National Nurses United

The National Voice for Direct-Care RNs

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March 4, 2020

CDC Incident Manager for Coronavirus
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Dear Incident Manager and Dr. Srinivasan:

Thank you for including frontline nurses in the Center for Disease Control's efforts to respond to the current COVID-19 outbreak on March 1, 2020. National Nurses United, the largest union for registered nurses in the United States, has been closely monitoring the situation in our hospitals as the number of patients continues to grow. Considering the dynamic and evolving nature of this situation, maintaining this open dialogue is vital. Nurses welcome your invitation for continued collaboration.

During our call you explained that the CDC has identified obstacles in coordinating the response to COVID-19. These obstacles include reports from healthcare facilities that there are shortages of N-95 respirator masks, severely diminished capacity to provide a negative pressure environment, and an anticipation that more patients will need hospital care as cases increase. As an additional challenge, the CDC has limited ability to assess PPE supply, coordinate dissemination of PPE stores, and assess negative pressure capacity.

Despite a stark lack of information and coordination, the CDC is exploring options that include changing current guidance to healthcare facilities that would decrease the level of protection. This would not only pose a serious threat to public health but also fails to protect healthcare workers from occupational exposure to COVID-19. NNU strongly opposes this approach or any approach that fails to provide optimal protection and infection control standards. Now is the time

to use every possible instrument available to guarantee the highest level of protection, guided by the precautionary principle, to prevent the spread of infection, protect healthcare workers, and preserve any capacity to respond to a widespread outbreak. Our analysis indicates the most strategic method for preserving PPE supplies is to reduce the need for its use via engineering and other controls.

Due to the patchwork nature of our public health system there is no clear authority or enforcement mechanism to ensure that the necessary steps are in place. At this moment, the nation and healthcare providers are looking to the CDC to provide strong leadership and expertise that is governed by science as opposed to industry pressures.
Since our call, NNU has received additional information from our members regarding the response to COVID-19 by healthcare employers. At this time, our members are working in facilities caring for patients who are under investigation or already tested positive for COVID-19. Some of our members are in quarantine after having been subjected to occupational exposures that occurred as a result of their employers failing to ensure adequate protections were in place.

RN Survey Results
As of February 28th, we had surveyed more than 6,000 nurses from 48 states, the District of Columbia, and the Virgin Islands. The findings of this survey indicate that the majority of US healthcare facilities are *completely unprepared* to safely contain COVID-19:

- Only 29% of respondents report that their facilities have a plan to isolate patients with possible coronavirus infection.
- Only 27% report having access to powered air-purifying respirators (PAPRs), the higher level of protection nurses need, in their unit, and only 63% of respondents report having access to N95 respirators in their unit.
- Only 30% report that their employer has sufficient PPE stock on hand to protect staff if there is a rapid surge in patients with COVID-19 infection.
- Only 14% report that their employer has an overflow plan to place additional, trained staff to enable safe care provision to patients on isolation for possible novel coronavirus. 43% report they don't know.
- Only 19% report that their employer has a policy to address employees with suspected or known exposure to novel coronavirus. 42% don't know.

The findings of our survey combined with experiences of registered nurses demonstrate that our nation's hospitals are not meeting the standards necessary to protect caregivers and effectively prevent the spread of infection. In many cases, it is clear that employers have failed to provide basic education to frontline caregivers, implement routine screening and isolation protocols, or provide effective PPE, which has resulted in occupational exposures to registered nurses and other healthcare workers with nearly every new case of COVID-19. Disturbingly, these

exposures have continued despite increased awareness through widespread media reports and updates from the CDC.

As we approach the prospect of patient surge, resistance from the healthcare industry to implement protective standards will continue to grow. The CDC must assess the accuracy of healthcare facility claims. Identifying the difference between an unwillingness to allocate the resources needed to fulfill their obligation to frontline caregivers and patients as opposed to an inability to access the resources and implement surge protocols is necessary to ensure that all available resources are used effectively.

Comments on Select CDC Guidance

Recent changes to CDC guidance and reports from registered nurses on the frontlines raise additional concerns:

1. Screening and Testing, Identifying PUIs
    a. There have been multiple reports, including from the CDC itself, of issues with the CDC's test for COVID-19. While there have been assurances that these issues have been remedied, the CDC has yet to release the necessary information (including the sensitivity and specificity) regarding their COVID-19 test for to truly understand the reliability of the test. This technical information is necessary for healthcare providers and healthcare facilities to be able to use the test appropriately. When will the CDC share this vital technical information with the public?
    b. Further, there have been multiple reports of patients who are symptomatic testing negative for COVID-19 several times before a positive test.
        - Ai, Tao et al. Radiology, Feb 26, 2020. Examined over 1,000 patients in Wuhan who underwent both chest CT and RT-PCR tests. Found that of patients with negative RT-PCR tests, 75% had positive chest CT findings, 48% of which were considered as highly likely cases. The mean interval time from initial to positive RT-PCR results was 5.1 days. https://pubs.rsna.org/doi/full/10.1148/radiol.2020200642
        - Sensitivity of the test can depend on where the sample was taken from. Study found that sputum samples more sensitive than throat swabs- https://www.medrxiv.org/content/10.1101/2020.02.21.20026187v1. Currently, the CDC recommends nasal and throat swabs only, recommends against sputum samples.
        - And a more recent report from the US- https://thehill.com/changing-america/well-being/prevention-cures/485425-coronavirus-patient-in-san-

antonio-mistakenly: "According to the Austin Statesman, San Antonio Mayor Ron Nirenberg said that the patient was quarantined after contracting COVID-19, where they tested negative for COVID-19 twice. They were discharged from the Texas Center for Infectious Diseases on Saturday before a third test recorded positive results."

A negative COVID-19 test does not mean with certainty that a patient is negative for COVID-19. NNU has heard from nurses that healthcare facilities are removing protections for patients who are symptomatic after one negative test. The CDC needs to communicate clearly about what a negative test actually means.

c. The CDC has changed their case definition to allow testing based on a clinician's judgment. However, the CDC's epidemiologic factors still are limited to individuals with close contact with a laboratory-confirmed COVID-19 patient or history of travel to an affected geographic area within the past 14 days. These recommendations do not reflect the current situation where community transmission is occurring. This, combined with the issues described above with the test, is irresponsible.

We urge the CDC to consider adopting the following case definition:

- SUSPECTED: Any patient with fever and/or symptoms of respiratory illness (e.g., cough, difficulty breathing) should be considered a suspected COVID-19 case.
- PROBABLE: If the patient tests negative for influenza and other respiratory viruses, they should be considered a probable COVID-19 case.
- PROBABLE: If the patient has clinical symptoms that match the characteristics of COVID-19 cases, they should be considered a probable COVID-19 case regard less of test results.
- CONFIRMED: If the patient tests positive for COVID-19.

Any suspected COVID-19 case should be investigated further and all protections and precautions taken until ruled out.

All protections should be implemented for any probable or confirmed COVID-19 case.

This means that precautionary leave (minimum of 14 days) should be implemented for any nurse exposed to a probable or confirmed COVID-19 case.

As always, the astute and experienced judgment and expertise of nurses and other healthcare professionals is of the utmost importance in responding to this outbreak. The CDC must communicate clearly with healthcare professionals and the public regarding the reliability of their test. Using the case definition

above would be more protective than the CDC's current definition, furthering the ability of our healthcare facilities to prevent the spread of this virus.

2. Regarding What Healthcare Personnel Should Know about Caring for Patients with Confirmed or Possible COVID-19 Infection
    a. There are some inconsistencies between the 2/29/20 update to and other CDC guidance documents. Specifically, this guideline does not mention the evidence that asymptomatic patients can be infectious, nor does it highlight changes to the screening algorithm made on 2/27/20 by CDC.
    b. CDC guidelines on screening do not fully reflect the dynamic nature of transmission in this country and the need for additional screening and testing of people to get ahead of community spread. Any person with symptoms of respiratory illness needs to be considered a possible COVID-19 case (see above).
    c. Increased guidance to employers is needed regarding the importance of communication with frontline staff. We are receiving reports that staff are learning about PUI and Covid-19 cases from the media before their employer. CDC guidelines recommend contacting occupational health when there is an unprotected exposure. However, healthcare workers cannot identify this risk if the employer hasn't notified them that there might be a potential case. This underscores the need for increased transparency from employers around potential exposure and using the precautionary principle to protect healthcare worker safety. We are receiving reports that some employers are confused about HIPAA privacy laws and the obligation to notify staff of patients in isolation.
    d. It is of vital importance that clear information on disinfection protocols for PPE and surfaces is disseminated to all workers including environmental services.

3. Regarding, CDC guidance Conventional Capacity Strategies for Optimizing the supply of N95 Respirators
    a. Engineering Controls
        i. AIIR isolation for any PUI – ALL PUIs should be in AIIR wherever possible; CDC recommendations do not mention use of HEPA filters as temporary measure, which can help reduce risk to healthcare workers but are NOT a substitute for AIIR.
        ii. Physical barriers are helpful but not a replacement for proactive other engineering controls such as properly maintained ventilation systems and separated triage areas
        iii. Curtains between areas is NOT an adequate engineering control unless the patient is cohorted with other COVID cases.
    b. Administrative Controls

i. RN reports indicate that employers are misinterpreting this guidance. We are receiving wide-spread reports of employers who are collecting all masks and placing them under lock and key creating administrative barriers that increase risk of exposure and create potentially life-threatening delays in patient care.

ii. We are receiving reports that in many cases, patient isolation masks are not directly accessible to patients. Masks must be available at every point of entry.

iii. "Just in Time" management strategies for supplies and PPE have been creating a problem in healthcare facilities for some time. In nurses experience, "Just in Time" has, in reality, meant "Too Late". The CDC has recommended this strategy for fit testing in healthcare facilities. Annual fit testing should be a standard practice in all healthcare facilities and is required by OSHA. All healthcare workers must be trained and fit tested immediately.

iv. The CDC has placed emphasis on acute care preparation. We have identified a need for stronger guidance in outpatient facilities. Training on indications and use of PPE must be provided to all direct care and front line HCWs who must also have access to PPE. At least one incidence of occupational exposure has already occurred in the outpatient setting.

v. We have identified a learning need in respect to patient cohorting. Cohorting patients is a process with which healthcare facilities and frontline healthcare workers have had no or very limited first-hand experience. As we anticipate the need for cohorting of patients additional guidance from the CDC will help to ensure proper implementation. Additionally, we have concerns that employers, in their efforts to reduce exposure to the cohort environment, will not staff these environments with sufficient registered nurses and support staff such as environmental services, which may result in caregiver fatigue and environmental conditions that increase the risk of the spread of infection.

vi. We are concerned with the CDC's promotion of telemedicine as a mechanism to limit the number of people going to the hospital. From NNU's experience, there is a high risk that screening will be performed by unlicensed assistive personnel, aided by algorithms which are designed to discourage people from receiving care that they need. Budgetary concerns and algorithms cannot override or replace the independent professional judgement and assessment by a skilled registered nurse. Astute clinicians were the first to recognize infection in China as well as cases in the US that screening algorithms alone would have missed. NNU recommends a robust public health response that includes the capacity to perform

screening en masse in an environment that safely isolates patients and provides healthcare workers with proper protection.

c. Regarding CDC guidance for Crisis/Alternate Strategies
    i. Implementing this guidance is premature and the CDC must communicate that clearly. The CDC must administer clear and meaningful guidance outlining what steps must be taken before considering crisis or alternative strategies. It must be absolutely clear, with factual evidence, that there is a systemic need to implement crisis/alternate strategies before they are implemented. It is irresponsible for the CDC to recommend the implementation of crisis/alternate strategies in response to isolated incidents or shortages that have resulted from the failures that result from "Just in Time" resource management strategies. The CDC is an important source of guidance during crises like COVID-19, and we urge the CDC to ensure that protections for nurses and other healthcare workers, and in turn their patients and our communities, are maintained.

Now is the time for CDC to strengthen its protective guidance. Preventing exposures and infections in frontline caregivers is essential to ensuring that our nation's healthcare system is able to maintain its integrity throughout the course of this public health threat. As part of our continued response, NNU has sent letters with recommendations for action to Vice President Mike Pence and US Congress, OSHA. Those letters are attached.

To reiterate, we welcome open dialogue with the CDC, hoping that we can advance our mutual goals of protecting the public, caring for patients, protecting frontline caregivers, and preventing the spread of this infection. If you have any questions regarding the contents of this letter, please contact me at 510-433-2771 or jthomason@nationalnursesunited.org.

Sincerely,

Jane Thomason, CIH
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National Nurses United