Measuring Vital Signs for Ebola Preparedness

SEIU Healthcare: Health and Safety Committee Meeting

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Background

The Ebola Virus Disease (EVD) is an acute, severe and potentially fatal disease characterized by haemorrhagic fever. The virus was discovered in 1976 in Zaire (now the Democratic Republic of the Congo [DRC]) and has since had relatively few outbreaks. In the past, EVD was largely confined to rural areas which was thought to limit transmission. However, in December 2013, the largest and first regional outbreak of EVD reached West Africa, with the first outbreak reported in southern Guinea in December 2013.

Since then, there have been confirmed cases in the following countries: Guinea, Liberia, Senegal, Sierra Leone, the Democratic Republic of the Congo (DRC), Mali, Spain and the U.S. The outbreak was not recognized until March 2014 (three months after the outbreak in southern Guinea) when it infiltrated the borders of Nigeria when an individual travelled on a commercial plane on July 20th from Liberia. Shortly after, on August 8th, the World Health Organization (WHO) declared EVD an epidemic, yet some studies suggest the outbreak could have been circulating in the Western region for almost a decade.

As of October 22, 2014, the Center for Disease Control (CDC) reported the disease has claimed 4877 lives out of 9935 total cases.[1] Of these cases, 433 health workers have been infected, of whom 244 have died, according to the World Health Organization on October 25th, 2014.[2] On October 24th, the first case of Ebola was declared in Mali, where the patient later died, according to the Medecins Sans Frontieres (MSF).[3] By December 6th, the virus had killed 6128 people of 17290 cases.[4]

For a more detailed information sheet see: "Ebola: Facts and Fiction"

[1] "2014 Ebola Outbreak in West Africa," *Centers for Disease Control and Prevention*, 22 Oct 2014.

[2] "Ebola Response Roadmap Situation Response Update," *World Health Organization*, 25 Oct. 2014.
[3] "Ebola," *Doctors Without Borders/Médecins Sans Frontières (MSF)*, 24 Oct. 2014.
[4] "2014 Ebola Outbreak in West Africa." *Centers for Disease Control and Prevention*, 04 Dec. 2014.

The Precautionary Principle: General Outlook

As the situation unfolds, healthcare workers *must* be protected by strict health and safety precautions as they have a significantly higher risk of exposure to Ebola. This concern spans healthcare employees involved in all aspects of the healthcare process, such as housekeepers, doctors, nurses, food service workers, PSWs and EMS workers. Given that the transmission is largely through contact with bodily fluids, these risks can be mitigated and even eliminated completely if the proper health and safety precautions are implemented in each healthcare facility.

The transmission of the virus is largely through contact with bodily fluids which means in general, there is a perceived lower risk of contracting it compared to other diseases such as SARS which was airborne. Another distinguishing factor is that the mortality rate of Ebola is largely determined by the quality of healthcare and level of infrastructure to support the treatment of affected patients. Therefore, we must ensure that the Canadian healthcare system is providing the highest quality of care within the most stable infrastructure and with the least amount of impact on healthcare workers.

In order to do so, we must follow the precautionary principle, which is outlined in the MOHLTC Directive #1 revision on October 30th 2014:

"Under section 77.7(2) of the HPPA, for the purposes of section 77.7(1), the CMOH must consider the precautionary principle where in the opinion of the CMOH there exists or there may exist an outbreak of an infectious or communicable disease and the proposed directive relates to worker health and safety in the use of any protective clothing, equipment or device."[5]

The **precautionary principle** requires the implementation of the following general recommendations:

- Sufficient amount and the safest quality of Protective Personal Equipment (PPE), particularly with Powered Air Purifying Respirators (PAPRs)
- Proper training on the most up-to-date PPE procedures according to the Centers for Disease Control and Prevention (CDC)
- Proper training and education on incubation, prevention and containment protocol
- Proper training on sending patients to designated Ebola hospitals and notifying rapid response teams
- The appropriate training for the removal of waste, equipment and bodies with Ebola contact
- The appropriate and safe level of staffing
- The introduction of appropriate products to assist in safe donning and doffing
- Rigorous drills which involve all of the above procedures

[5] Health Protection and Promotion Act, R.S.O. 1990, c. H.7, sec. (77).

Tailored approach to our units:
An analysis of the Ebola preparedness policies of employers

To ensure the safety of our members and frontline healthcare workers in general, SEIU Healthcare has requested any documents pertaining to Ebola preparedness and risk assessment tools in health care facilities we represent. The purpose of this is to identify key gaps in the safety discourse, exemplary initiatives, and to provide general recommendations to improve policy. Certain facilities will be highlighted for their positive efforts and where there are individual critiques, these matters will be handled directly with the institutions.

Facilities that do not have policies in place, notably some long term care homes, should produce protocols *immediately* as they are certainly not immune to risk and because healthcare workers and patients must be protected pre-emptively. Some facilities are simply presenting their emergency protocols which is problematic because they are not specific to pandemics and Ebola's specific risks. Facilities who have not yet sent the information to servicing representatives are encouraged to do so, as this is an exercise in encouraging safety, not discipline. Moreover, given that one of the problems with health and safety discourses is that they focus on the individual, in this case, all healthcare stakeholders must work together and share information to protect frontline health workers.

In general, many health care facilities are providing their staff with proper guidelines regarding hand washing, PPE, donning and doffing procedures and general information about Ebola. In theory, these individual policies and procedures should complement the Ministry's most updated directives and that is true for the most part. However, some facilities are missing key elements of the directive, with some even distributing false facts on the nature of the disease itself (e.g. related to incubation periods). Given the complexity of the disease and the speed at which new research and resources are coming to light, it is understandable that there may be flaws in the information. To warn against misinformation, it is best to pull information from the MOHLTC directive or other authoritative sources, such as WHO, MSF or PHO. In general, it is crucial to have information regarding the following areas in their protocols:

- Symptoms
- Transmission and incubation
- Risk Assessments
- Hand washing
- Patient testing
- PPE (donning and doffing procedure outlined in steps, list of required PPE equipment, aerosol generating procedures, eye protection, etc.)
- Routine practices
- Screening/Triage protocols
- Cleaning and decontamination (frequency, materials, equipment, procedure)
- Lab testing procedures, where necessary
- Internal transportation
- Internal and External communication
- Protocol for patient who dies of Ebola/and a protocol for handling survivors

- Travel advisory information regarding high risk countries

Importance of Training

Many of these elements intersect, revealing the most important element: **training**. In general, training considerations are lacking in the healthcare facilities' policy. Even for those hospitals that mention all the above issues, the only way front line HCWs will be immune to the threat of Ebola is if all of these elements are pieced together to form extensive safety protocols. It also must be underlined that only those who have received training should ever come into contact with an Ebola patient. Even more importantly, **there must be an emphasis on safety drills, both on paper and in practice. The only way to ensure safety of front line healthcare workers is to perform regular drills, taking into consideration all that could go wrong**. Examples of easily made mistakes are: if an infected or suspected patient comes from another point of entry, if they have sat in the waiting room, if they have gone to the washroom while in the waiting room, if the PAPR masks are defective, if a frontline healthcare worker is exposed, if other patients start panicking, if a manager is at home sick. All of these scenarios could easily occur in a crisis, especially given the amount of fear and panic that is associated with epidemics. The only way to ensure that these issues are responded to in a safe manner is to have regular safety drills which are sensitive to language capabilities/knowledge and which involve *all* front line health care workers. Moreover, the safety drills must be tailored to the specific facility.

SEIU International Director of Health and Safety, Mark Catlin, notes that in the U.S., many hospitals are providing Just in Time (JIT) training, which is a recipe for disaster.[6] Similarly, he notes that training needs to be tailored to their hospital, as opposed to hospitals printing out instructions and members figuring out how to "do it on the fly."[7] In a survey conducted by the Association for Professionals in Infection Control and Epidemiology (APIC) on October 24th, it was estimated that only 6 per cent of hospitals were ready for an Ebola.[8] According to the survey, which asked APIC's infection preventionist members how prepared the facility was to receive an Ebola patient, of the 1039 respondents in acute care hospitals:

- 6 per cent reported their facility was well-prepared
- 5 per cent said it was not prepared
- Remaining responses reported various levels of preparedness in between two extremes
- 40 per cent indicating they were somewhat prepared
- 51 per cent (one in two hospitals) had only one of less than one full time equivalent infection preventionist on staff.[9]

The U.S. Occupational Safety and Health Administration (OSHA) did not shy away from criticism and accountability, as their Chief Medical Officer, Michael Hodgson, notes that a panel

[6] Mark Catlin, *SEIU International*, Personal Interview (Telephone), 30 Oct. 2014.
[7] Ibid.
[8] Association for Professionals in Infection Control and Epidemiology (APIC), *APIC Survey Finds U.S. Hospitals Lack Infection Prevention Personnel and Resources to Confront Ebola*, 24 Oct. 2014.

[9] Ibid.

hosted by The Institute of Medicine and National Research Council was an indication of their "failure of planning."[10] Hodgson states, There may be some lessons on thinking about the overlap between occupational health and occupational disease and failing to think through reality; the reality of work in the real world."[11] Hodgson expressed an honest and accountable speech, where he said that the MSF has successfully managed all the health outbreaks in many countries and that perhaps some of their lessons were not disseminated as effectively as they could have been. Throughout the speech, he notes the myriad of questions that unfold from the situation, such as: How do you manage the air flow? How do you ensure enough physical space is provided when donning and doffing with a buddy? How much training is needed to doff safely? How do you manage waste in a modern hospital? What are JIT management strategies in the hospital? Given the effectiveness of the MSF approach to infection control, where is the boundary between appropriate use of surgical masks and respirators? What is needed for proper protection? When plumbers come and fix leaks in a hospital, is that a hazard? How do air plane staff clean air plane washrooms? How do truck drivers who get into an accident deal with waste? Do we know the proper PPE for each worker? In conclusion, using the example of SARS and subsequent work refusals, Hodgson poses two final questions: "How can we better define ways that the public health system communicate these risks to workers in ways that they understand those questions?… how do we create a safety culture that makes people comfortable and lets people come to work?"[12]

We need to ensure that we address the multitude of issues *before* we are faced with an Ebola patient, as right now, we are in a flux of failed planning as well.

In Canada, as of October 17th, the Ontario Ministry of Labour (MOL) has issued 50 compliance orders to 13 hospitals and one paramedic service since August – mainly to do with inadequate training and lack of PPE.[13] Of large concern was the lack of training, PPE and directives of EMS workers, where there were various reports by EMS workers in Toronto, Peel and Hamilton that felt untrained and ill-equipped to deal with a suspected Ebola patient.[14] Also, as reported by EMS unit chair for CUPE Local 416, Mike Merriman, some members were on the verge of work refusal.[15] On October 27th, 2014, ten Toronto Paramedic Services employees walked off the job as they had not received adequate Ebola training, but were ordered back to work two days later by the MOL. Thankfully, the MOHLTC issued a directive to all paramedic workers on November 7th, although a faster turn-around time would be encouraged given the EMS is often the first point of contact. Yet, to their credit, the turn-around time for the updated protocol was much faster as it was released on December 9th. When developing and updating such directives, there should also be an open forum where employees can voice their concern to their managers to help identify gaps in the protocol. It is ultimately up to the Ministry to hold

[10] Michael Hodgson, *The Institute of Medicine and National Research Council Panel*, 4 Nov. 2014.
[11] Ibid.
[12] Ibid.
[13] Kelly Grant, "Inspections Find 13 Ontario Hospitals Unprepared for Ebola Cases," *The Globe and Mail*, 17 Oct. 2014.
[14] Kelly Grant, "Ambulance Staff Lack Training, Equipment for Ebola in GTA," *The Globe and Mail*, 26 Oct. 2014.
[15] Ibid.

employers responsible for implementing safety drills, and to dictate their frequency based on advice from occupational health and safety professionals. **We have communicated with the MOHLTC and MOL about these issues and have specifically requested an increased focus on training drills associated with a timeline.**

Shifting the Onus of Responsibility

The compartmentalization of safety protocols is symptomatic of the individualistic approach to health and safety issues in general. This chronic issue has led to a discourse where the onus of responsibility is shifted towards the individual employee, as opposed to the employer. The language surrounding safety of HCWs in the Ebola case is no exception as some of the hospital policies place the burden of responsibility onto the worker, when in reality, the employer is the one who has the legal duty to protect the workers' safety. As noted by Catlin, the onus of responsibility is being put on the members but they do not have resources which reveals a weird disconnect which we saw vestiges of with TB, SARS and H1N1.[16] For example, some directives in SEIU-represented facilities in Ontario state that it is up to the individual employee to inform themselves about the protocols provided, when in fact, the employer and extensions of the employer (managers/supervisors) have a duty to relay this information to their employees in an effective manner, largely through training. As revealed on the Government's Canadian Centre for Occupational Health and Safety, managers and supervisors' responsibilities include ensuring prescribed PPE equipment, advisement of potential and actual hazards and to take every reasonable precaution in the circumstances for the protection of the workers.[17] Since managers and supervisors act on behalf of the employer, they must follow and entrench the duties of the employer which include that employers must:

- establish and maintain a joint health and safety committee, or cause workers to select at least one health and safety representative
- take every reasonable precaution to ensure the workplace is safe
- train employees about any potential hazards and in how to safely use, handle, store and dispose of hazardous substances and how to handle emergencies
- supply personal protective equipment and ensure workers know how to use the equipment safely and properly
- immediately report all critical injuries to the government department responsible for OH&S
- appoint a competent supervisor who sets the standards for performance, and who ensures safe working conditions are always observed.[18]

Given this duty of responsibility for workers' safety, the discourse around Ebola and other occupational health and safety issues must revolve around their management of hazards, as

[16] Catlin.

[17] Canada, Canadian Centre for Occupational Health and Safety, *OH&S Legislation in Canada - Basic Responsibilities*, 17 June 2008.

[18] Ibid.

opposed to the individual health workers' management. Of course, there are certain duties which only the individual can perform. Therefore, the most important clarification tool would be to outline the structure of the team, specifically tailored to the Ebola file. For example, in the MOHLTC directive, it is stated that a manager or supervisor must be available on site as well as liaise with the OHS team. Coupled with protocol around training, the delegation of tasks would add an extra layer of protection to front line health care workers.

Some hospitals have achieved a great balance of these initiatives as well as other complementary ones. Toronto Western, the first designated Ebola referral centre has taken the lead on Ebola preparedness, where they have an isolation unit with six rooms ("pods") and an invisible negative-pressure air flow system. The facility is one of the few of its kind and was developed using lessons learned from the SARS outbreak in 2003, serving as a one size fits all solution that is so necessary in hospitals.[19] Thinking specifically about Ebola, the hospital has also taken their own approach to PPE, where they focus on the comfortability and safety of the workers.[20] The comfort level of workers must be tested to ensure the PPE is practical.

Therefore, training must include clinical function practices for HCWs to self-determine their individual level of comfort in order to diagnose the collective solution to PPE *prior* to a suspected or confirmed Ebola patient.

In addition to usability, the most successful initiatives are those that allow for the greatest education on the nature of the disease, with the most comprehensive approach to Ebola protocols. Of note is also Cambridge Memorial Hospital as it provides a good breakdown of the process and how it affects and concerns specific classifications of workers (e.g. waste management, linen management and post mortem procedures). Another example is Canadian Red Cross (CRC) which provides a breakdown of each Standard Operating Procedure (PPE, Outbreak Management, Hand Hygiene, Infection Prevention and Control Program, Respiratory Protection) and details the different responsibilities according to their job classification (coordinators/dispatchers, supervisors/coordinator/management staff and front line staff). Moreover, the procedure protocols outline whether or not the directives concern volunteers as well. Since these are exhaustive documents, the CRC makes the information more accessible by providing an algorithm graph, which other hospitals such as Sunnybrook Health Sciences Centre, Scarborough Centre for Healthy Communities and Brant Community Healthcare System also provide.

Visual aids, such as algorithms are extremely helpful educational tools as they provide a comprehensive and easily digestible understanding of protocol process. Sunnybrook Health Sciences Centre, which is a designated Ebola referral hospital has used information pulled from

[19] Marco Chown Oved, "Ebola-ready Ward at Toronto Western Draws on SARS Experience," *The Toronto Star*, 28 Aug. 2014.

[20] "Video: Toronto Western Hospital Gears up for Ebola," CP Video, *The Globe and Mail*, 17 Oct. 2014.

the WHO and MOHLTC resources, including infographics and a video resource specific to Sunnybrook staff. It is imperative that health care facilities develop interactive, engaging and accurate educational tools which are visible in the hospital as well as online.

Other examples of important initiatives include:

- The Pandemic Planning Team and policies that are in place at Cheshire Homes in North York which aims to prevent infection but also prepare and react to potential Ebola patients
- Circle of Care in Toronto and North York exclusively mentions the procedure for PSWs in homes and how client service supervisors will equip them with the right knowledge and skills to execute safe practice
- Humber River Hospital in Toronto emphasizes the need for rigorous and repeated training with very detailed protocol (e.g. location/inventory of PPE at the hospital)

The underlying principle that informs precautionary principle is **education**. **Workers *must* be educated with the knowledge about Ebola and trained about the protocols to use.** A government-led public awareness campaign would be extremely useful in educating the general public as well as HCWs. It would also prevent panic and hysteria which is often associated with epidemics.

Discrimination and Education

Education should also be used to combat racial discrimination. This is an issue which we find abhorrent and know that it is surfacing among individuals in some instances. For example, in some of the health care facilities, some members are reporting that they are experiencing more racist comments and attitudes and there seems to be a stigma manifested towards people of African descent. Such disgusting attitudes are not only specific to Ontario, but are also being observed in the U.S., according to SEIU International's Health and Safety Director.[21] Certain employers' policies around Ebola are also discriminatory in the sense that they generalize the high risk areas as all of Africa, as opposed to just the high risk countries in the large continent. It is important for healthcare facilities to warn against generalizations and only limit their warnings to countries affected by Ebola, so as not to discriminate in a broad sense and to avoid creating increased hysteria. Moreover, staff should be encouraged to report the discriminatory comments as harassment to show that such attitudes are not tolerated.

Catlin explains that some of the older nurses who are represented by the union are reporting that the discrimination is reminiscent of the early 1990s during the height of the HIV/AIDS epidemic when there was also a stigma towards black people in general but also specifically in the hospital setting.[22] Such observations are in line with other media reports, such as the *Daily Beast* which reported that a small community college in Texas announced in a personal letter to a Nigerian applicant that the school would not be accepting students from

[21] Catlin.
[22] Ibid.

countries with Ebola.[23] Discrimination has also been recorded by *The Washington Post* and *Reuters* in Dallas, both of which reported that African immigrants are feeling ostracized and alienated at present.[24] Such racial discrimination is unacceptable and must be remedied through widespread education. Additionally, just as there must be preventative training measures initiated regarding the protection of workers during epidemics, there also must be enhanced anti-racism training across the board to avoid such abhorrent discrimination.

Catlin also reports that HCWs that treat Ebola patients are being ostracized within their community at home and at work, specifically if they've been working in the Ebola department. Yet, as Catlin positively notes, this is an opportunity to bring OHS issues with HCWs to the forefront.[25]

Product Control

As recommended by some occupational hygienists, the use of **"Glo Germ" products** could be extremely useful in safety and prevention training**.** Judy Stone, an infectious disease expert from Pennsylvania, claims that Health workers should be training with products like Glo Germ because "The substance can be spread over surfaces like bed rails, then workers can see where they've picked it up and how they could have potentially been contaminated."[26] However, Stone claims that infection control budgets have been slashed and that at one hospital, stethoscopes were being transferred between rooms due to budget restraints, meaning they could be carrying drug-resistant bacteria along the way.[27]

The product is applied as a gel and can be used to complement the use of personal protective equipment (PPE), specifically in training workers about exposures to hazardous substances. The gel and oil is designed so that when the oil and gel is applied, if placed under a UV light, the hazardous materials are visible. The product's website states that it can cling to any type of surface and that it is "a powerful training tool to demonstrate proper doffing of protective gear."[28] Since thermal contamination is very difficult to see with the naked eye, this product would allow for healthcare workers to see if they have contaminated themselves in the training process and therefore learn proper procedures prior to exposure. **Certain hospitals are introducing the product into their Ebola training but it must be introduced on a much larger scale, which should be mandated by the MOHLTC.**

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[23] Hanna Kozlowska, "Has Ebola Exposed a Strain of Racism?" The Opinion Pages: OpTalk, *The New York Times*, 21 Oct. 2014.

[24] Ibid.
[25] Catlin.
[26] Robert Langreth and Caroline Chen, "Who's in Charge of Ebola at Hospitals? 'Screaming That We're Not Prepared,'" *Bloomberg L.P.*, 13 Oct. 2014.
[27] Ibid.
[28] "Bio-terrorism/PPE Training," *Glo Germ*, 2014.

Another outstanding issue that must be resolved is the **guidelines for safe use of environmental products**. At this point, there has been no mention of a recommended or standardized hospital disinfectant, which is extremely problematic given past complications with infectious diseases and cleaning products. In the U.S., there is a body called the Environmental Protection Agency (EPA) which is a Federal government agency that overlooks human health and environmental regulations. Along with other guidelines, the EPA has recommended that hospitals, "Use a U.S. Environmental Protection Agency (EPA)-registered hospital disinfectant with a label claim for a non-enveloped virus (e.g., norovirus, rotavirus, adenovirus, poliovirus) to disinfect environmental surfaces in rooms of patients with suspected or confirmed Ebola virus infection."[29] The EPA recommends these disinfectants because enveloped viruses such as Ebola are susceptible to a broad range of hospital disinfectants used to clean hard, non-porous surfaces, whereas non-enveloped viruses are more resistant to disinfectants. Moreover, EPA-registered hospital disinfectants for non-enveloped viruses are antiviral and capable of deactivating both enveloped and non-enveloped viruses.[30] **Therefore, as a precaution, the EPA recommends the products with a higher potency than what is normally required. This is a perfect example of how the precautionary principle can be applied to protect workers. SEIU Healthcare recommends that there is a standardized approach to more resistant disinfectants used in all healthcare settings, similar to the EPA. However, SEIU Healthcare would like to see the MOHLTC or another relevant body make such guidelines mandatory.**

Summary of recommendations

To summarize, some of issues that must be brought to the forefront by both the employer, the MOL and the MOHLTC are as follows:

MOHLTC:

- Ensure all employers are following directives
- Ensure information that is being disseminated is correct
- Implement timeline for frequent safety drills
- Work with MOL to ensure that there are regular, mandated safety drills tailored to each specific hospital
- Provide visual resources to aid in safety training for health care facilities
- Ensure PPE directive requirements are practical, comfortable and safe for employees
- Implement the use of "Glo Germ" product for enhanced safety in donning and doffing
- Mandate anti-harassment training in Ebola training module
- Work with MOL to ensure sufficient amount and the safest quality of Protective Personal Equipment (PPE), particularly with Powered Air Purifying Respirators (PAPRs)
- Instigate protocol for out-sourced labour (e.g. plumber)
- Maintain appropriate and safe level of staffing
- Provide update on status and proposed use of rapid response team

[29] "Interim Guidance for Environmental Infection Control in Hospitals for Ebola Virus," *Centers for Disease Control and Prevention (CDC)*, 1 Aug. 2014.
[30] Ibid.

Employer:

- Produce protocols on Ebola immediately as no one is immune to risk
- Provide an open forum for employees to identify gaps in protocol
- Ensure protocols include all elements of the directive (listed earlier)
- Ensure all of the information is correct
- Pull from other resources to encourage accuracy (e.g. CDC, MSF, MOHLTC)
- Supervisors and managers to follow the duties of employer listed above (i.e. establishing JHSC, following precautionary principle, supplying PPE)
- Tailor training to the specific workplace and include clinical function practices to measure comfort, practicality and safety
- Report to MOHLTC and MOL on any potential safety hazards or questions
- Provide visual aids (e.g. algorithms)
- Implement the use of "Glo Germ" product for enhanced safety in donning and doffing
- Provide anti-harassment training and emphasize reporting system for racial discrimination
- Report to the MOHLTC and MOL if there is not a sufficient amount and safe quality of PPE, particularly with PAPRs
- Provide appropriate training on sending patients to designated Ebola hospitals and notifying rapid response teams
- Provide appropriate training for the removal of waste, equipment and bodies with Ebola contact
- Maintain appropriate and safe level of staffing

As you can see, there is a lot of cross-over in duties. This indicates that the MOHLTC and the MOL need to mandate the recommendations, as well as enforce their implementation by employers.

To assist in this process, the **union insists the MOHLTC develop an expert team of specialists including:**

- Infection prevention and control (IPAC) specialists
- Industrial hygienists (expert in PPE)
- Industry health and safety personnel
- Other physicians and nurses who will wear PPE

This team would be an implementation mechanism of all of the above recommendations for training. It would ideally provide training tools, such as videos, which are more interactive and effective communication for safety prevention in a standardized manner all throughout the province. One **extremely important interactive tool** would be a video demonstrating the OHS process from the time a suspected patient enters the hospital until the time they leave. The video would ideally demonstrate the safety procedures for all HCWs. Such an approach would allow for a consistent, expert and effective approach to OHS.

The underlying principle in any approach is that healthcare workers *must* be educated accurately, vigorously and consistently on the newest protocols. Safety experts emphasize that

the most important principle in the guidelines is a **team approach** to using PPE, where healthcare workers use the "buddy system" to ensure proper procedure. Moreover, healthcare experts underline the importance of training *all* healthcare staff with proper procedure, and not just those assumed to have direct contact.

Our commitments:

- Continue to review the Ebola preparedness policies produced by individual employers
- Continue to work in collaboration with other unions to provide consultation to the MOHLTC and MOL regarding directives and any other matters related to HCWs' safety
- Communicate with Joint Health and Safety Committees at SEIU Healthcare
- Organize educationals with guest speakers (e.g. infection specialist)
- In addition to providing other resources, will create blog to provide ongoing content and information to members and HCWs in general

Know Your Rights

Workers' right to know is one of the three **fundamental rights** of Canadian employees:

- Right to refuse unsafe work
- Right to participate in the workplace health and safety activities through Joint Health and Safety Committee (JHSC) or as a worker health and safety representative
- Right to know, or the right to be informed about, actual and potential dangers in the workplace

If workers' right to know about unsafe conditions is not respected, then healthcare employees have the **right to refuse unsafe work**, according to section 21 of the Occupational Health and Safety Act.[31]

Right to Refuse Unsafe Work in the Context of Ebola

Currently, some of our members are reporting that vital safety precautions are ***not*** being taken. It **only takes one** healthcare worker who is not informed for the disease to enter the workplace. Therefore, just as there must be a collaborative effort amongst healthcare workers, more importantly, there needs to be a collaborative effort amongst employers, health and safety committees, the Ministry of Health and Long Term Care and the Ministry of Labour to ensure the workers' **right to know** is protected.

Prior to invoking this right, which is a last resort if the issue is not resolved, employees have obligations under section 28 of the Occupational Health and Safety Act (OHSA) to report any safety hazards they are aware of to their supervisors or employers.[32] Therefore**, employees *must* report any unsafe work to their employers and supervisors regarding the Ebola issue**. Once they are notified, the employer and supervisor has a legal duty to investigate the situation immediately in the presence of a workers from the Joint Health and Safety Committee, health and safety representative or another worker chosen by the union.

On October 18th, 3-5 housekeepers refused to work and clean the room of a suspected Ebola patient at McMaster's Children's Hospital due to a lack training and PPE knowledge; similar reasons provided by the Toronto EMS workers who walked off the job.[33] Kathy MacKinnon, the union chair of CUPE 7800 health and safety committee, stated that it was "pure chaos."[34]

ONA has mentioned in their "Ebola Virus Disease (EVD) Advice – Memo #3" that:

You have a ***limited personal*** right under the *Occupational Health and Safety Act (OHSA)* to refuse unsafe work. But, it does exist,

[31] Occupational Health and Safety Act R.S.O. 1990, c. O.1
[32] Ibid.
[33] Joanna Frketich, "Mac Cleaners Refused to Clean Suspected Ebola Patient's Room," *The Hamilton Spectator*. Metroland Media, 18 Oct. 2014.
[34] Ibid.

- if your employer does not comply with the CMOH directive and;
- there is a suspected or confirmed EVD patient and;
- you are at risk of exposure to that patient and/or their environment;
- and you believe you are endangered.

ONA believes you have the right to refuse that work. The government has committed to ensuring that all ED RNs and the Critical Care RNs in the 10 Ebola Treatment Centres will have appropriate training, drills, testing and PPE. This means that hopefully you will have a safe work environment and will not need to consider your right to refuse unsafe work.[35]

Protection during SARS

One form of education is being aware of what your rights are under the Occupational Health and Safety Act, specifically pertaining to Ebola preparedness. The most relevant comparator is the labour standards that were applied with employees during the SARS outbreak in Toronto, where there was a large issue with employees refusing work due a lack of safety training. Canada has been lucky enough not to experience any known cases of Ebola at this stage and therefore is in a perfect position to inform workers of their labour rights. Many of the facilities' policies mention mandatory quarantining, as determined by public health recommendations. **Therefore, we would like to see the MOL produce a Q&A that answers questions about work refusals and compensation considerations during mandatory quarantining.**

In regards to compensation during mandatory quarantining, in the SARS case, the Federal government announced in April 2003 that the usual two week waiting period for unemployment benefits would be waived for individuals quarantined because of SARS, along with the removal of the doctor's note requirement. In 2005, The Canada Employment Insurance Commission in 2005 stated: "This measure was taken so that persons who are quarantined would receive an income and would not have to choose between respecting the quarantine by staying home from work or risking the spread of an infectious disease."[36] However, given the regressive nature of today's Employment Insurance system, a significantly low number of individuals were eligible for EI, specifically low wage workers. In total, there were only 771 claims that were paid out, with an average weekly benefit of $289.[37] However, in May 2003, the Federal and Ontario Governments established a compensation scheme for health care workers who were not covered by EI for loss of income. A $330 million total was doled out in 2006 as part of the hospital reimbursement as well as a simultaneous $700 million fee-for-service physicians who lost income during the crisis.[38] **Once again, as opposed to providing reactive policies, it would be beneficial to workers to know their employment rights and schemes for compensation, under the hopeful assumption that such schemes would follow past precedence.**

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[35] "Ebola Virus Disease (EVD) Advice – Memo #3," *Ontario Nurses' Association (ONA*), 20 Oct. 2014.

[36] Qtd. in Lesley A. Jacobs, "Rights and Quarantine during the SARS Global Health Crisis: Differentiated Legal Consciousness in Hong Kong, Shanghai, and Toronto," *Law and Society Review* 41.3 (2007): 529.

[37] Ibid.

[38] Ibid.

In volume 5 of The SARS Commission, "SARS and Public Health Legislation," Mr. Justice Archie Campbell noted that "In any emergency, it is essential to compensate those who suffer an unfair burden of personal cost by reason of their cooperation with public health measures like quarantine."[39] The most significant finding as to why there was resistance against quarantining was expected loss of income. As well as reviewing the resulting 2003 and 2006 compensation initiatives, most importantly, the Commission recommended that:

> Emergency legislation require that every government emergency plan provide a basic blueprint for the most predictable types of compensation packages and that they be ready for use, with appropriate tailoring, immediately following any declaration of emergency.[40]

We would like to support this recommendation and will look into how it has been pursued, if at all, in the last six years since the report was published.

Analysis of MOHLTC Directives

[39] The Honourable Mr. Justice Archie Campbell and Government of Ontario, SARS Commission, *SARS and Public Health Legislation: The SARS Commission. Second Interim Report, Volume 5*, The Commission (2005): 301.
[40] Ibid, 306:324.

Below is a list of the most recent directives:[41]

- Ebola Virus Disease Directive #1 – Precautions and Procedures for Acute Care Settings – October 30th (updated from October 17th Directive)
- Summary of Changes to the CMOH Directive for Acute Care Settings
- Ebola Virus Disease Directive # 2 - Paramedic Services Land and Air Ambulance and First Responder Practices and Procedures - November 7, 2014

In general, there has been a good dialogue developing with the MOHLTC and other unions, including CUPE, Unifor, ONA and SEIU, whereby the MOHLTC is consulting with the unions on their directives prior to their release. We have advised the MOHLTC on changes to the above directives, which we are hoping to be released in the near future, along with a LTC directive.

MOHLTC Directive #1: Acute Care (October 17th)

The Ministry of Health and Long Term Care (MOHLTC) issued a directive for all acute health care settings on October 17th in preparation for a potential Ebola case. The directive outlines various procedures concerning PPE, risk assessments, nursing care, transportation of patients, monitoring of potentially exposed health care providers and the internal communication structure. The report states that while the overall risk of infection is low in Canada, **those who have the highest risk are indeed health care workers**. As a result, the report clearly outlines procedure, authority over procedure and important issues. It is important to note that the report states that in general, the precautionary principle should govern protocol.

With regard to **procedure and authority**, some of the highlights include:

- Employers must conduct facility risk assessments to identify potential hazards/workers at risk
- Health care providers must conduct a point of care risk assessment before each interaction with a patient
- Health sector employers should ensure that health workers are incorporating the latest in OHS/Infection Prevention and Control (IPAC) recommendations from the MOHLTC for EVD into their point of care risk assessments, including any enhancements or modifications to PPE
- Hospitals are encouraged to direct returning travellers or high-risk persons directly towards the Emergency Department
- Patients showing up at out-patient clinics should be screened by asking for a 30 day travel history and questioned about symptoms
- Emergency Departments (EDs) with Airborne Infection Isolation Rooms (AIIR) should use them to isolate suspected EVD patients
- The patient should be kept it at all possible in the ED, pending results of testing and possible transfer to a referral centre[42]

[41] Ontario, Ministry of Health and Long Term Care, *Emergency Management: Ebola Virus Disease*, 08 Dec. 2014.

The **referral centres,** as dictated by the MOHLTC include:

- Children's Hospital of Eastern Ontario
- Hamilton Health Sciences
- Health Sciences North
- Hospital for Sick Children
- Kingston General Hospital
- London Health Sciences Centre
- The Ottawa Hospital
- St. Michael's Hospital
- Sunnybrook Hospital
- University Health Network's Toronto Western Hospital

As far as the **nursing care recommendations**, important highlights include:

- Two registered nurses are required for providing care at all times
- Only those nurses who are fully trained, tested and drilled on hazards, protections and equipment donning and doffing should provide care and must have no other duties
- PPE should be removed and disposed of in the anteroom and the hand hygiene performed before touching the face
- Fully trained and tested nurses and other HCWs should observe each other's doffing of PPE to ensure that inadvertent contamination of eyes, mucous membranes, skin or clothing does not occur
- Health care organizations have an obligation to ensure staff are trained in the use of PPE
- A manager or supervisor should be available at all times, and should liaise with OHS[43]

In terms of PPE, the report provides a **breakdown of the proper PPE** that should be employed by different staff at different stages of infection. According to the report, The Chief Medical officer of Health requires the use of the equipment listed below as well as sufficient quantities in a variety of sizes.

For health care providers conducting **triage** of all patients in emergency departments:

- ❖ fit tested N95 respirator
- ❖ face shield
- ❖ gown (fluid resistant or impermeable)
- ❖ gloves

For health care providers that are at risk of exposure to a **suspect** or **confirmed** case of

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[42] Ontario. Ministry of Health and Long Term Care, *Ebola Virus Disease Directive #1 – Precautions and Procedures for Acute Care Settings,* 17 Oct. 2014.

[43] Ibid.

EVD and/or the suspect case's environment, as well as a confirmed case of EVD the report calls for all of the above as well as goggles, double gloves (one under and one over cuff) and a full body barrier protection instead of the gown.[44]

The report goes on to state that Aerosol Generating Medical Procedures (AGMP) on suspect and confirmed cases should be performed only if medically necessary and that all AGMPs should be performed in an Airborne Infection Isolation Room (Negative Pressure Room), with the use of a powered air-purifying respirator (PAPR) with a hood. All staff entering the AIIR must wear PAPR with a hood, full body barrier protection and double gloves.

The **housekeeping** responsibilities are also a fundamental part of the process. As such, some of the instructions include:

- All used cleaning wipes/cloths of waste should be disposed of in leak-proof colour-coded bags/containers, double bagged and outer contained wiped with disinfectant before removal from the room
- The frequency of cleaning should be based on the level of contamination with blood and/or body fluids.
- Housekeeping equipment should be disposable or remain in the room for the duration of the patient admission.
- Discharge/terminal cleaning of the room should follow the recommended practice for discharge/terminal cleaning of a room on Contact/Droplet Precautions
- In addition to routine cleaning, staff must remove all dirty/used items, dispose of curtains and discard of everything in the room that cannot be cleaned[45]

In terms of **transportation** concerns both **internally and externally**, the report highlights issues such as:

- Patients should not leave the room except for essential medical procedures
- Transport staff must be aware of the patient's status and the required PPE
- HCWs providing transport must discard PPE as they leave the room and put on new PPE once in
- Staff transporting the patient should wear full PPE (i.e. full body protection, respirator, gloves, full face shield)

Specifically in relation to **EMS workers**, the report outlines:

- Only certified ambulance services will transport a suspect or confirmed case
- EMS must be notified of the patient's status to determine the requirements for transportation of the patient from any facility
- EMS will provide designated ambulance resources, specially trained paramedics and specialized PPE to perform the inter-facility transfer
- Dispatch centre screening will provide insight to EMS staff in risk assessment for PPE[46]

[44] Ibid.
[45] Ibid.

ONA provides a good breakdown dividing the responsibilities of the employer and employee under the directive:

Your employer

- Your employer has the duty to take every precaution reasonable in the circumstances to protect you, and this includes implementing the CMOH Directive #1
- Your employer must provide priority special training to all Emergency Department (ED) Registered Nurses (RNs) in Ontario and to Critical Care RNs in the 10 Ebola Treatment Centres where Ebola patients will be cared for. Other points of patient entry where training may be required are being discussed in each facility
- Your employer must set up a separate space in the ED with access to a dedicated washroom, to be used for any identified suspect case of EVD
- Your employer must ensure only RNs trained, tested and drilled on hazards, protections and equipment donning and doffing, will provide care and must have no other duties.
- Your employer must ensure if you are conducting **triage** in EDs that you have, and be trained, tested and drilled on using:
- Fit-tested N95 respirator
- Face shield
- Gown (fluid resistant or impermeable)*
- Gloves[47]

*Note that engineered controls are our first defence (plexiglass). We are in discussions with the government on having plexiglass between the patient and triage RN until risk assessment is completed. There may be changes to Directive #1 as our engineered controls discussion evolves.

Your employer must ensure if you are at risk of exposure to a **suspected or confirmed EVD patient** and/or their environment (e.g., equipment, surfaces contaminated with blood and/or body fluids) that you have, and be trained, tested and drilled on using:

- Face shield.
- Fit-tested N95 respirator.
- Goggles.
- Full body barrier protection (this could be either impermeable gowns, pants, boots, etc. or
- hazmat type suit (e.g., Tyvek).
- Double gloves (one under and one over cuff).
- 2 RNs are required for providing care at all times.[48]

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[46] Ibid.

[47] Linda Haslam-Stroud. "Ebola Virus Disease (EVD) Advice – Memo #3." *Ontario Nurses' Association (ONA*). 20 Oct. 2014.

[48] Ibid.

Aerosol Generating Medical Procedures (AGMP) on suspect or confirmed cases should be performed in an Airborne Infection Isolation Room (AIIR) and any of you who enter the AIIR must have, and be trained, tested and drilled on using:

- Powered Air Purifying Respirator (PAPR).
- Full body barrier protection.
- Double gloves (one under and one over cuff).
- 2 RNs are required for providing care at all times.

You (employee)

- You are required by law to work safely and in accordance with the law, the CMOH directive and use the equipment, protective equipment and clothing your employer requires to be worn.
- If your employer has not complied with the measures, procedures, equipment and training required by the CMOH, and/or you have any health and safety concerns, you are required by law to report them to your supervisor immediately. Use the attached form and copy your ONA Bargaining Unit President.
- If your supervisor does not resolve your concern and make you safe from exposure to EVD, you must report this to your ONA Joint Health and Safety Committee (JHSC) member and/or your ONA Bargaining Unit President, who will raise your issue as high and as quickly as necessary to protect you. The Minister of Health wants ONA to advise him about your reality on the front line providing care, and your reports have been, and will continue to be invaluable.[49]

In the summary of the directive, the report states that further directives will follow the report for EMS, as well as primary care and laboratories, training, testing, transportation of specimens and waste disposal which are still pending.

While these directives are very useful, it is important to note the use of "should" and "is encouraged" in relation to some of the recommendations, compared to others which are more strongly framed. In order to ensure enforcement and accountability, there *must* be more pressure placed on the employers to abide by these policies.

[49] Ibid.

MOHLTC Directive: Acute Care Revisions (October 30th)

A revised version of the Directive was issued on October 30, 2014. The *major changes to the Directive* include:

- Explicitly referencing the 11 designated hospitals
- Clarifying that enhanced personal protective equipment (PPE) beyond usual routine practices and additional precautions is not recommended for reception staff at outpatient clinics in hospitals
- changing the requirements for PPE by health care workers conducting triage in emergency departments when a suitable structural barrier (e.g., Plexiglass shield) is in place
- allowing for more judgement by health care workers regarding the placement of suspect case within the hospital
- clarifying the roles of the registered nurses providing care for suspect and confirmed cases, as well as the trained observer
- instructing hospitals to limit the number of health care workers that come into contact with suspect and confirmed cases, as well as to maintain a log of each health care worker that enters the patient's room
- clarifying that for paediatric cases, a parent/caregiver may be admitted to the patient's room following informed consent and training on the use of PPE and other precautions
- providing health care workers with discretion in choosing to wear goggles in addition to the use of a full face shield
- outlining the various types of PPE that could constitute full body barrier protection for health care workers at risk of exposure to a suspect or confirmed case
- providing health care workers with discretion in selecting a powered air-purifying respirator or fit-tested N95 respirator when conducting an aerosol-generating procedure on a suspect or confirmed case
- eliminating guidance for emergency medical services from the Directive (this information will be included in a separate CMOH Directive)
- clarifying that health care workers with protected exposure to a confirmed case (e.g., wore recommended PPE at all times) in Ontario should be closely monitored.[50]

Critique

SEIU prescribes to the critiques provided by ONA, as ONA's President, Linda Haslam-Stroud has been exceptionally active on reviewing the directives and listing the MOL orders. So as not to reinvent the wheel, the following critique was provided by ONA on the revised acute care directive released October 30th:

[50] Ontario, Ministry of Health and Long Term Care, *Summary of Changes to the CMOH Directive for Acute Care Settings*, 30 Oct. 2014

In summary, our primary concerns fall in four key areas. We have provided the government our feedback on this Directive including:

- We believe employers must conduct a **facility wide** risk assessment to identify health care workers (HCWs) that may be at risk of exposure to a patient with suspect or confirmed EVD and/or that patient's environment or waste. We also believe employers must **train** HCWs to conduct a point of care risk assessment to evaluate the likelihood of exposure to an infectious agent/infected source and to choose the appropriate safe work practices. As well, Employers should ensure that HCWs are **provided, trained and incorporate** the latest EVD-related occupational health and safety (OHS) and infection prevention and control (IPAC) directions from the Chief Medical Officer of Health into their point of care risk assessments, including any enhancements to personal protective equipment controls.

- We recommend ONA members providing care to suspected or confirmed Ebola patients in the context of any aerosol-generating procedures request PAPR (powered air-purifying respirator), rather than fit-tested, seal-checked N95 respirator, until we are convinced of the evidence that the N95 respirator is sufficient protection.

- All HCWs providing care to suspected and confirmed Ebola patients must wear full body barrier protection to ensure no exposure of skin. The revised Directive #1 provides for two options:

    - single use (disposable) impermeable gown that extends to at least mid-calf, single-use (disposable) impermeable boot covers that extend to at least mid-calf, and single-use (disposable) surgical hood OR
    - single use (disposable) impermeable coveralls – with an integrated or separate hood and integrated or separate impermeable boot covers.

- ONA is recommending the use of the impermeable coveralls option in addition to the other PPE: N95 respirator, full face shield, and double gloves as outlined on pages 7 and 8 in the revised Directive #1.

- We believe that ONA members must be trained, tested and **drilled** with respect to personal protective equipment (PPE). **Drilling must** be part of testing to ensure the safe use of the PPE. Ongoing drills must be completed to continue to ensure that HCWs are familiar with the safe use of PPE.[51]

Some general recommendations on behalf of SEIU Healthcare include:

- Strengthen the language in general around employer accountability (i.e. "must", not "should")

[51] Linda Haslam-Stroud, "Ebola Virus Disease (EVD) Advice – Memo #4 Government Amendments to Directive #1 Issued on October 30, 2014," *Ontario Nurses' Association (ONA*), 31 Oct. 2014.

- Emphasize the mandatory nature of training
- Set guidelines about the frequency of subsequent safety training after the initial recorded session
- Outline the mandatory reporting method for training drills of each facility for all staff
- Ensure that employers are adhering to such directives by working closely with MOL and unions
- Provide a timeline of when future directives will be released

For future directives, it is recommended that they must provide more specific information and mechanisms of accountability, particularly related to the specific amount of PPE required, the definition of a relevant travel history, EMS provisions as well as primary care and laboratories and more powerful wording around the responsibility of employers and the application of PPE protocols.

MOHLTC Directive # 2: Paramedic Services Land and Air Ambulance and First Responder Practices and Procedures - November 7, 2014 (now updated: Dec. 9th)[52]

Designated Land and Air Ambulances

Designated paramedic service providers shall have and prepare dedicated ambulances that shall be used solely for the purpose of transporting confirmed EVD cases to designated hospitals (designated for referral or treatment of confirmed EVD patients), and EVD patient transfers between hospitals and designated hospitals, and will not be dispatched for any other ambulance response.

Exception: Designated ambulances will be used to transport a suspect EVD case only when the patient arrives on an international flight at Pearson International Airport and is identified as suspect EVD case through the use of the EVD screening tool by a paramedic during the point-of-risk assessment.

Designated paramedic service providers at the time of the release of this directive are:

1. City of Greater Sudbury Paramedic Services
2. Frontenac Paramedic Services
3. Hamilton Paramedic Services
4. Middlesex-London EMS
5. Ottawa Paramedic Services
6. Peel Regional Paramedic Services
7. Superior North EMS
8. Toronto Paramedic Services
9. Ornge

They shall contain the minimum necessary equipment and shall be outfitted at the time of each service request with only with sufficient equipment to perform the requested transfer. Equipment that may be required during such a transfer shall be available in the ambulance but as much as possible, will be stored in a manner that minimizes the risk of contamination.

Designated ambulances will **transport an EVD patient** in the following manner:

1. In a manner as directed by the attending physician in consultation with infectious disease specialists, the receiving designated facility and the paramedic service provider, that considers the potential for contamination, acuity of the patient and safest approach for the patient, attending paramedics, support staff and hospital staff involved in preparing the patient, transfer of care and transportation. This must include full-body covering of the patient, with no exposed skin or clothing. Draping of the interior of the back of the

[52] Ontario, Ministry of Health and Long Term Care, *Paramedic Services Land and Air Ambulance and First Responder Practices and Procedures*, 7 Nov. 2014.

ambulance as operationally feasible and using an impermeable material should be performed to reduce contamination, or

2. In a designated negative air pressure containment vessel2 (vessel) that is secured to the ambulance stretcher and that provides filtration of any air exchange, is supported by both AC power and battery backup power sources, and has been supplied or accepted by the Ministry of Health and Long Term Care as appropriate for the designated purpose

Risk Assessment Procedures:

Paramedics should conduct a point of care risk assessment at a minimum of two (2) metres from a patient before **each interaction** with a patient and/or the patient's environment to evaluate the likelihood of exposure to an infectious agent/infected source and to choose the appropriate safe work practices, including appropriate PPE. Ambulance services shall ensure that paramedics are incorporating the latest in occupational health & safety and infection prevention & control recommendations from the Chief Medical Officer of Health for EVD into their point of care risk assessments, including any enhancements or modifications to PPE.

Patients presenting in pre-hospital environments shall be screened by the ambulance communication centre according to the most current version of the EVD screening tool, as well as by the paramedics at the scene (as outlined above).

Patients screened by the ambulance communication centre and identified as potentially a suspect EVD patient shall be screened again using the EVD screening tool by a paramedic, upon arrival of the ambulance. The assessment should be conducted by one paramedic immediately upon arrival, and prior to another paramedic entering the scene.

Procedures

Patient Transportation from Pre-Hospital Setting to ED

When a suspect EVD patient in Ontario is identified by an ambulance communication centre, the anticipated destination or receiving ED will be notified by the ambulance communication centre. When a suspected case of EVD is initially identified by a paramedic after patient assessment at the scene of any emergency land or air ambulance service request, the receiving ED must be notified immediately by the paramedic or ambulance communication centre to allow appropriate receiving preparations by the hospital through the ambulance communication centres.

The initial assessment and triage by ED staff, and transfer of care to ED staff of patients with suspected EVD will occur in the ED ambulance bay.

Following initial assessment and triage by the ED staff, and if the patient is **cleared** of EVD suspicion, the paramedics may discontinue enhanced precautions.

If the initial assessment and triage by ED staff indicates that EVD is suspected, the paramedics shall continue enhanced precautions until deep environmental cleaning and decontamination of

the ambulance has been completed. These deep environmental cleaning and decontamination processes will be conducted per local paramedic service and first responder service policies.

Personal Protective Equipment

In some cases, patients with EVD may not be recognized immediately. The consistent and appropriate use of RPAP remains the best defense against the transmission of EVD and other infections. RPAP includes the use of hand hygiene, cleaning and disinfection of all shared equipment, regular environmental cleaning using an approved hospital grade disinfectant, meticulous attention to safety around the use of needles and sharps, and a complete and careful risk assessment during the initial patient encounter.

RPAP, including the use of appropriate PPE, should always be followed by paramedics and first responders. Sufficient quantities of PPE in a variety of sizes shall be provided by the ambulance service or first responder agency to ensure that the PPE is the correct size for the paramedic and first responder required to use it.

Suspect or Confirmed EVD Cases
For confirmed or suspect EVD cases (as identified by the communications centre or on scene by the paramedic), the following PPE is required:

- fit-tested, seal-checked N95 respirator
- full face shield and safety eyewear
- double gloves, one under and one longer glove over the cuff
- impermeable full body barrier protection - the aim should be no exposure of skin, which for example can be achieved by the use of the following components: full head protection to cover the head and neck, gown, and foot coverings (foot coverings to provide at least mid-calf protection); or
- one piece full body protective suit (coverall) with integrated or separate hood and covered seams, and foot coverings providing at least mid-calf protection

Training provided to users for the chosen protective equipment must follow the component manufacturer's advice, and any other training regimen developed by the employer for the specific components expected to be used by the paramedics or first responders.

When removing PPE, first use alcohol-based hand sanitizers (as described above) on gloves. Paramedics must avoid contact between contaminated gloves/hands and equipment and the face skin or clothing. Hands must be cleaned before contact with the face. If there is any doubt, clean hands again to ensure mucous membranes (eyes, nose, mouth) are not contaminated.

Paramedics should observe each other's doffing of PPE to ensure that inadvertent contamination of eyes, mucous membranes, skin or clothing does not occur. This is of particular importance if the PPE being worn is new or different from what paramedics normally wear.

Types of Training

Training must include the following core areas:

General Awareness training

- Knowledge of EVD (symptoms, mode of transmission, etc.)
- Knowledge of the pre-hospital care setting's emergency preparedness and response plans for EVD (including any hazard-specific plans for EVD)
- Knowledge of health and safety measures and procedures identified in Directive #2 Paramedic Services, as related to individual's work groups and job functions. Knowledge of workplace measures and procedures for management of suspected or confirmed EVD cases.

Specific training and demonstrated competency in appropriate and safe use of PPE

- Use of Routine Practices in infection prevention and control (i.e., RPAP as noted previously).
- The selection of appropriate additional precautions, including PPE based on a point of care risk assessment.
- Confidence and proficiency in donning and doffing of PPE (appropriately sized to the individual using it) consistent with organization's protocols.
- Understanding of the strengths and limitations of different pieces of PPE.
- Proper fit and inspection of PPE for damage or deterioration.
- Appropriate disposal of PPE after use.

Hands-On PPE Training, Testing and Frequent Practice

All organizations must ensure that hands-on practical training, testing, and frequent practice on donning and doffing PPE is provided for identified work group or job functions. This training should include best practices for the use of unfamiliar PPE (e.g., observation, refresher training, etc.). Training on PPE must be consistent with both Directive #2 for Paramedic Services and the PPE selected for use by each organization.

All paramedics identified for hands-on practical training must demonstrate competency in performing Ebola-related infection control practices and procedures (as required by their function) and specifically in using the appropriate sequence for donning and doffing of PPE. This competency must be verified by a trained observer/coach and documented as per the procedures below.

Training should be repeated and practiced frequently, with just-in-time refresher training provided in instances of increased risk of exposure to a patient with suspect or confirmed EVD, or that patient's environment, waste, or specimens.

Cleaning and Decontamination

Blood and all body fluids from EVD patients are highly infectious.

Safe handling of potentially infectious materials and the cleaning and disinfection of the land or air ambulance and equipment is paramount. Waste management is also critical.

Use hospital-grade disinfectants to clean the ambulance and follow the manufacturer's recommendations.

Refer to PIDAC's Best Practices for Environmental Cleaning for Prevention and Control of Infections in all Healthcare Settings for more information. Waste management and other environmental concerns with respect to management of EVD-related materials will be addressed in a future directive and specific information and direction that supplements or supersedes information on waste management in this directive may be provided. All hospital-grade disinfectants must have a DIN number.

Note that the sequence of steps may require adjustment depending on the circumstances at the time of exposure.
Paramedics who have been caring for or exposed to an EVD patient, and subsequently develop fever (greater than 38 degrees Celsius) or other symptoms consistent with EVD and within 21 days of last known exposure, shall:

1. Not report to work or immediately stop working and isolate self from others.
2. Notify their employer and local public health unit for further direction.
3. Seek prompt medical evaluation and testing as clinically indicated.
4. Comply with work exclusion as per their local public health unit (PHU) until they are deemed no longer infectious to others.

For asymptomatic paramedics who had an unprotected exposure (e.g., not wearing recommended PPE at the time of patient contact or through direct contact to blood or body fluids) to a patient with EVD:

1. They should receive medical assessment and follow-up care including fever monitoring and monitoring for other symptoms compatible with EVD twice daily for 21 days after the last known exposure.
2. The PHU will conduct daily monitoring for 21 days from the last exposure.
3. They shall not have any patient contact for 21 days following the unprotected exposure. Other proposed activities (which cannot consist of patient care) will be reviewed by public health;[53]

Analysis

Positive aspects:

[53] Ibid.

- "All organizations must ensure that hands-on practical training, testing, and frequent practice on donning and doffing PPE is provided for identified work group or job functions." – Comprehensive guidelines regarding type of training and hands-on nature
- Outlines process for workers who came in contact with infected patients
- Provides directive for type of disinfectant (hospital-grade/must have DIN number)
- Provides insight on future directive for waste management – infers they are not complete
- Training competency must be verified by a trained observer/coach and documented

Negative aspects:

- "Paramedics *should* observe each other's doffing of PPE" – use of should is not strong enough
- "Training *should* be repeated and practiced frequently, with just-in-time refresher training provided in instances of increased risk of exposure to a patient with suspect or confirmed EVD, or that patient's environment, waste, or specimens." – use of should means that it can be applied loosely in an extremely important area
- Outlines process for workers who came in contact with infected patients but does not mention compensation for quarantine period
- Still needs to be more specific about what type of disinfectant (as mentioned earlier)
- "These deep environmental cleaning and decontamination processes will be conducted per local paramedic service and first responder service policies." – incomplete process
- No mention of where the donning and doffing occurs

Updates

On December 9th, SEIU Healthcare and other unions were notified by the MOHLTC that the following directives are ready for publication:

- updated *Chief Medical Officer of Health Directive for Paramedic Services*
- a summary of changes to the *Chief Medical Officer of Health Directive for Paramedic Services*
- new *Chief Medical Officer of Health Directive for Primary Care Settings*
- screening tools for paramedic services and primary care settings

SEIU Healthcare is in the process of reviewing the new, updated directives.

MOL Inspections

From August 1st to October 15th, the Ministry of Labour has conducted Ebola workplace readiness inspections on the following hospitals:

1. William Osler Health Centre: Etobicoke Campus
2. Pembroke Regional Hospital, Trillium Health Centre (Mississauga Site)
3. North York General Hospital, Niagara Health System (St. Catharines Site)
4. Sunnybrook Health Sciences Centre
5. Peterborough Regional Health Centre
6. Hamilton Health Sciences (McMaster University Medical Centre)
7. Lakeridge Health Corp
8. Humber River Hospital Finch Site
9. Hopital Communautaire de Cornwall Community Hospital
10. Toronto Western Hospital (UHN)
11. North York General Hospital
12. Thunder Bay Regional Health Sciences Centre
13. Toronto General (UHN)
14. Peel Regional Paramedic Services.

For specific details on the individual inspection reports, please contact Natasha Luckhardt at n.luckhardt@seiuhealthcare.ca

The union is currently in the process of finding out what the Ministry's procedure will be to investigate other hospitals in the province as this is a critical step in preventing increased exposure risk by healthcare workers and the general public. Additionally, the Ontario Nurses Association (ONA) issued a concern on October 9th, 2014 stating that the MOL's inspections are limited in their investigation of different entry points. Unfortunately, SEIU Healthcare has received some extremely concerning reports that some hospitals are designating a donning and doffing area using masking tape or a shower curtain in the same room where suspected Ebola patients are treated. This practice is absolutely unacceptable and illegal given the mandatory nature of the MOHLTC directives. While there are known budget constraints in the Ministry, more funds must be allocated to increased flow of inspectors throughout Ontario. SEIU is pushing for more information and accountability on behalf of the MOL for details on these specific cases as well as other potential land mines. SEIU will also be pushing for information on how the MOL accommodates the changing PPE guidelines. All of these initiatives are being discussed amongst Ontario healthcare unions as well as the OHA.

In addition to widespread MOL inspections and the safety recommendations proposed earlier, the following measures are recommended:

- As mentioned earlier, to provide workers with a Q&A on their labour rights regarding Ebola (specifically about compensation and quarantine procedures)
- To provide a subsequent inspection of the EMS services, particularly in the Toronto, Hamilton and Peel regions where they were previously found to be ill equipped – in particular, to see how the MOHLTC Directive impacted their safety

Curing Chronic Unpreparedness

Finally, one of the largest considerations is how to develop a healthcare system where the infrastructure is already set up to respond to such emergencies. Ebola is not the first epidemic that we have encountered in Canada and it presumably will not be the last. According to the Defence Research and Development Department in Canada, Chemical, Biological, Radiological-Nuclear (CBRN) Research and Technology Initiatives capacities facilitated the development of the Canadian Ebola vaccination by the PHAC which is currently on trial.[54]

Such CBRN capacities must be developed further to extend to safety measures in hospitals and the protection of healthcare workers to ensure a one size fits approach to potential outbreaks. This would ideally ensure a standardized and stable procedure governed by the precautionary principle.

In the meantime, as the situation remains in a state of flux, the union will provide members with up to date guidelines and resources which will help protect their right to health and safety. In general, the **recommended resources** for the most up to date and accountable reports are:

- The Public Health Agency of Canada (PHAC)
- The Center for Disease Control (CDC)
- Medicins Sans Frontieres (MSF)

Please contact your **Joint Health and Safety Committees** for any safety concerns as they are responsible for submitting concerns to the employer. The employer must then respond within 21 days.

As mentioned by Mark Catlin, in his 30 years of experience, "Ebola is the most fast-moving occupational disease the nature of what has to be done is so complex that any one issue ripples into ten other questions about how to we do it here."[55] **It is up to the MOHLTC, MOL, employers and other healthcare stakeholders to work with unions such as SEIU Healthcare and SEIU International to answer these questions pre-emptively and swiftly as opposed to in a sluggish, reactionary manner which often characterizes approaches to OHS.**

General recommendations

[54] Canada, Defence Research and Development Canada, *Foresight Helped Make Canada a World Leader in Ebola Research*, 10 Sept. 2014.

[55] Catlin.

- The continued development of detection technologies and vaccinations
- To provide continued support to Western Africa to support their health infrastructure
- Continuity between different bodies
- Update on rapid response team
- Training on how to work with rapid response team
- More mechanisms of responsibility

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