

Speaking notes
for Patty Rout
re: SARS Commission
September 30, 2003

Good afternoon. My name is Patty Rout. I am a lab technologist at Lakeridge Health Corporation in Oshawa. In addition to being Vice Chair of OPSEU's Health Care Divisional Council, I am also Chair of our Hospital Professionals Division.

I would like to thank you for the opportunity to speak on behalf of the people I work with every day, as well as the many other dedicated health care workers that OPSEU represents! Most are regulated health professionals like myself. Many are in health care service and clerical careers.

They work in:

Public Hospitals

Provincial psychiatric hospitals

Provincial laboratories

Ambulance services

Public health units

Community Care Access Centers

Community home care agencies

Community mental health agencies

Nursing homes

Long-term care facilities

We want you to understand the working conditions imposed upon us during the SARS crisis and the broad spectrum of workers that were forgotten by their management.

We want you to understand, as our employers do not, that there are more than just doctors and nurses who were affected and needed protection during the SARS epidemic.

To help you understand how these workers were all affected by the SARS crisis, I will walk you through what happens to a patient at various points in the health care system. Who they meet – and what risks the worker is exposed to.

An ambulance paramedic may provide the first medical care to the SARS patient. In addition, patients were transferred from one site or hospital to another, increasing the risk of infection. Masks were an issue for these workers because initially they weren't instructed to wear them and no one was properly fit tested.

The hospital admitting clerk is the next health care worker the patient and/or the family members interact with. A number of admitting clerks at the Grace were exposed to SARS, and subsequently hospitalized and/or quarantined. Yet admitting clerks were told that there was no need for a mask or any other protective equipment.

Every suspected SARS patient had to have a chest x-ray to help with the diagnosis. Some required other tests and scans too. This brought them in close contact with medical radiation technologists who are required to move and position patients to ensure the proper views are taken for the necessary high quality results.

Depending on the time of day, these films may be taken in the Diagnostic Imaging Department or in the emergency department. This meant that patients were not put into the safer negative pressure rooms. In addition, SARS patients were wheeled through the corridors on their way to and from the DI department, possibly spreading their disease along the way.

An OPSEU member said “At the beginning of SARS, radiology staff were berated for wearing protective gear as it would frighten the patients. We were not in the first wave of mask fitting even though we were almost the first group in the Hospital to deal with the SARS patients.”

Electrocardiogram technicians were also frequently called to work with SARS patients in

the emergency department. Yet they were not treated the same as nurses, even though they worked in the same areas. Where the nurse did the cardiogram they came gowned and masked and goggled. But the ECG technicians were told it wasn't necessary for them.

SARS patients invariably had respiratory complications. This brought them into contact with the respiratory therapist (RRCP) who would help to ventilate the patient who was unable to breathe.

Aerosols (respiratory droplets) were a real concern for these workers. Some doctors refused to wear Stryker Suits, the higher level of protective gear that resembles space suits. They also did not want the RRCP to use them

as it slowed them down. In some hospitals the Stryker Suits were in such poor working condition that the respiratory therapist was unable to use them.

Jack will speak about RRCP issues in greater detail during his presentation.

Another important part of diagnostic testing is blood work. A phlebotomist draws the blood from the patient and here is what one of our phlebotomists said:

“There was no training or instruction. Sometimes you wore double protection, sometimes you wore triple and no one explained why. We deal with MRSA (antibiotic resistant bacteria), TB,

and HIV. We know what to do with those diseases. Why is it not the same with SARS?”

“Nurses had people assisting them when they were in protective gear. We had our tubes of blood and no staff to hand them to.”

“So many things went wrong. Our workload was incredible - because of the sharing of casual staff, and the shortage of workers.”

Many health care workers, such as ECG technologists, phlebotomists and X-ray technologists working on portable machines, are not stationed in a single location. Instead they move throughout the hospital, and have to worry about their equipment being contaminated, as well as themselves. During

the SARS crisis, they had to stop and clean equipment between patients. This took a lot of time.

In the hospital laboratories, lab assistants separated all the SARS specimens to prepare them to send to provincial lab. They were told they did not need masks because there were no patients in the lab. Maybe not, but their samples came from SARS patients and could have been highly infectious! Although universal precautions are used for handling specimens in a lab, no one knew for a long time whether or not the virus was airborne. Therefore, these workers were at continual risk.

Infection control said “Don’t worry; you do everything under a hood anyway”. But there

were no fume hoods to work in – usually only the Microbiology section has those. Members donned protective equipment even though their management told them not to, causing some unnecessary disagreements.

Once admitted to the hospital, SARS patients come in contact with even more health care workers, the number varies according to the severity of the illness. At various times during their stay, patients may come in contact with housekeeping staff, dietary staff, dietitians, physiotherapists, social workers, pharmacists and many more.

Nurses and doctors in emergency departments were told to double or triple their protection but our members were working in the same areas,

or walking through those same areas, without any protection at all. When nurses and doctors were quarantined because of possible exposure to SARS, it was not felt necessary for other staff that had been in the same area to be quarantined too.

Pharmacy technicians prepared the drug for the SARS patients. They knew how to handle things in the pharmacy but they did not know procedures for entering other hazardous areas. They entered infectious areas where probable SARS patients were being treated, such as Intensive Care Units and Emergency Departments, with no personal protective equipment. There was no signage to tell them what to do. No one thought they could be infected.

Communication was very poor. Health care workers watched to see what others were doing and then asked for the same equipment to be supplied to them. Often, they were told that they didn't need it but no one explained why.

In the interests of time I have concentrated on acute care hospitals in the GTA but a few words also need to be said about other GTA health care facilities, as well as facilities outside the GTA.

Confusion reigned in rehabilitation and long term care facilities in the GTA. In some areas there were no precautions in place to wait out the 10-day quarantine period. When there was a probable SARS patient they transferred him/her

out. Not all staff were contacted about the quarantine and many were afraid that they may have taken it home to their families.

Communication to both patients and their families was very poor. At first, patients were not allowed to have their families in, so staff stayed extra hours to feed the patients. Patients were extremely frightened and alone and recreation therapists spent extra time trying to keep the patients comfortable during the outbreak.

Unfortunately, the SARS crisis was seen as primarily a GTA problem but, because of the mobility of patients and staff, there was tremendous potential for it to have spread throughout the health care system across the province. We have OPSEU members in

Sudbury who routinely come to Toronto to work weekend shifts in respiratory therapy. Patients who come to Toronto for specialized treatment are discharged home to distant communities.

Families visited patients while SARS 2 was incubating unknown at North York General Hospital and returned home to their communities. All of these situations could have precipitated a far greater crisis.

In community agencies, OPSEU members provide health care to people in their homes and schools. These dietitians, occupational therapists, social workers, personal home care workers, speech language pathologists, RNs and RPNs do not always know what they are encountering in these situations. This makes it difficult to put in place appropriate precautions to

protect the worker. This time they found themselves in the front lines of SARS with little information or protection.

The SARS crisis placed a huge emotional and physical toll on our GTA members. We, as health care workers, know that there are risks in our workplace and take precautions to protect ourselves. We have always been told that we will be fine if we follow the universal precautions (i.e. treat all patients the same, as if they were infectious). But we found out differently. The procedures in place were not good enough to protect us for SARS. Not only were we personally at risk, we were at risk of taking home a deadly disease to our families.

For example, autopsy attendants at one hospital were never trained to remove personal protective equipment properly and found out after the fact that they had not followed the proper procedure during an autopsy of a SARS patient. In addition, one of them found out later that the mask they wore at autopsy failed the mask test. They fortunately did not become ill.

Because of the one site rule there were not enough staff to do everything that needed to be done. Biomedical technologists who keep the equipment running properly were put on call for 24 hours per day for weeks in order to cover all the sites at one multi-site hospital. Other staff, such as RRCs and x-ray technologists, were required to work additional hours. Many of them doing so on home quarantine. This meant they

were required to wear masks for 12 hours at home and 12 hours at work. No wonder they were exhausted!

Compounding the stress was the confusion about basic procedures such as reporting test results for SARS. Microbiology technologists were getting results but, because no 2 facilities were using the same form or the same reporting system, none of the reporting was done the same. Confusion arose as to what was to be reported to the doctors

We know the percentage of health care workers that were infected or quarantined was very high. But the government and employers forgot many of our members! New infection control procedures must be put into effect now to

include all health care workers. We are the people working with these hazards. We should be part of the process developing these procedures.

Who is looking out for the HCW that I work with everyday?

Why were we not included in the directives?

Why did we not have procedures in place to protect us?

All health care workers came together as a team during SARS1 and 2. Sadly, some workers were treated with greater respect than others.

I'll turn now to Pat and Jack to talk more about their experience at The Scarborough Hospital.