



CANADIAN  
**NURSES**  
ASSOCIATION

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# Canada's Pandemic Preparedness

**Brief to the  
Senate Committee on Social Affairs,  
Science and Technology**

October 22, 2010

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This document was prepared by the Canadian Nurses Association (CNA) in pursuit of its mission, vision and goals. The information presented in this document does not necessarily reflect the views of the CNA board of directors.

CNA is a federation of 11 provincial and territorial nursing associations and colleges representing 139,893 registered nurses and nurse practitioners. CNA is the national professional voice of registered nurses, supporting them in their practice and advocating for healthy public policy and a quality, publicly funded, not-for-profit health system.

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## INTRODUCTION

CNA's position and policy advocacy on pandemic response is based on the *Code of Ethics for Registered Nurses* (Canadian Nurses Association [CNA], 2008a) and the *Emergency Preparedness and Response* position statement (CNA, 2007). During the H1N1 pandemic, CNA joined forces with nurses, health-care organizations and governments to:

- identify the key issues to nurses and bring concerns to the federal government, especially the Public Health Agency of Canada (PHAC) as the lead for pandemic response;
- share information received from PHAC, as well as other resources, with nurses/our members through our website;
- promote common messaging among partners, including vaccination of nurses and use of personal protective equipment; and
- work collaboratively with PHAC and other agencies, providing input on issues from the nurses' point of view.

"The nursing profession plays an integral role in all aspects of emergencies, including mitigation, preparedness, response and recovery" (CNA, 2007, p. 1). Registered nurses (RN) are this country's largest group of health-care providers, as well as one of the most trusted professions by the general public. The nursing perspective is central to understanding issues in health care and population health. RNs are present throughout the system, helping deliver the health care Canadians need. At the community level, RNs are actively involved in schools, child care facilities, prisons, universities, workplaces, seniors' centres, summer camps, reserves, rural areas and parishes, among others. As such, RNs are involved in every aspect of pandemic preparedness and response – and are uniquely placed to address health priorities.

During the H1N1 pandemic, **RNs working in health promotion and disease prevention** provided education on recognizing signs/symptoms of influenza, preventing disease transmission and the importance of vaccination; surveillance for early detection of symptomatic cases; and assessment of health-care needs and determination of appropriate interventions of vulnerable populations.

**RNs working in public health programs** assessed, managed and reported suspected cases; managed outbreaks at institutions such as schools and long-term care facilities; responded to questions from the public and health-care professionals through dedicated phone lines; and organized and delivered mass vaccination clinics.

**RNs working in primary and acute care** focused on the triage, assessment and specialized nursing care of symptomatic patients in physicians' offices, private homes, community health clinics, hospital units and intensive care beds. Nurses staffed influenza assessment centres, set up in many regions to alleviate the demand on hospital emergency departments. To further alleviate pressures on the health-care system, nurse practitioners provided patients with "diagnosis and curative interventions, wellness strategies and early interventions" (CNA, 2009a, p. 2). Nurses also worked as **infection control practitioners**.

**Nurses were involved in pre-pandemic planning.** Nurse managers were responsible for ensuring safe staffing ratios; availability of supplies and equipment; and policy development, implementation and evaluation. And nurses with their associations – both nationally and provincially – monitored responses in order to identify areas that worked well and areas that needed improvement.

## ACTION AREAS FOR STRENGTHENING FUTURE RESPONSE

While there are many strengths in the system, lessons learned from the H1N1 pandemic reveal five important areas for action to strengthen future response:

## 1. OPTIMIZING NURSING KNOWLEDGE AND EXPERTISE

RNs “contribute to the health-care system through their work in direct practice, education, administration, research and policy” – all of which could have been more effectively utilized during the pandemic response to “coordinate health care, deliver direct services and support clients’ in their self-care decisions and actions” (CNA, 2008b, p. 5). Many RNs told CNA that their expertise was not fully utilized in the context of the H1N1 pandemic.

- **Involvement in planning** – At the local level, in most health units, nurses were part of interdisciplinary teams that planned and set up vaccination and influenza assessment clinics – and their input was admirable and valued. However, many nurses told CNA they were not involved in such planning. Considering their expertise based on research and experience in acute and primary care, as well as their commitment to community development, optimizing nurses’ involvement in decisions – from local to national levels – enhances the anticipation of needs, system trouble shooting and streamlining of processes that affect patients’ quality of care.
- **Nursing leadership** – In emergency and pandemic situations where nurses are asked to work out of their usual practice setting, many professional and practice issues arise that require strong, experienced nursing leadership. Nurses expressed concern to CNA that non-health professionals were sometimes in decision-making positions where nursing knowledge and expertise was needed. It is paramount that experienced nurse leaders are put into positions that support nurses in carrying out the clinical and ethical decisions for which they have been prepared.

**Recommendation 1: That the Public Health Agency of Canada establish policies and guidelines that engage nurses and other health professionals in all levels of pandemic planning, response and evaluation.**

## 2. Health and safety of nurses and health teams

CNA believes in taking a precautionary approach to protecting nurses, “which requires that even in the absence of scientific certainty, reasonable actions be taken to reduce risk” (CNA, 2007).

In its July 2003 brief to the National Advisory Committee on SARS and Public Health, *Lessons Learned and Recommendations*, CNA noted the concerns of nurses nationally about inconsistent standards, protocols and even availability around the use of N95 respirators during direct care for patients. Among its 11 recommendations to the Naylor Committee was the “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 (CNA, 2003, p. 11). Assurance of adequate respiratory protection was still an issue during the H1N1 pandemic.

In a November 2009 letter to members, CNA’s president encouraged RNs to “get the H1N1 vaccination to protect themselves, their families and their patients,” stating that the “scientific evidence is clear: the important health benefits the vaccine offers far outweigh any potential risks” (CNA, 2009b, p. 1). CNA also provided resources on the risks and benefits of vaccination, with an emphasis on patient protection, which would support an informed decision.

Access to support services for RNs is critical, as health-care capacity is related to the resilience and well-being of health-care providers. Many nurses responding to the pandemic put in very long hours and operated under intense pressure.

Policies and practices for preventing and controlling infection were dominant in the minds of RNs. Also needed are policies and practices to support the health of health-care workers first and to prevent “unsafe practices due to rising levels of staff fatigue aggravated by excessive workloads, staff shortages and inattention to safe

labour practices” (CNA & Registered Nurses’ Association of Ontario, 2010, p. 2). It’s crucial that, during a pandemic, front-line health-care professionals stay healthy themselves with reasonable work hours; breaks; support for family preparedness plans; and easy access to vaccination, personal protection and treatment.

**Recommendation 2:** That federal and provincial/territorial governments ensure adequate funding to (1) support needed staffing and resources, and (2) promote quality environments that ensure safe practice.

**Recommendation 3:** That federal/provincial/territorial governments, public health authorities and employers adopt the precautionary principle to safeguard health practitioners whose health and safety may be at risk, especially where there is a lack of definitive evidence.

### 3. Vaccination

Issues surrounding the deployment of the vaccine (e.g., selection of priority recipients, demand exceeding capacity to vaccinate, supply of vaccines) had both practical and ethical implications for nurses.

Prioritization recommendations represented a challenge at the front line and nurses faced ethical (or moral) distress (CNA, 2008a) because of the restrictions and inconsistent implementation practices. Following the H1N1 pandemic, CNA began a formal survey of nurses to gather key recommendations and lessons for future public health crisis management. Further analysis is ongoing, but in preliminary results of that survey nurses told us that “adherence to priority lists for vaccine administration” was the most important ethical issue experienced in responding to H1N1 (CNA, 2010). It was particularly challenging when a family had members who were in priority groups and non-priority groups. The recommendations did not follow the same logic as with the seasonal influenza vaccine, where contacts of members of high-risk groups are usually a priority, and RNs repeatedly acted against their professional judgment. The multiple changes to eligibility criteria required the recruitment of additional staff for more efficient screening of patients to support nurses in the direct delivery of immunization. Supervisors frequently had to deal with people who were expressing anger, fear and frustration. As one RN poignantly expressed it, “We fix, we mend, we support, we help – we are not used to turning people away.”

Public health units needed to set up clinics at an unprecedented scale with few staff experienced in vaccination. (Many public health units do not provide vaccination to the public on a routine basis, which is done in family practice settings.) On-the-job mentoring was important as large contingents of additional staff were trained at very short notice, with varying degrees of success. Modules were developed without appropriate time for testing and critical review. Recruitment was a huge challenge, and many health units hired temporary agency nurses or put out calls for volunteer nurses.

The highly visible effort to immunize Canadians was an important learning experience. The achievement of 41% coverage of Canadians over 12 years of age was an accomplishment. Many creative solutions were implemented to try to deal with the long lineups, complex staff scheduling, training, administrative processes and volume of information for telehealth lines. Collaboration between nurses, physicians, paramedics and many other professionals was crucial to the successful delivery of mass immunization clinics.

**Recommendation 4:** That the Public Health Agency of Canada undertake a full evaluation of the issues encountered with the implementation of priority groups in the H1N1 response, and work with professional associations to implement the findings of this evaluation to ensure better support for health professionals and to guide resource allocation.

**Recommendation 5:** That the Public Health Agency of Canada evaluate experiences in mass vaccination and develop, in consultation with nurses and other health professions, best practices that would ensure coordinated and timely access to vaccines, especially for vulnerable populations, during public health crises.

#### 4. Communications

CNA appreciated PHAC's evidence-based approach to the pandemic, using data and information from around the world to inform implementation of the pandemic plan. CNA members accessed PHAC's website regularly, as well as their provincial sites. In some jurisdictions, health-care provider hotlines and regular stakeholder teleconferences provided direct access to infection control experts and government officials.

In the compressed timeframe of a public health crisis, communication is difficult – and crucial – to a successful response. In the case of the H1N1 pandemic, communications was an area of significant challenges.

- **Clear, consistent direction** – The speed with which the H1N1 virus spread meant that response plans were also being created and/or implemented quickly. Information was inconsistent regarding, for example, criteria for antiviral prescription, criteria for priority populations for vaccination, and clinical practice guidelines. Guidance documents on these and many other questions were being issued from federal, provincial, regional and municipal levels of government, as well as from other technical organizations – sometimes with contradictory information. In CNA's survey of nurses concerning the effectiveness of public health management during H1N1, nurses indicated "conflicting sources of guidance or advice" as their top concern regarding information (CNA, 2010). As a result, RNs sometimes found it difficult to make evidence-informed decisions. More time was required to make comparisons between different guidance documents and develop institutional guidelines. In some cases, this resulted in inconsistent clinical practice.
- **Usability** – Working under difficult and fast-paced conditions, nurses needed access to clear, accurate, user-friendly materials from PHAC and other levels of government. What they received were many long and technical documents that took valuable time to read and interpret. In many instances, the information was simply not pragmatic or concrete enough to apply in practice settings. As a result, staff at hospitals, community clinics, public health units and other health-care facilities had to dedicate time to interpreting the documents and creating more succinct, user-friendly resources for front-line professionals. The result was a duplication of effort across the country to develop many similar documents at a time when human resources were stretched.
- **Timeliness** – Speed is key to an effective emergency response – and that was no different during the H1N1 pandemic. Nurses experienced delays in receiving information from PHAC. The cause seemed to be related to the agency's efforts to obtain consensus at the federal, provincial and territorial levels; however, not only did this cause delays, consensus did not ensure consistency in the delivery of care across the country.

Communication with the public was complicated by the announcement of seemingly conflicting information by the government (e.g., "there will be vaccines for all Canadians," then "only priority groups can have access at this time"). As well, the traction of media stories focusing on the deaths of previously healthy teens or young adults, compared to the attention on messages concerning the prevention of transmission of infections, symptoms to look out for and services available, posed communications problems. Communication regarding the vaccine and its safety was also a challenge that merits further study. Relationships with the media need to be built in order to prevent public panic and misinformation.

***Recommendation 6:*** That the Public Health Agency of Canada evaluate the communications during the recent H1N1 response and coordinate with federal and provincial/territorial public health authorities and agencies and professional associations in the development of a coordinated communications plan to improve the consistency, usability and timeliness of guidelines, information and tools.

## 5. Health system capacity

Hospitals, long-term care facilities, community health centres and public health units are functioning at full capacity, with little surge capacity for the event of an emergency. There are nursing shortages in many parts of Canada. In this context, nurses raised concerns about the ability to deliver mass vaccination campaigns and to receive and care for a large number of seriously ill patients. In the evaluation of the SARS response, the National Advisory Committee recommended increasing Canada's capacity in public health (National Advisory Committee on SARS and Public Health, 2003). Public health nursing capacity was of great concern, with many provinces experiencing a shortage. Effective surge capacity in public health units is possible only with a large nursing workforce. The H1N1 pandemic demonstrated the need for more investments in this area of health human resources.

- During the pandemic, RNs were redeployed from different sectors of the health-care system to areas with a high demand for nursing skills – but communicable and outbreak management teams could not abandon their daily work. CNA heard stories of nurses “dropping everything” to staff the vaccination or influenza assessment clinics, work in outbreak control, man information lines, and work in outreach to vulnerable patients and in other areas of pandemic response. Ensuring this surge capacity requires guidelines and policies for nurse recruitment, orientation and developing designated competencies in advance of a pandemic; all of this is critical to supporting the effective deployment of nursing staff.
- Provincial/territorial regulatory bodies discussed the need for expedited registration for qualified, non-practicing or retired RNs, and in some cases these nurses were able to work at vaccination clinics and in other settings under temporary licensing categories.
- In Alberta, temporary legislative changes permitted qualified RNs to complete a certification process to prescribe and dispense anti-virals within influenza assessment centres alongside nurse practitioners and physicians. Pharmacists were available for consultation. Nurses were asked to expand their scope of practice to meet the high demand for assessment and treatment of symptomatic patients to alleviate the demand to emergency departments, urgent care centres and primary care clinics.
- In some health units, student health professionals were used, taking a competency-based approach. Student nurses were trained to administer vaccine under the supervision of their university clinical advisors. Under the guidance of RNs, other student health professionals were used for health screening and consent processes.
- Another aspect of the health system's capacity to deal with a pandemic is its ability to do real-time tracking and reporting of patient information. Electronic health records, accessible to all health-care professionals, make this possible. Continued investment in e-health is critical.

***Recommendation 7:*** That the Public Health Agency of Canada engage health professionals, relevant responders and organizations in a consultation to review the Canadian Pandemic Influenza Plan for the Health Sector to determine strengths and gaps identified during the pandemic, and inform changes in preparation for future public health crisis situations.

***Recommendation 8:*** That federal and provincial/territorial governments make additional investments in the public health nursing workforce to enhance health promotion, disease and infection prevention and protection in Canada, and to strengthen pandemic surge capacity.

***Recommendation 9:*** That federal and provincial/territorial governments and public health agencies work with professional associations to evaluate experiences where RNs practised to an expanded scope of practice during the H1N1 outbreak, and incorporate best practices into pandemic planning as a means of enhancing response during periods of heightened demands for assessment and treatment.

**Recommendation 10: That professional regulatory bodies and employers establish more effective processes and protocols for employing retired or non-practicing health-care providers during emergency public health or pandemic situations.**

**Recommendation 11: That the federal government make additional investments to accelerate the implementation of electronic health records so they are accessible to all health-care professionals, to enable real-time tracking and reporting of patient information.**

## **CONCLUSION**

There has been significant improvement seen in Canada as a result of evaluating and learning from the difficulties faced in the SARS crisis, especially with the creation of PHAC. CNA commends the Senate Committee for reviewing issues of pandemic preparedness highlighted in the experience with the H1N1 pandemic and looks forward to working together with stakeholders to contribute to the strengthening of the Canadian capacity for pandemic response. As the national professional association for RNs in Canada, CNA is poised to support the federal government in its efforts to strengthen Canada's pandemic preparedness in advance of future challenges.

## **RECOMMENDATIONS**

1. That the Public Health Agency of Canada establish policies and guidelines that engage nurses and other health professionals in all levels of pandemic planning, response and evaluation.
2. That federal and provincial/territorial governments ensure adequate funding to (1) support needed staffing and resources, and (2) promote quality environments that ensure safe practice.
3. That federal and provincial/territorial governments, public health authorities and employers adopt the precautionary principle to safeguard health practitioners whose health and safety may be at risk, especially where there is a lack of definitive evidence.
4. That the Public Health Agency of Canada undertake a full evaluation of the issues encountered with the implementation of priority groups in the H1N1 response, and work with professional associations to implement the findings of this evaluation to ensure better support for health professionals and to guide resource allocation.
5. That the Public Health Agency of Canada evaluate experiences in mass vaccination and develop, in consultation with nurses and other health professions, best practices that would ensure coordinated and timely access to vaccines, especially for vulnerable populations, during public health crises.
6. That the Public Health Agency of Canada evaluate the communications during the recent H1N1 response and coordinate with federal and provincial/territorial public health authorities and agencies and professional associations in the development of a coordinated communications plan to improve the consistency, usability and timeliness of guidelines, information and tools.
7. That the Public Health Agency of Canada engage health professionals, relevant responders and organizations in a consultation to review the Canadian Pandemic Influenza Plan for the Health Sector to determine strengths and gaps identified during the pandemic, and inform changes in preparation for future public health crisis situations.
8. That federal and provincial/territorial governments make additional investments in the public health nursing workforce to enhance health promotion, disease and infection prevention and protection in Canada, and to strengthen pandemic surge capacity.



9. That federal and provincial/territorial governments and public health agencies work with professional associations to evaluate experiences where RNs practised to an expanded scope of practice during the H1N1 outbreak, and incorporate best practices into pandemic planning as a means of enhancing response during periods of heightened demands for assessment and treatment.
10. That professional regulatory bodies and employers establish more effective processes and protocols for employing retired or non-practicing health-care providers during emergency public health or pandemic situations.
11. That the federal government make additional investments to accelerate implementation of electronic health records so they are accessible to all health-care professionals, to enable real-time tracking and reporting of patient information.

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