COVID Comes to the House of Old

On March 5, 2020, a nurse working at North Vancouver's **Lynn Valley Care Centre tested positive for COVID-19.**

Three days later, the first Lynn Valley resident died. Then 20 more residents died over the next 8 weeks. Attention shifted to the barrage of residents' deaths in Ontario and Quebec facilities. By the end of September, just over six months since the first death in Lynn Valley, this Canadian tragedy had taken 7,609 lives in residential care homes. 82% of Canada's first-wave deaths were residents of care facilities, making our country the grim reaper par excellence among the nations of the Global North.

The situation in under-resourced facilities during COVID outbreaks was messy, unthinking, and heart-breaking. Workers fell ill or were scared to come in for their shifts. In aging, for-profit facilities, particularly in Ontario where as many as 3 or 4 residents share a room, the virus slipped easily between flimsy curtains separating beds. According to the Globe and Mail's sources, some years ago, unionized care-aides at Lynn Valley had been let go then rehired on contract for less money and fewer sick days. In the critical days of early March 2020, this meant that ailing workers were loath to call in sick.

The carnage continued. When public health staff entered the 134-bed Résidence Herron (Dorval, QC) on March 29th they found frail elderly residents in a state of dehydration, unfed, and covered in urine and feces. Only three staff were in attendance. A month later, both Quebec and Ontario called in the army - some 1,650 trained personnel - who filed

damning reports when they departed. Stories of bug infestations, residents denied baths or pain medication, and workers untrained in sanitary protocols spilled into the media. Noting longstanding deficits in the sector, Prime Minister Justin Trudeau stated emphatically that Canada, "needed to take action as a country."

In health and social services, the conditions of work are the conditions of care. Before March 2020, care aides typically floated between facilities, picking up shifts for wages as low as $13 per hour. However, as the 2003 SARS outbreak demonstrated, casual health workers can unknowingly transmit infection from one work setting to another. BC moved decisively to stop the spread of infection, first banning all visitors and then the practice of working across care homes. Ontario and Quebec followed suit, but not quickly enough. Workers were sick, in short supply, and exhausted. In the first year of the pandemic 23,000 long-term-care staff were infected and 28 died.

COVID hit long-term care in central Canada, the prairies and BC with a vengeance in the late fall of 2020. The names of the places where so many elders died should be etched into the steps leading to our provincial and federal legislatures: Tendercare, Extendicare, Little Mountain, Roberta Place, George Derby, Capital Care Lynnwood, Maples Personal Care Home, CHSLD Sainte-Croix.

Researchers noted the prevalence of for-profit facilities among homes with high death counts in the second and third waves. Closing care homes off meant fewer doctor visits, little hospital care or specialist treatment, deeply lonely elders, and no loving family to give a hug or coax a reluctant resident to finish a bowl of soup.

Politicians' press briefings and media reports tended to be selective and often lacked depth. We heard little about the difficult situation of long-term-care staff - a racialized and disregarded workforce largely made up of women from the Philippines and the Caribbean. There was no accounting of how family rights were stripped away in embattled seniors' facilities right across the country or how Ontario offloaded hospital patients into care homes in the panicked first weeks of the pandemic. Why didn't we learn about facilities like the City of Toronto's massive Castleview-Wychwood Towers, where strong leadership, effective teamwork and a responsive public health bureaucracy beat back COVID? And not a scrap of attention was paid to disabled younger adults in long-term care, shut in for months on end.

The story of COVID in the House of Old will continue to unravel in slow, sad pandemic time. Weary of fear and caution, concerned with extreme weather and mounting grocery bills, settler Canadians may not yet realize - let alone reflect on - how we failed our vulnerable elders. This is a major issue of our time. Our parents, our children, and our future selves will judge us on the quality of our response.

Past is Present in Long Term Care

History matters, especially to those who are relegated to the **margins of power.**

Few Canadians appreciate how the heritage of the English workhouse imposes itself, ghostlike, on today's eldercare residences. Incarcerated workhouse residents - many of them frail and elderly - were denied personal dignity and the right to leave the facility. The food, the daily routine, and the atmosphere were punishingly institutional.

Canadian workhouses, a British colonial transplant, had the same punitive character as insane asylums, prisons, reformatories for wayward youth and residential schools. In Ontario, municipalities administered Houses of Industry and Refuge where the poor and infirm worked for their keep. Over time, these institutions evolved into Canada's first old-age homes, but they remained shameful places of last resort. At the Provincial Home for Old Men in Kamloops, BC, opened in 1894, new residents lost the right to vote and had to turn over everything they owned.

A big shift began with the 1927 federal old age pension. A monthly cheque in their pocket meant that low-income seniors in good health could choose to live independently. Old-age homes became places for infirm elders.

Over the next decades, BC and Ontario launched hospital programs to relocate elderly patients from public hospitals to small private hospitals and boarding homes. These businesses monetized care for frail seniors and were the genesis of today's for-profit facilities. Traces of the workhouse lingered in these new institutions: officials investigating Victoria's

Maple Rest Nursing Home in 1933 found 16 patients housed in a dimly lit basement with little ventilation.

A new kind of eldercare emerged in the 1950s and 60s. Former workhouses closed their doors to be replaced by low-rise municipal or non-profit, old-age homes that combined the ambience of the suburban home with resort-style living. For middle-class pensioners needing support, there was no shame in moving here and enjoying cafeteria-style dining, a hairdresser on site, and lawn bowling with new friends at Ottawa's Carleton Lodge or the Pioneer Home in Prince Rupert.

The next civic development in senior care was publicly funded home support, which provided company, help with cooking and cleaning, and personal care. In BC, home care was to be the central plank of a new Long Term Care Program, an economical service that would improve quality of life for many elders. But these people-first seniors' services were not part of Canada's national Medicare system. Without protection from the federal government, they could not be sustained, especially when privatization of government services increased and provincial cutbacks accelerated from the 1980s into the millennium.

There remains a capacity for goodness and positive change in Canada's residential eldercare system. Music therapy snuck into Vancouver's care facilities just before restraint hit in the late 1970s and remained standard for decades. More recently, some innovative Ontario institutions have introduced progressive care models. Peel Region tested the Butterfly Program in one dementia unit, shifting the institutional emphasis from

task completion to emotional bonds. The results? A dramatic drop in resident depression and medications, decreased staff sick days and increased staff retention - all of which added up to yearly savings of $50,000.

Disability advocates tell us that small acts of brutality and a constant negation of personhood mark the lives of vulnerable, institutionalized people. In long-term care, this is reflected in the way staff and residents are not given time to connect, and rigid institutional rules prohibit, for example, cleaning staff from talking to residents. Increasingly over the past decades, residents enter care close to end of life and in frail condition. Yet, unbelievably, long-term care does not incorporate hospice, with its gentle, holistic support and excellent pain management. Similarly, antipsychotics are frequently used to regulate resident behavior. Proven methods of dementia care through music and dance therapy, connection to nature, and close personal relationships are considered too costly and don't fit the institutional culture of our current system.

When the pandemic hit, the fate of Canada's elders living in long-term care had already been determined by our history, politics, and poor policies, thwarting the efforts of administrators, workers, and families that tried to protect them.

Yet history is more malleable than we might think. It is about change, always, but it is also about choice. Difficult histories can be recognized, reconciled, and purposefully set aside. The history set out here is burdened, but it is our inheritance. Our responsibility is to take the lessons of the past and craft a different future for Canadian elders.

Radical Futures in Eldercare

We need to do better by our elders. Today's long-term **residential care facilities have failed them.**

Surgeon-author Atul Gawande says we should burn them all down. That isn't going to happen. Canada will always require high-level, 24-hour, professional care for some seniors, but we need a sweeping and radical transformation of the system. We have a moral imperative to deliver this to Canadians, in memory of residents and workers who died and in recognition of those who mourn.

The chairs in this exhibit point to promising directions. Joy, whose husband Bob died at Lynn Valley facility when COVID took its first long-term care residents, states, "A lot of these places, they need a complete overhaul. It's the way things are managed and something else... that they should be trying." A Toronto care worker says that when she has time to connect with residents, "You feel in your heart this is the best day ever." Moon's devoted granddaughters reference the Chinese ethos of holding aged kin close with loving respect. Courtney recalls grandmother Maggie's apartment with its vibrant red walls, a stark contrast to the "Wow, this is depressing" medicalised institution where her life ended. The round chair held by Wikwemikong Nursing Home on Manitoulin Island speaks to a place where elders are encircled by culture and community.

We have the knowledge needed to revolutionize eldercare. The research is done, the data organized and analyzed, the books and articles published, the reports presented to government, and models of best practice to emulate.

What might Joy's "something else" include?

A public eldercare system that sustains full lives and good health as people age, a continuum of care from independent living to end of life.

Hospitable residential-care facilities set in the heart of communities, divided into well-staffed resident/worker pods with their own communal spaces.

Adopting rights-based institutional practices that support dignity, diversity and respectful care relationships.

Daily access to the therapies of nature, music, dance, film, art, community and celebration to decrease institutional dependence on wheelchairs and anti-psychotic medications.

Integration of hospice within residential care for the frail elderly.

Facilities specifically for younger people in need of 24-hour residential supports.

Joy's "something else" is an eldercare system worth working for - and here is what we must do:

Bring together a broad lobby group of elders, seniors advocates and organizations, long-term care residents, workers across the eldercare sector, family members, volunteers, geriatric professionals and researchers. Create noisy coalitions with others calling for "Care-First" health and social policy - people living with disabilities or mental health differences, housing advocates, and child-care, immigration, and climate activists.

Write letters, generate petitions, and protest publicly, pushing politicians at all levels of government to make system change. In eldercare this means reversing decades of cutbacks by providing adequate funding for eldercare, ending for-profit care for vulnerable people, and centring eldercare on equity, justice and kindness.

Contact this project if you wish to be part of recreating eldercare for Canadians: info@covidinthehouseofold.ca

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