



The National Voice for Direct-Care RNs

WASHINGTON DC
8455 Colesville Road
Suite 1100
Silver Spring MD 20910
phone: 800-287-5021
fax: 240-235-2019

OAKLAND
155 Grand Avenue
Suite 100
Oakland CA 94612
phone: 800-504-7859
fax: 510-663-1625

March 4, 2020

The Honorable Eugene Scalia
Secretary of Labor
United States Department of Labor
200 Constitution Avenue, NW
Washington, D.C. 20210

The Honorable Loren Sweatt
Principal Deputy Assistant Secretary of Labor for Occupational Safety and Health
Occupational Safety and Health Administration
United States Department of Labor
200 Constitution Avenue, NW
Washington, D.C. 20210

Re: National Nurses United Petitions OSHA for an Emergency Temporary Standard on Emerging Infectious Diseases in Response to COVID-19

Dear Secretary Scalia and Principal Deputy Assistant Secretary Sweatt:

National Nurses United (NNU) is the largest union for direct care registered nurses (RNs) in the United States. As such, we are concerned that our members are afforded their right to a safe and healthful workplace and are thoroughly protected by their employers from hazardous exposures that may occur in the course of doing their jobs. On behalf of our members and all nurses and other healthcare workers in the United States, we urge you to take immediate action to ensure nurses and all healthcare workers are protected during the COVID-19 outbreak by granting this petition for the promulgation of an Emergency Temporary Standard on Emerging Infectious Diseases.

COVID-19 is quickly becoming a global pandemic, spreading to 74 countries in a matter of weeks.¹ According to the World Health Organization, a total of 91,783 cases have been identified in 74 countries, and 3,123 people have died of the virus as of March 3rd.² As of the same date, the total number of confirmed and presumptive positive cases in the United States is 60,³ which is likely an underestimation given the U.S. Centers for Disease Control

¹ World Health Organization, (March 3, 2020), "Novel Coronavirus (COVID-19) Situation Dashboard," online at <https://experience.arcgis.com/experience/685d0ace521648f8a5beee1b9125cd>.

² World Health Organization, (March 3, 2020).

³ U.S. Centers for Disease Control and Prevention, (March 3, 2020), "Coronavirus Disease 2019 (COVID-19) in the U.S." online at <https://www.cdc.gov/coronavirus/2019-ncov/cases-in-us.html>.

and Prevention's (U.S. CDC) limited testing capacity, recent reports of community transmission, and rapidly evolving situation.^{4,5}

In every emerging infectious disease event the world has seen, nurses and other health care workers are on the frontlines caring for the most vulnerable, high-risk patients. Nurses nationwide stand ready and willing to provide the lifesaving care patients with COVID-19 infections need, but nurses and other healthcare workers must have the highest level of protection to be able to do their jobs safely. The health and safety of nurses and other healthcare workers is of paramount importance to an effective response to emerging infectious disease events. Fundamentally, nurses and other healthcare workers have the same right as other workers to a workplace free from hazards that threaten their health and safety, including infectious diseases.

OSHA should take immediate action and fulfill its obligation to protect the health and safety of workers by granting this petition and passing an emergency temporary standard to protect nurses and other healthcare workers from emerging infectious diseases like COVID-19.

I. OSHA is obligated to engage in responsible rulemaking to protect worker health and safety and must promulgate an Emergency Temporary Standard on Emerging Infectious Diseases.

Through the Occupational Safety and Health (OSH) Act of 1970, Congress mandated the prioritization of the safety and health of workers and the prevention of occupational injury and illness and created an obligation by employers to provide a workplace free from recognized hazards.⁶ Pursuant to this Congressional mandate, OSHA is obligated to promulgate and enforce an emergency temporary standard where two elements are determined:⁷

- (A) that employees are exposed to grave danger from exposure to substances or agents determined to be toxic or physically harmful or from new hazards; and
- (B) that such emergency standard is necessary to protect employees from such danger.

COVID-19, like other emerging infectious diseases, constitutes precisely such a grave danger to nurses and other health care workers. This is a novel virus about which little is known. Healthcare employers are ill prepared to respond safely to prevent employee exposure to COVID-19. Where OSHA determines employees in other industries are at risk of COVID-19 exposure and a standard is necessary to protect those employees, OSHA should take appropriate action. Given the central role nurses and other healthcare workers face in response to emerging infectious diseases and the attendant high risk of exposure, NNU urges OSHA to take immediate action to protect nurses and other healthcare workers from COVID-19.

⁴ Chen, Caroline et al. (Feb 28, 2020), "Key Missteps at the CDC Have Set Back Its Ability to Detect the Potential Spread of Coronavirus." *ProPublica*, published online at <https://www.propublica.org/article/cdc-coronavirus-covid-19-test>.

⁵ Schnirring, Lisa, (Feb 29, 2020), "Three states report new community spread of COVID-19." *Center for Infectious Disease Research and Policy*, published online at <http://www.cidrap.umn.edu/news-perspective/2020/02/three-states-report-new-community-spread-covid-19>.

⁶ 29 U.S.C. § 651 (1970)

⁷ 29 U.S.C. § 655(6)(c) (1970)

II. Emerging infectious diseases like COVID-19 expose nurses and other healthcare workers to grave danger and are new hazards.

A. COVID-19, Like Other Emerging Infectious Diseases, is a New Hazard.

Emerging infectious diseases are those “whose incidence in humans has increased in the past 2 decades or threatens to increase in the near future...which respect no national boundaries.”⁸

These infectious diseases can include:

- New infections resulting from changes or evolution of existing organisms
- Known infections spreading to new geographic areas or populations
- Previously unrecognized infections appearing in areas undergoing ecologic transformation
- Old infections reemerging as a result of antimicrobial resistance in known agents or breakdowns in public health measures.

COVID-19 is a newly emerged and identified coronavirus, similar to SARS. Researchers have proposed that the virus evolved to jump from animals to humans, but this remains unconfirmed.⁹ Even as our knowledge of this virus is growing rapidly, there is still much unknown. As the National Institute for Occupational Safety and Health (NIOSH) recognizes,¹⁰ in these situations the very fact that little is known about the infectious disease amplifies the danger posed to healthcare workers when their employers wait for information or evidence before taking protective action.

Unfortunately, the world has seen several emerging infectious disease events in recent decades—severe acute respiratory syndrome (SARS), Middle East respiratory syndrome (MERS), H1N1 influenza, Ebola, Zika, and others. Nurses and healthcare workers have been at significant risk of exposure to each of these emerging infectious diseases.^{11,12,13,14} Emerging infectious disease events have increased in the current and previous centuries, and experts expect that trend to continue and worsen due to the climate crisis, globalization, dense urbanization, lack of public

⁸ U.S. Centers for Disease Control and Prevention, (last reviewed May 30, 2014), “EID Journal Background and Goals: What are ‘emerging’ infectious diseases?” online at <https://wwwnc.cdc.gov/eid/page/background-goals>.

⁹ Cyranoski, David (Feb 26, 2020), “Mystery deepens over animal source of coronavirus.” *Nature*, published online at <https://www.nature.com/articles/d41586-020-00548-w>.

¹⁰ U.S. National Institute for Occupational Safety and Health, (Last Reviewed March 28, 2018) “Emerging Infectious Diseases.” Online at <https://www.cdc.gov/niosh/topics/emerginfectediseases/default.html>.

¹¹ Chan-Yeung, M., (2004), “Severe acute respiratory syndrome (SARS) and healthcare workers.” *Int J Occup Environ Health*, 10(4): 421-7.

¹² Elkholy, A.A. et al. (May 2, 2019), “MERS-CoV infection among healthcare workers and risk factors for death: Retrospective analysis of all laboratory-confirmed cases reported to WHO from 2012 to 2 June 2018.” *J Infect Public Health*, published online at <https://www.sciencedirect.com/science/article/pii/S1876034119301443?via%3Dihub>.

¹³ Lietz, Janna et al., (2016), “The Occupational Risk of Influenza A (H1N1) Infection among Healthcare Personnel during the 2009 Pandemic: A Systematic Review and Meta-Analysis of Observational Studies.” *PLoS One*, 11(8): e0162061.

¹⁴ Suwantararat, Nuntra and Anucha Apisarnthanarak, (Aug 2015), “Risks to healthcare workers with emerging diseases: lessons from MERS-CoV, Ebola, SARS, and avian flu.” *Current Opinion in Infectious Diseases*, 28(4): 349-61.

health infrastructure and funding, lack of protections within healthcare facilities, and other factors.^{15,16,17}

In emerging infectious disease events, it is of the utmost importance that healthcare employers provide the fullest protections for nurses and other healthcare workers, especially when the hazard is a novel infectious disease. OSHA should pass an emergency temporary standard to require healthcare employers to provide protections during an emerging infectious disease event like COVID-19. The current urgency of the situation with COVID-19 should motivate OSHA to take immediate action.

B. COVID-19 can cause life-threatening infections, exposing nurses and other healthcare workers to grave danger.

Several published reports have established a basic picture of clinical symptoms and outcomes for those infected with COVID-19. These symptoms can include fever, cough, muscle soreness, weakness, diarrhea, headache, and other symptoms. While some symptoms appear to be common, there is also diversity in how COVID-19 manifests (Table 1).

Table 1: Symptoms of COVID-19 Reported in the Scientific Literature			
Symptom	Huang et al. (Feb 15-21, 2020), report on 41 admitted hospital patients with laboratory-confirmed COVID-19 infection in Wuhan, Hubei Province, China ¹⁸	Wang et al. (Feb 20, 2020), report on 105 patients with COVID-19 infections in North Shanghai, China ¹⁹	Liang et al. (Feb 28, 2020), report on 457 patients with lab-confirmed COVID-19 identified from 7 studies ²⁰
Fever	98%	82.9%	89%
Cough	85%	62.9%	63%
Fatigue or weakness	44%	17.1%	51%
Headache	8%	Muscle soreness 6.7%	8%
Diarrhea	3%	8.6%	7%

¹⁵ Petersen, E. et al. (2018), “Emerging infections—an increasingly important topic: review by the Emerging Infections Task Force.” *Clinical Microbiology and Infection*, 24(4): 369-75.

¹⁶ Nii-Trebi, Nicholas Israel, (2017), “Emerging and Neglected Infectious Diseases: Insights, Advances, and Challenges.” *BioMed Research International*, published online at <https://www.hindawi.com/journals/bmri/2017/5245021/>.

¹⁷ Brooks, Daniel R. and Walter A. Boeger, (2019), “Climate change and emerging infectious diseases: Evolutionary complexity in action.” *Current Opinion in Systems Biology*, 13: 75-81.

¹⁸ Huang et al. (Feb 15-21 2020), “Clinical features of patients infected with 2019 novel coronavirus in Wuhan, China.” *The Lancet*, 395(10223): 497-506

¹⁹ Wang, Changhui, et al. (Feb 20, 2020), “The Epidemiologic and Clinical Features of Suspected and Confirmed Cases of Imported 2019 Novel Coronavirus Pneumonia in North Shanghai, China.” Preprints with *The Lancet*, published online at https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3541125.

²⁰ Liang, Bo et al. (Feb 28, 2020), “Clinical Characteristics of 457 Cases with Coronavirus Disease 2019.” Preprints with *The Lancet*, published online at https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3543581.

Several additional reports underline the potential seriousness of a COVID-19 infection, including damage to lung tissue that has become characteristic to COVID-19. A recent study describes this damage:

“COVID-19 pneumonia manifests with chest CT imaging abnormalities, even in asymptomatic patients, with rapid evolution from focal unilateral to diffuse bilateral ground-glass opacities that progressed or co-existed with consolidations within 1-3 weeks.”²¹

The Chinese Centers for Disease Control and Prevention (Chinese CDC) reported recently that approximately 20% of COVID-19 cases are classified as severe or critical.²² COVID-19 infections may result in life-threatening conditions including acute respiratory distress syndrome, acute kidney injury, cardiac injury, and liver dysfunction (Table 2) and may require hospitalization, intensive care, intubation, or other significant life-saving interventions. In some cases, COVID-19 may lead to death; the Chinese CDC reported that 2.3% of confirmed COVID-19 cases died.²³ There is currently no cure, only supportive treatment, and no vaccine.

Clinical progression/outcome	Yang et al. (Feb 24, 2020), report on 52 critically ill patients with COVID-19 who were admitted to an intensive care unit (ICU) in Wuhan, China ²⁴	Liang et al. (Feb 28, 2020), report on 457 patients with lab-confirmed COVID-19 identified from 7 studies ²⁵
Acute respiratory distress syndrome	67%	12%
Acute kidney injury	29%	2%
Cardiac injury	23%	3%
Liver dysfunction	29%	-
Death	61.5% at 28 days	8%

There are three possible transmission pathways that infectious diseases, especially those that cause respiratory symptoms like COVID-19, can follow: contact (direct/indirect), droplet, and aerosol transmission. There is currently no available evidence regarding the transmission pathway(s) for SARS-CoV-2/COVID-19. SARS-CoV-2/COVID-19 is similar to SARS-CoV and, to a lesser degree, MERS-CoV. There is sufficient evidence to indicate that direct and

²¹ Shi, Heshui et al. (Feb 24, 2020), “Radiological findings from 81 patients with COVID-19 pneumonia in Wuhan, China: a descriptive study.” *The Lancet Infectious Diseases*, published online, [https://www.thelancet.com/journals/laninf/article/PIIS1473-3099\(20\)30086-4/fulltext](https://www.thelancet.com/journals/laninf/article/PIIS1473-3099(20)30086-4/fulltext).

²² Wu, Zunyou and Jennifer M. McGoogan (Feb 24, 2020), “Characteristics of and Important Lessons From the Coronavirus Disease 2019 (COVID-19) Outbreak in China: Summary of a Report of 72 314 Cases From the Chinese Center for Disease Control and Prevention.” *JAMA*, published online at <https://jamanetwork.com/journals/jama/fullarticle/2762130>.

²³ Wu, Zunyou and Jennifer M. McGoogan (Feb 24, 2020).

²⁴ Yang, Xiaobo et al. (Feb 24, 2020), “Clinical course and outcomes of critically ill patients with SARS-CoV-2 pneumonia in Wuhan, China: a single-centered, retrospective, observational study.” *The Lancet Respiratory Medicine*, published online, [https://www.thelancet.com/journals/lanres/article/PIIS2213-2600\(20\)30079-5/fulltext](https://www.thelancet.com/journals/lanres/article/PIIS2213-2600(20)30079-5/fulltext).

²⁵ Liang, Bo et al. (Feb 28, 2020).

indirect contact, droplet, and aerosol transmission are important to the transmission of both SARS-CoV and MERS-CoV.²⁶

C. Healthcare workers around the world have been infected with COVID-19 and some have died.

Several reports have emerged from China and other countries with widespread COVID-19 transmission of healthcare workers who have become infected after providing care to patients with possible/confirmed COVID-19 infections.

The Chinese CDC reported recently that 1,716 healthcare personnel have been infected with COVID-19 and that 14.8% of those cases have been classified as severe or critical. Reportedly, at least five healthcare workers in China have died from COVID-19. However, media reports have suggested that the true number of healthcare workers infected in China may be more than 3,000.²⁷

Japan has reported infections among healthcare personnel and workers assisting with the quarantine aboard the Diamond Princess cruise ship.^{28,29} Reports have been made of several healthcare workers infections in South Korea.³⁰

The preparedness of healthcare facilities is essential to prevent exposure of nurses and other healthcare workers to COVID-19 as well as further spread of the virus in the United States. Healthcare employers have not fully protected nurses and other healthcare workers from exposure in the United States. The recent COVID-19 case confirmed at the University of California, Davis Medical Center—the first case identified indicating community transmission in the United States—highlights the potential for widespread exposure of U.S. nurses and other health care workers. Because the employer was not prepared for one COVID-19 patient, 25 registered nurses and at least 80 other health care workers have been placed on precautionary leave.³¹ This level of exposure from one patient at one hospital clearly demonstrates that the time to put the strongest protections in place is now.

²⁶ National Nurses United, (Feb 16, 2020), “Selection of Protective PPE for Nurses and Other Health Care Workers Caring for Patients with COVID-19,” published online at https://www.nationalnursesunited.org/sites/default/files/nnu/files/pdf/flyers/0220_NNU_HealthSafety_COVID-19_PPE_Report.pdf.

²⁷ Danmeng, Ma and Denise Jia, (Feb 18, 2020), “Coronavirus Among Medics More Widespread Than Reported, Research Shows.” *Caixin*, published online at <https://www.caixinglobal.com/2020-02-18/coronavirus-among-medics-more-widespread-than-reported-research-shows-101516740.html>.

²⁸ Al-Arshani, Sarah, (Feb 11, 2020), “A Japanese health worker caught coronavirus on the quarantined cruise ship where 174 passengers have tested positive.” *Business Insider*, published online at <https://www.businessinsider.com/japan-health-worker-got-coronavirus-on-quarantine-ship-diamond-princess-2020-2>.

²⁹ Japanese Ministry of Health, Labour and Welfare, (Feb 13, 2020), “About outbreak of patient associated with new coronavirus (the 29th case),” (machine translated), online at https://www.mhlw.go.jp/stf/newpage_09505.html.

³⁰ Yonhap News Agency, (Feb 26, 2020), “(2nd LD) More mass infections may come from hospitals, medical facilities,” online at <https://en.yna.co.kr/view/AEN20200226006952320?section=national/national>.

³¹ National Nurses United, (Feb 28, 2020), “Nation’s hospitals unprepared for COVID-19.” Online at <https://www.nationalnursesunited.org/press/nations-hospitals-unprepared-covid-19>.

Please note that the most up-to-date numbers have been used in the petition.

II. An Emergency Temporary Standard is immediately necessary to protect nurses and other healthcare workers from the hazards posed by emerging infectious diseases like COVID-19.

A. Voluntary measures by industry are insufficient to protect nurses and other healthcare workers from COVID-19.

Healthcare employers in the United States are not taking the appropriate and necessary steps to protect nurses and other healthcare workers from COVID-19 exposure. Over the past few weeks, NNU has been conducting the first-in-the-nation survey of nurses across the country about preparedness and response to COVID-19 in their workplaces. As of March 2, 2020, more than 6,500 nurses have responded from 48 states, the District of Columbia, and the Virgin Islands. Nurse respondents work at hospitals, clinics, and other healthcare facilities. The findings of this survey indicate that most nurses report that their employers are not taking necessary steps to prevent occupational exposures to COVID-19 (Table 3). Without a mandatory standard, health care workers are left unprotected and unprepared.

Table 3: Results of NNU’s Survey of Nurses Regarding Their Employers’ Protections for COVID-19
Results from over 6,500 nurse respondents from 48 states, the District of Columbia, and the Virgin Islands (March 2, 2020).
44% report that their employer has provided them information about novel coronavirus and how to recognize and respond to possible cases.
58% report that their employer has instituted travel/exposure history screening for all patients with fever and/or respiratory symptoms.
29% report that there is a plan in place to isolate a patient with a possible novel coronavirus infection.
27% report having access to powered air-purifying respirators (PAPRs) on their units. 63% report having access to N95 respirators on their units.
30% report that their employer has sufficient PPE stock on hand to protect staff if there is a rapid surge in patients with possible coronavirus infections.
65% report having been trained on safely donning and doffing PPE in the previous year.
66% report having been fit tested in the previous year.
14% report that their employer has an overflow plan to place additional, trained staff to enable safe care provision to patients on isolation for novel coronavirus.
19% report that their employer has a policy to address employees with suspected or known exposure to novel coronavirus.

B. OSHA has taken similar action previously, resulting in significant protection for nurses and other healthcare workers.

OSHA has recognized the importance of worker protections against occupational exposure to infectious diseases before and taken action to pass an emergency temporary standard in response to an infectious disease outbreak. In 1989, OSHA upheld their Congressional mandate by developing an emergency temporary standard to promptly provide needed protection to health care workers occupationally exposed to bloodborne pathogens, responsive to the exposures caused by lack of employers’ prevention and high morbidity and mortality from hepatitis B among healthcare workers. This emergency temporary standard and the permanent standard that

necessarily followed—the Bloodborne Pathogens Standard—subsequently significantly reduced the number of hepatitis B infections from 8,700 to 800 cases within four years of the standard’s publication.^{32,33}

Similarly, the emergency temporary standard requested by NNU and the subsequent permanent standard would significantly improve protections for health care workers from exposure to emerging infectious diseases like COVID-19. An emergency temporary standard is needed now in response to the current COVID-19 epidemic/pandemic and the ways that nurses and other healthcare workers are placed in grave danger.

A permanent standard on infectious diseases is needed to protect nurses and other healthcare workers from hazards posed by infectious diseases not covered by the Bloodborne Pathogens Standard, including emerging infectious diseases. NIOSH and OSHA have long recognized the hazard posed by infectious diseases in healthcare workplaces.^{34,35} In fact, in response to a union petition, OSHA has completed significant work on developing an infectious diseases standard, establishing clearly the need for such a standard.³⁶ However, such standard has been placed on OSHA’s long-term regulatory agenda since Spring 2017.

The current COVID-19 pandemic demands immediate action from OSHA to ensure that nurses and other healthcare workers maintain their essential right to a safe and healthful workplace and to help reduce further community spread among health care workers and the public.

III. OSHA should include these fundamental elements of an Emergency Temporary Standard to Protect Nurses and Other Healthcare Workers from Exposure to Emerging Infectious Diseases.

A. Such an Emergency Temporary Standard on emerging infectious diseases must be based on the precautionary principle.

To protect nurses and other healthcare workers from the hazards posed by emerging infectious diseases, like COVID-19, OSHA should construct an emergency temporary standard that is based on the precautionary principle. The precautionary principle states that “When an activity raises threats of harm to human health or the environment, precautionary measures should be taken even if some cause-and-effect relationships are not fully established scientifically.”³⁷

³² U.S. Occupational Safety and Health Administration, (Nov 27, 2001), “OSHA Archive: CPL 02-02-069 (formerly CPL 2-2.69): Section VII Background,” online at https://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=directives&p_id=2570#VII.

³³ Jeffress, Charles N., (June 22, 2000), “OSHA Archive: STATEMENT OF CHARLES N. JEFFRESS BEFORE THE SUBCOMMITTEE ON WORKFORCE PROTECTIONS HOUSE EDUCATION AND THE WORKFORCE COMMITTEE,” online at <https://www.osha.gov/news/testimonies/06222000>.

³⁴ U.S. National Institute for Occupational Safety and Health, (last reviewed Jan 13, 2017), “HEALTHCARE WORKERS: Infectious Agents,” online at <https://www.cdc.gov/niosh/topics/healthcare/infectious.html>.

³⁵ U.S. Occupational Safety and Health Administration, “Healthcare: Infectious Diseases,” online at https://www.osha.gov/SLTC/healthcarefacilities/infectious_diseases.html.

³⁶ U.S. Occupational Safety and Health Administration, “Infectious Diseases Rulemaking,” online at <https://www.osha.gov/dsg/id/>.

³⁷ Hayes, AW, (2005), “The precautionary principle.” *Arh Hig Rada Toksikol*, 56(2): 161-6.

The precautionary principle should govern all decisions made about protections for an emerging infectious disease as it emphasizes anticipatory action. Following the precautionary principle is necessary to protecting nurses and other healthcare workers from the hazard posed by an emerging infectious disease where little may be known. Nurses and other healthcare workers have a fundamental right to a safe and healthful workplace and infectious diseases should be no exception. In addition, the full protection of healthcare workers is a fundamental and necessary part of limiting the spread of viruses—this has been proven time and again with SARS, MERS, H1N1, Ebola, and others. It is critical that nurses and other healthcare workers are kept safe not only to provide critical care for patients with potential COVID-19 infection, but also to continue caring for other patients.

B. Several elements must be implemented by healthcare employers to protect nurses and other healthcare workers and therefore should be included in OSHA’s emergency temporary standard. In response to COVID-19, as with other emerging infectious diseases, health care employers must have in place comprehensive exposure control plans that must include the proper screening and isolation procedures, engineering controls, the highest standard of personal protective equipment (PPE), safe staffing, and other protections. It is of importance that healthcare employers also make plans and preparations to safely respond to a possible surge in patients with COVID-19. All protections must be implemented in a proactive, preventive manner; when they are implemented in reaction to confirmed cases or in reaction to healthcare worker exposures, that endangers the health and safety of nurses and other healthcare workers.

OSHA has many resources on which to draw in developing an emergency temporary standard on emerging infectious diseases like COVID-19. The California Division of Occupational Safety and Health (Cal/OSHA) has a long-standing enforceable standard that addresses many of the necessary elements for protecting nurses and other healthcare workers from infectious diseases not covered by the Bloodborne Pathogens Standard, including emerging infectious diseases.³⁸ Cal/OSHA’s Aerosol Transmissible Diseases Standard should serve as a baseline for OSHA’s work on an emergency temporary standard responsive to COVID-19 as well as a subsequent permanent standard. In addition, OSHA has released guidance regarding COVID-19 for healthcare and other industries, which includes some of the following necessary elements.³⁹

The following elements are necessary, at minimum, to protect nurses and other healthcare workers from COVID-19. Healthcare employers should:

- Communicate clearly with nurses and other staff regarding COVID-19 preparation, protocols, and any confirmed or suspected cases in the facility. When employers do not communicate clearly with staff it opens the door to misinformation and confusion which creates additional risk of transmission. Employers should ensure that nurses and other healthcare workers receive effective training and education regarding their plans, protocols, preparations, and response to COVID-19. Such training and education should

³⁸ 8 CCR §5199; Also see California Department of Public Health, (Jan 2018), “Cal/OSHA’s Aerosol Transmissible Disease Standards and Local Health Departments,” online at <https://www.cdph.ca.gov/Programs/CCDCPHP/DEODC/OHB/CDPH%20Document%20Library/ATD-Guidance.pdf>.

³⁹ U.S. Occupational Safety and Health Administration, “COVID-19: Control and Prevention,” online at <https://www.osha.gov/SLTC/covid-19/controlprevention.html#health>.

be implemented proactively, in preparation for a possible COVID-19 case, rather than “just in time,” after a COVID-19 case has arrived at the facility, when it is too late.

- Implement screening protocols to promptly identify and isolate patients with possible COVID-19 infections at the first point of contact/entry in the healthcare facility or before arrival at the healthcare facility. Such protocols should be proactive and preventive, based on the precautionary principle, rather than reactive.
- Ensure prompt isolation of patients with possible COVID-19 infection. These patients should be placed in airborne infection isolation rooms until COVID-19 or other infectious disease has been ruled out. These airborne infection isolation rooms must be constructed and consistently maintained so that they provide protection to staff and patients. A separate waiting area should be established for any patients or visitors with respiratory symptoms to prevent exposures.
- Provide the highest level of PPE to nurses and other health care workers who are providing care to patients with possible COVID-19 infections. PPE should be selected based on the precautionary principle. For COVID-19, NNU maintains that the highest level of PPE includes a powered air purifying respirator (PAPR), coveralls that are impervious to viral penetration (meeting ASTM F1671/ISO 16604 standards), and gloves.⁴⁰ All respiratory protection should be implemented as required by OSHA’s Respiratory Protection Standard, including annual fit testing for respirators requiring a fit test, training and education, and other requirements.⁴¹ Health care employers must have in-person, hands-on training and education for all nurses and other health care workers regarding PPE and safe donning and doffing practices. Again, such training and education should be implemented proactively, in preparation for a possible COVID-19, rather than “just in time,” after a COVID-19 case has arrived at the facility, when it is too late.
- Make staffing assignments to ensure that nurses and other health care workers caring for patients with possible or confirmed COVID-19 infections are able to do so safely. When patients are on isolation, additional time is needed to safely don and doff PPE. Wearing PPE can be extremely physically taxing; nurses who need to wear PPE ensembles for long periods of time should be given breaks and relief when needed. Additional staff may be necessary to assist nurses and other health care workers in donning and doffing PPE safely. Ensuring that nurses providing care to patients with possible or confirmed COVID-19 infections are, at minimum, on 1:1 assignments can help prevent unintentional spread of the virus via contaminated objects or surfaces.
- Implement effective procedures to identify any possible occupational exposure and to follow up immediately with affected staff. If a nurse or other health care worker is placed on precautionary leave, that leave must last for at least the minimum incubation period

⁴⁰ National Nurses United, (Feb 16, 2020).

⁴¹ 29 CFR §1910.134

and the employer must maintain all pay, seniority, and benefits for the entire length of the leave.

- Maintain sufficient PPE stock and supply to protect nurses and other healthcare workers, including during a possible surge in patients with respiratory symptoms. In the context of worldwide and regional PPE shortages, rationing or reuse of PPE should be implemented only after all other avenues have been exhausted, and nurses' professional judgment on when it is safe to reuse or conserve respirators must be heeded. Stockpile and procurement plans and procedures must be in place to ensure respiratory and PPE supplies are readily accessible.
- Begin preparation immediately for a potential surge of patients with respiratory symptoms, which should include at least preparing separate waiting areas such as surge tents, preparing plans to deal with significant numbers of patients such as overflow areas, 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.
- Make a COVID-19 vaccination available, in the event it is developed, for free and in a time and place convenient to their work to nurses and other healthcare workers.
- Develop robust housekeeping and environmental cleaning protocols and plans. Such housekeeping and environmental cleaning protocols should be based on the precautionary principle, providing the highest level of protection without waiting for scientific evidence that it is necessary. Employers must consider all aspects of environmental cleaning, including specific ensuring that common, public areas are cleaned effectively following identification of a possible or confirmed COVID-19 case. This must also include protocols to respond if a patient with COVID-19 must leave the negative pressure isolation room to travel through the facility for medical procedures or care.
- Establish and maintain clear records of their implementation of these protective measures, any and all exposures to COVID-19 and what follow-up occurred, and other records.

Nurses and other health care workers stand ready and willing to provide care that patients with COVID-19 need, but they need strong protections from their employers to be able to do so safely. All health care workers must receive the highest level of protection in their workplaces, as determined by the precautionary principle. We urge OSHA to take immediate action to protect nurses and other healthcare workers from COVID-19 by granting this petition and issuing and enforcing an emergency temporary standard. If you have any questions, please reach out to Jane Thomason at 510-433-2771 or jthomason@nationalnursesunited.org.

Sincerely,



Bonnie Castillo, RN
Executive Director
National Nurses United

CC: Vice President Mike Pence
Ambassador Deborah Birx, White House Coronavirus Response Coordinator
Secretary Alex Azar, Department of Health and Human Services
Dr. Robert Redfield, Director, Centers for Disease Control and Prevention
Dr. Anthony Fauci, Director, National Institute of Allergy and Infectious Diseases
The Honorable Nancy Pelosi, Speaker, US House of Representatives
The Honorable Kevin McCarthy, Minority Leader, US House of Representatives
The Honorable Mitch McConnell, Majority Leader, US Senate
The Honorable Chuck Schumer, Minority Leader, US Senate
All Members of the Committee on Education and Labor, US House of Representatives
All Members of the Committee on Oversight and Government Reform, US House of Representatives
All Members of the Energy and Commerce Committee, US House of Representatives
All Members of the Health, Education, Labor & Pensions Committee, US Senate
All Members of the Committee on Homeland Security and Governmental Affairs, US Senate
Mr. Andy Levinson, Deputy Director, Directorate of Standards and Guidance, OSHA
Ms. Maureen Ruskin, Deputy Director, Directorate of Standards and Guidance, OSHA
Mr. J. Joseph Wheeler, Deputy Assistant Secretary, Office of Congressional and Intergovernmental Affairs, Department of Labor