CANADIAN FEDERATION OF NURSES UNIONS
LA FÉDÉRATION CANADIENNE DES SYNDICATS D'INFIRMIÈRES ET INFIRMIERS

POSITION STATEMENT

UPDATED JULY 16, 2021

Safety Is Not Negotiable
Pandemic Preparedness – the Coronavirus 2019 (COVID-19)

> *When it comes to worker safety in hospitals, we should not be driven by the scientific dogma of yesterday or even the scientific dogma of today. We should be driven by the precautionary principle that reasonable steps to reduce risk should not await scientific certainty. Until this* ***precautionary principle*** *is fully recognized, mandated and enforced in Ontario's hospitals, workers will continue to be at risk.*
>
> **Justice Campbell, Chair of the SARS Commission**

INTRODUCTION

New evidence and information on COVID-19 is emerging daily, and CFNU's recommendations remain based on science and occupational health and safety legislation and principles, including the precautionary principle.

As well, the occupational health and safety principle of the hierarchy of controls applies. It starts with eliminating the hazard whenever possible. When that cannot be accomplished, a combination of engineering and administrative controls, combined with appropriate personal protective equipment, must be applied. The system is called a hierarchy because you must apply each level in the order that they fall in the list; a systematic comprehensive and integrated approach must be taken to reducing hazards; a hierarchy of controls cannot be applied in a piecemeal fashion.

It is incumbent upon federal/provincial/ territorial governments and employers to provide appropriate protection to health care workers, and to take a leadership role on infection prevention and control in health care settings.

The federal government has committed to procuring and allocating the necessary PPE to provinces, including fit-tested NIOSH-approved N95 respirators.

The Public Health Agency of Canada (PHAC)[1], the Centers for Disease Control and Prevention (CDC)[2] and the World Health Organization (WHO)[3] have now formally acknowledged that one

[1] Public Health Agency of Canada. (2020, November 3). COVID-19: main modes of transmission. Retrieved from https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/health-professionals/main-modes-transmission.html
[2] Centers for Disease Control and Prevention (CDC). (2021, May 7). Scientific Brief: SARS COV-2 Transmission. Retrieved from https://www.cdc.gov/coronavirus/2019-ncov/science/science-briefs/sars-cov-2-transmission.html
[3] World Health Organization (WHO). (2021; updated April 30, 2021). Coronavirus disease (COVID-19): how is it transmitted? Retrieved from https://www.who.int/news-room/q-a-detail/coronavirus-disease-covid-19-how-is-it-transmitted

of the main routes of transmission for COVID-19 is from infected individuals, who spread the virus through both large and small fine respiratory droplets as well as aerosol particles generated when they cough, shout, talk, sing or breathe, and that aerosolized particles may linger in the air and be inhaled. In light of this fact, governments and employers must secure respiratory protection (fit-tested N95 respirators or better) so as to protect health care workers caring for presumed and confirmed cases of COVID-19.

Examples of engineering controls: plexiglas barriers; sufficient and effective ventilation systems with appropriate air change per hour, and air cleaners;[4] designated COVID-19 units, negative pressure rooms; private rooms with private toilet and patient sink; designated hand washing sinks for HCW use.

Examples of administrative controls: employers' pandemic plan; active screening protocols; respiratory protection program; enhanced environmental cleaning; application of precautions (droplet and aerosol (small droplets and particles which linger in the air), contact, airborne); safe patient transportation policies; training, testing and drilling; education, surveillance and auditing practices; visitor restriction and protection policies; policies on procuring, supplying and accessibility of adequate and appropriate PPE; provincial/territorial and federal guidance and directives to adequately protect workers from the risk of inhaling the virus via the aerosol/airborne route.

Examples of PPE: fit-tested NIOSH-approved N95 respirators or better (e.g., reusable elastomeric respirators) for workers at risk of exposure to a suspected or confirmed COVID-19 patient/resident/client, with an adequate and accessible supply (along with training on how to don and doff respirators); gloves, impermeable gowns, medical masks, full face shields or goggles, hair and foot coverings.

THE EVIDENCE

According to the Canadian Institute for Health Information (CIHI), the number of health care worker infections tripled from July 2020 to mid-January 2021 and reached 65,920, comprising 9.5% of total cases in Canada[5]. As of July 2021, Statistics Canada reported that about 100,000 Canadian health care workers had been infected with COVID-19 (where occupation code was provided)[6]. Over 50 health care workers have now died from COVID-19 in Canada.[7]

As the CFNU detailed in its 2020 report by Mario Possamai, *A Time of Fear: How Canada failed our health care workers and mismanaged COVID-19*, other countries fared much better because they learned from the SARS epidemic in 2003. In July 2020, after the COVID-19 first wave, China's infection rate for health care workers stood at 4.4% of the national total, while

[4] U.S. EPA. Air cleaners, HVAC filters and Coronavirus (COVID-19). Retrieved from https://www.epa.gov/coronavirus/air-cleaners-hvac-filters-and-coronavirus-covid-19#:~:text=Portable%20air%20cleaners%20and%20HVAC,virus%20that%20causes%20COVID%2D19

[5] CIHI. (2021, January 15). Cases and deaths in health care workers in Canada. Retrieved from https://www.cihi.ca/en/covid-19-cases-and-deaths-in-health-care-workers-in-canada-infographic

[6] Statistics Canada. (July 9, 2021, release). Preliminary dataset on confirmed cases of COVID-19, PHAC. Retrieved from https://www150.statcan.gc.ca/n1/en/catalogue/13260003

[7] CFNU. In Memoriam: Canada's health workers who have died of COVID-19. Retrieved from https://nursesunions.ca/covid-memoriam/

Taiwan and Hong Kong had infections of health care workers that remained in the single digits because they chose to protect health care workers with respiratory protection (N95 respirators).[8]

A 2021 study from the UK, examining the efficacy of surgical masks versus face filtering pieces, such as N95 respiratory masks, confirms Possamai's conclusion that introducing N95 respirators in China significantly reduced the country's infection rate among health care workers. According to the UK study, "Upgrading face masks to filtering face piece (FFP3) respirators for healthcare workers on covid-19 wards produced a dramatic reduction in hospital acquired SARS-CoV-2 infections, according to research carried out at Addenbrooke's Hospital in Cambridge."[9]

It is unacceptable that so many health care workers have gotten sick and died. It is also apparent that measures taken to protect workers, including the personal protective equipment provided, are not sufficient or appropriate.

Aerosol Transmission of COVID-19

Since January 2020, the Canadian Federation of Nurses Unions and its Member Organizations have documented the potential risk of aerosol transmission of COVID-19, and urged that the precautionary principle be applied in order to protect health care workers from contracting the virus. As the evidence has mounted with respect to COVID-19 being spread in the air, many experts now consider close-range aerosol transmission the dominant mode of transmission.[10]

In November 2020, the Public Health Agency of Canada confirmed that close-range aerosol transmission of COVID-19 occurs. According to the PHAC, when a person infected with COVID-19 coughs, sneezes, sings, shouts or talks, small aerosolized droplets or particles called aerosols can linger in the air and potentially be inhaled into the nose, mouth, airways and lungs of those in the room. The PHAC recognizes the virus is spread most commonly amongst those in close contact within indoor environments, and one can become infected from someone with or without symptoms. The PHAC also notes the importance of adequate and appropriate ventilation in order to decrease the concentration of aerosols that may be suspended in the air in the room and to reduce the chances of SARS-CoV-2 spread, if those aerosols contain the virus.[11]

In a May 2021 scientific brief[12], the CDC acknowledged the significance of close-contact "inhalation of air carrying very small fine droplets and aerosol particles that contain infectious virus", noting that the risk of contracting the virus was greatest within 3 to 6 feet of an

[8] Possamai, M. (2020). *A Time of Fear*. Retrieved from https://www.atimeoffear.com/
[9] Wise, J. (2021, July 29). COVID-19: Upgrading to FFP3 respirators cuts infection risks, research finds. *BMJ.* Retrieved from https://www.bmj.com/content/373/bmj.n1663
[10] CFNU. Research Summary on COVID-19. Retrieved from https://nursesunions.ca/cfnu-research-summary-on-covid-19/
[11] The Public Health Agency of Canada (2020, November 3). COVID-19: Main modes of transmission. Retrieved from https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/health-professionals/main-modes-transmission.html
[12] Centers for Disease Control and Prevention (CDC). (2021, May 7). Scientific Brief: SARS COV-2 Transmission. Retrieved from https://www.cdc.gov/coronavirus/2019-ncov/science/science-briefs/sars-cov-2-transmission.html

infectious source where the concentration of particles was likely to be greatest. In the same update, the CDC recognized the potential for aerosol particles to spread farther than 6 feet, remaining in the air for minutes to hours, under certain circumstances such as within enclosed spaces with inadequate ventilation.

Similarly, on April 30, 2021, the World Health Organization updated its transmission guidance[13] to formally acknowledge the SARS CoV-2 virus could be carried in the air.

POSITION

It is the position of the Canadian Federation of Nurses Unions (CFNU) that, in the event of an outbreak of any new respiratory virus, we acknowledge that the required and best respiratory protection for health care workers at risk is, minimally, fit-tested NIOSH-approved N95 respirators or higher levels of protection (e.g., powered air-purifying respirators (PAPR) or elastomeric respirators), given the emerging science, occupational health and safety legislation, and the precautionary principle.

Failure to institute the precautionary principle throughout the health care system, including in acute and long-term care facilities, home and community care, has resulted in nurses and other health care workers becoming vectors spreading the disease to each other and their patients, residents, clients or families. For infection and prevention control measures to be effectively implemented, the hierarchy of controls, as described above, must be implemented throughout the organization, in conjunction with joint health and safety committees that include direct care providers (including nurses) and their unions.

Based on an organizational infectious disease risk assessment, all nurses and frontline health care workers at risk in their area of work, or any area they may have to work in, with the potential for exposure, and/or who are caring for a suspected or confirmed COVID-19 patient, should be provided, fitted for and have unfettered access to a NIOSH-approved N95 or greater respirator (i.e., powered air-purifying respirator (PAPR), elastomeric respirator), and be trained, tested and drilled by the employer to safely don and doff it. All PPE (gloves, impermeable/isolation gowns, medical masks, N95 respirators, and face and eye protection (such as full face shields or goggles) should be supplied in all patient/resident care areas and in adequate amounts, and stored so they are readily accessible at the point of care for all health care workers.

It is critical that employers recognize, promote and respect the importance of health care workers performing a point-of-care risk assessment (PCRA) before every client interaction, to determine the personal protective equipment (PPE) health care workers require for the patient, task and environment. **Guidance must make it clear that an employer cannot deny access to the necessary and appropriate PPE – regardless of the care/task being provided or undertaken – including fit-tested N95 respirators, if a health care worker determines that they are required.**

[13] World Health Organization (WHO). (2021; updated April 30, 2021). Coronavirus disease (COVID-19): how is it transmitted? Retrieved from https://www.who.int/news-room/q-a-detail/coronavirus-disease-covid-19-how-is-it-transmitted

Universal Masking in Health Care Settings

Given the evidence of non-symptomatic transmission, health care workers and visitors should wear a medical mask at all times when in patient care areas in hospitals, long-term care facilities and community settings.

Patients/residents/clients who are able to comply should wear medical masks as a form of source control anywhere within the health care facility and within their homes or their rooms when health care workers request they don a mask.

Collection of Respiratory Specimens

Given the evidence of close-range aerosol transmission, the potential for non-symptomatic transmission, and the collection of a specimen from an anatomic region where viral loads may be higher, health care workers performing nasopharyngeal or throat swabs must be provided the ability to access fit-tested N95 respirators (or higher levels of protection) based on their PCRA (minimally, contact and droplet precautions must be in place) and be trained, tested and drilled in all PPE use.

Screening, Testing and Triage

For those workers involved in triage and screening and testing for COVID-19, ideally a floor-to-ceiling plexiglas barrier with a speaker phone would eliminate worker exposure to the hazard, if there is no further direct contact with a patient required. If the barrier is not in place and direct contact cannot be avoided, other administrative and engineering controls (such as disposable equipment, signage procedures, training, separate examination rooms and waiting area with adequate ventilation with appropriate air changes per hour throughout the facility) should be in place before direct contact with the patient. Workers must have the ability to access fit-tested N95 respirators based on their PCRA (minimally, contact and droplet precautions must be in place) and be trained, tested and drilled in all PPE use.

To reduce the spread of COVID-19 in health care facilities, emphasis must be placed on preventing the virus from entering the facility. Therefore, effective and comprehensive screening and testing programs for both visitors and staff entering all facilities must be in place.

Designated COVID-19 Units

Hospitals and long-term care residences must cohort and isolate patients with presumed or confirmed cases of COVID-19. This has been an effective infection prevention and control model used internationally.

Given the potential for non-AGMP aerosol spread of the virus, all workers caring for suspected or confirmed cases in designated COVID-19 units must be required to wear, minimally, fit-tested NIOSH-approved N95 respirators, if available, to prevent aerosol transmission of the virus. Head and foot protection, eye protection (i.e. full face shields or

goggles), gloves, impermeable (or at least fluid-resistant) gowns must also be worn in these areas.

Aerosol-Generating Medical Procedures 'Hot Spots'

It is essential that airborne precautions and the use of fit-tested NIOSH-approved N95 respirators or preferably better (i.e. elastomeric respirators, powered air-purifying respirators (PAPRs)) be mandated at all times in clinical areas considered aerosol-generating medical procedures 'hot spots' (e.g.: intensive care units (ICU), emergency rooms, operating rooms, post-anaesthetic care units and trauma centres) that are managing COVID-19 patients. Where possible, AGMPs should take place in negative pressure rooms (or AIIR – airborne infection isolation rooms), or single-patient/resident rooms if an AIIR room is unavailable, and PAPRs should be used as respiratory protection for AGMP procedures.

Supply Issues

Upon producing evidence to the joint occupational health and safety committee of the employers' procurement attempts for all types of respiratory protection (fit-tested N95 respirators and reusable/cleanable respirators) from all vendors and from government – and as a last resort in the event of dire supply shortages of disposable N95 respirators – employers must notify and discuss alternative strategies to immediately address and resolve the supply issue with affected health care unions.

At a minimum, in this eventuality all employees must be equipped with personal protective equipment for contact and droplets precautions for suspected, presumed or confirmed cases of COVID-19, including gloves, eye protection (full face shield or goggles), isolation/ impermeable gowns, head and foot coverings, and medical masks, for which they must also be trained, tested and drilled in safe use.

The Critical Importance of Point-Of-Care Risk Assessment (PCRA)

Point-of-Care Risk Assessment is required to be completed by all health care workers for all interactions with patients/residents/clients.

Even in the event of supply issues, the point-of-care risk assessment (PCRA), an activity that is based on the individual nurses' professional judgment (i.e., knowledge, skills, reasoning and education) must determine the protective equipment a nurse is provided, and if it is inadequate – given the patient acuity, environment or other factors – nurses must be provided access to a higher level of PPE regardless of the care/task being undertaken. Guidance must make it clear that a health care worker cannot be denied appropriate protection as required by the PCRA.

Underlying the PCRA is the principle that individual health care workers are best positioned to determine the appropriate personal protective equipment (PPE) required based on the situation and their interactions with an individual patient. They do so by evaluating the likelihood of exposure to themselves or others based on a specific task, environment,

conditions, interaction or patient. Among the factors that should be considered in the PCRA are: the potential for contamination of skin or clothing; exposure to blood, body fluids or respiratory secretions; the potential for inhaling contaminated air or aerosolized particles; the patient's ability or willingness to comply with infection control practices (e.g., wearing a medical mask); whether care requires very close contact or prolonged close contact; what engineering (i.e. appropriate ventilation/air changes per hour and air cleaners) and administration controls are in place; and whether the patient could require an aerosol-generating medical procedure at any point and/or is in an AGMP hot spot (e.g.: intensive care unit, emergency room, operating room, post-anesthetic care unit or trauma centre) that is managing COVID-19 patients. Personal protective equipment should be selected based on the potential for exposure in order to minimize the risk of exposure to HCWs, a specific patient or other patients in the environment.

The PCRA does not abdicate the employer, however, from their legal obligation to provide appropriate PPE and protect all workers adequately under the *Occupational Health and Safety Act*, as indicated below.

Precautionary Principle and OH&S Law

A legal opinion, posted by a leading Canadian law firm Osler, Hoskins & Harcourt LLP, recommends employers "benchmark to current best practices" and follow "appropriate precautionary measures": "Where there is conflicting evidence as to whether a certain precautionary measure is required or not, hospitals should adopt the elevated precautionary measure(s). Hospitals should be cognizant that it will be the hospital that will be legally liable for any failures to protect patients and staff from harm, even if hospitals have relied on federal, provincial or municipal government directives in establishing its own plans, policies and procedures."[14]

Similarly, Katherine Lippel, Distinguished Canada Research Chair in Occupational Health and Safety Law, argues that: "The precautionary principle that provides that prevention measures be put in place when scientific uncertainty prevails is intrinsic to OHS law."[15]

The legal ruling in Ontario from Justice Morgan in Ontario Nurses' Association v. Eatonville/Henley Place, 2020, and the Stout award have reinforced the importance of the point-of-care risk assessment and respecting nurses' professional and clinical judgement when determining what PPE is necessary: "Nurses must be provided with PPE, including N95 respirators if, in the nurses reasonably professional and clinical judgment, they determine such PPE is necessary."[16]

Employers' responsibilities are clearly laid out in provincial OH&S law: employers must work with joint OH&S committees on their pandemic plans, protocols and measures; provide training, testing and drilling for all employees on health and safety measures; establish a respiratory protection plan and provide fit-testing for N95 respirators or better to all

[14] Retrieved from https://www.osler.com/en/resources/governance/2020/coronavirus-covid-19-lessons-learned-from-sars-a-guide-for-hospitals-and-employers
[15] Possamai, M. (2020). *A Time of Fear*. Retrieved from https://www.atimeoffear.com/
[16] Ibid.

employees who may need them as based on their areas of work or potential work responsibilities; and employers are also responsible for making PPE readily accessible and available to health care teams so they can do their jobs safely.

It is our position that a pan-Canadian approach to emergency preparedness must incorporate the precautionary principle so that all nurses and health care workers across Canada have the same access to health and safety in their workplaces, including the same standard for personal protective equipment (PPE) and pandemic planning.

Effective infection control and health and safety strategies must incorporate a hierarchy of controls approach, as described above, developed and implemented throughout the organization, in conjunction with joint health & safety committees that include nurses and their unions.

If AT ANY TIME you feel that your employer is not following the OH&S laws and principles as outlined above, please contact your union immediately.

Nurses are expected to be prepared, 24 hours a day, to face any number of health emergencies. The ability to respond quickly and efficiently to emergencies is fundamental to the nursing profession. However, rapid response requires the support of many parts of the health care system. It requires emergency preparedness planning, proper administrative and engineering controls, the support of the administrators of the health system, as well as employers and governments to ensure the necessary protocols, measures, procedures, training and protective equipment that take into consideration risk and the precautionary principle.

For workers, we recognize the critical importance of the point-of-care risk assessment and that individual health care workers, using their knowledge, skills, judgement and education, are best positioned to determine the appropriate PPE required based on their interaction with an individual patient in a particular environment.

Questions or concerns? If you have any questions or concerns, please speak with your union or a member of your Joint Occupational Health & Safety Committee.

EMPLOYER'S CHECKLIST

- Consult the Joint Occupational Health & Safety Committee on all measures, procedures and training with respect to COVID-19.
- Review and update existing institutional pandemic plans, developed in conjunction with the joint OH&S committees, to ensure they include staffing, communication, education and training for staff with respect to pandemic preparedness plans and the health risks of the current emergency and/or pandemic situation.
- Ensure that workers have ready access to appropriate PPE, are regularly trained and fit-tested for the N95 respirator or better (at least biennially or in accordance with personnel changes) and regularly drilled in any potential hazards, including the reason for and use of protective equipment such as the N95 respirator or better (e.g., powered

air-purifying respirator (PAPR), elastomeric respirator), how to don and doff all equipment, and all safety protocols.

- It is essential to ensure that health care providers are fully trained, tested and drilled in the care provisions/protocols required during a pandemic, including conducting a point-of-care risk assessment before each interaction with a patient and/or the patient's environment to evaluate the likelihood of exposure to contact, droplet and/or aerosols in providing care and/or care procedures, equipment and treatment settings to determine the appropriate safe work practices.
- Conduct a comprehensive organizational risk assessment, including determining all points of potential entry (and how to restrict them using prominent signage and limiting access) and other points of potential exposure for workers (e.g., screening, triage, isolation rooms).
- Implement changes in policies, procedures, equipment and the environment to eliminate or minimize identified risks in accordance with a hierarchy of controls approach to hazards.
- Have in place relevant travel screening and worksite/unit exposure controls. Ensure that sufficient protective measures and equipment are in place for all screening locations at all entry points.
- Have in place suitable structural barriers (e.g., ceiling-to-floor plexiglas barriers at triage and registration), disposable equipment, separate examination rooms and waiting area.
- Secure an adequate supply of appropriate fit-tested N95 respirators or better (e.g., reusable elastomeric respirators), gloves, impermeable gowns, head and foot protection, full face shields or goggles, as well as PAPRs (for aerosol-generating medical procedures, e.g., intubation) and full body protection on hand.
- Have airborne infection isolation rooms (negative pressure rooms) available and prepared for immediate occupancy whenever possible.
- When a suspected patient is identified, implement isolation measures in a negative pressure room for those with symptoms and move patient immediately to this room, separate from other patients, with access to a dedicated washroom or commode, and ensure that only trained and properly equipped personnel (with appropriate PPE, including respirators) are assigned as care providers and to enter these rooms.
- Create dedicated teams of clinicians who are protected with and trained, tested and drilled in the use of proper personal protective equipment for COVID-19, including teams trained in the use of N95 respirators or better (e.g., elastomeric respirators) and PAPR, if available (for aerosol-generating procedures), donning and doffing protocols, who can care for both suspected and confirmed cases of COVID-19 on each shift.
- Ensure sufficient staffing is available to supplement nurses and other health workers who need to care for patients in isolation, and schedule work in a manner that allows for multiple rest periods and recovery periods, as well as implement systems for monitoring fatigue.
- Implement surge capacity protocols as needed.
- In the event of staff shortages, contingency plans for staffing must be drawn up in close cooperation with joint occupational health and safety committees and affected nurses' unions.
- In the event where staff are transferred between unit/sites, or there is a redeployment of staff, staff must be sufficiently orientated, trained and educated so they are effectively

prepared for work in the new unit/site, and the union shall also be notified of the transfer or redeployment.
- Implement enhanced cleaning protocols ensuring cleaners wear the appropriate PPE.
- Use disposable equipment whenever possible; non-disposable equipment should be dedicated to the patient.
- Undertake a review of the facility's ventilation to ensure that there are sufficient air changes to help mitigate the risk of aerosol transmission.

NURSE'S CHECKLIST

- Comply with existing workplace infection control policies and procedures.
- Stay home when you are ill.
- Update your N95 respirator fit-testing and wear an N95 respirator, or better (e.g., elastomeric respirator), if there could be any risk of exposure to COVID-19.
- Use required droplet, contact and additional airborne precautions such as (but not limited to): gloves, full face shields or goggles, impermeable gowns, N95 respirators, powered air-purifying respirators (PAPR) when available (for aerosol-generating medical procedures, e.g., intubation).
- Conduct a point-of-care risk assessment before each interaction with a patient and/or the patient's environment to evaluate the risk of exposure to contact and/or aerosol transmission in providing care and care procedures, equipment and treatment settings; at any time during this risk assessment nurses may request an increase in PPE.
- In the event that a nurse is transferred between units/sites or redeployed, and the nurse identifies the need for orientation, training or education, the nurse shall notify the employer.
- If you have any health conditions of concern when caring for COVID-19 presumed or confirmed cases, please consult your health care provider.
- Avoid touching your eyes, nose and mouth with hands to prevent self-contamination; clean hands before contact with any part of the body.
- Avoid contact between contaminated gloves/hands or equipment and the face, skin or clothing when removing PPE.
- Familiarize yourself with your collective agreement and legislation with respect to pandemic preparedness, occupational health and safety (OH&S) and the right to refuse dangerous work.
- **STOP if you do not have the required personal protective equipment or properly fitted respiratory protection, and/or have not been trained, drilled and tested in its care, use and limitations, and speak with your manager or supervisor; document the situation and copy your union and Joint OH&S Committee representative.**
- **REPORT any health and safety concerns, including gaps in adequate protocols and procedures and/or communications, inadequate ventilation, access to PPE, fit-testing and/or training or other health and safety concerns to your manager or supervisor, copying your Joint OH&S Committee and your union.**