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Ministry of Long-Term Care

1st Session
42nd Parliament

Tuesday 20 October 2020

Chair: Peter Tabuns
Clerk: Thushitha Kobikrishna

Journal des débats (Hansard)

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Comité permanent des budgets des dépenses

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Mardi 20 octobre 2020

Président : Peter Tabuns
Greffière : Thushitha Kobikrishna

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CONTENTS

Tuesday 20 October 2020

LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON ESTIMATES

COMITÉ PERMANENT DES BUDGETS DES DÉPENSES

Tuesday 20 October 2020

Mardi 20 octobre 2020

The committee met at 0901 in room 151 and by video conference.

MINISTRY OF LONG-TERM CARE

The Chair (Mr. Peter Tabuns): Good morning, everyone. We'll reconvene the Standing Committee on Estimates. I'd like members that the committee will not meet this afternoon, and I want it put on the record why. Standing order 63(e) states, "No estimates shall be considered in the committee while any matter, including a procedural motion, relating to the same policy field is being considered in the House."

There is an opposition day motion on the orders and notices paper to be debated Tuesday afternoon which concerns issues of long-term-care policy. As this committee is continuing its review of the Ministry of Long-Term Care, I felt it would be appropriate to cancel the meeting out of respect for the standing orders. So that's why we'll not be meeting this afternoon.

We're going to resume consideration of vote 4501 of the estimates of the Ministry of Long-Term Care. There is now a total of four hours and 17 minutes remaining for the review of these estimates. When the committee last adjourned, the official opposition had seven minutes remaining for their round of questions.

We'll go to the official opposition, but, Ms. Armstrong, you wanted to raise a point before we went into questions.

Ms. Teresa J. Armstrong: Yes, thank you, Chair. So just before we begin the questioning, there were outstanding items that the government said that they would provide, and this includes a comprehensive list of what was allocated to long-term care during the fall COVID-19 plan. Can the Clerk let us whether this information is available?

And I just want to put on record that when we have asked questions that required a follow-up during health estimates last year and the government promised to provide them, we never did receive that information, despite our requests.

The Chair (Mr. Peter Tabuns): Thank you very much. Is there any follow-up from—

The Clerk of the Committee (Ms. Thushitha Kobikrishna): From what I can recall, there wasn't any follow-up pertaining to the recent questions. If the ministry wants to confirm that we've received anything—

Mr. Richard Steele: I'm sorry, I didn't hear your comment.

The Clerk of the Committee (Ms. Thushitha Kobikrishna): From my understanding, we haven't received anything new from the ministry to answer these questions.

Mr. Richard Steele: Okay. I know I've seen material prepared, so we will check in on the status and get back to the committee.

The Chair (Mr. Peter Tabuns): Thank you very much. With that, I turn it over to the opposition. Ms. Armstrong.

Ms. Teresa J. Armstrong: Thank you, and good morning, everyone. Some questions that I had were: Can the minister clarify how much money the government has allocated toward testing long-term-care staff, residents and caregivers?

Hon. Merrilee Fullerton: Good morning, and thank you for the question. The testing funding is largely done through the Ministry of Health, so I will pass the question to the deputy on that if he has any further information specific to long-term care.

Mr. Richard Steele: Yes, thank you. I don't have the exact costs. I can certainly talk to the approach that has been used for testing in long-term care in terms of both outbreak management and regular surveillance testing of staff, and then, more recently, visitors as well.

The role of the ministry has been to work with the Ministry of Health to establish, based on the pubic health advice, what would be an appropriate testing regime for long-term care, but the actual cost of providing that testing sits, as the minister noted, with the Ministry of Health.

Ms. Teresa J. Armstrong: Okay, so if we can ask for that figure to come back—

Mr. Richard Steele: Yes, I don't—absolutely, I think it could be possible to estimate it based on the number of tests, but I'm not sure the cost would be held in that precise format at the Ministry of Health. They would, I'm sure, have information on the total costs of testing, but I don't know that they would have a breakdown specific for particular settings—long-term care, retirement homes, other settings—but we can certainly pursue that with them.

Ms. Teresa J. Armstrong: Today, as per the Globe and Mail story, the delay in turnaround for tests means that staff may not know which residents have COVID and which staff may be sick. Can the minister confirm what the government has increased in funding for long-term-care testing ahead of the second wave? How much of this is federal contributions, and can we have a breakdown of

what is federal and provincial funding for long-term-care testing?

Hon. Merrilee Fullerton: Thank you for that—very similar to the first question. These numbers reside in the Ministry of Health; they don't reside in the Ministry of Long-Term Care. You would need to look to the Ministry of Health for that information, but I'll ask the deputy if he'd like to comment on that as well.

Mr. Richard Steele: No, there's not really anything additional. It is similar to the first question. Testing: The lead is the Ministry of Health, so any information around your testing budgets and your respective provincial or federal contributions and so on would be questions for the Ministry of Health.

Ms. Teresa J. Armstrong: So it's fair to say that you will contact the ministry for the first question and endeavour to get those allocated—

Mr. Richard Steele: We can certainly reach out to the Ministry of Health on that, yes.

Ms. Teresa J. Armstrong: Okay, great.

Any delay in test results can potentially be dangerous once there's a COVID-19 outbreak. Is there any plan to prioritize lab testing for long-term care and other congregate care settings? If not, can the minister explain why there's no plan for that?

Hon. Merrilee Fullerton: Thank you again. The lab testing is prioritized for long-term care. Of course, keeping our residents and staff safe is a priority for this government. We look at the surveillance testing in long-term care. It is working so much differently from the first wave when we were struggling to understand the asymptomatic spreads of this virus, the evolving nature of COVID-19. With wave 2, it's clear that there is asymptomatic spread, and the surveillance testing is helping to pick up staff before they get into the homes, keeping our residents safe. We are noticing, consistent with the scientific information now, that community numbers are an indicator of our long-term-care home risk in terms of having staff that could test positive.

The surveillance testing is working and we're very pleased to see that. The majority of our homes have no resident cases, even though they might be deemed in outbreak because, as you know, an outbreak means one resident case or one staff case, and as soon as that happens, it's deemed to be an outbreak. But the majority of our homes are doing very well with no resident cases. I think that's a really important piece, and it indicates that we're picking up the staff cases before they get into the home. Certainly, the testing and the process that the testing is done, that's something that is continually refined, depending on what's happening with the testing availability.

There are many issues to weigh here. We're working very closely with the Ministry of Health, public health and Ontario Health to make sure that the testing proceeds as required.

The Chair (Mr. Peter Tabuns): Madame Gélinas.

M^me^ France Gélinas: Thank you, Minister. Along those lines, you've just told us that the surveillance testing is working, but your ministry would not know how much this costs and would not know if money would be better used if we did something different. It seems like there's a bit of a disconnect there.

Hon. Merrilee Fullerton: I really have to be clear that this is a virus that spreads, in many instances, with no symptoms. So we've seen pockets of COVID—and I think back to the first home that we had. It was not a downtown Toronto or a downtown Ottawa home. So it just shows that this virus can be elsewhere, and we have to be vigilant. We have to make sure that every measure is taken, that every tool is used to keep COVID from getting into the homes. Compared to the first wave, there's no doubt that the surveillance testing is helping, and it's a huge part of what we need to be doing.

M^me^ France Gélinas: Along those lines, right now in my riding, but I assume it's the same everywhere—on Tuesday, they go into a specific long-term-care home and they test everybody there. If you're not on shift, you have to come to be tested and all of this. Could this on-site testing be made available to caregivers? Caregivers still have to—

The Chair (Mr. Peter Tabuns): I'm afraid you're out of time. My apologies.

0910

Before we go to the government, we've been joined by MPP McDonell. MPP McDonell, I have to have you confirm your identity and the fact that you're located in Ontario right now. If you would please do that.

Mr. Jim McDonell: Jim McDonell. I'm in Williamstown, Ontario.

The Chair (Mr. Peter Tabuns): Thank you very much. With that, we go to the government. MPP Skelly.

Ms. Donna Skelly: Good morning, Minister. It's nice to see you this morning.

Shortly after the creation of the Ministry of Long-Term Care, the Long-Term Care Homes Public Inquiry, headed by Justice Eileen Gillese, submitted its report, which had 91 recommendations. I know that not all of those recommendations were to the Ministry of Long-Term Care. Some were for the Ministry of Health, the Solicitor General, the Attorney General, long-term-care home operators and other people.

Minister, you've reported back twice now on the progress that has been made with Justice Gillese's recommendations. Can you please update the committee on the progress that is being made within those recommendations?

Hon. Merrilee Fullerton: Thank you, MPP Skelly. I just want to reiterate how not only have we been addressing these issues—which began when we first became a ministry back in the summer of 2019—all along, but during COVID we've been dealing with the issues, obviously on an emergency basis with COVID, and at the same time making sure that we move forward with the important recommendations of Justice Gillese. I'm pleased to be able to say that about 80% of those recommendations are either completed or well under way.

Looking back at the summer of 2019 and how incredibly moving it was to hear from Justice Gillese and to be able to talk to the families there when she was delivering her recommendations—and how seriously we took those recommendations to get up and moving, particularly around medication and staffing. The staffing has been an ongoing effort. We looked at the registered staff, but we also included personal support workers in an expert panel to be studied to address a comprehensive staffing strategy that we will roll out by December 2020. So we just want to thank Justice Gillese for everything she's done and her insights in this. My heart certainly goes out to the families who were affected and to, really, everyone who was impacted by this.

Looking back, this has required a collaboration across ministries. It wasn't simply the long-term-care ministry that was addressing these recommendations. I think it's really important to recognize the collaboration we've had with our representative organizations, the OLTCA, AdvantAge Ontario; these are incredibly important relationships that we have to keep long-term care moving forward to rebuild and repair and advance long-term care. Justice Gillese's recommendations were certainly foundational.

I've said all along, and for many years, that we need to modernize long-term care. We need to bring it into the 21st century after many years of neglect, whether it was the staffing or the medication issues that were really front and centre with the Wettlaufer public inquiry. Justice Gillese's recommendations have really informed us with a very positive way forward, and we're very pleased with the progress that we've been making.

Looking at some of the other accomplishments related to this:

—a directive to the sector on medication management concerning glucagon;

—investing a $10-million annual training fund to help front-line care staff acquire new skills;

—entering into a three-year, $1.8-million partnership with the Institute for Safe Medication Practices Canada to help long-term-care homes strengthen medication safety practices.

These are areas that we started with, in terms of the recommendations, but many of the recommendations touched on areas that are ongoing and will take considerable time to solve. But we're well on our way, particularly on the staffing, to understand what our homes need on a regular basis to address a long-standing staffing crisis, as well as to be monitoring the homes that are in outbreak as we speak to make sure that they are getting the staffing requirements they need. This is something that is done on a daily basis.

There are really two issues here: One is an overarching need to address the staffing in a comprehensive way, which is well under way, as well as the issues on a day-to-day basis with monitoring the homes. And so you might get confused by talking about the staffing issues overall or the staffing crises overall versus when I mention no staffing issues in certain homes. They are two separate issues and they both need to be addressed on a regular basis, which is exactly what we're doing.

We're modernizing long-term care. We're making it safer. Certainly COVID-19 has posed a whole new set of concerns on an urgent basis and we have been acting swiftly to address those. I am very pleased and proud of the work that we've been doing, despite the really challenging issues with COVID-19. I thank everyone who has been part of that for their work and their passion for what they do. This really is thousands of people day to day doing what they need to do—and our personal support workers and staff in long-term care who have been so dedicated and compassionate, and determined to get us through this.

You've seen the staffing recommendation from the Justice Gillese recommendation, but it's also an issue that many, many people are working very diligently on to address. From my perspective during COVID, we know that our staffing situation is much more stable compared to the first wave, and that our homes are being able to provide a level of certainty that was not there in the first wave.

So things are definitely moving in the right direction. I'm very proud of our government's efforts to respond to Justice Gillese's recommendations. I'm very thankful for her input in this very important area.

The Chair (Mr. Peter Tabuns): MPP Triantafilopoulos?

Ms. Effie J. Triantafilopoulos: Thank you, Chair. I believe the deputy was going to add something to that.

Mr. Richard Steele: Yes. I believe, actually, ADM Janet Hope had additional comments on our progress on the public inquiry.

The Chair (Mr. Peter Tabuns): Okay.

Ms. Janet Hope: Good morning. My name is Janet Hope. I'm the assistant deputy minister for the long-term-care policy division with the Ministry of Long-Term Care. I'm very pleased to be here today to provide information on progress being made to address the recommendations of the Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System, which is more commonly known as the Gillese inquiry. As members of the committee will know, the inquiry was launched in response to a nurse using insulin to kill long-term-care residents in her care. These were particularly heinous crimes, as it was a caregiver who was harming some of our most vulnerable citizens.

On July 31, 2019, Justice Gillese delivered her comprehensive final report containing over 1,200 pages, divided into four volumes, with a listing of 91 recommendations, a detailed outline of the investigation into the offences, a strategy for safety, and an explanation of the inquiry process. Her honour's recommendations revolved around systemic issues in Ontario's long-term-care sector, including the risks of malicious attacks. The recommendations were grouped under four key themes: awareness, prevention, deterrence and detection.

Justice Gillese directed her recommendations to many different parties within the province, in addition to the

Ministry of Long-Term Care. Recommendations were also directed to the Ministry of Health, the Attorney General and the Solicitor General, including the Office of the Chief Coroner of Ontario. Additionally, recommendations were directed towards Ontario Health, the local health integration networks, the College of Nurses of Ontario, and individual long-term-care-home licensees.

The Ministry of Long-Term Care has worked with all of these partners, as well as other system partners such as AdvantAge Ontario and the Ontario long-term-care-home association to collaborate as we have moved forward. Together, we've acknowledged the vulnerabilities in the long-term-care system, which the offences and the inquiry exposed. We're working together to make the necessary improvements the public inquiry recommended.

Justice Gillese's first recommendation was for the government to report back publicly a year after the release of the report, and that progress report was issued on July 30 of this year. I'm pleased to be able to provide an update today on the recommendations which have been successfully implemented and those that are under way as we continue with the ongoing work to strengthen and improve the long-term-care sector in Ontario.

0920

In the process of implementing the Gillese inquiry's recommendations, our long-term-care system, of course, was confronted with COVID-19, and the staffing concerns that have been amplified during this crisis speak to the serious challenges with long-term-care staffing province-wide. As Justice Gillese recognized, this is a shortage that has been building for decades as our population has aged.

While Justice Gillese's report offers a critical guide for the safety and security of residents of long-term care, the current reality has raised additional issues which will also need to be addressed, and we look forward to the recommendations of the independent Long-Term Care COVID-19 Commission, established this summer, as we continue to modernize Ontario's long-term-care system to make it a safe, comfortable and dignified place to call home.

With this in mind, I'll now walk the committee through the progress the province has made in implementing Justice Gillese's recommendations. We've certainly taken Justice Gillese's report seriously, and our work in implementing the recommendations has been a top priority. As the minister noted, 80% of the report's recommendations are completed or under way, and meaningful steps have been taken across the sector to bring about real and lasting change.

The first area in Justice Gillese's report was the theme of awareness. Justice Gillese emphasized the need for awareness across the health sector of the risk of intentional harm and how to report it. Justice Gillese stressed the critical value that awareness brings to closing gaps in the long-term-care system, stating, "It is not possible to detect or deter something unless you are aware that it exists." To that end, the Ministry of Long-Term Care has been working with the Office of the Chief Coroner and the College of Nurses of Ontario to increase awareness among staff, families and visitors of long-term-care homes of their duty to report any suspicions of abuse or neglect.

The Office of the Chief Coroner is focusing on establishing best practices across the long-term-care sector, educating coroners and establishing an awareness campaign about the vulnerabilities that long-term-care residents face. The Office of the Chief Coroner is also partnering with Queen's University on this initiative. This collaboration will result in the establishment of a centre of excellence focused on addressing the needs and vulnerabilities of our aging population. This includes establishing clear expectations about the education and training necessary to prepare health care professionals to effectively recognize and respond to intentional harm within the long-term-care sector.

The College of Nurses of Ontario, which is the regulatory body for nurses, has also been working to establish processes to enhance awareness within the sector. For example, the college has revised their reporting guide to include information about a nurse's professional responsibility to act in their patients' best interest and to protect their patients from harm. The guide sets out clear expectations for nurses, particularly when it comes to reporting to the college on any improper treatment or care, suspected abuse or neglect by another registered staff member.

In fact, it is a legal obligation under the Long-Term Care Homes Act that staff—and, in fact, any member of the public—with reasonable grounds to suspect improper or incompetent treatment, abuse or neglect of residents report it immediately to the Ministry of Long-Term Care. To that end, the Ministry of Long-Term Care has developed information posters targeted towards families, visitors and staff in long-term-care homes to increase awareness of the obligation and methods for individuals to immediately report any suspicion of abuse or neglect of a long-term-care resident.

I'll move on now to the second theme: prevention. Justice Gillese noted that the best way to protect long-term-care residents is through preventative measures. To quote Her Honour: "The best way to deter health care serial killers is to strengthen the long-term-care system by building capacity and excellence throughout it."

In this regard, 21 of Justice Gillese's recommendations relate to training and the importance of increasing staff capacity and competencies. That is why the ministry has committed to a new, annual $10-million education and training fund. This investment will help to improve the quality of front-line care and outcomes for long-term-care residents. It will also ensure long-term-care staff are developing new skills and adopting evidence-based practices.

Investments in this fiscal year are focused on the response to issues identified during the spring with COVID-19. One of the offences occurred in the home and community care sector, and as a result, Ontario Health—or OH, as we refer to it—and the local health integration networks, or LHINS, have been working on an initiative to include reporting of unusual incidents in the annual pre-

qualification application process for prospective contracted home care providers. The pre-qualification applications are the first step of an ongoing process for external service providers to be screened and placed on a dedicated list of trusted service providers.

In addition, Ontario Health and the LHINs are working to revise the standard agreement for home care services. The revised agreement will include updated obligations that will strengthen the safe delivery of Ontario Health- and LHIN-funded home care services, and increase the accountability of service provider organizations.

Additional preventive measures that the province has employed include increasing the awareness of the MedsCheck at Home program, as recommended by Justice Gillese. This program, which is funded by the Ministry of Health, allows eligible home care patients to have an opportunity to meet with a pharmacist in their home, ask questions about their medications and have the pharmacist review their current medication supply.

Also, Ontario Health and the LHINs have established working groups that are developing a suite of patient-facing education materials on medication safety. These materials will focus on supporting patients in accessing the MedsCheck program and on the safe use of medications in the home. The group is also developing materials for patients and staff on the recognition of the signs and symptoms of medication toxicity, as well as the safe storage and disposal of medications.

The third area of inquiry recommendations identified deterrence as a key way to prevent harm to long-term-care residents by creating additional safeguards within the system. Justice Gillese identified medication management and staffing as key areas of focus to deter those who would cause intentional harm, and to strengthen safety. Specifically, Justice Gillese recommended that "the already solid medication management system in long-term-care homes must be strengthened through infrastructure changes, the use of technology, and increasing the role of pharmacists."

The ministry has been working to strengthen medication management and safety in the long-term-care system. Medication management refers to the process of prescribing, dispensing, storing, administering and destroying medication that long-term-care licensees, physicians, nurse practitioners, nurses and pharmacy service providers use to avoid medication errors. This process is particularly critical for Ontarians who reside in long-term care, who are prescribed an average of 10 drug classes per resident to treat multiple medical conditions.

Before the release of the Gillese report, the province was working to improve medication management. The ministry created a working group with key sector partners that was tasked with identifying barriers to effective medication management in long-term-care homes and solutions that would address these barriers. The goal of this work is to improve medication safety so that long-term-care residents do not experience adverse outcomes, such as—

The Chair (Mr. Peter Tabuns): I'm sorry to say, with that, you're out of time. Thank you very much.

Ms. Janet Hope: Thank you.

The Chair (Mr. Peter Tabuns): With that, I will go to the official opposition. Madame Gélinas?

M^me^ France Gélinas: I will repeat my questions because I don't think you will ever remember them after so long.

The ongoing testing in our long-term-care homes means that there are actually tests being done in our homes, and I was wondering if you would consider letting the essential caregivers be tested on site rather than having to make an appointment to go and be tested in the pharmacy?

0930

Hon. Merrilee Fullerton: That's a very good question. Just to reiterate: Each resident can designate two essential caregivers to be able to come in and assist them, whether it's with feeding or activities of daily living or even emotional support, which is so critical.

That is a clarification I'd like to make, because there are some people who are equating a change in visitor policy with the essential caregiver policy. There are visitors allowed in, but they must be the essential caregivers, not general visitors in homes that are in outbreak or in homes with high problems with COVID.

Looking at the testing and understanding how those caregivers can best be tested, it is a situation that we're looking at, understanding how best they can be accommodated and to get those tests back also in batches, because it makes a difference if we can get them to come back together. It is something that we're looking at.

I don't have anything further to add on that, but perhaps the deputy does.

Mr. Richard Steele: No. With respect to essential caregivers, you are correct. At this point, they are not being tested in the home, at least for the most part that I'm aware of. They are indeed required to secure their testing at a pharmacy or an assessment centre.

As we continue to think about how we deliver testing and enhance testing in long-term care, certainly, as some of the additional testing technologies come online that may be perhaps a little simpler to administer in the homes—antigen testing, for example, as that becomes available and potentially deployed for surveillance testing—it may be that that starts to create some additional options as to how tests can be administered in a way that would be more convenient for caregivers.

I think it's recognized that there is a burden involved for caregivers and other visitors having to go and get tests. That is recognized. It's not an ideal situation, that's for sure, but there are some logistical challenges of performing the tests in the homes.

As the minister says, it's definitely something we'll continue to look at and certainly recognize the value of dong that, if it can be done.

M^me^ France Gélinas: Okay. I'll push that a little bit further. If a home is willing to test their essential caregivers—they know them; they come every day etc.—would they be allowed to let an essential caregiver be tested while the testing is going on for their staff?

Mr. Richard Steele: Let me take that one back. I'm not aware of something that would prohibit that, but it's

possible that I'm missing something in terms of just the logistics of the testing and batching the tests up and sending them to the lab and managing all of that. There may be something I'm missing in terms of how all of that works. I'm not aware of a prohibition, but let me get back to you on that—or let us get back to you on that.

M^me^ France Gélinas: Okay. Down the same line, we have our essential caregivers who need to be tested all the time. If you do the inquiry and it turns out that they cannot, for reasons unknown, be tested in the home, is there any way that we could identify them so that when they go get tested, they are sort of prioritized? In my neck of the woods, it's a long time before you get your results.

Mr. Richard Steele: Again, fair comment. I think in general, the objective has certainly been to try to keep test turnaround times down. I know we did collectively see an increase in test turnaround times through the latter part of September and early October, but I understand they are back down in target ranges now, so that would be helpful.

Again, I can see the benefit of what you're describing, but I'm not sure of what logistically would be involved in order to actually isolate and segregate and separate in some manner those caregiver tests for prioritization. You can appreciate that the more streams of prioritization you have coming into the lab, the more complicated it becomes and more difficult to actually manage test turnaround time.

There are some trade-offs there in terms of how much prioritization happens and how many different categories of prioritization happen in terms of ensuring that the overall volume of tests can get turned around quickly. So there are some trade-offs.

M^me^ France Gélinas: Okay. Just so that everybody knows, my preference would be to let them be tested while everybody else is being tested in the home. Many homes are willing to do this. I have a feeling some of them have started—maybe not telling you openly. But it would be really good if that could be done.

Minister, you started by saying that, in December of this year, we will have your new I think you call it human resources plan—

Hon. Merrilee Fullerton: Comprehensive staffing strategy.

M^me^ France Gélinas: Comprehensive staffing strategy. So we note that the staffing panel has said, "Staff up now. Don't delay; don't wait." Are we going to see anything before, or are we going to have to wait until the strategy is released in December?

Hon. Merrilee Fullerton: Thank you for the question. This is something that we've been working on all along as we became a new ministry. There's no question coming in that there was a shortage of PSWs. We heard that loud and clear, and we began to work to address that.

PSWs are in health, and the human resources strategy overall is one driven and led by the Ministry of Health. We have the majority of personal support workers working in long-term care, but we don't control that. We can provide input, and we have done that. We also included it in Justice Gillese's recommendation that was for registered staff. But we consulted and collaborated with the Ministry of Health and included the personal support worker piece on that at that time.

Definitely the staffing is ongoing, not only for the capacity that we're building—we need more—but also to shore things up at the moment. That's why we have really innovative programs ongoing, like the return-of-service program and the fast-track program. That's why we introduced the amended regulations to provide flexibility to our long-term-care homes in terms of staffing—the amended regulations as well as the emergency orders.

All of these were designed to help our homes manage the staffing during the COVID challenge in the first wave. That's not subsided; we've continued to work on this, knowing how critical it is for our homes. And also, when COVID does get into the homes and the effect on staff, the uncertainty and the concern, some of them will choose not to come to work. Some of them have tested positive and must self-isolate at home. That's why that surveillance testing is absolutely critical. We've also been working with the federal government to try and expedite those rapid tests, because that would make a difference and it would certainly help with the turnaround times. If it's minutes or hours, it's much better than days. So that's a really critical piece to providing certainty to our staff in long-term care.

So the staffing piece, we've never relented on that. It's something that we hit the ground running on with the Justice Gillese recommendations, with the expert panel and their recommendations. It's critical that we keep working on this, but I really want to emphasize that if there were 6,000 PSWs out there, I'm fairly certain our homes would have hired them. We just can't create them like an assembly line. You don't just turn on a knob and out they come. This requires proper training. It requires creating a culture in long-term care so that people want to come and work in long-term care. It needs to be a place where they are valued, and I think that our government has demonstrated that they are valued, not only from the vocal support, the supports in the homes, but also from the dollars we've put behind that: $461 million to supporting our PSWs in long-term care, the $3 wage increase. Certainly, we can see that the homes that are going into outbreak with zero resident cases and some staff are doing very, very well, and our staff numbers are staying, they're holding.

I'm under no illusion how difficult this would be to change the culture in terms of one of continuous improvement and support for staff, because this is a long-neglected sector, and we've been working on this since day one.

I'll ask the deputy if he would like to add anything.

Mr. Richard Steele: Just to complement the minister's comments, just a couple of other things in the shorter term that I think are and will have a positive impact as we work on the staffing strategy. Certainly, the PSW wage enhancement is going to be of some significance.

0940

The other point I think is worth noting, as I think we talked about in the previous session, as we've limited admittance to ward rooms, we have seen a reduction in occupancy in long-term-care homes. But we have, at the

same time, maintained funding levels. So effectively, we're providing funding for the same amount of staffing for a smaller number of residents. That also obviously provides some short-term relief as we go through the fall, in terms of the pressure on staff and their ability to support residents.

The Chair (Mr. Peter Tabuns): MPP Armstrong.

Ms. Teresa J. Armstrong: You mentioned the ward beds, so I wanted to go over that with respect to the second wave. In a follow-up to the reports on the three- and four-bed ward rooms last week in the Huffington Post, they published a story where the ministry communications rep indicated that not all long-term-care homes submitted an assessment plan that reveals whether the home is prepared for a second wave.

There are 626 long-term-care homes in Ontario. How many have submitted a plan to the ministry? And will the minister make these plans public? If no, why not?

Hon. Merrilee Fullerton: Planning is ongoing. We're in regular contact with our homes to understand what their situation is, whether it's staffing, PPE or infection prevention and control. Obviously, we've been very clear in acknowledging the ward rooms, and that's shown through studies as well. We know that this is a piece that needs addressing, and we've been making sure that we understand the issues with the data here, because again, the neglect of this sector is quite remarkable for many, many decades now. There was not initial data easily retrieved, and so we've had to create that data. So while we've been working to address the capacity issues in long-term care, the staffing issues, the IPAC issues, the outbreaks, we've also been working to make sure that we have the data that we need to understand the circumstances of the homes. All of this has had to be done simultaneously.

I thank the ministry and the deputy for being on this so quickly. I believe he can comment on the ward rooms as well.

Mr. Richard Steele: Thank you, Minister. A couple of things: a question on the ward rooms and a question on the assessment plans in the summer.

In terms of the ward rooms, again, I think as we talked about in the last session, through directive number 3 that Dr. Williams issued, there are limitations on admitting new residents to any ward room that would bring the occupancy level above two. The impact of that over the last number of months has been a significant reduction in the number of residents in those ward rooms. But, as I think we've talked about, that is still a work in progress, if you like. There are still homes with ward rooms. There are still rooms with more than two residents in them at this point in time as that works through. We have seen a significant reduction in occupancy, from 99% as we headed into the first wave of COVID down to about 94% or 95% right now. That is largely related to that reduction in occupancy rooms.

You had a question around the assessments that were undertaken in the summer. Those were assessments that we asked each home to undertake and then work with their Ontario Health region to identify and address any gaps and ensure that they had appropriate supports and partnerships in place. The intent of those assessments was not that they be provided to the ministry individually; it was that they be used as a mechanism for the home to work with our Ontario Health regions to ensure that there was clarity on any gaps and any areas where the home would need additional support. That's the purpose that they were used for.

The Chair (Mr. Peter Tabuns): Madame Gélinas.

M^me^ France Gélinas: Just to continue, of the 626 homes, how many of them have wards? How many of them now only have two people in their ward rooms? Do you have a pretty good understanding of where they're at? The directive from Dr. Williams is not to admit, but that doesn't do anything for people that are already there. Are you putting anything forward for people already there? How are you managing that?

Mr. Richard Steele: As the minister referenced, in terms of the data on exactly where we are at a given point in time in terms of ward rooms, that is data that we're trying to capture right now. We developed an electronic tool that was actually implemented last week. It ultimately will be used to gather a range of data, but a particular interest on our part is in understanding occupancy, not just ward room occupancy, but occupancy in general, and on a more real-time basis. Right now, we kind of only get that data with a two-month lag, which is obviously problematic for us. So that system has been implemented. Homes are being trained on it as we speak, essentially, and we anticipate having a first cut of that data. It probably won't be perfect the first time around—likely, when you implement a new system and data gathering tool. There are some data quality issues we'll need to work through. But we anticipate within the next week or so we should have a first cut of that data that will give us a good, comprehensive picture of just where we do stand right now, and then we will keep refreshing that data on a weekly basis.

M^me^ France Gélinas: Do you intend to give a further directive or to give orders to the homes to not only not admit into a ward room but to also transfer people out of ward rooms as other rooms become available?

Mr. Richard Steele: Minister, do you—

Hon. Merrilee Fullerton: I'll comment on that because I think it's an important understanding. Going into COVID, our homes were at 99% capacity. Certainly, if we look at the residents in the homes, it really is their home, and so we must not treat people as widgets to be moved about. They are people; this is their home. We have to respect their rights and understand the importance of the consultation that would be needed if they were to be moved. For many people in the last year and a half of their life, who are in long-term care, they're very frail, very complex, medically speaking, and so it's not as though you just start moving these people around.

Obviously, we want to make sure that we take every measure possible to prevent spread within the home, and we know the ward rooms play a role in that. Certainly, in the homes in outbreak, the cohorting of residents is a

critical piece to maintaining the quality of care and reducing the risk of spread.

But it's absolutely essential that we all understand that this is their home and they have rights, as they should have. I just think that should be at top of mind, that we have to be resident-centred when we talk about long-term care and what we do in long-term care.

M^me^ France Gélinas: I appreciate the empathy. What I'm looking at is that most of the ward rooms—well, all of the homes with wards are old. For most of them, it means that the ventilation is not good. We're starting to see a level of risk to the residents versus the fact that you don't want to move them around. Are we looking at a negative-pressure kind of thing developing in those old homes? And who pays for this? I know the technology is there. When they remove asbestos, they create it on the spot, and it works. Are we looking at that kind of stuff coming into our long-term-care homes?

Hon. Merrilee Fullerton: We're looking at every measure possible and using every tool possible. The situation surrounding the minor capital funding, the $61.4 million that we announced with the $540 million for long-term care just a few weeks ago—this was, in part, to address this issue. What level of engineering can be accomplished in the homes that are existing? How can we make sure that every tool and every measure is taken surrounding that aspect, as the evidence and science evolves with COVID-19? It continues to evolve and we continue to take measures to provide our homes with the support that they need to address this.

I'll ask the deputy if he would like to comment further?

Mr. Richard Steele: I don't think I need to comment—

Hon. Merrilee Fullerton: Okay. Thank you.

M^me^ France Gélinas: When we look at training for infection prevention and control, are you satisfied that all of the tens of thousands of people who work in our long-term care now have—

The Chair (Mr. Peter Tabuns): I'm sorry to say, Madame Gélinas, you're out of time.

We go to the government. Ms. Triantafilopoulos?

0950

Ms. Effie J. Triantafilopoulos: Thank you, Chair. MPP Jim McDonell has a question.

The Chair (Mr. Peter Tabuns): MPP McDonell, the floor is yours.

Mr. Jim McDonell: Thank you, Minister, for that discussion. It's interesting to note: I was talking to one of our homes just this week, and they talked about how, over the last eight months, they no longer have four people in their wards, that they've been able to get it down. It was just a discussion we were having and that came up. So I can see you are making progress, and it means their numbers are down, but they're working through this.

I know there's a been a lot of commentary made over the past year on inspections, since before the pandemic. A lot of the terminology that gets thrown around has often muddled the issue—RQIs as opposed to comprehensive inspections or annual inspections, and so on. So can you give us a detailed explanation of the inspection system in the long-term-care-home sector?

Hon. Merrilee Fullerton: Thank you, MPP McDonell. I'm glad you've been out and speaking to your long-term-care homes, whether it's the people that are working there, the administrators or others. So thank you for being in touch with them—perhaps virtually these days. I know you're out and about in your community quite a bit, so I appreciate that.

First of all, if we look at the inspections, the safety and the well-being of our residents in long-term care is the number one priority of our government, and we're committed to making sure that they are protected. In terms of the confusion surrounding RQIs, as they're called, or an inspection process, the Auditor General had a report back in 2015, because there was a backlog of inspections the way they were being done, the RQIs. Some of the homes that were really at risk were not getting their inspections because of the backlog. So there was a report that came from the Auditor General and the previous government began to understand that issue.

In 2018, the recommendation by the Auditor General to switch to a high-risk inspection process was fully implemented. That really made sure that the homes that were being identified as at-greatest-risk were getting the scrutiny that they needed.

Also, to make sure that everyone is clear, we do have a line where anyone working in the home, any family member, any resident, anyone who has concerns about what is going on in a long-term-care home can reach out, call that number and make sure that their concerns are addressed. Someone will look into it within 24 to 48 hours to see what level of response is required. So this is a very important aspect of how we maintain scrutiny within the homes.

But in terms of numbers, there were over 2,800 inspections last year, but since January, the ministry has completed 1,339 inspections. That's really before the year is finished, obviously, so we expect that will be an ongoing effort. But I really want to make sure that everyone understands that the reason why it was changed to high-risk inspections was based on the Auditor General's report to provide the level of scrutiny that was really required for homes that seemed to have more problematic episodes.

Also, public health is in on the ground. Their eyes are in our homes as well to understand what is really happening in real time. They want to make sure that their work is also integrated. So whether it's public health that's involved, Ontario Health providing its levers to help with the IPAC, the infection prevention and control teams, or whether it's staffing—because we recognize we need to provide certainty and stability to our staff members so that they have confidence that the measures are taken to address the concerns that they have. Same with family members: It really is an issue about trust. I think that that is a really important aspect of the inspections that we do and the way we do them.

I know there has been an attempt to say that a small number have been done. There are thousands of inspections being done, as well as other measures of addressing

concerns within the home. Some inspectors were redeployed to monitoring capacity and doing crucial work, ensuring the needs of the front-line workers and the residents were being addressed. That was very early when we were first understanding what was happening with COVID, listening to our health experts, listening to our public health experts, our science tables and public health tables.

This is something that we needed to address very early on to make sure the inspectors were safe as well. So for a moment in time the inspectors were contacting the homes remotely until we had a full understanding of the risk that was posed to them as well. We worked with the unions to create a level of comfort for the inspectors going in. So we have to be respectful of everyone's concerns and their well-being.

The hardest-hit homes were really under scrutiny with public health, with labour inspectors, with the Ministry of Long-Term Care inspectors, and we've been committed, since day one, as we began as a ministry, to the safety and well-being of residents and staff and the inspections are part of that.

I really want to thank the Auditor General. The Office of the Auditor General is also doing another look at this and we expect a report down the road.

Also, the Ministry of Long-Term Care inspectors issued more compliance orders in 2019 than in 2018, 2017 and 2016 already. I've touched on the Auditor General's report to see if there's anything else I would like to mention here.

I think the Ministry of Labour inspectors are experts in workplace safety, and they enforce the Occupational Health and Safety Act. Just to summarize, there are many eyes on our long-term-care homes.

We've also heard from the Patient Ombudsman—and I think that was a well-received report—to understand what else can be done, and obviously the independent commission to understand what more we can do, and there is consideration of an interim report.

The inspections are one part of making sure that our homes receive the scrutiny that is needed, and this is ongoing. The commitment from our government is to the safety and well-being of residents and staff in our long-term-care homes as a number one priority.

I think there's someone else from our ministry who's going to speak.

Mr. Richard Steele: I think our ADM of operations, Sheila Bristo, had some additional comments to make.

Hon. Merrilee Fullerton: Thank you.

Ms. Sheila Bristo: Thank you, Minister. Good morning, Chair and committee members. My name is Sheila Bristo, and I'm the assistant deputy minister of the long-term-care operations division. The long-term-care operations division is responsible for implementing the regulatory compliance inspection program for the provincial long-term-care sector, which serves over 100,000 Ontarians annually.

Long-term-care homes account for $6 billion in government spending that helps ensure long-term-care residents have access to the high-quality, specialized care that they need. Working with our partners across Ontario, the division is leading the modern, risk-based assessment approach to ensure long-term-care-home licensee accountability and the implementation of legislation, regulation and policy related to long-term care.

The development and operation of long-term-care homes is a very serious matter, and Ontarians can take pride in the fact that our long-term-care-home inspection program is the most rigorous in Canada. Not only is the program rigorous but it is constantly evolving, based on the needs of residents and the challenges that present themselves.

While Ontarians are keenly interested in the health of our long-term-care system, we face a great deal of public and independent oversight which has brought forth formal recommendations that help structure the ongoing development of our program. We welcome this oversight and the perspective it brings to our decisions around improving the long-term-care system. At times, we are required to adapt quickly to changing realities that demand an innovative approach, and this adaptability was put on full display during the unprecedented COVID-19 pandemic.

1000

Before going into the specifics of the response, I want to set out some details about the sector and the way in which the inspections branch operates. The sector is sizable, both in geographic terms and in terms of numbers. There are more than 78,600 long-term-care beds and over 620 homes across our province. These homes operate under a number of different governance structures that may be for-profit, not-for-profit or municipally operated. Regardless of the governance structure, all homes must meet the same licensing and regulatory standards.

The sector employs over 52,000 dedicated staff who provide interdisciplinary care to over 100,000 residents annually. These dedicated staff include nurses, personal support workers and allied health professionals, such as physiotherapists, dietitians and programming staff. They are providing high quality, resident-centred care to some of our province's most vulnerable and increasingly medically complex individuals.

One of the Ministry of Long-Term Care's core mandates is that of compliance and enforcement. This falls under the purview of the long-term-care inspections branch. The inspections branch operates across the province in seven different administrative areas called service area offices, each having a complement of inspectors and administrative staff overseeing their region's long-term-care homes. Every inspector is a health care worker holding one of the three following designations: registered nurse, dietitian or physiotherapist.

In addition to the service area office, the inspections branch central support team provides education and training, data quality and oversight, and operational policy support. Finally, a centralized intake assessment and triage team acts as the interface between the ministry and the public and long-term-care homes.

The long-term-care homes inspections program was developed after the Long-Term Care Homes Act and O. Reg. 79/10 came into force on July 1, 2010. At the heart of this program is a focus on the residents' quality of care and quality of life. With this focus in mind, we have the following program objectives: We strive to maintain alignment with the governing act and regulation; ensure that residents in long-term-care homes continue to be protected and cared for, and their dignity and rights respected; assure the public that our first priority is the care and safety of residents; build an evidence-based and resident-centred inspections process; and, finally, improve objectivity and consistency through a structured information-gathering process.

Embedded in the Long-Term Care Homes Act is the Residents' Bill of Rights, which details 27 distinct rights, including the right to receive safe, consistent and high-quality, resident-centred care in settings where residents feel at home, are treated with respect and have the supports and services they need for their health and well-being.

Our inspectors conduct a range of different proactive and reactive inspections, all of which are unannounced.

Complaint inspections are carried out when the ministry receives information from the public, residents, family members or staff. These complaints are made by way of our action line or through direct correspondence.

The critical incident system inspections are done when the home reports information to the ministry about an incident that has occurred. The Long-Term Care Homes Act requires that details of certain incidents be reported to the ministry.

Follow-up inspections occur when a compliance order has been issued to a home and inspectors return to ensure that the non-compliant areas have been corrected.

Resident quality inspections are carried out in two stages. The first stage involves clinical record reviews, observations and interviews with residents, staff and family members. This is followed by a focused inspection based on the results of the first stage.

Lastly, there are a number of other inspections, such as those initiated by the service area office, follow-up on directors' orders, and special inspections designed to review specific areas of concern. There is a steady stream of information coming to the ministry regarding long-term-care homes. This information may take the form of a phone call, an email, a critical incident report or a report from the action line.

Managing this volume of information with an intake assessment triage team is a critical part of the inspection process. Triage staff examine this information, determine if there is potential non-compliance with the act and regulation, and if so, what level of risk is posed by the non-compliance. This triage forms the basis of the subsequent action taken, be it an inspection for high-risk situations or an inquiry for low-risk situations.

Our triage staff do an exceptionally good job of managing a very large volume of intakes. On a monthly basis, the ministry triages over 300 complaints and over 1,300 critical incidents.

When inspectors visit long-term-care homes to complete inspections, they make observations, carry out interviews and review records at the home with the goal of determining compliance with the Long-Term Care Homes Act. When non-compliance is found, there are a number of different actions an inspector may take in response. These include written notifications, voluntary plans of correction, compliance orders and director referrals.

If the problem persists, escalated enforcement action is taken by the director, including a cease of admissions or a mandatory management order where external management teams are hired to assist the home with its operations. In extreme cases where long-term-care-home licensees neglect their duty to properly operate a home and care for the residents, the ministry has the right to revoke the licence entirely.

After an inspector visits the home and gathers information, a determination is made on whether or not compliance was found. In every case, the inspector writes a report giving key details about the reason for the inspection, the activities conducted during the inspection and the non-compliance found, if any. The licensee and the home administrator are provided copies of this report.

A public version of these reports is then posted online for any member of the public to see. The historical record of inspection reports for each and every home is also available online. In this way, we maintain the transparency of our inspection activities and findings.

As with all areas of the health system, the standard operating procedure for the inspections branch was disrupted this spring with the onset of the COVID-19 pandemic. Our network of connections to and relationships with the long-term-care homes was put to use immediately to give decision-makers critical information on the status of more than 600 long-term-care homes in the province.

Early on, staff began compiling daily reports with updates on COVID-19 progress in the long-term-care homes, including case numbers and concerns related to staffing and personal protective equipment. We reached out to homes directly to determine which ones had additional capacity and issued temporary emergency licences—

The Chair (Mr. Peter Tabuns): I'm sorry to say, with that, you're out of time.

Ms. Sheila Bristo: Thank you.

1010

The Chair (Mr. Peter Tabuns): We go to the official opposition. Madame Gélinas.

M^me^ France Gélinas: I will finish the questions that my colleague gently interrupted me on. I was talking about staff training in infection control and safety protocols, including the safe use of PPE. We all know where we were at before the pandemic. Do you feel that now the homes are all doing good in IPAC, infection prevention and control?

Hon. Merrilee Fullerton: This is an ongoing concern, obviously, as there is more evidence and science surrounding COVID and what is needed in different contexts. Looking at the announcement we made a few

weeks ago to get six to eight weeks of PPE to all our homes in Ontario, looking at the $30 million that we announced a couple of weeks ago with the $540-million package, looking at the IPAC training and the hiring for IPAC specialists, we'll call them, in the homes: This is something that we feel will ultimately result in about 150 hires—that's what we estimate—from the $20 million or the $10 million. Perhaps the deputy can clarify that piece in terms of the $30-million breakdown, the $20 million and the $10 million.

Mr. Richard Steele: A couple of things: In terms of the funding for IPAC resources and training, yes, that includes $20 million for essentially—let me take a step back. The model for enhanced IPAC support that we're putting in place, in partnership with the Ministry of Health, is kind of a hub and spoke. The hub-and-spoke metaphor doesn't seem to work very well for people, but essentially there's a hub and then kind of satellites around the hub. The hub is intended to be a sub-regional centre of expertise in IPAC that can support a number of congregate settings, including long-term care.

Within each home, the funding that the minister referenced is intended to increase capacity for IPAC leadership within the home. We'll be working closely with Ontario Health to identify how to prioritize that funding to the homes that are most in need. Many homes already do have IPAC expertise in the home. Some don't, and those are the gaps that we really want to fill. In addition to that, the funding we're providing will also provide for enhanced IPAC training for staff in the homes.

I'd say a couple of other things, though, in terms of IPAC that have been happening really through the course of the year, particularly and specifically through the summer and early fall. In many homes, you're working with either public health or hospital partners that have now gone through multiple rounds of IPAC assessment, with recommendations provided to them of areas for potential improvement. In addition to that, we worked closely with Public Health Ontario to put together a comprehensive online learning program for all of the different roles in long-term care so that staff can, again, go through that supplementary training around IPAC.

M^me^ France Gélinas: Sorry to interrupt. Could any of this training and this online—could that become available to essential caregivers who end up spending a lot of time in the homes? Or, right now, is the money solely available for hired staff?

Mr. Richard Steele: I believe there is a module of the training available for long-term care through Public Health Ontario that is targeted at essential caregivers. We are also looking at: Is there anything more we can do on the training side for essential caregivers? There are various sources of training that we're looking to for various roles in long-term care. So we continue to look at, to your question, is there more that could be done around supplementary training for family caregivers?

So yes, that's something we continue to look at, if we could do more. But my understanding is that there is a module that is currently available and developed.

M^me^ France Gélinas: Thank you. How is this training available to all of the agency workers that work in one home now? If they're an agency worker, are they allowed to take part in that training?

The Chair (Mr. Peter Tabuns): I'm sorry to say, Madame Gélinas, that we have run out of time.

The committee is now adjourned until October 21 at 3:30 p.m., following routine proceedings.

The committee adjourned at 1015.

STANDING COMMITTEE ON ESTIMATES

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Also taking part / Autres participants et participantes
M^{me} France Gélinas (Nickel Belt ND)

Clerk / Greffière
Ms. Thushitha Kobikrishna

Staff / Personnel
Mr. Jason Apostolopoulos, research officer,
Research Services
Ms. Sandra Lopes, research officer,
Research Services