CNA Brief to the National Advisory Committee on SARS and Public Health:

LESSONS LEARNED AND RECOMMENDATIONS

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CANADIAN NURSES ASSOCIATION
ASSOCIATION DES INFIRMIÈRES ET INFIRMIERS DU CANADA

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Introduction

> *"I can't help but think, the best is yet to come as the SARS experience gets debriefed and we can make system changes to prepare more effectively for the next emergency."*
>
> Janis Leiterman, VON Canada Clinical Services Director

The Canadian Nurses Association (CNA) is a federation of 11 provincial and territorial professional nurses associations representing more than 117,000 registered nurses and nurse practitioners. The mission of CNA is to advance the practice of nursing in the interest of the public.

This brief was developed in consultation with nurses and nursing organizations from across the country.

CNA appreciates the invitation to contribute to the work of the National Advisory Committee on SARS and Public Health. CNA recognizes that the public health system is an integral component of the health system in Canada. The strength of the health system depends on the resilience of each of its components. Due to the inattention – policy and fiscal – to the public health component, the health system has become a two-legged stool. Our collective capacity to identify potential threats to health, conduct timely analyses and inform health stakeholders and the public and implement appropriate services and community surveillance strategies has been hampered.

This was evident during the SARS outbreak in spring 2003. SARS challenged both the acute care and public health components of the health system. It highlighted communication issues within and between the two components. It also showcased the effects of decisions to limit, in some cases, permanent staffing and, in other cases, to terminate other staff experts. It also demonstrated the degree of public anxiety about the health system.

But the SARS experience is not an isolated one. The holes in the public health system have been linked to the contaminated water threats in Walkerton, Ontario, in North Battleford, Saskatchewan and in Newfoundland.

Similarly, Canada's population health statistics speak to the crumbling of the public health system. Increasing levels of obesity in both adults and children, faltering infant mortality rates relative to other developed and developing countries, growing incidence of unintentional injuries and high rates of diabetes among Aboriginal peoples are examples of situations reflective of the absence of effective public health policies.

Nurses deliver many public health services, including home care, surveillance, research and public education. CNA has long advocated that governments invest in the public health system. To stabilize the two-legged stool, CNA has recommended the development of a national public health strategy, which would recognize the links among the components of the health system and the relationship between public health infrastructure and positive health outcomes.

CNA hopes that the report of the National Advisory Group will make recommendations that will strengthen the public health system and position Canada to address health threats.

For nurses, as for most Canadians, investments in the health system, are a priority[1] (Communication Canada, 2002). Canadians consider health care a key component of the value system that defines and identifies them as a people (Vail, 2000). Nurses hear that view expressed daily by patients and their families. Nurses also recognize the value of the health system to Canada's economy.

Nurses know the health system must be invigorated. We believe investments are most needed in renewing the health workforce. We also know investments are needed to improve the responsiveness and the efficiency of the health system itself. These investments will make Canada competitive with its international partners. They will also help Canada revitalize the health system so that it is capable of meeting the health care needs of Canadians.

[1] See the public opinion survey results contained in the annual *Health Care in Canada* reports published by the Pollara polling company. See as well Communication Canada's Spring 2002 *Listening to Canadians Communications Survey* of more than five thousand Canadians between April 25 and May 13, 2002. This survey found that 93 per cent of those surveyed gave health care "high priority." This is the highest interest rating of any issue – ahead of national security in the wake of the September 11 terrorist attacks in the United States, unemployment, the state of the economy, taxation, public debt or any other public policy issue.

Lessons Learned From SARS Outbreak

CNA discussed with nurses and nursing organizations, their experiences of the SARS outbreak. Three issues were identified: health human resources (HHR) shortages, communications and infrastructure gaps. The following is a synopsis of the comments on these issues.

HHR

Human resources are the engine of the health system. In fact, the sustainability of the health system depends on investments in recruitment and retention of professionals and other workers. In the last decade, the health workforce has been cut back and largely forgotten. This is particularly the case in public health.

A second issue for nursing is the lack of permanent staffing. This has led to increasing numbers of nurses working for multiple employers, often in different settings such as home care, long-term care and acute care. The SARS issue highlighted this phenomenon and its implications. During the SARS outbreak, working in more than one site in the Toronto area was disallowed. This constrained the numbers of nurses available at individual sites. The challenge of staffing both public health and acute care facilities was further complicated by the quarantining of nurses and other health professionals.

From the nurses' perspective, SARS and the management processes put in place to deal with it (including disallowing multiple-employers) had financial implications. The decreased numbers of elective procedures also reduced the demand for services in the community.

The fourth issue related to HHR is increased stress and anxiety in a workforce that already has the highest incidence of occupational illness and injury. The stress went beyond the workplace with family members, including children, of nurses being ostracized.

There are other issues including adequate educational preparation of providers related to unknown new diseases. The following comments from nurses across the country tell the story:

> *"Staff that worked even one shift in a hospital was not allowed to work their other nine shifts per fortnight in the community sector. This created personal financial stress, as well as challenges in delivering service at a time when home care played a crucial role in keeping individuals at home and out of hospitals and long-term care facilities. It felt like we were holding up both ends of the health care continuum without any support."*

> *"What makes SARS so different from the other unknown entities in emergency nursing is the fact that we have little education and/or training with regards to it. Emergency nurses are educated/trained on how to deal with a fast- paced changing environment such as the acute MI, trauma, MVAs etc. but there has been nothing in regards to SARS. As first-line health care workers, many of us felt, and still do feel, that we were not being heard as to how stressful the possibility of SARS is to any of us."*

> *"Here (in B.C. Emergency Department) we were dealing with an unknown entity that kept changing in regards to severity of the illness - how best to isolate it and prevent others from coming down with the disease. To top this off, there were limited*

resources and on some shifts absolutely no resources to assist with this unknown. Resources in the way of manpower did not exist."

"We have one nurse from our Manitoba hospital leaving to go to Toronto to assist in an ICU. We will be impacted in regards to staffing as her needs will have to be filled during heavy vacation time. Also this may end up being extended if she has to be quarantined."

"The need to have well established back up plans to provide back filling for staff in affected areas was highlighted."

Nurses in the community felt, and continue to feel, increased anxiety related to trying to ensure compliance with all directives, reassure clients, manage concerns of their own family members, deal with financial implications due to interruption in usual employment pattern of working in more than one sector, and/or reduced employment opportunities in the community due to SARS containment initiatives. In addition, the establishment/maintenance of therapeutic nurse-client relationship required additional time and new approaches given the barriers of mask, gloves and gowns.

Productivity was affected by new protocols, although performance expectations of staff were not adjusted.

"The expectations regarding how quickly we could turnaround changes in practice and communication were unreasonable given the decentralized environment that we all work in."

"*Longer visit times are required to phone ahead to do screening, screen all household contacts and appropriate follow up."*

"*In some instances, there was a reduction in work availability related to decreased hospital activity such as elective surgeries, etc."*

"The SARS experience has focused attention on the drawbacks of a home care workforce (indeed an entire nursing workforce) that is predominantly casual, working in more than one health care sector."

Communications

Inadequate communications infrastructure and processes were the most pervasive issue for nurses and others. There were no formal mechanisms to share information among stakeholders. Despite their networking mechanisms, the involvement of their members and their knowledge of the system and its component parts, professional associations were not engaged in discussions about the SARS outbreak or the development of strategies to deal with it. Inconsistent and unclear messaging, delays in acquiring information and overlooked alerts resulted.

Nurses and nursing organizations identified the inability to get timely and reliable information and direction.

"In the beginning, my best source of information was the Globe and Mail and CBC news."

"*The inability to have a direct discussion between home care providers and policy decision-makers slowed the access to relevant information in an emergency. This was frightening for both staff and clients given the rapidly evolving knowledge base and the degree of risk."*

"*Providers have no direct communication with the Ministry of Health and Long-Term Care (MOHLTC) and had to wait until the end of each day to receive communication from, and as interpreted by the Community Care Access Centres (CCACs). The CCACs (quite appropriately) do not have clinical expertise and on some occasions their approaches needed to be reviewed by service provider organizations. Vigorous advocacy efforts were required to ensure approaches were in keeping with clinical principles."*

Nurses also identified inconsistencies in information and advice:

"At the national level, VON was collaborating with both Health Canada and the Ontario MOHLTC and trying to adopt the most evidence-based position where there were inconsistencies."

"It seemed as if the variability in direction from public health departments and CCACs was greater the further they were located from the epicentre."

"The Peel Infection Control representative was of the mind, after collaboration with CCAC staff, that masks could be left in the home and re-used by other nurses. She did point out that the moisture resulting from sealing in a Ziploc bag could present a medium for growth, but suggested the bag be left slightly unsealed or that the mask be stored in a paper bag. Home care nurses have very little control over their environment when they are in the home, let alone when they are not in the home. Health Canada told me that even crushing compromises the effectiveness of a mask. I asked that this position be based on broad consultation and based on as much evidence as possible before such supply decisions are made."

Lack of information, conflicting and inadequate information also affected the public, whose anxiety levels were (are) high. As one nurse phrased it:

"Clients needed reassurance and time to ask their questions and clarify their understanding of what was happening. Many clients were fearful of letting the nurse visit. Some clients disliked or resisted the SARS screening questions."

Professionals and health organizations were not well-supported with information. There was neither an information system nor a communications system. In some cases that meant nurses were unable to successfully convey alerts regarding potential SARS victims. The following comments describe both the processes and the frustration.

"VON Canada branches in Ontario were receiving "individuals under investigation for SARS" long before the branches knew what this definition meant (staff thought they were SARS patients), had access to protective gear or advice about how to proceed."

"Medical information was limited as the coordinator was not a medical person, although she did a pretty good job given the circumstances and the diverse needs of all of the CHC's that participated in the telephone conferences. After May, information about local SARS outbreaks were (is) handled by the local Medical Officer of Health at the Windsor-Essex County Health Unit. The web site contains general information regarding SARS for the public. An attempt to establish a communication link with staff at the health unit was not successful in terms of how we at our health centre would be notified in the case of an outbreak in our area. Not all staff in the infectious diseases department of the health unit has access to bulletins and directives from the MOHLTC.

Communication with our public (our client base) is through individual contact, posting information in public places and a widely distributed newsletter containing pertinent information.

Communication via the Provincial Operations Centre (POC) provider web site was (is) extensive but not always clear, and required much time to monitor and interpret for our individual situation.

Bulletins and directives are distributed internally for all of our staff to read. Each staff member has been given a copy of the revised 'new normal' directives and this has been discussed at staff meetings. We still need to do mask fit testing."

"Feedback from nurse managers in our (VON) branches across Ontario revealed that calling regional public health departments often resulted in speaking to a casual p/t worker giving advice on subjects they knew very little. This advice varied from worker to worker and from region to region."

"*The greater Toronto area (GTA) CCACs collaborated on their communication and supplies management, which was greatly appreciated. However the CCACs outside the GTA have not grouped together, meaning that cross-provincial providers must respond to the initiatives of each separate CCACs and manage the wide discrepancies in approaches."*

"Our small community in Manitoba is also affected. We have had to have ongoing communication with all staff each time there is an update about how we should be triaging patients. This is difficult to do with shift workers and the constantly changing information."

Infrastructure

Some nurses expressed a lack of confidence in the infrastructure in their community to deal with a new infectious disease.

"I urge those who are examining our ability to respond to look closely at the infrastructure, or lack thereof, in rural areas. We would not have been able to organize nor sustain a response to the level that Ontario did. It has been well recognized in recent reports that infectious diseases such as SARS have no boundaries. We must, therefore, examine the potential that it could be in anyone's back yard. What would these various responses look like?"

"My overall sense of our centre's capacity to handle SARS cases is very limited due to our facility limitations. I feel that the staff is prepared and able to do the job. I am disappointed that we have not been included in local planning for control of an outbreak and with the lack of information coming from the health unit. I feel that most of the planning resources went into local acute care facilities and the local CCAC with good reason. However, community resources such as ourselves 'were not in the loop' so to speak. I would argue for better communication through all provider levels."

Several nurses spoke about the home care infrastructure in Ontario. They attributed some of the issues in dealing with SARS to the contracting out of home care to "*multiple providers, each working independently due to the competitive environment and the majority without the breadth and depth of clinical and managerial infrastructure*."

Nurses also expressed concern about the lack of knowledge of policy-makers about community-based health services:

"Infection control practitioners/experts tend to be hospital based because of funding models."

"It was clear from early directives that the MOHLTC decision-makers did not have an understanding of home care delivery issues. It was frustrating receiving the information from service contractors, who were unable to discuss the information or respond to questions. The process was time-consuming with our questions being forwarded to the MOHLTC through the contractors and then waiting for responses, which invariably led to more need for clarification."

"…on asking if we could walk through the New Normal Directives together, there was no one that could clarify outstanding issues. This is the case even when I call the SARS Hotline for professionals. I was very grateful for their 24/7 presence and commitment to support. They could respond to the best of their ability and never took questions lightly. Sometimes though, all they could do was assure you that they would move your question up the line. The best of these ask quite a few questions to try and understand the home care context of the question, but you wonder how your question is really conveyed through so many layers."

"It became much more clear over time how to practise in the epicentre, but less so in other parts of the province. For example, do nurses in Thunder Bay need to carry SARS kits in the event of encountering a symptomatic client in the home? While CCACs in the epicentre are supporting supply costs for these kits, CCACs in other parts of the province are not. Does the MOHLTC recognize that just as people travel from Asia to Toronto, people from northern Ontario routinely travel to Toronto, particularly for health care not available in the north?"

There were comments from all parts of the country about inertia and fear. The following statement is typical of these comments:

"many hospital staff, administration, governments and the general public did not want to think that it (SARS) existed so downplayed the disease."

There were difficulties getting personal protective equipment in sufficient quantities. Access to protective equipment was difficult and inconsistent depending on whether one worked in the community or in acute care. The lack of appropriate "isolation" facilities was also a concern. The following comments paint the picture faced by many nurses, of the budget constraint challenges, priority-setting among components of the health system and inadequate facilities.

"I understand the concern around cost of supplies, but if there is a clinical rationale for wearing the mask, then each nurse deserves to be confident about the integrity of the mask she is putting on. What price is the death of a nurse in the line of duty?"

"Getting N95 masks and goggles to outfit staff (in Windsor, Ontario) *is an ongoing problem. Reimbursement for exceptional supplies, equipment, and staffing has been promised by the MOHLTC (not yet received)."*

"It was very demoralizing at the beginning to discover that our staff would not be able to access equipment to protect themselves, because suppliers across the country had been told they could only sell to the hospital sector."

"We have had several episodes where we were suspicious of patients that may have SARS. It was very difficult for us to isolate these individuals as we only have one single room in the Emergency department, and it is not equipped with negative pressure air flow. Also there is no private washroom for the individual."

"We do not have any negative pressure rooms in our emergency department so it was decided to use one of the security rooms as our "SARS" room. Did this make sense? I personally do not think so as the room is part of the main emergency area. As well, on shifts when we had more than one suspected SARS patient present at the same time, we ended up using interview rooms as our isolation rooms without handwashing areas such as sinks, etc."

"Our capacity to isolate individuals is extremely limited by lack of space. We have no negative pressure rooms or examination rooms that can be vented to the outside. In addition, our clinic is located in the basement of a local secondary school. School officials have been very cooperative in controlling student access to our facility."

"Because of the limited supply of N95 masks and goggles our response capacity to a large number of suspect cases could not happen and all cases would have to be referred to an acute care facility."

"Although we have been fortunate enough not to have any cases of SARS here in our province (Newfoundland and Labrador), *just the process of preparing for the potential has put a strain on our resources. In our region, we serve a population of 100,000 over vast geography, and we have limited resources, both human and fiscal. We have a medical officer of health and one communicable disease control nurse. During the SARS out breaks, both these individuals spent about 90 per cent of their time dealing with issues or preparedness related to SARS, from developing policy and educating our staff to finding materials and compiling isolation kits. It was our opinion that if we had an*

outbreak of SARS, we would probably last a week before our system would be under major strain. Our public health nursing staff is few in number (32 in total): we have no casual or relief pool, and our nurses are responsible for all aspects of our public health programs."

Recommendations

In response to the issues identified by nurses and described above, CNA has eight recommendations. They are listed in order of priority.

1. Development of a national human resource strategy for the health sector, including all of its components. This strategy will address education issues, workplace and employment issues, as well as scope of practice, continuing education and training. CNA believes the strategy must recognize the reality of multiple-employers, not just for nurses. At the same time the strategy should have as a principle the creation of permanent job opportunities. Another key element of the strategy would focus on increasing public knowledge of the expertise and knowledge of various providers.

2. Creation of a communication system to support all providers and organizations, regardless of size. In the first instance, all stakeholders must have timely access to the same quality and degree of clinical support. The communications system must also include a process to facilitate identification of issues and challenges by all providers.

3. Requirement for participation in policy development processes of experts in community-based health services.

4. Development of a national public health strategy that would have clear linkages with other components of the health system. The strategy would include public/patient education, health surveillance, research and legislation. It would articulate a framework to ensure the assessment of the health consequences in decisions related to environmental contamination, literacy, food security and health determinants.

5. Recreation and maintenance of infection control expertise in Canada. This expertise, whether co-located or not, must be linked and would be tasked with ensuring baseline infection control knowledge and practices in urban, rural and remote facilities, across the health system. Some of the expertise must be devoted to community-based services, including the home care sector.

6. Governments need to invest in research on health outcomes related to productivity; organization of human resources, including health care delivery models, skills mix and team structure; casualization; knowledge accrual; as well as measuring the effectiveness of interventions. In every province in the last few years, there have been changes to the structure and functioning of the health system. The changes include regionalization of decision-making, elimination of management positions, reorganization of work units into multi-disciplinary teams, the introduction of information technology and cuts to staff. Little research has been done on the impacts on the health of patients from any of these changes. Armed with the anecdotal evidence from the SARS outbreak, governments must assess the resilience of the health system and all of its components.

7. Governments must assess the health outcomes of the competitive model for delivering home care and other services. Can or will for-profits respond with the speed and quality to ensure safety of communities in rapidly evolving public health emergencies?

8. Establishment of guidelines for personal protection for health care providers and the development of indicators to be used as part of the accreditation process for acute care and community-based facilities.

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