Ethics Table Policy Brief #3
Version date/time: 03-25-2020, 3:30 PM

For circulation beyond Bioethics Table?
Yes ☒ No ☐

Topic

Priority Setting of Personal Protective Equipment – Within Health Care Institutions and Community Support Services

Policy Problem:

Ontario faces critical shortages of personal protective equipment (PPE). Procurement efforts are underway provincially to augment supply of PPE. Health service organizations are implementing measures to ensure evidence-based use of PPE based on CMOH directives and guidance. Given critical shortages, priorities must be set for how PPE supply should be distributed within health care institutions and community support services.

Policy Question(s):

What priorities should be set for the allocation of PPE within health care institutions and community support services?

Relevant Ethical Principles:

Ethical principle	*Brief interpretation in the context of the policy question*
Minimize risk of harm to health workers and patients/clients/residents	PPE is intended to protect health care workers and other staff from risk of harm due to infection, and in doing so, protect others, notably patients/clients/residents, from subsequent transmission of infectious diseases. Given supply shortages of PPE, the allocation of PPE should strive to maximize its intended benefits, i.e., prevention of infection and the spread of disease, and therefore minimize harm, particularly among those most at risk from infection and severe illness due to infection. In particular, a reciprocal obligation exists to minimize harm among those put at risk of exposure to infection (of COVID-19 or otherwise) during their participation in direct patient care.

Ensure a proportional response based on best available evidence	Proportionality helps to ensure the least harm to health care workers, staff, and patients/clients/residents arising from PPE allocations and related restrictions on health and support services. Prioritization decisions should be proportionate to the real or anticipated limitations in PPE supply.
Ensure health care workers and staff are treated equitably	PPE should be allocated in a manner that best ensures similar cases are treated equally, where irrelevant characteristics such as seniority do not serve as the basis for allocation decisions, that allocation considers the interests and needs of the most disadvantaged, and that decisions about allocation are made through fair processes. Allocation of PPE should not arbitrarily disadvantage any health and support service sector, health care and support service provider, or health care/service provider organizations.
Foster trust	Foster and maintain public, patient, and health care worker confidence in PPE distribution system by communicating in a clear, transparent, and timely fashion, including rationale about what criteria are informing PPE allocation decisions and staff assignment decisions expectations around accepting or refusing work assignments.

Each of the above principles ought to be upheld wherever possible, but can come into conflict with one another. The process by which the above principles are balanced when making allocation decisions should adhere to principles of procedural fairness, including transparency and consistency.

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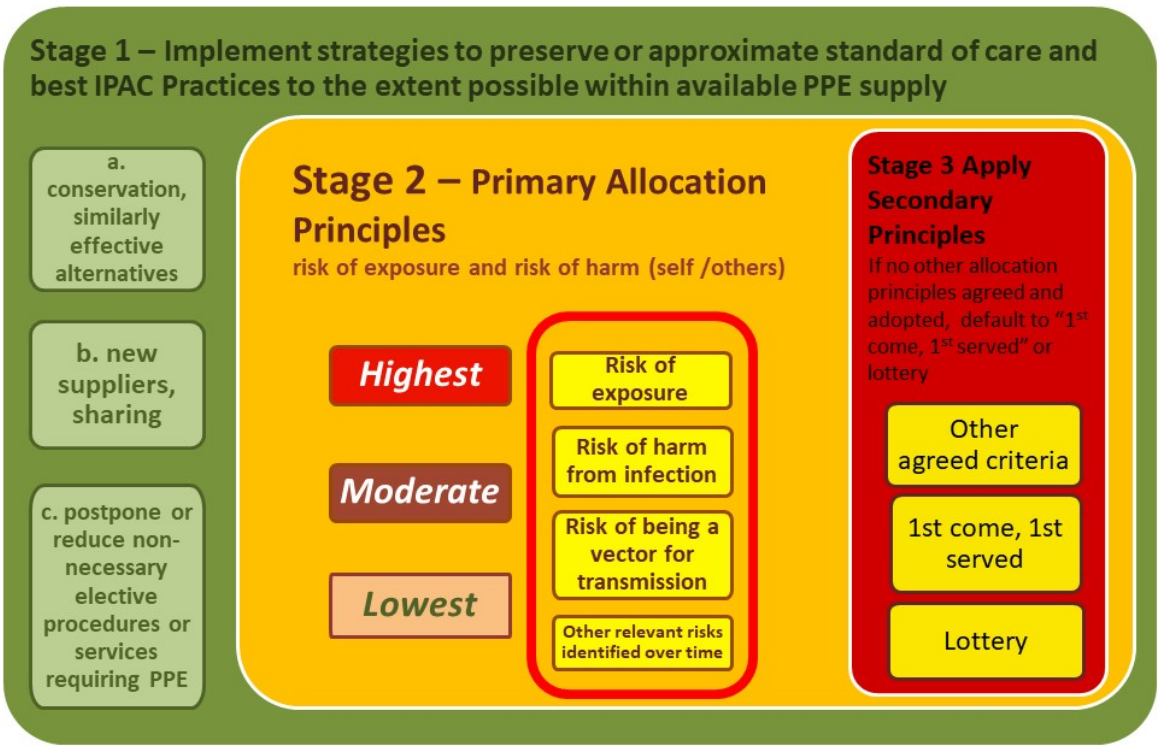
General Guidance:



Stage 1: Procurement, preservation, and conservation activities should continue. PPE supplies and usage practices should be surveyed and reviewed at frequent intervals. Preservation and conservation requires utilizing PPE for training purposes and, where safe, for direct care. It also requires minimizing the need for PPE by using alternatives. Non-essential and elective services should be ceased, or reduced to minimal levels for allowable exceptions, as per CMOH directives, to allow PPE to be allocated to critical health system functions. Cohorting COVID-19 positive patients/clients/residents, and thus cohorting staff who care for them, should be considered.

Stage 2: Priority should be given to those providing direct care to patients/clients/residents with COVID-19 (and other diseases that require PPE). In order, priority should be given to:

a. Healthcare providers who are at **highest** risk for exposure to (or risk of harm from) COVID-19 (or other diseases that require PPE) that are providing direct care and services to patients/clients/residents.
b. Healthcare providers who are at **moderate** risk for exposure to (or risk of harm from) COVID-19 (or other diseases that require PPE) that are providing direct care and services to patients/clients/residents.

c. Healthcare providers who are at **lowest** risk for exposure to (or risk of harm from) COVID-19 (or other diseases that require PPE) that are providing direct care and services to patients/clients/residents.

Risk of harm should be evaluated and categorized based upon the best available evidence as well as the availability of alternative infection prevention and control measures (e.g., the provision of virtual care, PPE alternatives, etc.). Risk assessments may be guided by Tables 1 and 2 below. Risks for consideration if providing care without adequate PPE include:

a. Risk of exposure
b. Risk of harm to self or others from infection
c. Risk of being a vector for transmission

TABLES 1 & 2 OF COMBINED RISK ASSESSMENTS

Step One in Estimating Risks* – Provider Specific Risks						
Provider Harm from infection / **Provider Risk of Exposure**	**1**	**2**	**3**	**4**	**5**	**6**
1	1	2	3	4	5	6
2	2	4	6	8	10	12
3	3	6	9	12	15	18
4	4	8	12	16	20	24

Step Two in Estimating Risks* – Risks Provider Poses to Patient/Client/Resident						
Provider Value from Step One / **Risk if transmitted to care/service recipients**	**1-4**	**5-8**	**9-12**	**13-16**	**17-20**	**21-24**
Low -1	**4**	**8**	**12**	**16**	**20**	**24**
Medium - 3	**12**	**24**	**39**	**48**	**60**	**72**
High- 5	**20**	**40**	**60**	**80**	**100**	**120**

*The above tables include arbitrary numerical values that only provide guidance when other factors are considered. The actual risks and corresponding value will be determined as data is analyzed regarding specific factors associated with exposure, likely severity, demographic-related risks, etc. Cut-off points will be determined by those responsible for coordinating service provision locally. High risk provision will only be provided where providers are conscientiously participating despite the risk and there is consent from patient/client/resident or their SDM.

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Stage 3: When decisions must be made between health care providers or staff within a level of priority as described in Stage 2, prioritize health care and staff using principle that promotes equality, such as:

a. Other agreed upon criteria that are developed and sanctioned by affected stakeholders

If no other agreed upon criteria exist:

b. First-come, first-served
c. Lottery