



A Union of Professionals

**AFT Nurses and  
Health Professionals** ❤️

# Is Your Workplace Ready for COVID-19?

## Response to the CDC Respiratory Protection Guidance Change

MARCH 13, 2020

AFT Nurses and Health Professionals, along with other unions, pressed the Centers for Disease Control and Prevention to strengthen its guidance on respiratory protection for healthcare workers in the midst of the COVID-19 outbreak. Instead, the CDC went in the opposite direction, downgrading the recommended respiratory protection for healthcare workers caring for patients with suspected or confirmed COVID-19.

Under the revised guidance, the CDC says that surgical masks are an acceptable alternative to N95 respirators and that the existing supply of N95s should be reserved for healthcare workers conducting aerosolizing procedures. The CDC (as are we) is understandably concerned about the supply of N95 respirators. However, there are a number of options for maintaining protections for healthcare workers the agency could promote to reduce the risk of transmission to healthcare workers. Surgical masks are not designed to provide respiratory protection from airborne disease; they are only designed to protect the wearer against large droplet splashes.

The CDC's current guidance appears to be based solely on the critical low supplies of N95s, not science. The CDC says that COVID-19 is spread only through contact and droplet transmission, yet it undercuts its own argument by also saying that facilities should return to the use of respirators for workers caring for patients with suspected or confirmed COVID-19 when supply chains are restored. Earlier guidance on COVID-19 noted that other coronaviruses, such as SARS and MERS, can be spread through aerosol transmission. A small study demonstrates that COVID-19 produces aerosolized viral

particles. Moreover, the large number of healthcare workers infected in China, the rate of infection among people quarantined on cruise ships forced to breathe recirculated air and examples of transmission in Singapore apartment buildings indicate that it is quite likely that the virus is transmitted through the air.

We believe that the CDC should follow the precautionary principle—in the absence of definitive evidence for or against aerosolized transmission, the CDC should offer guidance that is as protective as possible.

Employers will take this guidance as definitive. We must do all that we can to argue for protocols and equipment that can reduce the risk of transmission to healthcare workers and the spread of infection to others. The union should be informed of how facilities plan to change their protocols and respiratory protection programs, as well as any training of healthcare professionals.

The union should also be informed on how facilities will perform risk assessments and hazard assessments of exposed healthcare workers. The union should also know how facilities will maintain their supply of N95s and other respiratory protection (it shouldn't be a mystery).

Please use this document, the talking points document and the sample information request letter to advocate for these controls and sound infection control practices. We will continue to call for the Department of Health and Human Services to release the national stockpile of respirators, promote the use of reusable respirators and incentivize American manufacturers to produce more N95s.

Find these resources and more at [www.aft.org/coronavirus](http://www.aft.org/coronavirus)

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# Minimize the risks of exposures through educating patients, screening and isolation

## SCREEN PATIENTS BEFORE THEY COME INTO THE FACILITY:

- Instruct patients to call ahead; screen via the phone.
- Use telemedicine for as many cases as possible to avoid people coming in.
- Delay elective procedures.
- Conduct triage in the parking lot; call people into the emergency department when they are ready to be seen.

## AT THE ENTRANCE/WITHIN THE FACILITY:

- Establish universal precautions for all patients coming into the facility. We should assume that everyone is infectious, since many COVID-19 infected individuals are asymptomatic. All patients should be masked until known not to be infected.
- If management will not do that due to a low supply of surgical masks, insist masking any patients with fever or respiratory symptoms.
- If management has made surgical masks and N95s less accessible in order to conserve the supply, demand a process that will ensure they are available to staff when a patient suspected of having COVID-19 presents and during care.
- Have signage at the entrances about masking and cough etiquette.
- Provide a separate entrance if possible for potential cases or screen and test people in their cars.
- Designated triage staff members should meet people as they enter and give out the masks. Patients with fever and/or lower respiratory symptoms should be sent to isolation rooms (negative pressure, if possible).
- Emergency medical services should call ahead to the emergency department if bringing in potential cases.

- Provide tissues and hand sanitizer in waiting areas.
- Increase dilution ventilation within the emergency department and waiting areas—and if possible, throughout the facility.

## SUSPECTED AND CONFIRMED CASES:

- Find out how many negative air pressure rooms there are and who ensures maintenance and proper operation.
  - Find out what the plan is to isolate patients when there are no available negative air pressure rooms.
- Cohort patients to avoid the spread to other areas of the hospital.
  - Create systems to avoid cross contamination (radiology, testing, environmental services food service, pharmacy—ensure a closed loop).
  - Cohorting patients in this way makes it easier to use powered air purifying respirators or elastomeric respirators and conserve the supply of N95s.
- Set up logs for people entering the rooms.
- Limit visitation for patients.
- Make sure patients wear masks when not in isolation.

## ADMINISTRATIVE CONTROLS TO PROTECT STAFF:

- Insist on clear communications to staff.
- Provide training in real time for staff (protocols, personal protective equipment, what do to if exposed, etc.).
  - Training with a live trainer, with opportunities to ask questions and practice.

- Cohort the staff—ask for volunteers to the dedicated team—to avoid infection spread to other areas of the hospital.
  - Ensure sufficient staffing of this team so they do not become fatigued and burned out, which will weaken their immune systems.
 

Nurses will end up doing non-nursing tasks as a way to limit the number of personnel in the room and use of PPE—so limit the number of patients each nurse cares for.
  - Backfill other areas of the hospital and hire agency nurses as needed.
- Limit the number of staff who enter the patient rooms.
- Establish medical surveillance of nurses caring for suspected or confirmed patients—reporting temperature and any symptoms, and testing if symptoms occur.
- Have a buddy system for donning and doffing PPE.
- Conduct risk assessments for staff in outpatient settings where respirators may be warranted due to aerosolizing procedures (audiology, lung function testing).

#### PERSONAL PROTECTIVE EQUIPMENT:

- Push the employer to purchase powered air purifying respirators (PAPRs) and half-mask or full facepiece elastomeric respirators. A PAPR costs about \$1,000. Full facepiece elastomeric respirators cost about \$250 and half-mask elastomerics cost about \$50, not including the cost of the filters. Right now, a case of 160 3M N95s costs nearly \$3,000, and an individual one costs \$20. While the initial cost of these reusable respirators is high, and there are some costs associated with the filters and batteries, a convincing argument can be made that it will save employers money in the end by reducing their dependence on disposable N95s and avoiding staff conversions. Putting people on furlough is also expensive.

- PAPRs should be used for high-risk procedures that produce aerosols (such as cardiopulmonary resuscitation, intubation, extubation, bronchoscopy, nebulizer therapy and sputum induction). The guidance now says that N95s can be used during these procedures. If the employer can provide PAPRs, it should.
- Provide facial shields (or goggles, but shields are better and less likely to disturb the respirator seal), gloves and gowns.
- Find out who will be responsible for cleaning, disinfecting and charging batteries for reusable respirators. Workers who are at higher risk of severe disease due to age, pregnancy or pre-existing conditions, such as diabetes, heart disease, cancer or asthma, should have an N95 or stronger respirator if they care for suspected or confirmed COVID-19 cases. If they cannot be medically cleared to wear a respirator, they should be assigned to a low-risk area of the facility.
- Staff must have refresher training on donning and doffing and checking the seal for respirators.
- Fit testing should be conducted for N95s, N99s and N100s.

#### PROTOCOL FOR EXPOSED NURSES:

- The employer must have clear communication on whom to notify if a worker is exposed.
- Exposed staff must have a 14-day quarantine with no loss of pay, annual leave or sick time.
- Staff need instructions on how to self-monitor.
- Provide alternative housing for those living with young children or immune-compromised people.
- The employer should pay for testing and for healthcare costs if conversion results in illness.

The AFT will continue to press for more rigorous guidance from the agency as well as seek protective regulations. Stay in touch!

**Questions or concerns about your health and safety on the job**  
**Contact our union at 202-716-5510 or [smarkle@aft.org](mailto:smarkle@aft.org)**

Find these resources and more at [www.aft.org/coronavirus](http://www.aft.org/coronavirus)