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October 2021 Edition

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Mandating COVID-19 vaccination

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Pandemic fallout.

In the wake of the pandemic, there are huge backlogs in the health-care system: delayed surgeries, postponed tests, undiagnosed illnesses.

Once again, nurses and health-care professionals will be expected to fill the gaps.

We know what's ahead. Increased workloads, more stress, and the painful reality of frustrated patients who need care, but there's simply not enough of us. Nursing is in crisis. Ontario's critical nurse shortage must be met with a meaningful show of support in order to keep skilled registered nurses in the profession.

#KeepNursingStrong

October 2021 Edition

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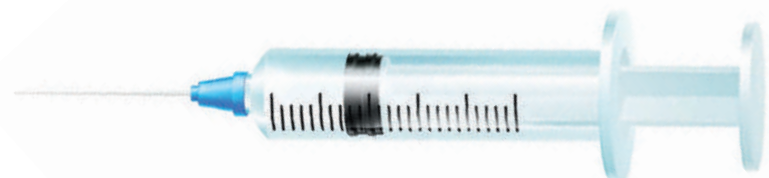
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Without a nurse a bed is just a bed

Solutions for the nursing shortage in Canada

By Linda Silas

Throughout the COVID-19 pandemic, we repeatedly heard about a shortage of beds in hospitals and long-term care. Field hospitals were deployed, equipment was relocated and supplies were stockpiled. In marshalling these resources, governments often failed to ask a basic question: who will provide the care?

The diverse roles and highly specialized skills of nursing staff were frequently overlooked during the pandemic. A competent critical care nurse can't be produced on demand. Nor are nurses readily interchangeable; their unique training, on the job experience and regulatory bodies dictate what they can (and cannot) do to care for certain patients.

As we move through the second year of this global pandemic, it is time we recognized the heavy physical and psychological toll this experience has had on nurses. Burnout is now endemic, and nurses are leaving the profession in droves.

When COVID-19 arrived at our doorstep, our health care system was already stretched thin. Now, after hundreds of thousands of overtime hours, countless back-to-back shifts of up to 24 hours in length, and many cancelled vacations, nurses are being told they cannot rest because our health care system has no give.

To make matters worse, some governments are eagerly looking to balance their books on the back of nurses through wage cuts, wage freezes and rollbacks. Quite a thank-you gift!

Many nurses have had enough of being under-supported, undervalued and outright disrespected; many are taking early retirement or heading back to school to shift to other, more rewarding, work. Others, in quiet desperation, are quite simply walking out the door.

In the first quarter of 2021, there were almost 100,000 vacancies in the health care and social assistance sector, representing nearly one in five vacant jobs in Canada. As the pressure on nurses continues unabated, these numbers will surely grow. Workload issues existed pre-pandemic; COVID-19 has made them worse.

The repercussions of the predicted nursing shortage, along with its negative impacts on wait times and patient care, are now evident in every province in Canada. Governments and employers are looking to fill the gaps by offering thousands in signing bonuses, attempting to lure nurses from other provinces. This is a temporary solution at best; moving nurses from place to place won't solve the nursing crisis.

Continued on page 6

UPCOMING DEADLINES

NOVEMBER 2021 ISSUE

EDITORIAL: October 6

ADVERTISING:

Display – October 22 | Material – October 26

Monthly Focus:

Technology and Innovation in Healthcare / Artificial Intelligence (AI)/ Patient Experience/ Health Promotion: Digital health advancements and new technology in healthcare including the use of artificial intelligence. Programs and initiatives focused on enhancing the patient experience and family centred care. Programs designed to promote wellness and prevent disease including public health initiatives, screening and hospital initiatives.

+ SPECIAL MEDTECH 2021 SUPPLEMENT

DECEMBER: 2021 ISSUE

EDITORIAL: November 9

ADVERTISING:

Display – November 19 | Material – November 23

Monthly Focus:

Medical Imaging /Year in Review/Future of Healthcare/Accreditation/Hospital Performance Indicators: advancements in healthcare for 2022. An examination of how hospitals are improving the quality of services through accreditation. Overview of health system performance based on hospitals performance indicators and successful initiatives hospitals have undertaken to measure and improve performance. A look at medical imaging techniques for diagnosis, treatment and prevention of diseases.

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World-first COVID vaccine booster trial shows third shot is very effective

Scientists with the Ajmera Transplant Centre at UHN have conducted a first-in-the-world randomized placebo-controlled trial of third dose COVID-19 booster vaccine for transplant patients that shows substantially improved protection.

"We knew from previous studies, that two doses were not enough to produce a good immune response against COVID-19 in transplant patients," says Dr. Deepali Kumar, Director of Transplant Infectious Diseases, UHN and joint-Senior Author of the study published in the *New England Journal of Medicine*.

"Based on our study, a third dose of COVID vaccine is definitely the best way to increase protection in transplant recipients."

The study enrolled 120 transplant patients between May 25th and June 3rd. None of them had COVID previously and all of them had received two doses of the Moderna vaccine. Half of the participants received a third shot of the vaccine (at the two-month mark after their second dose) and the other half received placebo.

The primary outcome was based on antibody level greater than 100 U/ml against the spike protein of the virus. In the placebo group – after three doses (where the third dose was placebo), the response rate was only 18 per cent whereas in the Moderna three-dose group, the response rate was 55 per cent.

"This is an important win for our patients because the results are quite conclusive," says Dr. Atul Humar, Medical Director of the Ajmera Transplant Centre, UHN and the joint-Senior Author of the clinical trial. "The third dose was safe and well tolerated and should lead to a change in practice of giving third doses to this vulnerable population."

NEUTRALIZING ANTIBODIES AND T-CELL RESPONSE

In addition to its primary outcome, this study also looked at the effectiveness of neutralizing antibodies – anti-

Dr. Deepali Kumar working at the research lab



bodies that neutralize the virus – and in this case, 60 per cent of the patients in the Moderna group developed neutralizing antibodies versus 25 per cent in the placebo group.

The study also found a big difference in T-cell response between the two groups. T-cells are another arm of the immune system that functions to prevent severe disease, and there was a substantial improvement in the ability of the three-dose Moderna group to allow the patients to develop a robust T-cell response against the virus.

The randomized double-blind placebo-controlled study is considered the gold standard in medicine, for showing whether something truly works or not. This study showed a definitively positive response in both major arms of the immune system: the antibody arm and the T-cell arm.

Additionally, the third booster vaccine was very well tolerated with only mild side effects and did not cause acute organ rejections – an important finding, as there were concerns that repeated vaccinations could increase the incidence of organ rejection in transplant recipients.

FAST-TRACKING SCIENCE AMID A PANDEMIC

Normally a study of this kind would take at least one year, but the team at the Ajmera Transplant Centre executed a rigorous and successful protocol in just a few months.

"We were able to do this because our team worked non-stop for months," says Dr. Humar. "And we are in a global emergency, lucky

enough to have generous philanthropic donors and an existing vaccine trials infrastructure already set up."

The results have been shared with regulatory bodies and decision-makers including the United States Food and Drug Administration (FDA), The Canadian National Advisory Committee on Immunization (NACI), the American Society of Transplantation, and others. The research team hopes for an expedited approval to benefit as many transplant patients as possible.

FUNDING AND NEXT STEPS

Research into the effectiveness of COVID-19 vaccines in transplant recipients has recently received a boost in funding for a national study. The Government of Canada, through its COVID-19 Immunity Task Force (CITF) and Vaccine Surveillance Reference Group (VSRG), is investing over \$2.8 million so that Dr. Kumar's team can further study the effectiveness of COVID vaccines across multiple transplant centres in Canada.

"Our goal is to help coordinate the efforts of provincial and national organizations that are involved in public health and vaccination research and facilitate information sharing among public health agencies and patient partners," says Dr. Kumar. **H**

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A bed is just a bed

Continued from page 4

Nurses' unions have repeatedly sounded the alarm about insufficient staff; this is now our main message for employers and governments.

Tragically, it took a global pandemic, and many deaths, to finally highlight the complete absence of federal leadership when it comes to health workforce planning and the implication this has for meeting Canadians' health care needs. Without basic data on health workers, including nurses, decision-makers are forced to plan in the dark.

Significant federal investments are also needed to better manage and support the health workforce.

Other countries, such as New Zealand and Australia, have taken proactive steps to bridge the gap between the nursing supply and public demand. They have created national coordinating bodies to provide better data and tools for workforce planning. We should follow suit. The federal government should create a health workforce agency with an explicit mandate to significantly enhance existing health workforce data.

To date, over 50 health care organizations, representing employers, associations, unions, and educators along with over 200 individual sig-

natories, notably including hospital CEOs, have signed onto this proposal.

In the meantime, the federal government urgently needs to invest in retention programs to stem the exodus of nurses from the profession. While recruitment and new hires are essential, new graduates depend on the mentorship of more experienced nurses, especially in the early stages of their careers.

The health workforce is an important public investment; it accounts for more than 10 per cent of all employed Canadians and nearly eight per cent of GDP. The construction industry in Canada has better workforce planning through Buildforce, than the health care sector. This enables the construction industry to forecast its qualified labour needs years into the future.

We need to do the same in health care.

If we value nurses, if we want to keep patients and residents safe, and if we want to ensure wait times don't continue to grow, we need to invest in better national health care planning.

In poll after poll, Canadians rate health care as a top priority; it's time for the federal government to invest in what matters to Canadians. ■

Linda Silas is a nurse and president of the Canadian Federation of Nurses Unions.



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Recent cannabis use linked to heart attack risk in younger adults

Adults younger than 45 years who reported recently using cannabis were two times more likely to have had a heart attack (myocardial infarction), and this link was stronger in frequent users, according to new research in CMAJ (*Canadian Medical Association Journal*).

These findings add to evidence from earlier studies showing a link between heavy cannabis use and myocardial infarction in people in hospital settings. The current study carefully examines the relationship that frequency of cannabis use and method of consumption have with risk of myocardial infarction in younger adults in the community who aren't at high risk of heart attack because of their age.

Researchers looked at data from a survey conducted by the US Centers for Disease Control and Prevention (CDC) including over 33,000 adults aged 18–44 years, of whom 17 per cent reported using cannabis in the past 30 days. Heart attack was reported in 1.3 per cent (61 of 4610) cannabis users and 0.8 per cent (240 of 28,563) non-users. Cannabis users were more likely to be male, smoke cigarettes, use e-cigarettes (vape) and be heavy alcohol drinkers, which may have contributed to their risk; however, these factors, plus other risk factors for myocardial infarction, were adjusted for in this analysis.

"With recent legalization and decriminalization, cannabis use is increasing in young adults in North America, and we do not fully know its effects on cardiovascular health," says Dr. Karim Ladha, a clinician scientist at Unity Health Toronto. "We found an association between recent cannabis use and myocardial infarction, which persisted across an array of robust sensitivity analyses. Additionally, this association was consistent across different forms of cannabis consump-

tion, including smoking, vaporization, and other methods such as edibles. This suggests that no method of consumption is safer than another in this regard."

This observational study provides information on the relationship, but not biological mechanism, for cannabis use and myocardial infarction.

"We analyzed the Behavioral Risk Factor Surveillance System data set (2017–2018) because it is the best available source for providing insights which are generalizable and nationally representative," says Nikhil Mistry, a PhD candidate at the University of Toronto. "As a young adult, it is important to be aware of the risks associated with cannabis use, especially in the current climate where we are exposed to a wealth of misinformation and non-evidence-based health recommendations."

Dr. David Mazer, a clinician scientist at Unity Health Toronto, adds, "Not only young adults, but physicians and other clinicians need to be aware of this potentially important relationship. Cannabis use should be considered in cardiovascular risk assessment. When making decisions about cannabis consumption, patients and physicians should consider its associated benefits and risks, in the context of their own health risk factors and behaviours."

"The large sample size, generalizability and detailed data on cannabis consumption of this cross-sectional study provide unique insight into this growing public health concern. Further studies and more data are needed to confirm these findings and elucidate the mechanisms contributing to cannabis-associated cardiovascular outcomes," the authors conclude. ■

"Recent cannabis use and myocardial infarction in young adults: a cross-sectional study" was published September 7, 2021.

Children and youth at low risk of severe acute COVID-19 during first part of pandemic: Canadian study

New research has found that children and youth may be at low risk of severe acute COVID-19, according to a study conducted during the first half of the pandemic and published in CMAJ (*Canadian Medical Association Journal*).

Researchers with the Canadian Paediatric Surveillance Program (CPSP) looked at hospitalizations of children with SARS-CoV-2 infection and factors for severe disease among children and youth admitted to hospital. The study included data on 264 children and youth with SARS-CoV-2 infection hospitalized across Canada between Mar. 25 and Dec. 31, 2020, and involved 2800 pediatricians. The data were collected before the Delta variant became dominant in Canada.

Of all the children and youth with SARS-CoV-2 infection admitted to hospital, 43 per cent were admitted for other reasons – such as medical concerns unrelated to COVID-19 or for infection control purposes – and the infections were picked up incidentally.

“Our study shows that the clinical presentation and severity of disease caused by SARS-CoV-2 infection were different in children than in adults in the first part of the COVID-19 pandemic in Canada,” writes Dr. Shaun Morris, co-senior author, infectious diseases physician at The Hospital for Sick Children (SickKids) and associate professor, Department of Paediatrics at the University of Toronto, with coauthors.

The authors initially expected that children and youth could be at higher risk for severe disease given what is typically seen with viral respiratory infections in the pediatric population.

The most common symptoms of the 150 children and youth admitted primarily for COVID-19 were fever (70%), vomiting (35%) and cough (34%). Half (50%) of the children and youth admitted to hospital with COVID-19 were described as having severe disease, 21 per cent of patients were admitted to the intensive care unit and 13 per cent needed cardiac or respiratory support beyond low-flow oxygen.

“Although children have recently been shown to have the highest seroprevalence of SARS-CoV-2 anti-

“OUR STUDY SHOWS THAT THE CLINICAL PRESENTATION AND SEVERITY OF DISEASE CAUSED BY SARS-COV-2 INFECTION WERE DIFFERENT IN CHILDREN THAN IN ADULTS IN THE FIRST PART OF THE COVID-19 PANDEMIC IN CANADA.”

bodies from infection among all age groups in Canada (3.3%), the relatively small number of pediatric hospital admissions highlights that children have less severe infection than adults even though they may be infected more frequently,” writes Dr. Fatima Kakkar, co-senior author, infectious diseases physician at Centre Hospitalier Universitaire Sainte-Justine, and associate professor, Department of Paediatrics at Université de Montréal, Montréal, Quebec.

Children and youth with severe disease were more likely to have an

underlying health condition such as obesity, and neurological and respiratory conditions (other than asthma). About half of those with severe disease had at least one comorbidity.

Infants and teenagers had higher rates of hospitalization than school-aged children. The authors suggest it may be because physicians were being extra cautious in the case of infants, while the higher hospitalization rates in teenagers might be because they may be at increased risk of infection and exhibit more severe disease.

Deaths in children from COVID-19 were very rare, consistent with previously published studies.

“Overall, the results of this study serve to inform parents and policy-makers that severe acute disease in kids was rare during the study period,” says Dr. Morris. “It is important to note that these study results reflect the burden of disease before the Delta variant.”

While the Delta variant is known to be more infectious, it’s not yet known whether it causes more severe disease in children or youth.

The authors advocate for continued monitoring in case of potential changes in COVID-19 epidemiology and better understanding of disease severity in healthy children and youth, as well as those with underlying health conditions.

“Characteristics of children admitted to hospital with acute SARS-CoV-2 infection in Canada in 2020” was published September 27, 2021. **■**

Problematic internet use and teen depression are closely linked study finds

Most teenagers don’t remember life before the internet. They have grown up in a connected world and being online has become one of their main sources of learning, entertaining and socializing. As many previous studies have pointed out, and as many parents worry, this reality does not come risk-free. A new study is one of only a few that examines PIU’s effects on older adolescents.

The paper, published in the journal *Child Development*, looks at data gathered by a longitudinal study of 1,750 high school students in Helsinki over three years.

The researchers identified three principal determinants of PIU among adolescents. The first was loneliness, defined as a lack of satisfying interpersonal relationships or the perceived inadequacy of social networks. Other studies on PIU also identified loneliness as a predictor.

Parenting practices, as perceived by the teen, also predicted PIU. The researchers looked at both parental caring, such as the expressions of warmth, empathy, interest and closeness towards the child, and parental neglect, defined as the uneven availability or unresponsiveness to the child’s needs.

Not surprisingly, better parenting is linked to lower PIU, while neglectful parenting is linked to higher PIU. The researchers noted the differences in how maternal and paternal behaviour affected usage.

Maternal caring especially was associated with lower PIU, suggesting that high-quality mother-child relationships might have led to a decrease in the need to use the internet excessively. Paternal neglect, on the other hand, had a stronger relationship with higher PIU, as a lack of guidance and limits hindered a teen’s ability to set personal boundaries.

Finally, the researchers considered gender. They found boys more likely to engage in PIU than girls, as they tend to be prone to more addictive-like behaviour, are more impulsive and, as suggested by other studies, may have more online options such as gaming or watching YouTube videos or pornography. Girls may be more likely to be online for socializing purposes.

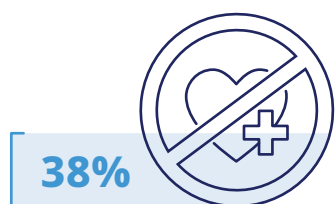
The researchers then looked at outcomes associated with PIU, again identifying three broad categories.

The first is depressive symptoms. If left unchecked, PIU appears to come with higher levels of depression. The two have been linked in previous studies, but researchers say their findings suggest a new interpretation.

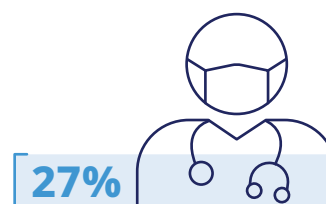
The other outcomes linked to PIU are higher levels of substance abuse and lower levels of academic achievement. These were to be expected and were also believed to be co-occurring **■**

Canadians with a chronic condition are reluctant to seek proactive healthcare during COVID-19

Of 492 respondents to an online survey, who have been clinically diagnosed with a chronic condition (i.e. diabetes, arthritis, obesity, cancer, etc.):



are **avoiding the healthcare system** altogether during the pandemic lockdown



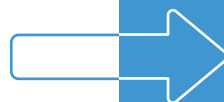
are **not comfortable seeing a physician in-person** during the pandemic

13% have not visited their physician since the start of the pandemic



Only **56%** have visited their physician **in-person** during the pandemic

Delaying chronic disease management can result in patients becoming critically ill and create increased demand on our healthcare system.



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This survey, commissioned by Novo Nordisk Canada Inc., was conducted using Leger's online panel between February 26 to 28, 2021 with 1,532 adult Canadians. 492 (35%) of the survey respondents have been clinically diagnosed with a chronic condition (e.g. arthritis, cancer, diabetes, heart disease, mood disorders, obesity, etc.). Leger estimates a probable margin of error of $\pm 2.5\%$, 19 times out of 20.



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INSULIN
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Canada's frontlines need reinforcing

By Paul-Émile Cloutier

Stories of heroic and innovative efforts of healthcare workers toiling to the point of exhaustion across Canada to battle the COVID-19 pandemic may make for inspirational reading, but right now our healthcare system is teetering on the brink of a major health human resources crisis.

With wave four of COVID upon us, and threatening to get worse with winter coming, the voices from the frontlines of care are sounding more desperate than inspirational:

"No matter what brought you to our (emergency) department, we will try to help. We'll continue to try to make things work. Because that's what we do. But every day we work like this will cost us more skilled staff as they leave due to burnout."

— Emergency Room physician, Saskatchewan

"It just kept getting worse and worse. I was having anxiety attacks where I would feel or be physically ill. I felt like I was going off to war or prison every day going into work."

— Intensive care nurse, Ontario, as told to The Globe and Mail

"The current pandemic has hurled us towards a full-blown nursing crisis."

— Linda Silas, President of the Canadian Federation of Nurses Unions

Healthcare is a people business. Having the right supply of qualified, resilient, and engaged healthcare workers is critical to ensuring high-quality care and the sustainability and continued evolution of our Canadian healthcare system. Further, with back-to-school, in-person learning upon us, a surge in demand for mental health services for children is likely to quickly overwhelm the system's ability to respond.

The people who make healthcare work in Canada are suffering. They themselves need care, but as for all Canadians, mental health services are in short supply with long queues. Our healthcare workers are also suffering because Canada has never had a national health strategy to ensure an adequate and sustainable workforce of physicians, nurses, other clinical



professionals, administrative and support staff, volunteers, researchers, and learners. We already see the impact on access, quality, and efficiency of patient care. We also fear a corresponding impact on patient safety and health outcomes.

Working with our member leaders in healthcare and health research institutions across Canada, we have identified the top three health workforce priorities we believe the next federal government should engage in as a partner:

- Ensure an adequate supply of health human resources with the competencies, skills, and diversity required to sustain and evolve our healthcare system and equitably serve the diverse population and needs of Canada.
- Support the health, wellness, safety, and resilience of our workforce with a Pan-Canadian mental health strategy, tools, and resources for healthcare workers.
- Promote equity, diversity, inclusion, and reconciliation in our health system by addressing systemic discrimination, removing barriers, and developing talent within equity-seeking and underserved communities so that we reflect and serve all communities in Canada.

Early in the pandemic, governments and industry worldwide focused resources and extensive budgets to address challenges with personal protective equipment, medical equipment, and facility challenges with unprecedented speed. Yet as the pandemic has dragged on for the past 18 months it is healthcare workers who sustained the response, day in and day out, often at a personal cost to their own health and wellness.

Many healthcare workers delayed or came out of retirement, students stepped in, and thousands of retirees returned to the workforce to support their colleagues. This has caused a temporary increase in our workforce numbers as seen in CIHI's recent report "Health workforce in Canada: Highlights of the impact of COVID-19". However, as workers move (or return) to retirement, and others choose to leave healthcare, we will be relying on a diminished workforce facing increased public demands, risking an exponential rise in burnout, mental illness, and even death.

Also worrisome is the fact that we do not yet know the long-term effects of COVID on our workforce. With better mental health awareness, reduction in stigma and the introduction of presumptive legislation in many prov-

inces, we anticipate an increase in claims for healthcare workers and first responders.

While this is more than concerning, we must ensure workers are both supported to seek care and have access to appropriate care is critical to their mental health and resilience and ultimately the sustainability of our workforce. Fundamentally, if we have learned nothing from this crisis, it is that more needs to be done to ensure healthcare workers have access to these services.

Canada's COVID experience has shown yet again that our dedicated and skilled health workforce can respond in the face of relentless adversity. However, with wave four here we must urgently implement the lessons learned from the pandemic to support that workforce. We need ramp up the care we provide to our caregivers. **H**

HealthCareCAN is the national voice of action for healthcare and health research institutions across Canada. As part of its commitment to advance health workforce issues, including supporting mental health and resilience among healthcare workers, HealthCareCAN recently established a Health Human Resources Advisory Committee (HHRAC) uniting healthcare People and Culture leaders from across Canada.

Paul-Émile Cloutier is President & CEO, HealthCareCAN.

The overdose crisis and the COVID-19 pandemic have changed the way people use drugs.

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Grateful COVID-19 patient gives back by participating in research

By Caitlin Renneson

Sharon Charlebois doesn't remember much about the 25 days she spent at The Ottawa Hospital fighting a severe case of COVID-19 in January 2021. Now that she's recovering at home with her husband, some memories come back to her in flashes.

"I remember the doctor told me that a ventilation helmet might help me avoid intubation," says Sharon, who was the first patient at the hospital's Civic Campus to use the helmet. "I remember holding Rebecca's hand and nearly squeezing it off when they were putting the helmet on because I was so nervous. Rebecca was really, really good to me."

Rebecca Porteous is a nurse and ICU research coordinator who was often at Sharon's bedside. Together with

THANKS TO PEOPLE LIKE SHARON CHARLEBOIS, RESEARCHERS ARE LEARNING HOW BEST TO USE STEM CELLS, ANTIVIRALS AND BLOOD THINNERS TO TREAT COVID-19.

Irene Watpool, she is responsible for making sure that every COVID-19 patient at The Ottawa Hospital has the opportunity to participate in research.

"When I was first hospitalized, I vaguely remember Irene talking about studies I could be involved in," says Sharon. "I asked my husband to call our niece who's a nurse and see what she thought. When she heard about the treatments being tested, she says, 'Yes, it's a really good idea to participate.'"

Sharon took part in several clinical trials during the course of her treatment at The Ottawa Hospital. One tested the antiviral medication remdesivir, while another looked at blood thinners to prevent blood clots. The blood thinner trial has since produced important results that have made a difference around the world.

While in the ICU, Sharon also agreed to participate in a made-in-Ottawa clinical trial of mesenchymal stem/stromal cells (MSCs) for severely

ill COVID-19 patients. This innovative trial, co-led by Drs. Duncan Stewart, Shane English, and Dean Ferguson, is designed to see if MSCs from the umbilical cord can help the body's immune system fight COVID-19 while reducing damage to vital organs. It builds on a previous clinical trial at The Ottawa Hospital in patients in severe septic shock – the first trial of its kind in the world.

Sharon was part of the trial's first phase, which looked at safety and dosing in nine patients with severe COVID-19. The second phase, which is looking at whether MSCs can improve recovery from COVID-19, is now underway. This part of the trial is expanding to other sites across Canada including Lakeridge Health (Durham, Ontario), St. Michael's Hospital (To-

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ronto, Ontario) and Centre hospitalier de l'Université de Montréal (CHUM).

"Biological therapies like stem cells have great potential to treat COVID-19 and many other diseases, but we need to rigorously test them in clinical trials," says Dr. Stewart, Executive Vice-President of Research at The Ottawa Hospital and professor at the University of Ottawa. "We're fortunate that here in Ottawa, we have unique facilities and resources to manufacture these therapies and lead these trials."

While Sharon's time in the ICU was incredibly difficult, she can't say enough about the amazing care she received there. She also appreciated how diligently the staff called her husband and family to keep them up to date.

"The staff in the ICU were just fantastic – they went above and beyond what they needed to do," says Sharon. "They were always there, asking if I needed anything, if I wanted a drink of water, if I wanted the TV on. They couldn't do enough for me."

Her family is grateful for the incredible care Sharon received at The Ottawa Hospital, and for the staff who saved her life.

After weeks spent in hospital without being able to see her family, Sharon was very happy to go home. She still uses a walker and experiences some shortness of breath, but with daily physiotherapy at home she can feel she's getting stronger.

Sharon hoped that participating in clinical trials would help her recover from COVID-19. But she's also glad that her participation will inform the care of patients who come after her.

"You know that having COVID-19 is so bad, so if you can help someone else, that's great," she says.

COVID-19 research at The Ottawa Hospital is funded by organizations such as the Canadian Institutes of Health Research, the Ontario COVID-19 Rapid Research Fund and the Stem Cell Network, as well as The Ottawa Hospital Foundation's



Left: Sharon outside her home in March. She still uses a walker and experiences some shortness of breath, but with daily physiotherapy at home she can feel she's getting stronger. Right: Sharon and Dr. David Neillpovitz celebrate the removal of her ventilation helmet, which is located between them.

COVID-19 Emergency Response Fund. Research at The Ottawa is also possible because of Core Resources

such as The Ottawa Hospital's Biotherapeutics Manufacturing Centre and Ottawa Methods Centre. **H**

Caitlin Renneson is a content writer at The Ottawa Hospital.

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Psychedelic-assisted psychotherapy:

Should we alter our perception of psychedelics for clinical use?

By Barbara Greenwood Dufour

The mention of psychedelics may bring to mind the counterculture movements of the 1960s and 1970s. So, we might not immediately think of these drugs in terms of their place in clinical therapy. But psychedelics were originally investigated in western medicine as medical treatments. Political concerns, as well as methodological issues with the research, put an end to their potential use in mainstream medicine – at least for a time.

Concerns around the lack of innovation in, and effective treatments for, mental health disorders have recently renewed interest in psychedelics as a therapeutic option. Now that improvements in research methods have addressed the previous methodological issues, minds are opening to the idea of psychedelics being used alongside psychotherapy to treat mental health conditions.

Psychedelics can cause hallucinations, which is why they're sometimes called hallucinogens. They include drugs such as psilocybin (also known as magic mushrooms), LSD (lysergic acid diethylamide), mescaline, and ayahuasca. There are some psychedelics that also produce a feeling of being out of control or disconnected from one's body and environment. These are also referred to as dissociative drugs. Examples of these include PCP (phencyclidine), ketamine, dextromethorphan, and Salvia. There are other types of psychedelics as well, such as the atypical hallucinogen ibogaine and the enactogen MDMA (3,4-Methylenedioxymethamphetamine).

Essentially, psychedelics are a group of substances that can affect a person's subjective perspectives or change the way they process thoughts, emotions, and behaviours. It's this change in perception and awareness that's thought to give psychedelics the potential to make psychotherapy – such as cognitive behavioural therapy or other types of talk therapy – more effective.

Psychedelic-assisted psychotherapy is currently in limited use. It's provided in research settings by medical professionals who are trained to administer psychedelics and monitor their effect during psychotherapy sessions. The psychotherapy itself is meant to change dysfunctional thinking patterns by teaching coping strategies and skills. The psychedelics, which might be given during one or more of the sessions, are intended to help patients be more open to and able to adopt the skills and strategies.

Psychedelic-assisted psychotherapy might be a new option for treating various mental health conditions. This could be an especially important development for people in whom the conventional medications and psychotherapy alone haven't worked well. To find out if there's evidence that psychedelic-assisted psychotherapy is effective, CADTH recently looked for the latest research on this topic. CADTH is an independent agency that finds, assesses, and summarizes the research on drugs, medical devices, tests, and procedures.

CADTH's found two systematic reviews (which included 31 individual relevant studies) and three randomized controlled trials (RCTs) on various combinations of psychedelic-assisted psychotherapy for anxiety, mood disorders, substance use disorder, or post-traumatic stress disorder (PTSD). The treatments most studied in the systematic reviews were MDMA-assisted psychotherapy for PTSD and psilocybin-assisted psychotherapy for treatment-resistant depression. Two of the RCTs looked at ketamine-assisted psychotherapy for substance (alcohol, cocaine) use or dependence. The third looked at psilocybin-assisted supportive psychotherapy for treating major depressive disorder. Both systematic reviews and the RCTs concluded that psychedelic-assisted psychotherapy is generally led to an improvement in symptoms and outcomes.



While the evidence suggests that these treatments are effective, what about the possible risks of using psychedelics alongside psychotherapy? To answer that question, CADTH found two safety trials that looked at the safety of MDMA-assisted psychotherapy – for alcohol use disorder in one trial and for PTSD in the other – and both found the treatment to be safe and well-tolerated. In addition, one of the systematic reviews and all the randomized controlled trials captured adverse events and none was reported.

There is increasing demand in Canada for access to therapy using psychedelics. For mental health and substance use disorders, psychedelic-assisted psychotherapy could fill the need for additional treatment options. However, the research has some limitations to be mindful of. For example, most of the studies were small (the majority involved less than 20 participants), and they don't tell us how

long the treatment's benefit could be expected to last (most followed participants for less than a year).

Additional research is in progress – for example, Canadian clinical trials are currently underway for both ketamine-assisted and psilocybin-assisted psychotherapy for treatment-resistant depression. The findings of this and other research might provide greater certainty on the safety and effectiveness of psychedelic-assisted psychotherapy.

You can access CADTH's report on this topic – Psychedelic-Assisted Psychotherapy for Post-Traumatic Stress Disorder, Anxiety Disorders, Mood Disorders, or Substance Use Disorders – at cadth.ca. CADTH has produced reports on a variety of other mental health-related topics, which you'll find at cadth.ca/mentalhealth. You can also follow CADTH on Twitter: @CADTH_ACMTS or talk to our Liaison Officer in your region: cadth.ca/contact-us/liason-officers. ■

Barbara Greenwood Dufour is a Knowledge Mobilization Officer at CADTH.



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Researchers work to understand and improve health for Indigenous Peoples after surgery

By Amelia Buchanan

Researchers at The Ottawa Hospital and the University of Ottawa are building a research program to better understand Indigenous Peoples' experience of surgery in Canada. Their latest study, published in *CMAJ*, is the first to analyze all available surgical outcome data for this population.

"Understanding surgical outcomes and access to surgical services is a first step towards addressing colonialism and structural racism within healthcare, so we can identify the gaps and determine what needs to be improved," says Dr. Jason McVicar, a Métis anesthesiologist at The Ottawa Hospital and assistant professor at the University of Ottawa.

ical conditions, rural or urban residence and income. Of the 1.9 million patients in the studies, 202,056 (10.2 percent) identified as Indigenous.

Taken together, data from these studies suggest higher rates of surgical complications, including infection and hospital readmission, among Indigenous Peoples compared to non-Indigenous people. Indigenous Peoples also had lower rates of life-saving surgeries, such as kidney transplant, cardiac surgery and c-sections, as well as lower rates of quality of life surgeries like knee and hip replacements.

The team also performed a meta-analysis of mortality data from four of the studies suitable for this analysis. This included a total of 5,939 participants, 292 of whom were In-



The study was led by Dr. Jason McVicar, a Métis anesthesiologist at The Ottawa Hospital and assistant professor at the University of Ottawa.

"Access to surgery is essential for good health," says Dr. Daniel McIsaac, an associate scientist and anesthesiologist at The Ottawa Hospital, and associate professor at the University of Ottawa. "Many major illnesses require a trip to the operating room, so unequal access to surgery and poorer outcomes after surgery is a major problem."

While the study findings are consistent with inequities in surgical outcomes for Indigenous Peoples in other high-income countries, the team found the Canadian data to be limited and of poor quality, showing that more research is needed. For example, the studies included in their analysis used different ways of determining Indigenous identity, and none specifically addressed surgical outcomes for Inuit or Métis.

"This study tells Canadians two things. We need better data, and what data we have tells us that we need to do better," says Dr. McVicar. "Better quality research by Indigenous investigators and real time outcome monitoring for Indigenous patients are essential to eliminating structural racism in the healthcare system."

Dr. McVicar was one of three Indigenous authors on this study, along with Dr. Nadine Caron (First Nations) and Dr. Donna May Kimmaliardjuk (Inuk).

"Indigenous identity data isn't routinely collected by healthcare services," says Dr. McVicar. "One of the steps that's needed is for healthcare systems to figure out how to safely collect Indigenous identity data in a way that does not further contribute to systemic racism. Those solutions will only be successful if Indigenous communities are equal partners in the process." **H**

DATA FROM THESE STUDIES SUGGEST HIGHER RATES OF SURGICAL COMPLICATIONS, INCLUDING INFECTION AND HOSPITAL READMISSION, AMONG INDIGENOUS PEOPLES COMPARED TO NON-INDIGENOUS PEOPLE

The team identified 28 previously published studies that compared surgical outcomes of Indigenous Peoples with non-Indigenous people in Canada. These studies adjusted for possible confounding variables like age, med-

igenous. After matching Indigenous with non-Indigenous patients who had similar surgeries, age and medical conditions, the researchers found Indigenous Peoples were 30 per cent more likely to die after surgery.

Amelia Buchanan is the Senior Communications Specialist at The Ottawa Hospital.

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Type 2 Diabetes and Cardiovascular Disease - Connections and Risks

Today, Canadians living with diabetes are three times more likely to die of heart disease. A leading expert in cardiovascular disease and diabetes, Dr. Mansoor Husain, cardiologist and Executive Director of the Ted Rogers Centre for Heart Research, shares insights into needs and trends he's seeing first-hand.

What do you see as the greatest issue impacting type 2 diabetes (T2D) and cardiovascular disease today?

We have a knowledge translation gap. Today, we are fortunate enough to have good scientific data that demonstrates the efficacy of treatments in managing T2D and cardiovascular disease. However, it's not being implemented. Data clearly demonstrates specific therapies can have significant impact on reducing disease complications and risks. We need to continue to educate the public, healthcare practitioners and health system payers to proactively adopt clinically defined standards of care.

Are there any trends or common themes you see in your daily interactions with patients?

COVID-19 has been a challenging time for many. Some patients are spending more time working from home and aren't as physically active. This can lead to stress and weight gain, which can negatively impact disease care. We need to double our efforts post-pandemic to ensure patients are using the best therapies available to support optimal disease management. Telemedicine will continue. However, it's not always easy to discuss new therapies and treatment changes in a virtual environment. Unfortunately, there continues to be misinformation surrounding disease care. While having significant benefits, social media



can also lead to misinformation. For instance, some mistakenly believe that naturopathic medicine can cure serious diseases such as diabetes. There's still a trend of anti-science and anti-knowledge that worries me and this needs to be combatted with evidence-based research, insights from real world data and clinical practice guidelines.

While I've seen first-hand how difficult it can be for patients to maintain a healthy lifestyle, it's also been extremely challenging for healthcare professionals during the pandemic. I'm more efficient when I have a patient physically in front of me, but in a telemedicine visit, it can take more time. Nothing can replace the connection a physician and patient experience in-person. There is the age-old cliché of a "bedside manner" in medicine which comes from physical interaction. I find myself spending more time trying to connect with my patients to get a feel for what is going on. I've never worked harder in trying to manage my patients during COVID-19.

Is there anything T2D patients could do to lessen their major adverse cardiovascular events (MACE) risks?

Patients must continue to do the things they were taught when they were first diagnosed with diabetes:

1. Regular exercise such as a daily 30-minute walk – rain or shine.
2. Continue to monitor their weight and be mindful of what they're eating and drinking.
3. Be aware of calorie density before consuming, so they can stay on-track, managing their condition effectively.

What is the most important take away for patients living with type 2 diabetes and cardiovascular disease?

Canadians living with diabetes, pre-diabetes or cardiovascular risks should proactively watch their blood pressure, cholesterol and activity levels.

If there's one measurement that should be checked daily, it's weight. Observing weight, calorie intake

and exercise are things we can all do. Weight is particularly important because any weight gain can only be prevented or reversed if you're on top of it.

Cardiovascular disease is caused by a combination of risk factors which include family history, smoking, blood pressure, cholesterol, obesity, and diabetes. It's important to manage all these risk factors and to make sure that people with diabetes are using treatments that have proven benefits.

I do feel a sense of optimism today. There's excitement knowing that we have treatments that are making a real difference for my patients. It's a rare experience in my career to see a paradigm shift. But, the work here is not done. We must continue to ensure we don't fail to take advantage of the knowledge in managing diabetes and cardiovascular disease and help guide Canadians to lead healthier and active lifestyle's, while managing their diabetes and cardiovascular disease effectively.

For more information on type 2 diabetes and cardiovascular disease visit Diabetes Canada's Clinical Practice Guidelines.

ABOUT DR. MANSOOR HUSAIN

Dr. Mansoor Husain is Executive Director of the Ted Rogers Centre for Heart Research and Professor of Medicine at the University of Toronto. He is also an Attending Staff Cardiologist at University Health Network. Dr. Husain completed post-doctoral research training in the Program of Excellence in Cardiovascular Biology at the Massachusetts Institute of Technology. His research is focused on the mechanisms of cardiovascular diseases such as hypertension, atherosclerosis and heart failure, with a particular emphasis on identifying new therapies.

* Disclosure - Dr. Husain has not been compensated for this article. Dr. Husain has been compensated as a consultant, speaker and researcher for various research-based pharmaceutical companies.

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The Overdose Crisis on canvas

By Jeremy Deutsch

To mark International Overdose Awareness Day 2021, Vancouver Coastal Health (VCH) has partnered with local artists with lived and living experience to launch Not Just an Art Show: The Overdose Crisis on Canvas. From August 31 through to September 3, artwork was on display at the Interurban Gallery in Vancouver's Downtown Eastside (DTES), featuring more than a dozen pieces inspired by the artists' thoughts around International Overdose Awareness Day and their experiences with the current overdose crisis.

rience relates to people who are currently using one or more substances.

This gallery offered people the opportunity to walk in the footsteps of people who use substances to understand the complexities of the crisis, which has been exacerbated by the COVID-19 pandemic. During 2020 alone, 1,728 people lost their life to overdose in B.C., which represents a 76 per cent increase of the previous year.

"People continue to die of overdoses in our communities at an unacceptably high rate. This art exhibition is an opportunity for artists from the commu-

DURING 2020 ALONE, 1,728 PEOPLE LOST THEIR LIFE TO OVERDOSE IN B.C., WHICH REPRESENTS A 76 PER CENT INCREASE OF THE PREVIOUS YEAR.

VCH collaborated with Portland Hotel Society to display the artwork in the heart of the DTES, with individual pieces contributed by more than a dozen artists with lived and living experience of substance use across the Vancouver Coastal Health Region. Lived experience relates to people who have used one or more substances and who are currently in recovery. Living experience

relates to people who are currently using one or more substances. This gallery offered people the opportunity to walk in the footsteps of people who use substances to understand the complexities of the crisis, which has been exacerbated by the COVID-19 pandemic. During 2020 alone, 1,728 people lost their life to overdose in B.C., which represents a 76 per cent increase of the previous year. "People continue to die of overdoses in our communities at an unacceptably high rate. This art exhibition is an opportunity for artists from the commu-



Peer workers form the backbone of frontline response to the overdose crisis. As individuals with lived and living experience of substance use, peer workers have in-depth, first-hand knowledge of harm reduction, treatment and recovery services. They form an important connection between people who use substances and the healthcare community.

"Peer workers play a core role and serve as critical supports across all of the overdose prevention sites," says Wendy Stevens, Peer Operations Co-

ordinator with VCH's Overdose Emergency Response Team. "While we remember those lost to this crisis, we also need to hold space for people who are in the trenches saving lives everyday."

"Frontline workers deserve respect for what they do," says Randy Pandora, an artist living in the Downtown Eastside. "They often don't get acknowledgement for saving lives by reversing overdoses long before any help arrives. That is what Overdose Awareness Day is about: saving lives." ■

Jeremy Deutsch is a Public Affairs Specialist at Vancouver Coastal Health.



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IPAC Canada asks for additional IPAC resources

By Gerry Hansen

Infection Prevention and Control Canada (IPAC Canada) has advocated for increased resources for infection prevention and control. Through its annual Hill Day and a pre-2022 budget submission to the Federal Government, IPAC Canada has recommended:

1. Increase the federal health transfer with a dedicated stream of funding for infection prevention and control; and
2. Investment in a national, integrated surveillance system to respond to all healthcare associated infections.

1. IPAC RESOURCES

We often say in healthcare that treatment is more costly than prevention. This notion extends beyond



Gerry Hansen

the direct costs of healthcare and into the economic toll that the spread of infections takes on society at large.



The pandemic has continued to offer glaring evidence of this sentiment and demonstrates that we cannot afford to repeat the same mistakes. The urgency applied in responding to COVID-19 needs to be matched by the urgency needed in adequately preparing for future pandemics.

IPAC Canada is concerned that provinces, territories and health authorities are being constantly asked

to do more with less. Fiscal discipline is different than fiscal austerity and it is critical that we do the right things now to prevent the worst-case scenarios in the future. Previous funding cuts to IPAC programs exposed significant gaps in Canada's systems of care during the pandemic, catching governments at all levels off guard. In addition, many of these gaps persisted throughout the pandemic despite the concentration on emergency funding to address COVID-19.

Across the country, Infection Prevention and Control Professionals (ICPs) are in short-supply, under-resourced and the education and training for healthcare settings is not available to the degree needed in meeting

Infection control measures in COVID-19 Assessment Centres are working, new study finds

By Sybil Millar

Measures that include surgical masks have been effective in preventing transmission of COVID-19 among staff working in four COVID-19 Assessment Centres (CACs) in Toronto, a year-long study has found.

A group of researchers including Dr. Jerome Leis, Medical Director of Infection Prevention and Control at Sunnybrook Health Sciences Centre, hoped to answer two questions. First, were healthcare workers (HCWs) working in these centres at higher risk of testing positive for SARS-CoV-2, the virus that causes COVID-19, compared to the general population? And second, were the infection prevention and control (IPAC) measures in place at these centres, such as the use of surgical masks rather than N95 respirators, effective at protecting those performing nasopharyngeal testing in this high-risk setting?

After the group studied 12 months of data, Dr. Leis says the answers were clear.

"Our results show that when embedded within a comprehensive bundle of measures designed to minimize COVID-19 transmission, the use of surgical masks was effective in protecting HCWs given a rate of infection similar to a population average that included non-essential workers," says Dr. Leis.

Of the 470 HCWs working in the four CACs, the positivity rate for SARS CoV-2 was 2.3 per cent, compared to 2.2 per cent in the Ontario population. In addition, no significant difference was observed in the rate of HCW infections between patient facing and non-patient facing roles, suggesting that when infections did occur, these were likely acquired in the community, and not during close contact with patients.

Of 354,027 patients tested in the four CACs during the study period,

21,951 were confirmed positive for the virus, a test positivity rate of 6 per cent. While HCW exposures during testing were generally brief, it's important to note that COVID-19 is most infectious immediately prior to and shortly after the onset of symptoms.

"COVID-19 cases diagnosed in a CAC, where patients are referred following a high-risk exposure or undergo testing at onset of their symptoms, are more infectious compared to a patient seen later in their disease course," says Dr. Kevin Schwartz, a co-investigator of the study and Infectious Disease physician at St. Joseph's Health Centre of Unity Health Toronto.

All four CACs, which included Sunnybrook, North York General Hospital, and Unity Health Toronto's St. Joseph's Health Centre and St. Michael's Hospital, implemented the same IPAC measures for COVID-19 testing recommended by Ontario guidelines. This included performing hand hygiene and wearing a surgi-

cal mask, eye protection, gown and gloves, as per Canadian recommendations. Even after a repeat analysis that excluded the period where staff began to have access to COVID-19 vaccines, there was no difference in COVID-19 risk.

The researchers note that a detectable difference in SARS-CoV-2 infection risk would be expected if these practices were inadequate, given that these HCWs were within close contact to nearly 22,000 patients with COVID-19, were essential workers during periods of lockdown, and are more likely to be tested.

Dr. Leis says the study, which was recently published in *Infection Control & Hospital Epidemiology*, adds to the body of evidence supporting current IPAC measures.

"Ontario CACs were implemented at the very start of the pandemic and these quality assurance studies are helpful in confirming that the measures have been adequate," he says. ■

Sybil Millar is a Communications Advisor at Sunnybrook Health Sciences Centre.

the moment. Federal, provincial and territorial governments should recognize the critical role that ICPs play and provide them with the funding and tools needed to relieve strains, both physical and financial, on the healthcare system. Investing in our capacities will create a marked reduction in these concerning outcomes. Increasing resources to the provinces and territories to fund robust infection prevention and control activities will improve patient safety in Canada and support our efforts to curb the rise of antibiotic resistant organisms and antimicrobial resistance.

2. SURVEILLANCE

IPAC Canada is calling for Canada-wide surveillance that ensures all Canadians, regardless of jurisdiction, are protected against the spread of infectious diseases. We are currently working in partnership with Healthcare Excellence Canada, Public

IPAC CANADA IS CONCERNED THAT PROVINCES, TERRITORIES AND HEALTH AUTHORITIES ARE BEING CONSTANTLY ASKED TO DO MORE WITH LESS. FISCAL DISCIPLINE IS DIFFERENT THAN FISCAL AUSTERITY AND IT IS CRITICAL THAT WE DO THE RIGHT THINGS NOW TO PREVENT THE WORST-CASE SCENARIOS IN THE FUTURE.

Health Agency of Canada, Canadian Institute for Health Information, and Association of Medical Microbiology and Infectious Disease Canada to strengthen HAI surveillance in Canada, but more action is needed from the federal government. IPAC Canada recommends that Health Canada collaborate with provincial and territorial health ministries to develop a national surveillance system with consistent case definitions from

coast to coast. This system should be accessible to all health professionals and should include data input by Infection Prevention and Control Professionals to ensure the people keeping Canadians healthy have the most up-to-date and accurate information at their fingertips

Through our 2021 virtual 'Hill Day', we received broad support and understanding on the critical work that ICPs do across the country both

during the current pandemic and in preventing future public health crises. The need for additional funding through mechanisms such as the federal health transfer was widely acknowledged as a critical step. We look forward to continuing these conversations with the federal government on this necessary additional capacity for infection prevention and control. In addition, although an integrated, national surveillance system has been a longtime advocacy priority for IPAC Canada, the COVID-19 pandemic provided us with an example of why this type of system is needed to prevent future pandemics. This recommendation was also met with broad support.

We will continue to urge the federal government to implement each of these important and interconnected recommendations to improve infection prevention and control in Canada. **H**

Gerry Hansen is the Executive Director, IPAC Canada. For more information www.ipac-canada.org

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Urinary tract infections:

Focus on safe medication use

By Elizabeth Si and Certina Ho

Urinary tract infections (UTIs), which can generally be classified into several categories (Table 1), are one of the most common conditions seen in the community for which patients seek medical care and are often prescribed with antibiotics. UTI is one of the main potential causes of inappropriate antimicrobial prescribing, which may lead to adverse events and/or secondary complications.

UTIs are relatively more common in women, infant boys, and older men. Women are prone to having UTIs, mainly due to estrogen related issues and structurally having a shorter urethra (than men). UTIs in older men are often associated with prostate enlargement, which may back up the flow of urine and potentially allow

more bacterial growth. Taking certain medications may also increase the risk of having UTIs. For example, sodium-glucose cotransporter-2 (SGLT2) inhibitors (e.g., canagliflozin, dapagliflozin, empagliflozin), one of the newer class of drugs for treatment of type 2 diabetes, has been associated with increased incidence of UTIs in patients, as they work by increasing the amount of glucose released or excreted into urine. Healthcare providers should monitor and evaluate patients who are taking SGLT2 inhibitors for UTIs, treat if required, and counsel on how they can recognize signs and symptoms of UTIs (Table 2). (As an aside, Health Canada has issued a safety review summary of SGLT2 inhibitors in 2016. Refer to their website for further information.)

Table 1: Urinary Tract Infections (UTIs)

(*Note: This is not a comprehensive list of the different types of UTIs.)

General Types of UTIs*	What does this mean?
Cystitis	Lower UTI or bladder infection
Acute Pyelonephritis	Upper UTI or kidney infection
Complicated UTIs	Infections that occur in patients with predisposing factors or health conditions, such as, obstructed urinary flow (e.g., due to urinary stones), foreign bodies within urinary tract (e.g., use of catheters), chronic diseases (e.g., diabetes), incomplete bladder emptying, or pregnancy.

Table 2: Urinary Tract Infections (UTIs): Signs and Symptoms

UTIs	Signs and Symptoms
Cystitis (bladder infection)	urinary urgency, dysuria, urinary frequency, pain or burning on urination, cloudy or foul-smelling urine, pain in suprapubic area and hematuria
Pyelonephritis (kidney infection)	fever, chills, flank pain, nausea and vomiting and cystitis symptoms

Table 3: Differential Diagnoses Pointing to Other Causes

(+Note: This is not a comprehensive list of differential diagnoses.)

Differential Diagnoses +	What are the common symptoms?
Vaginal Candidiasis	Vaginal itching and soreness, burning or pain when urinating, pain during sexual intercourse, vaginal discharge that is thick, white, and clumpy
Prostatitis	Pain in the lower pelvic area, high fever, urinary frequency with burning sensation

Burning sensation when urinating is a common symptom of UTI, and this is known as dysuria. Although dysuria most often indicates a UTI, this is a symptom that can also be related to many other potential causes or diagnoses. Therefore, it is important to recognize the signs and symptoms of UTI and eliminate other causes, which may have similar symptoms (Table 3). Inappropriate differential diagnoses will lead to inappropriate antibiotic prescribing.

SAFE MEDICATION USE

Before prescribing the agent of choice for UTI, it is imperative to take many factors into consideration. For example, asymptomatic bacteriuria, which is the presence of bacteria in urine but with no clinical symptoms, (in most cases) should not be treated with antibiotics, as this could lead to inappropriate UTI prescribing and contribute to antimicrobial resistance.

Continued on page 24

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Allergy clinic offers safe place for COVID-19 vaccine

By Dahlia Reich

Like so many people with serious health conditions, Joel McLaughlin lived in fear of contracting COVID-19. Yet, he was also terrified of what it would take to properly protect himself – the vaccine.

At 17, Joel has spent a lifetime in an out of hospital battling asthma, pneumonia and numerous allergies so serious that a mere touch could trigger a dangerous reaction. Dairy, eggs, tree nuts, peanuts, grass, trees, dog cats – the list of allergies is long. The Corun-

na teen carries three EpiPens with him at all times, and mom Carrie has had to administer the injection 13 times over the years.

As a youngster, Joel had a severe reaction to a flu shot and, two years ago, he landed in hospital with an allergic reaction to a virus. The actual source of both reactions has not been determined.

“So when it came to COVID, we couldn’t take any chances,” says Carrie. “We went into lockdown. With Joel’s asthma and a possible allergic reaction to the virus itself, we couldn’t risk it.”

For his safety, Joel, as well as his two brothers, stopped attending

school in March 2020 and didn’t return for the rest of the school year. But when the vaccine became available, new fears arose.

“We don’t take chances when it comes to any kind of shot,” says Carrie. “And yet we knew the COVID-19 vaccine was essential for Joel. He wanted to get the shot but it had to be done carefully and safely.”

The Allergy Clinic at St. Joseph’s Hospital has answered that call – for Joel and many others. For patients with potential allergies to the COVID-19 vaccine, the clinic is one of few in the province seeing patients who require consultation with a clinical allergist/immunologist.

“We are giving injections to patients who may be allergic to a component of the vaccine or have reacted to the first vaccine dosing,” explains Dr. Harold Kim, Medical Director of St. Joseph’s Allergy and Immunology Program and Chair/Chief, Clinical Immunology and Allergy in London. “Anyone with a suspected allergy to the vaccine is assessed to decide whether we would give it in our clinic or if they can receive it in a normal vaccination clinic.”

At St. Joseph’s, patients receive the COVID-19 vaccine in small and gradually larger doses over a period of time and are monitored closely for signs of reaction. By the end of their visit, they will have received the full dose.

In December 2020, Toni Ritchie, 58, had a severe anaphylactic reaction to an antibiotic but it was unclear which ingredient caused it. It was the first such episode she had experienced and there was a chance it may have been triggered by a non-medicinal component that is also present in the mRNA COVID vaccines. It was determined that Toni was a good candidate for the clinic at St. Joseph’s.

“If there was a chance I would crash again, I wanted to do it in a hospital where there was full medical support and a thoughtful, challenge-based protocol in place to minimize the risk.”

For Toni, who must keep on top asthma and has had autoimmune irregularities, vaccination to protect against COVID was vital. On July 7, she received the first dose of the Moderna vaccine in four separate amounts during which her oxygen levels, blood pressure and other indicators were monitored. She had no reaction and it was determined she could safely receive her second dose in her community. It too was uneventful.

“I think it’s a sensational initiative,” says Toni of the clinic. “There are a lot of people with allergy concerns who are holding back on getting the COVID-vaccine and they may not need to hold back. This clinic is a game changer.”

Dr. Kim agrees. Without the clinic’s cautious approach, many patients would not be getting the vaccine due to fear of a reaction, he says. “We have also likely prevented severe reactions with the protocol used at our clinic.”

Joel also received the first dose of the vaccine in segments at St. Joseph’s without any issue. He received his second dose in one shot at the clinic on Aug. 4 and now looks forward to resuming a more normal life – attending school, playing hockey and getting a part time job.

“It’s a big sigh of relief for me,” says Joel about being able to safely receive the vaccine. “It has been scary thinking about what the outcome would be if I got COVID and if I could never receive the vaccine.”

The clinic has been equally a positive experience for staff, says nurse Christina Attard-Kennel.

“Many of us were redeployed to assessment centres at the start of COVID and we talked about the hope for a vaccine. We are now part of helping patients receive it and are seeing the burden of the pandemic lifting. We have come full circle. It’s very satisfying.” ■

Urinary tract infections

Continued from page 22

Careful prescribing and judicious use of antibiotics are recommended for all prescribers. During a clinical consultation, healthcare providers should conduct a comprehensive medication review with patient (e.g., best possible medication history (BPMH), which includes asking patient about any antibiotic exposure or use within the last three months. This question is asked to prevent potential antimicrobial resistance and reduce unnecessary prescribing or use of antibiotics. Additionally, during the BPMH process, healthcare providers can check for drug allergies, identify (and prevent) potential drug interactions before safely prescribing the drug of choice (if needed). On the other hand, some patients may have recurrent UTIs, that is, experiencing two or more UTIs within six months, or three or more UTIs in a year. In this case, prophylactic antibiotics may be recommended. Although prophylactic antibiotics have demonstrated a positive effect in preventing

UTIs, there may be increased adverse events associated with antibiotic use. Therefore, patient preferences should always be taken into consideration, while risks and benefits associated with prophylactic antibiotic use must also be discussed with patients prior to prescribing and dispensing.

PREVENTION AND SELF-CARE OPTIONS

Healthcare providers should advise patients on preventative measures to reduce risk of recurrent UTIs. Although studies have not shown a correlation between behavioural modifications and reducing recurrences of UTIs, some self-care options (e.g., stay hydrated, urinate regularly, and avoid tight-fitting pants) may be considered. The Bladder Infection Fact Sheet (<https://www.toronto.ca/community-people/health-wellness-care/diseases-medications-vaccines/bladder-infection-fact-sheet/>), prepared by the City of Toronto, provides some quick tips and resources on UTIs for patients. ■

Elizabeth Si is a PharmD for Pharmacists Student at the Leslie Dan Faculty of Pharmacy, University of Toronto; and Certina Ho is an Assistant Professor at the Department of Psychiatry and Leslie Dan Faculty of Pharmacy, University of Toronto.

Dahlia Reich works in communications at St. Joseph’s Health Care London.



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Finding solutions for foggy eye protection

By Tracey Turriff

For well over a year, front-line home care staff have been wearing extra personal protective equipment (PPE) while providing care to keep everyone safe during the COVID-19 pandemic. Through a survey to learn about the experience of Personal Support and Nursing staff providing care while wearing masks and either face shields or goggles, VHA Home HealthCare (VHA)'s Research team discovered that nearly 70 per cent of the PSWs and nurses who responded indicated that their goggles and face shields regularly get



foggy and that this makes it harder to do their job.

"Our goal is create knowledge that will enable better care for our clients and lead to safer teams of providers"



I CAN SEE CLEARLY NOW THE FOG IS GONE

says Emily King, Manager, Research Operations at VHA. "When we realized so many of our nurses and PSWs couldn't safely provide care because they couldn't see what they were doing, we knew we needed to find a solution."

The team started by looking for ideas others might have tried for similar issues. They found medical professionals, swimmers and scuba divers who had shared their remedies, and treatments hockey and ringette players had used for similar challenges with head protection. "I tested 14 solutions and narrowed it down to 3 that seemed to work particularly well. I then ran additional tests on those, including diluting them and wearing eye protection for a longer duration after applying the solution," shares Huda Ameer, Research Assistant. "We then reached out to nurses and PSWs to ask them to test the top remedies during care for a real-life test of how the solutions worked and whether they were practical to use."

Ten personal support and nursing staff acted as field testers trying out each of the 3 treatments while providing client care, and then shared their experiences. The field testing led to a clear solution. The PSW and nursing testers recommend the use of Dawn dish soap or Live Clean baby shampoo to help everyone see clearly during client care.

"The dish soap Dawn is so easy to use," says PSW Veronica Foisy. "I work in a retirement home and after applying it once it lasted for a full eight-hour shift with four showers." And PSW Coach Joie Francisco shared "I have tried and tested the product in an extremely hot shower. The baby shampoo (Live Clean) gives clear vision for up to three clients."

Based on these field tests by personal support and nursing staff and their recommendations to their colleagues, we then set about sharing and scaling this solution.

"Financed by VHA's Ideas to Innovation Fund, we rolled out over 2,200 anti-fogging kits to our front line teams," says Head of Innovation Engagement, Pam Stoikopoulos.

"The response has been very positive," Emily adds. "So far most people are telling us that this solution is working for them. We expect health care providers at other organizations are also experiencing these issues and we hope this will help them as well."

All the findings are available on the VHA Research website at www.vha.ca/research/safer-teams/solutions-to-prevent-fogging-of-face-shields-and-goggles. Our partners at the Centre for Research Expertise in Occupational Disease (CREOD) are also helping to spread the word. Further information is also available by reaching out to searchhelp@vha.ca. **H**

Tracey Turriff is the Senior Communications & PR Manager, VHA Home HealthCare.



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Study helps explain vaccination rates and vaccine hesitancy

By Patrick Lejtenyi

A Montreal-led international survey of global attitudes around the COVID-19 pandemic is taking a close

look at what drives people to vaccinate themselves against the virus and what motivates those who are still avoiding it.

"The largest drivers behind people getting vaccinated are all altruistic," says Simon Bacon, professor of health, kinesiology and applied physiology in Concordia's Faculty of Arts and Science and one of the survey's principal investigators.

"There is a feeling that they are doing the right thing, that getting vaccinated is good for the general populace. In contrast, those who are unvaccinated are more concerned about the vaccine's safety and efficacy and whether vaccination will allow them to go to events. It becomes more about how the vaccine affects them as a person."



Simon Bacon is a professor of health, kinesiology and applied physiology in Concordia's Faculty of Arts and Science and one of the survey's principal investigators.

The data shows that coercive methods to increase vaccination rates, such as vaccine passports, are generally

THERE IS A FEELING AMONG THE VACCINATED THAT GETTING VACCINATED IS GOOD FOR THE GENERAL POPULACE. IN CONTRAST, THOSE WHO ARE UNVACCINATED ARE MORE CONCERNED ABOUT THE VACCINE'S SAFETY AND EFFICACY.

popular in Canada, with around 70 per cent of the population supporting them. However, they may not be as effective at boosting vaccination rates as some would hope: they do nothing to counter fears that the vaccine is either ineffective or unsafe. Early reports of serious side effects such as blood clots also undermined confidence in the vaccines in some respondents.

A SPECTRUM OF RESISTANCE

The unvaccinated are by no means a homogeneous group.

"We have to disentangle the difference between those who are vaccine hesitant and those who are vaccine resistant," he says. "Just less than 10 per cent of the population is vaccine resistant, meaning that almost nothing will change their minds about getting vaccinated. Another group, between 15 to 25 per cent of the population depending on the country, is not necessarily against the vaccine but does have some concern, usually driven around fears of efficacy and safety, or issues around access."

This group, the data shows, tends to skew toward being female and younger, to have reported financial or mental-health difficulties resulting from the pandemic and identify as being from traditionally underrepresented groups.

"It's a bit confounding, because we know that historically, underrepresented groups tend to have greater distrust in the health-care system in general. But those groups also tend to be from a lower socioeconomic status. It may not be their beliefs about the vaccine that is preventing them from getting a shot; it may be more practical issues."

Bacon says the researchers have adapted their questionnaire to better identify those who are hesitant from those who are deeply resistant.

AN ONGOING STUDY

Bacon and Lavoie launched the iCARE (International COVID-19 Awareness and Responses Evaluation) study in March 2020, just as most countries were implementing their lockdowns. Over the past 18 months, the study has examined public attitudes toward government and institutional responses to the pandemic, the effectiveness of the communication of government and health authorities' directives, personal feelings of anxiety, weight gain or loss, consumption of alcohol, tobacco and drugs and more. It has just completed its 12th cycle of data gathering.

The iCARE project is being conducted by the Montreal Behavioural Medicine Centre (MBMC), a joint Concordia / UQAM / CIUSSS du Nord-de-l'Île-de-Montréal academic research and training centre the pair founded in 2006. Some 200 researchers across 40 countries are collaborating on the project.

The 20-minute survey is available in almost 40 languages and to date, approximately 100,000 people from 175 countries have completed it. Its latest version is now available on the MBMC website.

iCARE is supported by the Canadian Institutes of Health Research, the Fonds de recherche du Québec-Santé and the Fonds de recherche du Québec – Société et culture. Study sponsors had no role in the design of the database and data collection. ■

Patrick Lejtenyi is an Advisor, Public Affairs at Concordia University.



Help develop a new National Standard for long-term care homes!

How can we improve operation and infection prevention and control of long-term care homes? CSA Group is seeking insights from health care professionals, long-term care home administrators, operators, frontline workers, caregivers, and community members on this important issue.

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Reimagining long-term care with lessons from the Pandemic

CSA Group outlines a new standard to enhance quality of life and protect residents, staff, and visitors

By Diana Swift

Nothing revealed the need for enhanced infection prevention and control, and other safety measures, in Canada's long-term care (LTC) homes than the tragic events caused by the SARS-CoV-2 pandemic. Hospital News spoke with CSA Group about its vision for a new, safer generation of LTC settings that would help prevent pandemic history from repeating itself, while contributing to the creation of a more home-like environment for residents.

"During the pandemic about 70% of deaths were in long-term care homes" says Doug Morton, CSA Group's Vice President, Government Relations. The residents' physical proximity in sometimes crowded quarters and advanced age were key drivers of the virus's terrible toll.

Conformity to CSA Group's new standard will help ensure safe, adequately supported, and high-quality homes for more than 250,000 Canadians and their caregivers and visitors.

In its role, CSA Group, which already has published some standards addressing different aspects of LTC homes, will focus on infrastructure and environmental design, including operating systems, design and layout elements, and technology, that will help ensure a more nimble response to future crises.

"Whether a future pandemic or the annual flu season, we can be ready to make and lay out a more rapid and organized response," says Dr. Alex Mihailidis, Scientific Director & CEO, AGE-WELL & Chair of CSA Group Technical Subcommittee on Long-Term Care Homes.



FRONT AND CENTRE: INFECTION CONTROL

With lessons learned from the pandemic, preventing and controlling infection is paramount. Comprehensive new operating practices and infection management will build on existing standards across a broad front: ventilation and air quality, heating and cooling, plumbing and water management, and medical gas systems. Another element will be waste disposal, including the dignified disposal of human waste. Flooring will be safer and senior-friendly; room design will diminish the crowded conditions that spurred transmission of COVID-19.

The new blueprint will address the advantages of installing microbe-resistant surfaces for furniture, food preparation and eating areas, bathrooms, and other high-touch areas. But if some homes lack the resources to achieve the ideal, says Dr. Mihailidis, the recommendations will offer practical alternatives for getting as close to

the optimum as possible. For instance, although the ideal would be to change all surfaces to antibacterial materials, they would outline effective, but less costly cleaning procedures to make surfaces safe.

New technologies, some already being piloted in facilities, will also play a role. "These include systems that collect health data and vital signs from residents with less physical contact," says Dr. Mihailidis.

Advanced technology will improve room cleaning, while other new tools will keep residents safely connected with their loved ones and communities, he adds.

VOLUNTARY AND INCLUSIVE

"As thorough as CSA Group's new standard will be, its adoption will be voluntary unless it's incorporated by governments, regulators, or best-practice guidelines," says Morton. "But we're having discussions with federal

and provincial governments, and we have members from government on the technical committee, so we're very hopeful."

A first draft of the standard will be available in February 2022 for public review and comment, and will be followed by the final standard being published in fall 2022. CSA Group's inclusive approach has engaged LTC residents, families, caregivers, and administration and addresses the concerns of Indigenous and other racial/ethnic groups as well as the LGBTQ2S+ community.

IMPROVING THE LIVING EXPERIENCE

Apart from physical safety, the new CSA standard will aim to provide residents with a more home-like living space – with, for example, furnishings that go beyond being antimicrobial to attractive, comfortable, and non-institutional. "This is their home," says Dr. Mihailidis. "Yes, healthcare is being provided, but the environment should not look like a hospital."

And given the negative impact of social isolation on residents' mental wellness highlighted all too starkly by the pandemic, the new designs would encourage safe visiting during normal times and outbreaks.

The standard takes into account cultural differences. "In our consultations with Indigenous leaders we've learned a lot about the cultural and spiritual importance of food preparation and sharing of meals," says Dr. Mihailidis.

In Canada's recent federal election campaign, fixing LTC emerged as top of political mind. Conceivably, the new CSA standard will help ensure that this remains a priority of our political will. ■

Vaccines and mandates

Imperfect, but now more defensible than not

By Maria McDonald and Kevin Reel

As practicing healthcare ethicists, we have been asked: “Is it ethical to mandate* Covid-19 vaccination?” Our answer six months ago would have been ‘not yet’. But ethical decision-making is typically about balancing facts with principles – like personal autonomy (freedoms) and beneficence (doing good). The principles of solidarity (acting together), collective good, prevention, and proportionality (reasonable restrictions to liberty to protect the public from harm) become increasingly important in a pandemic. Scientific knowledge changes. The virus has changed. Other variables have changed. Our opinion has changed.

Some basic facts are that Covid-19 vaccines are very safe and effective,

as demonstrated by the data on 27 million+ vaccinated people around the world. Covid-19 vaccines are not as ‘near perfect’ in their effectiveness as, for example, childhood vaccines which provide over 90 per cent protection. They are, nonetheless, the best option available at present – always in combination with other preventative measures such as distancing, masks, etc. Complications and side effects are minimal and well monitored. Public health decisions have been made considering all the information being collected. If you still cannot accept these premises, we’ll not change your mind here. Perhaps hearing about the experience of others who have reconsidered might be a better starting point for you.

With millions still unvaccinated in Ontario, there is too much opportunity for yet more damaging and deadly next waves, and for an even more virulent variant. Every person who is infected could be the source of another new variant. More certainly, every newly infected person is now more likely to infect others. Current statistics support the evidence that the unvaccinated are increasingly the most vulnerable to infection, serious illness, and long-term consequences. Nobody is completely safe.

Legally, there is a framework for introducing such mandates. Directives from the Chief Medical Officer of Health (CMOH) are one part of it. The power to issue such directives arises once the CMOH forms the opinion that there is an “immediate risk to the health of persons anywhere in Ontario from Covid-19”.

Labour agreements do not necessarily prevent implementation of these mandates. One employment and labour lawyer has argued “In a unionized workplace, if there is nothing in the collective agreement to prohibit mandatory vaccination, an employer may unilaterally institute such a policy under its management rights.”

And ethically? Successfully managing the many threats of Covid-19 is only possible with collective action – the principle of solidarity applies. Threats include delays in diagnosis and treatment of non-Covid-19 patients – that is, any one of us. Acting together is the best way to prevent harm to any one of us, and to preserving public goods (like the health and community care system and its ongoing capacity to care for ALL people with ALL health concerns).

Society needs to consider the long view. With that view in mind, mandating some short-term constraints on personal freedom can be defensible and justified by virtue ethics (with qualities like prudence, fortitude, and

selflessness guiding us), the ethics of care (recognizing our interrelatedness with others), and the evident consequences (foreseeable morbidity and mortality). We would hope that every reasonable person among us could agree that vaccination is ‘the best option’ in this extraordinary time.

Some are not convinced by these reasons, so we also appeal to the idea of duties. Our highly interconnected lives and networks now have the added connectivity of a dangerous and very contagious virus in our midst. With our cherished autonomy comes responsibility. Everyone is responsible for considering – honestly and calmly – how one’s own decision to get vaccinated or not may affect others in our families and communities. Everyone has a duty to seek out credible resources, including trusted health care providers, to answer concerns or fears.

To help encourage vaccination during a typical flu season, healthcare organizations have used ‘behavioural nudging strategies’. These have also worked to some extent for Covid-19 vaccination. However, the increasing array of risks of harm from Covid-19 requires action beyond these gentler strategies. ‘Mandates’ increase the nudges to varying levels, reflecting the risks of the ongoing pandemic.

This is a race against time and harm. Even while lamentable, we now consider vaccination mandates defensible given the changed circumstances. We argue this considering the individual lives that will be lost and others that will be damaged, and the high toll of further harms to the collective good if the spread of the virus is not minimized. We recognize that any defensible limitations to individual liberties must have their own limits, and we watch with interest legal challenges to these mandates. In our society, nobody will be ‘forced’ to get a vaccine, though some will have to make very hard choices between their reasons for


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not being vaccinated and the impact of adhering to those reasons if their workplace mandate includes termination. In the end, some unvaccinated individuals may have only two choices left: vaccination or a search for new employment with an organization not requiring vaccinations. Imposing this decision on that small minority of staff is a difficult decision to take. Those who make that choice clearly do so with great reluctance and fully recognize that few moments in living history have presented such strong arguments for this sort of temporary limitation on certain liberties.

Ontario is necessarily preparing for a difficult fall and winter with the next wave of COVID patients – likely involving more children this time. Yes, these mandates are an unprecedented

limit on some personal freedoms, but they are an arguably defensible approach to an unprecedented situation society can only face collectively. With the long view in focus, short term mandates will allow all to return – safely – to enjoying the individual freedoms to which we are accustomed. **H**

**‘Mandates’ for vaccination take many forms – essentially introducing any of a range of measures to promote vaccination. These include regular Covid-19 tests at differing intervals, to unpaid leave of absence, and in some cases termination of employment. The specifics are outlined in individual policies; no system-wide prescribed policy exists – only Directive 6 and its required minimum of vaccination, medical exemption or completion of education session.*



Maria McDonald is an adjunct member of the Joint Centre for Bioethics, Dalla Lana School of Public Health, University of Toronto and Kevin Reel is an Assistant Professor with the Department of Occupational Science & Occupational Therapy at the University of Toronto and the Dalla Lana School of Public Health.



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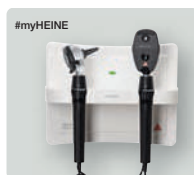
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We are stronger together

By Dr. Naveed Mohammad

Since the onset of the COVID-19 pandemic, the communities served by William Osler Health System (Osler) – the City of Brampton, North Etobicoke and the surrounding areas – have been hit particularly hard, consistently recording some of the highest positivity rates in the province. This has had a profound impact on Osler's staff, physicians and volunteers who have put forth an unprecedented dedicated effort to continue delivering safe, quality care to an influx of patients.

At the height of the third wave of the pandemic, Osler operated well over capacity and would have been challenged to meet the health care needs of its communities without the unrelenting support of its hospital partners. While providing care to their own communities during this extraordinary time, close to 40 hospitals and other health care facilities graciously accepted the transfer of more than 800 patients from Osler's inpatient hospitals – Brampton Civic Hospital and Etobicoke General Hospital. More than 33 health care professionals from the province of Newfoundland and Labrador, the Ontario Home and Community Care sector, Kemptville District Hospital and the Canadian Red Cross also answered the call and volunteered their time and expertise – some even arriving by military aircraft to support Osler in its time of need.

With the help of all our health care partners, as well as the support of the Ontario Government, Ontario Health, the Province of Newfoundland and Labrador, and the Royal Canadian Air Force, Osler was able to provide care for an exceptionally high number of patients with COVID-19 when they needed it most.

Our entire team at Osler and the patients we care for are profoundly grateful to all those who supported

Dr. Naveed Mohammad



THROUGH COLLABORATION AND AN UNWAVERING COMMITMENT TO PATIENT CARE, ONE OF ONTARIO'S HARDEST-HIT HEALTH SYSTEMS MANAGED THROUGH THE THIRD WAVE OF THE PANDEMIC

us during this difficult time. This support ensured all patients from Osler's communities, including many who were critically ill at the time of transfer, received quality, compassionate care at other hospital facilities. It has been a challenging time for all hospitals across Ontario, and we appreciate

the ongoing partnerships and collaboration that help make us stronger together.

The level of collaboration among hospitals across the province and the entire country during this time continues to be a source of inspiration. Collaboration makes us all better. ■

By Ana Gajic

A plane ride around the world to collect the belongings of a brother who died by suicide. A phone call that makes the difference between trying to die and deciding to live. The recurring anger an anniversary of a loved one's death drudges up each year.

Moments like these, rarely told, are captured in a collection of stories called *What It Takes to Make It Through: Stories of Suicide Resilience and Loss*. They were collected by Dr. Sakina Rizvi and Amanda Ceniti, two researchers at St. Michael's Hospital of Unity Health Toronto who worked on this self-funded project for five years. The book includes more than two dozen stories from across Canada: poems and prose written by people who had contemplated suicide, attempted it, or are bereaved by it. They edited only to abide by the safe guidelines around suicide. Other than that, the stories are told in the authors' own words.

"People have all these stories that are not being told. We wanted to create a space to hear some really raw experiences," says Dr. Rizvi, a scientist at St. Michael's and a therapist.

Dr. Rizvi was inspired to begin the project after reading about a man who shared his suicide note with a group of journalists. Reading about the actions his family members took after he died propelled Dr. Rizvi to seek out these untold stories of suicide. After that, the Arthur Sommer Rotenberg (ASR) Suicide and Depression Studies Program embarked on a mission to collect and publish stories of suicide through The Storybook Project.

"What caught me about the story I initially read was that the man's brother flew to Japan from the U.S. to collect his brother's things," Dr. Rizvi says. "When you're sitting on a plane next to someone, you never think someone's going on a mission like that."

The team put out a national call for anyone who had been touched by suicide to contribute a piece of writing.

As a therapist, Dr. Rizvi has the opportunity to hear many narratives impacted by depression and suicide. Receiving these pieces, she said, was different.

"When something's written down it has a weight and a permanence that's different," she says. "As a therapist,

Dr. Naveed Mohammad is President and CEO of William Osler Health System which includes Brampton Civic Hospital, Peel Memorial Centre for Integrated Health and Wellness and Etobicoke General Hospital, and serves 1.3 million residents of Brampton, Etobicoke and the surrounding communities within Ontario's Central West region.

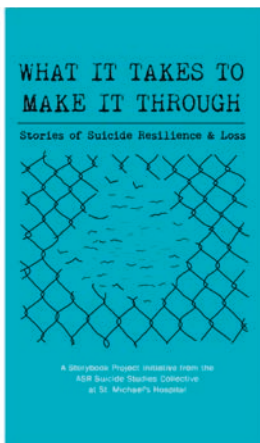
New book shares stories of resilience and loss from suicide

when someone tells me their story it's because we've built that trust. To have a perfect stranger let you in to that intimacy, there is something about that that is incredibly powerful and really inspiring in terms of the courage it took to do that."

Ceniti, a PhD candidate at the ASR and co-lead on this project, lost a close loved one to suicide and says the project has had a personal impact.

"It's been very helpful in my own journey, just getting a broader understanding of people's experiences. It breaks down the barriers of working through the grief process. The more perspectives you can see from all angles, the more understanding you gain."

Ceniti and Dr. Rizvi say they hope the main message of *What It Takes to Make It Through* is that no one is alone. For



that reason, Ceniti and Dr. Rizvi encouraged participants to use their real names, and were inspired to see that many people did. Seeing people share without fear reduces stigma around suicide.

"Suicide is a scary topic. It's very confusing for a lot of people to understand that someone could have thoughts of ending their life and they can't relate to it," Dr. Rizvi says.

"I'm hoping that people, through these stories, understand that there is nothing wrong with what you feel. It is completely understandable and suicidal thoughts are a very clear extension of the really deep pain that someone is feeling. It's my hope that people can really find the compassion for that."

Their hope is to use the proceeds of this book, which will all flow back into the program, to fund future collections based around specific communities that have been marginalized and may have higher risks of death by suicide.

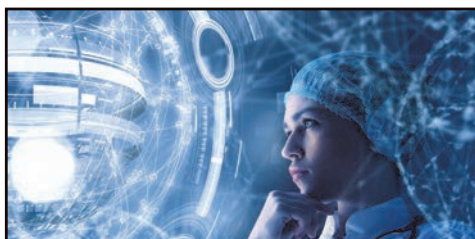
You can buy the book from the publisher's website, Amazon, and Book Depository. All the proceeds from this book will go to the ASR Program to support suicide research and education initiatives. **H**

Ana Gajic is a senior communications advisor at Unity Health Toronto.

H Hospital News

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Reducing emergency department visits and hospital admissions

By Beatrise Edelstein and Marilyn ElBestawi

Even before the COVID-19 pandemic, we knew that targeted strategies to reduce avoidable hospital admissions and emergency department (ED) visits were valuable. Seniors residing in LTC are at increased risk of hospitalization due to increased frailty, multiple co-morbidities, complex medical history, cognitive impairment(s) including dementia, and/or limited ability to physiologically compensate for critical illness. That being said, many hospital admissions can be prevented. In fact, a CIHI report published in 2014 demonstrated one-third of ED visits from LTCs were avoidable. Transfers to the ED can increase the risk of adverse effects on residents, as well as result in unnecessary health resource utilization. The importance of preventing unnecessary hospital admissions became even more relevant during the pandemic when hospitals were over capacity and caring for COVID-19 patients.

Initiatives aimed at reducing preventable ED visits support the Quadruple Aim by improving resident care, outcomes, reduce costs, and enhance staff experience and capacity. In December 2020, Humber River Hospital (HRH), along with seven LTC Homes: Villa Colombo Toronto, West Park LTC, Village of Humber Heights, Downsview LTC, Ukrainian Canadian Centre, Weston Terrace and Norfinch, was awarded one-time funding by Ontario Health (OH) Central Region, to implement the LTC Remote Monitoring solution Preview-ED®, along with a supporting escalation pathway connecting high risk patients to a virtual interprofessional hospital based team via LTC+.

Preview-ED® is an observation-based clinical deterioration tool based on the NHS National Early Warning Score (NEWS) 2 scoring system, and is used daily by Care Aides/Personal Support Workers in LTC

to systematically detect early signs of decline in the health status of LTC residents. This tool is focused on and is sensitive to identifying early signs of decline relating to four conditions: urinary tract infection, pneumonia, dehydration, and congestive heart failure. Weighted scores are assigned to observations on each of the nine indicators, where the scores for each indicator are totaled to provide an aggregate score that helps identify residents with changes in their health status.

Patients who are identified in Preview-ED® with a deteriorating health status are connected with LTC+, a virtual interprofessional team situated in the hospital to help mitigate preventable ED visits, providing rapid access to a suite of virtual and in-person clinical and diagnostic care. At HRH, LTC+ includes weekday access to a general internal medicine physician/geriatrician for urgent virtual consults to the LTC home primary care provider, a nurse navigator to coordinate timely access to ambulatory and community-based resources, a Nursing Led Outreach Team (NLOT), and/or an ED physician for virtual visit.

The PREVIEW-ED® tool was initially piloted at Lakeside LTC in Toronto and subsequently in Fraser Health in British Columbia where it was implemented in 79 LTC homes (8063 residents). In 2019, Villa Colombo Toronto LTC in partnership with HRH implemented Preview-ED® and demonstrated an over 25 per cent decrease in ED transfers for tool sensitive conditions, including urinary tract infection, pneumonia, dehydration, and congestive heart failure. The program in 2021 was then scaled to six LTC homes in North West Toronto and included the LTC+ program, serving up to 1,577 residents. Implementation resources were provided by HRH and included regular engagement with LTC leadership, champions and medi-



PREVIEW-ED® IS AN OBSERVATION-BASED CLINICAL DETERIORATION TOOL BASED ON THE NHS NATIONAL EARLY WARNING SCORE (NEWS) 2 SCORING SYSTEM, AND IS USED DAILY BY CARE AIDES/PERSONAL SUPPORT WORKERS IN LTC TO SYSTEMATICALLY DETECT EARLY SIGNS OF DECLINE IN THE HEALTH STATUS OF LTC RESIDENTS.

cal directors, data analysis/evaluation, and program reporting.

Initial outcomes included significant decreases in ED visits and hospitalizations from the participating LTCs with 49 per cent and 24 per cent reduction in ED visits for tool sensitive conditions and total ED Visits respectively, and 22 per cent and 25 per cent reduction in admissions for tool sensitive conditions and total hospital admissions respectively. These outcomes have resulted in 7.32 bed equivalents (all LTC transfers) and 1.65 bed equivalents (LTC transfers for tool sensitive conditions), increasing HRH capacity for acute patients. These results have been sustained six months post implementation.

The program had a positive impact on the LTC staff experience, with 79 per cent of 307 staff surveyed indicat-

ing they agree and strongly agree that Preview-ED® tool and process is useful to them and recommending PREVIEW-ED®. In addition, 85 per cent of staff reported that PREVIEW-ED® improved team communication and enhanced LTC staff capacity for early identification of residents' deteriorating status. Implementation of Preview-ED® resulted in early recognition of the critical role of collaborative relationships between LTCs and HRH in supporting the medical complexities experienced by LTC residents.

Building on successes and lessons learned from scale of PREVIEW-ED® to six LTCs, future directions include a focus on sustainability and spread of this valuable program to additional LTC homes. To learn more about PREVIEW-ED®, please visit www.previewtool.ca 

Beatrise Edelstein is the Program Director, Seniors Care, Inpatient Medicine, Allied Health & Ambulatory Services · Humber River Hospital and Marilyn ElBestawi is the PREVIEW-ED® developer.

Improving resident care with home-grown research

By Elizabeth Benner

When you walk through the resident halls of Unity Health Toronto's Cardinal Ambrozic Houses of Providence, each door tells a story.

The signs adhered to each resident's door – 'life stories' as they're called by the staff – within the long-term care home tell the story of the person inside – describing their families, their lives, and things they like to do.

The initiative came out of the early days of the COVID-19 pandemic, a scary time for the long-term care home. In an effort to protect the res-

idents from the virus, the Houses, like many long-term care homes in Canada, had to limit visiting and in-person interaction for their residents. The result was a slight uptick in the use of antipsychotic medication to keep residents, who may be distressed, as calm as possible.

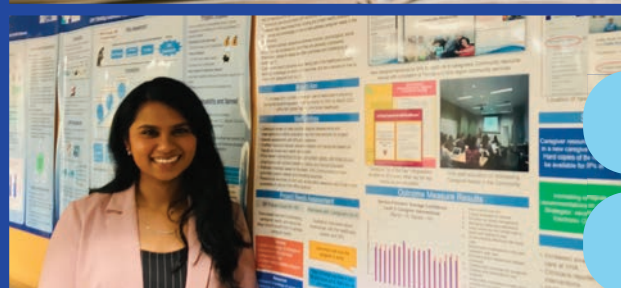
Dr. Ashley Verduyn, Medical Director at the Houses of Providence, turned to research led by her colleague at Unity Health Toronto, Dr. Jennifer Watt, a Geriatrician and Researcher at St. Michael's. The two have begun to collaborate on research proj-



ects across Unity Health, their first project focused on applications for an award-winning study led by Dr. Watt at the Houses of Providence. The article was published in the Annals of Internal Medicine in October 2019,

and suggested non-drug interventions led to more positive outcomes among patients with dementia displaying aggression and agitation.

Continued on page 36



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In long-term care homes, the conditions of work are the conditions of care

By Linda Silas and Pat Armstrong

As Canada faces the reality of entering a fourth wave, COVID-19 continues to take an immense toll on Canada's long-term care sector, where conditions have reached crisis proportions for residents and staff.

We've known for many years that Canada's population is aging and that we face significant challenges in funding and

staffing for long-term care. Tragically, it took a global pandemic and the avoidable deaths of thousands of seniors to finally shine a light on this longstanding crisis.

Many of the critical challenges in this sector are the direct result of decades of underinvestment, privatization and regulation that is both fragmented and unenforced. The current patchwork of services

and the reliance on for-profit care in many parts of the country has resulted in soaring costs, inadequate facilities, insufficient staffing and few protections for the health and safety of residents and workers.

Last summer's release of the Canadian Forces' troubling reports of the impacts of COVID-19 on predominantly private, for-profit long-term care facil-

ities in Quebec and Ontario shocked the public and decision-makers, and highlighted the deplorable conditions faced by too many seniors and workers. To date, 57 per cent of all Canadian COVID-19-related deaths have taken place in long-term care.

The sad reality is that these problems have persisted for decades out of the public eye.

Improving resident care

Continued from page 35

"Residents with dementia can exhibit behaviours like restlessness, agitation and aggression that at times can make providing personal care difficult for staff. Some of these behaviours may have worsened during the pandemic due to isolation and the lack of family and caregiver presence due to visiting restrictions that were mandated," Dr. Verduyn explains.

Dr. Jennifer Watt and Dr. Ashley Verduyn collaborated to implement Dr. Watt's research at the Houses of Providence in order to improve resident mental health during the pandemic.

Moving residents off anti-psychotics was a priority for the team at the Houses. According to Dr. Watt's study, patients with dementia who experience neuropsychiatric symptoms, such as aggression and agitation, are more likely to experience a lower quality of life and increased risk of death compared who patients who don't experience those symptoms. This risk is further complicated due to the association of pharmacological interventions with more potential harms in this group of patients such as falls, fractures and death.

Caregivers of patients who experience these symptoms also experience a lower quality of life.

The team implemented hand massages, life story reminiscing that resulted in signage posted on the residents' doors, music therapy, and stuffed toy

therapy (to replace therapy animals). Marnellie Hilao, the Behavioral Support Lead at Unity Health's Houses of Providence, and her team found ways to engage the residents who were craving interaction: setting up a makeshift hair salon, taking residents on a walk, modifying games to reduce contact between residents.

"Slowly now we're going back to normal," Hilao says.

Although the applications of Dr. Watt's paper were for patients living with dementia, she pointed out the observed statistical and emotional shifts when non-pharmacological methods were used for all residents at the Houses of Providence, not just those living with a particular illness.

"While our study is specific to those with dementia, the research has broader applications that an older patient's behaviour has meaning and is potentially in response to something in their environment. I think that's ultimately what it's pointing to, that it's trying to get to the underlying causes for those behaviours that older people are having," Dr. Watt says. "I believe research should be used to help people and I'm really fortunate so early in my career to have been able to work with such wonderful people who feel the same way and who are really taking research and using it to for patient care so quickly."

Since putting the research into practice, the number of residents



receiving antipsychotics dropped from 28 per cent of residents to 19.4 per cent. Despite admitting more residents who were taking antipsychotics from other facilities during the pandemic, the Houses of Providence still managed to decrease their numbers.

"We've seen immediate effects in the emotional well-being of our residents. We also have lower rates than

the provincial average in terms of residents with symptoms of depression," Dr. Verduyn says.

"I'm so very proud of the Houses team for their hard work throughout the pandemic. I also feel very fortunate to be able to collaborate with experts like Dr. Watt in implementing evidence based initiatives like this that ultimately improve the quality of life for our residents." ■

Elizabeth Benner is a communications intern at Unity Health Toronto

LONG-TERM CARE NEWS

This tragedy was the culmination of an approach that has long privileged business practices based on the search for profit over care, with too many employers failing to meet basic labour and care standards in favour of padding their bottom line.

The result is that workers – often racialized and/or newcomer women – face the impossible challenge of providing optimal care while contending with high resident-to-staff ratios, limited resources and few workplace protections.

As the federal government undertakes efforts to develop national standards for long-term care, we must ensure that they include conditions that will facilitate a robust publicly delivered and publicly administered system that will support workers in applying their skills to provide the care residents need.

The government must enact federal legislation to bring long-term care into the public health care system following the principles of the Canada Health Act, along with conditions that provinces and territories would

be required to meet in order to obtain federal funding.

As a nation, our objective should be to eliminate for-profit business from the long-term care sector – beginning with a moratorium on additional for-profit homes, followed by the gradual phasing out of existing long-term care facilities from private to public, or not-for-profit, ownership. This measure will be critical to reverse the current race to the bottom in the long-term care sector.

As multiple commissions and research studies make clear, any efforts to overhaul long-term care must recognize that the conditions of work are the conditions of care, and include basic standards for care, occupational health and safety, and staffing.

Safe staffing levels are an essential condition for decent care. We must ensure a minimum of 4.5 hours of direct care per resident each day, with a minimum of 45 per cent of this care provided by licensed nurses and at least one Registered Nurse per shift.



Where resident acuity is higher, staffing should be increased accordingly. Currently, there is no jurisdiction in Canada meeting these basic standards.

It's time we recognized the critical value of care work by ensuring that wages and benefits for long-term care workers match the value of the work they perform, and that care workers have job security as well as access to full-time employment.

With aging an inescapable reality for all of us, it makes little sense for governments to avoid addressing the issue

or to hand off responsibility for the care of seniors to private, for-profit companies whose ultimate focus is generating profit for their shareholders – not ensuring optimal working and living conditions in long-term care homes.

We call on federal, provincial and territorial governments to immediately implement these important recommendations to protect seniors and long-term care staff today and into the future.

Our loved ones deserve nothing less. ■

Linda Silas is a nurse and President of the Canadian Federation of Nurses Unions. Pat Armstrong is a Distinguished Research Professor Emerita at York University in Toronto.

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Opioid crisis continues

By Sophie Ash

The opioid crisis in Canada continues to be a major public health concern that has prompted numerous policy reforms. But, governing body and organizational efforts have done very little to reduce the growing number of opioid-related deaths, particularly as more people are turning to substance use during the COVID-19 pandemic. So, where do we go from here?

The opioid crisis in Canada began in the 1990s, when pharmaceutical companies were promoting opioids for safe and effective pain management yet downplaying their addictive nature. Opioid prescription numbers skyrocketed, accompanied by an increase in opioid dependency. Following push-back to reduce overprescribing, high rates of opioid dependency led to Canadians taking matters into their own hands to access these addictive drugs.

Today, street drugs are often tainted with powerful opioids, like fentanyl, making them unpredictable in their strength and content. Dr. Speranza Dolgetta, Medical Director at the Edgewood Health Network Bellwood Facility in Toronto, highlights: “The number of accidental deaths due to opioids adds to the tragedy – this is a preventable disease.” Since 2016, Health Canada estimates there to have been more than 9,000 opioid-related deaths.

The staggering number of opioid-related deaths and overdoses is heartbreaking, as is the potential for users to develop opioid use disorder (OUD). The term ‘OUD’ encompasses an intense desire to use opioids, an increased tolerance to opioids, and withdrawal symptoms when opioids are discontinued. Opioid use disorder can range from mild to severe. Severe cases of OUD are referred to as opioid dependency or addiction.

Given all this tragedy, the opioid crisis may seem hopeless. But it doesn’t have to be. We must call upon healthcare providers to help prevent,



diagnose, and treat OUD. Of course, governments and organizations have an integral role to play in changing policies, but they’re far removed from an individual with OUD. Laws that remove drugs from the streets and reduce overprescribing practices are a good start. However, laws do nothing to treat the complexities of addiction. Given the relationship that healthcare providers can foster with OUD patients, and their ability to address the multifaceted nature of addiction at an individual level, providers need to spearhead their efforts to end the opioid epidemic.

Then, which tangible actions can healthcare providers take? For starters, providers must be aware of risk factors for overdosing: having OUD; consuming more than one drug at once (known as polysubstance use); or experiencing voluntary or involuntary abstinence (e.g. in prison or as part of an inpatient treatment program), which greatly reduces an individual’s opioid tolerance. By being aware of these risk factors, providers can act preventively when caring for high-risk patients.

Likewise, the importance of educating patients and those close to them on the signs of overdose can’t be overlooked. The more we are familiar with what an opioid overdose looks like – breathing slowly or not at all, foaming

at the mouth, choking or vomiting, cold skin, blue nails and/or lips, and unresponsiveness – the more likely that individuals experiencing opioid overdose will receive the emergency care that they need.

Of course, recognizing an opioid overdose is critical, but so is knowing how to respond to one. Providers must be educated, and educate their patients, on naloxone kits. If providers can speak openly with their patients about naloxone, including how it’s used and where to access it, it will help reduce the stigma that users may feel, allowing them to access and use naloxone. “If you see someone overdose, call 911 immediately, then remember SAVE ME,” says Dr. Dolgetta. She urges providers to discuss the acronym SAVE ME (Stimulate, Airway, Ventilate, Evaluate, Muscular Injection, Evaluate again) with OUD patients and their friends and family so that these lifesaving steps are instinctive in an emergency.

Moreover, healthcare providers can have a significant impact on the success of an opioid detox. They must encourage positive prognostic factors, such as being employed or having a support system, to help an individual taper off opioids and refrain from relapsing. Arguably, the most impactful factor for successful withdrawal is having access to and engaging with a fam-

ily doctor. Dr. Dolgetta echoes this: “Patients without an attachment to a primary care physician have a 70 per cent increased risk of opioid relapse at one year.” While a patient tapers off opioids, their family doctor can provide accountability, a safe place to talk, and the continuum of care to monitor their mental and physical health.

Last, and by no means least, healthcare providers need to incorporate a biopsychosocial treatment regimen in OUD management. Despite drugs being available to assist those with opioid detoxification, known as opioid agonist therapy (OAT), addiction treatment requires a multidisciplinary approach. “Alone, medically assisted withdrawal management has not been shown to be an effective treatment for OUD,” Dr. Dolgetta emphasizes. “A counselling and OAT combination is best to ensure successful long-term management of opioid use disorder.”

The opioid crisis is on a dangerous trajectory. Healthcare providers have an urgent responsibility to educate, diagnose, and treat OUD patients, while considering the combination of biological, psychological, and social factors at play. Until we start treating addictions at an individual level, the opioid crisis will show no signs of slowing down.

Visit the EHN website to learn more: www.ehncanada.com. **H**

Sophie Ash is a freelance medical writer for EHN Canada.

Opening the door for Indigenous education

By Jane Cocking

Royal Victoria Regional Health Centre (RVH) has created a safe, welcoming place for staff and visitors to share conversations about Indigenous history with the installation of a Gord Downie & Chanie Wenjack Legacy Space.

RVH is the first public healthcare centre in Canada to install this Legacy Space. The project was initiated by Dr. Matt Follwell, radiation oncologist and Chief of Oncology at RVH's Simcoe Muskoka Regional Cancer Program. Dr. Follwell rallied his colleagues to fund the installation to support reflection and education on Indigenous issues, particularly with the discovery of mass residential school graves.

"Hopefully, it's acting more as a welcoming symbol, something that can put people at ease that we've acknowledged these things happened and there are historical traumas that are essentially still being lived out in our communities," says Dr. Follwell. "This is just the beginning. We still have a long way to go."

Since 2019, RVH has worked with the Downie-Wenjack Fund (DWF) and the North Simcoe Muskoka Indigenous Health Circle to become a DWF Legacy Space partner. The display cabinet, currently in the health centre's main lobby, is mobile to allow it to be moved to different areas of the building.

"The Legacy Spaces program exists because there is a need for safe, welcoming places where conversations and education about Indigenous history – and our collective journey

towards reconciliation – are encouraged and supported," says Kayleigh Jordan-McGregor, Development Associate, The Gord Downie & Chanie Wenjack Fund. "They also serve as symbols and reminders of the important work each of us needs to undertake, particularly employers, in responding to the Truth and Reconciliation Commission's 94 Calls to Action. It's an important step that all organizations can take to ensure that Indigenous perspectives are represented and celebrated in their workplace."

The installation at RVH was formally recognized during a ceremony in late October to coincide with the Secret Path Week, a national movement commemorating the legacies of Gord Downie and Chanie Wenjack. This is a meaningful week as October 17th and 22nd respectively mark the dates that Gord Downie and Chanie Wenjack joined the spirit world.

"Together with the Indigenous Health Circle and Indigenous community partners, RVH has been working to provide culturally safe care to Indigenous patients and their families. As a member of TEAM RVH, I am proud of RVH's Smudging Policy, which allows myself and Traditional Healers to perform Ceremony with patients and their families," says Roberta Manitowabi, Indigenous Patient Navigator in the SMRCP. "The launch of RVH's DWF Legacy Space is another important step toward Truth and Reconciliation, providing space and opportunity for reflection and Indigenous cultural safety education for Team RVH." ■

Jane Cocking is the Manager of Corporate Communications, Royal Victoria Regional Health Centre (RVH) in Barrie, Ontario.



Roberta Manitowabi, Indigenous Patient Navigator, and Dr. Matt Follwell, radiation oncologist and Chief of Oncology, both with Royal Victoria Regional Health Centre's Simcoe Muskoka Regional Cancer Program, take a moment of reflection at the new Downie-Wenjack Legacy Space

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