

**Testimony of Pascaline Muhindura, RN
On Behalf of National Nurses United
Before the
Subcommittee on Workforce Protections
Committee on Education and Labor
March 11, 2021**

Hearing on “Clearing the Air: Science-Based Strategies to Protect Workers from Covid-19 Infection”

Good morning and thank you, Chairwoman Adams and Ranking Member Keller, and members of the subcommittee for giving me the opportunity to testify here today. I have been a registered nurse (RN) for six years, and I am a proud union member of National Nurses Organizing Committee, an affiliate of National Nurses United (NNU). NNU is the largest union of RNs in the United States, representing over 170,000 members who work as direct care health professionals in every state in the nation.

I have worked as a critical care nurse at Research Medical Center, an HCA Healthcare facility, in Kansas City, Missouri for four years. When the pandemic began one year ago, my unit became a Covid-19 unit, and I have been caring for Covid patients ever since.

In my testimony today, I will share the details of my experiences as a Covid-19 nurse over the course of the pandemic and make three main points. First, my employer has failed to provide the N95 respirators and other workplace protections that my colleagues and I needed to do our jobs safely, which has led to many Covid-19 infections and ultimately the death of one of my coworkers. Second, the Centers for Disease Control and Prevention (CDC) and the Occupational Safety and Health Administration (OSHA) have failed to protect nurses and other frontline workers from Covid-19. The guidance issued by the CDC about Covid-19 transmission and worker protections has not been based on science and has directly led to infections and deaths of workers. Due to the CDC’s faulty guidance and the lack of an OSHA standard on infectious diseases, OSHA has been unable to effectively cite employers for Covid-related hazards. Third, it is critical that the CDC immediately recognize aerosol transmission of Covid-19 in their guidelines, and that OSHA issue an emergency temporary standard to protect workers from Covid-19 which recognizes aerosol transmission and the need for respiratory protection.

All Nurses and Health Care Workers on My Unit Contracted Covid-19 Because Our Employer Failed to Protect Us

Over the course of the past year, every single nurse and health care worker in my unit has contracted Covid-19. One of my colleagues died from Covid-19. As of March 5, 2021, at least 3,379 health care workers, including 345 RNs, have died from Covid-19 nationally.¹ Our

¹ For the methodology used to count health care worker and RN deaths due to Covid-19, see National Nurses United, “Sins of Omission: How Government Failures to Track Covid-19 Data Have Led to More Than 1,700 Health Care Worker Deaths and Jeopardize Public Health,” Sept 2020, available at

families have been put at risk of getting Covid-19 and many of our family members have gotten infected because of our jobs. All this illness and death was preventable – if only our employers and government had taken the necessary steps to protect us.

Our employers and government have failed to protect nurses, other health care workers, and our patients, despite the clear scientific evidence on aerosol transmission of SARS-CoV-2 and the measures necessary to prevent transmission (see Attachment 1). A vast body of scientific research has shown that this virus is transmitted through the inhalation of aerosol particles that are produced through breathing, talking, coughing, and sneezing, and which can remain viable in air for long periods of time and which can travel long distances. A growing number of outbreak investigations have found that aerosol transmission is the only possible explanation for the outbreak. Despite the evidence on aerosol transmission, many health care employers still do not provide the respiratory protection and other workplace controls that we need to be able to care for our patients safely.

The surgical masks that many employers, including mine, have given nurses to wear while caring for Covid-positive patients do not provide respiratory protection from infectious aerosols. An N95 filtering facepiece respirator is the minimum respiratory protection needed to reduce exposure to an aerosol transmitted disease. There are more protective respirators, specifically Powered Air-Purifying Respirators (PAPRs) and elastomeric respirators, which are safely reusable and offer a higher degree of protection. Unfortunately, in my hospital we are still fighting for N95s to be used for single use only, as intended by the manufacturer, and there is only limited stock of more protective respirators.

The reality is that our employers should have started with this highest level of protection from the beginning of the pandemic. Our Professional Practice Committee (PPC, a union committee to address health and safety and nursing practice in the hospital, of which I am an active committee member) submitted recommendations about preparations for a Covid-19 response to the Chief Nursing Officer (CNO) of the hospital on January 24, 2020. Despite those recommendations, when the Covid-19 pandemic first started in March, there was no preparation from hospital management to respond to the emerging outbreak, and we quickly saw that our employer had no strategy to contain the spread of the virus in our facility. There are evidence-based strategies for protecting health care workers from novel infectious disease outbreaks, and our hospital did not use them. Our union immediately called on our health care employers and all public health agencies to follow the precautionary principle, which states that we cannot wait until we know for certain that something is harmful before action is taken to protect people's health. We can always take layers off as we go but we can never add them back later.

It is because of the precautionary principle that nurses knew, more than a year ago, that we should have been given optimal respiratory protection to protect us from airborne transmission of Covid-19. But the hospital was not prepared with the personal protective equipment (PPE) stock that should be on hand in the event of an infectious disease outbreak, and none of the nurses on

my unit had been fit-tested for N95 filtering facepiece respirators (N95s). Fit-testing of N95s is necessary to ensure protection—and required by OSHA’s Respiratory Protection Standard²—and without it, nurses could not be assured that their N95 would protect them.

Our Employer Rationed and Withheld the N95 Respirators We Needed to Do Our Jobs Safely

For the first three weeks of March 2020, PPE including N95s remained available for nurses to use on our unit, although we had not been fit-tested for the N95s. During those first three weeks as the virus was slowly spreading in our community, our PPC compiled a list of health and safety concerns that we delivered to the CNO of the hospital. At the end of the third week of March, the PPC met with the CNO’s designee and the Critical Care Units Director to discuss our concerns. We raised many issues, including access to PPE, and the need for nurses to receive fit-testing for N95s. In that meeting, management informed us that doctors were already being fit-tested for N95s, but that they could not offer any guidance on fit-testing for nurses at that time. Given the relative chances of exposure, it was absurd that hospital management was fit-testing doctors but refusing to fit-test nurses. They told us that they were following CDC guidelines. We objected to this plan and pointed out that the CDC guidelines at the time allowed for bandanas to be used for protection against Covid-19 – which was a truly dangerous suggestion. In response, management laughed at us.

The day after that meeting, hospital management removed all the PPE from our units and placed it into a storage facility on one floor in the hospital. We were told that we needed to go to that particular hospital floor in order to check out any PPE that we needed and that PPE would be rationed. When we questioned why N95s and other PPE were being rationed, we were informed that the hospital had adequate supply of N95s and other PPE and management was choosing to ration these supplies because they were concerned about the possibility of a supply shortage in the future. Management consistently reaffirmed the strength of HCA’s supply chain, while continuing to ration supplies.

The next day, a patient was sent from the Emergency Department to the Cardiac Telemetry Unit, which was not supposed to receive any Covid-positive or potential Covid-19 patients. The RNs on the unit recognized the patient had signs and symptoms of Covid-19 even though the hospital had not classified the patient as a potential Covid-19 case. The RNs did not have access to PPE and cared for the patient without PPE. The patient later tested positive and was transferred to my unit. As a result of this exposure and our employer’s failure to provide adequate PPE, one of my colleagues, Celia Yap-Banago, contracted Covid-19 and lost her life.

The situation in those first months was dire. We continued to have little access to the N95 respirators and other PPE we needed. Not only were we forced to ration N95s and care for Covid-19 patients without respiratory protection, but we were also forced to reuse gowns. Patients were not effectively being screened for Covid-19. As a result, nurses, health care workers, and our patients were put at increased risk of exposure. Nurses were not promptly

² 29 CFR §1910.134

notified about exposures to suspected or confirmed Covid-19 patients and we were expected to continue reporting to work when we had been exposed.

The situation was chaotic and extraordinarily stressful. Our Covid-19 units were constantly experiencing deaths of patients and our hospital was often overrun. We were terrified every day that we would be exposed, and risk exposing our families at home, to Covid-19 because we did not have the PPE we needed.

I am lucky to work in a hospital where the nurses are represented by a union. It was through our union that nurses were able to successfully fight hard to force the hospital to get us some of the PPE we needed and to begin fit-testing nurses for N95s. When we received N95s, we originally had to use the same respirator for multiple shifts. The hospital tried to implement programs where they would use unproven procedures to "decontaminate" our N95s, procedures that not only had not been proven to work but that potentially damaged the N95s and also put nurses at risk of chemical exposures. With the union, we have continually fought back against the reuse, decontamination, and extended use of N95s with some significant success.

The science on the safe use of N95s is crystal clear: N95s are single use only respirators, and they should only be used one time, with one patient. Every time an N95 is reused, or used for an extended period, the risk of exposure increases. As you reuse an N95, the material of the mask degrades, the elastic becomes loose, and you cannot be guaranteed a proper fit.

One Year into the Pandemic, Employers Continue the Unsafe Rationing of N95 Respirators

Today, one year later, our employer is still not providing the protections we need. Even though N95s are now available on our unit, we are still fighting for them to be used properly. Our employer has plenty of supply but is still choosing to ration N95s. Right now, we are only allowed to use one N95 per shift. This means that we are using the same N95 with multiple patients, for a full 12-hour shift. After about four hours of wearing the N95, I can feel the mask degrading and the elastic getting loose, and I know the efficacy of the respirator is decreasing. Because we only have one respirator for the entire shift, nurses don't want to take the respirator off because our chances of exposure to the virus increase each time we take the respirator on and off. The respirator gets full of sweat and mucus and can be coated with the virus on the outside. Reusing a respirator or using it for an extended time is like using a dirty tissue to blow your nose. It is not sanitary and it is not the standard of care we should have.

The current policy on PPE use when taking care of Covid-positive patients is dangerous and irresponsible. We are still being told that we are not allowed to wear N95 respirators when taking care of certain Covid-positive patients. Management is requiring the use of level-three surgical masks for Covid-positive patients who are either on room air (which means that they are not using oxygen or a ventilator), or who are on a lower level of oxygen. We are only allowed to use N95s for aerosol-generating procedures or if the patient is on high-flow oxygen. This is contrary

to the scientific evidence showing that Covid-19 is transmitted via infectious aerosols emitted when Covid-positive individuals breathe, talk, cough, and sneeze.³

To be clear, in my hospital, nurses in Covid-19 units are still being forced to care for confirmed Covid-positive patients without any respiratory protection. This is despite the fact that there is existing supply of respirators in our hospital, and it is despite the fact that HCA, the corporation that owns my hospital, made more than \$3.7 Billion in profits in 2020.⁴

At the end of the day, not recognizing the aerosol/airborne transmission of Covid-19 and refusing to give us the respiratory protection we need has resulted in workers getting sick, and for some, it has resulted in death. This was the case for my colleague Celia.

I got Covid-19 the week of Thanksgiving. One week before I tested positive for Covid-19, I responded to a code blue for a Covid-19 patient. I was wearing the same N95 that I had been wearing throughout my entire shift and was doing chest compressions on the patient. It was a highly stressful situation, and I was sweating a lot. I knew that my N95 had already been degraded over the course of my shift, and I was very nervous about potential exposure. One week later, on the Sunday before Thanksgiving, I came into work and was feeling unwell and was coughing. There is a screening system before you enter the building, but the screeners let me walk through even though I told them I was coughing. I worked on the unit for about five hours before I was sent to the Emergency Department to get tested and found out I had Covid-19. In those five hours, I could have exposed many patients and coworkers.

The next two weeks were a harrowing experience for me. While my symptoms weren't critical, I was sick and suffering from a cough and shortness of breath. I share custody of my kids with their father, and at the time I tested positive, my kids were at his house. Because of my positive test, they had to stay with their father and I wasn't able to see them for two weeks, until I had fully recovered. I suffered from immense anxiety during this time and was unable to see any member of my family during Thanksgiving. I also was unable to spend my daughter's birthday with her. To make matters worse, my three-year-old daughter was experiencing respiratory symptoms during this period. While she tested negative for Covid-19, I felt very concerned that she may have been exposed to the virus from me. In the following weeks after I tested positive, many staff on my unit also contracted the virus.

Many of my nurse colleagues throughout the country have had similar experiences to those that we have experienced in Kansas City. In NNU's February 2021 survey of over 9,200 nurses, more than 81 percent report that they still have to reuse at least one type of single-use PPE (see

³ Experts Letter to Jeffrey Zients, Dr. Rochelle P. Walensky, and Dr. Anthony S. Fauci, Re: Immediate Action is Needed to Address SARS-CoV-2 Inhalation Exposure," Feb 15, 2021, available at https://aiha-assets.sfo2.digitaloceanspaces.com/AIHA/uploads/PressReleases/Immediate-Action-to-Address-Inhalation-Exposure-to-SARS-CoV-2_2142021.pdf.

⁴ HCA Healthcare Press Release, "HCA Healthcare Reports Fourth Quarter 2020 Results and Provides 2021 Guidance," February 2, 2021, available at: <https://investor.hcahealthcare.com/news/news-details/2021/HCA-Healthcare-Reports-Fourth-Quarter-2020-Results-and-Provides-2021-Guidance/default.aspx>

Attachment 4 for full results). And about 24 percent of hospital RNs report that their employer has recently limited the use of N95 respirators.

In addition to a lack of PPE, hospital employers across the country are still failing to provide the basic infection control measures that are needed to prevent transmission of Covid-19 within their facilities. About 54 percent of RNs report having ever been tested for Covid-19, despite testing being the only way to identify asymptomatic and pre-symptomatic cases. Many employers are also failing to conduct thorough contact tracing and failing to promptly notify RNs about exposures. Only 32 percent of RNs report that their employer informs them of exposures in a timely manner (see Attachment 4).

Covid-19 has Exacerbated Existing Health and Safety Concerns in Health Care, Especially Workplace Violence

While the pandemic has created its own life-threatening health and safety hazards, it has also exacerbated existing health and safety concerns in the hospital. For example, nurses have been dealing with high levels of workplace violence for many years. Throughout the pandemic, the frequency of violent incidents in the workplace has increased. NNU's most recent survey also found that workplace violence has been increasing during the pandemic—about 22% of hospital RNs reported a slight or substantial increase in workplace violence during the pandemic (see Attachment 4).

Workplace violence is something that all nurses experience on the job. In my unit, we have had severe violent incidents take place in the last few years. One of the nurses who worked in my unit was punched in the face by a patient in front of four other nurses. Nothing was done by management, and there was no follow up on the situation. A few weeks after the incident, she was reassigned to care for the same patient with no additional safety measures or supports, despite having been previously assaulted by the patient. My colleague felt fear and anxiety returning to work after this incident. Often, when nurses report workplace violence incident, management tells us that this violence is "just a part of the job."

In my first year as a nurse, I was taking care of a patient who was very agitated. At one point, the patient became angry and grabbed my stethoscope, which I was wearing around my neck. The patient began strangling me with the stethoscope. Luckily, a coworker was in the patient room with me at the time and was able to help me get free and leave the room. Since that time, I am careful to avoid wearing my stethoscope around my neck with any patients that may be violent.

The increase we have seen in workplace violence incidents throughout the pandemic is symptomatic of the many ways that employers have failed to protect the health and safety of nurses and other health care workers. These working conditions have deeply impacted the mental health of nurses and our families.

Pandemic Stress and Health and Safety Hazards Have Led to High Turnover

Nurses are exhausted. The turnover in my unit is rapid and is due to the stress of the pandemic and not having the protections we need. The people we started with last March are no longer working in my unit anymore. There are only two full-time RNs on dayshift who were working in my unit at the start of the pandemic that I know are still working there; everyone else is a travel nurse or is floating from a different unit. Over the course of 2020, 249 RNs left the bedside at Research Medical Center. This is roughly one-third of our entire registered nursing staff. The turnover has been shocking, but not surprising. The hospital has failed to adequately replace nurses; we currently have 115 fewer RNs in the hospital than we did before the pandemic. Many of my coworkers have left to work in other units that do not have Covid-19 patients.

People keep leaving because of the way we have been treated and the emotional toll of this job during the pandemic. With Covid-19, patients are some of the sickest we have ever seen and there is an environment of constant death in the hospital and in the Covid-19 units especially. Nurses are trained to deal with illness and death, and our job before the pandemic was often very stressful. But we need the staffing, the equipment, and the protections necessary to do our jobs well. On top of learning about a novel pathogen and trying to take care of our acutely ill patients, we have had to fight for the basic protections we need so that we can stay healthy and alive in order to provide patient care. This reality has made the pandemic unbearable for many nurses.

CDC, OSHA, and the Federal Government Have Failed to Protect Nurses and Health Care Workers from Covid-19

Something that has compounded the impact of the pandemic and having to fight for basic protections is that the CDC and other federal agencies have also abandoned us. Throughout the pandemic, the federal government, especially the CDC, has issued weak guidance that is not based on science or the precautionary principle. The CDC’s guidance for health care employers does not recognize aerosol/airborne transmission of Covid-19. The crisis strategies for PPE—which the CDC calls “optimization strategies”—gives employers a menu of options to avoid protecting their workers.⁵ The CDC guidance still allows employers to give nurses surgical masks when they care for Covid-19 patients or to require nurses to reuse N95s, putting us and our patients at risk of infection. CDC’s guidance on exposures to health care staff tells employers they do not need to do contact tracing if they do not want to put resources towards that while there is transmission within the community.⁶ This guidance treats respirators and facemasks as equivalent levels of protection, even though there is an abundance of research showing they are

⁵ Centers for Disease Control and Prevention, “Optimizing Personal Protective Equipment (PPE) Supplies,” last updated July 16, 2020, available at <https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html>

⁶ Centers for Disease Control and Prevention, “Interim U.S. Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to SARS-CoV-2,” last updated February 19, 2021, available at <https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html>

not. Management uses this CDC guidance as the rationale for these policies that have made my colleagues and myself sick and that led to Celia's death.

To be clear, my employer and other hospital employers across the country are using the CDC guidelines to justify withholding the PPE that we desperately need, despite having ample supply of PPE.

When my union filed a complaint with OSHA last spring, OSHA did not and could not issue a citation to my employer because of the CDC guidelines and the lack of an OSHA standard on infectious diseases (see Attachment 2). Our complaint addressed a multitude of hazards that our employer had not prevented, including the circumstances that led to the death of Celia Yap-Banago. OSHA investigated our complaint but did not cite our employer despite finding clear evidence that Celia and other nurses had been exposed to Covid-19 because of our employer's failure to provide PPE.

The CDC's reckless guidance and failure to recognize aerosol transmission of this virus has deeply contributed to the stress and exhaustion that nurses have experienced over the past year. CDC's crisis standards, which are not based on science, have been used as cover by hospital employers across the country for not providing optimal PPE or instituting proper infection control protocols, thus endangering nurses, other health care workers and our patients. As a result, nurses have been forced to work despite substandard protections so many times that it has become hard for some nurses to imagine what having optimal protections would be like. Before this pandemic, nurses could get fired for re-using an N95. Now, reality has shifted so far that having one N95 for a 12-hour shift is a win, despite the risk of exposure.

Throughout the pandemic, many of my colleagues and I have spoken out about these dangerous working conditions, the weak CDC guidance, and the lack of an OSHA emergency temporary standard on infectious diseases, and we have demanded the optimal PPE and other measures that we need to do our jobs. As RNs, we see this advocacy as part of our practice; we are patient advocates—that means doing what we can to make sure our patients get the safe, quality care they need. But speaking out like this can carry its own risks. For me, speaking out has put a target on my back at my workplace. Before Covid-19, I was a clinical instructor for nursing students and a preceptor for new employees. My performance reviews were always stellar. But since I began speaking out publicly and raising concerns about the dangerous working conditions during the pandemic, my performance reviews have dropped even though I am working the same way. The protection of the union has meant that I have not seen more severe retaliation. But this is not true for nurses in other hospitals who do not have the protection of the union.

Recommendations to the CDC and OSHA to Make Strong, Science-Based Decisions to Protect Workers and Combat Covid-19

As unionized direct care RNs, with our practice rooted in science, we have clear recommendations for what we need to be able to care for our patients safely. First, we need the

CDC to update its Covid-19 guidelines to be based on scientific evidence, especially regarding aerosol transmission of the virus. The CDC must rewrite a significant portion of the guidance for health care and other industries to make stronger recommendations regarding respiratory protection, ventilation, and other control measures to reduce and prevent aerosol transmission of Covid-19. Additionally, the CDC needs to revoke the crisis standards on "optimization" of PPE, which are guidelines based on supply considerations not science.

Second, we need a federal OSHA standard that fully recognizes aerosol transmission of Covid-19 and establishes strong requirements for our employers to implement the infection control plans needed to protect our health and safety at work. These infection control plans must include providing optimal respiratory protection, ventilation, patient screening and isolation, testing, paid precautionary leave, and more (as outlined in the Nurses' Proposal for a Comprehensive Federal Plan to Combat the Covid-19 Pandemic, see Attachment 6).

It is devastating to know with certainty that if these recommendations had been implemented immediately one year ago, my colleague Celia, along with thousands of other nurses, health care workers, and frontline workers would be alive today. I urge every member of this committee to take steps to ensure that the protections we need are implemented as soon as possible. This pandemic is not over, and employers across the country are still knowingly subjecting their workers to exposure to Covid-19. We need your urgent support to ensure that the CDC guidelines are updated and that OSHA issues a strong and enforceable standard to protect workers during this pandemic and any future infectious disease outbreaks.

Attachments:

1. National Nurses United Fact Sheet—Droplet vs. Airborne: How is SARS-CoV-2 Transmitted? Available at https://www.nationalnursesunited.org/sites/default/files/nnu/graphics/documents/0720_COVID19_aerosolTransmission.pdf.
2. Letter from the Occupational Safety and Health Kansas City Area Office to National Nurses United Labor Representative, Julie Perry, regarding OSHA Complaint No. 1583505 at Research Medical Center. Complaint filed July 13, 2020.
3. National Nurses United Statement about Celia Yap-Banago's death. April 22, 2020. Available at <https://www.nationalnursesunited.org/press/kansas-city-rns-hold-vigil-memory-research-medical-rn-who-died-covid-19>.
4. Results from National Nurses United's Surveys of Registered Nurses on Covid-19 in Their Workplaces.
5. National Nurses United, Unions, Allies Urge CDC to Acknowledge Covid-19 Aerosol Transmission to Help Bring Virus Under Control, Feb 23, 2021. Available at <https://www.nationalnursesunited.org/press/nurses-unions-allies-urge-cdc-to-acknowledge-covid-19-aerosol-transmission>.
6. Nurses' Proposal for a Comprehensive Federal Plan to Combat the Covid-19 Pandemic. Dec 10, 2020. Available at https://www.nationalnursesunited.org/sites/default/files/nnu/graphics/documents/1220_NU_Covid19_Comprehensive_Plan_Biden_12-10-2020.pdf.

DROPLET VS. AIRBORNE: HOW IS SARS-COV-2 TRANSMITTED?

The U.S. Centers for Disease Control and Prevention (CDC) states that the primary mode of transmission for COVID-19 is droplet transmission and that “airborne transmission from person-to-person over long distances is unlikely.”

Droplet vs. Airborne: Some History

The CDC’s categorical distinction between droplet (large) and airborne (small) transmission was established in the 1930s and has not been substantially updated since. This paradigm requires a focus on the behavior of isolated droplets and a simplified distinction between large and small droplets and their corresponding evaporation rates. Together, these give the false sense that droplets behave in only one of two ways and create a division between two types of transmission and their ranges, either close or far.

Droplet vs. Airborne: Updating the Science

Recent research confirms that when a person breathes, talks, coughs, or sneezes, they produce a multiphase turbulent gas cloud (or plume) of warm air containing respiratory droplets ranging in size from microscopic to visible (called “aerosols”). This plume and its aerosols are transported by ambient air. Aerosols remain suspended or fall in relation to a variety of factors including their size, evaporation rates, air current, temperature, and humidity:

Larger aerosols can remain suspended in the air for several minutes before settling on the ground or on a surface, while smaller particles can be kept afloat by the dynamics of the plume, allowing them to linger in the air and travel up to 27 feet through the room and ventilation systems.

For example, think about perfume spray which can be smelled from a distance for quite some time as the particles disperse throughout the room.

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Definitions:

DROPLET TRANSMISSION

Large respiratory droplets are propelled onto the face and mucous membranes of those nearby the infected person (within six feet).

AIRBORNE TRANSMISSION

Transmission of small respiratory droplets or droplet nuclei that can travel through and/or remain suspended in the air for a period of time leading to airborne transmission.

AEROSOL TRANSMISSION

An updated understanding of the complex ways that respiratory particles are created, how they move, and where they go.

*Drops fall continuously, depending on weight and other factors. The most **visible** drops would fall within **6 feet**.*

Turbulent gas cloud

*The study suggests that droplets of various sizes are trapped in a turbulent gas cloud, allowing them to travel up to **27 feet**.*



#ProtectNurses. All Our Lives Depend On It.



Is SARS-CoV-2 aerosol transmissible?

While modes of transmission have yet to be fully established for the novel SARS-CoV-2 virus, emerging studies support aerosol transmission.

- Two recent studies have found that SARS-CoV-2 can survive and remain infectious in aerosols from three to 16 hours.
- Recent research also shows that SARS-CoV-2 can survive on surfaces for an extended period of time.
- Evidence of environmental contamination also show that SARS-CoV-2 can travel long distances from patients. For example, genetic material from SARS-CoV-2 was detected on a number of surfaces in the Diamond Princess cruise cabins of both symptomatic and asymptomatic infected passengers 17 days after they vacated.
- A recent study of SARS-CoV-2 aerosolization from the University of Nebraska also found widespread environmental contamination. They found significant contamination on air handling grate as well as positive air samples in the hallways and on window ledges which were greater than six feet away from patients.

These data support aerosol transmissibility of COVID-19 and challenges the CDC's assertion that transmission over long distances is unlikely.

What does this mean for nurses and other health care workers?

The emerging evidence that aerosol transmission of COVID-19 is likely underlines the importance of protecting nurses and other health care workers—including both respiratory protection and contact precautions. Nurses and other health care workers should have the highest level of personal protective equipment (PPE) when caring for patients with suspected or confirmed COVID-19. The highest level of PPE for COVID-19 includes a powered air-purifying respirator (PAPR) and coveralls impermeable to viral penetration that incorporate head and shoe covering, and gloves.

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#ProtectNurses. All Our Lives Depend On It.





Julie Perry
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RE: OSHA Complaint No. 1583505

Dear Ms. Perry:

In response to your complaint concerning safety and/or health hazards at Research Medical Center, the Occupational Safety and Health Administration (OSHA) conducted an inspection. That inspection was completed on 07/13/2020. The results of our investigation of your complaint items are as follows:

Complaint item(s) and Responses:

ITEM 1: March 20th. Union stewards met with Stephanie Droppelmann and Director Kim Dannels (CNO designee). Reviewed multiple concerns and one was a request they fit test all RN's for N95's. Nurses were not being fit-tested for N95's. They said they had no intentions and were only doing this for doctors.

RESPONSE: A meeting was held with the nurses. Following the meeting nurses were given fit tests beginning on March 20, 2020 and on subsequent days. OSHA has a memorandum dated March 14, 2020, Temporary Enforcement Guidance- Healthcare Respiratory Protection Annual Fit-testing for N95 Filtering Face pieces during the COVID-19 Outbreak. If a good faith effort to comply with 29 CFR 1910.134 is being made then a citation is not issued.

ITEM 2: On March 21st, the Personal Protective Equipment warehouse was created on the first floor, in 1N. PPE had been removed from areas such as 3N, Medical Care and was only available on the first floor. Nurses were emailed on March 30 about having a PPE warehouse.

RESPONSE: Information was given to OSHA that medical staff were informed about the PPE warehouse during the week of March 20-27th huddles, the pre-shift staff meetings held on the floors. The PPE warehouse was being utilized to keep an inventory of PPE availability in the hospital. No citations regarding this complaint item.

ITEM 3: On March 22/23: A nurse on the 4th Floor, 4 N/C, Cardiac Telemetry Unit, received a Covid infected patient on the night shift of 3/22/20 from the ED. She voiced her concerns to the charge RN that the patient had signs and symptoms of COVID-19. There was no PPE to use on their unit. Celia Yap-Banago also had to care for the same patient without ppe until the patient was transferred to a Covid-19 cohort unit.

RESPONSE: A patient was transferred to the 4 N/C Cardiac Telemetry Unit that had pneumonia.

The patient had been screened in the emergency room using the CDC questions at the time: which were based on having a temperature, had the person travelled out of the country, was the patient experiencing Shortness of Breath. The night shift nurse recognized that the patient had signs and symptoms of COVID-19. The night shift nurse and day shift nurse did not wear PPE. Their unit 4 North was not supposed to have PUI (Patient Under Investigation) or COVID-19 patients. The PPE warehouse information was talked about in the pre-shift huddle meetings the week of March 20th-27th. The Charge Nurse was supposed to pick up PPE for employees at the time. The Charge Nurse on Day Shift took over once she was told that the patient could possibly have COVID-19. The patient could not be relocated until a doctor had ordered a COVID-19 test. The patient was then transferred to a PUI Patient Under Investigation unit. The charge nurse wore a level 3 mask, goggles, gown, and gloves. Citations were not issued in regard to this complaint item.

ITEM 4: March 24th, the Research Psychiatric Center, RPC, RN's do not have PPE in their center. It is housed in another building in RMS. The RN's do not have readily available access to PPE.

RESPONSE: Nurses and or charge nurses could get the PPE for use from the PPE warehouse even though it was housed in the Research Medical Center building. There was a Hazard Alert Letter issued in regard to fit testing at the Research Psychiatric Center.

ITEM 5: March 24th, RN's on 4 N/C are lacking the use of N95 masks and instead are using level 3 surgical masks. There have been complaints on how they were to cluster the covid or potential covids together and RN's would be assigned to only covids or non covids. If they had the covids/potential covids, they got 1 mask and 1 gown for the shift. The shifts are 12 hours.

RESPONSE: On March 24th, the hospital was conserving PPE as no one knew if there would be a PPE shortage. Level 3 masks were being used by staff caring directly for potential PUI (Patients Under Investigation). The N95's were required during intubating and aerosolizing procedures for employees in PUI and COVID-19 units. There was no citation in regard to this item.

ITEM 6: March 28 or March 29th. A nurse in the float pool was floated to 4W, PCU. The nurse was assigned to potential covid patients. This is a covid cohort unit, one came back positive on this shift. The nurse's N95 broke. The nurse tried to get a PAPR and was denied use. Nurse was told to use a surgical 3 and goggles.

RESPONSE: This incident was not able to be verified. The OSHA Compliance Safety and Health Officer was unable to interview those involved in this incident. No citations regarding this item.

ITEM 7: March 24th and March 30th, a nurse on 4W, PCU, was caring for potential covids. The doctors kept telling the nurse to be careful, they knew they had covid. The unit manager, Jillian Curley, RN was asked for an N95. The nurse was told if I give you one, I have to give one to everyone. By Friday, the test showed they were positive covids. March 30th, the director took the PAPR away when the nurse had 2 covid aerosolized patients.

RESPONSE: The employee was issued a surgical mask and a gown at the time of the first incident. At that time Level 3 masks were being used by staff caring for suspect COVID and

COVID-19 patients. An N95 was required during intubating and aerosolizing procedures if patients were PUI (Patients Under Investigation) or were diagnosed with COVID-19. The nurse that had the PAPR taken away had an N95 at that time. The nurse did not actually need the PAPR.

ITEM 8: There were covid positives on the 4N and 4C so far on the hospital's OSHA 300 log, all on this unit.

RESPONSE: Four employees had been denoted on the OSHA 300 log that had tested positive for covid from 4N and 4C.

ITEM 9: Multiple RNs have been out sick with covid like symptoms in March and April on multiple units. Tests don't always come back positive and so they are not logged on the OSHA 300 log.

RESPONSE: Employees are placed on the OSHA 300 Log once they have had a positive test to denote COVID-19 diagnosis. The employees also had to have a work place exposure to be logged on the OSHA 300 log.

ITEM 10: 4N/C units are sister floating cluster units with 4W PCU and the ICUS, the RNs float if staff is needed. The covid cohort units are 4W PCU and MICU, but possible covid patients are allowed to be anywhere.

RESPONSE: The patients were being primarily cohorted to 4W PCU and MICU during this inspection. There were not any citations regarding this complaint item. There are no longer Patients Under Investigation (PUI) units as testing is being conducted in the emergency room then employees are being sent to COVID units.

At the time of the inspection there is no standard regarding the Covid-19 virus. The conditions were not so great as to create a violation of OSHA standard(s). The employer had fit tested employees for N95 respirators. Few employees had been fit test at the Research Psychiatric Center but they had a smaller exposure of employees with COVID-19. As such, a citation for this item is not recommended.

Attached for your information is a copy of the Hazard Alert Letter which was issued to the employer. If you do not agree with our inspection results, you may contact me for a clarification of the matter.

Section 11(c) of the Occupational Safety and Health Act protects employees from being discriminated against because of their involvement in protected activities related to safety and health. If you believe you are being treated differently or action is being taken against you because of your safety or health activity, you may file a complaint with OSHA. You should file this complaint as soon as possible, because OSHA normally can accept only those complaints filed within 30 days of the alleged discriminatory action.

Please feel free to contact the office at (816) 483-9531 if you have any questions or concerns.

Your action on behalf of safety and health in the workplace is sincerely appreciated.

Sincerely,

for Kimberly Robinson

Karena Lorek
Area Director

Enclosure(s)

Kansas City RNs to Hold Vigil in Memory of Research Medical RN Who Died of COVID-19
National Nurses Organizing Committee
April 22, 2020



Registered nurses from across the region will hold a candlelight vigil Thursday night at HCA's Research Medical Center (RMC) in Kansas City in memory of Celia Yap Banago, a longtime RMC RN who died this week of COVID-19 after caring for an infected patient at the hospital. To make the tragedy worse, Celia, who died Tuesday night, was scheduled next week to celebrate 40 years of service for Kansas City area patients at Research. She was one of many RNs at the hospital who have expressed concern over inadequate COVID-19 preparation at RMC.

Those concerns include insufficient supplies of the optimal personal protective equipment for RNs and other health care workers, delays in notifying nurses of being exposed to a suspected infected patients and staff and expected to continue reporting to work when exposed.

What: RN Candlelight Vigil in Honor of RN who Died of COVID-19
When: Thursday, April 23, 8 p.m.
Where: Research Medical Center, 2316 E Meyer Blvd, Kansas City

"Celia was an amazing nurse that dedicated her service for countless years at Research and a dear friend to all of us," said Research RN Charlene Carter. "I feel that I can speak for many nurses when I say that the loss of one of our dear fallen soldiers on the front line of this pandemic is more than devastating, it is a wake-up call."

Across the U.S. dozens of RNs have died from COVID-19, thousands more have been infected. On Tuesday, NNU members held a social distancing protest outside the White House demanding that the Occupational Safety and Health Administration (OSHA) promulgate an emergency temporary standard so that health care workers are provided with the optimal PPE.

"We honor the life and career of Celia who gave so much of herself for her patients," said NNU Executive Director Bonnie Castillo, RN. "No nurse, no health care worker, should have to put their lives, their health, and their safety at risk for the failure of hospitals and our elected leaders to provide the protection they need to safely care for patients."

"Nurses have an instinctive conduct of being so selfless that I believe others don't realize. No nurse should have to sacrifice their life in exchange for conserved profits by the rationing of proper protective equipment," said Carter. "Nurses all over the country need proper protection every day so that we can continue to save patients' lives while sparing our own."

Research RNs were among HCA nurses at 16 HCA facilities across the country who participated in shift change, social distancing protests, earlier this month warning a lack of preparedness by the nation's largest hospital chain that they say places nurses, other staff, and patients at risk in the face of the coronavirus pandemic.

<https://www.nationalnursesunited.org/press/kansas-city-rns-hold-vigil-memory-research-medical-rn-who-died-covid-19>

EMBARGOED UNTIL 9 a.m. on WEDNESDAY, MARCH 10



**National
Nurses
United**

OUR PATIENTS. OUR UNION. OUR VOICE.

For immediate release: March 10, 2021

Contact: press@nationalnursesunited.org

National RN survey highlights continued hospital failures to prioritize nurse and patient safety during pandemic

*Results show that at pandemic's one-year marker, employers are still failing to
provide safe staffing, optimal PPE, and testing*

National Nurses United's (NNU) new nationwide survey of more than 9,200 registered nurses reveals that a year into the pandemic, registered nurses are still being placed in harm's way. RNs face continued issues ranging from unsafe staffing levels to hospital administrators failing to observe basic infection control and prevention measures -- such as forced reuse of personal protective equipment (PPE) despite manufacturers confirming adequate supplies.

This survey is the fifth national survey of nurses during the pandemic by NNU, the nation's largest and fastest-growing union of registered nurses. NNU's latest survey also reveals that in addition to the unsafe reuse of single-use PPE, - nurses continue to experience challenges getting tested, are not being notified in a timely manner when they are exposed, are suffering mental health impacts, and enduring increasing workplace violence.

"We are a year into this deadly pandemic and hospitals are still failing to provide the vital resources needed to ensure safety for nurses, patients, and health care staff," said NNU Executive Director Bonnie Castillo, RN. "This survey shines light on how hospital administrators are continuing to jeopardize one of society's most valuable workforces during Covid-19, registered nurses, by prioritizing profits over basic safety and infection control measures. Testing health care workers and patients for Covid-19, providing optimal PPE, and ensuring safe staffing is a no-brainer to help combat this pandemic."

Short staffing remains a major problem in hospitals, with nearly 53 percent of nurses reporting that it is their top safety concern. Nearly half of hospital nurses (47 percent) report that staffing has gotten slightly or much worse recently. In addition, 26 percent of nurses report being reassigned to units where new skills or competencies are required, often without adequate training.

Employers fail to provide RNs with the optimal PPE to do their job safely. A total of 81 percent of nurses report they are forced to reuse single-use PPE, which is practically unchanged from the more than 80 percent who reported having to do so in our November survey. The virus that causes Covid-19 is transmitted through infectious aerosols that are emitted when Covid-positive individuals breathe, vocalize, cough, or sneeze. Optimal PPE—including respiratory protection at least as protective as an N95—is an essential measure to battle this pandemic. Recent reports indicate that there is substantial N95 supply; which means these survey data indicate that hospitals are choosing to maintain crisis standards of care in order to cut costs. The health care model should focus on human needs, not profit margins.

Slightly more than half of the RNs who work in hospitals (52 percent) report that all patients are screened for Covid-19. This falls short of the necessity that all patients should be screened for Covid-19. Hospitals are failing to implement proven measures to prevent the spread of Covid-19 within the facility: Only 66 percent of RNs who work in hospitals report that their facility has a dedicated Covid unit or area.

Nurses are still not all getting tested and they are not being informed in a timely manner when they are exposed to Covid-19 at work. Slightly more than half (54 percent) of RNs overall and over half (61 percent) of RNs in hospitals report that they have ever been tested for Covid-19. This is an increase from the last survey in November, when just a third of RNs overall reported being tested, but again still falls short of the regular and on-demand testing that nurses should be able to access. Administrators must take seriously the task of identifying and responding to exposures in a timely manner, including conducting contact tracing and informing staff of exposure. But less than a third of hospital nurses (32 percent) say their employers inform them of exposures in a timely manner.

Covid-19 continues to harm the mental health of nurses, with the survey signaling that huge numbers of nurses are suffering the [moral distress and injury](#) that comes from knowing the right thing to do but receiving no support from or even being prevented by employers from doing it.

- A total of 43 percent of hospital RNs say they have more trouble sleeping than before pandemic
- More than 61 percent of hospital RNs report feeling more stressed than before the pandemic.
- A total of 57 percent of hospital RNs report feeling more anxious.
- 51 percent report feeling more sad or depressed.
- More than 58 percent of hospital nurses who answered the survey said they fear that they will contract the virus and infect a family member.

About 22 percent of nurses report facing increased workplace violence on the job, which they attribute to decreasing staffing levels, changes in the patient population, and visitor restrictions.

This data comes as the NNU recently [endorsed the recent re-introduction of the Workplace Violence Prevention for Health Care and Social Service Workers Act \(HR 1309\)](#). The federal legislation, reintroduced by U.S. Rep. Joe Courtney (CT-2), would mandate that the federal Occupational Safety and

Health Administration (OSHA) create a national standard requiring health care and social service employers to develop and implement a comprehensive workplace violence prevention plan.

This legislation is especially important given that health care and social service workers faced extremely high rates of workplace violence prior to the pandemic, and growing rates during the pandemic.

NNU's first [survey in March](#) focused on hospitals' lack of preparedness for Covid-19; the [second survey in May](#) highlighted government and employers' disregard for nurse and patient safety; and the [third survey in July](#) revealed the devastating impact of reopening too soon. The fourth [survey in November](#) showed hospitals and health care employers' lack of preparation for the fall/winter surge, despite more knowledge about the dangers of the virus and effective measures to prevent spread. This fifth survey shows the continuing disregard that hospitals and health care employers show for the safety of nurses and health care workers as we mark the one-year anniversary of the Covid pandemic.

The survey results were gathered from both NNU unionized nurse members as well as non-union nurses in all 50 states plus Washington, D.C. and three U.S. territories. The preliminary results cover the period Feb. 2 to Feb. 28.

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PRESS RELEASE

Nurses, Unions, Allies Urge CDC to Acknowledge Covid-19 Aerosol Transmission to Help Bring Virus Under Control

National Nurses United

February 23, 2021



National Nurses United (NNU) and 44 allied unions and organizations, representing over 13 million members and their communities, are joining in coalition to urge the U.S. Centers for Disease Control and Prevention (CDC) to update its Covid-19 guidance to fully reflect the latest scientific evidence regarding SARS-CoV-2 transmission through aerosols that infected people emit when they breathe, speak, cough, sneeze, or sing.

Today, the undersigned unions and organizations delivered a [petition](#) with over 10,000 signatures, including scientific experts, urging the CDC to fully recognize Covid-19 aerosol transmission now.

The Biden administration has made a commitment to science and transparency in the efforts to combat the pandemic. Under the previous administration, the CDC's refusal to recognize aerosol transmission of SARS-CoV-2 led to weak guidance, leaving workers and the public unprotected from Covid-19. As a result, countless workers in every industry—including health care, grocery, meatpacking and processing, warehousing, food service, education, transportation, and manufacturing—have been infected, hospitalized, and died from Covid-19 because their employers followed weak CDC guidance and they were not protected at work.

Fully recognizing aerosol transmission would require the CDC to update and strengthen its Covid-19 guidance to provide protection from inhalation of virus in the air, including through ventilation, filtration, and optimal respiratory protection, among other measures. It would also require the CDC to update its definition of “exposure,” which would improve the efficacy of contact tracing and case isolation. Recognizing the scientific evidence and making these improvements are essential and necessary steps to bringing the Covid-19 pandemic under control.

“Since the start of the pandemic, the nation’s nurses have demanded that the CDC’s guidelines be based on scientific evidence. Nurses know that to effectively battle this virus, we all need to get on the same page about how it spreads. The CDC’s failure up to this point to recognize aerosols as the primary mode of transmission hurts all other guidance and efforts that stem from this lack of understanding. We urge the Biden administration to honor its commitment to listen to experts in the battle against Covid-19, which includes having CDC and other federal agencies explicitly recognize aerosol transmission,” said **Bonnie Castillo, RN and executive director of NNU.**

“Ensuring strong COVID-19 protections for working people is key to preventing outbreaks, pulling us out of the pandemic and rebuilding our economy—and that starts with policies based on science. Workers’ lives and all of our lives depend on the CDC updating its guidelines and strengthening protections on the job,” said **Richard Trumka, AFL-CIO President.**

“Recognizing the ever-changing science of COVID-19 transmission is key to fighting the virus effectively, and keeping our nurses, healthcare professionals, educators and communities protected from further transmission. As it becomes increasingly clear that aerosol transmission – breathing, speaking, coughing, sneezing, and singing – can spread the virus, we urge the CDC to officially recognize this issue and offer the science-based guidance we have come to trust and expect from the agency,” said **Randi Weingarten, President, American Federation of Teachers.**

“We have hundreds of thousands of members considered essential workers and risking their lives every day to support us all. They and their employers depend on accurate science from CDC. And the science clearly shows the danger of aerosol transmission,” said **Thomas M. Conway, International President, United Steelworkers.**

“For the past year, the CDC guidance on COVID-19 has been ignoring science and health experts. The ATU has been saying aerosol transmission of SARS-CoV-2 is a problem on public transit as evidenced by our 135 brothers and sisters killed by this deadly virus and more than 4,600 infected. The ATU has been pushing for better airflow, more effective filtration systems on buses and trains, and improved PPE for transit workers and riders to help stop the spread of COVID-19 along with other safety measures. We are encouraged by the Biden Administration’s CDC Director Dr. Walensky’s call for a comprehensive review of all CDC guidance on COVID-19. We hope the CDC acknowledges the danger of aerosol transmission of this deadly virus and makes serious safety recommendations that will help save the lives of transit workers, riders and the public,” said **John Costa, International President of the Amalgamated Transit Union, the largest union representing transit workers in the United States and Canada.**

“The CDC’s failure to update their guidelines has life and death consequences. Workers are going into confined spaces every day without sufficient control measures and employers are justifying it by saying they are following CDC guidelines. If workers are going to be given the title “essential”, then they deserve the essential measures that keep them safe,” said **Marcy Goldstein-Gelb, co-executive director of the National Council for Occupational Safety and Health (National COSH).**

“We must remain vigilant as we continue to fight the pandemic. Recognizing COVID-19’s spread through aerosol transmission by the CDC is an important step that can slow the spread of this

deadly virus. This is an essential piece of a science-based response that will influence the way federal, state and local governments respond moving forward,” said **James Slevin, President of the Utility Workers Union of America.**

“Nurses know this virus is spread through the air. We are literally face-to-face with our patients, and we have to continue working with masks, gloves, and gowns that have been contaminated after hours with patients. We even have to watch how we put on and take off our equipment so we don't infect ourselves. We need the law to follow the science that shows the virus is an airborne threat. We need the CDC to make sure our nurses and healthcare workers are safe,” said **Mary C. Turner, ICU nurse and Minnesota Nurses Association (MNA) President.**

"Nurses in New York and around the country have been both relieved and hopeful that the Biden Administration has promised to follow the science on protection of the American workforce from COVID-19. The healthcare and other essential workforces have been devastated by COVID-19 infection and thousands have died due to their occupational exposure. Many of those exposures could have been avoided if the CDC had recognized the wealth of data that proves that SARS-CoV-2 is spread through inhalation of airborne virus particulates. The 42,000 members of NYSNA and essential workers everywhere deserve federal guidance that fully recognizes the risk of airborne exposure and recommends controls that effectively limit this exposure,” said **Pat Kane, RN, New York State Nurses Association (NYSNA) Executive Director.**

“It's critical that the CDC recognize that COVID-19 can spread via infectious aerosols. For our members, the implications of the CDC not accepting aerosolized COVID-19 transmission poses grave risk as employers rely on the CDC's guidance to implement appropriate mitigation measures. We must follow the science and acknowledge how the virus spreads to adequately protect communities, particularly as the virus mutates and potentially more virulent strains spread,” said **Stuart Appelbaum, president of the Retail, Wholesale and Department Store Union.**

“AFSCME 1526 believes that all workers are entitled to be treated with respect and dignity, and return home to their families alive and well. A primary focus by organizations has been on social distancing, cleaning and disinfecting, without taking into consideration the aerosol transmission of Covid-19. Having the CDC recognize Covid-19 aerosol transmission as a significant form of transmission will prompt changes in workplace protocols to reduce the overall spread of this virus. With strong CDC guidance, workplaces will be mandated to address one of the key ways workers are exposed through aerosol transmission of micro-droplets, which in turn will save lives,” said **Elissa C. Cadillac, President, AFSCME 1526, Boston Public Library Employees Union.**

"Throughout the pandemic, HPAE members have been exposed and sickened in the workplace due to a lack of protection against this deadly virus. Some have died. No wonder our healthcare workers frequently report feeling "disposable". Now is the time for the CDC to abolish guidance that would continue to leave our workers exposed and at risk, and to establish safer standards that would provide the necessary protections," said **Debbie White, President, Health Professionals and Allied Employees.**

“The Nurses of MercyOne Siouxland and members of the UFCW Local 222 feel that seeing the CDC take the step to recognize SARS-CoV-2 as an aerosol transmission would validate an exhaustive year and place trust back into the institution that is the CDC. As a nation we look towards the CDC for guidance to keep frontline healthcare workers and patients safe, this year has strained that trust. The frontline healthcare workers deserve to be given the correct protective measures that keep themselves, their patients, and their families safe. Recognizing SARS-CoV-2 as an aerosol transmission will be the first of many steps to rebuild the trust within the healthcare community. Seeing the CDC place the safety of our healthcare workers and the

patients they care for as a priority is long overdue, and absolutely necessary at this time,” said **UFCW Local 222**.

“Workers deserve COVID-19 protection based on the best science available. Aerosol transmission is a significant danger that requires strengthened protection guidance from CDC and the National Institute for Occupational Safety and Health. The COVID-19 Emergency Temporary Standard being developed by OSHA must also include strong protections against aerosol transmission. A failure to follow the science is a failure to protect essential workers and a threat to economic growth,” said **Juley Fulcher, Public Citizen’s Worker Health and Safety Advocate**.

“Some of the populations with the highest rates of COVID-19 infection are also populations that are hardest to reach with good culturally relevant information. We need the CDC to lead the way with clear, concise, and accurate messaging on aerosol transmission of COVID-19, so that community health workers, outreach workers, and health care providers around the country are supported in their work,” said **Migrant Clinicians Network**.

“The continuing workplace outbreaks among workers in such industries as health care, retail, grocery, food processing, warehousing, among many others, points to the critical need for improved protections based on the latest science about airborne transmission. We urge the CDC to follow the science, fully recognize aerosol transmission, and update their guidance now,” said **Laura Stock, Executive Director, UC Berkeley Labor Occupational Health Program**.

Unions and organizations that signed the petition urging the CDC to fully recognize aerosol transmission now (listed alphabetically):

AFL-CIO
AFSCME 1526, Boston Public Library Employees Union
Alaska Community Action on Toxics
Amalgamated Transit Union
American Federation of Teachers
Arts, Crafts & Theater Safety
Bakery, Confectionery, Tobacco Workers and Grain Miller’s International Union
Communications Workers of America (CWA)
Core Extension Health & Safety Company Ltd
COVID Action Group
Dr. Yolanda Whyte Pediatrics
Finding Your Balance Counseling
Franchimon ICM
Government Accountability Project
Health Professionals & Allied Employees (Debbie White, President, RN)
HEALTHY SCHOOLS NETWORK
Immigrant Service Providers Group/Health
International Association of Machinists and Aerospace Workers
International Chemical Workers Union Council
International Federation of Professional and Technical Engineers
International Union of Bricklayers & Allied Craftworkers
Jacobs Institute of Women’s Health
Kids for Saving Earth
Labor Occupational Health Program
LEGACY-The Landscape Connection
MassCOSH
Migrant Clinicians Network
Minnesota Nurses Association
National Center for Health Research

National Council for Occupational Safety and Health
National Nurses United
New York State Nurses Association
NYS Public Employees Federation
Occupational Health Management Services inc
Pennsylvania Association of Staff Nurses and Allied Professionals
Public Citizen
Quality First EHS, Inc.
Retail, Wholesale and Department Store Union
SafeWork Washington
Sheet Metal Occupational Health Institute Trust Inc.
Transport Workers Union of America
UFCW Local 222
United Steelworkers
Utility Workers Union of America

<https://www.nationalnursesunited.org/press/nurses-unions-allies-urge-cdc-to-acknowledge-covid-19-aerosol-transmission>

Nurses' Proposal for a Comprehensive Federal Plan to Combat the Covid-19 Pandemic

Since the Covid-19 pandemic began in the United States in January 2020, our country has been in crisis. Despite clear scientific and public health consensus on interventions that could slow the spread of the virus and reduce illness, suffering, and death, the outgoing Trump Administration has failed to take the necessary steps to control the pandemic.

Nearly a year into the worst public health crisis in recent history, nurses and other health care workers continue to care for Covid-19 patients and other patients without access to optimal personal protective equipment (PPE), testing, safe staffing levels, and other sound infection control policies.

Up to this point, the federal government's response has been one of denial and abandonment, racing to prioritize business interests over the lives and health of the people. We have seen the impact of a patchwork response from states and local areas—more than 15 million infections and nearly 300,000 deaths from Covid-19. We need a comprehensive federal response that is based in science and prioritizes health.

On behalf of more than 170,000 registered nurses, National Nurses United, the largest labor union and professional association for registered nurses in the United States, urges the incoming Biden Administration to take immediate, decisive action to mitigate the catastrophic death and suffering caused by the Covid-19 pandemic.

The following is a detailed proposal for a comprehensive federal plan to combat the Covid-19 pandemic, based on the expertise and experiences of registered nurses.

Protect Nurses and Other Essential Workers

- 1. Increase production and ensure efficient distribution of personal protective equipment and other medical supplies.**

On day 1, invoke the Defense Production Act of 1950 (DPA) to significantly increase production of critical medical supplies and PPE, including respirators, and create a comprehensive medical supply chain management system that is coordinated, efficient, and transparent.

Nurses and health care workers across the country still do not have the necessary PPE to provide care to their patients safely. This failure to ensure that PPE stock and supply is immediately accessible at each facility leaves nurses exposed to Covid-19, which has had deadly consequences for nurses, their patients, and their families.

It is essential that the DPA is fully invoked on day one to dramatically ramp up production and distribution of medical equipment and PPE in needed quantities to consistently provide optimal protections against Covid-19 exposure to nurses and other health care workers. As this novel coronavirus is transmitted via aerosols, the invocation of the DPA must ensure that the manufacturing of respiratory protection is scaled up. This life-saving PPE must include:

- Respirators, including powered air-purifying respirators (PAPRs, the highest protective standard), elastomeric respirators, and N95 filtering facepiece respirators
- Viral impervious coveralls
- Fluid-resistant isolation gowns
- Goggles
- Face shields
- Medical-grade gloves

We recommend early identification (before inauguration) of manufacturing facilities that can increase their manufacturing capabilities or can transition their manufacturing functions to produce critical medical supplies and PPE. Nurses are in dire need of PPE supplies right now, and we need the medical supply chain to be improved and expanded as rapidly as possible. To expand the manufacture of needed PPE and medical supplies, we recommend the following actions:

- Continued identification of manufacturing facilities that can increase their manufacturing capabilities or can transition their manufacturing functions to produce critical medical supplies and PPE.
- Direct increased production of critical medical supplies and PPE for existing manufacturing facilities that produce such supplies and PPE, which could include the use of the DPA Fund to increase the capacity of these manufacturing facilities, which could include expanding production hours, expanding manufacturing facilities, or hiring additional workers.
- Direct other manufacturing facilities to transition to production of the critical medical supplies and PPE needed for the Covid-19 response, which could include using the DPA Fund to procure and install the necessary equipment needed for these manufacturing facilities.

- Generate manufacturing purchase orders, issue loan guarantees, and support the installation of needed manufacturing equipment in manufacturing facilities to ensure the most expedient production of critical medical supplies and PPE.

In order to manufacture enough medical equipment to effectively respond to the pandemic, estimates on needed quantities must be based on optimal infection control—not on crisis standards of care. Federal guidance and hospital policies have allowed for the use of non-protective equipment, the reuse of single-use PPE, and for the use of faulty “decontamination” processes for N95s. Every time that single-use PPE is reused, nurses and patients are put at increased risk of exposure. Throughout the course of the pandemic, both state and federal government agencies have assumed the reuse and “decontamination” of single-use PPE when calculating needed PPE supplies, resulting in severe underestimates. This practice must end immediately.

Over the course of the pandemic, it has become increasingly clear that the national medical supply chain is broken. It will not be enough to simply invoke the DPA to increase production of critical medical supplies. It is imperative that the new administration builds a comprehensive medical supply chain system that is coordinated, transparent, effective, and efficient in both manufacturing and *distributing* PPE. The supply chain must be sufficiently robust to produce and distribute needed PPE for both the short- and long-term. To achieve this, we recommend the following actions:

- Create a coordinator to oversee all efforts of the federal government related to the supply and distribution of critical medical supplies and equipment.
- Establish a comprehensive oversight program to monitor the administration’s supply chain logistics and coordination.
- Conduct national assessments of critical medical supplies and PPE, made on a weekly basis, to determine the supply requirements across the country.
- Establish transparent reporting requirements on the distribution of supplies.
- Improve the strategic national stockpile including quickly replenishing stock and creating new and improved transparent processes for requests and distribution of the stockpile.
- Ensure the immediate and continued release and distribution of critical medical supplies and PPE, including from the strategic national stockpile, and restrict the hoarding of critical medical supplies and PPE.

More detailed policy plans on how to rebuild our national medical supply chain can be found in the Medical Supply Transparency and Delivery Act (S. 3627 /H.R. 6711), and in the Health and Economic Recovery Omnibus Emergency Solutions (HEROES) Act (HR 6800 - see specifically Sec 30511, Sec 30531 - Sec 30536, Section 110101).

2. Create and enforce strong national standards to protect nurses and other workers.

On day one, issue strong Emergency Temporary Standards (ETS) to ensure that health care workers and workers in other industries are protected from Covid-19 in their workplaces.

The Occupational Safety and Health Administration (OSHA) does not currently have a standard on infectious disease outbreaks. As a result, over the course of this pandemic, employers have neglected their duty to ensure the health and safety of workers, placing nurses and other essential workers at high risk of infection and death. Protecting nurses and other health care workers is essential—both to protect their health and also to protect their families, their communities, and our health care capacity. Strong, well-enforced national standards are needed to ensure that employers are taking the necessary steps to prevent transmission and protect their employees from Covid-19.

The OSHA ETS for Health Care Workers (hereafter referred to as “the OSHA ETS”) must be constructed based on the precautionary principle, which states that taking protective action should not await scientific certainty. The California Division of Occupational Safety and Health’s Aerosol Transmissible Diseases Standard should serve as the framework and be the minimum standard of protection for the federal OSHA ETS.

The OSHA ETS must require health care employers to do the following:

- Establish, implement, and maintain a written exposure control plan, created with employee and union involvement and following the precautionary principle.
- Conduct hazard assessments to identify all places, jobs, and tasks that involve risk of exposure to SARS-CoV-2. The hazard assessments and definition of exposure must be based upon the scientific evidence that this virus is transmitted via respiratory aerosols that are emitted by infected individuals, regardless of the presence of symptoms.
- Create and implement protocols to screen every patient before or upon arrival at the facility by screening for signs and symptoms congruent with Covid-19 and recent exposure history and conducting reliable diagnostic testing.

- Implement effective, optimal engineering and work practice controls to minimize and prevent employee exposure to SARS-CoV-2, including at minimum the following:
 - Establish separate and dedicated areas for Covid-positive, potentially infectious, and non-Covid patients in all areas of the facility. (When patients who do not have Covid-19 are mixed with confirmed and possible Covid-19 patients, the potential for transmission of the virus to patients and staff increases significantly.)
 - Place confirmed and suspected Covid-19 patients in airborne infection isolation rooms that prevent recirculation of air and improve ventilation in other areas of facilities. Implement protocols for removing isolation precautions for these patients following the precautionary principle.
 - Implement work practice controls that include an opt-out process for employees at high risk of serious illness from Covid-19, screening and restricting visitors, thorough environmental cleaning and disinfection, source control procedures including universal use of face coverings, and temporary scrubs and shower facilities for employees.
 - Provide safe staffing, including clinical competency for staff floating to a different unit, no mixing of Covid and non-Covid assignments, and shorter shifts in dedicated Covid-19 units.
- Provide optimal PPE to employees where these engineering and work practice controls do not prevent exposure. Optimal PPE for Covid-19 includes a PAPR, viral-impervious coveralls that incorporate head and shoe coverings, and medical-grade gloves. Requirements for providing PPE for Covid-19 should include:
 - Ensuring that all employees with contact activities have optimal PPE for Covid-19 available to them at all times.
 - Ensuring that all employees who provide care to or otherwise are in contact with suspected and Covid-19 patients are provided optimal PPE for every patient encounter.
 - Providing for breaks and relief so that no employee is expected to wear tight-fitting PPE for more than two hours without at least a fifteen-minute break.
 - Prohibiting crisis standards including reuse and decontamination of single-use N95 filtering facepiece respirators and other PPE. (Reuse of single-use N95 respirators and other single-use PPE is unsafe and should not be employed. PPE becomes contaminated during use and repeated

donning of contaminated PPE poses risk of exposure to staff. Single-use PPE can become damaged during reuse and may no longer provide protection. Decontamination methods have not been shown to be safe or effective and some appear to be ineffective, damage N95s, or introduce a new hazard to wearers of N95s.)

- Prohibiting rationing of N95 filtering facepiece respirators and other PPE. (Rationing use of N95s for only specific types of procedures, e.g., aerosol-generating procedures, is unsafe and reflects a refusal to acknowledge the growing scientific evidence that the virus that causes Covid-19 is aerosol transmitted.)
- Creating and implementing a respiratory protection program as required by 29 CFR 1910.134.
- Create and implement systems to actively identify and respond to all employee exposures to Covid-19. Response to an employee exposure to Covid-19 should include:
 - Open and continuous communication with workers about any potential exposure, including requirements to provide notice of potential exposures within 12 hours.
 - Placing employees exposed to Covid-19 on precautionary leave for at least 14 days from time of most recent exposure. Employers shall ensure there is no loss in employees' earnings, seniority, or any employee rights and benefits, as if the employee had not been removed from their job.
 - Providing Covid-19 testing at no cost to employees during their working hours to all employees who had potential Covid-19 exposure in the workplace. Testing shall be performed, at minimum, at the end of the 14-day precautionary leave. Results should be returned in a timely manner, within 48 hours.
 - Conducting an investigation and implementing changes to prevent similar exposures from occurring in the future.
 - Returning staff to work after a positive Covid-19 test only after their symptoms, if any, have resolved and after they have received two negative tests at least 24 hours apart. Asymptomatic positive staff should not be treated differently from symptomatic positive staff.
 - Providing medical services at no cost to employees with occupational exposure to SARS-CoV-2.

- Create and implement programs for ongoing weekly surveillance testing of all employees, regardless of symptom status, to identify and prevent facility outbreaks. If an employee develops signs or symptoms of Covid-19, they shall receive prompt, free diagnostic testing, regardless of occupational exposure status.
- Create and implement plans to respond to outbreaks in the facility.
- Create plans and prepare to respond to a surge of patients with Covid-19 or other infectious diseases (e.g., influenza), including expanding bed capacity, ventilator capacity, PPE stockpile, and other medical equipment. Preparation shall also include at least preparing separate waiting areas such as surge tents, ensuring staff are aware of surge plans before implementation, establishing plans to respond if significant numbers of healthcare workers are exposed or sick and unable to work. When there is an increase in Covid-19 patients or other patients with infectious diseases, employers shall implement their surge preparation protocols and plans. If employers are unable to effectively implement all necessary safety precautions to prevent transmission within the facility and to protect nurses, other health care workers, and patients from exposure, then the employer shall delay non-life threatening elective procedures.
- Provide training and education to employees regarding their exposure control plans, surge preparedness plans, and other Covid-19-related protocols required under the OSHA ETS.
- Review the effectiveness of the exposure control plan at least every three months during the Covid-19 pandemic. Employees and their representatives should be involved in the review.
- Prohibit employers from retaliating against an employee for reporting exposure to Covid-19, symptoms of Covid-19, a positive Covid-19 test result, or any other information or concerns about Covid-19 or the employer's exposure control plan.
- Create a Covid-19 log to record and track all Covid-19 cases among employees.
- Create and maintain records of implementation of the exposure control plan, including records of reviews, exposure incidents, inspections, testing, maintenance of engineering controls including ventilation, the respiratory protection program, training records, and any other records as appropriate under the OSHA ETS, which must maintain confidentiality of medical information as required by law and be made available to employees and their representatives upon request.

- Report information about Covid-19 cases at the workplace to the local health department and Covid-19-related in-patient hospitalizations or deaths that occur among employees within 24 hours or within 8 hours, respectively, of learning of them.

Throughout the Covid-19 pandemic, OSHA has neglected its duty to protect the lives and health of working people in this country. As of December 9th, federal OSHA reports it has received 11,312 complaints from workers since the beginning of the pandemic and reports having opened a mere 294 inspections in response to complaints (2.6%). We strongly urge the Administration to increase the number of OSHA inspectors, and to ensure that the OSHA ETS is strongly enforced with penalties for non-compliance.

3. Ensure that federal guidance is science based and prioritizes health and safety.

Overhaul weak U.S. Centers for Disease Control and Prevention (CDC) guidance that allows health care employers to defend dangerous practices that expose nurses, other health care workers, and patients to Covid-19.

The CDC has established a pattern during this pandemic of prioritizing business interests over science and protecting public health. CDC guidance has been downgraded multiple times in direct contradiction to the available science and has ignored the precautionary principle—which states that we should implement protections even in the face of scientific uncertainty about harm.

This must change. The CDC must prioritize health and safety. CDC guidance and other federal guidance must be overhauled and rewritten so that it is based on the precautionary principle and the available science.

The following CDC guidance documents must immediately be rewritten to reflect the precautionary principle and the available science on Covid-19 transmission, infection controls, and occupational safety and health:

- Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic
- Using Personal Protective Equipment (PPE)
- Optimizing Supply of PPE and Other Equipment during Shortages
- Strategies for Optimizing the Supply of N95 Respirators
- Implementing Filtering Facepiece Respirator (FFR) Reuse, Including Reuse after Decontamination, When There Are Known Shortages of N95 Respirators
- Strategies for Optimizing the Supply of Facemasks
- Strategies for Optimizing the Supply of Eye Protection
- Strategies for Optimizing the Supply of Isolation Gowns

- Strategies for Optimizing the Supply of Disposable Medical Gloves
- Discontinuation of Transmission-Based Precautions and Disposition of Patients with COVID-19 in Healthcare Settings (Interim Guidance)
- Interim Guidance on Testing Healthcare Personnel for SARS-CoV-2
- Interim U.S. Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to COVID-19
- Criteria for Return to Work for Healthcare Personnel with SARS-CoV-2 Infection (Interim Guidance)

4. End unsafe crisis standards and waivers.

The federal government must end all waivers of regulation or oversight and must require employers to end unsafe crisis standards of care. The U.S. Food and Drug Administration (FDA) must revoke emergency use authorizations for dangerous, unproven practices to reuse and decontaminate N95 filtering facepiece respirators and other single-use PPE. The federal government should ensure that emergency staffing and infrastructure are fully funded through state and local grants.

During the Covid-19 pandemic, health care employers and government agencies have introduced and embraced crisis standards. Many of these crisis standards allow health care employers to further focus on cost, at the expense of patient care and the health and safety of nurses, health care workers, and patients. Employers, aided and abetted by government agencies, maintained these crisis standards even as local Covid-19 cases decreased during the summer.

These unsafe crisis standards must end. Crisis standards of care, by definition, are unsafe and unsustainable. These standards fail to deliver safe, competent, and effective care. Careful planning, preparation, and coordination would prevent the need for crisis standards to be utilized at all. Health care employers should be prepared for public health emergencies. Government agencies must end the following unsafe crisis standards and, instead, advance effective protections and preparation measures to combat the Covid-19 pandemic and to protect nurses, other health care workers, and their patients:

- The FDA must revoke all emergency use authorizations on reuse and decontamination of N95 filtering facepiece respirators and other single-use PPE. Further, the federal government, through an OSHA ETS and overhauled CDC guidance, should ban reuse and decontamination of N95 filtering facepiece respirators and other single-use PPE. Reuse of single-use PPE is not safe and puts nurses and patients at increased risk of exposure to Covid-19. Decontamination methods are neither safe nor effective and should never have been implemented. Instead, health care employers and government agencies

should implement safely reusable, more protective respirators, including PAPRs and elastomeric respirators.

- The FDA must institute strict oversight of performance, manufacturing, and distribution of diagnostic and serological tests.
- The FDA must revoke emergency use authorizations on all medical devices that may harm patients or undermine hands-on patient care.
- HHS must revoke both waivers that expand the use of remote patient monitoring technologies which have been deployed in healthcare facilities and for use by patients at home as well as waivers of Medicare conditions of participation that allow for patients to be cared for in non-hospital facilities, including the home, without appropriate staffing, emergency equipment, and other capabilities needed to provide patient care safely.
- The federal government should ensure that emergency staffing and infrastructure are fully funded through state and local grants.
- End crisis nurse staffing models in health care facilities, including the use of nurse extender models. These crisis nurse staffing models undermine quality patient care and put patients and nurses at risk.
- End the crisis utilization of unlicensed students and retirees who have not recently been engaged in clinical care in place of actively licensed nurses.

5. Include measures to reduce negative impacts of the pandemic on nurses and other health care workers.

Ensure that nurses and other health care workers have access to paid sick and family leave, paid time during isolation due to exposures, and essential worker pay. Provide long-term health and survivor benefits for workers and their families.

Paid leave specific to Covid-19 is critical for those working during the pandemic and, in particular, for nurses who are exposed to Covid-19 as a result of inadequate workplace health and safety protections. Only 23 percent of health care and social assistance workers in private industry have any form of paid family leave, though 85 percent have at least minimal paid sick leave available. Federal Covid-19 legislation passed earlier in 2020 explicitly excluded nurses and other health care workers from these mandatory workplace benefits. It is important for the safety of their patients and coworkers for nurses and other health care workers to be able to stay home when they are sick.

Similarly, paid time covering isolation after every work-related exposure is essential to combating this pandemic. No worker should have to use their accrued sick or other paid leave to cover a workplace exposure that occurred because their employer failed to protect them.

Increasingly, we are learning about long-term health impacts of Covid-19, including long-term lung and heart damage, fatigue, and neurological impacts. Nurses and other health care workers who contract Covid-19 should have access to long-term health benefits. There should be no barriers to accessing any benefit programs for the long-term health impacts of Covid-19 for nurses and other essential workers.

More than 2,298 health care workers have died from Covid-19, including more than 265 registered nurses, as of December 9th, 2020. Families of nurses and other health care workers who have died from Covid-19 should have survivor benefits.

Nurses always deserve fair and equitable wages. During the pandemic, an essential worker pay differential is meant to compensate workers who have been excluded from governmental orders and public health guidance to stay at home because their work has been deemed “essential” or “critical.” These workers are, thus, forced to risk exposure to Covid-19 that is higher than the government has prescribed as safe. The labor of nurses and other essential workers is vital to our collective well-being and working during a pandemic adds complexity and danger for them and their families compared to those sheltering at home. These workers deserve to be paid more. Fairness demands providing additional compensation to people who, by virtue of being required to work outside their homes during a pandemic, are exposed to extreme working conditions. However, essential worker pay should *never* be a replacement for a safe workplace.

Build Effective and Comprehensive Public Health Infrastructure and Programs

6. Increase health care capacity and improve preparedness.

A comprehensive plan to combat Covid-19 must include measures to increase health care capacity and hold health care facilities accountable to being prepared to respond effectively to surges in Covid-19 cases.

Hospitals across the country are overwhelmed in capacity while many caregivers who have been putting their lives on the line are being infected and dying. Nurses are facing burnout, unimaginable stress, and some are resigning. Many nurses are still not being provided proper PPE and hospitals have failed to implement appropriate infection control measures throughout their facilities, which significantly increase both their risk of infection and their stress and anxiety. During the current surge, nurses are seeing

patients die who could have been saved, if their employers had the proper staffing and supplies.

When the pandemic first began, physical distancing and stay-at-home measures were imposed in some cities and states, in an effort to slow down potential surges and allow the health care system to increase capacity to handle the virus. Unfortunately, both the federal government and the hospital industry have squandered the lead time that could have been used to increase health care capacity.

Decades of hospital industry safety cuts have led to many of the current staffing and capacity crises. For many years, hospital industry executives have recklessly eliminated “less profitable” patient services, reduced staffing of registered nurses and other frontline caregivers, and minimized inventory of essential supplies from medicine to PPE. Now, in the midst of the accelerating Covid-19 pandemic, we are seeing the inevitable consequence of these profit-driven schemes.

A comprehensive plan to combat Covid-19 necessarily must expand health care capacity and hold employers accountable to preparedness for surges in Covid-19 patients. The following steps should be taken:

- National public hospital and health care infrastructure capacity must be made available including through the Federal Emergency Management Agency, the Army Corps of Engineers, and by reversing privatization of the Veterans Health Administration.
- The private health care sector must be required to be fully prepared to respond safely to future surges. This preparation must include expanding staffing and bed capacity and increasing the stock and supply of PPE, ventilators, medications, and other necessary equipment.
- The federal government must collect real-time data on hospital capacity, PPE and medical equipment supplies, and other vital data. This information must be made publicly available.
- The federal government must guarantee sufficient hospitals and staffing in rural and underserved areas to provide geographically accessible and timely care. Federal funding should be appropriated to reopen hospitals that have been closed and to prevent closure of hospitals. Such hospitals should be publicly owned, and the workforce should be afforded full collective bargaining rights.
- Commissioning of the Ready Reserve Corps funded by the Coronavirus Aid, Relief, and Economic Security (CARES) Act should be accelerated. The federal government should fully fund paid, additional benefitted permanent and reserve

positions with full collective bargaining rights to provide surge staffing when needed.

- All workers must have PPE and other needed health and safety protections to protect their lives and to prevent transmission within health care facilities.

7. Ensure testing, contact tracing, and case isolation.

The federal government must create a comprehensive national plan to identify, isolate, and trace close contacts of Covid-19 cases. To do so, the new administration must heavily invest in the resources, staffing, supplies, and coordination necessary for a robust testing, tracing, and case isolation program.

Other countries have effectively controlled the spread of this virus since the beginning of the pandemic because they have a robust public health infrastructure that enables widespread surveillance, identification and strict isolation of cases, and thorough contact tracing and isolation of contacts. The current pandemic response model, which has failed to include a robust federal testing program, has hindered our ability to combat the spread of this virus.

A comprehensive plan to improve the testing, tracing, and case isolation must:

- Be fully staffed, supplied, and provided space to enable robust surveillance, widespread testing, effective contact tracing, and prompt case isolation.
- Make free at the point of service, reliable diagnostic testing widely available, including to low-income communities and communities of color, regardless of known exposure or symptom status.
- Provide for ongoing surveillance, with repeated random population surveys of asymptomatic people and syndromic surveillance that includes early detection of comparable indicators (e.g., influenza-like illness) before a diagnosis is made.
- Ensure thorough contact tracing to identify all contacts who could have been infected by each case (i.e., forward contact tracing) and to identify other individuals who may have been exposed in the same place as the case (i.e., backwards contact tracing). Case identification, contact tracing, and isolation need to be conducted in workplaces as well as in community settings. Contact tracing programs cannot rely solely upon technology—which, at best, may provide exposure notification, just one aspect of contact tracing. Effective contract tracing requires human interaction.

8. Collect and make available reliable data on the Covid-19 pandemic.

Clear and reliable data, free of corporate influence, must be collected and made publicly available for an effective federal response to the Covid-19 pandemic.

Throughout the pandemic, federal and state governments have neglected, hidden, and manipulated Covid-19 data. Federal data collection on key health indicators was insufficient before the pandemic, and our experiences with Covid-19 have underscored the need for improved data collection and transparent reporting. Detailed, consistent data is necessary to understand how and where the virus is spreading, who is most vulnerable to infection, and whether interventions are effective. This data is necessary to learn valuable lessons in mitigating the spread of future pandemics.

To collect reliable data and make it transparently, publicly available, the following steps must be taken:

- Immediately restore hospital Covid-19 data reporting to the CDC. The CDC must then strengthen, improve, and expand its data tracking, free of any political or corporate influence.
- Standardize data reporting. Data must be updated and reported in a timely fashion. A lag time of even a week can delay an effective response.
- Collect and publicly report at least the following data:
 - Diagnostic testing and case counts at national, state, and county/local levels. This data, as well as cumulative totals, must be reported daily, and must include the following details:
 - Case reporting of probable cases, not just those confirmed through testing.
 - Gender/sex, race/ethnicity, age, and occupation breakdowns for cases.
 - Diagnostic testing data, including the number of tests performed and the types of tests used. This data must provide clarity on the number of tests conducted and the number of people tested.
 - Timing of testing data, including both the time from symptom onset/exposure to testing and the turnaround time for tests (time between swabbing and test result).
 - Case isolation and contact tracing data, including the time to isolate cases from identification, the time to trace contacts, and data regarding cases resulting from different types of exposures (including isolated cases and types of contact such as workplaces, public establishment, gatherings, etc.).

- Establishment-level data about outbreaks, including workplaces.
- Data on health care worker infections and deaths at an establishment-level. This data must be reported daily and must also include cumulative totals.
- Syndromic surveillance data must be reported at national, state, and county/local levels (influenza-like illness and Covid-like illness).
- Data on hospitalizations and deaths must be reported at national, state, and county/local levels. This data must be reported daily and must include the following details:
 - Probable cases, not just those confirmed with testing.
 - Gender/sex, race/ethnicity, age, and occupation data for hospitalizations and deaths.
- Hospital capacity data must be reported at national, state, and county/local levels. This data must be updated in real time and must include total and available hospital beds by type (e.g., ICU, medical/surgical, telemetry, etc.), staffing, health care worker exposures and infections, and nosocomial patient infections.
- Data on the stock and supply chain of essential PPE and other supplies must be reported at national, state, and county/local levels. This data must be updated in real time and must include:
 - Data on actual stock of PPE, ventilators, and other essential equipment and supplies held by health care facilities, national and state stockpiles, and others.
 - Data on actual supply from manufacturers of PPE, ventilators, and other essential equipment and supplies.
 - Data on need at hospital level of PPE, ventilators, and other essential supplies.

Addressing Health Inequities

9. Immediately disburse comprehensive economic stimulus and other supports to all people in need.

The new administration must immediately work with Congress to pass a comprehensive economic relief bill that will address the widespread economic

inequalities that have worsened due to this pandemic. These economic inequalities result in worsening health disparities.

The economic devastation that has accompanied this catastrophic pandemic has only furthered the deep economic and health inequalities in our nation. As a result of the pandemic, tens of millions of people have lost their jobs and their health insurance. Many are struggling to feed their families, pay their rent, and pay for health care.

Under the outgoing administration, the American people have not received the economic stimulus and supports that they direly need, leaving millions of people to suffer.

A comprehensive economic stimulus package must include:

- The extension of supplemental unemployment benefits through the end of the pandemic, of at least \$600 a week.
- One-time stimulus payment checks of at least \$1200 for every adult and \$500 for every child.
- The extension of the eviction moratorium.
- Premium pay, or essential worker pay, for all essential workers including registered nurses and federal workers.
- At least \$1 trillion in appropriations for state and local governments for Covid-19 response programs.
- Appropriations to ensure that all health care services are provided free at the point of service to everyone during the pandemic.
- Funding for the United States Postal Service of at least \$25 Billion.

10. Make vaccines and treatments available to all both domestically and globally.

Any treatments or vaccines that are shown to be safe and effective must be distributed equitably, and made available free, at the point of service, to all people.

With the possibility of new treatments or vaccines that are safe and effective being available in the near future, it is critical that our public health infrastructure is improved to allow for the efficient, safe, and equitable roll-out of these treatments or vaccines.

Domestically, the next administration must ensure that any vaccine that is scientifically shown to be safe and effective is made available at no cost to all people who would like to receive the vaccine. The administration must also ensure that the necessary administrative and health care supports are in place to ensure timely follow up care if needed for any patient that has received a vaccine.

The United States must also play a leadership role in ensuring that any treatment or vaccine is made available equitably in the rest of the world. This virus does not recognize borders, and our nation has the opportunity to play an important role on the world stage to ensure that low and middle-income countries have access to these treatments and vaccines at a low-cost.

The new administration should engage with the World Health Organization and the World Trade Organization to waive patents on Covid-19 medicines or vaccines so that they can be manufactured and distributed in low and middle-income countries.

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