New York State NURSES ASSOCIATION One strong, united voice for nurses and patients

Joint Assembly and Senate Legislative Hearing:
Impact of COVID-19 on Workers
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Testimony on behalf the New York State Nurses Association
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Introduction

The COVID-19 emergency severely affected hospitals throughout the state, but New York City area hospitals were particularly hard hit. As nurses, our members were in the front-lines of the battle against the pandemic and directly experienced the problems faced by all essential workers during the crisis.

Thousands of health care workers were infected during the pandemic and many of our members and other essential workers were disabled or died during the height of the outbreak.

At the height of the crisis, which was centered on New York City, Westchester and Nassau, there were more than 18,000 hospitalized COVID patients, including more than 5,000 ICU patients. Our hospitals were being overrun.

Nurses and other direct care workers were impeded in their response to this unprecedented health care crisis.

Nurses were forced to work in dangerous conditions without adequate personal protective equipment (PPE). Staffing levels were stretched even thinner than normal, placing inordinate stress on workers and affecting patient care. Infection control protocols and guidance from the federal and state levels were constantly shifting and often contradictory. Standards were repeatedly relaxed, raising the risks of exposure and infection for nurses and our patients. Quarantine and isolations protocols were inconsistent for nurses who were exposed, or showing symptoms, and the same was true for the use of paid leave. This resulted in nurses being called in to work even though they were possibly contagious or still sick. Nurses who were exposed, fell ill or died faced obstacles filing for Workers' Compensation, or had their claims challenged outright. In addition, most of the key decisions directly affecting our members and our patients were made by state policymakers and hospital administrators with little or no experience in direct patient care, with no input from nurses, and no transparency.

Nurses and direct care staff faced numerous obstacles and threats to their safety during the initial COVID-19 surge. These must be addressed as we prepare for the expected resurgence of the virus in the fall and winter.

NYSNA urges the legislature and the state of New York to learn from our experiences in the first round of the COVID crisis and to implement the following measures to prepare for the next surge:

1. Implement minimum safe staffing standards

During the height of the springtime surge, hospitals were directed to increase their bed capacity by at least 50% and the state added tens of thousands of ventilators to accommodate increased ICU patients. At the peak, hospitalizations and ICU usage rates substantially exceeded pre-crisis system capacity (about 53,000 beds and 3,300 ICU beds), with healthcare facilities in NY City even more overstretched.

The staffing situation before the crisis was problematic, with nurses regularly reporting that they were too short-staffed to provide proper levels of patient care. The state, despite sustained demands from nurses and patient care advocates, failed to implement minimum staffing ratios and other regulations to ensure safe patient care.

The lack of minimum staffing standards, equally enforced and applied to all hospitals, had several immediate effects when the pandemic hit New York. First, there was a general shortage of staff throughout the system, forcing nurses to scramble to provide care for large numbers of patients. Second, the crisis highlighted staffing disparities between hospitals within the system – financially well off hospitals had better staffing before and during the crisis than poorly resourced safety net hospitals, public hospitals and satellite community hospitals within large systems.

These disparities impacted mortality rates during the crisis, as has been widely reported in the press and academic research.

If the state had implemented uniform minimum staffing requirements throughout the hospital system, disparities stemming from unequal staffing patterns would have been avoided and fewer patients would have died.

Improved staffing standards would also lead to better care under normal circumstances and will improve the capacity of hospitals to respond to COVID and other public health emergencies. All patients, regardless of where they live or their income level are entitled to quality care and the same chance of survival.

Finally, we would note that the state was required to conduct and release a study of staffing patterns in hospitals and long-term care facilities by December of 2019. It is our understanding that the DOH has committed to release the study shortly. We call on the legislature to carefully analyze the study and other relevant data and to enact minimum staffing legislation to provide all patients with safe, quality care.

2. Address the PPE problem

During the height of the crisis, nurses and other health care workers experienced widespread and severe shortages of personal protective equipment (PPE), including disposable N95 respirators, protective gowns and face shields. The shortage also led to regular downgrading of infection control protocols that were driven by the need to conserve PPE rather than evidence-based scientific best practices.

The situation with N95 respirators was particularly acute, with nurses being required to reuse these disposable products for up to a week and other staff being denied respirators entirely, notwithstanding increasing evidence that the virus is airborne and lingers for hours suspended in the air.

The PPE situation has eased considerably during the lull, but if there is a resurgence in the fall and winter, combined with the ongoing and simultaneous spread of the virus in the rest of the country, we are concerned that we will again face critical and dangerous shortages of PPE.

We believe that the following measures need to be implemented to address this situation and prepare for the next round:

- Coordinate and control the production, acquisition, stockpiling and distribution of PPE supplies for health care workers and essential workers in all industries and sectors. The availability of PPE cannot be contingent on an employer's financial resources or personal connections. Shortages of PPE are unconscionable and threaten the public health;
- Respirators, masks, gowns, face shields, coveralls, head coverings, booties, gloves and any other necessary PPE will be available on all units, for all workers coming into contact with patients, and replaced after each patient care session with a confirmed or suspected COVID patient, or when the PPE is soiled, damaged or contaminated;
- To protect against supply chain disruptions, hospitals should maintain a sufficient onsite PPE stockpile for 90 days of operation at enhanced "conventional capacity" guidelines (as opposed to "contingency capacity" or "crisis capacity" guidelines that restrict the use of PPE);
- Require transparency about the actual levels of PPE on hand, at the hospital level and statewide, with regularly published, up-to-date information about the numbers of each type of PPE stockpiled;
- Increase the use of reusable rather than disposable respirators. Hospitals should be required (and receive funding if necessary) to purchase reusable elastomeric respirators and Powered Air Purifying Respirators (PAPRs) to reduce supply chain pressures and enhance capacity for future surges;
- The state should implement standard infection control procedures and PPE protocols that are scientific, evidence-based, and protect all workers from airborne exposure to COVID, including not just nurses and other direct care staff, but all hospital workers;
- Prohibit the sterilization and re-use of disposable single-use PPE (cleaning or sterilizing disposable PPE degrades the equipment and reduces its effectiveness);
- Ensure that all hospital staff (including ancillary or support workers) have access to full PPE and are all properly fit tested and trained in proper donning and doffing;
- Require surgical masks for all patients and visitors, as well as hospital staff who have no contact with the public.

3. Implement proper and uniform infection control protocols

During the crisis, infection control standards and protocols issued by the CDC, the State DOH and local health departments were constantly changing and in many cases watered down. These changes were often driven by a perceived need to conserve PPE or address staffing shortages, and were often implemented without any scientific or clinical basis. In fact, these changes were often implemented with the knowledge that they would increase the risk of exposure of workers and patients.

The DOH, for example, sanctioned the use of the CDC's downgraded protocols which include "crisis capacity" strategies for extended use and reuse of disposable N95 respirators. The CDC states these "strategies are not commensurate with U.S. standards of care but may need to be considered during periods of known PPE shortages."

Clearly, if the supply was adequate or "enough", PPE conservation measures intended only for use during a severe shortage, which carry a risk to caregivers and patients, would not have been sanctioned and implemented.

This dynamic was particularly apparent in the decision to classify COVID-19 as “non-airborne” with the primary transmission occurring through direct droplet or fomite contact or in certain “aerosolizing” procedures (i.e., intubation or extubation). This decision disregarded the precautionary principle and early evidence of airborne transmission, and was driven by the need to conserve PPE as a result of federal and state failures to prepare in advance of the pandemic.

Accordingly, NYSNA urges that the following measures be taken to prepare for the expected resurgence of the virus in the fall and winter:

- The state should require standardized, enforceable infection control standards that apply to hospitals and well as educational institutions, government agencies and private sector employers. These standards should be mandatory in nature and not merely recommendations;
- In hospitals, these regulations should require airborne transmission protocols and corresponding PPE standards, regulations for the cohorting of COVID-positive and suspected patients, including walk-ins and ED patients. Any changes or variations in the standards must be evidence-based and scientifically justified;
- The application of minimum ventilation standards and engineering controls tailored for hospitals and other healthcare settings;
- Mandatory source control measures such as mask requirements for visitors and patients in hospitals as well appropriate mitigation measures for other public and private settings such as social distancing, physical barriers, etc.;
- Training of all employees in the proper application and implementation of the mandatory infection control measures and protocols, including necessary training in the use of PPE;
- Any standards and protocols must be implemented by employers with meaningful input from front line healthcare workers and others who will or might be exposed to COVID at work.

4. Protect Nurses and other essential workers who are exposed or become ill

During the high-point of the pandemic, numerous nurses, health care workers and other “essential” workers were required to report to work while others remained at home. As a result, large numbers of these workers were exposed to or fell ill with COVID.

Among nurses and direct care workers in hospitals and nursing homes, infection rates were very high and many were forced to self-isolate due to exposure or to miss work because they fell ill. Though it is difficult to determine the infection rates among nurses and other essential workers, the State DOH did issue a report that attempted to blame the large number of nursing home deaths in New York on infected workers. In that report the DOH estimated that the infection rate among nursing home

employees was between 25 and 33 percent. This illustrates the degree to which health care workers were exposed to COVID throughout the health care system due to the lack of adequate PPE.

During the crisis, the legislature passed paid leave measures to allow paid time off for exposed workers to isolate, quarantine and recuperate from their exposure to the virus. In furtherance of protecting exposed workers, the CDC and state DOH issued guidelines recommending that people exposed to COVID should self-isolate or quarantine for 14 days. For nurses and other essential workers, the standard was reduced to 7 days (and have not had a fever for 72 hours). As a result nurses were being pressured or required to return to work even though they were still sick and possible contagious.

Nurses and other essential workers were also left unprotected if their exposure resulted in illness, disability or death. Under current law, COVID 19 is not classified as an occupational disease for purposes of getting health care, disability and death benefits under the Workers' Compensation Law. This means that these workers were discouraged for applying for benefits, had claims challenged and would have to prove that they contracted COVID at work to win their cases.

Given the critical role played by health workers and other essential workers during the crisis, it is unacceptable that these workers should not receive the supports and assistance that they earned with their sacrifice for the common good. Thanking them for their service is not enough.

Accordingly, NYSNA supports the following measures to recognize the sacrifices of nurses and other essential workers and provide them with fair support or compensation if they become ill:

- Ensure that nurses and other essential workers who are required to isolate or quarantine because of suspected or confirmed COVID infections are guaranteed a full 14 days of paid sick leave;
- Prohibit employers from pressuring or requiring nurses and workers to return to work before the 14 day leave period has expired or if they are still sick;
- Eliminate constantly shifting criteria for isolation and quarantine of staff exposed to or infected by COVID, since this leads to staff being recalled to work while sick or still contagious. No one should return to work early unless cleared to return by their physician or health provider;
- COVID 19 should be legally classified as an occupational illness for nurses and other essential workers, creating a legal presumption that the disease was contracted at work, and allowing workers or their survivors to receive health, disability and death benefits without submitting proof to that effect;
- Require all employers of essential workers to provide COVID recognition or hazard pay bonuses.

5. Give nurses, health care workers and other essential workers a seat at the table

As has been noted above, the pandemic generated a flurry of regulations, emergency measures, executive orders, infection control and PPE guidelines and policies, changes in hospital systems and numerous other measures.

In almost every case, these decisions and policies were implemented with little or no direct consultation or input from the workers who were directly affected and would be responsible for carrying out these directives.

This is an unacceptable, unaccountable and ultimately ineffective approach to addressing the problems that arose during the initial COVID-19 surge. Workers need a seat at the table. The legislature has acknowledged this principle in recently enacted legislation that requires public employers to develop COVID emergency plans in consultation with their union and non-union workforces.

NYSNA strongly believes that nurses and other direct care staff need to be included in the decision-making process at the policy level and within their workplaces. This inclusive and collaborative approach is also vital if we are to effectively learn from our mistakes in the first wave and to avoid repeating those mistakes in any resurgence of the pandemic.

Accordingly, NYSNA recommends the following:

- Transparency and information in the workplace - Nurses and other healthcare workers have a right to know what risks they're facing when they report to work. Hospitals should be required to make weekly reports to all staff, documenting essential information such as how many COVID-positive patients they are treating, levels of PPE inventory, and real-time reporting of the number of staff who've been exposed to or gotten sick from COVID-19, with robust contact tracing and notification. The state should also regularly publish similar information collected through the Hospital Emergency Response Data System (HERDS);
- Joint committees should be required to conduct comprehensive COVID-19 assessments of the workplace;
- Joint development of COVID surge and/or emergency preparedness plans;
- Inclusion of worker representatives in all state level decision making processes relating to the development and implementation of COVID policies and protocols, including state executive orders.