Ministry of Health
and Long-Term Care

Ministère de la Santé
et des Soins de longue durée

Ontario

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Contextual Framework for SARS Response

Introduction

This document supports the directives that outline required responses in a SARS outbreak. It describes the process used to develop directives since the declaration of a provincial emergency in March, 2003. It also references the approach to identify enhanced infection control standards within the province and related quality assurance mechanisms, expectations regarding occupational health and safety and training, and other work in progress.

As with the directives, this document is iterative and may change as circumstances dictate or as new information is made available.

Formulation of Directives

The first directives were released on March 27, 2003, one day after the declaration of the provincial emergency. The directives were designed to:

- Provide specific direction to health care providers as to the role they must play
- Ensure consistent responses to the outbreak
- Provide a margin of safety that would result in containment and management of the outbreak(s)

At that time there was little known about the particular characteristics of the virus causing SARS as the virus itself was new. This meant that the scientists and clinicians who developed the first directives relied heavily on traditional infection control, public health and medical microbiology responses to a viral respiratory outbreak.

Over the subsequent weeks and months, much changed:

- Identification of the coronavirus and its behaviour allowed for an easing of the restrictions on health care providers and, by extension, the people of Ontario
- The clinical and scientific advisors were formalized and expanded into the Ontario SARS Scientific Advisory Committee (OSSAC). Membership included

public health, infectious diseases, medical microbiology, occupational medicine, paediatric, emergency medicine, family medicine physicians as well as infection control practitioners and, latterly a hospital administrator
- Management of the outbreak was successful which allowed time for greater and more coordinated consultation with stakeholders, beyond the frequent teleconferences which were the hallmark of the first phase of the outbreak. Reference groups were struck: SARS Nursing Advisory Committee; Medical Reference Group; Toronto Reference Group (reflected acute care, complex continuing care, rehabilitation, long-term care, and community care access centres); and public health physicians. For this set of directives a broad community-focused approach was used which involved many more community associations and settings

The logistics of creating a directive were as follows:

- The need was identified by the evolution of the outbreak, by health care providers or by the OSSAC
- The OSSAC, through consensus, responded to the need in the form of a recommended directive
- The SARS Operations Centre (SOC)/ Provincial Operations Centre Health reviewed the draft recommended directive for internal consistency, consistency across sectors and ease of use prior to sending to the reference groups
- Reference groups' feedback was funnelled back through the SOC to the OSSAC for consideration
- The OSSAC finalized the recommended directive for SOC final review and the directive was sent to all sectors under the signatures of the Commissioners of Public Health and Public Safety

With no known presence of SARS in the world there has been an opportunity to review the directives in light of what is coming forward in the scientific literature and through conferences regarding the world experience with SARS. This information has been reviewed by the OSSAC and has informed the outbreak directives that are currently being circulated. In addition, draft directives are shared with Health Canada to ensure that the provincial and federal levels of government are producing documents that support the other.

Objectives of Current Directives

The directives circulated on October 22, 2003 were focused on expectations of acute care hospitals during an outbreak. This reflects our previous experience where the outbreaks of SARS were hospital-based. The directives circulated today focus on expectations in non-acute care facilities and community-based settings during an outbreak. With all of these directives in place we will have a system-wide, consistent approach for service providers during an outbreak. Patients, staff and the community at large can be assured that there are integrated plans in place to protect their safety.

Infection Control Expectations in Non-Outbreak Conditions

During the height of the outbreak, health care providers accepted and even sought out relatively unilateral direction as provided by the directives. As the measures taken were increasingly successful and the outbreak managed and contained, the practice of using directives in non-outbreak conditions has been increasingly challenged by those who must implement them. Some health care providers wished greater local autonomy and decision-making as they moved forward with incorporating the spectre of SARS into their regular work.

Extensive consultation resulted in the following feedback:

- Directives are appropriate for outbreaks but too cumbersome for normal circumstances
- The focus should be on early identification of infectious agents, not just SARS
- Surveillance is required to ensure that when (and if) SARS re-appears, it is quickly identified so that disease transmission is contained

A group was struck to distill the current directives, the national routine practice guidelines established by Health Canada and other source material into recommendations for Ontario standards in infection control when there is no wide-spread outbreak. These will ensure a consistent approach to infection control across the province The first area of focus is on surveillance activities across the province. You can anticipate seeing the surveillance expectations in the next several weeks. Until these standards are established, the current directives pertaining to non-outbreak conditions will prevail.

The World Situation

Currently there is no known case of SARS in the world. However it is recognized that cases of SARS may surface anywhere in the world at any time. A case of SARS, or even several cases of SARS, does not automatically mean there is an outbreak. The individual circumstances are important in assessing the level of risk that those patients pose to their jurisdiction and beyond. However, when a case of SARS is confirmed it will result in a change to Ontario's response. The level of change will be driven by both the world situation and local circumstances but will, at the least, be reflected in notification to all facilities and health professional colleges of the SARS-affected areas to be incorporated into screening tools for staff, visitors and patients.

Ontario will implement a tiered level of response. Health care providers will be directed to undertake actions appropriate to the level of risk identified as a result of the provincial assessment of the world situation.

Quality Assurance

It is recognized that directives and standards are only as effective as the degree to which they are followed. There will be requirements that, at the local level, self and other audits

be done and reported to the regional office of the Ministry of Health and Long-Term Care on a regular basis. Specifications for this are in development.

Orientation and Training

The directives are, by necessity, complex documents that require review and study to understand fully. Individuals who will be working with the directives must get appropriate orientation and training. There will be tools to assist health care providers with the steps to be followed in different situations in both hard copy and pdf files. You will receive a request for sign-back to confirm that your staff have been oriented and/or trained on the outbreak directives.

Provincial Transfer Authorization Centre (PTAC)

The centralized coordination of inter-facility patient transfers was a useful adjunct to our surveillance and our outbreak management programs in SARS I and II. The central repository provided an early warning system for any unusual types and levels of activity which had not yet been identified locally due to the dispersed nature of the local presentation. It also limited and managed the potential for patient spread of the disease.

This level of coordination introduced an involvement in transfer decisions that was not the norm. It was tolerated in the interests of managing an outbreak, as were the developmental challenges as the program evolved. However the ongoing role of PTAC in non-outbreak conditions needs to be resolved as to whether the introduction of this process in the traditional transfer planning process is outweighed by the early warning system that PTAC provides. A working group is being drawn together to make recommendations on the role of PTAC during non-outbreak conditions.

Health Care Worker Safety

The *Occupational Health and Safety Act* regulates health and safety in workplaces, including health care organizations. The Act is administered by the Ministry of Labour and the Act's purpose is to protect workers against hazards on the job.

The cornerstone of Ontario's workplace health and safety system is the internal responsibility system (IRS). It requires individuals at every level of an organization, whether they are workers, supervisors, senior executives or corporate directors or officers, to be responsible for health and safety in their workplace. The concept of the IRS is based on the principle that the workplace parties themselves are in the best position to identify health and safety problems and to develop solutions. Ideally, the internal responsibility system involves everyone, from the corporate directors to the worker, each person acting to their level of decision-making authority. When health and safety concerns are identified and cannot be resolved by the worker, they must be brought

to the attention of management and dealt with immediately. The system depends upon a complete, unbroken chain of responsibility and accountability for health and safety.

The joint health and safety committee (committee) or in smaller workplaces, the health and safety representative, has a role to play in monitoring the IRS. They are important contributors by performing a key advisory and audit role in raising awareness of health and safety issues, recognizing workplace hazards and bringing new or unresolved health and safety issues to the attention of those with direct accountability and authority. The committee that is effective in its role will not only ensure that hazards are corrected but will provide advice to the employer on how the IRS could be improved.

Those organizations with an effective IRS were equipped to respond most effectively during the SARS outbreak.

In workplaces such as health care facilities, employers and supervisors have the primary responsibility for health and safety in their workplace under the *Occupational Health and Safety Act.* Employers in this sector are reminded of their duties under the *Occupational Health and Safety Act* and Ontario Regulation 67/93 (Health Care and Residential Facilities) that is made under that statute.

There are times when there are differing opinions as to the appropriate level of response to a given situation. It is recommended that when there is disagreement, the more conservative approach be instituted until the disagreement is resolved. Further, to assist with problem resolution each site should develop an internal dispute resolution mechanism that is accepted by all the parties.

Other Initiatives

- Work is underway to heighten the seamlessness of the local, regional and provincial roles in an outbreak. Scenarios and proposed appropriate involvement by each of the levels is in development
- Identification of trigger points to activate different levels of response are being identified
- Organizational chart for SARS emergency response is being finalized