

CELEBRATING RESILIENCE, EXPOSING VULNERABILITY

SARS UNMASKED

A Report on the Nursing Experience with SARS in Ontario
Presented to the Commission to Investigate
the Introduction and Spread of SARS in Ontario
Public Hearing: September 29, 2003



The Registered Nurses Association of Ontario (RNAO) honours Ontario's nurses for their unwavering commitment to the people of this province and for putting their lives on the line day in and day out.

In memory of Tecla Lin and Nelia Laroza.

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Summary and Recommendations

Summary

The Registered Nurses Association of Ontario (RNAO) has prepared this submission to the *Independent Commission to Investigate the Introduction and Spread of Severe Acute Respiratory Syndrome (SARS)* to ensure nurses' voices are heard. The submission is a snapshot of RNAO's full report to be released later this year.

Nurses comprise 60.3% of all regulated health professionals. Nurses are present with their hands, minds and souls in all sectors, from public health to home care, and from acute care to long-term care. Nurses cure and care every day and every hour. Nurses have a unique perspective because it encompasses both an intimate and comprehensive view of our entire system of care, from the needs and concerns of patients and families to organizational and system issues. The nursing perspective is, therefore, critical to understanding the health care system's strengths and weaknesses. To hear nurses' voices and act on their advice is critical for the health and well-being of all Ontarians. Yet, despite all this, nurses' voices have too often not been fully integrated in decision making at bedsides or in boardrooms. We hope that this report does not suffer a similar fate and find itself relegated to a shelf.

RNAO's report, *SARS Unmasked: Celebrating Resilience, Exposing Vulnerability* answers the need to give voice to the many nurses who worked and lived through the SARS outbreak in Ontario. We listened, we learned and we acted by providing support, advice and advocacy throughout this crisis.

Our report acknowledges that this crisis was unlike any we had experienced before. Our report also argues that we – government, health organizations, and health care professionals – were ill-prepared to tackle SARS. Not only did we need to manage an infectious disease, whose origin and transmission were initially unknown, but we had to do this from within a depleted health care system. This is a system weakened from years of funding cuts and a workforce exhausted by a decade of relentless restructuring. SARS further challenged:

- A system that is poorly connected;
- A public health sector that is under-resourced and disintegrated;
- A home care sector that is destabilized;
- A hospital sector that is unprepared for major emergencies; and
- A nursing workforce that battles with dangerously low staffing levels, high workloads, and an over-reliance on part-time, casual and agency staff.

RNAO filed a request with Premier Eves for a full public inquiry and we stand by our call. Much has become public and much more remains private. We continue to be concerned by the level of secrecy regarding the SARS outbreak. If we don't hear and we don't know, we don't learn. And if we don't learn, we don't improve. The nagging question continues to haunt us: could we have avoided some of the death and devastation brought about by SARS in Ontario?

The findings of this report are based on what we heard during and since the SARS outbreak. RNAO has supported and advised hundreds of nurses during this period. What we learned during that process was enriched by 15 sector-specific focus groups and 51 individual interviews. The findings reflect a comprehensive view of nursing perspectives across all sectors, from those providing direct patient care, to nursing students, to those in administrative and educational roles. The Ontario Nurses Association (ONA), the Registered Practical Nurses Association of Ontario (RPNAO), the College of Nurses of Ontario (CNO), the Community Health Nurses Initiatives Group (CHNIG), and the Association of Nursing Directors and Supervisors of Ontario Official Health Agencies (ANSOOHA), also shared their perspectives with RNAO.

The voice of nurses. The key themes emerging from the focus groups and interviews are:

- **Nursing patients with SARS -- a sea of emotions:** Fear, anxiety and exhaustion; isolation and stigma; commitment and pride; frustration and anger – these were feelings consistently expressed. Throughout the outbreak, nurses endured the underlying fear they too would fall victim to this disease. They feared for their families, the same families from whom they had to be isolated. Anger was vividly expressed over the failure to recognize nurses’ clinical expertise and nurses’ frequent warnings that went unheeded. Our report clearly outlines how – in the face of these strong feelings – nurses demonstrated an amazing commitment to patients, the health-care system and the profession. Although staff nurses and manager were exhausted, they felt proud.
- **Work environment:** Nurses pointed to major health and safety concerns exacerbated by limited occupational health and infection control resources. During the outbreak nurses expressed serious concerns regarding the access to, and effectiveness of, protective gear. They also described the extreme discomfort from the extended use of face masks. We heard numerous concerns about the quality and timeliness of mask fit testing. We heard, and experienced, the “chaos of communications” during the first phase of SARS, and witnessed the significant improvements made in the second phase. We heard repeatedly about nurses’ concerns not being heeded by senior physicians and others in positions of authority.
- **Workforce:** The report clearly outlines what nurses in all roles shared with us: staffing shortages were a major issue prior to SARS and worsened dramatically during the outbreak. The over-reliance on part-time, casual and agency nursing was a barrier for staffing and for sustaining staff moral. The significance of multiple-employment took on a new dimension when nurses were directed to work for only one employer to contain the spread of SARS. It meant many employers had to rely on fewer nurses and many nurses could not count on their incomes. Some nurses described how pressured they felt to come to work sick, and to work double shifts, as sick time would not or could not be replaced. A few nurses shared that they were expected to come to work even though they had a “cold” or “flu like symptoms.” Adding to the workforce constraints was the failure to appropriately utilize student nurses who were nearing graduation. This is an important human resource that could have eased system problems. We heard the disappointment of students, most of whom felt left-out of an important experience and frustrated in their genuine desire to help. While many nurses described their continued commitment to the profession – all too many noted that things must change in order for them to remain in nursing.

- **Service issues:** System-wide we heard about problems in coordinating decision-making and directives between and within sectors. The result was considerable confusion. As all sectors moved to contend with SARS, other programs – and thus the patients and residents who rely on these programs – were neglected. Nurses spoke eloquently about how the restrictions imposed during SARS significantly affected the quality of care they were able to provide. Some of the most heart-wrenching descriptions in this section are of nurses who were themselves SARS patients. Overall, nurses described a system stretched beyond its capacity as it struggled to deal with SARS; a system significantly lacking necessary surge capacity.

On March 31st, RNAO launched the SARS Nursing Advisory Committee. Comprised of a senior representative from all major nursing organizations, affected health care organizations, and the Nursing Secretariat, the committee met every other day in an attempt to streamline communication and co-ordinate timely support. The committee has been formalized on a permanent basis as an Emergency Nursing Advisory Committee that meets monthly in normal times.

SARS was an experience that the nursing profession will never forget. To many nurses, it was the absolute worst of times. And yet – in so many ways – it underscored the resilience and strength of nurses. To be sure, the response to SARS exhausted individual nurses and tested the very limits of their professional commitment. If nursing is to be preserved and enhanced so it can continue to contribute to health and healing, systemic changes must occur. The recommendations that follow outline what nurses need from governments, employers, nursing associations and Justice Campbell so we can be better prepared – and better respond – for the next infectious disease outbreak or other major challenges. The next crisis might be just around the corner and we *must* be better prepared!

Recommendations

For Health Canada and Provincial/Territorial Ministries of Health

Recommendation 1: Collaborate to establish and maintain a central Canadian authority to oversee infectious diseases and other health emergency needs, such as the U.S. Centers for Disease Control and Prevention (CDC). This authority must include the necessary health-care expertise, from all sectors of the system, to ensure:

- a. A comprehensive and clear emergency preparedness plan, supportive infrastructure and resources to facilitate rapid action in times of need.
- b. Development and testing of best practice guidelines for managing infectious disease outbreaks, to ensure preparedness for any future outbreak.
- c. Infection control standards and protocols, as well as facilities and personal protective equipment that will secure patient and provider safety while maintaining principles of patient-centred care.
- d. An effective decision-making and accountability structure.

For the Ministry of Health and Long-Term Care (MOHLTC)

Recommendation 2: Establish and maintain an effective communication network as a key component of an emergency preparedness plan. This network should link government, health providers, professional organizations, unions, higher education institutions, and the public.

Recommendation 3: Immediately introduce whistle-blower legislation to ensure that nurses and other health care workers can express their concerns without fear of reprisal from employers. (RNAO first requested this legislation from the Premier of Ontario in March of 1998¹.) Failure to implement this legislation means that an important safety valve is missing from the health care system.

Recommendation 4: Invest appropriate funds to build capacity in the health care system, ensure quality patient care and healthy and safe workplaces. This includes:

- a. Re-investment in public health to ensure integration with other health care sectors and to strengthen system coordination and interconnectedness during normal and crisis times.
- b. Provide adequate and stable, multi-year funding to all sectors to facilitate long-term planning.
- c. Ensure stability and equity in wages for nurses across sectors to increase retention and ensure the public has access to necessary nursing resources.
- d. Ensure that nursing supply matches the demand for nursing services. Recruit 8,000 new and permanent full-time nursing positions between now and March 2004.

Recommendation 5: Eliminate managed competition and implement changes to secure a stable workforce that will provide quality and consistency of care to clients in the community sector.

For the Ministry of Training, Colleges and Universities (MTCU)

Recommendation 6: Increase the number of first-year RN nursing education seats by 500 in 2004 and by another 500 for 2005.

Recommendation 7: Secure adequate numbers of nursing faculty by supporting an additional 10 nursing faculty to attain doctoral education, in each of the coming four years.

Recommendation 8: Adequately fund academic and health care environments to support clinical placements for nursing students and adequate orientation and mentorship for nursing graduates entering the workforce.

For Government, Employers and the Nursing Profession

Recommendation 9: Establish a benchmark of 85% productivity for nurses and nurse managers in all health care organizations and implement staffing policies that will secure safe patient care at all times and surge capacity to respond to short-term crisis situations.

Recommendation 10: Address immediately the casualization of the nursing workforce. Establish a target of 70% full-time employment for RNs to be achieved by 2005 in all health care organizations in Ontario. Require employers to report annually on their progress in achieving this target. This will serve to enhance continuity of care, improve human resource capacity and

utilization, and reduce infectious disease spread. We urge employers to immediately implement the following strategies to achieve this target:

- a. Open full-time positions for any Ontario RN who wishes to work full time.
- b. Offer part-time nurses more hours per week.
- c. Minimize the use of casual and agency nurses.
- d. Minimize the use of overtime.
- e. Develop strategies to minimize multiple employment.
- f. Evaluate the safety of 12 hour shifts.

Recommendation 11: Involve nurses within all health care organizations in decision-making processes that impact their work. This participation must include nurses from the point of care to senior administration.

Recommendation 12: Establish organizational guidelines and open channels of communication at all levels to enhance the ability of nurses and other health care personnel to effectively communicate any concerns. These guidelines must guarantee protection from employer reprisals.

Recommendation 13: Develop guidelines for health care organizations and nursing education programs to continue clinical placements during times of crisis. Students possess knowledge and expertise needed by the system and they require the experience of working through a crisis situation for their professional development.

Recommendation 14: Develop strategies and forums to enhance communication and collaboration between nurses, physicians, and other health professionals.

Recommendation 15: Create organizational structures and provide resources that support the effectiveness of nursing administrative roles. This is necessary to facilitate healthy work environments and improve nurse satisfaction and patient outcomes.

Recommendation 16: Develop appropriate infection control and occupational health and safety capacity within all health care organizations. This requires ensuring adequate resources and providing regular infection control and emergency preparedness education for all staff.

For Justice Campbell

Recommendation 17: Use the discretionary power given to you within your terms of reference to fully capture the factors that contributed to, or detracted from, our ability to contain the SARS outbreak. Make recommendations that will lead to improvements in the resources, structures, policies, procedures and practices of all three levels of government, health-care organizations and providers, addressing those factors which limited the effectiveness and timeliness of the health-care system's ability to respond to SARS, including:

- a. the ability to protect the health and safety of health-care workers and the public.
- b. the systemic barriers which affected the quality and availability of nursing services during the SARS outbreak, including the excessive reliance on casual, part time and agency nurses.

- c. the circumstances which contributed to the second cluster of SARS in May 2003, and those that aggravated its spread, including the lack of response to early warnings raised by nurses, and other providers.

Introduction

A patient arrives in the emergency department of a large metropolitan community hospital complaining of symptoms that fit with a diagnosis of pneumonia. This common scenario was an innocent beginning to what would become an unprecedented crisis.

SARS Unmasked: Celebrating Resilience, Exposing Vulnerability answers the need to give voice to the many nurses who worked and lived through the SARS outbreak in Ontario. For the Registered Nurses Association of Ontario (RNAO), SARS was a major challenge that we tackled head on. As the outbreak unfolded, we listened, we learned and we acted. We provided support, advice and advocacy – throughout this crisis. Later on, for the preparation of this report, we further listened and we learned during the 15 focus groups and 51 additional personal interviews we had with nurses in all roles and all sectors.

The crisis was unlike any we had experienced before. We listened to the fear, the pride and the frustration of nurses. We listened to the crying calls and counseled on the unavoidable anxieties – “will I get it too?” We received emails and letters that repeatedly stated – “I have never been so proud to be a nurse.” We respected the doubts and heard so many nurses ultimately find a renewed commitment: “I don’t know if I can continue to be a nurse... but, if not me, who?” We watched colleagues work under oppressively hot, irritating and clumsy protective gear – many suffering from allergic reactions and excoriated skin. We listened to the fatigued voices and exhausted bodies. We calmed the families of our ill colleagues and consoled those who lost loved ones. And, we joined in the frustration and anger of nurses not being heard and their knowledge not being acted upon: we demanded a full public inquiry. This is what has brought us here today.

The anguish is deep, and the nagging question remains: Could the deaths and devastation brought about by SARS in Ontario have been lessened had people listened to nurses?

Justice Campbell: in our submission we reveal and “unmask” nurses’ experiences. We acknowledge the unknown and refuse to accept the avoidable. In doing so, we link nurses’ lived experiences with system and organizational policies and practices, many of which must change. The next disease outbreak might be just around the corner and we *must* be better prepared.

Our submission:

- Describes the impact of SARS on nurses and on our capacity to provide professional nursing services
- Spotlights nursing health human resource issues pre-SARS and during the SARS crisis
- Provides recommendations for system change within governments, health care organizations, and the profession to ensure nurses are able to provide quality patient care at all times.

Nurses’ voices form the core findings of RNAO’s submission. From all sectors – long-term care to acute care and homecare to public health – and from a cross-section of roles, the experiences

of nurses, before, during and after SARS are captured. We begin describing the context in which SARS was experienced. Understanding this context is critical to fully grasp the impact of this outbreak on patients, individual nurses, the profession and on our health-care system.

SARS in Context

Clinical Challenges

The fact that SARS is a new and emerging infectious disease is a significant factor in how it was defined and treated in various health-care settings. Much of the chaos and fear experienced during the first weeks of the outbreak was based on the lack of knowledge about cause or transmission. In spite of other, recent disease outbreaks requiring a public health response it soon became clear that SARS was unique in its rapidity of transmission, its concentration in the health-care setting and the extent to which it infected such a large number of health-care providers. SARS very quickly became a challenge of global proportions.

Phases of SARS

There were two distinct phases to the SARS outbreak in Toronto, each having a very different impact on nurses and patient care. *Phase one* was characterized by organized chaos as crisis management plans were implemented to contain and manage the disease while uncovering its origin and transmission. Fear and anxiety were the predominant emotions, but ones that were accompanied by a sense of success and pride as the number of new cases began to drop.

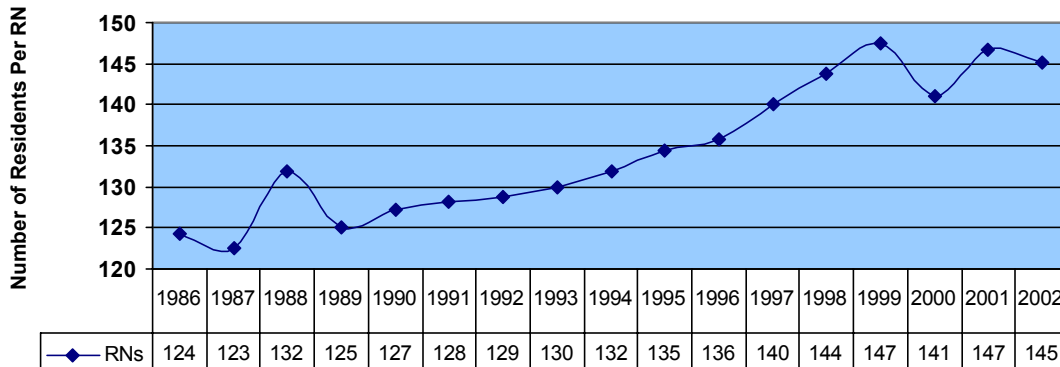
Phase two was experienced very differently. In part, this is because restrictions were lifted – in the eyes of nurses – far too soon. In phase two, nurses’ warnings about ongoing and unrecognized transmission were not initially acted upon. Then, as more stringent precautions were implemented, they added to the burden of an already exhausted staff. The quarantine and illness of many, many nurses and the subsequent death of two nursing colleagues made the workplace risk even more tangible and frightening. Adding to this fear was the belief by many of an unspoken pact that the crisis *needed* to be over. Following the World Health Organization (WHO) advisory, issued on April 23rd that included Toronto in the list of places “not to visit,” the official focus on SARS was significantly reduced. The once daily government ads, informing the public of “SARS symptoms to be aware of” essentially disappeared. Media attention switched from health care issues to economic recovery for the city and province. Nurses came through phase two feeling exhausted – physically and emotionally – and betrayed by a system that expects them to care but does not adequately protect them as they do so.

Nursing Human Resources: We Were not Prepared for SARS

Based on 2002 data from the regulatory colleges RNs account for 46.4% of all regulated health care workers and RPNs, 13.9%. Much of the patient care is delivered and coordinated by nurses.

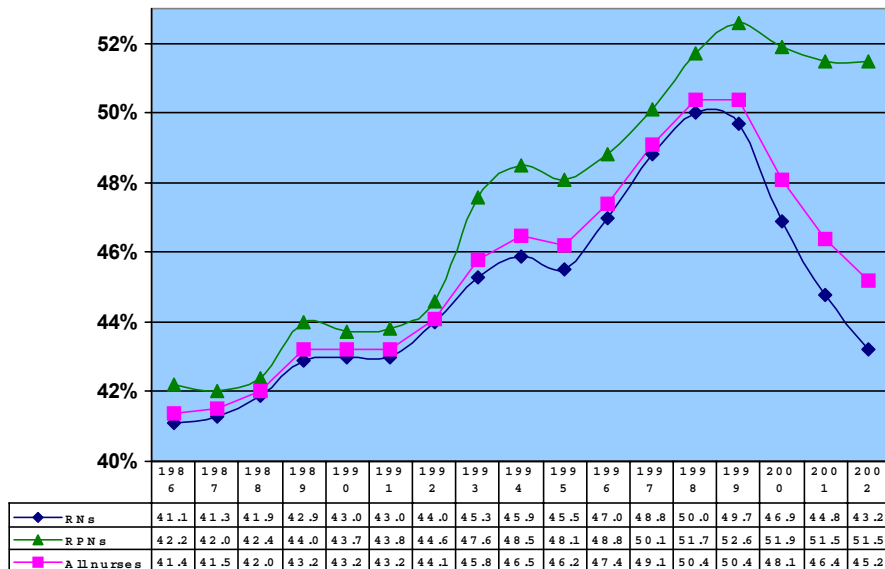
The years leading to the SARS outbreak were marked by a dramatic deterioration in nursing human resources capacity. Policy decisions led to dangerously low staffing levels, workloads that in many instances are unsafe, and an over reliance on part-time, casual and agency work that threaten the viability of the health care system in “good times,” let alone in emergency situations.

Chart 1. The Rising Population-to-RN Ratio in Ontario



Data source: College of Nurses of Ontario

Chart 2. The Changing Share of Part-time / Casual Nursing Employment in Ontario



Data source: College of Nurses of Ontario

Nursing Employment in Ontario

While measures to stabilize nursing in the past four years have been important, nurses continue to state that work circumstances have not substantially improved.² This reflects two factors. First, nursing employment has been unstable. RN employment rose in 2000, fell in 2001, and has risen again in 2002. Second, Ontario's population continues to grow quickly. These factors combined imply a deteriorating population-to-nurse ratios. In fact, according to the Canadian Institute for Health Information (CIHI) report released this month Ontario now has the worst RN-to-population ratio of all provinces in the country (65 RN's per 10,000 population, compared to 73.4 for the rest of Canada)³.

Over-reliance on Part-Time and Casual Employment

Across Ontario, the share of casual / part-time nursing employment peaked in the late 1990s at over 50%. Although it has improved slightly since then, it remains unacceptably high (see chart 2). Since SARS was by and large an issue for the Greater Toronto Area (GTA), the employment patterns in this area are of particular interest. From College of Nurses of Ontario (CNO) data, we see that the patterns of part-time and casual employment in Toronto and in the GTA are similar to that for Ontario as a whole. Table 1 shows the employment status of nurses employed in nursing in Ontario, in the GTA and in Metro Toronto.

Table 1. Employment Status of Ontario Nurses Working in Nursing: 2002						
	Jurisdiction	Not Spec.	Full-time	Part-time	Casual	Total
RNs (excludes RNECs)	Ontario	4,087	44,629	26,246	7,818	82,780
	GTA	1,502	17,344	7,460	3,132	29,438
	Metro Toronto	1,074	12,295	4,699	2,240	20,308
RNECs	Ontario	11	236	84	12	343
	GTA	3	64	21	8	96
	Metro Toronto	1	56	15	7	79
RPNs	Ontario	1,580	11,634	9,331	3,028	25,573
	GTA	429	2,883	1,887	706	5,905
	Metro Toronto	291	1,831	1,079	492	3,693
Total	Ontario	5,678	56,499	35,661	10,858	108,696
	GTA	1,934	20,291	9,368	3,846	35,439
	Metro Toronto	1,366	14,182	5,793	2,739	24,080

Data source for all tables: College of Nurses of Ontario, based on self-reporting by registrants with the CNO.

Table 2. Employment Status by Percent					
	Jurisdiction	FT	PT	Casual	Total
RNs (excludes RNECs)	Ontario	56.7%	33.4%	9.9%	100%
	GTA	62.1%	26.7%	11.2%	100%
	Metro Toronto	63.9%	24.4%	11.6%	100%
RNECs	Ontario	71.1%	25.3%	3.6%	100%
	GTA	68.8%	22.6%	8.6%	100%
	Metro Toronto	71.8%	19.2%	9.0%	100%
RPNs	Ontario	48.5%	38.9%	12.6%	100%
	GTA	52.6%	34.5%	12.9%	100%
	Metro Toronto	53.8%	31.7%	14.5%	100%
Total	Ontario	54.8%	34.6%	10.5%	100%
	GTA	60.6%	28.0%	11.5%	100%
	Metro Toronto	62.4%	25.5%	12.1%	100%

Source: Based on data in Table 1. The “not specified” category has been excluded.

Table 2 shows the employment status of nurses, in percentages. The GTA has a higher share of full-time and casual positions than does the rest of Ontario, and a lower share of part-time positions. This is a good news-bad news story. The higher prevalence of full-time employment is good; however the greater degree of casual employment is harmful, particularly in a situation like that presented by SARS. Within the GTA, the situation in Toronto is more pronounced: there is an even greater prevalence of both full-time and casual employment, and less part-time employment.

Nursing Employment: Lagging Behind Population Need

The GTA has 41.9% of the population but only 32.6% of the nursing employment in Ontario. Within the GTA, Toronto has 22.2% of nursing employment and only 21.7% of the population. We cannot consider Toronto “over-serviced” with nursing positions, since it provides health care services to people with more complex needs. Indeed, there are far more quaternary level services and more critical care beds. Thus, more nurses are required.

Multiple Employers

CNO data show a high number of Toronto nurses holding multiple jobs. Overall, 22.4% of employed Toronto nurses hold multiple jobs. The share is highest in the long-term care sector (32.4%) and lowest in the hospital sector (20.1%) – but even the latter figure is disconcertingly high. The community sector is at 23.1% and the other sectors at 27.0% (see Table 3).

All classes of nurses experience high rates of multiple employment: RNs (21.1%), RN(EC)s⁴ (32.9%) and RPNs (29.4%). Employment status is a good predictor of multiple employers. While

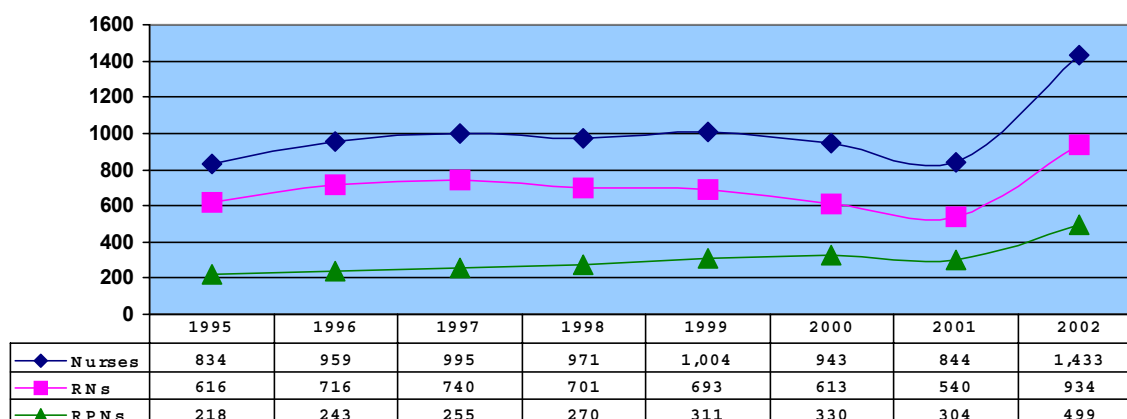
17.3% of full-timers have multiple employers, 27.3% of part-timers and 43.8% of casually employed nurses have multiple employers. Therefore the prevalence of casual employment is an aggravating factor in multiple employment.

Another human resource factor that received increased attention during SARS is the number of registered nurses working for nursing agencies. Chart 2 illustrates that while the overall use of agency nurses is low, Ontario has experienced a sharp increase in agency use from 1995 to 2002.

Table 3: Percentage Share of Working Nurses in Toronto with Multiple Employers

Group	% not spec	% FT	% PT	% Casual	% Total
Hospital	11.6%	16.2%	22.0%	41.6%	20.1%
LTC	21.2%	19.9%	45.2%	61.3%	32.4%
Community	17.6%	17.8%	31.1%	46.4%	23.1%
Other	13.1%	20.3%	34.7%	42.2%	27.0%
Not Specified	6.1%	17.6%	26.7%	42.6%	17.8%
Total Toronto Nurses	11.6%	17.3%	27.3%	43.8%	22.4%
Toronto RPN	14.1%	20.4%	38.2%	52.2%	29.4%
Toronto RNEC		25.5%	46.7%	71.4%	32.9%
Toronto RN	11.0%	16.8%	24.7%	41.9%	21.1%
Rest of Ontario RNs	7.3%	8.6%	16.6%	27.6%	13.0%

Chart 3. Number of Ontario Nurses Working for Agencies



Data source: College of Nurses of Ontario

Table 4. Agency Employment of Nurses in the GTA						
Jurisdiction	RN	RPN	Total	RN % Agency	RPN % Agency	Total % Agency
Metro Toronto	426	196	622	2.10%	5.31%	2.59%
Durham	14	7	21	0.56%	0.75%	0.61%
Peel	77	24	101	1.94%	3.88%	2.21%
York	55	22	77	2.07%	3.34%	2.32%
GTA	572	249	821	1.94%	4.22%	2.32%
Rest of Ontario	362	250	612	0.67%	1.27%	0.83%
Ontario Total	934	499	1,433	1.12%	1.95%	1.32%

One indicator of the degree of mobility of nurses between institutions is the extent of agency employment. The small, but significant, number of nurses who work for agencies in Ontario are concentrated in the GTA. Agency employment is particularly prevalent in Metro Toronto (2.59%), Peel (2.21%) and York Region (2.32%). Table 4 demonstrates that the GTA employs 57.3% of all agency nurses in Ontario (821 of 1,433) – a significant complicating factor when it comes to infectious disease containment.

Implications of Health Human Resource Context

Over-reliance on casual and part-time employment, alongside high levels of multiple employment and increasing levels of agency nursing staff, is problematic – even in non-emergency times. This over-reliance has resulted in decreased continuity of care for patients, and has created a large transient nursing workforce with less organizational involvement.^{5 6} The fact that almost half of the nursing workforce is employed on a non-full-time basis adds burden to the system and makes staffing difficult at all times and especially during emergency situations such as SARS. To add to the seriousness of this situation, it is projected that by 2006, 29,746 RNs will have left the Canadian workforce due to retirement or death, 9,878 in Ontario alone.⁷

There is a wealth of research showing that health outcomes depend upon adequate staffing by RNs. If this is lacking, patient outcomes are significantly compromised.^{8 9 10} Indeed, nurses have frequently expressed concerns that onerous workloads jeopardize patient safety. Grave concerns about workload have been repeatedly flagged to governments – federal and provincial.^{11 12 13 14 15} ¹⁶ One measure of the effect of excessive workload is the level of illness or disability of nurses and the fact is that nurses have the second worst statistics for work missed of all employment classes.¹⁷

Another critical factor is the research related to the concept, “failure to rescue”¹⁸ in which the link is made between the quality of surveillance and the number of experienced nurses relative to inexperienced nurses. Those units with more experienced nurses are more likely to detect problems or complications in a timely manner. It is difficult to understand how a newly graduated RN, who is forced to wait six or more years to attain full-time employment, will attain expertise within the patchwork of two, three, and sometimes four employers.

Nursing Administrative Support

Ontario has experienced a significant reduction in nursing administrative positions in the past decade. These include middle manager positions (e.g., Nurse Unit Administrators) and senior management positions (e.g., Chief Nurse Officer). This is the case especially in Public Health and in the hospital sector. As a result, only eight of the 37 Public Health Units in Ontario currently have a designated Chief Nursing Officer. In the hospital sector managers have moved from having one unit (in the early 1990s), to having two, three, and sometimes four units to oversee today.

Undoubtedly, the ability to cope with the SARS outbreak was compromised by all of these factors: over-reliance on part-time, casual and agency nursing work and a high number of nurses with multiple employers. As directives were released from Provincial Operations Centre (POC) restricting employment in multiple agencies, nurses were forced to choose one employer. As a result, many employers were stranded without adequate numbers of nurses and many nurses found themselves without sufficient work and income.

Nurses Voices

The findings of this report are based on what we heard throughout the SARS outbreak and after. RNAO has supported and advised hundreds of nurses during this period. Staff nurses, nurse managers, senior nurse administrators, nursing students and educators contacted RNAO by phone and by mail on a daily basis. We created an online support board where RNs and nursing students posted 2,345 messages. We sent regular email bulletins. We listened and we learned.

In August we conducted 15 sector-specific focus groups and 51 additional individual interviews. The findings reflect a comprehensive view of nursing perspectives from direct patient care to student nurses, to administrative and educational roles, across all sectors. Most participants were identified and recruited by the nursing leaders within each organization and others were self-selected through communication with the RNAO. The organizations approached for consultation had direct experience with SARS patients during the crisis. In some sectors, there were no SARS patients in their care but SARS directives had an impact on their services and staff. The Ontario Nurses Association (ONA), the Registered Practical Nurses Association of Ontario (RPNAO)¹⁹, the College of Nurses of Ontario (CNO), the Community Health Nurses Initiatives Group (CHNIG)²⁰, and the Association of Nursing Directors and Supervisors of Ontario Official Health Agencies (ANSOOHA)²¹, also shared their perspectives with RNAO.

The focus group and interview guide was developed from a review of key articles in the literature describing nursing workforce issues. Input was also received from experts in the field. The themes that emerged from these focus groups and interviews were *Nursing Patients with SARS – A Sea of Emotions*; *Work Environment*; *Workforce*; and *Service Issues*.

Nursing Patients with SARS -- A Sea of Emotions

Fear, anxiety and exhaustion; isolation and stigma; commitment and pride; frustration and anger were consistent themes throughout the focus groups and interviews. Nurses described powerful

emotions, and in many cases they were brought to tears as they spoke of the SARS crisis. Nurses are still taking time to process what has happened to them.

Fear, Anxiety and Exhaustion

The predominant emotion expressed was fear; fear that was rooted in the unknown nature of the illness and its spread, the risk of acquiring the disease despite using precautions and the potential that it could be brought home to family and friends. As the outbreak was identified, hospitals were instantly “locked down” and nurses were barred from leaving or entering the building until screening could be done on an urgent basis. In one instance, police were present to enforce this process.

“Oh my god, what is happening? This is one of the most dramatic things I have seen in all of my years of nursing.” (RN, staff nurse, Acute Care).

There was also a difference in how nurses described their fear in phase one versus phase two.

While phase one was marked by widespread fear and anxiety, phase two was characterized by a sense of panic. They shared how their fears were amplified from seeing more sick colleagues.

The perceived secrecy and their accumulated exhaustion only

added to their heightened anxiety. Even in settings where there were no clients diagnosed with SARS, such as the long term care facility sector, staff suffered tremendous fear.

“I dream of disembodied mouths gasping for air and wake struggling to catch my own breadth. I dream of ventilators that turn into vacuums and suck up the air they are supposed to deliver. My sleeping self struggles to fix the problem before everyone suffocates.” (RN, Staff Nurse, Acute Care)

Isolation and Stigma

Nurses working in SARS units told how they were often barred from leaving the unit as a measure to limit the spread of the disease. Supplies would be dropped off at the door of the unit. Nurses were directed to sit two seats apart in the cafeteria in an area separated from non-clinical staff and security staff was present to monitor compliance with this directive. The pizza delivery person would not deliver pizza and the taxi driver would not stop to take the ride. “It was like being in jail,” many nurses said.

“Friends and family would ask, “Should you be here? We don’t want you here. I don’t want to see you until this is all over.” (RN, Staff Nurse, Acute Care)

During their time off, nurses were directed to refrain from “congregating.” Social and educational events were cancelled and many nurses did not eat with their family and slept alone. Many nurses missed important family events and milestones e.g. Easter, Mother’s Day, graduations, weddings, and in one case, their child’s first steps. Nurses reported feeling devastated from this. In the words of a staff nurse in an acute care setting, “There was a complete invasion of our personal life.”.

Some local restaurants and libraries posted signs to say that hospital staff was not welcome. In several occasions, nurses’ young children were banned from daycare, only adding to the nurses’ burden and sense of stigma. Some nurses in quarantine were asked to keep their children home from daycare or school.

“The neighbours were not going outside if I was in my backyard. They were afraid of me. I thought I was going to explode. I just wanted to go outside and see normal people that were not wearing full protective gear.” (RN, Staff Nurse, Acute Care)

Quarantined nurses experienced even greater isolation. These nurses were either in *home quarantine* or *work quarantine*. Nurses in home quarantine needed to remain at home at all times, isolated from their families and other physical contacts. Nurses in work quarantine were also isolated at home but they needed to continue working with full protective gear while at the hospital. Some nurses stated that they felt better being at work because they didn't need to explain anything to people, they were accepted by their peers and they felt it was safer for their family if they were at work.

"I don't know what the experience of being in jail is like. But, it's like being in jail. Or you feel that is what the experience would be like. Or, like being on house arrest. But, you haven't done anything wrong." (RN, Staff Nurse, Acute Care)

"Just trying to get gas...The quarantine they made you was a working quarantine. You still have to get gas. You go to the gas station. You wear your mask. And the gas station attendant looks at you like you're a leper, or an alien. You know 'what are you doing coming out with a mask?'" (RN, Staff Nurse, Acute Care)

Many nurses used the phrase "social pariah" to explain the stigma that was associated with being a nurse during this crisis. Simply being a nurse working in a hospital meant that the public was afraid to be nearby.

Commitment and Pride

In the face of fear and isolation, nurses demonstrated incredible commitment to patients, to the health care system and to the profession. Even though they recognized personal risk, their duty to care took priority.

"We came to work. There was no choice. I needed to be there to help the patients get better." (RN, Staff Nurse, Acute Care)

"I needed to go into the patient's room and do what I needed to do." (RN, Staff Nurse, Acute Care).

Some expressed a renewed commitment to system change. As the number of new cases in phase one of the SARS outbreak began to subside, through the diligent efforts of all involved, a sense of success and pride in the ability to manage the crisis was

evident. Nurses were portrayed as heroes in the media for their valiant efforts. There was a shift from emergency management of the disease to a recovery phase and "new normal" in the approach to infectious disease. Nurses re-affirmed their commitment to nursing and to the satisfaction this type of work provides.

"This has been a very disturbing event that has left me with a different world view but more than ever has given me the opportunity to have nursed in probably the worst crisis in nursing history. I have to take something back from that. I feel an obligation as a survivor to make damn sure that this doesn't happen again." (RN, Staff Nurse, Acute Care)

Frustration and Anger

Many of the nurses interviewed expressed considerable frustration and anger over the failure to recognize nurses' clinical expertise. Nurses from

"Nurses ... were ignored and suppressed by administration and medical staff. They were discounted and considered not to have any knowledge of medical issues. What possible motivation could there have been for not listening to the nurses? (RN, Staff Nurse, Acute Care)

"How many nurses raise red flags and are not listened to? Nurses have the knowledge and expertise which is often unrecognized and under appreciated" (RN, Manager, Acute Care)

"Why did it take a nurse to hit the roof before someone would make changes?" (RN, Staff Nurse, Acute Care)

"Sometimes I wonder if she would have done better if treatment had started sooner" (RN, Staff Nurse, Acute Care)

all sectors told us that they were denied opportunity for input into decision-making; their recommendations as well as their knowledge and expertise were not taken into account. And, much too often, even their well being was ignored as nurses reported several incidents where they were not told that certain patients might have SARS. In

fact, on some occasions nurses were categorically informed certain individuals did not have SARS when they actually did. Their expressed anger was particularly intense over the belief, by many nurses, that SARS phase two might not have happened if administration and senior medical staff had listened to nurses.

Work Environment

Workplace Health and Safety

"Nurse : patient ratios are poor at best and this doesn't allow for good infection control. Good infection control takes time, to do it and do it well. If we want the shortcuts to end, we must manage the nurse:patient ratios."(RN, Infection Control, Acute Care)

Occupational health and infection control departments were characterized by inadequate staffing, competing priorities and the inability to manage all responsibilities of the role even prior to the SARS outbreak. Nurses practising in infection control roles shared that sound infection control practices could not be consistently applied by nursing staff largely due to the nursing workload.

During the SARS crisis, difficulties were only magnified. Frequently changing directives and the expectation of instant

implementation became difficult to manage. The lack of trained and expert infection control practitioners became the most prominent issue as the crisis unfolded. Nurses from other clinical roles were "deputized" into becoming infection control practitioners. There was no established link between Infection Control Practitioners and the POC making it very difficult to get clarification on key issues. It was also difficult to network with colleagues as there was no central body that wasn't already overwhelmed. Public Health had a different structure and different information than hospitals, which only added to the confusion. Some of the Public Health staff were

"I have never worked this many hours in any job. I was working from 7 a.m. to 10 p.m.. My life was my work. I don't think I could have continued much longer." (PHN)

seconded to other roles which created a resource drain in some areas of the province.

"I would feel lethargic from wearing the mask so long. I just prayed that I wouldn't make an error, I was doing about 6 checks of all the medications because I couldn't think straight." (RN, Staff Nurse, Acute Care)

Another very frequently mentioned health and safety issue during SARS was related to the extended use of face masks. Nurses were expected to wear masks for entire shifts on a daily

basis during the many weeks of the crisis. Despite several requests (from RNAO and the SARS Nursing Advisory Committee) to the POC and to employers that hourly breaks be encouraged so masks could be temporarily removed, most nurses did not have this opportunity and some reported that they worked entire shifts without any break due to staffing shortages. Nurses complained about a constant burning irritation of the throat, tightness in the upper chest, headaches, allergic skin reactions, swollen lips and tongue, dizziness, lethargy, sleep disorders and the exacerbation of other health problems such as asthma. Some nurses reported that they could taste and feel the fibers from the mask and were concerned over what might be the long term effects of prolonged mask use.

"I didn't sleep the night before I decided to work in the SARS unit. I knew that one suction catheter from a SARS patient would have enough virus in it to begin an epidemic." (RN, Staff Nurse, Acute Care)

"People were sick and worn down but we all hesitated to phone in sick. We knew we were needed." (RN, Staff Nurse, Acute Care)

Nurses continued to work, despite extreme fatigue and feeling ill. One nurse noted that the team could not have continued much longer due to exhaustion. Holidays were desperately needed and some were provided but there were no backup resources. In the homecare sector, the regular work of case managers was left unattended. Concerns were also raised about the potential for error that occurs when people are exhausted.

Nurses were the largest group of health care professionals to acquire SARS in the course of providing patient care. The Workers Safety Insurance Board (WSIB) reported that 79 nurses have missed work longer than 15 days due to SARS. As the crisis continued, a few of the nurses shared that sometimes the fear was paralyzing. Of particular concern was the fear of exposure to SARS while carrying out more invasive care. Nurses also expressed fear that the protection available to them was inadequate – particularly during prolonged and often emergency procedures, such as intubations.

"We assisted with intubations - a procedure that is often rushed in emergency situations. We also worry about the risk in caring for patients with BiPAP and HFO (pressurized systems) as there can be leaks in the system and we are more exposed to the virus." (RN, Staff Nurse, Acute Care)

Resources, Knowledge and Supports

Nurses reported divergent experiences in the availability of supplies and equipment to meet the emerging new standards for personal protection and patient safety. Some nurses reported always having the right equipment. Screening processes and assessment clinics were set up literally overnight. 'Hepafilters' were readily available in some hospitals and nurses reported that "you could feel them working immediately". SARS units were well supplied. In some hospitals, designated dressing rooms and "scrubs" were provided for staff so that they did not take their uniforms home.

"Negative pressure rooms were "make do." We understand that we needed to care for patients but didn't trust the safety of the set up." (RN, Staff Nurse, Acute Care)

"It is disappointing that after 22 years of infection control precautions, fit testing has never been considered in hospitals." (RN, Staff Nurse, Acute Care)

"We felt protected and more confident with the right equipment." (RN, Staff Nurse, Acute Care).

"We equated the lack of available supplies with a lack of support. They were not protecting us, why?" (RN, Staff Nurse, Acute Care)

An equal number of nurses reported significant problems in acquiring needed supplies. In the early stages of the crisis, some nurses were expected to re-use masks, some would break protocol if supplies were lacking and some actually used the same gown. Some units would hoard stock to ensure they would have what they needed. Several participants reported inconsistencies in the availability of supplies across their facility. Rooms were not well equipped and not set up for respiratory isolation (i.e., curtains or partitions separating patients; lack of anterooms).

During the second phase of SARS, mask fit testing was initiated as a new standard that posed additional challenges. This process required industrial specialists to perform precise tests taking 30-45 minutes for each nurse. A variety of masks were needed to meet the individual safety needs of staff. Consistently, nurses expressed concern over having practised through phase one of SARS without fit testing their masks.

There was considerable diversity in how the fit testing process was conducted. Some nurses reported that if an appropriately fitting mask was not available, the nurse could not, and would not, safely work in that clinical setting. Other nurses reported very different experiences. On several occasions, the fit testing process was abandoned as too many "failures" occurred.

"I was initially told that I wouldn't have to work in the unit if the mask didn't fit. I went through several masks and none of them fit properly – so I was sent home. The next day I was called and told that they weren't going to be doing any more mask fit testing." (RN, Staff Nurse, Acute Care)

Communication

Nurses in all sectors expected open and honest communication during the SARS crisis. The majority of nurses cited significant and serious problems in the quality and quantity of communication.

One frequently cited problem was that the directives from the POC changed frequently and unexpectedly. Directives would be announced on a Friday in the late afternoon with fewer staff or resources available to operationalize them. Concerns were also expressed that the input from providers was absent in the design of directives, a factor that contributed to difficulties in implementation. The directives posed unique problems for certain sectors. For example, the directives differed for GTA and non-GTA geographic areas. In the long-term care facility sector, many facilities are located on the boundary of the two regions. Some noted that the directives were interpreted differently depending on the facilities proximity to the epicenter hospitals.

"Empowerment of staff was a key to the retention of staff through this crisis... The people who provided the care were the most knowledgeable about the safety needs of staff and patients." (Manager, Acute Care)

Many nurses, particularly direct care providers, expressed concern about “too many secrets.” They reported that the seriousness of some situations was not openly conveyed to everyone. In one example, nurses who assisted with a bronchoscopy procedure on a patient given the diagnosis of “viral illness,” subsequently found out the procedure was done to rule in or out the diagnosis of SARS. In some settings, nurses were told they could not know how many patients and staff had acquired SARS due to confidentiality reasons. However, other organizations provided the data readily – of course without revealing specific identities. Several nurses expressed concern, reporting that they could no longer trust their employers or some members of administration to tell them what was going on.

*“...too many secrets.”
(Nurses in all sectors)*

“Barriers to communication such as the need to cascade a message beginning with the CEO to the directors, the managers and then to staff on 3 different shifts.” (RN, Manager, Acute Care)

Managers reported being well informed of issues and changes. However, being overextended with two, three, and sometimes four units, they barely had time to communicate with their entire staff, let alone take the time to provide individualized support. Some reported how exhausting it was to continually communicate verbally on an individual basis to large numbers of staff.

Decision Making Opportunities

There was widespread agreement that nursing involvement in the decision making process at all levels was critical to successfully manage the SARS crisis. Failure to listen to the voice of nursing resulted in some of the most significant negative outcomes for patient care, for nurses, for Toronto’s economy and for the profession.

“I want to be listened to when I question the need for isolating a patient, I have had experience with TB and I know when something needs to be done.” (RN, Staff Nurse, Acute Care)

Some organizations very successfully involved nurses in decision-making at the unit and organizational levels. Opportunities included unit-based problem-solving meetings, organization-wide practice councils and staff helping to shape provincial directives into policies and procedures. The most successful organizations were also described as having a “visible Chief Nursing Officer” and a “visible CEO.”

Nurses in other agencies reported high levels of frustration, anger and dissatisfaction over being left out of the decision making process and over their agencies failure to recognize the value of nurses’ clinical expertise.

Workforce

Staffing

Nurses told us that staffing needs were barely met even before the SARS outbreak. Some critical care units had managed to increase staff levels following months of concerted effort, but most reported continued shortages. The reliance on agency nurses was assessed by many as 50% of the overall

“So many clients were fearful about nurses coming into their homes. This, along with the additional time to explain and reassure meant added time with each individual.” (RN, Staff Nurse, Home Care)

"We couldn't have survived without them...but it is not sustainable. They were exhausted and had the added burden of wearing protective precaution equipment over an extended period of time."
(Senior Nurse Administrator, long-term care).

staffing complement. Nurses described how pressured they felt to come to work sick, and to work double shifts, as sick time would not, or could not, be replaced. A few nurses shared that they were called to come to work even though they had a "cold" or "flu like symptoms." In long-term care facilities funding (and thus staffing levels) is based on the previous year's activity. Thus staffing shortages were a major issue, with any added costs for one area leading to cuts in another. Senior administrative staff, from the long-term sector, shared how nursing staff responded so magnificently to the crisis, but warned that this intensity of response cannot be sustained.

SARS only magnified staffing difficulties. The creation of SARS units increased the demand for nurses, met in most cases by redeployment from other areas. Hundreds of Public Health Nurses were redeployed to the communicable disease team, leaving their regular work unattended. Exhausted nurses became ill, some with SARS; others were quarantined. In one instance, a single case of SARS resulted in the quarantine of 180 staff for 10 days. SARS also cast a spotlight on the number of nurses working for multiple employers. For home health nurses, the added time needed to pick up personal protective equipment, to review new directives and to spend more time with clients, increased the impact of staff shortages.

Workload

Nurses described workloads as heavy, with staff working at maximum capacity even before SARS. Nurses cited more patients and greater complexity of care needs as key factors influencing their increased workloads. Well before SARS, long-term care facilities witnessed significant increases in resident acuity, and public health and home care nurses also reported excessive workloads.

"We were already dealing with a tired staff, resources were tissue paper thin."
(Senior Nurse Administrator, Acute Care).

All participants agreed that workload increased dramatically with SARS. The protective equipment, added fatigue, frequently changing directives, increased anxiety of patient and family members and the added burden of having to carry out non-nursing tasks, as ancillary workers were reduced, all contributed to the horrendous workload. In long-term care facilities the restriction of visitors meant the loss of assistance in feeding residents.

"...horrendous, a battlefield, staff worked full out, barely coped, people just worked and worked and worked" (Senior Nurse Administrator, Acute Care)

Nursing Supply and Employment Status

Graduating adequate numbers of well-prepared nursing students into the profession is critical. Even prior to the SARS crisis, there were challenges to the nursing student experience. There were pressures in having adequate numbers of clinical placements and too often the clinical settings were compromised for the same work environment reasons that challenged nursing staff. Staffing shortages and increased workload meant that nurses in the various clinical sites had little time to invest in students' learning, such as acting as preceptors.

SARS only exaggerated these issues and brought additional challenges. The preparation of nursing students ended abruptly with the outbreak. Clinical placements were immediately cancelled as the SARS outbreak spread among acute care facilities. The implications of this were very serious. Some students had not completed enough clinical hours to progress to the next term. Alternate placements were sought but ultimately, they were not of the same clinical value. Summer placements for students were also cancelled as various hospitals remained closed due to SARS. One college reported that 100 placements have been postponed until the fall.

Many of the nursing students reported that they wanted to continue their clinical placements and were not afraid of the risk; many shared that they had missed out on great learning opportunities. Indeed, students in their final year, one term away from graduation, were in possession of critically important skill sets that could have eased some of the staffing problems during the crisis. Since this did not happen, students felt undervalued by the system; a reaction that only intensified with the knowledge that students in other health profession programs continued in some capacity (e.g. medical students and physiotherapy students).

*"We wanted to help and we wanted to be part of it. Why were we left out?"
(Nursing Student).*

"They cut all the nurses and the nurses needed to... find jobs. Now these nurses say: I don't want to give up my other jobs because I may lose this one tomorrow." (RN, Staff Nurse, Rehab)

Several of the Senior Nurse Administrators interviewed shared their surprise in finding out so many full-time nurses were also working for multiple employers. Nurses have told us they hold multiple jobs for several reasons, including financial need, lack of job security, and to enhance clinical skills.

Nurses continue to report difficulty in finding full-time work, even though they want and seek it. Several surveys^{22 23} substantiate this fact. Other nurses have chosen to work on a casual basis because of working conditions, including excessive workload and work intensity. This, in turn leads to exhaustion and stress, and prevents them from providing the care they know is needed.

Nurses also reported on another critical nursing supply issue – the reliance on nursing agencies to provide staff. Even before SARS, many clinical areas relied heavily on agency staffing to fill their needs. Some nurses reported that their units were staffed by two to three agency nurses for two to three shifts on a daily basis, or up to 50% of their overall staffing complement.

There were several problem issues in the utilization of nursing employment agencies for staffing purposes. The concerns about the use of agency nurses grew significantly during the SARS outbreak. Nurses shared their frustration about the added risk of working alongside other nurses who did not know the area – or patients. The fact that these agency nurses were being paid two or three times more in salary created considerable aggravation, anger and dissension among other nurses. We also heard from some organizations who shared that the higher pay given to agency-based nurses was an incentive to ensure there were enough nurses to meet the high care demands of SARS patients.

The reality that many agency nurses were unfamiliar with the organization and did not always have the required skill set, added even more responsibility to the regularly employed nurses. Resentment grew as nurses who were paid less were more accountable to come to work with patients with SARS every day, and agency nurses had the choice to refuse.

Another source of tension erupted as government made the decision to contract with one specific agency to provide staff for SARS alliance hospitals. Several of the other employment agencies complained about government foregoing an open and transparent tendering process. After much outcry, the contract was cancelled, but not before nurses endured more hardship. Even now we are hearing from nurses who claim they have not been paid for the work done during this solo-contract period.

Nurses told us about other sector-specific nursing supply issues. The long-term care facility sector faces the reality of 20,000 new beds – and the need to provide adequate staff to care for residents with higher acuity levels than ever before. In homecare, 70% of RNs work part-time and casual as a result of the competitive bidding process which has encouraged lack of employment stability and lower overall compensation packages. Nurses expressed fear that if SARS had entered the community, the sector would have been unable to respond.

With SARS, nurses were suddenly confined to one employment site, decreasing even further the supply of available staff. Organizations barely coped. And nurses suffered as their income dropped. The experience of SARS has offered all of us a stark reality check: we cannot allow this extreme over-reliance on part-time and casual nursing staff to continue. The nurses who shared recommendations on employment status were very explicit in their call for the need to immediately create more full time jobs, with appropriate pay, to reduce the need for nurses to seek multiple employers. They also suggested that an immediate opening of more full-time positions and an improvement in working conditions are the recipe for a decline in agency utilization.

Nurses need strong assurances that government and health-care organizations will take action to ensure system stability. During the years preceding the SARS outbreak, organizations like RNAO and others expressed clearly their concerns over system instability. These concerns have received limited attention.

"If there is any silver-lining to SARS, it is the spotlight it put on broader nursing issues. On the casualization of the profession. On the fragmentation of the profession. On the shortage that we have. And on the stresses that it creates in our public health system. And I hope, from this understanding that we have gained, that we can make changes." (RN, Administrator, Home Care)

Overtime and Absenteeism

Almost every nurse reported significant overtime usage pre-SARS as a key indicator of the reduced supply of nurses. Overtime and sick time rose dramatically as the SARS outbreak spread across the city. Increased overtime led directly to increased sick time. This reality is not surprising and has been discussed in the research literature in general, and also specific to Ontario.²⁴ Excessive use of overtime and related sick time are also linked to insufficient numbers of full-time nurses and an over-reliance on part-time, casual and agency staff. As discussed earlier in this submission, casual and part time nurses form the majority of nurses with multiple

“Working conditions will need to change markedly if we will keep the young in the profession. You can't just give them piecemeal work one day here another there – they need a home base and they need lighter workloads” (RN, Staff Nurse, Acute Care)

employers. Thus, when a last minute sick call for the upcoming shift is received in a unit, it is often the full-time nurses who, by the mere fact of being there, are requested to fill in the gap. Interim results from focus groups conducted by the Nursing Research Unit (NRU) reinforce this reality.²⁵ As a consequence, absenteeism is also

higher among full-time nurses than their casual and part-time counterparts;²⁶ a truly sick cycle has been created and must be urgently reversed.

Recruitment and Retention

Prior to the SARS outbreak, many acute care hospitals were involved in aggressive recruitment activities for specialty areas such as critical care, operating rooms and emergency departments. Retention of staff was an issue, with the majority of participants reporting high staff turnover rates, particularly junior staff who would move from a part-time or casual position in one agency to full time at another.

These gaps were accentuated during the SARS crisis. There are still some unknowns as to the impact of SARS on retention and recruitment. When asked to predict how SARS would impact the profession, a cross section of responses resulted. Some nurses talked about their decision to leave the profession; that the SARS experience was the final straw. Others were just as committed to staying and described the obligation they have to continue and the satisfaction that nursing work provides.

Many nurses described their commitment to the profession but at the same time noted that change must happen for them to stay and also to ensure that there is a nursing work force in the future, for good and bad times.

“I am not sure that staff could do this again. The perception of risk has changed.” (RN, Manager, Acute Care).

Service Issues

Coordinated and Consistent Care

Problems in coordinating decision-making between sectors was a system-wide issue. Public health was not adequately integrated with hospitals to manage SARS and we also heard about conflicting decisions by MOHLTC and Public Health. Nurses commented on the lack of province-wide coordination and a great sense of system confusion. That confusion was at times very apparent during the daily POC media briefings.

“No one put the picture together.” (RN, Staff Nurse, Acute Care)

At the operational level, nurses provided several examples of uncoordinated efforts that might have contributed to the spread of SARS and the lack of speedy containment. Significant concerns have been expressed that even though several nurses from the same unit came simultaneously sick with “Atypical Pneumonia,” they were not immediately hospitalized but sent home. Another example related to quarantined nurses. Public health nurses told us that they did not always know which nurses were in quarantine. Thus, they could not follow-up with them.

Nurses shared other examples of how the coordination and consistency of care were severely undermined during SARS. As hospitals rushed to establish assessment and screening services, services were significantly delayed. Nursing staff from one hospital reported that during the first days of screening, their emergency department was so overcrowded that patients were given pagers and told to wait in their cars until someone could see them. The increase in agency staff also undermined care coordination. Nurses shared how one critical care unit *did not have a single hospital-based nurse* over an entire weekend. In some settings, as the outbreak progressed, strategies for managing SARS patients became more coordinated. In one organization, an interdisciplinary team was designed to provide care and consultation specifically for SARS patients throughout the organization.

"Hospitals directed staff to go into quarantine without always informing public health." (Public.

"We were not familiar with the routines. This was more difficult for junior nurses who could not easily piece together the clinical needs of patients by just reviewing the chart. (RN, Staff Nurse, Rehab).

Continuity of care was compromised in rehabilitation settings, as large numbers of staff were re-deployed to other areas needing staff. Nurses shared that patient assignments often changed daily. In one location more than half of the nurses remaining had never worked on that particular unit.

In the throes of SARS, as hospitals closed, ambulatory clinics, diagnostic services and elective surgery were impacted. Appointments, dialysis treatments and transfers were slowed or suspended. Families had to resume care responsibilities for some clients as day programs were cancelled. Facilities became aware of how reliant they were on external providers, such as physiotherapy and occupational therapy.

"Resident care suffered as they did not have the services available to help them progress in their treatment plan." (RN, Staff Nurse, Long-term Care)

Public health nurses (PHNs) reported that many programs were pushed aside in order to deal with the SARS emergency. Programs for new babies, prenatal classes, parenting classes and school programs were cancelled. Outside of the SARS issue, the remaining nursing teams were working with only a third of the usual staff. Urgent cases were prioritized and managed but there was concern for the clients who fell through the cracks and received no service at all. PHNs also heard from people who were quarantined and were refused service by their family physicians. They spoke of the need to establish policies and procedures to assist the family physicians to manage similar cases.

Professional Standards

It is heart wrenching to hear nurses' accounts of struggling to provide safe and quality care through what they described as a "mental fog" caused by the extended use of the mask.²⁷ Nurses also spoke compassionately about the visiting restrictions imposed on families and the negative effect this had on the quality of care. Some patients had no visitors for three weeks and nurses described

"I quadrupled check my medications, terrified of making an error through the mental fog with which I must now contend." (RN, Staff Nurse, Acute Care)

feeling emotionally torn over being unable to provide the care they knew was needed. The ability to properly assess patients was also diminished. There were limits imposed on the amount of time nurses could spend in the room with patients and as interaction time decreased, patients began to feel more abandoned. The personal protective equipment also created a barrier to communication that was more pronounced with elderly patients. Many suffered confusion as a result.

"My patient is terrified. I squeeze his hand with my vinyl coated one, and try to reassure him in the face of dreadful uncertainty and our mutual fear." (RN, Staff Nurse, Acute Care)

Public health nurses expressed concern over how SARS will influence their ability to maintain and strengthen the health promotion and illness prevention aspects of their practices. They commented that SARS was the latest in a growing list of public health threats that have erupted in Ontario in recent years. Others include: contaminated water, increasing incidence of TB, and the overall reduction of public health services and funding since the early 1990s. These urgent problems direct attention and resources away from essential promotion and prevention programs. Thus, the standard, or level of services, to sustain health are significantly compromised in an environment that too often undervalues health promotion.

"I felt more like a prisoner than a patient. The food was dropped outside my room; couldn't they wait a minute and give it to me? I know, they were afraid of getting it (SARS) too – I just cried..."

The "nurse as the patient" was a new and frightening experience for many. While some nurses felt well cared for, several expressed concerns. Key issues related to delays in diagnosis and treatment, lack of emotional support and social isolation. The words from nurses ill with SARS, and from nurses who cared for their nursing colleagues with SARS, shed an important light on professional standards – as experienced by nurses themselves.

Surge Capacity

Nurses describe a system stretched beyond capacity as it struggled to deal with SARS. Organizations in all sectors were significantly compromised as they pushed to "ramp up" in response to the outbreak. The internal capacity to manage SARS was lacking in many acute care hospitals. In addition to staffing shortages, this included the lack of respiratory isolation capability and the subsequent "scrambling" to purchase hepafilters and convert rooms to negative pressure. Also, there were simply not enough rooms in Emergency Departments to contain the spread of this type of disease and patients on several occasions were cared for from behind curtains. When an organization could no longer manage the volume of patients coming to their door, patients were transferred to other facilities. This contributed to the ongoing spread of disease.

Similarly, capacity issues in long term care were most closely related to the availability of nurses, although equipment and physical plant concerns were also factors. During the SARS outbreak, admissions of patients to some facilities were stopped due to excessive workload and staff shortages. Hospital alternate level of care (ALC) patients were quickly transferred into available long term care beds to make space available for SARS patients. This in turn meant that community needs temporarily became secondary to the needs of acute care patients. Long term

care facility standards do not include the availability of isolation areas to an extent that would be needed if an outbreak occurred in such a facility.

The public health community did not have the surge capacity to respond to SARS without compromising existing public health services, particularly in areas serviced by nurses. Thus services were severely limited to important program areas – such as new breast feeding mothers and at-risk families.

In summary, not one sector possessed the surge capacity to respond to SARS without significantly compromising other programs and providers. Ultimately, patient and resident care was also compromised.

Concluding Remarks

Forty-four Ontarians died as a result of SARS. Two nursing colleagues and one physician colleague were among the casualties. Many more were ill, and most are still unable to fully regain their lives.

Fear, pride, commitment and anger are intermingled, leaving us both numb and determined. And, as painful as the experience has been for Ontarians and for health-care workers, one thing is clear: we must be better prepared.

We cannot complete this report without bringing forward the collective voice of the profession.

RNAO played a strong role throughout the SARS outbreak and a few key highlights must be captured in this report.

SARS Unmasked: Celebrating Resilience, Exposing Vulnerability brings out the voices of the many nurses who worked and lived through the SARS outbreak in Ontario. We consulted many, but could not reach everyone. Some voices remain silent for fear of reprisal from their employer, shame of being identified as having had SARS, or by choice.

RNAO's Role during the SARS Outbreak

Key Activity	Date
Formed and Chaired SARS Nursing Advisory Committee (SNAC)	March 31st, 2003 Cmte. met every other day throughout the Outbreak and continues to meet monthly
SARS online support board	April 4 th 2354 messages from RNs and RN students posted
SARS Hotline-phone/email	June 25 th , 2003
Intense online, phone, in-person advice and counseling to nurses	March 20 th ongoing. Hundreds of nurses have received support
Liaisons with nursing students and faculty	March 20 th to June 30 th
Weekly online bulletins to all RNAO members	March 20 th to present
Ads of acknowledgement and encouragement to the work of nurses in major newspapers	April 5 th
RNAO calls for a Full Public Inquiry	May 31 st , 2003
Developed and launched VIANurse - online registry for voluntarily redeployment of nurses during emergency situations (www.rnao.org)	July 23 rd
Media number of RNAO hits in the media = 643	- March 20-August 15

The anguish is deep, and the nagging question remains: could the deaths and devastation brought about by SARS in Ontario have been lessened, had people listened to nurses?

SARS was an experience that the nursing profession will never forget. To many nurses, it was the absolute worst of times. And yet – in so many ways – it underscored the resilience and strength of nurses. To be sure, the response to SARS exhausted individual nurses and tested the very limits of their professional commitment. If nursing is to be preserved and enhanced so it can continue to contribute to health and healing, systemic changes must occur. The recommendations starting in page 4 outline what nurses need from governments, employers, nursing associations and Justice Campbell so we can be better prepared – and better respond – for the next infectious disease outbreak or other major challenges. The next crisis might be just around the corner and we *must* be better prepared.

Justice Campbell, our submission “unmasks” nurses’ experiences with SARS. While we fully acknowledge the unknown, we refuse to accept the avoidable. We are hopeful that you do too. Only in doing so, will we collectively learn and prepare for the future. And only in doing so, will we collectively strengthen our health-care system. We owe it to those that were ill and to the families who’s loved ones died. We owe it to ourselves and to future generations.

“All during the month of May nurses were sounding the alarm bells, and nobody listened. And this isn't the first time that nurses have used their knowledge and tried to come forward, saying 'we're at the bedside 24/7— we see patterns.' But no one gave us the credit.

They call us part of the team. But we don't have the decision making capability, and I think that needs to change. Our knowledge needs to be turned into something, which can be part of a health care team, where we share decision making and authority. ” (RN, Staff Nurse, Acute Care)

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