the next five years.

We have also been working with the business community to identify sustainable building solutions to support nursing homes that require either replacement or infrastructure investments that will bring dignity to the elders they serve. These are just a few of our efforts.

Many of us believe that we have everything we need to create world-class care here in Nova Scotia. We have visionary leaders in our sector, a caring and compassionate workforce, an academic community applying ground-breaking research, world-class experts here in our own backyard, and a business community that is committed to creating innovative solutions that many of our members are already adopting.

I look forward to today's conversation. Again, thank you for the invitation.

THE CHAIR: Thank you kindly, Ms. Lowe. We're moving now to the Canadian Union of Public Employees. Mr. Rao.

Excuse me, Mr. Rao. We'll have to come back to you, maybe give you a moment to troubleshoot. We'll move on to the Nova Scotia Nurses' Union with Ms. Hazelton, please.

JANET HAZELTON: Good afternoon, everyone. My name is Janet Hazelton and I'm the President of the Nova Scotia Nurses' Union. We represent about 7,800 nurses working and living in Nova Scotia, including about 1,100 who work in the long-term care facilities across this province. We represent 95 per cent of the long-term care facilities. We have nurses working in 95 per cent of those facilities.

The Nova Scotia Nurses' Union has always been and continues to be a staunch advocate for the Nova Scotia long-term care workers and residents. COVID-19 continues to highlight long-term care issues across this country, offering us a continuous warning of what we are diligently working to prevent. So far, COVID-19 has claimed the lives of one out of five residents living in long-term care in this country. That is shameful.

Nova Scotia has largely been spared from long-term care outbreaks during the second wave of the pandemic. However, we cannot lose sight of the fact that we lost 53 residents in Northwood - that is very, very sad - as well as 10 others from this horrendous disease.

However, even within the Atlantic bubble, even through the second wave, we see very clearly how vulnerable our population is. We see that looking no farther than right next door in New Brunswick. We don't need to look to Ontario to see what could happen if we let up our guard.

As a union that represents the registered nurses at Northwood Manor, we welcome the opportunity to provide feedback to the Northwood Quality-improvement Review Committee to ensure the nursing perspective was included in the report's recommendations. Many of the goals of the Nova Scotia Nurses' Union were aligned with what was proposed and what recommendations came out of this report, especially the recommended funding of a standard minimum number of care hours.

We urged government to act on the recommendations in a timely manner. We were very pleased to see that the Department of Health and Wellness conducted an overall evaluation of the long-term care sector's response to the first wave. The lessons learned highlighted the need for additional resources even beyond the duration of the pandemic.

Keeping the virus at bay has been our best defence, but we know what can happen if it does enter a facility. A relatively low COVID-19 case count has left our revised long-term care response largely untested. Nova Scotia's long-term care sector was in dire need of changes long before the pandemic - changes that likely would have improved how we fared throughout the first wave.

In 2015, many of you may have seen our report *Broken Homes, Nurses Speak Out on the State of Long-term Care in Nova Scotia and Offer Solutions for a Sustainable Future.* We were reporting on the conditions in long-term care well before 2015, but we got it documented and it was research-based evidence, and we came out with many recommendations on how to improve long-term care for the residents of Nova Scotia. Unfortunately, many of them have not been followed to date.

To properly staff long-term care facilities, we need to increase the number of care hours to 4.1 hours per resident per day - a staffing ratio that is well-established in long-term care literature. Experts recommend that registered nurses and licensed practical nurses should provide a combined 1.3 hours of care per resident. When we stop and think about that, 4.1 hours of care to be taken in 24 hours to care for a very vulnerable population, many of whom cannot care for themselves or they wouldn't be there - that is not a lot.

We also say there needs to be 1.3 hours of licensed care. We need to make sure that these residents have licensed practical nurses or registered nurses actually seeing them and assessing them at least every other day. That is not possible with the staffing levels we have for licensed staff today.

We also had another report commissioned by Dr. Charlene Harrington, and that was in June 2020. She talks about the evidence around the 4.1 hours of care as well. I'm not sure - as a leader in this space - why we need to keep saying it over and over and over again. We had an expert panel come out a couple of years ago that talked about how there wasn't enough evidence to support 4.1 hours of care. That is untrue. There is a lot of evidence.

To Jason's point, we shouldn't even need the scientific evidence. Just walk in any long-term care facility in this province and ask the experts - the ones who are at the bedside giving the care or the licensed practical nurse or the registered nurse who hasn't had an opportunity to see a resident today because they're just that busy.

We need a new Homes for Special Care Act. This has not been revised since 1977. Think about that. We need hours baked into legislation so that everybody is getting the same amount of care regardless of who runs their home. Whether it's for profit, whether it's the community, it doesn't matter - it's baked into the Act so that we don't get into an Ontario situation where some people were taking staffing money and using it for other things.

[1:30 p.m.]

We're asking that we get a new long-term care Act that bakes in staffing levels. That's very, very important. It cannot be portable. We can't allow people to decide what they're going to spend their money on. To date, it is not portable. Staffing is not portable in this province, and it needs to remain that way so that we're not having administrators and others - not to say that they would, but you can't have it allowed that we're going to take this money and apply it to this. If it's for staffing, it's for staffing. If it's for RNs, it's for RNs. If it's for LPNs, and if it's continuing care assistants, it's for CCAs. We have to make sure people are held accountable to spend the money - taxpayers' money - on what it is we want, and the evidence shows 4.1 hours of care is what's absolutely needed.

The Ocean View Continuing Care Centre, a few years, ago had their 50th anniversary. I had the pleasure to go out to the barbecue to celebrate with the people I represent, as well as the residents. They have a humungous parking lot in the back. So I said to the administrator, isn't this great? Look at all the parking you have for your staff. He said, Janet, that's not for the staff. When we built this place, that was for the residents, many of whom had their own vehicles. They were driving to appointments. They were driving themselves to church. There's not - well, there might be one - but there are fewer than 10 people in long-term care today, I can assure you, that have a valid driver's licence and are driving a motor vehicle. And yet our staffing is the same.

It doesn't take much of an imagination to understand that people coming into our long-term care facilities today are much more compromised, they have lots and lots of cognitive issues, lots of physical issues, but they have the same amount of staff caring for them. That is a shame, and that is why we're in the mess that we were in across this country. Not just in Nova Scotia, but you just need to look to Ontario to see how desperate it was in their long-term care.

We have an obligation as Nova Scotians to step up and do right by our seniors. I can, again, almost guarantee you, there's not a child at the IWK Health Centre that's waiting two hours or an hour and a half to get fed. That wouldn't happen with our children, and it shouldn't happen with our seniors. They deserve our respect, they deserve our care,

and we need to step up as Nova Scotians and say it's time, and if we have to pay a little more, then so be it.

You can tell how passionate I am about this. I've been talking about this since I became president, and quite frankly, I'm getting a little tired of repeating myself over and over and over again. Not for two years, not for four years, for 25 years almost I've been doing this job. I came in talking about this, and I do not want to retire talking about this. Let's step up as Nova Scotians and make sure that this doesn't happen.

It's got nothing to do with COVID. It's more about dignity, respect, proper care for the seniors in our long-term care facilities. They deserve it, and we need to give it to them. Thank you very much.

THE CHAIR: Thank you, Ms. Hazelton. Mr. Rao.

GOVIND RAO: I apologize for the technical difficulties. I'm here today representing 18,000 CUPE members in the province of Nova Scotia, 5,700 of whom work directly in long-term care. I think that the solution to the long-term care crisis is quite simple. It includes three parts: the first is improving recruitment and retention; the second is improving staffing levels; and the third is making long-term care public.

First, on the issue of recruitment and retention, all the studies show that quality of care for residents rests squarely on the quality of the jobs in the sector. For example, the main quality of jobs, we'd have to say, is pay. The top pay rate for a continuing care assistant at Saint Vincent's Nursing Home in Halifax in 2020 is $18.96 an hour. This is $2.84 less than what the Canadian Centre for Policy Alternatives calculated is the living wage for Halifax. Since 2013, after inflation has been factored in, this has meant that the same worker has experienced an over two per cent pay cut, taking home $750 a year less.

Our members, as we've heard from other witnesses, are often short staffed, they're mandated to work overtime. They can't often leave their workplace to pick up their children after work because there isn't another worker there to replace them. They're denied vacation leave to attend important family events. Do we really need to ask why we can't attract and retain workers to a sector that pays you less the longer you work in it, doesn't grant vacation time and condemns you to live in poverty?

This government has set the table for the current crisis. The solution is not the creation of yet another unskilled CCA that is paid at a lower rate.

The second solution is, like we heard from Sister Hazelton on the issue of staffing levels, we need a 4.1 hours per resident day standard of care.

In January 2020, CUPE members who work at Glen Haven Manor in New Glasgow decided to demonstrate for everyone what actually a 4.1 staffing level looks like. They came in on their day off to bring the resident staff ratio up from the funded level of 2.45 to

4.1. What happened? Well, suddenly, staff had the time to talk to residents, to curl some of their hair. There were no falls during this period and no behavioural incidents in terms of our members and workers being beaten.

What I found most telling about this example and this overstaffing exercise was that one member told us that it was the first time in memory that she did not have to cry in her car for 10 minutes before being able to even drive home.

The final solution is that we must make long-term care public. We don't accept the idea that someone can walk in with millions of dollars and start up a private hospital in our province. Why do we think that it's morally acceptable to profit from our most vulnerable residents in long-term care? Every public dollar spent in Nova Scotia should go to care, not to pad profit lines.

Thank you for your time. I'm very happy to expand on any of these points in the question period.

THE CHAIR: Thank you. Finally, we have our friend from Unifor, Linda MacNeil.

LINDA MACNEIL: My name is Linda MacNeil. I'm the Atlantic Regional Director for Unifor. Unifor represents about 2,000 members in the long-term care sector in the province of Nova Scotia. That would be for about 23 homes, ranging from areas from Lunenburg to northern Cape Breton.

I know there has been some resource material that was online that you have access to. Part of that is our submission that was given to the expert panel back in November 2018. I won't regurgitate a lot of that, but there were three key points to that. This is often going to be repetitive when you're talking from the health care unions because we all are experiencing the same thing.

The three main recommendations we had were the funding and the staffing, recruitment, and let's not forget the retention, and the implementation and the accountability of the report. I do want to touch on the recruitment and retention piece. As Jason MacLean had mentioned, there was the reinstatement of the bursary, but at the end of the day, you may be at this point recruiting more CCAs, but without the data that we have been asking for of tracking what happens to the graduates after that, that is an issue.

There is a lot of turnover in many facilities. They graduate, they come into the workplace, and they see how stressful it is. They see the lack of staff, the lack of appreciation for the most part, also the working conditions as far as the infrastructure. We've had cases of members last Summer - and yes, the temperatures were high at that point, but a temperature of 35 degrees within a facility of residents almost passing out. The infrastructure, including Northwood, really needs to be looked at in a serious way. Unifor does represent Northwood as has been mentioned - the Halifax campus has been mentioned on a couple of occasions - and Unifor does represent the majority of workers and that would

include environmental services, dietary, CCAs, LPNs. Yes, we have a lot of contact with our members, and we've heard some of the situations that occurred during the first wave of the pandemic.

I think what you can see and what you have heard so far, and I'll reiterate it, is this is not a new issue. This has been going on for many, many years. Until the pandemic, and I think Ms. Lowe had alluded to that - the pandemic highlighted what the issues were in our long-term care facilities in this province. Unfortunately that had to happen, because prior to that, it seemed like it was always falling on deaf ears, even to the point of the last budget. I had done an op-ed on March 5, 2020 denouncing what was going on within the budget. At that time, it was just released. There was a little improvement, actually one per cent, to the long-term care facilities, but that didn't even bring it up to par to what the budget had cut from years previous.

I do think there needs to be a substantial improvement as far as the staffing, which you've heard previously, the 4.1 - and that 4.1 should be a minimum, by the way - because we need to improve the conditions. We need to improve the infrastructure so that when graduates come into a facility, they don't get scared off from that profession. They should take pride in what they do, and they should be able to, given the opportunity, do the work that I'm sure many in that profession love and take great pride in.

I would be pleased to answer any questions following this. Thank you.

THE CHAIR: Thank you everyone for your presentations and certainly for your ongoing efforts, not limited to the pandemic situation that we find ourselves in. If I can be so bold as to say thank you to all those front-line health care workers who have been going to bat for not only the patients but for all Nova Scotians. I know that my grandmother certainly appreciates the effort and contributions that they put in on a daily basis to keep her and her friends safe.

Just be mindful of the time to our members. Our presentations today have collectively gone a little longer than usual, so what I'm going to do is we will move to rounds. We're only going to get to one round of questioning, and we'll extend that round of questioning to 22 minutes per caucus. Is that agreeable, just based on - we have about 10 minutes of committee business, I think, to wrap up at the end, so that should enable us to complete that as well.

Ms. Adams.

BARBARA ADAMS: Is it possible to extend the meeting time to allow for more opportunity to ask questions?

BRENDAN MAGUIRE: Mr. Chair, I actually have something at 3:15, 3:10, right around there. I have to go pick my kids up, so I actually can't extend, unfortunately.

THE CHAIR: I'm going to say no as Chair just to keep us on track as per the situation with all other committees as well. Again, let's move to 22 minutes per round per caucus, and we'll begin with the Progressive Conservative caucus. Ms. Adams, please.

BARBARA ADAMS: Although I'm dismayed that we won't have more of an opportunity to ask questions, I am delighted to have all of you here today.

I know that as a physiotherapist who worked in a long-term care facility during the pandemic, I know first-hand what all of the staff and the residents and the family members were experiencing. I want to stipulate that although all of you got to do opening remarks, the public hadn't seen all of your reports that outline the actual details and the issues that have been going on for the past decade. I do want to stipulate for the record that there was a great deal of information that each of the unions have provided in their reports.

[1:45 p.m.]

As the long-term care critic for the PC Party, I have met with almost all of you and we released our long-term care strategy back in July 2020. Just to keep it on the topic of the 4.1 hours of care per resident per day, we have already committed to that. Having been somebody who worked in long-term care for many years, that is, as you say, the minimum that we need to have. We have committed to that. We've also committed to over 2,500 new long-term care beds to reduce the long-term care wait time.

While I know that the unions are here representing the employees as well, I also want to be the voice of the residents and the family members who have been calling me non-stop over the last several years - not just because of COVID-19.

I want to start off by saying that I thought that the opening remarks by the deputy minister and Ms. Stevens - who I've heard nothing but wonderful reports about - everyone who talks to me about her tells me what a great job she's doing - I was a little disappointed that it was light on the details because I know Ms. Stevens had done an updated report in 2018 that outlined all the statistics on wait times, how many beds we had, how many were vacant. We didn't hear how many beds were still vacant because they didn't have enough staff to open up beds or why we had to move 150 people into a hotel.

I'm hoping that we can get to some of the details today because we are seriously looking at an issue where someone presses a button and can't get to the bathroom. They're waiting a long time to be fed. They're being left in their chairs. They don't have a dunk chair because there's not enough equipment for them to do that. We can't continue. It's enough time, enough talk.

My first question is about the actual plan that is in place. Back in an article on July 30, 2015, it said the government was seeking input on continuing care. They talk about the fact that there was a *Continuing Care - A Path to 2017* report. When you go to that report, there is nothing there on the website. It says the file is not found so it has clearly been

removed. It also makes reference to a five-year continuing care strategy set for release in 2017. I'm wondering if the deputy minister could comment on where that five-year continuing care plan is right now.

KEVIN ORRELL: As you know, I began my job as deputy minister in April at the beginning of the first wave of the pandemic. I became aware of several reviews that were undertaken. The most prominent for me at the time I began was the long-term care expert panel, which reviewed some of the past reports and reviews that had been done. It is that report that I have had the most contact with - the recommendations and the way the government is moving forward on the 25 things that were recommended for long-term care in the province.

I think that took the precedence from previous reports to move forward in a robust way to improve long-term care. Of the 25 recommendations there, they've all been acted on. All of the short-term and most of the medium-term have been finished and there has been significant investment. The work of the department has focused largely on that.

To date, there was $10.12 million committed to act on the recommendations. The progress included - as per the recommendations - long-term care assistant positions for the facilities, marketing campaigns to communicate the unique and diverse skills required for long-term care, and the "build sector pride" that has been referred to for the workers in long-term care facilities.

The CCA bursaries, I would argue, are a very important part of attracting this sector to the workforce. This had recruited 100 people last year and 115 this year for training that is paid for by government. There has been work to explore the community hub models with the Centre of Rural Aging and Health receiving $210,000 in funding; completing a study on the residential care facilities in the province to better understand client population and their care needs; and release of a RFP to move forward on interRAI, which is a tool for long-term care homes. Among other things, it evaluates acuity, and it will give us evidence and quality data about how to move forward and to address what has been discussed in the opening remarks about hours of care.

We have also looked at LPNs and nurse practitioners to support clients, and their roles have been expanded. We've changed the regulations to allow nurse practitioners to provide primary care. There's funding to the nursing homes in Nova Scotia to create a hub online of resources and to assist in management of complex behaviours.

That, I think, has taken precedence over the previous reports and reviews.

BARBARA ADAMS: So I guess just to summarize, then, there is no five-year long-term care strategy, and there is just a reaction to several reports, like the pressure injury report that was as a result of somebody dying in long-term care, as well as the long-term care expert panel. I want to reference that, since you mentioned it.

Those of us who worked in long-term care look at the - I can't show you, but to look at the update on the expert panel's 22 recommendations, and I want to comment on one, because I've been calling on this long before there was an expert panel. The CCA grant program, when it was run before the Liberals took office in 2013, offered the CCA grant program to everyone who was a CCA. When the Liberals took over in 2013, they completely cut the program. I've been calling on it since I got elected to reinstate the program completely to every CCA.

Since that did not happen, then we undertrained by about 500 CCAs a year every year for the last seven years. We have a critical shortage because we couldn't attract people to take this course. In this long-term care strategy update, it shows a check mark where it says bring back the CCA bursary program to support CCA recruitment. It's a check mark. It's done. It was 150 students one year and I think about 150 the next, and they didn't even fill the program. We're talking missing 500 students a year every year for seven years. That's 3,500, and the government committed to only approximately 300. It is not a check mark, it's not done, it hasn't finished.

My question for Ms. Elliott-Lopez is that the expert panel update was last done in September 2019, which is over 15 months ago. When can we expect another update?

THE CHAIR: Ms. Elliott-Lopez, please.

VICKI ELLIOTT-LOPEZ: A good question. As you can imagine with the onset of COVID-19, it put many of our initiatives on hold, and so we had last consulted with our sector partners in the Spring right before COVID in March and had identified some actions to move forward, and then our attentions were diverted.

We recently reconvened to validate a number of assumptions from our Spring session in the Fall and to work with our sector partners to develop an action plan for moving forward with the remaining recommendations, which are all under way, and we recently submitted those to government, and we have a number of actions identified to move forward next fiscal year.

BARBARA ADAMS: I appreciate that. I don't know that we can afford to be diverted by COVID-19, and had the government seen fit to keep the Legislature going and the Health Committee meeting, we could have been having these discussions all the way along and helped support that.

Given the time frame, I just have one question for Ms. Susan Stevens. We had met outside of this with Dr. Brendan Carr, the head of the NSHA, about the supported living type of environment that Alberta offers, which is an intermediary level of care between home care and long-term care strategy.

I recall when we were talking about that that you were familiar with this supported living in community environments. I'm just wondering if you could comment on how you see that possibly working in Nova Scotia.

SUSAN STEVENS: Thank you for the question and thank you for your kind words earlier. When we met, I did indicate that in other provinces like British Columbia and Alberta, there are other supportive housing options that are available to residents that are not part of the system here in Nova Scotia. Those do include assisted-living-type facilities that are in some cases regulated by government - in other cases, regulated and funded by government.

I think as part of ongoing planning in the sector, I'll defer to my colleagues in government to talk about the government's perspective on this. I know we have had in the past conversations and discussions and explored looking at these other options to see if there are potential opportunities here in Nova Scotia.

BARBARA ADAMS: I appreciate that very much and the conversations we've had. Our Party, as we've stated in our long-term care strategy, is also committed to doing this so more people can stay closer to home, closer to family, and with a staffing ratio of 1:3 or 1:4 residents. With this short time, I'm going to turn it over to my colleague, Mr. LeBlanc.

THE CHAIR: Mr. LeBlanc.

COLTON LEBLANC: I want to thank all witnesses for joining us this afternoon for a very important discussion. Like my colleague, Ms. Adams, noted, it could very well have taken place months ago. It very well could have taken place during an inquiry. It could very well have taken place during a legislative sitting. Alas, here we are.

I want to take a moment to recognize those working in the long-term care sector from administration to nursing to support staff and everyone in between - so those in my constituency of Argyle-Barrington, right across the province.

I do want to note some of the comments from Deputy Orrell in his opening remarks. Some of the comments seemed to be directed or addressed to COVID-specific and not necessarily systemic issues that have been present, as noted by our witnesses and in their advocacy, for many years.

We've clearly communicated in our plan what we stand for and what we envision to direct the long-term care sector in a better path forward. It's noted in the report from the Minister's Expert Advisory Panel on Long Term Care that primary health care provides the right care by the right person in the right place. Sadly, in Nova Scotia, this is not happening in long-term care. It's not happening for those waiting for paramedics to arrive. It's not happening for those who do not have a primary care provider. I could go on.

When we look at the number of Nova Scotians who are still on the wait-list for long-term care, I think that speaks to it. I know that we're due for an update in January 2021 on the numbers of those waiting for placement from home. I was just wondering if by chance you have those numbers with you today - either Dr. Orrell or Ms. Elliott-Lopez.

KEVIN ORRELL: The current wait-list in hospital is approximately 233 patients who are waiting for placement to a long-term care facility. There are approximately 1,300 in community to make a total of about 1,500 in the province who are waiting for placement. There are significant efforts in place to keep the flow of patients from the hospital to facilities or a temporary facility.

In terms of our management of access and flow, this is a very important part of the management of the entire health care system so that people can be placed outside of a hospital environment when they are ready, because it's not always the best place to keep someone who requires a different type of care. It also continues to allow the health authorities to provide elective and investigative care to patients whose wait-list has been made longer during the pandemic.

The priorities by which we would deal with a wait-list include patients who are in community who reach a critical level and can no longer be cared for at home or have illness enough that requires support in a facility. They are our top priority for transfer. Then the hospital patients would be transferred, and then the third would be the people who are stable but ultimately will require transfer from a community to a long-term care facility.

[2:00 p.m.]

COLTON LEBLANC: I guess any which way you look at the numbers, if we have, let's say, 1,500 Nova Scotians who are on a wait-list for long-term care, they're on a wait-list for a reason, because they are unable to access the care that they need at home. Their families are unable to provide the care that they need. This is impacting the lives of the families themselves. It's sad that in today's day and age that our most vulnerable people in our province are not getting the care they need, and most importantly that they deserve.

In some opening remarks previously, it was said how the level of care that residents needed 20 years ago has differed significantly to now, and I think it's spoken about in the *Enough Talk* position paper by the Nursing Homes Association of Nova Scotia. I guess we could say enough talk. It's unfortunate that we are here having this discussion, and I do hope that we're not continuing this discussion at a later date after Ms. Hazelton's retirement.

You did acknowledge, Dr. Orrell, that we do need more beds, so I'm just wondering whether, within the Department of Health and Wellness and with Public Health colleagues, if there has been any sort of analysis of the epidemiological impact of having 2,500 more beds in our long-term care system.

KEVIN ORRELL: One of the mistakes that has been made is that we assume that the solution to all of the issues about long-term care revolves around creating more beds. The whole system of continuing care will require a remodelling. By that, I refer to the fact that we have to improve our ability to care for people in their own home or communities before they reach the level of requiring a long-term care facility. We have to improve the home care supports and the support that the client and the families require in order to keep someone in their home or in their community.

The second, very underutilized part of our continuing care spectrum is the residential care facilities. That part of it has been underutilized: people who are not able to stay in their own homes, but can move to a facility where, with some overview and care, they can continue to live in a more independent manner.

Thirdly, we should continue to look at our ability to improve the facilities we have and to increase the number of beds that are available in long-term care. In our province, long-term care patients who enter a nursing home do so at a much earlier age than the rest of the country, and we would like to see people staying in their own home or in a residential care facility for longer periods of time before they require the services of a full-care facility like a nursing home. This, I think, would create more usable beds and then with the addition of some new beds, that would help to reduce wait times and to care for people better.

The system can't be just considered to have more beds and that's going to solve all our problems. We need to revamp and remodel from home care right through to the nursing care environment. Susan will have something further to say about this.

SUSAN STEVENS: Just to add to the deputy's comments and further to your question, Mr. LeBlanc, those individuals who are waiting - there are almost 1,300 people waiting at home for long-term care currently - those individuals are waiting for their preferred facility, and as they wait, my team and the home care providers in the province and others are supporting them. We've been very pleased - we work very closely with the Department of Health and Wellness and our home care agencies in the province to manage the pandemic and all the challenges that has thrown at us and at the families to support them as best we can.

The department has expanded direct funding options, so there are new and different options for families to explore as they wait, and as the deputy indicated, we're very closely working with families, and if they're in a situation where they can no longer wait for their preferred facility, we will work with them and facilitate an urgent placement to long-term care.

THE CHAIR: We're going to move to our New Democratic friends. Ms. Leblanc will start us off.

SUSAN LEBLANC: It's been great to hear everyone's comments so far. I just want to - not to be outdone by my colleagues in the PC Party, but I just want to mention that

speaking of standards of care and 4.1 hours per day per patient, the NDP actually has a piece of legislation on the order paper, or it was on the order paper until we prorogued, actually, that bakes in those standards as Ms. Hazelton has said that are so essential.

Referring to that in a second. I want to start by talking about this. The quality review report from Northwood's experience in the first wave, as many of the reports have suggested, we've heard today many times and we've been hearing for many years, as everyone has said today, and as is committed to in our 2018 Care and Dignity Act that has been ignored by this government, that the department "Set and fund standard minimum care hours based on resident complexity across all facilities. Increase care hours to include previously evidenced levels."

So as we all know, a host of research and reports from this province and beyond has supported the idea that the minimum standards of care in long-term care facilities need to be increased. Government as a regulator has a role to ensure minimum standards and it's plainly obvious that we are falling short in many, many instances in this.

My question is - and I'd like to hear from the Department of Health and Wellness as well as other guests, unions, and maybe perhaps Ms. Lowe - my question is, can you explain the work towards establishing the minimum standards, and what hurdles are remaining before we can see this happen in Nova Scotia?

THE CHAIR: Ms. Leblanc, could you pick who you'd like to speak?

SUSAN LEBLANC: Sure. Let's say Dr. Orrell and let's say Mr. Rao from CUPE.

THE CHAIR: Excellent. Thank you. Dr. Orrell.

KEVIN ORRELL: The important thing about hours of care is that we have to recognize that appropriate care of patients in our long-term care facilities is a priority of the Department of Health and Wellness. We do recognize that this has to be a consideration, and we would like to base our decision-making on research and modern-day evidence.

There's no "one size fits all" that applies across the entire sector. Hours of care depend on the acuity of patients. Some nursing homes have very, very sick, more elderly patients than others, and the hours of care would be very different in different homes. The geography of the facility makes a difference as to the hours of care, how far apart the patients are, if patients can be cohorted by disease or by care needs in the geography of the facility.

Some nursing home patients stay for very brief periods of time. Some are in for a matter of a few months, and others stay for years. To dictate or to dedicate a certain number of hours when perhaps there would be an exodus that would not require that many hours, would oblige the care provider to have excessive hours that they may or may not need.

There has been pushback by the facility providers about care hours since they're the ones that determine that.

The other issue is that it may, in fact, discourage some admissions where people would recognize that a patient or a resident who requires more care may not be a desirable patient to bring into their facility who would require more hours. It would somewhat limit the flexibility of homes to take patients who are very, very ill and require a great deal more care.

We're in the process of obtaining the licence for interRAI. This is a tool. It's not the only thing that helps us make decisions about hours of care, but it certainly is a tool that evaluates acuity. It will help provide some very strong evidence based on world experience about the type of hours of care that are required. We will certainly move towards what's in the best interest of the sector and of the residents who are cared for in those environments.

GOVIND RAO: Our view is that it isn't as complicated a situation as Dr. Orrell describes in terms of establishing and bringing in an adequate minimum standard of care. There are a couple of facts that we can establish.

The first is that the 2.45 hours of care that was set in the early 1980s in our province has not changed since that period of time. In the early 1980s, people would walk or drive themselves to a long-term care facility. Now we know that they're being wheeled in. The level of acuity has absolutely increased. That's not in dispute. We also know from every report and every person you speak to in long-term care that the level of care is not adequate.

How do we get to an answer on the question? British Columbia has set a provincial standard of 3.36. Other jurisdictions have created models in which the funding and hours of care is set by levels of acuity. I think that the real challenge is one of putting the correct resources toward greatly increasing the hours of care that are available and doing the necessary studies. It shouldn't be taking us another year or two to do that. We should be able to do that in the next six months.

SUSAN LEBLANC: I would say, based on what we've heard from our experts, who are the union leaders in this discussion, as many of you have said the experts are the folks who are working at the bedsides of the residents, I think that we've heard very clearly from all of the labour folks here that minimum standards are important and possible.

The next question I have is for the Department of Health and Wellness. The department's Continuing Care strategy document Long Term Care Residential Care Facility, Facility Requirements, which was drafted in July 2009, states that "experience from new LTC facilities built in Nova Scotia have indicated that smaller household size and private bedrooms promote a more restful sleep for residents. There have been reports of fewer outbreaks of infection, as well as the ability to quickly limit its spread by containing the outbreak to the smaller unit."

Last year, our own Department of Health and Wellness review of the first wave of COVID-19 states, "Research highlights the benefits of using neighbourhood-based models consisting of single occupancy rooms, separate bathrooms, and small cohort-based common areas and dining areas . . ."

My point is, obviously, that this seems to be the best practice for infection control. This has been the best practice for infection control for around 10 years or maybe more. My question is, can the department clearly explain whether or not there is a commitment for a single room for every long-term care resident in the province? If so, what is the path or the timeline for that? If not, why not?

[2:15 p.m.]

KEVIN ORRELL: Based on our reviews and response to recommendations from those, we have moved quickly to ensure that there are no rooms in our long-term care facilities across the province with more than two people. Fifty-eight per cent of the rooms in long-term care now are single with single bathrooms. Forty-two per cent have double occupancy. There are no triple or quadruple rooms any longer.

Since 2007, any new build was always for a single room and a private bathroom. There have been no new additions since that time that have had double occupancy. We do recognize that there are some people who come in with their spouse who would prefer a double occupancy to live with the person they've lived with all their life. There are some who actually request roommates for the purpose of socialization and company.

We have moved quickly to no more than double occupancy at this time with the facilities that we have in the province. The new builds will no longer be built to occupy two people and share a bathroom.

SUSAN LEBLANC: I appreciate that update. We did hear something similar the last time we spoke at committee. I can't remember if it was this committee or the Public Accounts Committee, but I guess my question is, when are we going to get to the best practice of a single room - aside from couples and aside from people who request double rooms - the general practice of a single room with a single bathroom for every long-term care patient?

I'm going to skip my second question and come right to my third question. We know that Northwood - and someone has mentioned this already today - has had a multi-year-long funding request for capital building to build new floors at its Halifax campus in order to do just this - to provide every resident with a single room.

I'm wondering if anyone can speak to this. Does anyone have thoughts on or can speak to this question? Do you believe that the outbreak at Northwood would not have been as severe had these capital investments been made when they were first requested? I suppose I can direct that to Ms. Hazelton.

JANET HAZELTON: By the way, Dr. Orrell, I'm retiring in six weeks so get moving. (Laughter) That's a joke.

I think definitely if the infrastructure in many of our older facilities - and obviously it's not just Northwood, we have a lot of older facilities in this province - the R.K. MacDonald Nursing Home, Ocean View Continuing Care Centre - there are several older facilities where ventilation is an issue - a lot of seniors in a room. When you have four seniors in a room with all their stuff, it makes it harder to move around. Normally, when you come into hospital, you take your little bag and you have your stay and then you go home. There's not a lot of stuff in the room and you don't tend to leave your room while you're in hospital. You might go for a little walk down the hall, but generally you're confined to your space.

This is their home and so you can't tell someone you can't leave your home or you're in your bedroom - can you imagine - we can't even tell our children that they're going to be in their bedroom for four to six weeks. It's not reasonable to think that we could do that with our seniors.

The problem became that if one person in the room was COVID-19-positive, it's very difficult to isolate them quickly when there are three other people in the room. I do believe that if investments had been made in this province and in this country in our long-term care facilities - many of which have double occupancies, and sometimes there are up to six people using one washroom - it doesn't take an infection control specialist to understand that when you have a contagious disease - whether it's COVID-19 or the flu - it's going to go through those kinds of facilities with poor ventilation, and doubling up the people will make it go quicker because it's a contagious disease.

We know now that if someone is COVID-positive, we're asking them to isolate. We're asking them to go and be alone and not be around other people. The same rule applies. I think the quicker we get to single occupancy, not only for lifestyle or what's good for our seniors - I can't imagine moving in with a complete stranger for the end part of my life - the better it is for infection control and just quality of life for residents so that they can end their lives with the dignity they should and with the privacy, if they so choose, to have.

SUSAN LEBLANC: Since 2016, we have heard that a blueprint for Continuing Care is under way, but a vision has yet to emerge. In the meantime, this government has built only a handful of new beds over the last seven years.

The Nursing Homes of Nova Scotia Association is calling on the department to lead a sector-wide engagement process to build a vision and a framework for long-term care in Nova Scotia. I'm wondering if, Ms. Lowe, you could speak to how your organization has been involved with this and how this is going from your perspective.

MICHELE LOWE: From our perspective, we have not been involved at this point from a department level in terms of the development of a vision for a new Continuing Care blueprint.

However, we have ourselves worked on some key strategies that we believe are instrumental in creating a Continuing Care blueprint. Certainly, when we talk about the hours of care - when we talk about the frailty - what we cannot lose sight of is the fact that if we want to reduce the length of stay and if we want to bolster our supports for people who choose to live in their own home, we have to be able to look at what that impact is on the other end.

In terms of the hours of care, for instance, when we talk about a strategy, we have to look at the fact that one of the recommendations that we made was a revision of the funding models. Currently, we have a different funding approach for traditional facilities. We have a different funding approach for the newer builds that were created in 2010. What that means is that there are actually nursing homes in this province that have been funded that actually provides them with 4.1 hours of care. Even that is not enough.

If we look at that in terms of the frailty that we currently are seeing and we move five years out with a significant increase in dementia, which right now within our province, most of our administrators would tell you that 80 to 85 per cent of the residents that they are serving have some level of dementia - if we want to shorten the length of stay, that will require more acuity and more supports. There are so many things that we could be doing within our strategy that do not require new funding.

An example of that is responsive behaviours. Currently, if a nursing home has a resident who's admitted who has significant responsive behaviours and they are unable to manage them for whatever reason, they can apply to have funding for a 24-hour attendant. When you look at the cost associated with that right across the province, it's millions and millions of dollars that are going just to that one-on-one.

Typically, these attendants are not necessarily behavioural specialists. Why are we not funnelling those funds into a solution for responsive behaviours that could see either that resident move out into a temporary solution where they are managed and then brought back into long-term care as well as for those who are living in community who could also tap into that level of support?

These are just some of the things that would all be encompassing in a vision. We certainly are looking forward to having those engagements. We understand that the department is starting to move down that path. Certainly, we want to be able to be part of that.

THE CHAIR: Ms. Coombes.

KENDRA COOMBES: I'd like to start with this. At the beginning of June last year, Quebec's government launched a recruitment drive, backed by the full power of the government and funded fully to get 10,000 personal support equivalent workers, paid them $20 per hour for training, increased wages to $26 an hour, and worked to deploy these workers in nursing homes. British Columbia's government took action at the very outset of the pandemic to provide full-time work and increased wages to $21.75 per hour for personal support workers in long-term care to stabilize the workforce.

My question is to the unions. Can you talk about how our province compares to others - in both terms of focused attention to the staffing issue during the pandemic and prior, as well as generally? We all know that these staffing issues have been there prior to COVID-19, which only highlighted the issue.

THE CHAIR: Ms. Coombes, would you please direct your question with two minutes remaining?

KENDRA COOMBES: I feel like I'm playing Hollywood Squares. How about Unifor and then NSGEU?

THE CHAIR: Mr. MacLean, please.

JASON MACLEAN: As I said earlier in my opening statement, what we came across over the pandemic coming out was that it really showed the cracks in the system. We knew they were there already. We advocated for them to be fixed, but the most glaring thing here is a willingness amongst government to actually commit funds to be able to make these changes.

I appreciate what the deputy minister is saying. The deputy minister is actually talking about home care and talking about long-term care and tying them all together - just like NSGEU and CUPE were trying to do earlier on. We called for a wholesale review to look at what happened during this pandemic because we believe that the issues that were brought forward are issues that we were falling on for the last little bit.

What I look at are issues of people working in multiple facilities. That was an issue that we fell on when we were talking to the Department of Health and Wellness when we're trying to get Public Health guidance. A lot of people were being told that they couldn't work in a second facility or they were even given clean facilities or dirty facilities - facilities that had COVID-19 in them and some that didn't, and they were preventing people from working in different places.

Also what we noticed was under-staffing. We have locals now that I actually have a meeting with next week in Blomidon Court where it has been chronic, where they cannot get time off and they're burning out - people are leaving here. Then you've got to go to the reasons why people are working in multiple facilities - because the wage that they make is far below what somebody doing the work that they're doing should be receiving. People

are saying, I'm either going to go into acute care or I'm just going to get out of this field altogether, and people leave the field.

We have definite recruitment and retention issues. We have ratio issues. We don't have enough people that want to come into this sector or the home care sector. When people are taking advantage of these bursaries, they're getting into the field and all of a sudden it's not the same as it was that they were being taught when they did their on-the-job training, let's say in a hospital and everything else where they had the luxury of having lift teams and things of that nature. It's different when you're in the field. It's different when you're in long-term care as well when you don't have enough people there to help you.

I will leave it at that. Also, we had a huge issue and we're actually fighting . . .

THE CHAIR: Order. Thank you, Mr. MacLean, I know you have a lot to say. I'd just like to quickly . . .

JASON MACLEAN: I have one more point.

THE CHAIR: I was going to give Ms. MacNeil an opportunity to jump in here as well because we're over time as we speak right now.

JASON MACLEAN: Can I finish my point? It's about PPE.

THE CHAIR: Sure.

JASON MACLEAN: We've had this argument over and over with Dr. Strang and with those in the Department of Health and Wellness about people being able to use their own judgment on what type of PPE they might need or even to put a framework in place, which we've been denied and denied. We are having meetings with the Department of Labour and Advanced Education regarding those issues as well very soon.

THE CHAIR: Ms. MacNeil, quickly please.

[2:30 p.m.]

LINDA MACNEIL: Very quickly. In comparison to the other provinces, I strongly believe, as do others, that the monetary compensation in that classification, particularly the CCAs - if it were increased, that would definitely be an incentive to join that profession. But, as well, it is the staffing levels. In the other provinces, they have realized it wasn't appropriate, and they increased it.

We are asking for a minimal amount of 4.1, but at the end of the day an increase is an increase, and other provinces have done it in both aspects, and I think Nova Scotia should as well.

THE CHAIR: Ms. DiCostanzo.

RAFAH DICOSTANZO: I would like to start by honestly thanking everybody that is here today. Nova Scotia has done something amazing, and we're the envy of so many other provinces for the work that was done with COVID. I truly think this is because of all of you being able to work together and help each other. To me, you guys are all heroes and have done an amazing job.

My question is really about COVID and the money that we're spending. I know there is $26 million that was invested, and I'm wondering if Dr. Orrell or somebody else could help me understand, what is this mobile infection prevention and control drop team? How does it work, and did we use that in the first wave or just in the second wave? Can you elaborate on that?

KEVIN ORRELL: The spending and the investments made in the long-term care sector have been very significant. There has been $15.2 million in infrastructure investment in the Spring. The COVID-specific supports included $16 million for infection prevention and control, and occupational health and safety resources.

One of the recommendations dealt with the mobile IPAC teams that were placed. These were in each of the zones, they were designed to be mobilized in the event of an outbreak. Each had an IPAC consultant that worked in the zone, and then there was a provincial coordinator for all of this. There's significant presence now of IPAC in all of the zones. They can respond 24/7 and make IPAC practice much more robust in all of the zones during the second wave than it was in the first wave.

We had used $7.4 million in federal restart for small capital projects. Again, all of these are done with the impression that we are responding to the IPAC recommendations. There was $4.5 million in federal restart for increased cleaning measures, which was again a recommendation. So we have provided more cleaning supplies, more cleaners, and have attempted to correct what was identified in the reviews during the first wave.

There's been $2.8 million in federal restart for deployment centres to stabilize the staff and have the appropriate people necessary when or if there were to be a breakout. There was $6.2 million for COVID care, such as the residential care units where we would cohort positive patients and remove them from the other patients in a home so they don't expose those patients who are not infected.

Also: $10 million in long-term care assistance; $12 million for additional short-term system capacity, including the community transition units; $4 million in PPE, in addition to the PPE from provincial stockpile; $1.2 million for iPads for the purpose of socialization and mental health of residents; and $22.5 million in essential worker payments was also paid to employees of long-term care.

RAFAH DICOSTANZO: These are wonderful investments, and it has shown in the number of infections that have not reached any of our long-term care and how you've done it.

There was another thing that I think we were very good at. I'm not sure if that has a lot to do with controlling it once we realized that a worker who has no symptoms can infect. We took care of things differently after that. The restrictions were really hard on a lot of the family members, but how much has this restriction that we implemented early helped us to control the spread of this virus?

KEVIN ORRELL: Like anything that we offer in medicine, there were certainly pros and cons to all of this. To control the spread of infection, not only in long-term care facilities but basically in the province as a whole, the restrictions that limited who can enter our province and what we do when we are out in the community, such as masking, hand hygiene, and the use of PPE, et cetera - all of that, I believe, has significantly impacted the control of this COVID-19 virus.

Like anything, though, there are some consequences. It was particularly difficult for families and residents of long-term care facilities. They became very isolated and we did become very concerned about the mental health issues that arose because of that type of isolation, both for the resident in the facility and for their families outside of the facility.

It was especially difficult for those who lost relatives during that time. It became very hard on them to deal with their loss when they couldn't gather as we normally do for such times. We certainly extend our deepest sympathy to everyone who experienced that type of loss during the first wave.

To that end, we have made very significant efforts to improve the ability of families and residents to socialize together. When the epidemiology improved, we moved to outdoor visits. As it continued to improve, we went to indoor visits. The homes then opened up and we could have bus tours for small numbers of people that allowed them to be out and to see something besides the inside of the facility.

Regrettably, every restriction does come with a cost so we attempt to balance that as best we can. When the HRM area had a small surge, we did restrict once again in the long-term care facilities and we were very pleased that at this point in time we had a program for volunteers and designated caregivers. This did provide residents with contact with people who participate in their care and who can provide some social activity, so they weren't as isolated and as removed from their normal activities as they were during the first wave.

RAFAH DICOSTANZO: In your comments you made about home care support that our government has focused on that. If I may make a comment for most of the multicultural people in Canada: to us, we have bigger guilt because it's considered that

you've abandoned your parents if you put them in long-term care. We have this mentality that is very different. We will do anything to keep our parents at home.

I am very happy, and I commend the fact that we are trying to make sure we allow them to stay home for as long as possible and to give them the support. I have my parents who are both late 80s in Ontario, in Oakville, and I have my in-laws who are 90 and 94 who are here. I always compare our services between.

My question is to Susan Stevens if she knows about a pilot in Ontario - Oakville, Brampton, those four areas. It's called Support for Daily Living that my parents are receiving. It's about three hours a day, but it's very flexible. They have the same people going in and out. Honestly, there are four of us siblings and we are so grateful for the service that they are receiving, how well it's working and how they can communicate with us. I do a lot of work here from Halifax to help my parents.

It's three hours a day. They come in for an hour and a half in the morning, another half hour in the afternoon and another half hour before bed. There are services that are amazing that allow my parents to stay at home. Are we looking at something like that? Do we have things like that?

SUSAN STEVENS: Yes, we do. Our home care program continues to evolve and change. We look forward to continuing to work with the department and the home care agencies in the province to further the evolution.

We have contracts with home support agencies across the province. Through us and the Department of Health and Wellness, they deliver services in people's homes. The maximum service levels at this time are around five to six hours a day. On top of that, people can also receive nursing services so that five to six hours is the home support piece - the personal care and likely the types of services that your parents are receiving.

In addition to that, as I mentioned earlier to another question, we're really pleased to have worked with the department to see changes to other home care programs that provide some alternatives to families. The department increased the dollar amounts for the Supportive Care Program. That's a program for people who have some kind of dementia or other type of cognitive deficit but have a substitute decision maker and somebody who is assisting them. That program provides funding for that decision maker to hire privately.

We've seen the department as well extend that service limit from $500 to $1,000. For people who are waiting for long-term care - because the waits have been extended over the pandemic - we're able to exceed those service limits in certain circumstances.

We've also been able to assist families in some cases particularly - you raised the point about families that are from different cultural backgrounds and have different values and approaches to care for their parents. Under certain circumstances, we are able to make some exceptions to enable to pay certain family members to assist with their care.

I think these are very positive steps. We've talked a lot today about long-term care and what needs to happen in long-term care. There is work to be done in home care too. The two - as Dr. Orrell said earlier - need to move forward hand-in-hand. We're very pleased to be working with the department and our partners in the sector on both fronts.

RAFAH DICOSTANZO: My system is saying to me I have been signed out, so you may lose me, until I figure out what is going on with my system. I apologize. Thank you again.

THE CHAIR: Mr. Horne, I believe has a question.

BILL HORNE: Thank you to all the guests today. It has been very interesting. We have a long way to go. I would like to ask a quick question along the rapid outbreak response team that was developed, and ask about its mandate and if it has been initiated. Have they gone out in the field?

KEVIN ORRELL: It has been designed, in response to our ability to manage further outbreaks. I'm going to ask Vicki Elliott-Lopez if she could get us a little more detail on that.

[2:45 p.m.]

VICKI ELLIOTT-LOPEZ: We worked very closely with the Nova Scotia Health Authority, very much in response to the feedback that we received from the first wave, and we heard very clearly during the September Lesson Learned session with our sector partners that they wanted clarification from the Nova Scotia Health Authority and the Department of Health and Wellness on goals and responsibilities.

We never saw anything like what we saw in that first wave when we were all hands on deck and we were all in there with our sleeves rolled up, working the best that we could. I think we did a fantastic job, and accolades to everybody who worked together on the effort.

We certainly would work with our sector partners to continue to improve on that, and the rapid response teams were a direct result of that consultative effort that we did. I know Susan can fill in more details that I have, because it's her teams that are really leading the charge out there in the field, but they are NSHA-led through the zone directors. There is a phone number that our facilities that are experiencing an outbreak can call 24/7, and the NSHA contact in the field will mobilize a team to wrap supports around the facility and outbreak as quickly as possible. It's very much what we did in wave one, but in a very coordinated way.

Susan, I don't know if you have anything that you'd like to add to that.

SUSAN STEVENS: I think you've covered it. I'm happy if there's further questions, if you want further detail.

I think part of the question was, has the rapid response team been deployed? The answer to that is yes and no. As Ms. Elliott-Lopez indicated, there is a system response that we coordinate and pull together when a nursing home has an outbreak or any sort of COVID-positive situation, and we bring a range of supports and services from across the Nova Scotia Health Authority and the government to support them. They're working very closely with Public Health, who is directing the outbreak response, but then we're looking at what you need in terms of staffing, PPE, and so on.

Those teams were formed as we had outbreaks in wave one. We learned a lot, and we formalized that, we built upon that experience. So no, we haven't had to deploy those, because we have not had any further outbreaks in long-term care.

The yes part of the answer is our IPAC team that Dr. Orrell referred to earlier has been in every nursing home in the province in the last few months and done an audit and an assessment and has been working closely with the long-term care providers to ensure that they have the support from an IPAC and infectious diseases perspective, and that our IPAC team has that on-the-ground knowledge of every nursing home in the province. If we were to have an outbreak today or tomorrow in a nursing home, they would be deployed immediately, along with other supports from the Health Authority and from government to support that provider.

THE CHAIR: Ms. DiCostanzo, did you want to wrap us up here? You've got a couple of minutes.

RAFAH DICOSTANZO: I'm sorry, I'm just looking at my notes. I know I had two more questions, but I . . .

THE CHAIR: You've got a minute.

RAFAH DICOSTANZO: Maybe I'll just use it to thank everybody, and honestly, it's just wonderful how much Nova Scotia has worked together. People I'm talking to from other provinces and saying, you guys are doing so well. My sister wants to move here from Ontario because of how well we've done here. I think COVID brought us together and showed how good the Department of Health and Wellness can work together, and everybody that is here today has helped and gave advice.

If you have a few words, maybe just to end it on the positive that has happened here in Nova Scotia and what contributions you made from the union to the government, that would be wonderful. Just a short one.

KEVIN ORRELL: If I could further augment on that, we all come from different points of view and we all represent different interests, but as I said in my opening remarks,

it's the collaboration of everybody here. We don't always hear what we like, and we're asked questions that we don't always care for, but the bottom line is that we learn from each other, despite our different points of view from different perspectives.

I think it has all contributed to a very successful management thus far. I pray to God that it continues because we are basically the envy of the country and probably the world in terms of how we have proceeded with this second wave. Thanks to everybody.

THE CHAIR: Thank you, everyone. That's the time for questions today. Unfortunately, we're not going to have time for closing remarks. To all of our guests and your respective cohorts and shops, thank you for your continued work. There's evidently more that needs to be done, so we'll do our best to accommodate those in any way that we can, and continue to work together with all partners.

To our guests, you're welcome to exit the meeting while we wrap up a little bit of committee business. Thank you, folks.

COLTON LEBLANC: A note to our guests: if they did have any closing remarks, I'm sure we could welcome them to make a written submission.

THE CHAIR: Yes, for sure. Thank you.

Folks, as discussed at our last meeting, we're going to continue with our committee business as scheduled - just to reiterate that. The witness for the February 9th meeting, Deputy Orrell, has indicated he is not going to be present. I believe Ms. DiCostanzo has a motion that she would like to submit to the committee.

RAFAH DICOSTANZO: I would like to move that the Department of Health and Wellness provide a substitute witness to fill in for Dr. Orrell at the February Health Committee meeting. That is the motion.

THE CHAIR: The motion is to, at the discretion of the department, replace Dr. Orrell on behalf of that department due to his inability to be present at that particular meeting.

Is there any discussion? Ms. Adams.

BARBARA ADAMS: I'm also wondering if were going to make a change to the witnesses, since he isn't able to be here, if we might consider bringing in someone from the area of social work as well as mental health and addictions. I'm just wondering in terms of where we're talking about emergency mental health services, if there are any other witnesses that we could possibly include to help supplement that information.

THE CHAIR: Ms. Leblanc.

SUSAN LEBLANC: I feel like we should leave it the way it is. I'm okay with Dr. Orrell sending a substitute. I just feel like adding more witnesses as we've seen today where we have so many witnesses - they all had important things to say, but because their opening comments were so long, yet very important, it just took away the time for asking questions.

In my opinion, we should leave it with the amount of people we have now and I'm happy for them to send a substitute, but don't want to add anyone else right now.

THE CHAIR: Ms. DiCostanzo.

RAFAH DICOSTANZO: I agree with Ms. Leblanc. We have a substitute that has information that Dr. Orrell can bring. The agenda is set for that.

THE CHAIR: I'm just going to jump in here as Chair. We're kind of getting into perhaps some agenda-setting type stuff. In the past, it's been fairly common practice for representatives to be sent on behalf or as designates. I think that if we're going to bring other new folks into the mix, we should bring those up at further agenda-setting meetings. We'll leave it at that.

Is there any further discussion on the motion? Would all those in favour of the motion, please say Aye. Contrary minded, Nay.

The motion is carried.

Just note that there is some correspondence that we received from Lori Barker of Ronald McDonald House in response to the request for information made on our November 10th meeting last year. Members should have received this email December 14th and again this morning. Is there any discussion on that particular piece of correspondence? Hearing none.

As well, we have the organizational chart for the NSHA. It was sent to members on January 4th and again this morning. Is there any discussion on that item? Ms. Adams.

BARBARA ADAMS: I didn't see whatever came in this morning as we were getting ready for this meeting, but in the past we have requested both the Nova Scotia Health Authority, as well as the Department of Health and Wellness to give us complete, full organizational charts. We did not get full, complete organizational charts. I'd spoken with Ms. Kavanagh and she suggested that I raise the issue here today.

I believe in the past we had all agreed that we were going to get full, complete charts - not just a one-pager for an entire organization like the Nova Scotia Health Authority. I would just like to renew the request to have full, complete organizational charts for both the Department of Health and Wellness and the Nova Scotia Health Authority every three months.

THE CHAIR: The original motion was for those complete charts so I don't think we need to make a motion for a new scenario. Let's just pick up where we left off and if there is some discrepancy between what we're receiving today - I guess I would caution on whether we're getting into asking each department at some point for the entirety of their human resources team on each department. I know that this particular committee focuses on health. We'll just go with our original motion. I appreciate that, Ms. Adams.

Is there any further committee business, with a couple of minutes remaining? Ms. Kavanagh.

JUDY KAVANAGH (Legislative Committee Clerk): Could I just have some clarification from the committee then on whether they want me to take action on the NSHA charts? Does the committee want me to write to the NSHA and ask them to start providing their organizational charts in greater detail?

THE CHAIR: Yes, please.

Is there any further committee business? Hearing none, thank you, folks. Welcome back. Today's meeting is adjourned.

[The committee adjourned at 2:57 p.m.]