Ontario Nurses' Association

COVID-19
Questions and Answers
for ONA Members

Updated April 29, 2020

The Ontario Nurses' Association held a series of Telephone Town Hall and Facebook live events to answer members' questions regarding the 2019 Novel Coronavirus (COVID-19).

Below are the most frequent questions we have received arising out of these discussions and from those submitted through Facebook. The specific questions and answers in the chart below are grouped together under topic headings. Additional questions and answers may be added to this document, as more town halls are held. More information and government guidelines can be found on the ONA website at www.ona.org/coronavirus.

Please note that the answers below may change and we will update as the government's Guidance, Directives and Orders change through the course of the pandemic.

1. Proper Personal Protective Equipment (PPE) and Usage:

ONA's position on PPE has been clear from the outset of the COVID-19 pandemic: when a nurse or health-care professional is screening or treating suspected, presumed or confirmed COVID-19 patients, everyone should undertake a risk assessment to determine the proper PPE in the circumstance.

Directive #5 now specifically spells out the new measures for point-of-care risk assessments to guide requests for proper PPE. These new measures should assist with requests for access to proper PPE.

ONA will continue to advocate for more supply of PPE but know that we also need to conserve what is available to safely care for COVID-19 patients.

Government also issued a directive forcing every health-care provider in the province to report on a daily basis the status of their supplies of PPE and the burn rate. The government through this new procurement process and division will distribute/redistribute supplies based on this data.

When dealing with suspected or confirmed COVID-19 patients, a point-of-care risk assessment must be performed before every patient interaction.

If a member determines, based on their professional and clinical judgement, that health and safety measures are or may be required in the delivery of care to the patient, then the worker shall have access to the PPE, including an N95 respirator or equivalent or better.

If the employer does not agree, there are higher levels of PPE and environmental controls that can be considered.

In the end, however, the employer cannot unreasonably deny access to the appropriate PPE.

Research suggests that it may be possible to wear N95 masks for extended periods (up to eight hours); however, this is exceptionally limited and infection control protocols must be maintained.

ONA would only consider extended use if there is adherence to all possible administrative and engineering controls, and first and foremost, compliance with the manufacturers' guidance and advice.

Masks cannot be reused and must be discarded if:

- The mask has been used for any aerosol generating procedure;
- The mask is contaminated with blood, respiratory or nasal secretions or other bodily fluids of patients; and/or,
- Following any close contact with any patient co-infected with any infectious disease requiring contact precautions.

When N95 respirators are required, they must also be fit-tested to be effective.

2. Pregnancy and Autoimmune Conditions

Another common question is how are nurses and health-care professionals to manage at work when pregnant for this period, or for other health-related needs, such as autoimmune conditions?

In all these cases, we do know that both ONA's collective agreement, as well as the Ontario Human Rights Code, require your employers to accommodate you in the workplace.

ONA is taking the position that pregnant workers, and those with immunity conditions, should ask to be assigned to no risk/low risk areas.

If there is no work in no risk/low risk areas, then you could be placed on administrative leave and be paid by the employer. If not, then we would file grievances.

If this is an issue for you, reach out to your Bargaining Unit President. Your Bargaining Unit President has support from ONA staff, and we will work with you and your employer to provide accommodation during this time.

3. Payment for Sick Leave and Lost Hours

In the case of self-isolation when sick and lost hours, we are taking the position that the employer should be keeping staff with no work, self-isolation or lost hours whole.
We do encourage you to apply for EI and/or the Federal benefit if your employer is not keeping you whole. Ensure that your Bargaining Unit President is aware so that grievances can be filed on your behalf.

Of note, with the new Emergency Redeployment orders, we expect that employers will find work for all registered staff. If you are reassigned to available work, you are entitled to orientation to ensure you are safely able to care for or perform the work you are expected to do.

4. Self-Isolation After Travel or After Exposure and Return to Work

Another question we are often asked is about self-isolation for health-care workers after travel, or after exposure.

We have been advocating with the government on this issue insisting that nurses should have to be self-isolated for 14 days when they come back into the country, so that they can come back to work after those 14 days, rested and healthy and ready to provide care.

This actually should relieve some of the stress on nurses and health-care professionals, who are working through those first 14 days.

We do not want ONA members who come back into the country to be a risk to other health-care workers or to patients. This is why we are taking this position.

However, you must be aware that this is different from the Chief Medical Officer of Health's (CMOH) recommendation that is saying for health-care workers, not for workers outside of health-care or other essential workers in the province, but if health-care workers are well and not showing COVID-19 symptoms, you are expected to come to work. You are to self-monitor and determine if you have any of the symptoms that have been identified for COVID-19.

If you become unwell, you are to go home immediately, and then self-isolate for 14 days.

If you are unwell when you return to the country, then you tell your employer that, and then you begin your self-isolation at that point in time for 14 days.

However, the CMOH's recommendation also permits employers to identify workers who are essential to the operation of the facility, who can be ordered into work without self-isolation.

Do ensure that you protect yourselves and make sure that when you go into your workplace that you report to your health and safety staff to let them know your travel history.

The second part of the question around self-isolation is who is going to pay for you to be at home, not working?

It is ONA's position that if you are in self-isolation, the employer should be keeping your salary whole. Some employers are, in fact, doing that and then there are some that are not.

So, if you become ill, contact your ONA Bargaining Unit President. Your Bargaining Unit President can work with ONA staff and seek to ensure that your salary is kept whole during this period of self-isolation. ONA's goal is to have all of our members paid. And that includes if you're forced to self-isolate, just because you have returned to the country.

We also know there have been changes made to Employment Insurance (EI), but we do want to make sure you are kept whole and not at the reduced rate under employment insurance.

Recently, we have received questions related to COVID-19 testing for health-care workers and the process to return to work.

The main problem is that the Chief Medical Officer of Health (CMOH) has not issued a clear directive on testing for health-care workers and the process to return to work.

In addition, clear guidance has not been issued in terms of health-care workers returning to work who are deemed critical to operations.

So far, we only have guidance that has been issued.

First from Chief Medical Officer of Health, dated March 19, with recommendations to all parts of the health-care system that health-care workers should not come to work if they are sick (symptomatic).

However, if deemed critical to continued operations, the recommendation is that workers undergo regular screening, use appropriate PPE for 14 days and undertake active self-monitoring, including taking your temperature twice daily to monitor for fever, and immediately self-isolate if symptoms develop and self-identify to your occupational health and safety department.

If a health worker begins to feel unwell while at work, they should immediately don a surgical mask and notify their manager and/or occupational health and safety department.

The second guidance is from the Ministry of Health, dated April 10.

This essentially says, if critical to operations, return to work and self-isolate at work.

This means maintaining isolation outside of work until 14 days after symptom onset (or until two negative swabs) but continuing to work while wearing appropriate PPE at work, and not working in multiple locations.

The most recent guidance is from the Ministry of Health, dated April 17.

This guidance clarifies that in exceptional circumstances where additional staff are **critically required**, an earlier return to work of a COVID-19 positive health-care worker may be considered under work self-isolation recognizing the staff may still be infectious.

In the case of a positive symptomatic health-care worker, there should be a minimum of 72 hours after illness resolving, defined as resolution of fever and improvement in respiratory and other symptoms. In the case of a positive asymptomatic health-care worker, there should be a minimum of 72 hours from positive specimen collection date to ensure symptoms have not developed in that time.

This guidance, as you can imagine, is causing quite a bit of confusion and inconsistency in application across the province in various settings, and we are continuing to press the Chief Medical Officer of Health to issue a directive that if people are positive, or have any symptoms, certainly they should not be at work. However, we have continued to meet resistance. When employers say all health-care workers are deemed critical to operations, it is causing quite a bit of anxiety and uncertainty.

Please check with your Bargaining Unit President to inquire about whether your position is critical to operations given the reduced capacity in hospitals at this time.

5. Limited Right to Refuse Unsafe Work

We are receiving numerous calls and questions from members asking if they can refuse to work because the employer will not provide them with an N95 respirator when being asked to screen/assess possible coronavirus patients, and/or care for persons under investigation or confirmed as coronavirus patients. The new measures for point-of-care risk assessments should be of assistance.

Under the *Occupational Health & Safety Act* (OHSA), health-care workers in places like hospitals and long-term care homes do have a right to refuse unsafe work, but it is more limited than industrial workers and community health-care workers.

When dealing with infectious disease, health-care workers can refuse to work as long as the elements of the work and workplace are NOT INHERENT in their work and refusing does not endanger them or someone else.

Where the employer fails to implement measures or protections, this is not inherent to the work of health-care professionals. Instead, there is an increase in the risk over and above the normal conditions. We must distinguish inherent dangers from dangers that the employer can eliminate or reduce. We do not believe it is inherent in your job to work without proper protective equipment (PPE), just as it is inherent in a firefighter's work to go into a fire without adequate PPE.

If an employee believes the employer does not have the necessary PPE (including N95 respirators) or other safety measures in place to safely screen, assess and/or care for a person under investigation – or care for a confirmed coronavirus case – and choose to exercise their right to refuse unsafe work – ONA believes the employee would have this right. It is not inherent in their job to work in an area with an infectious agent without PPE, known to protect against the hazard, even though OHSA puts limits on your right to refuse.

Please speak with your Bargaining Unit President for further advice on the steps to follow.

6. Redeployment of Health-Care Staff

The government has issued a number of emergency Orders on redeployment in each sector.

Please speak with your Bargaining Unit President about the principles ONA developed for redeployment.

The chart below lists examples of specific questions received and the answers for your review.

Question	Answer
ONA Actions	
What is ONA doing on members' behalf during this crisis?	Leadership is raising issues at all government tables. Leadership is in communications with senior government officials from the Premier's office to the Minister of Health and the Chief Medical Officer of Health. Your ONA President is responding to multiple requests from provincial media throughout the day. You can see our media releases here: https://www.ona.org/media-releases/ Directions on labour relations matters have been sent to staff labour relations officers and to Bargaining Unit Presidents.
What is going to be put into place to make the government accountable to our profession, to keep us safe? I worked during SARS, and that was a horrible, horrible time, and we were promised that that would not ever happen again, and it feels like, "Yeah, actually it is. Here we are."	We think what's important is the government has been working to get PPE, but if there had been stockpiles we were promised post-SARS, and post the Campbell Inquiry, and all those things, we wouldn't have been in the mess we were in the first place. We know it gets said from time to time, and certainly the press is on it: "Why haven't we had lessons learned?" We will continue to advocate for that. The supply for the moment is slowly improving, as we've said before we do not agree, there is no science that supports sterilizing N95 masks. Yes, we know that an N95 if it's properly fit tested, and the wearer wears it properly provides 95% protection, which is why we think the addition of a face shield, and other precautions, which is also why we talk about other precautions, it should provide very good protection. We are on this government, the press is all over this

Question	Answer
	government, and we will hold them accountable. We are holding them accountable now, and we will continue to do that. You should not have only one mask per shift. If your mask is soiled or damaged, it needs to be changed during your shift. If you're having trouble, call your bargaining unit president, and we will help to intervene.
Our employer is interfering with our joint health and safety committee. What is ONA's strategic plan to highlight these negative actions by our employers that's bringing risk to not only nurses but the public at large?	Unfortunately, the issue you've described is happening with a number of hospitals and so the joint health and safety committee is not getting information that they require, to assess the effectiveness of infection control programs, the monitoring of staff who are contracting COVID-19, exposures to those individuals. We are escalating that issue to the Ministry of Labour. The Ministry of Labour is not being very supportive and in the calls being made and the attempts to try to get this information shared and to ensure the effective functioning of the joint health and safety committee. So, the reality is we are actually pursuing appeals at the Ontario Labour Relations Board, where there are at least three different hospitals, where there is insufficient sharing of information, obstructing the work of the joint health and safety committee. Part of the role of the joint health and safety committee is to identify situations that may be a source of danger or hazards to workers and to make recommendations to alleviate and address those hazards. If the Ministry of Labour inspector is not supporting the work of the joint health and safety committee, we will pursue it to the labor board. PPE is for nurses and health-care workers. It is your armor. It's your protection to keep you in the workplace, to protect Ontarians as we move forward through COVID-19.
Self-Isolation and Return to Work	
Will I be paid if I have to self-isolate after travelling outside of Canada?	The Ontario Hospital Association (OHA) has recommended to the hospitals that staff are paid when on self-isolation. We know that some hospitals are and some are not. Where a hospital is not paying staff, we are filing grievances.

Question	Answer
	Please contact your Bargaining Unit President if a grievance is necessary in your case. You can also apply for Employment Insurance (EI) in the meantime to mitigate your loss. (The federal government has announced changes to EI such as removal of the one-week waiting period).
Despite the new government guidance, my employer is still telling me to come in to work after I have travelled outside of Canada. What should I do?	The Ministry or Health released its directive related to self-isolation, found here: www.ona.org/coronavirus The directive for the most part is in line with Minister Elliott's announcement and requires health-care workers to self-isolate. However, the directive contains an exemption for "particular workers who are deemed critical, by all parties, to continued operations" that allows these individuals to work, while self-monitoring. You can find the directive here: https://www.ontario.ca/page/2019-novel-coronavirus See travel section #6. You need to contact your Bargaining Unit representative who will advocate that you need to stay at home in self-isolation for 14 days. If the employer does not agree, then you may need to obey now and grieve later. ONA has filed grievances and will challenge the direction to return to work prior to the 14 days, including contacting the Ministry of Labour. Our position is that not all health-care workers are deemed critical or essential workers.
Travelled back home recently. I'm told by my employer to return to work immediately. Should I not be in self-isolation? Public Health says self-isolation.	You should be in self-isolation for a period of 14 days. ONA is pursuing the issue of employers requiring return to work if you are asymptomatic.
As a regular part-time employee, how will I be paid in self-isolation?	The government has relaxed rules for access to EI for those in self-isolation. We are advocating for full pay, and some employers have already committed to do so.

Question	Answer
If I have vacation booked and am now in quarantine, how do I get the vacation back?	If your vacation has to be cancelled, you should get it back. Vacation should not be used when in self-isolation, but may be used as a method to receive pay while disputing the requirement to do so through a grievance.
Hospital has decided that staff coming home to Canada do NOT have to self-quarantine/isolate for 14 days.	There have been revisions to the directive that speaks to self-isolation for "essential workers" such as healthcare. There should be an individual agreement between the parties for each and every worker being required to return to work as it relates to them being "essential."
How are the other staff and elder patients protected, if management and Occupational Health and Safety allow workers returning from vacation in the United States to work without quarantine?	This is one of ONA's many concerns and we remind the Ministry of Health, government officials and employers of this daily.
What is ONA's position on members who need to isolate themselves because they are in a high-risk group (autoimmune disease) or living with someone who is?	ONA acknowledges and advocates for individuals who are high risk to remain in self-isolation, or minimally away from risk.
What do you suggest for me (older nurse over 70) re: going to work as RN in a general hospital?	Each individual has the right to determine the risk to their health in consultation with their physician. ONA encourages you to seek your physician's advice as to your level of risk.
The absence of employee screening.	Staff should be screened for travel and symptoms and self-isolate as identified.
If you are self-monitoring and begin to show symptoms and do test positive, how far back will contact tracing go? And from when were you contagious?	Public Health would determine the length of time back for contact tracing, which would need to be based on your history.
Do I as a nurse have access to the COVID-19 tests, so I know if I am a potential hazard to my aging parents and young niece? What is the best way of not getting it, if a patient is exhibiting symptoms of the disease?	Test kits are only available at Assessment Centres. There are fraudulent ads indicating you can buy them on line. It is not recommended you use these test kits as they are not valid. The best way to protect yourself is by using proper Personal Protective Equipment at work and if symptomatic, by self-isolating and contacting Telehealth regarding access to testing.
I had a fever last Friday and was sent home but told that if do not have a cough I can work my next shift. Should I come to work?	You should speak with your physician and/or contact Telehealth for advice on the need for testing or self-isolation.

Question	Answer
A health-care worker tested positive and other workers and patients were exposed. When will directives on self-isolation include exposure?	Direction is out regarding the need for self-isolation related to contact with a positive case. Confirm Direction with Public Health.
My work called me and said I was exposed to COVID-19 but asked me to come to work tomorrow. Shouldn't I be isolating and aren't I putting my residents at risk?	You should first call Public Health but our position is that you should not be at work. It sounds like you work in long-term care, and you would be putting residents at risk until you are cleared. We have been speaking to Ministry about accelerating COVID-19 testing for our members and have had repeated conversations with the Chief Medical Officer of Health – health-care workers need to have high priority for testing. Ensuring you are safe to return to work is important to protect Ontarians, residents, and other health-care workers.
I saw on the news if you have come into contact with a positive COVID-19 patient; you are advised to stay home for 14 days. What happens if it is your co-worker and you did not know it was your co-worker and they were not wearing a mask when you had contact with them?	The news has been clear that if you are exposed, you need to stay at home. You should consult with your Public Health Unit. I would err on the side of saying it was from work if you had COVID-19 positive patients, and fill out an exposure form and potentially a Form 6, if necessary. The Form 6 requires the hospital under the Occupational Health and Safety Act to provide information to your employer.
I have not shown any signs or symptoms of COVID-19. Public health says that I do not have to test for COVID-19, but my employer wants me to do so. What's your recommendation?	The action plan that just came out actually says that the Chief Medical Officer of Health has made recommendations that everyone working in long-term care gets tested, and this is all about making sure that we don't have anyone working in long-term care, or anywhere for that matter, who could be an asymptomatic spreader. It's a challenge. It's a choice you would have to make, but we do know they're trying to get everyone to be tested in long-term care, and we've been lobbying to make sure all are tested. In the early going no one was being tested and we were saying health-care workers actually should be a priority.
I was in direct contact with a resident who tested positive resident for COVID-19. I was having headaches and kind of fatigue but my test came back negative. I didn't go into self	Our advice to you is if you have symptoms you should go and get tested again. You may have been tested before you converted. People don't convert at the same time. You could

Question	Answer
quarantine because my supervisor told me I have to come to work and use PPE. I'm worried because some of these residents are showing symptoms even though they're negative and I'm worried about my family. What do I do?	have tested at a time when your viral load was very low. We suggest you get tested again. You stay off work until the test comes back and you were exposed at work and your employer should be paying you. And if your doctor says that you've got symptoms, they should tell you to stay off work and you should be off until you get cleared. And you should also speak to your bargaining unit president who can liaison with the labor relations officer, just to ensure everything's in place for you.
Proper PPE	
What is ONA's position on the use of N95s versus surgical masks?	It is the position of all the major health-care unions that the scientific evidence **does not confirm with certainty** that the virus spreads solely by droplets. The virus can be borne by air, and therefore N95 respirators are the appropriate level of precaution when screening/assessing for potential infection and when caring for confirmed or suspected COVID-19 cases. To the extent that there is conflicting evidence, the precautionary principle and the higher level of protection applies. Conduct risk assessments for each area to determine the appropriate Personal Protective Equipment (PPE) required. Please visit our website at www.ona.org to participate in an online email campaign regarding proper PPE for nurses and health-care professionals.
My employer is reassigning staff to higher-risk areas.	The employer has the right to reassign but must follow the reassignment language in the collective agreement. The provisions of the collective agreement are overridden by government Orders, as issued for hospitals and long-term care. You should consult with your Bargaining Unit President.
For an NP who has been redeployed to a COVID-19 assessment clinic, the employer isn't providing an N95. What can ONA do to help her get an N95?	The minimum screener equipment should be a shield and mask. It is ONA's position that it should be a N95 mask given fit testing. ONA is

Question	Answer
	filing grievances for the failure to provide N95' routinely and when requested.
At what point can health-care workers refuse to care for patients if we don't have the proper PPE? We are already running low on masks. Both surgical and N95s.	The right to refuse is an individual right tied to how safe the worker believes working conditions are in the circumstances. Limited stock should not change the concern that the worker has. It is the employer's duty to provide adequate supply.
If there is no Isolation room available, the intubated COVID-19 patients will stay in the main unit and separate with the curtains, because COVID-19 is droplet precaution.	If there are no isolation rooms, there should be a private room with an anteroom for donning and doffing of PPE. Curtains are not enough and ONA does not agree that this virus is droplet precautions only.
The yellow PPE gown is easily broken and is not water proof. Is it safe PPE for COVID-19?	ONA advocates for the highest level of PPE for contact with COVID-19 patients – suspected or positive. A wet gown is not an effective barrier nor is a wet surgical mask.
When home visiting prenatal clients and young babies, we are being told to continue as usual. Being in a home for an hour without any kind of PPE, does this not put us and the clients at risk?	A risk assessment and screening of the situation you are entering is required. If there is any concern that there may be a risk – PPE should be worn or the visit can be delivered through an alternate means e.g. telephone.
Labour and Delivery: it's impossible to be the recommended six feet away distancing from patients and their partners. Are we allowed to wear masks and gloves during the entire patient care?	It is ONA's position that PPE should be worn if unable to maintain social distance or a shield between caregivers and patients.
We are only screening patients when they arrive on our unit in labour; should we be screening their support people as well?	Yes
How can we move forward with the employer, if they won't fit-test? We can't be prepared.	Grievances should be filed, if the employer is refusing to fit test. This can also be raised with the Joint Health and Safety Committee as an identified worker risk.
Can our employer deny our concern to swab certain patients that we think are exposed to COVID-19, even if no travel history? Regarding droplet precautions are employees allowed to file grievances or call the Ministry of Labour, if employer is adamant about surgical masks being adequate?	Travel is not the only criteria for swabbing. Screeners should not be questioned if they believe there is cause to swab. ONA is filing grievances for the appropriate level of PPE. There is a limited right to refuse to work, contact Bargaining Unit President for further information.

Question	Answer
What does ONA consider to be an aerosolized treatment? If I am working with vents, it is aerosolized? Do you agree?	An aerosolized treatment is any treatment or intervention that can cause "spray" such as intubation or a vent that could become disconnected.
Can I be forced to work beyond my commitment if I have to care for family at home?	No, you cannot be forced to work beyond your commitment, unless the provisions of the collective agreement have been overridden by a government Order i.e. hospitals and long-term care. Speak to your Bargaining Unit President if this happens.
Regarding care of ventilated patients, patients with COVID-19, should we be wearing an N95 at all times while in the room?	Under the new directive, it is our position that if, based on your Point of Care Risk Assessment, you believe that you need a N95 then that is what you should be wearing. We also interpret the new directive as requiring a N95 when working with intubated patients.
My concern is we have gone forward with needing to use N95, but we get pushback from the hospital saying they do not have them or they are running out. I continue to say that is not my problem. Can I continue to say that?	The hospital is responsible for your safety. The directive says that if you believe, based on your Point of Care Risk Assessment, you believe you should be wearing a N95 then one will not be unreasonably denied.
We are going to be getting COVID-19 patients. We do not have N95 masks. The only time they have been available is when the patient was coding. If we refuse work, what happens?	Go back and do your point of care risk assessment, determine if the patient is symptomatic, if they are coughing – you should be able at that point of care assessment to wear an N95 mask. If not, raise the issue with your Manager and call your Bargaining Unit President. You should go through the new process. Your hospital should have access to N95 masks and they should be available on the unit. We know they are going to control them as many hospitals have reported theft. If not, let us know and we will intervene and help you out.
I am in ICU; we have a number of COVID-19 positive patients. Most of our 107 RNs feel we should have scrubs. We have some management walking around in scrubs, physicians gets scrubs, residents get scrubs and we are denied. There are scrubs available in OR change rooms. As nurses, we are not allowed to use them. We should not have to bring dirty uniforms home. They have given us instructions on how to wash them. Heard today that nurses in Quebec	Infection control principles support using hospital laundered uniforms; that way you are not carrying it outside of the hospital. We will have to raise this issue with the Ministry and OHA because this has not been addressed. You should check if your hospital has any old uniform policies. If your hospital does not supply scrubs, you should come to work in street clothes, change at work, and then put your uniform in a plastic bag before you return home. We have been in contact with Quebec

Question	Answer
are getting scrubs. What is ONA's position on this?	nurses. There are some situations where they are providing scrubs but it is not everywhere. We agree there should be things in place so you have the proper uniforms. We will continue to raise this.
We are trying to reduce the spread of COVID-19. From what I am hearing, we are reduced with the number of PPE or N95. When SARS was happening, people were much better at keeping health-care safe. We are approaching patients we know nothing about. Yet we are expected to be checking them to make sure it is safe to be at that point, then we find out they have a cough or a temperature, but then we have already been in contact. How is this reducing the spread of COVID-19?	It depends on where you work in a hospital and where you are assessing a patient. We say screeners should be using droplet precautions and perhaps an N95. We also know a number of hospitals have ordered special plexiglas screening booths that screeners can stand/sit behind that are protective without needing PPE. It depends on if you are in an in-patient area. You should have had report or some idea of what you are walking into. It is hard to answer the question without specifics. All patients are supposed to have been screened. Speak with your Manager or Bargaining Unit President to advise there is an unsafe situation.
I work in a day surgery unit. Because our patients are low risk, we are not allowed to wear PPE to avoid frightening patients. Should we not be allowed to wear masks and shields?	All of your day surgery unit patients should be screened before they get to you. If screeners identify any risk, you should be able to wear appropriate PPE. Most organizations have stopped elective surgeries. Screening must be done on any patient that comes in. If day surgeries are still happening in your organization, you want to make sure the screening process has been completed. Community spread is definitely a concern. As far as patients being frightened, any patient coming into hospital now should not be surprised to see staff wearing PPE.
Regarding risk assessment, where we suspect a patient may have COVID-19, we have been told that we still have to wear surgical masks. We do not feel comfortable. We would like to be provided with an N95. Can we request the N95 if we feel the patient may have it?	Care providers and health-care professionals should be doing a point of care risk assessment. If you are waiting for tests to come back or if the patient is known to be COVID-19 positive, the assessment is yours. The Manager does not make a blanket assessment about the unit and the risk. You should be doing that and assessing what level of PPE is reasonable for the patient you are providing care to. We know COVID-19 patients change very quickly, which is why it should be based on point of care risk assessment. If the Manager does not agree,

Question	Answer
	go back and have a conversation and pressure them to do that.
The new directive #5 indicates you are to don and doff as you feel needed but we are also being told to wear surgical masks until they are soiled. How do we know they are still good unless they are soiled or wet? What is the government/ONA's stance on changing these masks? I do not know when mine is soiled or not.	The new guidelines and recommendations say that surgical masks can be used over the course of many patients. Conserve masks as long as possible, but once wet, soiled or removed, you should immediately discard the mask.
My employer is directing staff to Human Resources if they refuse work and they may be disciplined. What does ONA recommend about how to approach this?	This is not a situation of obey now and grieve later. If you are trying to secure PPE or other health and safety measures and the employer is engaging in intimidation, discipline, or other harassing behaviour, that is actually reprisal and it is illegal in Ontario. All the worker has to say is they feel their safety is in danger. Get the support of ONA to be able to advocate on your behalf. Be ready with the point of care assessment. The employer is obliged to escalate the matter. It could be referred to the Ministry of Labour. No employer should be penalizing employees for engaging in their rights and protections under the Occupational Health and Safety Act.
What are the recommendations for PPE for those people working in community settings with high risk populations? Home visiting nurses in close contact with vulnerable mental health clients who require injectable medications? What are the recommendations for PPE for nurses who are seeing clients in clinic settings i.e. a person coming into a Sexual Health clinic?	Like other areas of practice a Point of Care Risk Assessment should be done for each client and based on that assessment you can determine what level of protection you need.
My question is what would ONA consider as a responsibility for the management to keep our members at the home safe during this pandemic. I understand nurses at hospital will have access to N95, but I'm a bit confused about nurses in long term care. Could you please advise if I need to ask questions towards the management on this issue. So far what I know is that they are supplying everything but N95, but that could change. I will need to clarify with them. Can you give me any directives?	All health-care workers, regardless of the practice setting they are in, should have access to proper PPE. The directives make it clear that they now apply to long-term Care. Like anywhere else, N95 masks should be available to you.

Question	Answer
We are missing shields and not having impermeable gowns for suspected and pending cases and we have yellow gowns. When will we get the right PPE?	I think first and foremost, if your hospital has a shortage of PPE, a protocol exists to deal with the new normal in the hospitals in Ontario. While we go through dealing with getting full supplies, the normal supply chain level will be about five days in every facility. Then hospitals, long-term care homes are supposed to go through the regional tables, the regional command tables to get additional supplies, and if they can't get them now, then going through the provincial stores, and that's the central command table. We have been told that there is not a shortage, actually that they are able to get gowns. There are shields being produced here in Ontario. Shields should not be shared between people. A lot of hospitals are actually distributing shields or googles to individuals with cleaning instructions, and then putting names on them so people know who they belong to. As for other places in the hospital, if you are following normal infection control respiratory precautions with other patients you should continue to do that. COVID-19 patients are being treated one way, but if you still have active TB patients, or whatever, those are in other areas of the hospital, you should still be using the appropriate infection control protocols that you have always used, and that includes supplies. If you haven't spoken to your Bargaining Unit President about the issues that you're having on your unit, please do so, and keep them in the loop as to what's happening.
We currently have a patient or a resident who's admitted with an open trach site, and we've been advocating for precautions with suctioning. What is ONA's position on appropriate PPE for this procedure?	Well, there is no doubt that deep suctioning on a trach, if you don't have an inline suction, is considered to be an aerosol-generating medical procedure. We think it's certainly, at a minimum, you should be wearing a mask and a shield, a mask and googles, and if you think it's infectious, and you've been fit-tested, and there are N95s, you should if you have a reason to assume that it is, that the patient is infectious, you should protect yourself, and wear the N95. It comes down to the point of care risk assessment.

Question	Answer
We were told by several managers, and our medical director that an N95 was not necessary at all, unless we are using high-flow oxygen such as anything over six litres per minute for our COVID-19 patients. Some of our patients are very unwell, end-of-life, requiring four to five litres oxygen per minute, some requiring IV antibiotics. Where did this directive come from, and what is your stance on that?	Our stance is yes, high-flow oxygen is an aerosol-generating procedure that would require an N95 mask. Non-invasive BiPAP or CPAP, any of those kinds of things, open suctioning, sputum induction, and the other thing we would say if you have patients who are aggressively coughing, then you should still be wearing an N95 mask if you are giving treatment to that patient. Push back on your employer, and reach out to your bargaining unit president.
In the home care sector, we go from home to home, and we cannot keep two metres distance from our patients. Our employer encourages employees to use one or two masks for the entire day with the googles. We are discouraged from using the gowns. How do we push the employers to be proactive, and take proper steps in ensuring that everybody is safe?	We advise you need to go back and have a conversation with your employer, probably with the assistance of your LRO. Given the advice of the federal Medical Officer of Health saying that we should consider everyone to be positive – and they're even now saying that people in the public might be thinking they should be wearing a mask – you should be wearing a clean mask going into every patient, so that if you did get exposed you are not transmitting. We think it's a conversation, you need to go back to your LRO and have with your employer, and push.
I'm assigned to a COVID-19 patient and my employer is only saying that we can only use N95 masks for aerosol generating procedures. Based on my point of care risk assessment, if my patient who's positive for COVID-19, is coughing significantly and a lot, and I feel like a lot of this is being transmitted in the air, is it warranted for me to ask my employer to wear an N95 for this patient?	Absolutely. It's warranted. It says in the directive. The directive says all health-care workers or other employees who are within two meters of a suspected or confirmed COVID-19 patient or residence, will have access to appropriate PPE and it can include a surgical mask or an N95 or better. If you think you're at risk because the patients are aggressively coughing, you have the right to ask for an N95 and if you're denied, you should call your bargaining unit president and get some assistance. But the employer cannot unreasonably deny it. If they think you're being unreasonable, they should question you, but they should still, if you insist, give you a mask until they can work through the procedure, until they can work through a process to determine whether or not it is appropriate. So you shouldn't be denied that mask.
When the PPE runs out, what is our obligation for patient care in a COVID-19 room?	At the moment, what ONA it is saying to government, to the Ontario Hospital Association, is that they should now be releasing better than the N95's out into the

Question	Answer
	system. We know there are a number of other products on the market and quite frankly, in the government warehouses and in some of your hospital storage areas. We know for instance that Sunnybrook is a hospital that was prepared to be an Ebola site, should we need it. So we know other hospitals have PAPRs, which are the hoods with the air purifying devices on them. There are N100s, there are a variety of other products on the market and we're saying they should be released to you now for two reasons. One, especially in dedicated COVID-19 units, whether it's an ICU or a COVID-19 unit, some of our members could start wearing that now. It would help save the supply of N95 masks. Even though some hospitals are saying you should save N95s and they're planning to re-sterilize them, we are saying at this point there is no science that proves that is safe and until we see science, we're not agreeing to use them. The government is telling us that they have supply and they are ensuring that hospitals have five to seven days. They do have supply in stock and they are expediting supplies to organizations. This issue around disposing of your masks in biohazard bags because maybe possibly there might be some science under development about reprocessing. All of that is really up in the air, the science is not clear on it. There is no endorsement from 3M for instance, at this point, and they're a major manufacturer of N95s and there are all kinds of theories. But, at the current time, there is no clear science on it and we are not agreeing to being able to use reprocessed masks. There are some outdated N95 masks that are out there in store rooms and what our position is on those, is that they could be used but could be used in place of a surgical mask if there's a shortage of a surgical mask. But, the issue with that still is around if there is integrity to the mask. So, we're not there and there's nothing that has been demonstrated to us that would change our position on it. We say go higher, don't go to lower protection.

Question	Answer
My hospital has an active outbreak going on and my manager is locking up supplies in her office and not leaving staff to have it. How is this acceptable?	Well, it's not acceptable. You have to have the access to personal protective equipment. If you don't have access, please raise it with your bargaining unit president, and with the joint health and safety committee. And, alternatively, if you don't have PPE, you should be calling in the Ministry of Labour. You could also, if it's on the evening or night shift, call the supervisor for the hospital in the off shift to get that information please.
We want some clarification. Do we have to wear N95 in the COVID unit because actually, our DOC, gave us only one N95 for patients who have a CPAP or BiPAP, when we have to go for connection or disconnect the patient, after that we're not allowed to use N95. Today my director of care said that, we had to do a swab for COVID-19. She says, "Oh, you don't need to use a N95. RNAO was saying for two weeks now that it's not airborne, we're okay. But you can use... You do an assessment and if you want the N95 you can have it. So why is another nursing profession going against what RNAO nurses are trying to do to protect the nurses?	Well this is actually exactly why we did an injunction at the other home. So you should be able to go in, do a point of care risk assessment and then determine if there's any risk of any kind of airborne generation of the COVID particulate. So absolutely, when you're doing an aerosolized generating medical procedure, like a disconnecting BiPAP or CPAP, absolutely then. If you're going in to turn the patient and they're COVID positive and you can't reposition yourself in a way, where you're not standing near their face and they're coughing or anything like that, you should absolutely, then depending on what the risk is, if you can turn away, then you should be able to then identify you need a N95. Further to that, those N95 masks should not be locked in offices. Those masks should be accessible so that if there's any kind of emergency, you can easily access the mask that is properly fitted to your face size. Please reach out to the bargaining unit president and your Labor Relations Officer.
Today, my director of care said that we had to do a swab for COVID-19. She says, "Oh, you don't need to use a N95. You do an assessment and if you want the N95 you can have it.	We believe that there is the possibility that the science is unclear and certainly there's more and more science all the time that this virus can be borne by air. And doing swabbing, some people react very aggressively. But it is the point of care assessment by the nurse, if you want to wear a N95, if certainly your employer is giving you the green light on it and that is your assessment... every nurse does a point of care assessment. But what we're talking about is when you approach a patient, you're already planning your assessment. You're planning what you're going to do with that patient and how you will approach them.

Question	Answer
	And that's really what the point of care assessments are all about.
I'm actually in a cluster facility in a long-term care facility and the employer provides us our PPE, but I actually have a COVID positive patient and the PPE that they provide us is just a gown, a mask, but a surgical mask that's made basically out of tissue paper. It's not the surgical mask that we know and a pair of goggles, like that's it. I'm wondering if the normal protocol would be to have access to an N95. I know that the office has it locked up, but if we need access to it, for let's say this particular case, should we get access to a N95?	If that patient is actively coughing and there's a risk and you see a risk depending on the treatment that you're going to provide and you think you would need access to an N95, then you should have access to it. You should definitely though, at a minimum, if you're looking after a COVID positive patient in any kind of community setting, you should have on at least a level two mask, not a level one mask. This is something you should take back to your bargaining unit president or your labour relations officer, was there an organizational risk assessment done for your setting and if not, there should be one done. And the joint health and safety committee should have been part of that process. But, those masks should not be locked up. We can't emphasize that enough... no good comes of masks being locked up. There should be at least a limited availability of the appropriate sizes out, for people to have access to. Even if they only leave two out for the morning of the size that fits you and then they come out and refresh, but they should absolutely not have the only ones in supply locked up.
We're being told by our educators and managers that regular care for ventilator patients, both COVID positive and COVID suspects, are just droplet care, citing I guess the ministry of health guidelines. Now from research that I've done, Vancouver Health Infection Prevention and Control, their indications, I'll read right off their document. Due to the heightened risk of unplanned AGMPs, IPAC recommends all ventilator patients with influenza like illness are placed on airborne and contact precautions and this refers to the disease and condition table for duration of precaution. I don't understand why one IPAC or Infection Prevention and Control in Canada is different from another one in Canada.	We're following the science and that is erring on the side of caution. That's the principle that we are working under and we're watching the science as it evolves. But the science is not clear. So that's why the allowance for the nurse's point of care assessment, particularly where there could be or is going to be aerosol generating medical procedures or the patient's response to the treatment could cause the virus to be released in the air. That's what we're talking about. And certainly if the COVID patients and the care of COVID and presumed COVIDs, those patients and the staff that are caring for them should be all cohorted. But aside from that, it is the individual nurse's point of care assessment and in the nurses professional judgment is what that's about. And if you believe you should be wearing a N95, you certainly seem to be in a clinical

Question	Answer
	setting that would be something you would want to consider. In Directive number five, which is the minimum directive, it's very clear as interpreted by the court, by the judge, that it is determined by the nurse who was providing the care. So it's not by your colleagues, and as the judge said, "The nurse is not directed to call management personnel to weigh in on the issue the point of care. It is the actual nurse in his or her clinical judgment.
I just wanted to bring to light what happened on our unit. So I work on a palliative medicine floor and as of Sunday there were 10 nurses that had tested positive. The unit is on outbreak, it is closed right now. We didn't really get it from patients that were isolated. It was more so our regular patients that were not isolated, who were asymptomatic. And a lot of times when we tried, when staff would wear gloves or gowns on just to protect themselves educators and charge nurses, would say, "You know you don't really need to do that," and some staff were even denied certain PPE. We never really had N95 on the unit to protect ourselves, even though we had a couple of trach patients. So there is a lack of PPE even in the hospitals, not just in long-term care and a lot of times nurses are being questioned with regards to their judgment. We had a patient on trach and who ended up being positive and didn't have the negative pressure so the nurses had to fight for level 4 gowns and all of that. It's just we are trying to bring it to light and we just want to know like what else we can do to bring light of the situation so that it doesn't really happen to others.	The fact of the matter is that Directive 5 is in place. It starts with a point of care risk assessment. Your employer cannot unreasonably deny you. And make sure your bargaining unit president knows what's happening and what the challenges are that you're facing and certainly your health and safety leads would be brought in as well to kind of help support you there. We are monitoring the situation in hospitals and what we are finding is sometimes they're imposing general rules or policies around where N95 should be utilized, and we have written to those hospitals to say that that is not consistent with the nurse conducting the point of care risk assessment, without interference from management. If nurses feel there health and safety is at risk, they can also initiate a work refusal.
I have a question about the using N95 on a ventilator COVID positive patient. Even though ONA has repeatedly said we should use the N95 mask on a point of care assessment, I find it very unsafe to go to a patient room who is positive for COVID and ventilated, and we had incidences that a ventilator became disconnected, during turning and then people being exposed and	The fact of the matter is N95 masks should never be locked up and not accessible. If there's an emergency, a code, anything, people should have full access to two N95s, even if the employers only put out a few of each size at a time and then replenish, they should never be under lock and key so that there is no way to get them. It is up to you at your point of care risk assessment. If you're

Question	Answer
without an N95 mask. The hospital continues to say it is safe to go into the room with the surgical mask and a face shield. And I find people coming out with the same mask outside and exposing other people as well. I feel very unsafe. In my unit, the N95 are locked up and only the charge nurse is allowed to take the keys inside and they decide who is supposed to get their N95 for the shift.	going to turn an intubated patient and there is a risk of that patient becoming disconnected, then you should have on an N95 mask. We know there is pushback, but you need to push back and do your point of care risk assessment and protect yourself and your coworkers. Speak with your health and safety rep, your bargaining unit president for sure let them know what's happening and certainly they can reach out for the support of our staff if they need to in order to pursue things and make sure that we can do everything we can to help support you because it is your risk assessment. It's the nurse's risk assessment, that's key here.
So there's a question that asks about allied health-care professionals performing AGMPs and can they do a risk assessment?	The Directive five, when it talks about health-care workers doing AGMP, it is speaking to regulated health professionals. So if you are a regulated health professional, yes you are doing risk assessments and if you are performing aerosol generating medical procedures, you also should have access to N95.
We are seeing issues screening people in the community and get 4 masks per week. asking about getting full PPE for the community.	There should be prescreening done before anybody goes into anyone's home. If they're wearing PPE, there should have been clear prescreening done and there shouldn't be cross-wearing PPE between people's homes. It's something that your bargaining unit should be taking back to the joint health and safety committee and to your employer and having conversations and your LRO can certainly help with that.
Working in Multiple Sites/Locations	
Should I be working at more than one hospital/agency?	Directive #3 does advise staff working in more than one long-term care home to speak with their employer. For other agencies, there is no directives against working at more than one hospital/agency, but we know from SARS that it makes sense to limit yourself to working at one employer. You should speak to your employers about this. You could pick up more hours at the one employer and not have to work at the other.
Employees who have two jobs at two different facilities - do they have to choose	Yes, there are now orders for working in only one long-term care home or in one retirement

Question	Answer
one of the facilities to work at during the pandemic?	home. We believe the other place they are selecting to work at should ensure sufficient hours. There is no directive in the hospital sector at this time. Some facilities are asking people to select one employer. We are saying it is up to the individual to choose. There are timelines in the orders.
I do know that we've been given the directive not to work in multiple long-term care homes. One of my employers is not ONA. Am I allowed to keep both jobs, or do I have to resign?	First of all, you don't have to quit your other employer to go, and work for another employer during this period of COVID-19. What the directive actually says, and what government has said to us, is you have to pick an employer that is your choice. If you want to stay in long-term care, you can. They have been funded to be able to increase your hours, so if you have an interest in staying in the long-term care home you can do that, ask them to top up your hours so that you don't lose wages. The other employer puts you on emergency leave under the Employment Standards Act, under the new emergency leave so they cannot terminate you, and you have a right to go back to that job at the end. Regardless of which job you choose you go on emergency leave, and you have that right to go back to the other job. You've mentioned that the other employer is not ONA. It doesn't matter because the Employment Standards Act would apply, it doesn't have to be a unionized facility.
Accommodations in Your Workplace	
I am on maternity leave. Is my employer allowed to order me back to work?	No, you cannot be forced back to work from maternity leave unless the provisions of the collective agreement have been overridden by a government Order i.e. hospitals and long-term care. Speak to your Bargaining Unit President if the employer tries to call you back to work. ONA has advised employers that calling employees back from maternity leave is NOT appropriate.
For nurses who are pregnant, how can they take time off for health reasons?	We are taking the position that pregnant workers ask to be assigned to no risk/low risk areas. Speak to your Bargaining Unit President who can work with your Labour Relations Officer if necessary. If there is no work in no risk/low risk areas, then you could be placed on administrative leave. Our

Question	Answer
	position would be that you should be paid by the employer and if not, then we would file grievances. You should apply for EI to mitigate your losses. "The Society of Obstetricians and Gynaecologists of Canada issued a committee opinion regarding COVID-19 during pregnancy. Information can be found on their website."
If you're a full-time nurse who booked vacation in the six week time only for it to be cancelled, will she be able take back the vacation days at a later time?	Vacation that has been approved can only be canceled with the RN's agreement unless the provisions of the collective agreement have been overridden by a government Order i.e. hospitals and long-term care. If it has been canceled, then the vacation days are to be put back into the vacation bank for use at a later time.
Day care closure - what does she do with her child?	If there are no family or friends that can care for the child, then there are Emergency Leave days under the Employment Standards Act (ESA) that may be utilized. The government has announced access to emergency child care centres for health-care workers.
I believe that now is the time for ONA to insist that these Attendance Awareness programs be discontinued or at least suspended for a period of time.	Any illness/absences related to COVID-19 do not count towards attendance awareness programs. If you employer is counting this illness, speak to your Bargaining Unit President.
If a caregiver is ill or unable to come, am I expected to work and leave my two very young children alone? What are my rights for this?	There is an Emergency/Caregiver Leave provision under the Employment Standards Act (ESA) that allows you to not attend work in this situation. You would notify your employer that you are utilizing an emergency leave days under the ESA.
Am I allowed to call in sick, even if it is unpaid, if I am caring for a sick child or spouse/family member?	Sick leave is intended to be used when you are sick; there are provisions under the Employment Standards Act that provide for Emergency/Caregiver Leave.
How many hours in a given day is it reasonable for me to be working right now?	You should not be working anymore that your regular shift. If the employer asks you to work longer, they should be compensating you according to the collective agreement. The College of Nurses' standards apply at all times.
For the sixth and subsequent illness, will there be an exemption?	COVID-19 illnesses are to be exempt from attendance awareness programs as well as

Question	Answer
	sixth and subsequent illnesses, especially if it is your employer putting you off sick.
Are we allowed to take a leave of absence due to school closures, if we have no babysitters?	Under the Human Rights Code, employers are obligated to accommodate based on family status. In order to establish that right, you need to be able to show you have no reasonable alternative to childcare. In relation to a child who may be immunocompromised, that could be raised as an issue under family status. If the child suffers from a disability, that could make exposure to a health-care worker a significant risk to the child. I would suggest providing basic information about why the child is immunocompromised and request to be assigned to a lower risk area. Disability of a child can be recognized when asking for an accommodation.
My question is related to being on maternity leave and the possibility of being called back into work.	If it should happen, please call your Bargaining Unit President. ONA has been clear with OHA that this is a non-starter for us. Your Bargaining Unit President will be able to assist you with that.
Compensation Issues	
I work in an outpatient testing department. If we shut down, would I be compensated?	The collective agreement provides for rights during a short-term layoff, which this would be considered unless the provisions of the collective agreement have been overridden by a government Order i.e. hospitals and long-term care. We are aware some employers are reassigning to other units so there is no loss of pay in that case. Normally, you would have the right to bump the most junior staff in the facility, accept the layoff, retire (if eligible) or move to a vacant position.
What is the mechanism for members without sick pay to receive some compensation?	Members without sick pay have the ability to apply for EI benefits.
I'm working in a COVID-19 assessment centre. Do I get hazard pay?	No, the collective agreement does not provide hazard pay.
Staff will not be paid sick leave if on mandatory quarantine (not ill) due to travel to any area outside of Canada. Staff who develop symptoms of respiratory infection after travel outside of Canada and are eligible will receive sick pay in accordance with their applicable collective agreement or non-union policy. *So my question is what is the real answer to the quarantine question?*	All staff who have travelled are to self-isolate for 14 days. The employer should keep your pay whole as recommended by the Ontario Hospital Association and the government for all non-essential workers. If this is not happening, please speak to your Bargaining Unit President to file a grievance. Apply for EI insurance to mitigate your losses.

Question	Answer
Redeployment Order – Adequate Training	
I work on Mental Health Unit. They are now cross training everyone from EDP to Mental Health and everyone from Mental Health to EDP. They are not doing simple training. Our staff are concerned because it is not the full amount of training. They are concerned that going forward, when COVID-19 is over, that this will be considered adequate training. Will this be considered adequate training? Will we be able to say I do not feel like I have the adequate skills, knowledge, etc.?	They can do that under the emergency redeployment order. Once the emergency measures are over, the collective agreement applies. Language related to reassignment applies. Once this is over, they should not be able to rely on what they did in the emergency.
Premier Ford announced that health-care facilities could hire untrained workers if they experience shortages while providing care. What is ONA's position on this?	Yes, in the redeployment orders, it does talk about that they can hire agency, temporary and volunteers. We are very concerned about the relaxing of standards in long-term care. We have expressed those concerns with the government. Under the order, they have the capacity to do that. Our position is that if they start doing that, we need to see what efforts they have taken to ensure adequate staff. We have continued to identify this as a risk and that it is too risky. Whether they do it or not, we do not know. Some family members are volunteering to help. Even the hospital order, says they can use volunteers to perform work. In most cases for ONA bargaining units, we are less likely to see volunteers than some of the service bargaining units. There is no doubt we are resisting having them come in and working in the capacity as a Registered Nurse.
Is it reasonable to refuse work in an area where you are not trained, e.g. Operating room to ICU?	You need to raise with the person trying to reassign you that you do not have the level of competency to work in that area. They will either decide to move you somewhere else or look to get you training. The legislation that the enacted the order suggests that people should be reasonably qualified, whether by training or otherwise. Employers are supposed to do an inventory of skills of employees so we need to make sure they are turning their minds to this. If a nurse does not feel reasonably competent, they can raise that as health-care professionals because of their college regulations.

Question	Answer
As a new nurse, my unit will soon be taking COVID-19 patients. I do not feel like I have had enough training. How can I protect myself?	Employers should be making sure you are comfortable. Ask for a mentor or preceptor. Shift the onus back onto your employer. Your employer is obligated to provide training on PPE and on the donning and doffing of gowns. Under the emergency order, it says to provide appropriate training.
Redeployment Orders	
Question related to order, Public Health has been deemed to be in a state of emergency. We are handling all calls and contract chasing. Are they allowed to have volunteers doing our work?	The emergency order allows other staff to be brought it but they should only be assigned work that they are qualified/capable of doing.
I have nurses who are being redeployed. Can they bump into a unit that they are experienced at or do they have to take the redeployment?	Redeployment is covered by the order and the order takes away bumping rights. We have asked LROs to work with Bargaining Unit Presidents to see if employers are willing to discuss redeployment. We may get agreement with some employers.
In the emergency deployment order, could I be pulled from my care coordinator position to bedside nursing during this 14-day period?	A new order currently does cover LHINs and home care employees but there is an option to not agree to be redeployed.
I am the clinical educator. We have learned that we will have 250 City of Windsor employees deployed to our home. We are short in all categories.	There is a new order that covers redeployment of municipal employees to maintenance in long-term care and into public health. I think it is a conversation you want to have with your employer sooner than later. It might be that they are preparing to redeploy in the event staff get sick. We know in the homes where there are outbreaks, a large number of staff have been tested or confirmed positive and are off sick and the other staff are under incredible pressures. I would hope they are not deploying into RNs and RPNs. Ask questions; find out what they are training them for. They also may not be able to provide fit-testing, given the shortage of masks. Call your Bargaining Unit President and LRO when you know more details.
My hospital has two separate campuses under one employer, and some of us from surgical areas have been deployed to ICUs for the interim pending this surge that has not yet happened. I had asked to go back to my original campus to do some project work,	Hospitals, and some other areas are setting up specific hospital sites that would look after COVID-19 patients, and they are trying to stop any kind of cross-spread. I think your question is probably going to be answered by government who has a planning table. They

Question	Answer
and was told that I can't go in between sites because I'm now considered 'hot' as being a worker in the ICU at the other campus, and dealing directly with the COVID-19 patients. When we do get resent back to our original home units, do we need to be isolated for the 14 days?	brought back the former Medical Officer of Health from the City of Toronto to help them plan post-COVID-19, and how we're going to get back to normal again at the end of this. But, we would suggest if you've been actively looking after COVID-19 patients, chances are that you're going to need to do swabbing with all health-care workers at the end. It might not be that you get quarantined or self-isolate for 14 days, it might be a lesser period of time. Hopefully we're testing more, and quicker by that point as well, and that you'll be able to get back to your site sooner than that. But I think it's a bit too early to tell, but I would suspect they'll be swabbing involved, and the period might be shorter for either self-isolation, or you may have to go back to your site and wear a mask so that you're not spreading at the other site when you go back. We will raise this issue again at the table with government, as they start to look at how do we come out of this down the road. We're not there yet, but they're planning on all of this. Sometimes testing has to be done repeatedly because the viral load, and initial test maybe negligible. But then after repeated exposures for instance, and or just a change in someone's condition suddenly their viral load can pop up, and they can become positive but asymptomatic. We think it's good infection control practice to keep people isolated so you don't have the transference. But aside from that it's about, "Okay, so then how do we come out of this? What are the processes or steps that can help?" We will follow up, and certainly see what they're thinking on that, and what the Chief Medical Officer of Health is thinking about that returning to sites.
Anyways, I'm a temporary full time job share and my day shifts were removed and then as of today, the night shifts that were guaranteed to me were removed. So my nurse manager made the decision for me to be, because I volunteered to work at the LTC, but on the basis that I also had a few of my night shifts given to me. Anyways, when	We've been really clear with the OHA and they agree with us. The advice they've given the hospitals is that they go with volunteers first and that before volunteers go in the IPAC team goes in, health and safety folks are in. You are still represented by the Ottawa Hospital. You're still covered under that collective agreement and all the rights and

Question	Answer
I went into my two shifts yesterday and the day before, when I went into the LTC, there was no nurse ... there was no manager, there was no directive. The LTC never gave us any. And they never gave us what rules were to adjust to what their needs were. So we pretty much went in there blind. So yesterday I went, got my temperature taken, and then I just... So basically both of my days of employment were on the high complete COVID floor. And, I felt lost. And then there was the nurse there that was running the place. She says, "Well, what can you do?" I'm here to help for whatever your needs are. So she was expecting me to give out medication and I said, "Listen, I don't have an access code to your items."	obligations that you have under that collective agreement, they're supposed to be training some kind of orientation certainly, to what the rules are. It was never expected that nurses or health professionals would walk in there and take over totally the work. In this scenario, you've described everything that's not supposed to happen. We've been clear with the OHA that people who are deployed, that there is supposed to be somebody from the hospital on site. And through them you are to then discover or find out what your role is and make sure that you have all the proper orientation that you need, so you can do it safely. You need to know their safety protocols, you need to know their policies. The first step is to raise this with your bargaining unit president. Also, the fact that hospitals are helping out and bringing people in, while it's a great thing, you should not be floating between homes. You should go to one home and one home only and you should be sent there for a series of shifts, so that you're not fluctuating back and forth between the hospital shifts and long-term care shifts. So that we're not risking cross infection or any kind of spread associated with our members.
This has to do with the nurses coming from the hospital to help out in long-term care. Last night they came in and the nurses were not oriented as to the floor. They did not have access to the computers to chart or to give meds and so they were of little help to the staff. So, staff going from floor to floor is a problem. We have an outbreak on the fifth floor, which has about 61 residents and the majority are positive.	Yes, we agree people should come in with some orientation so that when they come in they can help, they can chart. The one thing we do know is that if they are bringing in registered nurses or regulated health professionals of any kind coming in to help in long-term care, is that they need to come in, with orientation and training. Because the college standard says, they have to perform according to their registration level, not to the level of assignment they have. We need to protect hospital nurses who are volunteering and are willing and able to help, but they also need to be in a position where they truly are helpful in the long-term care homes.
What's the expectation if you're going to be redeployed to long-term care. Because when you work at your one facility in a hospital, you're used to your hospital setting, you know everything there but if you're	We've asked for there to be orientation and training. In some cases, you may be working with a registered nurse from the home, in which case you may not be expected to do a med pass. If you're expected to do a med

Question	Answer
expected to go into a long-term care setting, you don't know anything about the residents, you don't know in terms of their documentation and not much safety as well too? Because of the liability you are a practicing nurse unlicensed, right? So, that's just my concern. Like if you were to be redeployed, you're going to this nursing home today. It's just a safety concern.	pass, you're going to need orientation on the medication administration system as well as their charting. It is one of the reasons why we have been insisting that they develop a plan and they do orientation even if it's only a couple of days to get people in there, but to get people at least familiar. You should get some site orientation to where things are, where there are supplies and all of that, then we'll help with the issues about you feeling unsure about your nursing license and ensuring the college and nurses standards. There's a checklist for individual members who are being redeployed so you can review that and look at the things that we say that you need to know about before going. That checklist for membership is up on our COVID website.
I'm wondering why the principle for deploying hospital staff to long-term care is different than what we're seeing with the LHIN employees. For the hospital staff you said infection control and health and safety specialists are going in to make sure the site is safe prior to hospital staff going in to that facility and that's not what we're seeing when LHIN staff are being deployed there.	So one thing that's different is that for the LHIN staff, it's voluntary. But the reality is that the LHIN employee, you are still their representative and the employer should not be sending people into workplaces that are unsafe without PPE, without clear rules. Definitely we still stand by all those principles. The one thing that is different with the hospitals is that there is an order and the order clearly says there has to be some training and orientation. But, part of this starts with our bargaining unit presidents in the LHINs, going back to the employers and asking for exactly the same thing for the LIHN's staff who are volunteering to be redeployed, to be in place as will be for the hospitals and so that we can ensure the same principles.
They are deploying us from hospital to nursing home to do some swabbing for the patient and the staff. After that, going back to work. Is that allowed? I was just wondering. Normally they do four hours to do the swabbing there and then after that they want us to go back to work and then continue our shift for 12 hours.	People should not be going back and forth. If people are going back and forth, they should be changing their uniforms, they should be making sure that they're wearing a mask when they're back in the hospital. We have been asking the hospitals not to be doing this and risking cross infection. The other risk it puts people under, it also potentially can cause spread even in the long-term care homes and we don't need that either. You should be reaching out to your bargaining unit president

Question	Answer
	and really should be limiting the amount of mobility on shifts.
Nursing Students	
Is there any insight that can be given to graduating nursing students such as myself? We've all been kicked out of placement and are unsure when we are graduating but there is a need for nurses right now. We haven't heard anything from the CNO or the college yet.	The College of Nurses of Ontario (CNO) has released an Emergency Assignment Class for new graduates to assist in the pandemic respond. Learn more and see if you qualify here: https://www.cno.org/en/trending-topics/covid-19-faqs/#emergency-class-faqs
Are there any insights that can be given to nursing students who are unsure what will happen to our school year?	The provincial government has moved all post-secondary institutions into online learning. Online learning supports, including year-end exams, are available to postsecondary institutions. For labs and practicums, every institution is handling this differently. The Canadian Nursing Students' Association (CNSA) is inviting nursing students to share information about what's happening at your institution to inform an advocacy strategy. Please contact Nadine Abd Elmalak, the Ontario Regional Director, at ontario@cnsa.ca. ONA and the CNSA collaborated on a letter to the Minister of Colleges and Universities to raise nursing students-specific issues, including cancelled semesters as well as concerns around virtual labs and placement opportunities.
What financial supports are available for nursing students during this pandemic?	Applications have now closed for summer student jobs at ONA. Thank you to everyone who applied. There is a six-month interest-free deferral for Ontario Student Assistance Program (OSAP) loans (for both the Canada and Ontario portions). This applies to students who have graduated, who are about to graduate or who have recently graduated. Applications are now open for the federal governments Canada Emergency Student Benefit (CESB). This benefit provides financial support to post-secondary students, and

Question	Answer
	recent post-secondary and high school graduates who are unable to find work due to COVID-19. The federal government has also announced changes to the Canada Summer Jobs program to support students and young people. Students are encouraged to contact their local Member of Parliament and Member of Provincial Parliament to inquire about supports.
Is there any insight that can be given to graduating nursing students? There is a need for nurses right now. How can we help?	ONA is in close contact with the Canadian Nursing Students' Association (CNSA). You can read their emergency statement for students here. The CNSA is advising all nursing students to keep concepts of safety, liability and scope of practice at the forefront of their endeavours. The College of Nurses of Ontario has released an Emergency Assignment Class for new graduates to assist in the pandemic respond. Learn more and see if you qualify here: https://www.cno.org/en/trending-topics/covid-19-faqs/#emergency-class-faqs In addition, Ontario Health has launched a Health Human Resources Matching Tool. This tool allows workers and volunteers to enter their available hours and skills and they will be matched with an employer whose needs best match the worker. *Note that ONA does not endorse working or volunteering in more than one health-care facility during a pandemic. This is also advice recommended by Ontario's Chief Medical Officer of Health and now in specific orders for long-term care and retirement homes.*