ONA Ontario Nurses' Association

ONA's Advice on PPE

ONA has reviewed feedback from leaders and members following our communication on April 9 and we are providing some clarity. In addition, on April 10, Directive #5 changed to include all health-care workers in hospitals and long-term care under the same directive.

ONA's position on access to PPE is clear and remains consistent:

- When dealing with suspected or confirmed COVID-19 patients, a point-of-care risk assessment (PCRA) must be performed before every patient interaction.
- If a member determines, based on their professional and clinical judgement, that health and safety measures are or may be required in the delivery of care to the patient, then the worker shall have access to the PPE, including an N95 respirator. If the employer does not agree, there are higher levels of PPE and environmental controls that can be considered. In the end, however, the employer cannot unreasonably deny access to the appropriate PPE.

- **Examples for Physical/Environmental Control Option:**
- Cohort all COVID-19 positive patients together. There is no requirement to change PPE between these patients/residents.
- Utilize baby monitors or iPads to communicate and view patients from outside of the room.
- Have COVID patients/residents in private rooms with the door closed.
- **Examples for Care Option:**
- Limit the number of times you need to enter the patient's or resident's room by using extension intravenous (IV) tubing to monitor the IV or IV pumps from outside of the room.
- Consider if there is another nurse or health-care professional already wearing PPE who can enter the room to complete a task or treatment.
- Use team nursing with a team of staff only caring for COVID positive patients or non-COVID-19 patients on a single shift.
- Group treatments together to prevent the frequent donning and doffing of PPE.

These are just a few examples of strategies that can limit exposure and decrease the number of staff encounters; thus decreasing the usage of PPE.

- **However**, when working within two metres of suspected or confirmed COVID-19 patients, staff must have access to appropriate PPE. This will include access to: surgical/procedure masks, fit-tested NIOSH-approved N-95 respirators, or approved equivalent or better protection, gloves, face shields with side protection (or goggles), impermeable or, at least, fluid resistant gowns. There must be training on the safe utilization of all PPE, including how to safely don and doff all of these supplies and be fit-tested for an N95 mask.

- The PCRA should include the frequency and probability of routine or emergent Aerosol Generating Medical Procedures (AGMPs) being required. N95 respirators, or approved equivalent or better protection, must be used by all health-care workers in the room where AGMPs are being performed, are frequent or probable. AGMPs include but are not limited to: Intubation and related procedures (e.g., manual ventilation, open endotracheal suctioning), cardio pulmonary resuscitation during airway management, bronchoscopy, sputum induction, non-invasive ventilation (i.e., BiPAP), open respiratory/airway suctioning, high frequency oscillatory ventilation, tracheostomy care, nebulized therapy/aerosolized medication administration, high flow heated oxygen therapy devices (e.g. ARVO, optiflow) and autopsy.

N95 masks:

I want to be very clear that ONA does not endorse any practice that puts ONA members or patients at risk.

Research suggests that it may be possible to wear N95 masks for extended periods (up to eight hours); however, this is **exceptionally limited** and infection control protocols must be maintained. ONA would only consider extended use if there is adherence to all possible administrative and engineering controls, and first and foremost, compliance with the manufacturers' guidance and advice.

- **Masks cannot be reused** and must be discarded if:
- The mask has been used for any aerosol generating procedure;
- The mask is contaminated with blood, respiratory or nasal secretions or other bodily fluids of patients; and/or,
- Following any close contact with any patient co-infected with any infectious disease requiring **contact precautions**.

In these very limited circumstances, N95 masks may be able to be donned more than once, if the above conditions are met. Further, there must be care to prevent hand contamination during doffing and re-donning; hand hygiene is key. If a mask is considered soiled, or cannot be safely donned, this practice should

not be used.

Expired N95 masks can be worn but should be treated as equivalent protection to a surgical mask.

Future Mask Decontamination:

ONA knows that employers have directed staff to dispose of used N95 masks in biohazardous containers for potential reuse. Research is currently underway; however, ONA understands, according to the Centers for Disease Control and the National Institute for Occupational Safety and Health, that the following masks cannot be decontaminated:

- N95s used during AGMPs;
- N95s contaminated with blood, respiratory or nasal secretions, or other bodily fluids from patients;
- N95s following close contact with any patient co-infected with an infectious disease requiring contact precautions; and
- N95s that no longer retain their structural integrity.

At this time, there is very limited research on decontamination of the N95 respirator. Until there is scientific evidence supporting safe decontamination, that does not invalidate the integrity of the mask and risk members' health and safety, **ONA will not agree to their reuse**.

N95 Mask Shortage and Higher Levels of Protection:

Given the shortage of masks, particularly N95s, ONA has advised employers/government to make available to our members a higher level of protection, such as powered, air-purifying respirator (PAPR). PAPRs may also require fit testing, if they have tight-fitting face pieces (rather than a hood or helmet). It has been well documented that not all respirators fit all individuals. Individual face shape and size are important to obtaining an acceptable fit factor. Other options include Surgical N95, N99, N100, R95, P95, P99, P100 and Elastomeric respirators, which we have suggested that any of these are appropriate for you to wear in the workplace, especially with AGMPs. Not only do these masks provide a higher level of protection than N95 masks, many are reusable, thus reducing the usage and preservation of N95 masks.

PPE Supply Management:

The supply of PPE is currently being managed provincially and through five regional tables. This means that the new normal for employers will only be a five to seven day supply of PPE on site, when we hope supplies will be replenished

for the next five to seven days; at least until the supply chain normalizes again.

The province and Canada are working on increasing the supply chain in the coming days and weeks. In the meantime, we all need to work on ensuring every health-care worker is safe and has access to the appropriate PPE. This means where able, please conserve PPE as recommended by the manufacturers, researchers and ONA.

Directive #5 Extended to all Health-Care Workers

ONA has been working with government to develop principles regarding PPE in the hospital sector, which resulted in ONA winning amendments to Directive #5 on March 31.

ONA understood it was the government's intention to have immediate discussions with the other health-care unions. This finally happened over the last few days (ONA was not involved), and on April 10, Directive #5 was revised to include all health-care workers.

In the section below, we outline the changes to Directive #5 for hospitals and the revised Directive #5 for Long-Term Care and Retirement Homes.

We have devoted many hours of discussion and lobbying to get us to this point. We are disappointed with the change to the clarity in the original document regarding the care of intubated patients, yet there is a way for our members to continue as before. We believe that this agreement represents the best solution at this time, given the supply challenges in the system, and treats all health-care workers with equity and fairness.

For hospitals, we continue to work through a legal strategy. For long-term care, we are finalizing our legal strategies to address continuing disputes arising from before as well as the implementation of this agreement.

If you have any questions or concerns, please contact us at CovidQuestions@ona.org.

Direction #5 for Hospitals within the meaning of the *Public Hospitals* Act and Long-Term Care Homes within the meaning of the *Long-Term Care Homes Act, 2007*

All public hospitals and long-term care homes must immediately implement the following precautions and procedures, as applicable to regulated health professionals, as defined under the Regulated Health Professions Act (health-care worker), employed by or in public hospitals and long-term care homes. In addition, this includes, where specified, other employees employed by or in

public hospitals and long-term care homes (other employees), dealing with suspected, presumed, or confirmed COVID-19 patients or residents:

1. Public hospitals and long-term care homes, health-care workers and other employees must engage on the conservation and stewardship of personal protective equipment. Public hospitals and long-term care homes must provide all health-care workers and other employees with information on the safe utilization of all PPE, and all health-care workers and other employees must be appropriately trained to safely don and doff all PPE.

Note: the only change is the application to long-term care homes.

2. Hospitals and long-term care homes must assess the available supply of PPE on an ongoing basis. Public hospitals and long-term care homes must explore all available avenues to obtain and maintain a sufficient supply of PPE.

Note: the only change is the application to long-term care homes and the clarity at the end of the second sentence adding the words "of PPE".

3. In the event that the supply of PPE reaches a point where utilization rates indicate that a shortage will occur, the government and employers, as appropriate, will be responsible for developing contingency plans, in consultation with affected labour unions, to ensure the safety of health care workers and other employees.

Note: the changes in this section included removing a reference to a 30-day supply and a reference to ONA, instead now referring to all affected labour unions.

Note: the only change for items 4-7 in Directive #5 is the application to long-term care homes. See this link.

8. For long-term care homes only, all staff and essential visitors must wear surgical/procedure masks at all times for the duration of full shifts or visits in the long-term care home. For further clarity, this is required regardless of whether the home is in outbreak or not. During breaks, staff may remove their surgical/procedure mask but must remain two metres away from other staff to prevent staff-to-staff transmission of COVID-19. This is to be implemented in conjunction with all other requirements contained in Directive #3 dated April 8, 2020 or as amended.

Note: this clause only exists in long-term care homes providing an extra precaution to protect against COVID-19 spread in long-term care homes. This provision was previously set out in Directive #3, applying to long-term care

homes only.

9. All health-care workers or other employees who are within two metres of suspected, presumed or confirmed COVID-19 patients or residents shall have access to appropriate PPE. This will include access to: surgical/procedure masks, fit tested NIOSH-approved N-95 respirators or approved equivalent or better protection, gloves, face shields with side protection (or goggles) and appropriate isolation gowns.

Note: the first change is the application to long-term care homes. For hospitals, the change is the removal of the requirement for "impermeable or, at least, fluid resistant" and replacing with "appropriate isolation" gowns. Members can determine the level of gown required as part of their PCRA.

10. The PCRA by the health-care worker should include the frequency and probability of routine or emergent Aerosol Generating Medical Procedures (AGMPs) being required. N95 respirators, or approved equivalent or better protection, must be used by all health- care workers in the room where AGMPs are being performed, are frequent or probable.

AGMPs include but are not limited to; Intubation and related procedures (e.g., manual ventilation, open endotracheal suctioning), cardio pulmonary resuscitation during airway management, bronchoscopy, sputum induction, non-invasive ventilation (i.e., BiPAP), open respiratory/airway suctioning, high frequency oscillatory ventilation, tracheostomy care, nebulized therapy/aerosolized medication administration, high flow heated oxygen therapy devices (e.g., ARVO, optiflow) and autopsy. Any change to this list is to be based on the Technical Brief "Updated IPAC Recommendations for Use of Personal Protective Equipment for Care of Individuals with Suspect or Confirmed COVID-19" dated March 25, 2020, as amended from time to time, which has been prepared by Public Health Ontario.

Note: the first change is the application to long-term care homes.

For hospitals, the change is the removal of "or with any intubated patients" and the addition of "during airway management" during CPR. The reference to the Public Health Ontario IPAC Recommendations was added to define AGMPs. ONA's position is unchanged, if caring for an intubated patient; a member's PCRA should treat intubation as a risk of AGMP and should wear an N95 mask.

11. In accordance with O. Reg 68/20 made under the Retirement Homes Act, retirement homes must take all reasonable steps to follow the required precautions and procedures outlined in this Directive.

Note: This clause ensures that Retirement Homes also follow the above #1-10.

It is important to remember that hospitals, long-term care homes and all health-care workers are also required to comply with applicable provisions of the *Occupational Health and Safety Act* and its Regulations.

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In Solidarity,

Vicki McKenna, RN
President