A PRESENTATION

TO

JUSTICE ARCHIE CAMPBELL

Independent Commissioner to Investigate the Introduction and Spread of Severe Acute Respiratory Syndrome (SARS).

Submitted by:
Service Employees International Union
Canada
November 17, 2003.

I INTRODUCTION

- Good Morning, I am Sharleen Stewart, Canadian Vice President of the Service Employees International Union, and with me are Rose Ann Clarke from North York General Hospital, Ted Mansell, SEIU Canada's Health and Safety Director, and John Van Beek.

- I want first to thank you Justice Campbell for providing SEIU an opportunity to elaborate on SEIU Canada's concerns about occupational health and safety policies, regulations, and enforcement compliance in Ontario's hospital sector.

- I want to again for the record state whom SEIU represents. It is critical to understanding our concerns.

- SEIU Canada represents 90,000 members across Canada. We are part of SEIU, which has 1.6 million members in health care and related industries across North America.

- In Toronto SEIU represents hospital workers at Sunnybrook, Women's College, St. Michael's , Mount Sinai, Princess Margaret, North York General, Toronto East General, Humber River Regional Hospital, William Osler, Toronto General, Baycrest, Runnymede Chronic Care Hospital and West Park Hospital, in addition our members also work in nursing homes, retirement homes, home care and community living settings.

- As Registered Practical Nurses, environmental and housekeeping staff, clerical workers, dietary personnel, porters, technicians, and skilled trade workers, we are too often the forgotten health care workers. The critical work our members do in preventing the spread of disease and infection in the hospital environment is often overlooked or undervalued. Often characterized as "ancillary services", there is little acknowledgement of the essential roles, both direct and indirect roles, that our members play in providing patient care.

- The role that our members play on the front lines of the health care system is most powerfully underscored by the fact that at least 10 SEIU members were diagnosed with and treated for SARS. Hundreds of others were in work quarantine or home quarantine.

- SEIU members are proud of and committed to the work they do. Our members were front and center during efforts to address and contain the SARS outbreak. Like other professionals in hospital environments, they courageously accepted the very real and heightened risks associated with doing their jobs during the SARS outbreak.

- At the same time, and understandably, many of our members were worried and frightened by the risks and uncertainties of having to work in a SARS environment. Particularly worrying was the very real fear that they would expose and infect members of their families, should they unknowingly be infected with SARS.

- For months, our members lived with these fears, and with the stresses of working under quarantine, always putting the health and well being of patients they serve first. They did their best to understand and support their institution's efforts to combat SARS.

- Unfortunately, as we now know, much of this risk and uncertainty was unnecessary and could have been avoided. This is particularly true of the failure of the workplace health and safety regime to perform in many of the hospitals that were directly involved with SARS. Yet, local health and safety committees have an absolutely essential role to play in not only protecting workers, but in providing a conduit for information both to and from workers.

- Some workplace health and safety systems performed well in certain hospitals. But, these hospitals were the exception. In many others, workplace health and safety systems and procedures were either ignored or marginalized.

- For much of the 1990s the province dismantled, downsized or delegated its responsibility for workplace health and safety to the workplace parties. In many workplaces, there was simply no way for workers to address their concerns, where the framework for workplace health and safety was neglected or has essentially been abandoned.

- We have included several anecdotes in this brief which illustrate how the workplace health and safety system in hospitals had gone terribly off the rails, and was simply incapable of effectively rising to the challenges presented by SARS.

- Finally by way of introduction, a central theme of this submission has to do with the need to integrate hospital efforts to deal with health and safety issues, with those relating to disease and infection control. As this submission indicates, too often hospitals approached these problems as if they existed independently of each other.

II INFECTION CONTROL

- In our first presentation SEIU said that the most important aspect of the Commission’s work would be to review current infection control policies and procedures of Ontario hospitals. We argued that hospitals have not taken a due diligence approach to infection control.

- We pointed out specific references about the state of infection surveillance and control in Canadian hospitals.

- While SARS caught every health care institution off guard, the neglect of infection and disease control matters in Canadian hospitals was well documented before the SARS outbreak and substantially undermined the capacity of the challenges presented by SARS.

- We repeat that hospital service support staff were the last to be informed and the last to be trained. Yet, workers such as housekeeping, dietary and clerical staff are key to controlling the spread of infection. No one should ever devalue the work they do.

- In reading the hospitals' presentations to this Commission in September, SEIU is alarmed about the defensive position some hospitals took.

  There must be attempts made by health care institutions to improve. Statements such as, "We followed directives at all times," "We consulted," "We listened," ring hollow in light of our experiences.

- None of the hospitals contacted for the Health Canada study identified infectious diseases a priority program. (Naylor, 2003, p. 144).

- The start of any infection control program must begin at the institutional level. Hospital explanations of how difficult and confusing provincial protocols were to implement during the SARS crisis ring hollow.

- Each institution must be responsible for its own protocols. That there should be province wide standards adopted, there is no argument, but, this is an after the fact argument. Infection control protocols were not adequate in too many hospitals.

- SEIU in its first brief said that if hospitals did not have a reliable infection control program for SARS, they could at least have benchmarked their procedures, for the protection of patients and staff, on the Centers for Disease Control Tuberculosis guidelines.
- The discussion regarding infectious disease protocols in Ontario, since SARS, has been the domain mainly of the academic medical community on the one hand and hospital administrators on the other. The former advances points of view about how infection controls should have been carried out. The latter takes a generally defensive position about how their specific institutions did not know what they were dealing with [It's all new.] and how well their particular institution had managed the crisis.

- SEIU can not debate the science of infection control. We are not trained medical practitioners or epidemiologists. But, we can comment on the health and safety environment in Ontario hospitals.

- To this day standards for an occupational health and safety between Ontario hospitals greatly vary.

- Two of the three Toronto hospitals that reported no formal outbreak policy were SARS facility level 3 (highest) during the outbreak. Only 18 hospitals submitted infection control protocols even though 32 said they had them. (Naylor, 2003, p.147).

- There is no question that there must be uniform standards developed for hospital infection control, if not across Canada, then at least for Ontario. Our members lives too are at risk.

- Canada lags behind many other countries such as the United States, United Kingdom and Australia where national strategies are in place to improve quality and patient safety. (Romanow, p. 154).

- "The high rates of transmission to health care workers during SARS indicated that many had limited awareness of the correct precautions and how to apply them. 80 per cent of Canadian hospitals do not meet the standard control recommended by the Canadian Infection Control Alliance of one infection control practitioner per 175 beds. (Naylor, 2003, p.39).

- Infection surveillance and control resources and activities in Canadian acute care hospitals have not been assessed for 20 years. (Zoutman, 2003).

- The National Nosocomial Infections Surveillance (NNIS system at the Centers for Disease Control) requires one FTE infection control staff member for the first 100 occupied beds and an addition 1.0 FTE is required for reach additional 250 beds. No Ontario hospital comes close to meeting this criteria.

- Environmental infection control strategies and engineering controls can effectively prevent infections according to the CDC (MMWR, 2003). The CDC guidelines take into account the existing scientific data, theoretic rationale, applicability, and possible economic effects.

- The CDC guidelines are concise and detailed. They update many previous CDC guidelines from hand washing to the prevention of nosocomial pneumonia. The CDC quotes Albert Einstein, "The important thing is not to stop questioning."

- We must continue to question present infection control practices in order to improve them. Rationalizing past practices is not helpful. Increasing a hospital's due diligence and its occupational health and safety practices are.

- In a report on infection controls in Scottish hospitals (BBC News, January, 2003) the National Health Service in Great Britain claimed that the real challenge is to introduce a culture of surveillance and vigilance. Improving hygiene is a never-ending task because hospital acquired infections cost the British economy an estimated £186M a year and infections also delay hospital discharges. Managers according to the report are to ensure sufficient resources are spent on high quality cleaning services. And it's not about the number of times one cleans, but the number of staff you have to do it. Clean hospitals help to stop hospital-acquired infections.

Infection control programs are frequently under-resourced and have been vulnerable during health care restructuring.

"Activities and personnel are combined with other programs, or positions are simply eliminated." (Nicolle, 2001).

"Appropriate policies and procedures for patient care practices to minimize the acquisition of nosocomial infections must be developed, updated regularly and monitored for compliance. These include hand washing, outbreak control, isolation practices, use of invasive devices and environmental issues related to housekeeping, linen management, food preparation and disinfection and sterilization of equipment. (emphasis added) (Nicolle, 2001).

Hospitals in their submissions to this Commission in September acknowledge front line direct care staff, but there is not a mention of service support workers. They too contracted SARS. Some are not back to work yet.

Hospital service workers are vital to ensuring hospital infection control programs are carried out. Too many hospitals do not have adequate standards for cleaning or protecting workers who perform cleaning duties.
Just before SARS I housekeeping staff at North York General lost their day shift supervisor. He was never replaced.

In September, St. Michael's hospital told SEIU 200 environment assistants would be laid off. Even if one believes the hospital's restructuring strategy, at the end of the day, at least 35 housekeeping positions will be completely eliminated.

Hospital housekeeping practices must play a large part in infection control policies and procedures. It is, therefore, important that hospital services such as housekeeping, dietary and laundry services remain in house where these services are the direct responsibility of the hospital corporation. "Contracted in" or "contracted out" services allow the contractor

to set quality standards lower than a medical evidence based standard for infection control. Contracted services too easily will fall outside the surveillance of direct hospital infection control managers.

Studies also show that downsizing and contracting out hospital support services may contribute to nosocomical infections. (Hospital Infection Control, 1996).

"Contracts with external providers are not always specific enough to ensure acceptable levels of cleanliness and may allow for repeated non-compliance with targets for levels of cleanliness." (Audit Scotland, 2003).

The NHS in Great Britain has developed draft standards of cleanliness in hospitals (NHS Estates, 2003). The recommendations include the need for cleaning departments to have both operational and strategic plans in place.

Recommendations include:

- All cleaning staff must be adequately trained with both classroom and on-the-job training including Great Britain's version on WHMIS.

- Cleaning staff should have access to accredited training for a national Vocational Qualifications.

- Supervisory staff should have appropriate professional qualifications, such as a Diploma in Management Studies.

Hospital service workers must be seen to be part of the front line team in protecting all workers and patients in Ontario hospitals. The service workers are the first to see their jobs restructured, downsized, or eliminated in the health care system's continual emphasis on reducing costs.

A U.S.A. journalistic investigation found hospital cleaning and janitorial staffs are overwhelmed and inadequately trained, resulting in wards where germs have grown and multiplied for weeks, sometimes years almost everywhere (Berens, 2002). SEIU's experience is not much different in Ontario.

These workers have been subjected to more part-time and casual work. It is a work force that is extremely dissatisfied with its work environment (Romanow, p. 110).

After all the downsizing options have failed to deliver the desired financial objectives, hospital administrators, encouraged by governments, have and advocated for more private for-profit health care delivery.

Critics suggest that the quality of private-for-profit run facilities can be lower than publicly run facilities and that in some cases, these arrangements have resulted in beds being closed and staff being reduced. (Romanow, p. 30).

A recent letter from economists to Ontario's Health Minister states:

> We have no experience with P3 hospitals in Ontario so projecting their ultimate cost is difficult. All the same, experience with the P3s in other jurisdictions, including those in the health care sector, suggests that they are likely to be at least 10% more costly than public sector alternatives.
>
> In a hospital sector already cut to the bone, the opportunities for offsetting efficiencies are limited. Moreover, lowering costs is likely to mean fewer and less qualified staff. Not only does this have obvious and immediate consequences for patient care, but as the recent SARS outbreak vividly illustrates, health care workers and support staff have key roles to play in controlling the spread of disease and infection in the hospital environment.
>
> Given these limitations, unless the province is willing to pay more for the same level of service then something has to give, and that is usually the extent and quality of care. For example, for the Royal Ottawa Hospital, some of the operating cost savings projected by the hospital appear to be the result of reducing the number of hospital beds by 30 per cent. Moreover, neither the hospital nor the government offered any assessment of the ancillary costs of community care for the new outpatient and group home populations that will result from these beds reductions. The experience of P3 hospitals in the UK confirms that substantial reductions in service often occur in the P3 environment. (Auerbach, et al, 2003).

Laundry Services

Most hospitals ship soiled linens to off site laundries. According to Health Canada there are only a handful of reports that suggests soiled linen as a cause of cross infection. We also know the SARS virus can live on surfaces up to two days. Hospital laundry is not separated as to disease. Carts used to collect dirty laundry are used to transport clean laundry. Soiled linens constitute one of the largest concentrations of microbial contamination in the hospital environment and cause cross infection throughout a hospital. (its.itmonline).

SEIU maintains that moving hospital laundries off site has the potential to transmit disease to the outside environment. Hospitals should be perceived as self enclosed containment entities. To arrest disease transmission, laundry should be processed in house.

Procedures in handling hospital linens must be upgraded in order to reduce infections. Workers need to know how soiled linens must be handled in order to control the spread of air-borne micro-organisms.

This can not be done if the supervision of laundry is outside the hospital setting.

Employers must launder workers' personal protective garments or uniforms (MMWR, 2003). Many hospitals do not provide a uniform allowance. Staff take their uniforms home to launder and, thus, take potential infectious diseases outside of the hospital.

Medical Waste

The CDC has developed specific recommendations for handling medical waste. (MMWR, 2003). A good start in developing an effective infection control program would be for Ontario hospitals to benchmark their medical waste disposal policies to these recommended standards.

III ONTARIO HOSPITAL CLEANING PRACTICES AND WORKER HEALTH AND SAFETY

- The examples SEIU provides here are anecdotal. They are notes taken of informal interviews SEIU staff conducted with several members who were on the front lines of the fight to contain SARS. They hi-light the need to give more attention the role of housekeeping, waste disposal and laundry facilities have in disease and infection control.

- It is not uncommon for those promoting the privatization of hospital support services to compare hospital workers to those providing similar services in a hotel. The stories that follow illustrate the obvious point that a hospital is not a hotel, and role of all hospital workers is essential to ensuring that hospitals are places people get well, not sick.

HOSPITAL 1

A TORONTO SARS HOSPITAL
(Housekeeping worker's comments)

- Even though policies and procedures for infection control were in existence prior to SARS, the universal precautions weren't working and that's why it needed to rely on the Ministry of Health's directives.

- Just prior to the SARS outbreak the housekeeping department lost the day shift supervisor. This individual was never replaced. And therefore, no-one could provide the proper training.

- Supervisors are just as busy as we are, but even now the hospital provides no specific training on WHMIS. Medical waste training is limited to universal precautions.

- Co-workers are aware there is a Joint Health and Safety Committee, but most are not aware of their rights under Ontario Occupational Health and Safety Act. Names of JHSC members are not posted, and for union stewards it is hard to balance one's work duties and one's health and safety role.

- Workers think the Infection Control Program is a joke.

Another housekeeper, who contracted SARS and has been back to work for about four weeks, says there has been some changes but they are not nearly enough.

He believes the hospital does not inform us enough. There is a lack of information and education.

He says housekeepers do get orientation, but it may be at least a month after they are hired, because orientation is done in groups. So for the first while one is doing their job blind.

There is no WHMIS training. The only training workers get is job specific training. Workers don't know where MSDS, are kept. Workers do not know who JHSC members are. They don't know where the health and safety bulletin boards are. Minutes of the JHSC are not distributed to staff.

"They just don't get it."

The JHSC is overshadowed by management.

This worker has yet to be fit tested for a mask since returning to work.

Since the SARS outbreak he has become more skeptical. He doesn't trust the system any more after SARS I, when workers were told they could take off their masks.

EAP was offered workers but this individual worker thinks this only "turns into a group hug. We don't need that crap, we want changes."

The worker says that staff don't see the new protocols doing anything to protect their health. The only thing workers see is the screening, but people slip through the screening process.

If there is one thing he could change it would be the education provided staff. "Workers should not be afraid to refuse unsafe work. Now people are afraid to push the 'red button' to stop the line until the defect is fixed."

HOSPITAL 2 - Hospital outside the GTA

(Housekeeping worker's comments)

The hospital did start screening procedures but infection control policies or procedures were not upgraded. The hospital had contracted out its environmental services management to a large multi-national corporation in April 2001. Housekeeping staff remain employees of the hospital.

There is virtually no training for new employees. The management company just gives a standard protocol regarding gloves, masks and gowns. There is no waste removal training.

New employee training for housekeeping is basically done through a mentoring roll. A longer service employee trains the new hire. Even a person who may only be employed for a month could be told to mentor a new hire.

Management just doesn't know what is going on in regards to protecting workers' health and safety. Workers are not told about their rights under Ontario's OHSA. Management expects the stewards to tell workers. JHSC members are not universally known to workers.

Work place inspections, however, are done on a regular basis.

HOSPITAL 3 - Toronto Hospital

(Housekeeping worker's comments)

This hospital is a cut above the rest.

Housekeepers do get a general orientation of the hospital when hired. They are given biological and chemical training and receive WHMIS training on a yearly basis. Fire training is done twice per year.

JHSC members' names are posted, as are monthly workplace inspection reports. Housekeepers probably do not know their rights under Ontario OHSA. Information is posted though not always communicated.

Staff had N-95 masks for ages and are fit tested.

The housekeeper SEIU spoke to was not sure who did the training.

There is no evening or weekend supervisor. Duties are turned over to a worker with a pager and if a situation arises the supervisor is called at home.

HOSPITAL 4 - Toronto Hospital

(Housekeeping worker's comments.)

Housekeeping staff in this hospital think that over all SARS was handled well.

Proper PPE and training are in place. The hospital is making a pledge to re-train every one. WHMIS training is provided. Staff know where they can access MSDSs.

JHSC meeting minutes are posted. In June, 2003 13 more FTE cleaners were hired.

Housekeeping staff get the sense that there is management commitment to an excellent health and safety culture. The hospital knows it is important and staff value the knowledge of the hospital's health and safety manager.

It is the worker's understanding workplace inspections are done only quarterly, contrary to section 9(27) of Ontario's OHSA.

IV INTERNAL RESPONSIBILITY SYSTEM IS FAILING

Prevention and control of employee injury and exposure begins with an organizational commitment to provide a safe work environment for employees (Keith, 2003).

A worker's comments:

> Before SARS in March I was aware that there was a JOHSC as I was an alternate member. However, I was never notified of any meetings at any time in the 3-4 years that I was in this capacity. Up until March 2003 and the SARS outbreak at the Grace Hospital we had had updates on WHMIS, had fire drills and I was aware that there were certain codes for communicating that there may be a problem within the organization i.e. disaster, fire, and evacuation. However, in the past few years, I can't remember a time line, we hadn't had any fire drills or WHMIS. that is probably the extent to which I was aware of health and safety. It is not clear whether the occupational health department cared more about getting employees back to work than protecting their health and safety.

During the first SARS outbreak it became apparent that the Health and Safety Committee had been a "Sleeper Committee". During the first meeting which I attended at the end of March 2003, I was disturbed because of the fact that the co-chairs didn't appear to be interested in meeting at all and in fact a co-chair said, " I don't see what this has to do with the Health and Safety Committee, I don't think that we have a role to play in SARS, this is more of an infection control thing". There didn't seem to be much organization within the committee and there was lack of effective communication due to the confrontational attitude that existed. Members objected to the frequency of the meetings saying that they were too busy and neither one of them wanted to record the minutes. The management soon lost interest and didn't show up for meetings. Only after there was a work refusal did the co-chairs start to take the things that the worker members were saying seriously. However, they were still confrontational and non-communicative. Only when the MOL was finally on site, due to the fact that we had a critical injury did the worker and management co-chairs show the professionalism and interest that should have been there all along.

The difference between now and then is that the Committee is more structured, we are working on defining our Terms of Reference, meetings are more organized and committee members are taking their roles more seriously. The occupational health department has been expanded and there are at least 3 more occupational health nurses who deal with worker illnesses and returns to work. This department now reflects some of the needs of the worker.

On April 8, 2003 SEIU sent a letter to the Assistant Deputy Minister of Health and Long Term Care and all hospitals in Toronto who are subject to a SEIU collective agreement (Appendix A). It asked some basic questions as to how our members are being protected. Only a few responded and that long after the time requirement for responding to health and safety concerns (Sec 9(22) OHSA).

Employers are obligated to respond to JHSCs about workplace health and safety issues.

Too often JHSCs did not convene often enough to allow for problem identification or development of training and control measures. Sec 9 OHSA mandates employers to establish JHSCs that have the power to identify dangers and hazards, make recommendations for the improvement of health and safety and obtain information from the employer.

Responses from housekeeping workers in this brief shows training to be completely inadequate in too many hospitals.

In a survey conducted for the Workers Health and Safety Centre, 40 per cent of all employees in Ontario say they receive no safety training and 26 per cent only an hour or two of training. Just six per cent say they get a full day of training (Zwelling, 2002).

SEIU thinks these statistics also reflect the lack of training in health care settings.

SARS fit the definition of a critical injury under Sec. 51 OHSA. As such hospital JHSCs should have been informed within 48 hours of a hospital staff member having contracted SARS. In most cases, the JHSC was not informed.

OHSA places the onus on the employer to protect workers from workplace hazards and exposures. (Sec. 25, 26, 27).

Section 42 mandates the employer to provide information and instruction to a worker as required by Section 25 (2)(a).

Under the Health Care and Residential Facilities Regulation (Ont. Reg. 67/93 amended by Reg. 142/99 Sec. 10 provides for personal protective equipment to be properly used and to be a proper fit.

Porters in one hospital for the first couple of weeks of the initial SARS outbreak were given only surgical masks and not N-95 masks.

In one hospital, though there was a commitment, that the SARS unit would be staffed on a volunteer basis these workers were not informed of that.

Housekeeping and dietary staff and porters were not informed of potential hazards and given no training. They were simply told they would be working on the SARS unit because the Emergency Department was shut down.

The potential for disease transmission as a result of this human resource deployment decision could have resulted in even more wide spread infection. Infection containment procedures must also apply to hospital personnel. It is just not enough to isolate patients and equipment. All hospital personnel too must remain isolated within the disease unit, if we are to have any confidence infectious diseases will not be transmitted.

Having staff move from an infection control isolation wing to other parts of the hospital simply increases the risk of disease.

Emergency personnel assigned to the SARS unit when no longer required on the SARS unit were then be assigned to other hospital departments or wings for the balance of their shift.

In another hospital, a cleaner received a reprimand on his file because the supervisor felt the worker was very argumentative and unprofessional when he had been assigned to clean a SARS related isolation room. The letter states, “it’s my expectation that when you are asked to do something, you will do it. If you have personal issues, you need to address them directly with your supervisor, not other

people... I recognize these are difficult times ... these are not normal circumstances... I would like to remind you that the Hospital has made every effort to ensure the safety and protection of all our employees."

Rather than reassuring the worker, or trying to understand the health and safety concerns, the worker may have had, the attitude of the hospital administration is "just do as you are told, we know best."

A hospital can not just assign support workers such as housekeeping staff, "to just go in there to clean," without proper training and communicating to them the risks they may encounter.

On May 30 MOHLTC issued an *Interim Health Care Alliance Infectious Control and Management Plan* for the four designated SARS Alliance hospitals.

Each alliance facility was to formalize agreements on staffing, resources and supplies, and ensure that stringent transfer protocols were in place within facilities within the catchment zone.

The document said, "Staff in the four centres will be provided with the optimal dedicated specialized Infectious Disease Support Infection Control expertise; our goal is the optimal safety and supports for staff, patients and the broader community."

The document goes on to state, "ensure that full precautions are consistently enforced for all staff, ensure that mask fitting is in place as required. Ensure that effective and coordinated communication plans are in place for all staff levels, community and zone facilities - communications should be co-ordinated with MOHLTC as appropriate."

For emergency department personal that didn't happen. In a telephone conversation with a union representative, the HR Director simply said, "No one refused to work on the SARS unit."

V RECOMMENDATIONS

The following recommendations are preliminary. SEIU will be preparing a more comprehensive brief for the commission before it concludes its work.

1. The health care sector and hospitals must practice due diligence in regard to infection control. Province wide standards need to be developed so that each institution practices the same infection control procedures.

2. The role of the Joint Occupational Health and Safety Committees in health care institutions/hospitals need to be enhanced. Health care workers, particularly support staff such as housekeeping, dietary and clerical staff must not be afraid to speak out for fear of losing their jobs. These workers must have full access to training, and the right to know about any infectious diseases, substances, or hazards that may affect their health and safety.

   Involuntary assignments to hazardous environments without proper training, education, and complete PPE must be prohibited.

   Specific certification programs for hospital workers' health and safety representatives need to be developed and must include training in the control of infectious disease.

   Sec. 9 (12) of OHSA prescribes what an employer shall ensure at least one member of the committee representing an employer and workers be certified.
   In multiple union work places such as Ontario hospitals, each union should be entitled to have at least one member certified. This will enhance the training and communication within the entire employee group the certified member is responsible for.

3. There needs to be a higher standard of province wide planning and preparedness for combating infectious diseases. Almost 10 days elapsed from the time WHO issued a global alert to the time Ontario's Commissioner of Public Health urged all Ontarians at risk of developing SARS to call their family doctor.

4. The Ministry of Labour inspection branch needs to adopt a more proactive interventionist approach to ensure employers are complying with the Occupational Health and Safety Act and its regulations.

5. There is a shortage of expert staff in Ontario hospitals to manage infection control programs. Many hospitals had to rely on outside expertise to develop protocols.

6. Infection control training and communication strategies need to include institutional support staff. Communication delays result in misinformation and fear. All health care workers have the right to know how their health and safety may be jeopardized

and how they can take preventive measures to minimize exposure. Proper health and safety training and precautions should be a mandatory part of a health care institution's hiring practices and employee orientation programmes.

7. Health care institutions need an adequate supply of personal protective equipment on hand. From now on it is not adequate to say only X personnel get gowns, gloves and N-95 masks and Y personnel only get substandard protection.

8. Health care institutions' management can not place cost containment measures for protective equipment and supplies ahead of infection containment initiatives. The pennywise pound foolish philosophy of health care administrators, concerned only with budgets, in the end will always cost more. Proactive rather than defensive measures need to be developed. These must come under the direction of infection control experts.

9. Hospital management teams must be educated and trained in occupational health and safety policies and procedures, with particular emphasis on health and safety policies as they relate to the healthcare sector.

10. Staffing of all hospital departments need to be reviewed. During an infectious disease outbreak there are not enough staff available to handle the workload. Human resource policies must be developed to address health care staff recruitment and retention issues.

11. Part-time work in health care institutions must be reduced. Part-time workers must work at several health care sites to earn a living wage. During an infection/disease outbreak, they are restricted to work in only one location. This is the right policy to arrest disease transmission, but restricting part-time workers from working at multiple sites puts added stress on the staff who remain available at only one site.

    There is no reason why part-time health care positions cannot be combined into full-time staff positions.

12. For healthcare workers who lost work, had hours reduced or lost work because of hospital department closures or quarantines should be provided full wage and benefit loss replacement.

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April 8, 2003

Dear

The effects of Severe Acute Respiratory Syndrome have taken a toll on all workers in health care settings.

As a union, the Service Employees International Union Local 204 is concerned that the health of all patients, their families, the general public, and our members are protected from any medical illness or disease and the economic effects the SARS epidemic may have on them.

As of this writing SEIU Local 204 has learned that staff nurses at North York General Hospital are under investigation for SARS.

As a union Service Employees International Union is concerned about the lack of information forth coming from the hospital.

Nine nurses are now at home under quarantine.

In a SARS update bulletin, (bulletin #12) you say, "there is no evidence that SARS was passed on to these nurses when they were wearing protective SARS gear and caring for patients. None of these nurses were caring for SARS infected patients at North York General Hospital."

How can you be so sure? SARS had to be transmitted by someone, somewhere. A health care setting would appear to be a likely location, particularly if three nurses in the same facility are under investigation.

Service Employees International Union Local 204 wants to be sure North York General Hospital is doing everything in its power to follow the regulations in the Ontario Occupational Health and Safety Act. Our members have the right to know, the right to participate in identifying and controlling SARS and the right to refuse unsafe work if it does not interfere with a patient's well-being.

...../2

April 8, 2003

With this understanding, we ask North York General Hospital to answer the following questions:

1. Has the hospital since the SARS epidemic first became known issued appropriate PPE to guard against infection, airborne, droplets and contact transmissions? (hand-hygiene, gowns, goggles, footwear cover, and proper respiratory protection [N95 respirators])?

   The current scientific evidence indicates SARS is not airborne transmitted. What antiviral agents or disinfectants is the hospital using to try "to kill" the virus on all surfaces?

2. When was PPE first issued in your facility (date and time)?
3. Have any employees been excluded from duty if they report a fever or respiratory symptoms. If so have they been informed that they should avoid contact with persons both in the hospital and in the community at large?

4. Has the hospital conducted daily screenings or medical surveillance on all hospital employees? We note that bulletin 12 states you are working on setting up an assessment area. Why were these response teams not being put in place at the first instance of the Hospital having learned of the SARS epidemic?

   Has and is the hospital screening all staff who work at a partner site, a Long Term care facility or a Home Care Agency?

   For employees who may be at additional risk such as pregnant women, what has the hospital done to protect these workers?

   Have symptomatic employees been sent home and under quarantine?
5. When did the hospital start to conduct training in regard to SARS and has this information been shared with and approved by the Joint Health and Safety Committee?

6. What other precautions has the hospital taken to ensure visitors to the hospital are not carriers of SARS, other than for personal masks and a security guard at the entrance?

7. For any employees who may have lost time from regularly scheduled shifts or sent home under quarantine, will they be fully compensated?

   Thank your for your understanding and concern.

   Sincerely,