**Joint Statement: COVID-19 and Personal Protective Equipment (PPE)**

Protecting the health and safety of health care workers[1] is an imperative for government, employers and unions/associations.

During the current COVID-19 pandemic, it is critical that appropriate steps are taken to protect the health and safety of all health care workers and patients in Newfoundland and Labrador. Utilizing the precautionary principle and preventing exposure to and transmission of COVID-19, while also preserving supplies of specialized equipment for when they are required to safely provide care, is critical.

This joint statement is issued by the Registered Nurses' Union Newfoundland & Labrador (RNU), Newfoundland and Labrador Association of Public and Private Employees (NAPE), Newfoundland and Labrador Medical Association (NLMA), Canadian Union of Public Employees (CUPE), Association of Allied Health Professionals (AAHP), Professional Association of Residents of Newfoundland and Labrador (PARNL), Government of Newfoundland and Labrador and regional health authorities to provide clarity on the approach in this province.

The parties agree to the following personal protection equipment (PPE) standards for health care workers in Newfoundland and Labrador dealing with suspected, presumed or confirmed COVID-19 patients:

1. The Chief Medical Office of Health will continue to provide guidance, based on best practice, supplemented by new evidence as it becomes available during the pandemic, on the criteria for determining suspected, presumed and confirmed COVID-19 patients.

2. All health care workers who cannot maintain a two meter personal distance from patients, residents, clients or family members who meet the criteria for suspected, presumed or confirmed COVID-19 shall have access to appropriate PPE (according to the procedure described in (3) below). This will include access to: surgical/procedure masks, fit tested NIOSH and/or Health Canada approved N-95 respirators or approved equivalent or better protection, gloves, face shields with side protection (or goggles), impermeable or, at least, fluid resistant gowns.

   The employers commit to provide health care workers with information on safe utilization of all PPE and employees shall be appropriately trained to safely don and doff all of these supplies.

3. A point-of-care risk assessment (PCRA) must be performed before every patient interaction to determine the risk of exposure and appropriate routine practices and

[1] Health care workers include all employees, contractors, managers, and those holding medical privileges.

additional precautions required for safe care [2] (Public Health Agency of Canada, 2017). Based on the PCRA, if a health care worker determines, based on their professional and clinical judgement of patient acuity, environment or otherwise, that PPE is required, they shall have access to the appropriate PPE. This will not be unreasonably denied by their employer, or the employee shall be deployed to another area. The PCRA should include the frequency and probability of routine or emergent aerosol-generating medical procedures being required. A health care worker who is not required to complete a PCRA but is required to perform work within two metres of a suspected, presumed or confirmed COVID-19 patient should consult with the direct care provider to determine appropriate PPE.

4. At a minimum, contact and droplet precautions must be used by health care workers for all interactions with suspected, presumed or confirmed COVID-19 patients or clients. Contact and droplet precautions includes gloves, face shields or goggles, gowns, and surgical/procedure masks.

5. Airborne precautions (including N95 respirator or approved equivalent or better protection) must be mandatory in areas where aerosol-generating medical procedures (AGMP) are being performed, are frequently performed, or in areas where there are intubated patients, including but not limited to emergency rooms, operating rooms, intensive care units and bronchoscopy suites.

   AGMPs include but are not limited to: intubation and related procedures (e.g. manual ventilation, open endotracheal suctioning), cardio pulmonary resuscitation, bronchoscopy, sputum induction, nebulized therapy, non-invasive ventilation (e.g. BiPAP), open respiratory/airway suctioning, high frequency oscillatory ventilation, tracheostomy care, nebulized therapy/aerosolized medication administration, high flow heated oxygen therapy devices (ex. ARVO, optiflow) and autopsy.

6. The parties agree with the importance of conservation and stewardship of PPE and will assess the available supply of PPEs on an ongoing basis. The parties commit to continue to explore all available avenues to obtain and maintain a sufficient supply. The employers, government, and health care unions/associations will assess and discuss the available supply of PPE on a weekly basis.

   Contingency plans will be developed for the possibility that the supply of PPE may reach a point where current supplies are anticipated to last for only 10 days (i.e. a

[2] Risk Assessments : 1) Health Care Workers have a responsibility to perform a Point-of-Care risk assessment before every patient interaction ; 2) Organizations have a responsibility to conduct an Organizational Risk Assessment and education/train staff accordingly; 3) Organizations should apply a hierarchy of hazard controls, which include elimination and substitution, engineering and systems controls, administrative controls, and personal protective equipment.

shortage). The government and employers, as appropriate, will be responsible for developing these contingency plans in consultation with unions/associations, to ensure the safety of health care workers.

**References**

Public Health Agency of Canada (2017). Routine Practices and Additional Precautions for Preventing the Transmission of Infection in Healthcare Settings. Retrieved from https://www.canada.ca/en/public-health/services/publications/diseases-conditions/routine-practices-precautions-healthcare-associated-infections.html

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