PSA Submission

Auditor General's Review: Personal Protective Equipment (PPE) during COVID-19

May 2020

PSA
For a better working life
New Zealand Public Service Association
Te Pūkenga Here Tikanga Mahi

About the PSA

The New Zealand Public Service Association Te Pūkenga Here Tikanga Mahi (the PSA) is the largest trade union in New Zealand with over 75,000 members. We are a democratic organisation representing members in the public service, the wider state sector (the district health boards, crown research institutes and other crown entities), state owned enterprises, local government, tertiary education institutions and non-governmental organisations working in the health, social services and community sectors.

The PSA has been advocating for strong, innovative and effective public and community services since our establishment in 1913. People join the PSA to negotiate their terms of employment collectively, to have a voice within their workplace and to have an independent public voice on the quality of public and community services and how they're delivered.

The PSA is an affiliate of the New Zealand Council of Trade Unions Te Kauae Kaimahi (CTU).

Objective of the review

We welcome that the Auditor-General will provide an independent review of the Ministry of Health's management of personal protective equipment (PPE) required for the COVID-19 response. This review is intended for the public and for Parliament to understand the Ministry's management of stock of PPE, its adequate supply and distribution process to those who need it. The intention of the review is to contribute to improvements of this process where appropriate.

The PSA's experience of management of PPE required for the COVID-19 response

The PSA represents workers throughout the State Sector, both directly employed and contracted to the community and private providers. This includes those working for instance in border agencies (including Customs, the Ministry for Primary Industries and Aviation Security), in District Health Boards and community health services and those working in residential and community facilities delivering disability and social services such as youth justice, youth justice, family support, budgeting, food banks, family violence etc.

The early stages

The PSA is now involved in various working groups related to PPE over the past weeks and engaging directly with employers at both senior management and workplace level to ensure the essential services workers and service users are protected from spreading or receiving COVID-19.

Unfortunately, we were not engaged in discussions about PPE use and distribution from the beginnings. As a result of the lack of engagement we had to invest a lot of time into lobbying politicians and senior Ministry of Health (MoH) officials to be included to contribute our knowledge and experience of the sector.

The formation of working groups was problematic also because other necessary participants were not included. The community sector as such was put off to the side and de-prioritised.

There was inconsistency between statements made by the Prime Minister and the Director General (DG) of Health and what was happening in practice. This created frustration as MoH guidance did not follow public assurances. The distribution of PPE also contributed to a loss of confidence of workers to be safe and to keep others safe.

There appeared to be limited ability to ensure a commitment, made by the DG, was implemented, which was possibly a result of the DG not being able to direct DHBs either individually or as a group.

Also, the time it took to develop and update guidance was a problem. Guidance needs to be regularly updated as circumstances change and new information becomes available. Leaving old incorrect guidance in the public domain unchanged until the whole guidance could be consulted on was inefficient and damaging. As specific points of guidance were consulted on and agreed it should have been updated rather than waiting for every aspect to be agreed before updating.

We acknowledge the hard work of those at the Ministry of Health developing and publishing the guidance. We are aware that they worked long hours under intense pressure. It is not the fault of the individual person involved in this. The Ministry needs the capacity to do this level of work. We are the union for people working at the Ministry of Health and we would be pleased to engage with the Ministry to improve processes and resource allocation where possible.

Exposure of systemic issues

The PSA has witnessed shortcomings in the Ministry of Health's management of the distribution process which put our members and their clients at serious risk. Our experience and analysis points to significant disjoints between the different parts of the health system, for example

- Director General of Health (DG) vis-a-vis parts of the MoH: The DG didn't seem to be well connected and some officials within the MoH appeared to be siloed.

- MoH vis-a-vis the DHBs: The lack of a national DHB approach contributed to a disjoint between DHBs meaning that different regions took different approaches and people living in different regions experienced the supply of PPE differently.

- DHB vis-a-vis private businesses or community organisations: Different DHBs were and are taking different approaches towards private business and community organisations' PPE distribution.

- MoH vis-a-vis private businesses or community organisations: Different private business and community organisations were and are taking different approaches towards PPE distribution.

In addition, our members in the contracted out sector struggled not only with unsafe working conditions by not being provided with adequate resource to maintain appropriate hand hygiene or ability to use PPE. They also struggled with financial uncertainties due to income drops and adequate leave support in line with Ministry of Health guidelines (especially for high risk groups and those who contracted COVID or had to self-isolate).

Overall, the PSA recognises the immense task of distributing PPE quickly to essential workers on the ground. One of the underlying issues (independent of COVID-19) is that the health and disability system is fragmented and therefore struggles to distribute e.g. PPE evenly and equitably (especially under urgency such as the present COVID-19 pandemic) or to consistently implement policy and guidelines. The pandemic has exposed the already existing shortcomings of NZ's health and disability system with its contracted out services and the dispersed funding system.

Other systemic issues we have observed include:

- The move across DHBs to just in time supply procurement, and the lack of dedicated pandemic equipment storage separate from hospitals under intense space pressure may have contributed to their inability to provide adequate supply and distribution of PPE.

- Overall, our experience has been that: where organisations have a strong health and safety culture and mature health and safety systems already in place; and where the PCBU has quickly taken the lead responsibility within the organisation for the COVID-19 health and safety response, including PPE distribution; there have been fewer problems with PPE distribution and supply. There are examples of this included in the public service sector specific section below.

- Supply and distribution can be good but PPE can still fail to protect people if organisations do not have strong business as usual health and safety induction and training processes already in place.

- Where there are strong, functioning health and safety employee participation processes in place, and a strong and constructive relationship with the union, issues can be identified and resolved quickly.

- Where health and safety functions within organisations are more focussed on risk and assurance and governance of the health and safety function than they are on coalface health and safety, this has worked against the organisation being able to respond quickly and put appropriate health and safety measures in place, including in relation to PPE provision and training.

- Within the State services: coordination and collaboration between the different peak organisations with responsibility for aspects of workplace health and safety; and role clarity for each of these organisations, could be improved. Each of these organisations (e.g. the Ministry of Health, Worksafe, the Government Health and Safety Lead and the Government Property Group) has their own specific mandate and/or legislated responsibilities in relation to workplace health and safety in the public health crisis. The Ministry of Health needs greater capacity to manage this.

- Overall, organisations are much better prepared to deal with civil defence emergencies than they are with public health emergencies. There could be a more integrated and consistent approach within organisations to planning and preparing for all types of emergencies.

- Some of the risks associated with poor PPE supply and distribution in a pandemic situation could be mitigated by measures such as ensuring by default provision of sanitisation and dedicated handwashing facilities in all community facing services and facilities, including airports.

Below the PSA shares information by sector for your information. It shows that a review of PPE supply, stock maintenance and distribution is not complete by simply focusing on the Ministry's management of the process. The examples below highlight the importance of reviewing the entire supply chain from the Ministry, via the DHB, provider or agencies to the worker who needs it.

The PSA recommends a follow-up review into the distribution processes of organisations directly involved in distributing PPE to their workforce. The PSA is available to contribute relevant information to this process. The improvement of all distribution processes on all levels is essential for future pandemic outbreaks to keep the workforce and the public safe and to be able to continue essential services under highly unusual circumstances.

District Health Board (DHB) Sector

Main issues

- Lack of advice from MoH regarding respiratory patients, probable COVID-19 patients; until 25 April only had information on PPE; COVID-19 positive patients from 28 March. See for example this article highlighting the confusion in the sector.
- General issue was lack of availability of PPE, being locked away (due to risks of theft) or staff being told by senior staff not to use it
- PPE in short supply due to theft and therefore equipment being locked up
- Different information being given by PM and MoH regarding use of PPE
- Lack of showering facilities
- Poor disposal facilities
- Lack of evidence about some Aerosol generating techniques.
- Minimal information/ protection from none symptomatic cases
- Lack of consideration for admin staff working in Emergency Departments /COVID-19 wards; only last week we were told the COVID-19 response team was reviewing all the receptions and waiting rooms.
- The Chief Operating Officer (COO) group was looking at this several weeks ago. PPE group still looking at it
- Not all groups were given good education/support regarding donning and doffing

Southern DHB

Improper use of by orderlies and PSA suspects it could have been down to lack of training for this group. Example, orderly would don a mask when coming to pick up a patient from a service, then remove mask and shove in a pocket, then re-don the same mask when they next came back into department.

Shortage of N95 masks, particularly size small. The fit testing took weeks, and then they were only made available in ICU and theatre. Chief Financial Officer was charged with distribution, but she does not have the clinical knowledge to know all the places they are needed. The Chief Medical Officer (CMO) seemed to have little knowledge of aerosol generating procedures or actions.

The DHB is being very cautious with using reusable goggles, face shields, gowns, gloves, surgical masks, and N95 respirator masks and often not using them appropriately. For example, a nurse was getting a suspected COVID-19, 90+ years-old patient, awaiting test results with a cough ready for a shower. The patient was generating aerosols, but the nurse was not allowed to use the N95 mask. This was directed by the duty manager as the patient had not yet tested positive even though he was being managed in isolation.

Hutt DHB

N95 mask initial stock had perished elastic, this was replaced but still had high fit failure rates.

CCDHB

The receptionists at CCDHB are wanting Perspex screens in situations where a 2-metre distance cannot always be maintained. Some areas already have them, others don't. Consistent protection for administration and clerical workers was lacking.

Waikato

Physiotherapists had to do respiratory treatment without access to full PPE which lead to secretion being expectorated on Physiotherapists head.

Counties Manukau

There was confusion prior to revised guidelines for type of PPE to use with respiratory patients – physios and SLTs. Clerical staff in the early days were being admonished told off if they were seen wearing masks. They would have liked Perspex screens put up at reception desks and ward clerk desks moved. Staff were concerned to simply stand back with no PPE whilst the clinical staff walked past their desk with a patient all in full PPE.

CDHB

Staff only have access to PPE (in locked place) to attend to clients, who have probable/confirmed case of COVID-19 or urgent respiratory needs. PPE kits that staff have been shown by infection control nurse have blue gloves, goggle, yellow gown, surgical mask (not N95).

Community Public Services (CPS) Sector

Community support workers work in close contact (for personal cares within one metre) with clients. Their clients are those who are elderly, ill, injured or disabled. Most of their clients are vulnerable and at risk (the majority within the MoH definition of those who are at risk of severe illness if they contract COVID19). Their duties involve personal care, often of an intimate nature. Disability support workers support people with intellectual and physical disabilities living in community homes or their own homes providing 24/7 support. Mental health and addiction support workers work support people living in community homes and their own homes.

Support workers visit clients in their homes including homes in retirement villages. They travel from client to client during the day, entering homes to provide client support. Many homes have become less clean due to the reduced or cancelled home management support during level 4 and level 3 or as clients cancelled this service due to fear of exposure to COVID-19. Some support workers may provide support for more than 10 clients per day, and one large Home Support provider stated that they have 240,000 close contact client interactions per week.

The employers in this sector are for profit and not for profit organisations, who are awarded contracts via DHBs, MOH and ACC. The vast majority of home support workers are employed by four for profit agencies.

Main issues

- COVID-19 required constant changes to the **existing guidelines for the distribution and use** of PPE. While this iterative process was unavoidable and possibly necessary it was inefficient. Earlier we highlighted that updating guidance and ensuring the latest guidance was available didn't happen in a timely manner. Guidance was only made available when every issue and situation was agreed upon meaning that incremental improvements couldn't be put into practice immediately.
- The **supply chain**, from MoH to DHBs and then onto providers, meant that the correct PPE was significantly delayed and has still not kept up. Originally there was no centralisation of PPE distribution. Then there was a half-way house of centralisation with supply still having to be regionally delivered through DHBs. Different DHBs operated to different criteria for distribution. Some were worried about running out of supplies and held back supply. Some held back on the basis people wouldn't know how to use it despite support workers receiving training (like other health workers).
- Due to COVID-19 with the increased demand for PPE some Community Home Support Providers were not receiving even their pre-COVID-19 recommended PPE and were unable to distribute these to support workers. This included limited distribution of gloves and hand sanitiser.
- Adequate PPE was not available to support workers despite workers' and unions' repeated requests since late March 2020, these requests were made at the highest levels of government including Ministers and senior MoH officals
- The time lag of MoH updating PPE guidelines is significant in that DHBs were supplying to the level required on the 28 March guidelines. (minimal masks for workers working with those that required mask use prior to COVID-19)
- Clinical guidance was that support workers did not need masks – our view was that if a support worker is working with a client within less than 1-metre they should have masks.
- Although the DHB 'had stated they had filled the providers orders for PPE' providers have informed the union that this is not correct with many orders not being filled. It appeared that DHB distributing PPE did not have knowledge of the number of personal cares provided, the type of cares and did not fill orders to enable masks to be used for cares that met the guidelines of those clients more at risk of severe illness if they contracted COVID19.
- The supply was further compromised because different DHBs took different approaches to the provision of PPE leading to inconsistencies delays and shortfall in PPE provision. Providers dealt with multiple DHBs who had their own differing systems about PPE supply to providers which further complicated the situation.
- The nature of the work was and continues to be poorly understood. The actual work and duties performed by support workers in the community sector support workers do is not fully understood by DHBs and MOH, and this has led to problems with getting PPE guidelines amended appropriately.

Timeline of issues

Please note that supporting documents such as guidance and announcements were provided separately.

- The MoH issued guidance on PPE for Support Workers in the Community on **28 March 2020,** these guidelines state no mask was required for personal cares for those clients who were immunosuppressed. As per MoH guidelines on social distancing, support workers requested PPE including masks to be provided for personal cares as personal cares require physical contact with clients.
- On **31 March 2020** the Director General for Health Ashley Bloomfield advised via pubic broadcast that masks would be provided to Community Support Workers referring to the requirement to 'feel safe' for support workers and clients.
- MoH published guidelines for front line healthcare workers on **7 April 2020**. These guidelines were conflicting i.e. referring to social distancing but also risk assessment (masks not required) and that a mask could be worn for 4 hours (there appeared to be no consideration that a support worker would drive between numerous clients within a 4 hour period; this being related to a lack of understanding the nature of work) and also stated that 'we cannot afford to waste or misuse a valuable resource'.
- A joint letter statement on the provision of masks and PPE for Community Support workers was signed by the unions PSA and E tū, the Home and Health Care Association and DHB's on **22 April 2020**. This joint statement required a risk assessment and that if a support worker requested masks, they would be provided to them.
- On **23 April 2020,** MoH updated PPE Poster and FAQ and both were made available on the MoH website on **25 April 2020**. The resources continued to advise to masks being worn for 4 hours and a risk assessment which continued to exclude vulnerable clients.
- **7 May** MoH published updated posters for PPE use in Disability and Community Health Care.
- Some providers are still not providing adequate PPE and some providers have had sporadic supply of hand sanitiser available for support workers with some employers requiring support workers to provide their own soap and towels. Other employers expected support workers to use their clients' soap and towels as adequate hand hygiene.
- Despite the guidelines changing on 7 May 2020, some employers have not provided adequate numbers of masks to support workers to use with all clients who are at higher risk of severe illness of contracting COVID-19 (as defined MOH website).

As a consequence of support workers not having access to adequate PPE the following has happened:

- Clients have refused support workers' care and may have put themselves at risk due to personal cares not being provided.
- Some support workers have sent their own children to live elsewhere during the lockdown to keep them safe as they have not felt safe without PPE being provided to them.
- Support workers are suffering from anxiety about the safety of their clients, their loved ones and themselves
- Unions have advised support workers to defer work where adequate PPE is not available.

- Some support workers have been stood down on pay as they have not had gloves to provide cares (exposure to faecal matter) until gloves arrived for them to use.
- When having received PPE from DHBs, some providers required supports workers to travel in their own time and at their own expense to pick up PPE supplies.
- The media statements assuring that there was sufficient supply of PPE, while support workers were struggling daily to receive any, caused anger and frustration, and giving them a sense that they are considered of least value and are expendable.

Public and State Services Sector

For our members working in the State services, other than District Health Boards (DHBs), PPE supply and distribution has been the responsibility of individual agencies and, on the whole been well managed. For example, the border agencies (including Customs, the Ministry for Primary Industries and Aviation Security), agencies have engaged extensively with us and actively problem solved and resolved any issues raised. This is in contrast to our experience with DHBs and contracted providers.

We have received feedback about a number of specific agencies:

<u>Organisations at the border (including MPI, AVSEC, Immigration and Customs)</u>

- Overall, these agencies have managed the distribution and supply of PPE without the need for supply from the Ministry of Health. They had distribution processes already in place and supplies in stock from the measles outbreaks and previous pandemics.
- They have health and safety systems in place and have engaged regularly and constructively with PSA representatives throughout to ensure necessary PPE is available and used.
- Had they not had adequate supply or systems in place then they would have needed support from the Ministry of Health, which would have placed even greater pressure on the Ministry's ability to ensure distribution of PPE to DHBs and contracted providers within the health and disability system.
- Default provision of handwashing facilities in airports where staff are stationed would complement the use of PPE and mitigate against risk from any unevenness in supply.

<u>Corrections</u>

- Very clear leadership from the PCBU, effective systems for supply and distribution and clear guidance on use.

<u>Oranga Tamariki (includes both community social work, residences and care homes)</u>

- Good practices and systems for supply and distribution in place right from the start. Advice about use could have been clearer had it been centrally delivered. Greater health and safety system maturity will contribute a stronger coalface understanding of the hierarchy of controls and how to do a risk assessment around them.

Ministry of Justice

- Some initial problems with supply of PPE for security officers. Resolved after engagement with us.
- Earlier and clearer public health guidance on when PPE should be used would have assisted.

Thank you for considering the information.

For further information, please contact:

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