OPSEU/ ONA
Joint Report on Health & Safety Matters Arising from SARS

November 2003

Toronto, Ontario

This document has been prepared for the purpose of the SARS Commission

Table of Contents

The recommendations provided in this document are preliminary. Further recommendations will follow.

Prepared by: Lisa McCaskell, Health and Safety Officer, OPSEU
Erna Bujna, Labour Relations Specialist, Workers Compensation/Occupational Health and Safety, ONA

1. INTRODUCTIONS

1a. The issues that arose during the SARS crisis are critical to OPSEU and ONA

- ONA membership – 48,000 members mainly comprised of RNs with approximately 1,500 allied Health Care Workers across the Province. ONA has approximately 21,500 members in Region 3, the area most affected by SARS. This region consists of the regional municipalities of Durham, York, Peel, Halton and Toronto.

- OPSEU membership – 113,000 members in total, more than 28,000 health care workers. Of these 28,000, there are approximately 15,000 members in the hospital sector, most of them members of regulated health professions, such as respiratory therapists, x-ray technologists, laboratory technologists, physiotherapists, occupational therapists, diagnostic imaging technologists, speech therapists and many others. This sector also includes OPSEU members who are cleaners, office and clerical workers, and other non-regulated health care workers. OPSEU members who contracted SARS were those who delivered patient care as well as clerical workers in hospital admitting departments.

- WSIB reports that they have received 160 claims for compensation from Health Care Workers (HCW) who exhibited symptoms of SARS; they received another 98 claims from HCWs who were exposed to SARS but did not develop symptoms; two HCWs and one physician have died of SARS following workplace exposures.

- Health and Safety (H&S) officer duties at OPSEU and ONA – ONA has one Health and Safety Officer, OPSEU has two. They respond to member and staff requests for research, guidance and support on all health and safety issues. They develop educational materials for members and staff and deliver them. They liaise with other unions in their health and safety activities, develop union policies on health and safety, assist with health and safety litigation, and lobby for legislative change.

1b. No one was prepared for SARS

- everyone should have been better prepared, given 9/11 and all the false alarms about biological terrorism

- all parties should use SARS as an opportunity to become better prepared to deal with the next emergency, as well as to improve everyday practices that will contribute to improved worker and public safety

1c. Three main areas to be addressed:

The Provincial Operations Centre (POC) Directives; the Occupational Health and Safety Act (OHSA), focusing on the roles of Joint Health and Safety Committees (JHSC) and the Ministry of Labour; and infection control policies and practices

- although both OPSEU and ONA have a number of other issues that will be raised with the SARS Commission, this document focuses on issues that had an impact on worker health and safety

- other issues have been brought to the Commission either in the Public part of the inquiry, or during private interviews with union members, by the Commission

- in the health care sector, worker health and safety and the health and safety of patients are mirror images of each other. It is the unions' experience that when considering infectious diseases, it is critical to understand that if health and safety policies and practices are deficient, infection control measures will also be poorly implemented; inadequate infection control measures will result in a workplace where workers' health and safety will be at risk.

2. THE DIRECTIVES

2a. Overview

- **March 18, 2003, a letter from the MOHLTC was sent to all physicians** in Ontario, warning them of the arrival of SARS in the province. It states that it is an update of an earlier letter sent March 14, 2003, which neither ONA nor OPSEU have seen. Not only does the March 18 letter give detailed information about what was known about SARS at the time, it also gives instructions on Infection Control measures. The letter advises that Health Care Workers (HCW) who have direct contact with suspect SARS cases use gloves, gowns, eye protection and N95 masks. Neither union has any knowledge that any of this information was communicated to HCWs in any health care facility. Why would critical information pertaining to the protection of HCWs and infection control practices be sent only to physicians?

- **Nine days later, on March 27, 2003, the first Hospital Directive** was issued by the POC for all Acute Care hospitals in the province. This first Directive required staff only in the Emergency Departments of GTA and Simcoe County Hospitals to wear N95 masks and other protective gear. Workers in the rest of the hospital were not required to take any special precautions to protect themselves. This distinction between what protection was recommended for which groups of workers in the same facilities arose again and again throughout the crisis. Both unions were constantly trying to establish which workers in which areas were required to wear what personal protective equipment (PPE)

and why. And then both unions were trying to assess if the Directives were protective enough and communicate that message to the members.

- The March 27 directive requested hospitals outside the GTA and Simcoe County to screen patients for SARS. Hospitals in the GTA and Simcoe County had a number of restrictions placed on them – surgical masks on patients and others entering Emergency departments, protective clothing (gloves, gowns, eye protection, N95 mask or equivalent) for all staff in Emergency departments, limitations on visitors, restrict number of entrances, etc.

- For convenience, in this document, the Provincial Operations Centre has been deemed the source of all the Directives, although it was never clear if final authority for the Directives lay with the POC or the MOHLTC. The occasional document was even issued directly by the Ministry of Public Safety and Security. The Directives were always posted on a MOHLTC website using Ministry letterhead, but they were signed by the Commissioner of Public Security and the Commissioner of Public Health and Chief Medical Officer of Health. The relationship between the Ministry and the POC was not made clear.

- Directives subsequent to the March 27 document, came fast and furious, targeting Acute Care facilities most often, but also giving direction to long-term care facilities, Community Care Access Centres, home care workers, and physicians' offices.

- **March 29 Directive** requested acute care hospitals in GTA and Simcoe County to ensure they move to round the clock Infection Control coverage and that for all staff when in any part of the hospital (not just emergency departments) to use frequent hand washing techniques and to use an N95 (or equivalent) mask and to ensure that masks are fit tested.

- ONA/OPSEU assumes Directives went directly to each hospital by email, although it was not clear whether they were distributed by the Ontario Hospital Association (OHA) or the MOHLTC. Once inside the hospital, both unions are not certain what happened next. In some instances, hospitals posted and distributed the Directives in their entirety; in most cases that OPSEU/ONA are aware of, only the employer's interpretation of the Directive was distributed in the workplace

- Member complaints to ONA/OPSEU indicate that in their facilities the Directives were treated as "maximum" measures to be taken to decrease the risk of transmission of SARS to the public and to HCWs. It is OPSEU and ONA's position that the Directives should have been treated as "minimum" measures in the same way that the *Occupational Health and Safety Act* sets minimum standards for the protection of workers.

- **In summary, it is ONA/OPSEU's assessment that the Directives often did not offer enough protection to workers. A striking example of this was a Directive requiring respirators only in Emergency Departments. Additionally, it is the union's concern that the hospital and MOL decisions to treat the Directives as maximum measures rather than as a minimum may have resulted in increased exposures and infection of health care workers.**

OPSEU/ONA'S CONCERNS REGARDING THE PROCESSES OF CREATING, DISTRIBUTING AND IMPLEMENTING THE DIRECTIVES

2b. Lack of transparency during the process of creating and revising the Directives

- In the early days of the crisis, both unions had difficulty getting access to the Directives at all. Although OPSEU/ONA was involved in teleconferences discussing the Directives, it was not until April 7, almost two weeks after the first Directive was released, that both unions gained access to what was called the MOHLTC "Dark Site." This is where the Directives were posted. Until this point, both unions had relied on contacts within the OHA or from union members to provide them with the Directives that were governing the work and the safety needs of health care workers. Even when both unions were issued the password to access the MOHLTC site, ONA/OPSEU was warned in writing that "the site is not intended for the general public and is password protected to provide access to healthcare providers/associations only" (undated memo from John Bozzo, Communications and Information Branch, MOHLTC). Shortly thereafter, both OPSEU and ONA began to post the Directives in their entirety on their own websites for members, accompanied by interpretations and advice.

- Prior to SARS ONA/OPSEU, was not aware that there was a POC, nor that there was a POC-in-waiting, that would spring up in the event of a crisis such as the SARS outbreak.

- To date, OPSEU/ONA are not sure who exactly was working at the POC, how they were chosen or what their roles were – ONA reports that at the OHA meetings this question was raised numerous times – To date both unions still do not know.

- Most importantly, ONA/OPSEU did not know the background and expertise of the people who were drafting the Directives that directed the daily work of health care workers.

- On April 1, 2003 Erna Bujna (ONA), Catherine Bowman (OPSEU) and other union representatives attended a face-to-face meeting with the OHA. The purpose was for unions to meet with representatives from the MOHLTC, the MOL and the OHA to discuss issues arising from the recent SARS directives.

- Teleconferences among the above parties and other stakeholders were held twice weekly. Unfortunately, they were often frustrating for union representatives who did not obtain answers to Health and Safety questions in a timely fashion from representatives from either of the ministries or the OHA. Sometime at the end of April, teleconferences were reduced to once per week. OPSEU/ONA continued to press OHA's representative, (Vice-President, Human Resources, Management Services) and the MOHLTC representatives to answer questions.

- After attending weeks of teleconferences, many health and safety issues had not yet been addressed. To ensure that these concerns had been formally registered, Valerie MacDonald, on behalf of ONA's SARS Group sent a memo to the OHA representative reminding her of the outstanding issues. To date some of these issues remain outstanding.

- On May 7, 2003, the OHA's representative advised that the teleconferences would end regardless of the fact that the unions still had many unanswered questions. Regular participants included representatives from OPSEU, ONA, SEIU, OCHU and OHA – participants from MOHLTC and MOL varied.

- The teleconference meetings gave both unions an opportunity to provide indirect input. However, it was a slow process and took weeks to get a question answered, if at all. By the end of SARS 1, both unions still had no answers to some of the basic questions such as an explanation of the POC process and never really knew if OPSEU/ONA's concerns were heard by the POC. If a change was made to a Directive that appeared to address one of the concerns, the unions learned of it only when reviewing the new Directive.

- Some time in June, 2003, the Ministry began to post the Directives on its public site. To date, ONA/OPSEU does not understand why the content of the Directives was considered to be top secret and not a public document until June.

- When the Directives were changed, either strengthened or relaxed, because there was no rationale offered, and because OPSEU/ONA did not know the process being used to determine the changes, the unions' confidence in the Directives was diminished. Both unions sought clarification and explanations for the changes at the OHA/MOHLTC meetings where ONA, OPSEU and other representatives repeatedly asked representatives from the MOH why the directives were being relaxed and requested that they take these concerns back to the POC. It was OPSEU/ONA's position that the Directives should always err on the side of safety. Neither union received answers to questions about relaxing the Directives.

- For example, if workers throughout a facility are required to wear certain personal protective equipment (PPE) one day, and the next day only workers in the Emergency department are required to wear this PPE, and there is no explanation or rationale offered,

it is difficult to be confident that every precaution is being taken to protect the health of our members. One example of such a change is found in two consecutive Directives for Acute Hospitals. The March 29 Directive for All Acute Hospitals in the GTA/Simcoe County required that "All staff when in any part of the hospital … Use an N95 (or equivalent) mask (ensure mask is fit tested)." The April 1 and 3, 2003 Directives to All Ontario Acute Care Hospitals (which replaced the March 29 Directive above, and others) required staff to wear an N95 mask in SARS patients' rooms, and for direct contact with any patient in Intensive/Critical Care Units or Emergency Departments.

- This lack of transparency led many of the members to speculate and raise concerns to both unions whether political interference because of loss of tourism, or shortages of equipment had led to the changes, or whether in fact there were good epidemiological reasons to explain decisions.

- On March 31, 2003 a senior MOL representative spoke with ONA's health and safety representative Ms. Erna Bujna about various Health and Safety issues. The MOL representative was unable to answer questions without first running them by the MOL's Command centre as he had not seen the Directives. Why had a key MOL official not yet seen the Directives? Ms. Bujna then sent him the Directives as he did not know when he would be receiving them through Ministry channels.

- A few other examples also illustrate the confusion and speculation caused by the lack of transparency of POC processes: when, on April 24, the POC issued a new Directive to Acute Care Hospitals that was much more specific and clear than previous ones, ONA/OPSEU speculated whether the April 22 visit from experts at the CDC had had an impact. For the first time a clear detailed Directive had been issued that dealt with many of the unanswered questions; OPSEU/ONA representatives became concerned about the role of the Ministry of Labour at the POC and wondered whether the first mention of respirator fit-testing on March 29 was a result of MOL input. Those speculations were never resolved.

- **In summary, the two unions were not privy to the make-up and processes of the POC, the creation of the Directives took place behind closed doors, and union input, questions and suggestions about the Directives were seldom recognized. Consequently, neither union could be confident that the Directives would adequately protect the health and safety of their members.**

2c. Directives were incomplete

There were notable gaps in the Directives that in the opinion of both unions and individual workers could lead to absurd and possibly dangerous results. In some instances, the Directives were just simply confusing. Some workers who had been

exposed to SARS were put on what was termed "working quarantine" and allowed to work, although they were confined to their homes during time off. No official attempts to accommodate pregnant workers were made. And during the first month of the crisis, Directives offered remarkably little detail to assist employers and workers to implement them. Both OPSEU and ONA attempted to address some of the gaps in their Hazard Alerts and various documents giving advice to members. Both unions also addressed these gaps at the OHA teleconferences, however neither union felt they received adequate responses to most of their issues.

Following are some examples:

- **Transportation problems for HCWs on working quarantine:** ONA raised concerns that health care workers on working quarantine were still using public transportation. In order to prevent the possibility of further exposure of the public, participants of the OHA teleconferences asked that the MOHLTC address this in their directives.

- **Screeners:** Directives were not clear as to the PPE that screeners should wear in any facility, therefore creating much confusion and anxiety.

- **Pregnant workers:** There was no information contained in any of the Directives to address concerns raised by pregnant workers. Their concerns focused on two main areas: health effects of wearing the N95 respirators, and exposure to Ribavirin, one of the drugs being used to treat SARS.

  Workers, pregnant or not, agreed that wearing the N95 masks for any length of time caused increased fatigue, probably because of decreased oxygen intake (the mask restricts breathing) and increased carbon dioxide levels (the mask restricts successful exhalation because as you exhale, air containing carbon dioxide is trapped in the mask and then is rebreathed). Pregnant workers breathing is already affected by the pressure of the growing fetus on the diaphragm, and they have higher oxygen needs because they are also oxygenating a fetus. The interference in their breathing caused by the mask led to extreme fatigue.

The following examples were communicated to OPSEU: Pregnant workers, in some cases, requested to be accommodated into work areas where they would not be required to wear a respirator for an entire shift. Some employers may have accommodated workers; some refused. In one case, a manager suggested that a pregnant worker "try a surgical mask" and return to work. In another case, pregnant lab workers were advised they did not need to wear respirators if they had no patient contact - this direction was later rescinded.

The other issue that worried pregnant workers was use of the drug Ribavirin. Because the drug is known to cause birth defects, it is contraindicated in pregnancy. Workers were concerned that if they became ill with SARS, they would not be offered Ribavirin. They

were also worried about mixing and administering the drug. This concern affected all HCWs who either were or could become pregnant. Although one of the professional associations, the College of Respiratory Therapists of Ontario, attempted to relieve those concerns in an email that went out on what is known as the CSRT Professional Practice Leaders Listserve, no information was forthcoming in any of the Directives.

At the beginning of April, ONA's representative wrote to the Ministry of Labour, requesting guidance and clarification on a number of SARS-related issues, among them the specific health and safety needs of pregnant workers. In its response, the Ministry cited the section of the *Health Care Regulation* relating to reproductive hazards, but offered no specific guidance on how the specific risks related to SARS were to be dealt with. Early in May, the same MOL representative advised Ms. Bujna by telephone that the Ministry of Labour would not be issuing any special guidance for pregnant workers. This was later confirmed at an OHA teleconference, where attendees were advised that neither Ministry (MOL and MOHLTC) would issue a directive on the issue of pregnant workers. Because the issue was not dealt with by the POC, workers' anxiety and mistrust could only increase.

- **Length of Time to use PPE, storage, how to know when contaminated, donning, doffing, adverse health effects (latex allergy):** Both unions received a number of queries requesting more information on the N95 masks. These topics were also raised frequently by Respiratory Therapists in an email discussion group moderated by the Canadian Society of Respiratory Therapists. Workers wanted to know which masks were appropriate, when the masks should be replaced, whether it was safe to have facial hair when wearing the mask.

  Issues about adverse health effects such as latex allergy and skin irritation were also raised, as the directives did not deal with them.

  In addition anecdotal evidence of OPSEU members, Local 256, who worked for Hamilton Emergency Medical Services throughout the crisis also raises issues about PPE. Although paramedics were issued N95 masks and a written training package, there was no fit-testing of masks, no opportunity to practice donning and doffing respirators safely without contaminating themselves. EMS workers who were required to wear N95 masks were never advised to shave their beards to ensure a better face seal.

  Members also raised questions about the safe removal of their isolation gowns and laundering their personal uniforms.

- **Detailed Directives at Last:**

  April 20 and 24 Directives to All Ontario Acute Care Hospitals Regarding Infection Control Measures for SARS Units: On April 20, for the first time detailed direction was given on matters such as air supply to SARS units and patient rooms, procedures such as applying personal protective equipment, removing personal protective equipment,

minimizing patient contact during patient care activities and cleaning. Four days later, a revised Directive was released that contained even more detail.

These Directives offer the first concrete evidence that the POC had begun to recognize that employers, supervisors and workers did not understand how to implement the previous Directives. It is surprising that in an acute hospital setting accustomed to caring for patients with infectious diseases, that such detail was necessary.

Following are some examples of details offered in the late April Directives:

- while previous Directives had requested only that suspect and probable SARS patients be placed in negative pressure rooms, the April 24 Directive set out that patient rooms must be negative pressure to corridor/nursing station, that air exchanges in the room must be maximized, that patient rooms must function with no re-circulation of air to the hospital, that the engineering department must ensure 24/7 monitoring of air supply/exhaust, that negative pressure for each room and unit be checked at least twice per week, and that SARS unit and SARS patient room doors stay closed at all times. One would have assumed that the requirement for negative pressure rooms and units would have meant that all these things were in place, but apparently they were not.

- previous Directives had made no mention of sharing patient equipment. The April 20 Directive states that if equipment is to be shared, disinfection protocols must be written and approved by infection control. The same Directive requires that dedicated patient equipment be "wiped down after each use with disinfectant impregnated wipes or equivalent product." The April 24 Directive is even more specific requiring that the equipment be "wiped down after each use with a cloth well-saturated with disinfectant (diluted as per manufacturer's direction)." One would have assumed that this level of detail was not necessary, but it was.

- most importantly, these two Directives give detailed instruction for the first time to HCWs to assist them to put on and take off their PPE one step at a time in the correct order to avoid contaminating themselves. Until this point, HCWs were simply instructed to use various pieces of PPE according to where they were working and what duties they were performing. Both unions wonder why it took so long for the directives to provide this level of detail?

- the sections in these Directives covering cleaning on the SARS unit are set out in excruciating detail. Until these Directives were issued, there had been no direction offered to ensure that adequate cleaning was being performed that would protect patients and workers from infection. Some of the details in these Directives address what is not known about SARS such as how long the virus lives on hard surfaces; however some details are standard cleaning routines that should have been applied when dealing with any droplet borne infectious illness.

- **The First Directives for High Risk Procedures**

  Directives to All Ontario Acute Care Hospitals for High-risk procedures in Critical Care Areas During SARS Outbreak, April 29 (Interim), May 1: Between April 15 and 21, nine HCWs at Sunnybrook and Women's Hospital were diagnosed with SARS following exposure to a SARS patient during a complex and prolonged medical intervention. Approximately a week later, the POC released these Directives to address the exposures that may take place during treatment and diagnostic procedures that can produce airborne respiratory secretions carrying SARS. The U.S. Centres for Disease Control published its first SARS-related document concerning aerosol-generating procedures on patients March 20.

  One of the critical aspects of SARS is that it is primarily a respiratory infection, often requiring a variety of diagnostic and treatment procedures that generate airborne respiratory secretions. We question why these Directives were issued more than a month after the SARS emergency was declared and after nine HCWs were infected during a procedure where the risks of exposure were known to be greater.

- **Late Directives for Fit Testing and Respirator Program**

  The *OHSA Regulation 67/93 For Health Care and Residential Facilities* at S.10(1),(2), mandates that: "*A worker who is required by his or her employer or by this Regulation to wear or use any protective clothing, equipment or device shall be instructed and trained in its care, use and limitations before wearing or using it for the first time and at regular intervals thereafter and the worker shall participate in such instruction and training."* It also states that: "*Personal protective equipment that is to be provided, worn or used shall be a proper fit.*" This was the law in the Health Care sector for 10 years before the SARS crisis.

  It appears that some hospitals in Ontario did not apply this part of the law or that some employers and/or supervisors did not know it was the law. One example of the confusion about fit testing is found in a June 2003 memo from the Director, Infection Prevention and Control from the University Health Network in Toronto, which states that "Canadian regulations have never required fit testing in the healthcare setting." In the unions' opinion, this statement contradicts the requirement in the *Health Care Regulation* that requires employers to ensure that the "Personal protective equipment that is to be provided, worn or used shall be a proper fit."

  The *OHSA* requires an employer when appointing a supervisor to appoint a competent person for the purposes of the *OHSA*. The section of the memo cited above, caused both unions to question the state of institutional knowledge of, and the ability to apply the requirements of *OHSA* in respect of the appointment of competent supervisors.

  It is the role of the Ministry of Labour to enforce Regulations under the *OHSA*. In the case of respirators, the MOL uses as its enforceable standard, the 2002 Canadian

Standard Association's Z94.4 'Standard, Selection, Use and Care of Respirators' which requires all Canadian workers to pass a fit test before wearing a respirator. Until the SARS crisis, it appears that the MOL had chosen not to ensure compliance with this regulation.

Both unions believe that the lack of pre-existing respiratory programs may have placed workers' health at risk when the crisis hit. Respirator programs provide guidance on issues such as who assists with fit-testing, where respirators are obtained, the life of masks, how to determine if they are soiled or damaged, donning and doffing, maintenance and storage, and what to do if a properly fitting mask cannot be found for some workers.

As early as its March 26 Hazard Alert, OPSEU stressed proper respirator fit testing, "The employer must advise you of the risks, provide the correct respiratory protection (N95 masks), ensure you know how to test the face seal of the mask, provide you with gloves, gowns and eye protection when appropriate, and ensure you wear the equipment when needed. The employer must provide a written infection control policy and protocol".

- **March 29 Directive to Acute Care Hospitals:**

  This was the first reference to fit-testing in a Directive, but it made no mention of how to do it, who could assist, where respirators were to be obtained, the life of masks, how to determine if they are soiled or damaged, how to store, how to put on and take off, what to do if a properly fitting mask cannot be found for some workers.

  Directives two days later (March 31) to GTA Long-Term Care Facilities and Community Care Access Centres repeated the requirement for fit testing. That is the last mention of fit-testing until a May 2, 2003 Communiqué that listed mask suppliers who also provided fit testing services. The Communiqué did not emphasize the importance of fit-testing, nor refer to mandated requirements in the *Health Care Regulations* and the *CSA Standard*; it simply stated that, "Studies document that proper fit testing enhances the effectiveness of masks. Through fit testing, employees can learn which type of mask best fits their facial features."

  Although the MOHLTC began to stress the importance of fit testing in May, it was much later before workplaces began the process of fit-testing. The May 13, 2003 POC directives were the first to refer to the *Health Care Regulation* requirements for fit-testing, stating "Personal protective equipment must be properly used and maintained consistent with the *OHSA Regulation 67/93 s.10*. N95 or equivalent masks must be qualitatively fit tested to ensure maximum effectiveness". The directive also provided a link to the NIOSH website.

  However the May 13, 2003 Directive for Acute Care Facilities caused confusion because of a phrase that was not in any of the other May 13 directives for non-acute facilities. The Acute Care Directive stated: "fit testing should be initiated immediately in identified high

risk areas." For workplaces that utilized only that particular directive, it was not stated that ALL workers should be fit-tested, just those in high risk areas.

On May 15, MOHLTC issued a news release stating that Ontario supports the CDC recommendations on new infectious disease protocols. Dr. D'Cunha stated, "We now have very effective guidelines on the use of masks that includes fitting them and wearing them properly, inspecting them for cleanliness and knowing how to use them."

Finally, fit-testing began, however sporadically, due to union complaints and a work refusal. As a result of a nurse's June 6 work refusal, the MOL wrote orders that the nurse be fit-tested before being required to work in a workplace that required protection. Later in June, 840 workers at Mount Sinai were fit-tested. Yet OPSEU workers at Lakeridge Hospital in June were still being ordered into high-risk areas without being fit-tested for respirators. Some staff at this hospital reported that they were told that they could work in high risk areas without a fit test if they didn't move their head. A Baycrest June 12 memo to cost centre managers states that fit testing will begin "in the near future". Bridgepoint trained their fit-testing trainers on July 3 and planned to complete Phase 1 of their fit-testing program by July 31.

2d. <u>Directives did not address work processes of workers other than nurses and doctors, nor other potentially vulnerable workplaces</u>

- While nurses reported the Directives to be vague, confusing, contradictory and non-specific, the Directives at least acknowledged the work they were performing. In contrast, many other Health Care Workers found nothing at all in the Directives to guide them in their specialized work. This was especially true for HCWs who performed critical diagnostic and treatment functions during the SARS crisis and those in clerical jobs in the front line in Emergency, Admitting and critical care areas.

  As discussed above, it was not until April 20 and 24, that detailed Directives were released that gave clearer direction on how to safely enter and exit a SARS patient's room. There was even direction on safely removing specimens from a patient room. These Directives also gave the clearest direction on cleaning equipment inside patient rooms. However, other than stating that every effort should be taken to avoid sharing equipment and that disinfection protocols for shared equipment had to be written by infection control, no other guidance was given.

- Consider for example, the concerns of an x-ray technologist required at times to perform x-rays with a portable x-ray machine that is moved from one patient room to the next. Chest x-rays are one of the critical tools used to diagnose SARS. Some patients were required to have daily chest x-rays. Portable x-rays were considered safer, since suspect and probable SARS patients would not have to be transported through the hospital to the x-ray department. But how were the technologists to ensure that their machines did not become contaminated and carry infections from one area to the next? Logically, one

assumes that the machine should be disinfected after each use. There is no Directive to explain how this should be done, or if indeed portable x-rays were a safer option at all. Nor is there any apparent recognition that if cleaning protocols must be inserted into already heavy workloads, what the implications will be for productivity and workers' health.

On the other hand, if suspect and probable SARS patients are brought to the x-ray department, how is the department to be kept uncontaminated and therefore safe for other patients and workers? The cleaning protocols for patient rooms in the April 24, 2003 Directive are elaborate and time-consuming. What is to be done in other areas of the hospital where patients travel for tests? One assumes that all hard surfaces that patients could touch or cough or breath on during their time in another department should be disinfected, but the Directives were silent on this issue.

- Another critical and overlooked area was respiratory therapy. These workers, known as RTs, travel throughout the hospital performing a number of functions critical to the diagnosis and treatment of patients with respiratory problems. RTs perform such functions as maintaining mechanical ventilation for patients, intubating (inserting an airway) patients who cannot breath for themselves, suctioning respiratory secretions from patients, taking special blood samples from patients, and assisting with cardiopulmonary resuscitation of patients.

  It was not until nine HCWs had contracted SARS following a prolonged attempt to intubate a patient at Sunnybrook Hospital, that finally on May 1, 2003, a Directive giving guidance for "High-Risk Procedures in Critical Care Areas During a SARS Outbreak" was released.

  Until this time, the workers themselves were trying to assess how to perform their duties as safely as possible for themselves and other patients. On an email discussion group monitored by the Canadian Society of Respiratory Therapists, the multiple daily questions, answers and postings by professional RTs struggling with the issues that arose as they worked through the crisis demonstrate their concern. It was apparent from the email discussions that different hospitals and individual practitioners had come up with a variety of solutions for extremely complex problems. Although the May 1, 2003 Directive addressed some of the same issues, it was in no way complete enough to assist the RTs with their daily work.

- Laboratory workers were also ignored in the POC Directives. OPSEU could find no mention of any special precautions recommended to laboratory technologists when working with blood, sputum or other samples from probable or suspect SARS cases. When OPSEU Health and Safety Officer, Ms. Lisa McCaskell received a member query on April 22 about laboratory precautions, she had to refer the member to a U.S. Centres for Disease Control Guideline released April 16, 2003.

- Another group of HCWs who were invisible in the Hospital Directives were clerical workers who work in Emergency and Admitting Departments and elsewhere throughout hospitals. Five OPSEU clerical workers contracted SARS because of workplace exposures. One of the first indications OPSEU had that the Directives were not taking this group into account was the April 1, 2003 Directive to All Acute Care Hospitals which replaced two previous Acute Care Directives (March 27 and 29). While on March 29, 2003, all staff in any part of the hospital in GTA/Simcoe County Acute Care hospitals were required to wear N95 masks, on April 1 the Directive to all Acute Care Hospitals in the province required staff caring for or entering the room of a SARS patient and HCWs in direct contact with patients in Intensive/Critical Care Units or Emergency Departments to wear N95 masks. "Direct contact" was never defined. On first glance that would appear to remove the requirement for clerical workers in critical care areas to wear respirators. However, those workers are often a metre or closer to patients as they take information and assist them in a variety of ways.

  OPSEU released its fifth Hazard Alert on April 3, 2003 to address that issue among others. OPSEU pointed out the many questions the "direct contact" qualifier raised and advised members to continue to request the PPE they believed was necessary and to request an emergency JHSC meeting to discuss the changed directive and how it was to be interpreted. No subsequent Directives ever addressed the particular needs and questions of this group of front-line workers.

- OPSEU represents approximately 45,000 public servants, members of the Ontario Public Service, many of whom were also affected by the SARS crisis. OPSEU members who work in Corrections, the Ministry of Transportation, and other areas where they have close contact with members of the public, raised their concerns about SARS through their union during the crisis. Some Ministries, such as Ministry of Public Safety and Security, were proactive and developed comprehensive SARS protocols with the input of the provincial Health and Safety Committee and local JHSCs. Other Ministries, such as Transportation, took much longer to develop a protocol for their Driver Examination Centres, and only after a number of work refusals by Driver Examiners and much pressure by the union.

  Some OPSEU members, particularly those who deal directly with the public, complained the communication and guidance they received from their employers was too general. They reported to OPSEU that they did not receive direction that specifically addressed situations in their workplaces. Other members complained that employers only addressed SARS-related concerns, after repeated requests by workers. Members stated that communications were "reactive" rather than "proactive" and accordingly, they did not feel that their employer was taking their health and safety concerns seriously. In some workplaces, despite requests by worker members to their employers for an emergency JHSC to discuss SARS and possible precautions, employers were reluctant to call a meeting.

2e. Employers interpreted Directives differently

- Throughout the healthcare sector, in acute care, long-term care, community care and elsewhere, employers interpreted the Directives and communicated how they were to be implemented to their employees. While this is understandable, both unions learned of interpretations that they did not believe were acceptable. At times both unions had concerns that certain interpretations of the Directives may have placed the health and safety of our members at greater risk.

- The POC was aware of these problems and issued at least two notices on June 3 and 7, 2003 advising the hospitals that compliance with the Directives is mandatory and that they are not to be breached or modified. Neither ONA/OPSEU are aware of any action other than these notices issued by the POC to address this problem.

The following are examples of interpretations placed on directives by individual facilities:

- Humber River Regional Hospital (HRRH): On Friday, March 28, 2003,OPSEU issued a Hazard Alert reflecting the March 27, 2003, POC Directive to All Acute Care Hospitals. The Hazard Alert quotes the Directive stating among other things: "All staff in GTA and Simcoe County hospital emergency departments and clinics to wear protective clothing (gloves, gown, eye protection and mask – N95 or equivalent)."

  Later that same day, OPSEU received a copy of "SARS Update #3" distributed by the Director, Employee and Labour Relations at HRRH. That document stated that: "Provincial officials have advised us that N-95 Masks are now required ONLY for staff and physicians involved in the care of patients in isolation. For all others, including clinics and Emergency Department, surgical masks are acceptable protection."

  When OPSEU followed up with this Director to find the source of the information that resulted in this contradiction of existing Provincial Directives, she stated that the direction had come from a meeting of something called the "West Cluster Management Group" that was associated with the "Emergency Management Office." It was unclear if this group was connected to the POC or who they were. She could provide no name or phone number where OPSEU could pursue this. OPSEU assumed that the Update was later changed to reflect the POC Directives, although the union received no formal notification.

- On April 1, 2003 OPSEU representative at Lakeridge Hospital reported to OPSEU "Several pharmacy members were in Emerg the Thursday (March 27, 2003) that the SARS patient came in, they only wore the yellow masks not the 95 when in Emerg…" The March 27, 2003 POC Directive states that: "All staff in GTA and Simcoe County Hospital Emergency Departments and Clinics to wear protective clothing (gloves, gown, eye protection and mask – N95 or equivalent)."

- A June 5, 2003, St. Michael's Hospital e-mail limited fit testing to staff and physicians who have direct contact with SARS patients in a health care or support role, staff and physicians providing specialized care, such as medical imaging procedures to patients with SARS, and to emergency department staff and physicians. It further stated, "If a member of the Emergency department team does not pass the fit test, they will be assigned to Minor Emergency area duties." The memo then states: "All other staff and physicians – As airborne or aerosol spread of SARS happens very infrequently and usually only under special circumstances (i.e. during intubation), it is not necessary for any staff and physicians other than those identified above to be fit tested." This was written despite the fact that the May 31, 2003 directives indicated "Hospital staff shall use full SARS precautions (gowns, gloves, N95 mask or equivalent, protective eye-wear) in all patient care areas.

- On June 2 and 3, 2003 (Monday, Tuesday) staff at Mount Sinai in Labour and Delivery (L & D) requested management to allow them to wear the PPE as indicated in the May 31, 2003 Directive. An ONA Board of Director's member working at Mount Sinai communicated the following to ONA: "They (staff in L & D) were told that L & D had minimal risk and this was not required. A few nurses ignored the management response and continued to wear the mask and were "laughed at." Wednesday (the day following their request) the medical student arrived on the unit following his ten day quarantine and on Thursday he went home feeling unwell and developed a fever, associated with classic SARS symptoms…they feel that their families and the public were exposed unnecessarily."

- On Wednesday June 4, 2003 ONA was advised that Sunnybrook and Women's College and Health Sciences Centre "as of Monday (June 2, 2003) had declined to follow the POC directives to all acute care hospitals."

2f. Directives confusing as they changed rapidly – changes neither highlighted nor explained

- It was the unions' experience that the Directives were often revised in substantive ways with no explanation or warning. The Ministry of Public Safety and Security recognized this in an April 3, 2003 letter to Ontario Health Care Facilities, where they attempted to reassure the parties that the changes were based on "updated, evolving information." Despite POC recognition that frequent changes were of concern to the hospitals, there seemed to be no attempt to broadcast to all stakeholders when new Directives were released. The changes to the Directives, made from one day to the next, were not highlighted or communicated in any way. Both unions were forced to regularly check the MOHLTC "dark site" to see if new Directives had been posted, and then to review them in excruciating detail to try to understand what changes had been made and to speculate why.

There were a number of occasions when one of the union representatives had just finished a Hazard Alert/Advice to members explaining the latest Directive and then just before posting on the website, would discover that a new revised version of the Directive had been posted by the Ministry. In attempts to discover the rationale behind some of the changes and guidance offered by the Directives, both unions routinely consulted guidelines being issued by Health Canada, the World Health Organization and the Centres for Disease Control. These other guidelines at times offered more detailed and clearer advice.

- On March 29, 2003 MOHLTC issued Directives that stated, among other things**:**

  For all staff when in any part of the hospital:

  Use frequent hand washing techniques
  Use an N95 (or equivalent) mask (ensure mask is fit tested)

  It also clearly outlined additional precautions for staff that visit patient care units, for staff having direct patient contact, information about the reuse of masks and gowns and when they must be disposed of and replaced. It also provided direction about infection control methods to follow after each patient contact.

  On April 1/03 ONA raised concerns at the OHA/MOHLTC/MOL meeting that despite the requirement in the March 29, 2003 directive, for all staff to wear PPE including the N95 masks the directive was still incomplete and silent on many other issues.

  On April 1 and 3/03**,** new Directives to all Ontario Acute Care Hospitals were issued that reduced the amount of protection for workers. The new Directives state: "However the routine use of gowns, gloves and masks is not required provided the patient is not in respiratory isolation." (This directive was developed just after OPSEU/ONA learned at the OHA meeting on April 1, 2003 that the masks were in short supply.) ONA and OPSEU were outraged because no rationale was provided for the change even though both unions raised questions about the change.

  It appeared to ONA and OPSEU that employer concerns about not being able to adequately supply masks to all staff may have influenced the POC to change its Directives**.** Rather than deal with the supply problem, it appeared it was easier to change the Directive.

  On May 13, 2003, a "new normal" Directive was issued. It was confusing. This Directive only briefly referenced the *OHSA*, and stated that fit testing should be initiated immediately; however it appeared to identify only high-risk areas as needing to do fit testing. On May 21, 2003, in response to the new Directive, ONA issued further Occupational Health & Safety advice.

May 31, 2003 the POC released a Directive that appeared to offer better protection to workers. However both unions believe that the content of this Directive should have been issued immediately at the start of SARS II. Both unions question why the POC did not issue this important directive earlier?

On June 16/03, the POC issued a new Acute Care Facilities' Directive that again reduced protection to workers and provided no rationale for this decision. (This followed the first ever SARS HCW work refusal as discussed in part 3 of this paper.) On June 17, 2003 ONA, outraged with the relaxation of the directives, immediately posted on its website an ONA Position document. OPSEU in its June 19, 2003 Hazard Alert questioned whether the new directive was an attempt by the POC to avoid further work refusals about personal protective equipment.

2g. At times, decisions that were made raised questions that concerns other than worker health and safety and public safety may have influenced the content of the Directives

The following examples raised suspicion at OPSEU and ONA that the Directives and approaches to SARS were not always based entirely on scientific and epidemiological evidence:

- Sunnybrook and Women's Hospital – In a June 4/03 e-mail from the President and CEO he states that the hospital has an issue with "the appropriate use of full droplet precautions where necessary as opposed to a blanket application of this directive in every area of the hospital." The memo goes on to say: "We have consulted GTA teaching hospitals and they agree that the directives need further interpretation. To try and correct this situation, we have sent our very own Dr. Mary Vearncombe and Dr. Andrew Simor to work with the Ministry of Health and other Infection Control practitioners today to revise these directives. The group should be finished their work either today or tomorrow and we expect to have new directives relatively soon."

  Both unions wonder how Sunnybrook could expect in advance that their input would result in a change to the directives. Additionally both unions query what scientific evidence Sunnybrook had that they considered to be superior to evidence previously relied on by the POC scientists.

- Mt. Sinai Hospital – The MOL was targeting Mt. Sinai for a proactive MOL investigation into respirator fit testing and training for June 13, 2003. On June 13th, the proactive inspection for Mount Sinai was cancelled. See details in part three of this paper. Prior to this decision, ONA had complained earlier in June to the MOL that Mt. Sinai was not meeting its obligation to fit-test employees as per the directives. Both unions wonder why the MOL decided to cancel this proactive inspection despite ongoing member complaints.

- Probable and suspect SARS – case definitions: OPSEU members and the public expressed concern that the Health Canada and POC definitions of probable and suspect SARS minimized the number of cases reported by the hospitals and the province. No rationale was offered for the differing definitions, but there was speculation that the POC relied on Health Canada's definition because it resulted in fewer cases being diagnosed as SARS.

  From at least May 1, 2003, the definitions used by Health Canada and those used by the World Health Organization differed. The WHO defined suspect cases those with SARS symptoms and "one or more of the following exposures during the 10 days prior to the onset of symptoms: close contact with a person who is a suspect or probable case of SARS; history of travel, to an area with recent local transmission of SARS; residing in an area with recent local transmission of SARS." The definition of probable cases was built on the suspect case definition and relied additionally on x-ray, blood tests or autopsy findings. In the WHO definition, a case should be excluded only if an alternative diagnosis fully explained the illness.

  Ontario had initially relied on Health Canada definitions of probable and suspect SARS. That definition of suspect case included only people who, in addition to the physical symptoms, had close contact with a diagnosed case of SARS or traveled within 10 days to a SARS transmission area. "Residing in an area with recent local transmission" was not one of the criteria. Therefore, a person could be excluded essentially if they had the physical symptoms but didn't travel or come in contact with a person with SARS.

  On May 29, one week after the second major outbreak of SARS that occurred at North York General, the MOHLTC adopted the WHO definitions of SARS cases. Health Canada also adopted the WHO definition. Twelve probable cases on May 28, 2003 jumped to 29 on May 29 when the WHO's more inclusive definitions took effect.

  It is believed that the reliance on the earlier Health Canada case definitions that required an epidemiological link to a known case or travel to a SARS transmission area, rather then the less rigorous WHO definition may have contributed to the failure to recognize that SARS had re-emerged at North York General Hospital in mid-May.

Recommendations:

- *That the structure, membership and mandate of the Provincial Operations Centre be communicated to stakeholders and the public and that in future crisis situations the work of the POC be made more transparent to stakeholders.*

- *That the development, including the process and rationale, to amend, revise and post Directives must be transparent and easily understood, especially by the stakeholders who must implement the Directives.*

- *That in the future, all POC communications be forwarded to all affected parties such as workers in affected workplaces, Joint Health and Safety Committees, and affected unions and that such communications be posted in a fashion accessible to all concerned.*

- *That all POC communiqués and Directives that affect worker health and safety will also reference the Occupational Health and Safety Act, its Regulations and appropriate Standards and Guidelines. It must be clarified that the OHSA and its regulations remain the law even in a provincial emergency.*

- *That the Ministry of Labour have a greater role on a future POC when workers' health and safety is being impacted by decisions made at the POC. For example, a senior Inspector and Industrial Hygienist should have been active participants at the POC. (See section below on the Occupational Health and Safety Act and the Ministry of Labour.)*

- *That in future, if decisions are being made that will influence work processes, that there be members of the POC who have recent and extensive knowledge of those work processes. In addition that representatives with expertise in health and safety from the affected unions work closely with the POC.*

3. THE OCCUPATIONAL HEALTH AND SAFETY ACT AND THE ROLE OF THE MINISTRY OF LABOUR

3a. Overview of relevant legislation

The most relevant sections of the *Occupational Health and Safety Act* cover the duties of the employer, duties of the supervisor, rights and obligations of workers, the role of the Joint Health and Safety Committee, the powers of Ministry of Labour inspectors and the right of workers to refuse unsafe work. In addition the *Regulation for Health Care and Residential Facilities* under the OHSA offers guidance to workers and employers dealing with hazards specific to the health care sector. For long periods in many workplaces and for the entire crisis period in others, it appeared to both unions as if the *Occupational Health and Safety Act* did not exist – or at the very least it was as if it did not apply when the workplace hazard was an infectious illness.

The following is a short list of the most relevant sections of the OHSA and the *Regulation for Health Care and Residential Facilities* during the SARS crisis:

- S.25(2)(a) – the employer has an obligation to provide information, instruction and supervision to workers to protect their health and safety

- S.25(2)(h) – the employer has the duty to "take every precaution reasonable in the circumstances for the protection of a worker"

- S.27(2)(c) – the supervisor has the duty to "take every precaution reasonable in the circumstances for the protection of a worker"

- S.25(2)(c) – the employer shall "when appointing a supervisor, appoint a competent person" and competent is defined as being familiar with the *Act*, its regulations and hazards in the workplace

- S.25(2)(e) – the employer is obliged to assist and cooperate with the JHSC and health and safety representatives as they perform their functions

- S.28(1) and (2) – workers must work in compliance with the *Act* and its regulations, wear any protective equipment required by the employer, report hazards and contraventions of the *Act* to his/her supervisor, no worker shall alter any protective equipment or devices or work in a way that may endanger himself or others

- S.9(18) – sets out the main functions of the Joint Health and Safety Committee which are to identify hazards to workers, make recommendations to the employer and workers for the improvement of health and safety of workers, recommend to the employer and workers the establishment of programs, measures and procedures respecting health and safety of workers, obtain information from the employer about hazards, be consulted about and have a designated member present at the beginning of any testing that has to do with health and safety

- S.43(1)(a) and (b) – this is the section that sets out the limitations on the right to refuse unsafe work for health care workers, among others. In general terms, health care workers do not have the right to refuse if the circumstance that they consider to be hazardous is "inherent in the worker's work or is a normal condition of the worker's employment" or "when the worker's refusal to work would directly endanger the life, health or safety of another person"

- S.50(1) – the Employer shall not make any reprisals on workers who have exercised their rights under the *Act*

- S.51 and 52 – sets out the Employer's obligations to report fatalities and critical injuries, as well as non-critical injuries and occupational illnesses to the JHSC, the union and the Ministry of Labour

- S.54(1)(a) – a Ministry of Labour inspector can enter any workplace at any time, with the exception of a private dwelling

- S.57(1) – when an inspector finds a contravention of the *Act* or a regulation, he/she can order the employer to comply with the provision forthwith or within a period of time

- S.57(6) – when an inspector finds that a contravention of the *Act* or regulation is a danger or hazard to a worker, he/she can issue a stop work order until the hazard is fixed

- *Health Care & Residential Facilities Regulation S.8, 9, 10: Sections 8 and 9* set out the general duty to establish measures and precautions to protect workers' health and safety. Section 10 addresses the employer's obligations when a worker is required to wear personal protective equipment.

- *Critical Injury Definition Regulation 834* defines critical injury for the purposes of the *Act*

- Internal Responsibility System (IRS) – Although the OHSA never mentions the Internal Responsibility System, it is a cornerstone of the health and safety system contemplated by the *OHSA*. In theory, all of the parties' rights, duties and obligations combine into a system that will allow the workplace parties to resolve health and safety concerns in the best interests of all. The IRS is based on the notion that the workplace parties have equal rights and responsibilities and that most health and safety problems can be successfully addressed because it is in the interests of the employer and the workers to have a safe and healthy workplace. However, this approach seems to ignore the reality that the workplace parties do not have the same amount of power and that it is the employer who controls the workplace. Both ONA and OPSEU have a great deal of experience with workplaces where the IRS simply does not work.

Both unions are aware of many instances where there appeared to be violations of the OHSA and the *Health Care Regulation*. Some examples of possible violations of the *Occupational Health and Safety Act* and or *Regulation* are:

Failure of some employers and supervisors to provide enough, correct or any PPE to workers (*OHSA S. 25 (2) (h) & 27 (2) (c)*)

Some supervisors did not appear to understand their responsibilities to ensure that workers health and safety concerns were addressed. (s. 25 (2) (c) and s. 27 (2) (c)).

Some employers gave little or no instruction to affected HCWs, especially those whose concerns were not addressed by the directives. (s. 25 (2) (a))

Some employers refused to allow JHSC meetings to address the SARS crisis. (s.25 (2)(e))

Both unions received reports that employers had not reported critical injuries or occupational illnesses to the JHSC and to the trade union. (s.51 & 52 (1) and (2)).

Neither union is aware that any employer had introduced and implemented a respiratory protection program prior to the SARS crisis. (s. 10 (1) and (2) *Health Care and Residential Facilities Regulation*)

Both unions received reports of employers who had not developed measures to ensure that pregnant workers health and safety was also protected. (s.9(1) 8.)

3b. Joint Health and Safety Committees ineffective or do not meet at all

- It is the experience of both ONA and OPSEU that in many cases, pre-SARS, the health and safety systems inside many hospitals were weak and ineffective. Both unions have received reports that JHSCs often did not meet, or met infrequently, health and safety issues were rarely resolved, workplace inspections did not take place, legislated training was not up-to-date, and workplace injuries and illnesses were not reported to either the JSHC or the MOL (as required by *OHSA S.51, S.52*).

- Consequently, when the SARS crisis arrived, members reported that their employers took the position that there was not a role for the JHSCs or the Internal Responsibility System. It was ONA/OPSEU's position that JHSCs should meet on an emergency basis to address SARS-related health and safety concerns. Although both unions regularly gave this advice in writing and verbally to their members and to their local union leaders in attempts to get their JHSCs to meet, very few were successful. Even when the JHSCs did meet, these meetings were often ineffective. Additionally, both unions raised the lack of JHSC involvement at the OHA teleconferences and still very few JHSCs met regularly.

  The following are examples of these problems:

  On March 26/03 an ONA Labour Relations Officer for The Scarborough Hospital (TSH) reported that the Union had requested the employer to cooperate and hold emergency meetings of the JHSC. OPSEU's Local President was making the same request. It wasn't until April 1/03 that TSH finally agreed to hold a JHSC meeting on April 2/03. However, the ONA Labour Relations Officer reports that the first full JHSC meeting did not actually take place until April 16, 2003. TSH was meeting daily with Union Leaders but

did not want to involve the JHSC. When regular JHSC meetings began in April 2003, OPSEU members reported that a number of issues were dealt with successfully.

At North York General, workers reported numerous health and safety concerns that indicated the IRS was not working. The ONA Bargaining Unit President called the MOL for assistance with various unresolved health and safety issues and was told that these were internal matters and not a violation of the Act. No help was forthcoming from the MOL.

At Toronto Rehabilitation Institute, ONA received a report that despite requests to meet the employer refused to acknowledge the need to have a JHSC meeting.

On June 10, 2003, after a suspected outbreak of SARS originating in the Lakeridge Dialysis Unit, requests by OPSEU members for a JHSC meeting were denied. The employer said it did not think a JHSC meeting was necessary although it did agree to meet with local union presidents. When the union advised the employer it would consult with the MOL about this issue, the employer relented and agreed to allow the JHSC to meet.

Toronto Hospital Corporation (University Health Network UHN), North York General, St. Michael's Hospital and Sunnybrook and Women's College Health Sciences had to be ordered by the MOL to consult with the JHSC on the employer's fit testing compliance plan.

At UHN ONA learned that meetings with the JHSC were problematic as the employer did not have an employer co-chair. ONA learned in April that UHN had cancelled meetings of the JHSC.

At Princess Margaret Hospital (PMH) given the current SARS situation (with a recommended moratorium on meetings) both co-chairs agreed to cancel the April meeting of the JHSC

- **In summary, if the hospital sector had a properly functioning health and safety system with safety conscious and responsive employers, "competent" and active supervisors, and active JHSCs made up of well-trained members, both unions believe that a number of problems could have been avoided and perhaps fewer workers would have become ill with SARS. As soon as the SARS crisis was recognized, it is the unions' position that all employers should have acted aggressively to ensure training, equipment and safety supervision was in place, and JHSCs should have been holding emergency meetings to discuss existing infection control measures to protect workers and to discuss and consider the Directives coming from the POC. It would have been useful for the JHSCs to meet collaboratively with personnel in charge of infection control to ensure that the Directives were being interpreted in manner that was appropriate for existing conditions in their facility.**

Effective JHSCs would have been able to quickly assess where the risks of exposure to SARS were greatest and would have worked to ensure that workers understood the Directives and could implement them. Effective JHSCs would have known or could have assessed existing knowledge bases in different groups of staff taking into consideration previous training, education, and languages spoken in order to ensure that the measures in the Directives were being communicated appropriately and adequately to staff in every department.

In most cases, the ideal scenario sketched out above did not take place. Much of both unions' time was spent offering basic education to members and JHSC members about their rights under the OHSA and the employers' obligation to protect workers' health and safety. Both unions were almost always just trying to get the JHSCs to meet.

3c. Ministry of Labour Enforcement Activities Curtailed

It is the role of the Ministry of Labour to enforce the OHSA and its regulations. It appeared to both unions that there was a deliberate attempt on the part of the MOL to curtail the enforcement activities of its inspectorate from the very beginning of the crisis. OPSEU received a March 26, 2003 draft protocol for all MOL district and regional offices that prohibited any MOL staff from attending at any SARS affected worksite, even in the case of a work refusal.

This draft memo, which we understand to have been operative throughout the crisis, instructs MOL staff who receive a "formal worker complaint under OHSA" to refer all such complaints to the District Manager. In "unusual circumstances," the District Manager is to "contact the Regional Director." The protocol advises that lawyers at Legal Services Branch and MOL physicians will be available to provide assistance to the District Manager.

In bold print the protocol states: "The District Manager will handle all SARS complaints personally and over the phone. He or she will not attend the SARS worksite personally and will not send another MOL employee to the workplace."

Workers should be advised of the internal responsibility system or if "technical advice" is required, the worker should call Tele-Health Ontario.

Work refusals are to be dealt with in a similar manner.

ONA and OPSEU found this approach by the Ministry be one of the most frustrating and possibly dangerous aspects of the SARS crisis.

It is the unions' position that a number of events and issues should have triggered Ministry of Labour enforcement activities during the SARS crisis:

- Even before the crisis hit, there were serious problems with enforcement of the OHSA in the health care sector. In January, 2003, months before the SARS crisis, ONA (Erna Bujna) and other Ontario Federation of Labour Health and Safety Committee members met with the Director of the Workplace Insurance Health & Safety Policy Branch, MOL and a number of his colleagues to discuss various outstanding Health and Safety issues. MOL enforcement was discussed, as was the need for MOL Inspectors to have a heightened responsibility to respond when a worker's right to refuse is limited (s.43 (2) OHSA). Acknowledging that there were problems with lack of enforcement, the Ministry agreed to arrange a meeting between the Regional Directors and Labour to discuss issues around enforcement.

- The large number of HCWs who became ill with SARS as a result of workplace-exposures should have led to an investigation by the MOL. If that many industrial workers suddenly developed a life-threatening work-related illness, both unions believe that the MOL would have launched investigations immediately. The illnesses were constantly in the media, as were reports of shortages of equipment, including respirators.

- The requirement for "fit-testing" of the N95 respirators in the March Directives and then from May forward, should have led the Ministry to inquire whether fit-testing was being done. The Ministry was or should have been aware that Hospitals may have had no previous experience with this procedure, despite requirements that had existed in *Health Care Regulation s.10* since 1993.

- The MOL was involved with the production of the Directives, which should have led to more active scrutiny of their implementation where health and safety was affected.

- There were repeated requests on the part of OPSEU and ONA staff for the MOL to become involved as both unions learned that there were breaches of the Directives and contraventions of the *Act* and the *Regulation*. Calls from HCWs to the Ministry about unresolved Health & Safety concerns should have prompted the MOL to enforce its powers under S. 54 of the *OHSA***.** Additionally, Ms. Bujna had reported to the joint teleconference meetings attended by MOL officials that critical injuries (SARS) were not being reported to the MOL as per S.51 of the *Act*. These failures to report should have prompted an immediate MOL investigation.

Chronology of events involving the Ministry of Labour

Following is a chronology of events that affected ONA and OPSEU members. It demonstrates the Ministry of Labour's lack of involvement throughout the crisis.

- During the first round of SARS, which emerged mid-March at the Grace site of The Scarborough Hospital, approximately 64 employees (paramedics, clerical, RNs, doctors) were diagnosed with SARS as a result of workplace exposures. It was documented in various media, popular and scientific, that health care workers (HCW) were contracting SARS.

  It was both unions' position that suspect cases of SARS are an occupational illness under s.52 (2) of the *OHSA* while probable cases of SARS are considered critical injuries under s. 51 of the *OHSA.* Employers have an obligation to report critical injuries immediately to the MOL and to the JHSC and in writing within 48 hours and to investigate with a view to preventing a recurrence. Employers also have an obligation to report all occupational illnesses within 4 days.

  The Ministry of Labour had an obligation under their own policy to investigate critical injuries to ensure that the employer was taking all precautions reasonable to protect workers. Although the *Act* is silent on the MOL's obligation to investigate occupational illnesses as defined in s. 52 (2), the MOL's policy indicates that an inspector shall respond to all reports of occupational illness and/or disease.

  Both unions have been informed that the MOL is investigating the two SARS related fatalities, however, to date, neither union has any knowledge of the MOL initiating any form of critical injury or occupational illness investigation into what factors contributed to so many workers contracting SARS during the course of their work.

  On March 29, 2003, the Provincial Operations Centre (POC) first called for fit-testing of N95 respirators in their Acute Hospitals Directive. OPSEU, in its SARS Hazard Alerts, had first advised members on March 26 that they needed to be able to check the "face-seal" of their respirators and be trained on how to use the respirators safely. The POC Directives called for fit-testing in their March directives, were silent on fit-testing in their April Directives and then required fit-testing in all Directives from May forward. In addition, the CDC and Health Canada guidelines specifically set out that fit-testing must be done for the N95 masks.

- On March 30, 2003, ONA's Bargaining Unit President at North York General Hospital, contacted the MOL requesting their assistance regarding the failure of the JHSC to meet. She was told it was an internal matter and not a violation of the *Act*.

- On April 1, 2003, ONA wrote to the MOL's Provincial Physician regarding several Health and Safety issues. In question 3 of ONA's attachment dated April 1, 2003, ONA queried whether the MOL would employ a heightened response to their members' unresolved H & S concerns and complaints given their limited right to refuse unsafe work under the *OHSA*. On April 15, 2003 the MOL replied, stating that they were responding to concerns, complaints and work refusals. However, the Ministry did not respond specifically to the query on the possibility of a "heightened response."

- Right to refuse unsafe work under the *OHSA* was an issue OPSEU and ONA members asked to have clarified. Both unions anticipated and received questions from their members about work refusals. OPSEU published a section on Right to Refuse in almost all of its regular Hazard Alerts. The steps of a work refusal were set out, as were the limitations faced by HCWs under the *OHSA*. ONA had asked the MOL for its position on work refusals for HCWs in the April 1st correspondence referred to above.

  The MOL's response of April 15/03 was not detailed enough to give adequate direction to HCWs. ONA was concerned that a worker who did not follow precise steps could be disciplined by the College of Nurses of Ontario. Therefore about one week later ONA completed its own Right to Refuse document and posted it on its website.

- On April 11/03, NYGH Bargaining Unit President reported to ONA that the MOL was advising workers that SARS was not a critical injury under the *OHSA*. ONA vehemently opposed this interpretation. It was ONA's position that the MOL's refusal to recognize SARS as a critical injury under the *OHSA* diminished the employer's responsibility to immediately investigate with a view to preventing a recurrence. It also removed a fundamental right of the worker members of the JHSC to investigate and prevent further injuries. Under the *OHSA (s.9(31))*, if there is a critical injury, worker members of the JHSC can designate a worker member of the committee to investigate and to report the findings to the MOL and the committee.

  At the joint OHA/MOH/MOL teleconference meetings, ONA repeatedly asked the MOL for its position on SARS as a critical injury. Several MOL representatives on various dates promised a response, yet none had fulfilled that commitment. On April 23, 2003, ONA e-mailed the OHA's committee liaison, requesting responses on several issues including critical injury.

  On May 1/03, a MOL representative finally informed ONA that the MOL was taking the position that SARS was not a critical injury. It continued to be ONA's position that the

MOL interpretation of "critical injury" was further endangering workers. ONA provided further arguments to the MOL's representative that supported SARS as a critical injury and asked that she take ONA's position back to the science committee for consideration. She agreed.

Later that same day the MOL's representative contacted Ms. Bujna and the only question that came back from the science committee was "Why do you care." Among many reasons, Ms. Bujna explained that the definition of an injury as critical triggers an investigation, which then should lead to better prevention.

Shortly thereafter, the MOL's Provincial Physician advised Ms. Bujna that the MOL had accepted that Probable SARS was in fact a critical injury and that the MOL would be calling all Health Care employers to advise them of their reporting obligations under the *Act*.

- Between April 15 and 21, nine HCWs at Sunnybrook Hospital were diagnosed with SARS following exposure to a SARS patient during a complex and prolonged medical intervention. These exposures and subsequent illnesses were well documented in the popular media and shortly afterwards in scientific journals. In an article published in the Morbidity and Mortality Weekly Review (May 16, 2003), the authors speculate on the various reasons that there were so many exposures and illnesses among HCWs. All were related to lack of training on how to minimize exposures during high-risk procedures; one HCW was documented as wearing a beard while he had his respirator on. No one had advised him to shave it. There had been no fit-testing of respirators.

  To date, neither union is aware of any MOL investigation into events at Sunnybrook that contributed to this volume of occupational illnesses.

  On April 25, 2003, Wayne Samuelson, President of the Ontario Federation of Labour, wrote to Premier Ernie Eves, and Minister of Labour Brad Clark raising issues around the level of protection offered by the Directives, Labour's opinion that the Directives were less protective than the *OHSA*, that respirator fit testing was not being done, that there were shortages of N95 masks and that workplace protection was uneven across the province. Mr. Eves responded stating that he was referring the issues raised to the Ministers of Labour and Health. Mr. Clark responded that he had forwarded Labour's concerns to Drs. Young and D'Cunha at the POC.

- On May 22 and 23, news of a new SARS outbreak (SARS II) emerged at St. John's Rehabilitation Hospital and North York General Hospital (NYGH). It quickly emerged that a number of patients who had SARS had been transferred to other Toronto hospitals. In addition, it was discovered that a large number of HCWs had contracted SARS during the time that the initial outbreak appeared to be waning. This news was in the media by

the time union representatives met with MOL managers on May 27. To the knowledge of both unions, the MOL took no action as news of this situation was revealed.

ONA also received verbal reports that HCWs at North York General had been reporting the unusual patient illnesses to their supervisor. HCWs reported they were cautioned that they were over-reacting and no action was necessary. This indicated to both unions that the infection control system was inadequate to protect workers, as was the Internal Responsibility System (IRS) as workers reported that their complaints about a hazard to their own health were discounted. A total of 42 HCWs from North York General were diagnosed with SARS by early June.

- On May 27, 2003, a number of union representatives (OPSEU, ONA, CAW, OFL, Toronto Workers Health and Safety Legal Clinic) met with the MOL's Director of the Occupational Health and Safety Branch Operations Division and MOL Regional Directors. Union representatives raised a number of enforcement issues at this meeting. OPSEU and ONA specifically raised the SARS issues again and advised the Ministry that they believed the Ministry was not fulfilling its role. OPSEU/ONA pointed to the number of occupational illnesses, contradictions in the POC directives, confusion regarding PPE within the hospital sector, lack of fit-testing, and lack of training. Both unions strongly advised the Ministry that it needed to get involved more proactively and that it should not rely on POC Directives and internal hospital infection control practitioners to ensure workers' health and safety during the SARS outbreak. This meeting had no apparent effect.

- By June 6th, ONA had received numerous enquiries from individuals seeking answers to their Health and Safety questions. During SARS II, it became apparent to OPSEU and ONA that employers were not responding to HCWs concerns about their health and safety. Calls from workers about masks not fitting and their fears of exposure led three of ONA's representatives to call the MOL themselves on June 6, 2003 requesting the MOL to go into NYGH and St. Michael's Hospital to issue orders at least around fit testing and supervisor competency.

- On June 6, an RN member of the Ontario Nurses' Association initiated a work refusal because her N95 mask did not fit her properly. For the first time, to OPSEU's and ONA's knowledge, the MOL became directly involved in the issue of respirators and fit-testing.

- The MOL determined that the work refusal was valid under the *OHSA*. At the Investigation meeting on June 9/03 the MOL issued orders to the employer with almost immediate compliance dates. The orders required the employer to implement a respirator program for all workers with direct patient care in the SARS unit, the ICU, the Emergency Dept., all employees and patient screeners and includes cleaning staff that enter SARS patient rooms. At this meeting, it appeared to ONA that the employer's focus

was on fit-testing and training of nurses and doctors. It was ONA who had to remind the employer that fit testing must include all workers who enter SARS patient rooms. Similar orders were also issued to St. Michael's Hospital.

- Shortly after this, the Provincial Physician advised ONA that the MOL was going to start targeting all Toronto hospitals regarding the fit testing and training issues, starting with Category 3 and 2 facilities. This was almost three months into the outbreak where it had been reported repeatedly that HCWs were one of the groups at highest risk of contracting SARS. Over 100 workers contracted SARS as a result of workplace exposures and two nurses and a physician died. Many more were quarantined as a result of workplace exposures and countless people's lives were disrupted. The emotional and physical toll is yet to be accounted for.

  In this same week ONA reported to the MOL that ONA had received complaints that Mount Sinai was refusing to fit test. ONA requested that the MOL include Mount Sinai in the first round of its investigations. On June 11th, The MOL's Provincial Physician advised Ms. Bujna that the MOL would visit Mount Sinai either on Friday, June 13 or June 16. (June 13th was later confirmed.)

- On June 10, 2003 Ms. Bujna wrote to the MOL's Director of the Occupational Health and Safety Branch Operations Division to follow up on the numerous Health and Safety issues that had been raised with the MOL at the January and May MOL/OFL meetings. To date ONA has not received a response.

- On June 12 Barb Wahl, ONA President, wrote to this MOL Director asking for more Ministry resources to facilitate the "proactive investigations". She did not receive a response.

- On June 13 Barb Wahl, ONA President, wrote to this MOL Director again regarding disclosure of information as per the OHSA, about ONA members who contracted SARS and requesting the MOL to investigate forthwith any and all critical injuries. To date no response has been received.

- On June 13, the MOL Provincial Physician advised Ms. Bujna that the MOL would not be doing any more proactive investigations. Despite questioning by the ONA representative the MOL representative would not disclose who in the Ministry had made this decision or what influenced the decision. It is the position of the unions that critical decisions like these should be a matter of public record. Although the Ministry later resumed some proactive investigations, Mount Sinai was never visited by the Ministry.

- June 17, 2003 NYGH sent MOL an updated list advising them of all Occupational Illnesses. The unions are not aware of any MOL critical injury investigations at NYGH to date.

- On June 18, 2003 Barb Wahl, ONA President. wrote to the then-Premier regarding her concern for member and public safety due to the MOL's decision to scale back the proactive inspections and the MOHLTC decision to reduce protection to HCWs in the June 16th Directives. The Premier did respond on June 26, 2003. ONA was not satisfied with the response as it did not in the union's opinion adequately explain the MOL's actions or the MOHLTC's rationale for reducing protection to health care workers.

  On June 28, one HCW, Registered Nurse Nelia Laroza, died from SARS following a workplace exposure at North York General Hospital during the second SARS outbreak. The second outbreak was identified May 23, approximately two months after the first outbreak. The MOL has initiated an investigation into this fatality but ONA has not seen a fatality report at this time.

  While it may be that no one factor will be identified as responsible for this worker's death, both unions must ask what responsibility the MOL may have in this case given its reluctance to investigate previous occupational illnesses and possible violations of the *Act* and the *Health Care Regulation*, numerous requests from OPSEU and ONA to Ministry employees to get involved, and calls from workers to the Ministry requesting advice on health and safety concerns.

  Despite the requirement for fit-testing and requests for assistance from workers and their unions, and MOL knowledge that hospitals are not industrial settings where workers and employers are familiar with respirators, initially the MOL appeared to make a determination that there was no need to act proactively to ensure that employers were meeting their obligations under section 10 of the *Health Care Regulation* to fit-test their employees and to train them adequately. Both unions believe it was ONA's formal complaints in June that finally triggered the issuing of orders in some of the facilities.

  Both unions believe that if a similar situation had emerged in an industrial setting (a large number of critical illnesses arising from workplace exposures, a requirement for new Personal Protective Equipment for potentially exposed workers, and a workforce largely unaccustomed to this form of PPE), that the Ministry would have acted swiftly and proactively to ensure that all reasonable precautions were being taken to protect workers from further illnesses.

- On July 19, a second registered nurse, Tecla Lin, died of SARS. She had been exposed early in the first outbreak when she had volunteered to work on the SARS unit of her hospital, West Park Healthcare Centre. Although little was known about SARS when West Park opened its interim SARS unit, the illness was known to be highly

communicable, either by droplet or respiratory transmission. West Park has a state-of-the-art respiratory unit, opened in February 2000, featuring negative-pressure isolation rooms for highly infectious clients and specific procedures such as protective respirators for staff and restrictions on patient movement. The unit is designed to care for patients with complex and multi-drug resistant tuberculosis.

OPSEU/ONA does not know if the SARS unit was housed within that special respiratory unit; however, even if it was not, one would have assumed that West Park would be one of the safest hospitals in the province in which to care for highly infectious respiratory illnesses given their reputation and their expertise. The unions await the fatality report from the MOL, which may explain what went wrong.

Recommendations:

- *That there be an obligation for the MOL to expeditiously investigate all Health and Safety complaints of workers with limited right to refuse unsafe work under s.43 (2) of the OHSA and that this be reflected in the Occupational Health and Safety Act. (OHS decision 94-21 discusses the obligation to investigate expeditiously.)*
- *That the Ministry of Labour Policy Manual be amended to include an obligation for MOL inspectors to perform proactive inspections of health care facilities given the dramatic failures of the IRS during the SARS crisis.*
- *That the OHSA be amended to reflect that all members of a Joint Health and Safety Committee receive Certification training.*
- *That the Ministry of Labour Policy Manual be amended to clarify the role of MOL inspectors when enforcing the OHSA in the health care sector. (e.g. must have a heightened responsibility to respond to workers' health and safety concerns where workers have a limited right to refuse unsafe work)*
- *That the Ministry of Labour Policy Manual be amended to clarify the role of MOL inspectors during a health care crisis that affects workers in any sector.(e.g. ensuring that MOL inspectors fully investigate all events of the crisis that affect workers.)*
- *That the MOL Policy Manual be amended to ensure that the Ministry develops a pool of inspectors and hygienists with training and expertise in health and safety hazards within health care facilities*
- *Amend the OHSA so that workplaces of a certain size with large number of identified hazards must automatically have one worker member of JHSC dedicated full-time to attend to workplace health and safety issues.(at least in emergencies)*
- *That the Regulation for Health Care and Residential Facilities (s.10 (1)) be amended to ensure that worker who need protective equipment are provided with it and receive proper training, fitting and instruction for care and maintenance.*

Section 10(1) would state: "A worker who is or may be required by his or her employer or by this Regulation to wear or use any protective clothing, equipment or device shall be instructed and trained in its care, use and limitations before wearing or using it for the first time and at regular intervals thereafter and the worker shall participate in such instruction and training."

4. INADEQUATE INFECTION CONTROL POLICIES, PROTOCOLS AND TRAINING

The SARS crisis in Ontario highlighted what both unions believe to be endemic problems in hospital infection control practices. Anecdotal evidence and observation displayed problems with lack of staffing throughout facilities including hospital infection control departments, a lack of, or inadequate infection control policies and procedures, and an apparent lack of knowledge on the part of health care workers about some infection control principles. It appeared that employers did not understand their responsibilities under the OHSA to ensure compliance with infection policies and procedures.

Both unions believe the following examples illustrate some of the most important gaps or problems with infection control practices specifically in the hospital sector. This is not to say that there are not problems elsewhere, particularly in long term care facilities where staff training may be weak and running water for washing hands in patient rooms may not be available. However, since the SARS crisis remained confined to the hospital sector, the following remarks address only that sector.

- April 20 and 24 Directives to All Acute Care Hospitals Regarding Infection Control Measures for SARS Units: As discussed above in Part 2c of this document, it was not until April 20 and again on April 24 that detailed direction was given on matters such as applying and removing personal protective equipment, minimizing patient contact during patient care activities, removing specimens from patient rooms safely, and housekeeping. These Directives indicated to the unions that the POC, more than one month into the crisis, was finally realizing that some employers, supervisors and workers did not know how to safely implement the previous Directives.

  Although some of the requirements in the Directives called for measures that were unusual, such as the requirement for face shields and N95 respirators, other measures such as double-gloving, removing uniforms before leaving hospital, the order in which to remove PPE, when to wash hands, minimizing patient contact, and how to prevent contamination when removing specimens from a patient room, should have been understood and implemented already by infection control departments. This does not appear to have been the case in many facilities.

  In retrospect, there appear to have been three main problems: infection control departments in individual facilities did not have the resources to reach out to staff to ensure that they were working safely, both to protect patients and themselves; secondly,

prior to the SARS crisis, HCWs seem to have lacked adequate knowledge about infection control procedures which made it difficult for them to implement the stringent SARS controls adequately without instruction and guidance; finally, employers failed to engage their internal responsibility systems, to pull the expertise from their infection control experts and mobilize it using training, supervision and joint health and safety committees to integrate the science of infection control with the principles and practice of an effective health and safety program.

- Cluster of SARS cases among Protected HCWs: Between April 15 and 21, nine HCWs at Sunnybrook and Women's Hospital were diagnosed with SARS following exposure to a SARS patient during a complex and prolonged intervention to intubate the patient. The procedure took place in a negative-pressure room and the HCWs were all wearing PPE.

  The process of intubating a patient is known to have the potential to generate respiratory secretions that may become airborne. Thus the risks of exposure to the virus are increased either because secretions are briefly airborne and can be inhaled or because they contaminate a surface that a HCW subsequently touches before unconsciously touching her/his mouth, nose or eyes.

  In a May 16, 2003, article published in the Morbidity and Mortality Weekly Review, "Cluster of Severe Acute Respiratory Syndrome Cases Among Protected Health-Care Workers -- Toronto, Canada, April 2003," the authors speculate that: "Direct contact with the patient or contact with an environment contaminated by large respiratory droplets might have led to HCWs infecting themselves as they removed their PPE." The article goes on to state: "Many HCWs apparently lacked a clear understanding of how best to remove PPE without contaminating themselves" (emphasis added). The article calls for proper training of HCWs in the correct use and removal of PPE and to remind HCWs "of the importance of hand hygiene." This is the same article that notes that the patient's primary nurse wore a small beard and that the nurse reported that he could sometimes feel air entering around the sides of the mask.

  This event that tragically resulted in HCWs contracting SARS more than a month after the original SARS crisis was declared, points to a serious lack of infection control knowledge that predates the crisis. Why did HCWs not understand how to remove their PPE in the correct order? Even though they were wearing more equipment than they may have been used to, a basic understanding and logical application of infection control principles as required by section 8 and 9 of the *Health Care Regulation*, should have allowed them to figure out how to accomplish this safely. In accordance with legislative requirements, employers should have ensured training in the use of equipment and application of infection control principles. Additionally, if workers were confused, their supervisors and employers had a responsibility to ensure the confusion was addressed. If trained properly as required under the *OHSA*, all HCWs should have understood that if they were offered a mask for respiratory protection, the mask would have to fit their face tightly to be able to give that protection. Yet it was not until well into the crisis, that

HCWs began to request that they be fit-tested for their respirators. As documented earlier, both unions received complaints that employers initially resisted these requests.

- Observations of faulty infection control practices: Throughout the crisis, but especially in the early days, all of us who watched television or walked past a hospital in the GTA were witness to the same images – HCWs outside their hospitals with their N95 mask either perched up on top of their head, or dangling from its elastic straps around their necks. HCWs were seen wearing their isolation gowns overtop of their scrub suits or uniforms outside the facility. In the coffee shop across the road from the Women's College site of Sunnybrook, HCWs were coming in to buy lunch fully suited up in their isolation garb.

  These actions indicate a lack of basic understanding of infection control principles. Alarmingly, it indicates that supervisors and employers also lacked basic infection control knowledge since these dangerous practices were allowed. HCWs outer garb - masks, gowns, gloves – if it was worn inside the hospital, must all be considered contaminated, and must be removed either when leaving the patient room, or the unit, depending on the protocol in place. The April 20 POC Directive advised, "All staff assigned to the SARS unit should wear a clean surgical scrub suit or other uniform that is laundered by the hospital (to be removed before leaving the hospital after each shift)…" If employers had made infection control a priority, which should be an integrated part of their health & safety program, previous to the SARS crisis this advice would have been unnecessary. Employers/supervisors and HCWs would have known that wearing uniforms home after working in an environment with a highly contagious and potentially fatal virus was unsafe.

- The State of Infection Surveillance and Control in Canadian Acute Care Hospitals (Dick Zoutman, et. al., *American Journal of Infection Control*, Aug.2003, Vol.31, No.5, p.266-273): Just as SARS II was winding down, this article, the first assessment of infection surveillance and control measures in Canadian hospitals in 20 years, was published by AJIC. The evidence presented in the article verified personal experience and observations about infection control practices in Ontario hospitals. One hundred seventy-two of 238 (72.3%) hospitals responded to a survey that requested information on what are considered to be the essential components of effective infection control programs.

  The study reports that in approximately 42% of hospitals there were fewer than one infection control practitioner per 250 beds (an effective program should have at least one per 250 beds); additionally approximately 40% of infection control programs did not have appropriately trained professionals to provide services. The study points out that, "Nosocomial infections are second only to medication errors in frequency among adverse events befalling hospitalized patients" (p.266). In addition, "Nosocomial infections and antibiotic-resistant pathogens cause significant morbidity, mortality, and economic costs" (p.266). (Note: the rise of antibiotic-resistant infections is usually considered to be the result of over-prescribing antibiotic medications and poor infection control practices.)

The study concludes: "There were deficits in the identified components of effective infection control programs. Greater investment in resources is needed to meet recommended standards and thereby reduce morbidity, mortality and expense associated with nosocomial infections and antibiotic-resistant pathogens" (p.266).

It should be noted that the survey found that over 97% of hospitals had infection control manuals and 83% of hospitals had programs for teaching and updating staff on infection control practices (p.269). Given the recent experience of the SARS crisis, there is an obvious need for further research into the content of these infection control manuals and the effectiveness of hospital teaching programs.

- Personal nursing experiences: Ms. Lisa McCaskell nursed in two general hospitals between 1979 and 1990, working as a bedside nurse and a nursing supervisor. Following are a number of points that Ms. McCaskell believes have contributed to the decline in good infection control measures:

  - when the majority of HCWs held full-time jobs, hospitals provided change rooms and lockers where it was expected that you would change into uniforms including shoes, before coming to start your shift. It was also expected that one would change back into civilian clothes before leaving for home. As full-time workers have become scarcer and the work-force casualized, HCWs often hold many jobs. Access to lockers and change rooms has become limited and many workers come and go from hospitals in their uniforms.

  - when Ms. McCaskell first started nursing, Universal Precautions, as a means of infection control did not exist. Nurses and other HCWs cared for various infectious diseases - TB, meningitis (both droplet borne), gastrointestinal illnesses, hepatitis, etc. At that time, HCWs took different precautions according to the route of transmission. Patients were placed on isolation, instructions for staff were placed on each infectious patient's door, necessary PPE was provided and workers were instructed on how to proceed. It appears that with hospital downsizing, cutbacks in infection control staff, and an assumption that Universal Precautions will protect staff from every infection, that knowledge has been lost and staff are no longer properly instructed.

  - as the incidence of TB declined in the 1980s and 1990s (with exceptions among some populations), it appears that concerns about airborne or droplet borne respiratory infections have also declined. Concurrently, it appears that HCWs knowledge about these illnesses and how to protect themselves, has also declined. Health Canada guidelines published in 1994 advised that HCWs should wear properly fitted N95 masks when caring for patients with suspected and/or active tuberculosis. Yet as evidence in this document demonstrates, neither union encountered one employer who had ensured that any health care worker had been fit tested as per section 10 of the 1993 *Health Care Regulation* or the Health Canada guidelines prior to the SARS crisis.

- Throughout this document, problems with infection control practices, policies, knowledge and training have been demonstrated. In every instance where a worker's health and safety is placed at risk because they lack knowledge, adequate instruction, or the proper equipment, patients' health and safety are also placed at risk. Although these submissions are focused on worker health and safety, it must be understood that if employers were taking all precautions reasonable to protect worker health and safety (*OHSA s.25 (2) (h)*), that patients would also be safer. For example, if a worker contaminates herself/himself taking off PPE, she/he may go on to contaminate someone or something else that a patient may touch. If an x-ray tech is not instructed on how to clean a portable machine and given the materials and time to clean it properly, she/he is at risk, but so is the next patient she/he visits. Example after example can be given to demonstrate that the two issues – infection control and worker health and safety – are inseparable and simply reflections of each other.

Recommendations:

- *That the SARS Commission recommend the creation of a national centre for disease control that would be modeled on the U.S. Centers for Disease Control and Prevention. The mission of a Canadian centre for disease control would be to provide research-based information and education on infectious disease control and prevention for the people of Canada.*

- *That the SARS Commission recommend that MOHLTC increase funding to public hospitals, targeted at improving infection control programs within those hospitals in order that they can implement evidence-based recommendations that have been proven to prevent infection. A vital component of infection control programs must be appropriate training of all health care workers.*

- *That JHSCs are consulted with and have input into the development of all infection control policies and programs including training as per section 8 and 9 of the Health Care Regulation*

- *That supervisors are trained and maintain their competency regarding their legislated responsibility to ensure that infection control practices are followed in the workplace.*