

EXPOSED & AT-RISK

New Jersey healthcare workers reveal how our safety systems failed them during the COVID-19 pandemic



A new HPAE survey details systemic failures in New Jersey public health infrastructure and recommendations on preparedness plans and urgent measures to mitigate surges in COVID-19 and future outbreaks.



HPAE

Putting care first

DEDICATION

This report is written in memory of HPAE members who contracted and died of COVID-19 while caring for patients stricken with the disease.



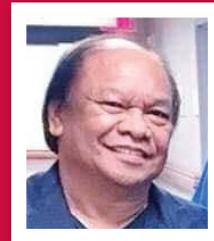
George Sisnero, RN
31 Years of Service
Local 5089 - University Hospital



Maria Luisa Lopez, RN
11 Years of Service
Local 5185 - Bayonne Medical Center



Nagi Abraham
Lab/Hematology, 11 Years of Service
Local 5094 - University Hospital



Alfredo Pabatao
Transporter, 18 Years of Service
Local 5030 - Palisades Medical Center



Susan Cicala, RN
8 Years of Service
Local 5089 - Northern State
Prison/Rutgers UHC



Nancy Martell
Patient Care Technician,
18 Years of Service
Vice President, Local 5030 -
Palisades Medical Center



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Go to www.hpae.org/campaigns/exposure-report
to view additional resources.



**Dear HPAE
frontline caregivers:**

This pandemic has exposed so many inequities in our healthcare system – not only in who is more likely to get sick and who has access to healthcare, but in who is left unprotected.

We witnessed firsthand as some employers downgraded protective equipment for frontline workers, because they, along with federal safety agencies, put their priorities elsewhere. The critical failure to develop standard pandemic plans and keep supplies stockpiled, along with a defunded system, left us, the front-line caregivers, unprotected and exposed.

What they forgot was what we know – if we are not safe, neither are our patients.

Still, our members have always answered the call, and throughout this “first wave” of the COVID-19 pandemic, that's what you all did, even when you were at risk and on your own in figuring out how to keep everyone around you safe.

Our members showed up, met the disease head-on, then went home worried about exposing their families. Our union was often alone in opposing the shortcuts in equipment, the violations of safety standards and the retaliation against those who stood up for safety. We knew that now was not the time to relax standards, but to strengthen them.

While we understand and support reopening our economy, it is clearer than ever that we must do it safely, with respect for the capacity of our healthcare system, and with the willingness of our government agencies to enforce safety rules. As president of HPAE, I was pleased to be appointed to the Governor's Restart and Recovery Advisory Council so I could be your voice in how we move forward safely, when and if we need to pause, and how to make sure we are prepared to manage future surges of COVID-19 – or the next disease outbreak.

That's why we conducted this survey – to hear from you – and to form our demands of safety agencies and employers. In this report, you will hear the voices of your co-workers, your experiences, your fears, and your clear demands for what you and your patients need.

It will take all of our voices – at our healthcare institutions, at our local, in the halls of Trenton and Washington D.C., and in our communities – to make sure we are better equipped with the resources we need and with our right to speak up protected.

A handwritten signature in black ink that reads "Debbie White". The signature is written in a cursive, flowing style.

Debbie White, RN
President, HPAE



SUMMARY: If we are not safe, neither are our patients.

As 2020 began, a contagious and deadly disease emerged, first in Asia, then quickly in Europe. It reached the U.S., at first appearing to be limited in spread and scope. By the end of February, U.S. communities on both coasts were facing SARS-CoV2, the highly infectious virus strain that causes COVID-19.

The nearly 3 million U.S. confirmed cases and 133,000 deaths, including more than 175,467 cases and 15,229 deaths in New Jersey between the early days of the outbreak and mid-July, exposed the enormous inequities in our healthcare system and the huge gaps in our public health infrastructure and preparedness systems that should have helped to prevent, monitor and contain the disease's rapid spread.

HPAE, New Jersey's largest healthcare union representing 14,000 nurses and other healthcare staff, conducted a member survey to chronicle frontline experiences contending with the virus. Over the past months of the 'first wave' of the virus, HP AE also set up a hot-line for members, conducted interviews, bargained with our healthcare facilities to improve worker and patient safety, engaged in policy discussions with state agencies, filed complaints with federal agencies over safety conditions, and worked with our national union, the American Federation of Teachers (AFT), to advocate for immediate and long-term policy changes.

The environments in which nurses and healthcare workers provide care – whether in hospitals, clinics, nursing homes or patients' homes – are shared with our patients. If we are not safe, neither are our patients.

Our survey, returned by 1,100 HP AE healthcare workers, gave us a frontline picture of the shortcomings of our pandemic response and the impact those gaps had on not only the workers, but on the care they provided and on the public's safety. It shows us what our nurses and healthcare workers learned: they were largely alone, with little consistent guidance from state or federal agencies; policies in their healthcare institutions were based more on economics than public safety; and there was even less enforcement of existing laws to protect them as they went through their day. Seeking to protect patients, they were left unprotected.

- **The majority of workers surveyed reported providing direct patient care to COVID-19 patients without appropriate personal protective equipment (PPE), with 63% who used their own PPE at work to stay safe.**
- **78% re-used their N95 respirators, contrary to past protocol and safety standards; and some workers reported being mandated to return to work prior to the federal guidelines for quarantine.**

From the start of the pandemic, government agencies and our healthcare employers failed to track workplace exposure, illness, or deaths among frontline healthcare workers. Inadequate exposure tracking and testing caused unnecessary exposures and illness among workers and risked the health of our patients as well. This report contains the survey results, HP AE's advocacy work and our recommendations for re-building our public health infrastructure, preparedness plans, and urgent measures needed to mitigate future outbreaks and surges in COVID-19. Repeatedly, frontline workers reported serious gaps in information, short-cuts in safety procedures and shifting guidance from employers and government safety agencies.

Our survey gave us a frontline picture of the shortcomings of our pandemic response and the impact those gaps had on not only the workers, but on the care they provided and on the public's safety. It shows us what our nurses and healthcare workers learned: they were largely alone, with little consistent guidance from the state or federal agencies.

Survey respondents reported:

- Shortages and absolute lack, in some instances, of personal protective equipment (PPE), including respirators, surgical masks, gowns and face shields
- Improper use and reuse of PPE and gaps in training and fit-testing of PPE
- Failures of federal and state agencies to provide consistent guidance and enforcement of known and proven protocols for prevention of exposures
- Fewer protections and changing standards and safety protocols
- Lack of transparency of exposure and guidelines to protect staff
- Lack of availability and delays in testing for staff and patients
- Inadequate quarantine and paid leave time policies for staff
- Retaliation against staff who raised concerns or objections to unsafe practices



These failures point to hospitals and other healthcare employers, but also to the state and federal agencies charged with protecting the health and safety of both workers and patients.

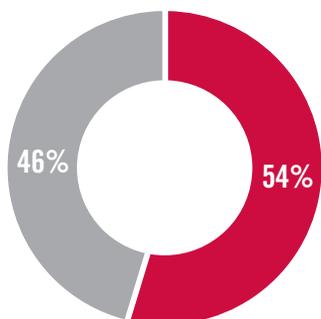
Our survey data, along with interviews and decades of experience with protocols and safety standards, inform the recommendations for policy reforms at the state and local levels found in this report. Frontline nurses and healthcare workers have the experience and knowledge to keep their patients safe, and with every recommendation, we demand the involvement and input from these frontline workers.

The picture that emerges – the lack of PPE, the weakening of safety protocols, lack of guidance on the frontlines – gives pause into reopening without major reforms and new policies that focus on protecting those who protect us.

BACKGROUND

In late February, M., a Registered Nurse working at a Hackensack Meridian Health (HMH) hospital, treated a suspected COVID patient. M. was outfitted with a plastic gown, a pair of goggles, gloves and a surgical mask with an attached eye shield. The patient too had on a surgical mask.

The majority of healthcare workers surveyed said they were exposed to COVID-19 at work.



“Once the triage was complete, I was told to remove my PPE, call for a cycle clean and to go about my day. The cycle clean took over an hour to complete. At the time of this triage, we were not being told to wear a surgical mask at all times, it was up to our discretion.”

M. never found out whether that one patient was positive for COVID-19, but she went on to treat many more sick patients with a possible COVID-19 diagnosis. The PPE she wore that day to treat that first potential COVID-19 patient was the best PPE she would have during the time she cared for patients in the early days of the global pandemic.



"I continued going to work, never once having any formal training for following protocols in caring for a COVID-19 patient. We would have 'huddles' that would inform us that the hospital was working 'diligently' to ensure our safety, but no exact examples were ever given.

"We would receive emails that our CNO (chief nursing officer) and the President... were doing their best to keep us safe. Again, no specifics were ever provided, nor had either of them ever come to the ER (emergency room) to see if we needed anything."

Although fit-tested in February for one specific type of respirator protecting her from disease transmission, her employer later told M. there was a shortage, and she should work with a different kind of N95 respirator because that was what was available. She could not get a good seal to her face with the new N95 and it was never checked to make sure it would protect her from patients who could potentially spread the virus. Her employer ignored complaints that the replacement N95 respirator was too big and did not fit or protect her as she treated COVID-19 infected patients on every shift.

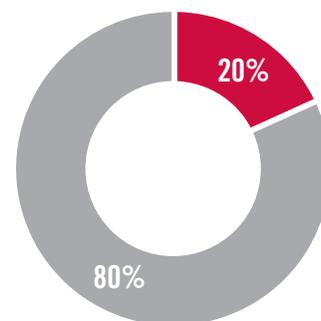
As the pandemic continued into March, management gave nurses conflicting instructions almost by the hour.

"First, we were told that we only needed to wear surgical masks, then we were told that we needed N95s but no surgical mask, then it was that we needed only a surgical mask and goggles, then we were told that we only needed a surgical mask and a face shield. The rules just kept changing."

Management said the changing rules were because the federal Centers for Disease Control and Prevention (CDC) kept putting out new recommendations and they often ignored the standards from the federal Occupational Safety and Health Administration (OSHA), the agency that regulates worker protection. In any case, requests for more gowns, gloves, surgical masks and N95 respirators went unmet.

"Constant CDC 'updates' caused us to have to change how we would gown up... I decided at that time, since I didn't feel protected by HMH, that I was going to wear an N95, place a surgical mask on top, and use a full-face shield, gown, and gloves which I changed with every patient who I saw outside. I was told by my manager that the need for such attire was unnecessary but instead decided that I would do my best to protect myself."

20% of healthcare workers surveyed, 1-in-5, said they were sickened with COVID-19



It was too late. She got sick to her stomach on the way to work one day in late March and was told not to come in. A test later confirmed she was positive for COVID-19. As she tries to heal, her days are filled with appointments with medical specialists, and navigating hospital bureaucracies to ensure healthcare bills are paid and her job will not be taken away. This has been the story of countless nurses during the course of this pandemic.



Early in March, New Jersey was coming to grips with the outbreak – but before declarations of state-of-emergency and global pandemic announcements by the CDC – D., a Registered Nurse with the Visiting Nurses Association, noted a complete shortage of N95 respirators as nurses were being sent out to evaluate and care for patients suspected of being infected with COVID-19.

Meanwhile, S., a delivery room nurse at Inspira Health Network, noticed a doctor was in extreme respiratory distress. A resident physician also had COVID-19 symptoms. Staff learned about these exposures from word-of-mouth.

Across the state, nurses and other healthcare workers reported similar circumstances: they found out they were exposed to positive COVID-19 patients or co-workers only after exposure and through informal channels.

Early in March, as the outbreak was building, Virtua Memorial Hospital forced nurses to take masks off, downgraded use of N95 respirators to surgical masks and discouraged the use of surgical masks in common spaces.

Emerging information about how COVID-19 spreads shows that disease transmission happens through: high risk procedures; aerosols by coughing, sneezing, or talking; airborne means by breathing; and through contaminated surfaces. COVID-19 is highly infectious and deadly. Yet, healthcare facilities compelled their personnel to take less precautions than are required for the common flu.

It would take another two weeks into March before our nation and states like New Jersey would issue emergency declarations and start taking essential measures, such as social distancing and self-isolation, wearing masks in public, and restrictions on movement, in efforts to “flatten the curve” and curb a disease outbreak devastating our communities.

With limited planning, sparsely available PPE, without pandemic training, clear guidance, or resources, nurses and healthcare workers bore the brunt of the outbreak on the frontlines. They continued to work, providing care while they got sick. Some have died.

Throughout this first wave of COVID-19, HPAE has been on the frontlines, advocating with healthcare executives, state and federal agencies, and elected officials for the PPE and resources needed to care for COVID-19 patients safely in healthcare facilities. While supplies of many of these resources were at first scarce, employers in our industry were not transparent about what they had, and hoarded and provided substandard supplies. They ignored OSHA safety standards, and denied PPE to employees, resulting in heroic healthcare workers unable to maintain their own safety.

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Key findings

In addition to the survey returned by 1,100 HPAE frontline caregivers about safety conditions in their healthcare setting during the COVID-19 pandemic, HPAE staff have collected hundreds of written statements, conducted dozens of interviews with members, consulted with DOH, OSHA, and PEOSH enforcement agents, and discussed protocols and standards with our national union and other experts.

Regulators and elected officials need to pay close attention to the safety of healthcare workers and their patients as we face additional anticipated surges before an effective and safe vaccine is readily available.

HPAE member survey responses, interviews, and comments make crystal clear the obstacles they encountered in treating patients through this epidemic while protecting themselves, including dearth of available testing, limited availability of proper equipment, and lack of training.

Of the more than 50% respondents who said they were exposed to COVID-19 while working, 36% were notified by management, 38% were notified by a co-worker, and 55% discovered the information themselves.

Survey respondents reported:

- 54% were exposed to COVID-19 in their workplace
- The majority (51%) of healthcare workers had to perform direct COVID-19 care without appropriate PPE
- After workplace exposure, only 36% were notified by their employer, while 56% discovered their exposure on their own
- 57% were not tested for the virus
- 24% had to return to work while still having symptoms of COVID-19
- 78% reused their N95, most for multiple days and some for a week or more

Shifting guidance

Employers failed to follow the most basic CDC guidance by not quarantining exposed workers for the recommended 14-day period.¹ Some workers were told that if they tested positive and were asymptomatic, they had to come into work despite exposure and the risk of transmitting disease to both patients and coworkers. Almost a quarter of those who responded said they had to return to work while still symptomatic, despite CDC guidance for continuing isolation whenever showing symptoms of this disease.²



1. See corresponding worker statements; also, CDC. "Quarantine and Isolation."
<https://www.cdc.gov/coronavirus/2019-ncov/if-you-are-sick/quarantine-isolation.html>

2. See corresponding worker statement; also, CDC. "When you can be around others when you had or likely had COVID-19."
<https://www.cdc.gov/coronavirus/2019-ncov/if-you-are-sick/end-home-isolation.html>



R., RN at an HMH hospital: “Every day rules regarding PPE changes. First they told us to throw out N95s after each use. Now, we must reuse them for at least five days. Yesterday we only had TWO face shields on the unit and were asked to wipe them down and SHARE them among the whole shift and incoming shifts. We need more PPE to protect us.

Employers are responsible for implementing OSHA’s Respiratory Protection Standard.³ This Standard mandates provision of tight fitting respirators for workers exposed to airborne or

aerosolized hazards. It requires that employers produce a written respiratory protection program (RPP) and implement medical clearance evaluations, accurate fit testing, effective training, and provision of free respiratory protection devices to employees exposed to inhalation hazards.

Our healthcare employers across New Jersey simply ignored foundational components of the OSHA RPP. These included: preparing COVID-19 specific protection plans to reduce exposure; medically screening and clearing all workers assigned to wear respirators for protection; mandating that employees receive COVID-19 specific safety training; and providing respirators that fit and protect each employee from COVID-19 disease hazard.

CDC recommendations to employers for worse-case scenarios allowed scarves and bandanas as acceptable protective equipment for healthcare workers, causing the CDC to lose credibility and seed distrust in the hearts of healthcare workers who had depended on them for reliable, science-based safety guidance. When the American Hospital Association (AHA) chose to beat back the OSHA Emergency Temporary Standard for healthcare workers, those very same workers knew they were on their own.

78% of respondents reported having to reuse their N95 respirator and 44% reported reusing respirators for multiple days.

B., an RN at Virtua Memorial Hospital: “I had a patient in the last few days with a CT consistent with pneumonia, who had flu and RSV (Respiratory Syncytial Virus, which is a contagious respiratory illness) ruled out, but no further testing was considered to ensure it is not COVID-19. I had little guidance what criteria is being used to decide if a patient is going to be tested for COVID-19.

3. OSHA Occupational Safety and Health Standards on PPE. 1910.134 – Respiratory Protection. <https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.134>



FRONTLINE EXPERIENCES

Shortages of personal protective equipment (PPE)

Numerous studies from the U.S. and around the world have attested to COVID-19 transmission through viral aerosols, the microscopic particles released when infected people cough, sneeze, speak, sing, or even just breathe. For direct COVID-19 patient care and high-risk procedures (such as intubation and nebulizing) the only way to prevent inhaling viral aerosols is to wear a fit-tested N95 or better respirator in addition to protecting the face, clothing and skin from exposure.

In addition to being spread through air, COVID-19 can be transmitted when virus particles reach the eyes. Both of these routes of infection are most hazardous at close distances of approximately six feet or less, and only an approved respirator combined with eye or face protection will protect from this hazard. COVID-19 is also transmitted through respiratory droplets and contact with contaminated surfaces. Transmission can occur when the healthcare worker gets a live virus on their face or hands, then touches their eyes, nose or mouth.

The PPE required for COVID-19 patient care includes medical grade waterproof gowns, gloves, eye and face protection such as splash goggles, full face shields, and respiratory protection for direct care and high risk procedures.⁴ Surgical masks and universal masking of patients, visitors and workers alike are required for all low risk contact. PPE must be federally certified and must fit the worker it is assigned to.⁵ Without using the right PPE, people are exposed and may themselves become infected with COVID-19.

PPE shortages in healthcare settings were an almost universal feature during the first months of the COVID-19 pandemic.

As one registered nurse said at the height of the pandemic, **“WE ARE TRYING TO FOLLOW ALL THE PROCEDURES TO SURVIVE.”**



Healthcare workers who responded to our survey reported missing PPE while providing COVID-19 care, endangering themselves and their patients:

- The majority (51%) surveyed reported having to perform direct COVID-19 care without appropriate PPE
- Specifically, of those that responded:
 - 33% had to perform COVID-19 care without a face shield or goggles
 - 33% had to perform COVID-19 care without an N95 or better respirator
 - 19% had to perform COVID-19 care without a gown
 - 10% had to perform COVID-19 care without a surgical mask
 - 34% did not have the PPE needed while present for aerosolizing procedures, which poses the highest risk for COVID-19 transmission

4. HPAE website. Respirators, Masks and Face Shields, https://www.hpae.org/wp-content/uploads/2020/05/2055_PPE-Face_v2_.pdf

5. HPAE website, Why do we fit test? <https://www.hpae.org/wp-content/uploads/2020/04/Respirators-and-Fit-Tests.pdf>



We know exposure to both asymptomatic and symptomatic infection contributes to the spread of COVID-19.

A Sunrise House environment staff member: "For those of us that work in housekeeping, we have no disposable gowns to wear, no protective booties for our shoes and no face mask, besides the masks we wear over our face when we are handling dirty laundry."

Scant training and fit testing

Workers did not receive training on how to put on a reused respirator safely, or how to recognize when their N95s no longer protected them, because they had never received the initial fit testing or training required for every new respirator type assigned.

Many healthcare workers lacked training about how to use the PPE they did receive and many had to supply their own personal PPE to protect themselves, in clear violation of OSHA and PEOSH requirements that employers assess the need for PPE and provide it free of charge to their workers.

S., a Registered Nurse at Christ Hospital worked the evening shift, and was not given the size N95 mask for which she was fit tested. She was fitted for a size small duck bill style N95 when she was hired. A supervisor told her to: "tape her mask around her face and tie the surgical mask tight to seal the bottom." She could not get a seal as the mask was still loose fitting around her chin area.

- One quarter of respondents reported they were not trained about the PPE needed for COVID-19 care

T., RN at Inspira "I was sent home and asked to go out on leave because I brought in my own N95 to wear. My managers called me in telling me I had to take off the mask because it would cause hysteria and possible cross contamination - but yet the other buildings are giving N95s to staff. And, on the news, they show the general public wearing masks but I'm on the frontline and I'm told not to. The shift before me and the shift after me were given N95 masks and told to hide it under surgical mask, but yet I was not issued one and told, it's droplet, that I don't need N95 at all."

Failure of hazard assessment guidelines

Healthcare facility employers downgraded their PPE standards in tandem with worst-case-scenario guidance from the CDC about how to deal with a shortage of N95s and other PPE. The CDC published three different strategies for protecting workers during times of COVID-19 disease surge and PPE shortages. Each strategy depended on the employer providing engineering controls such as barriers, increased ventilation, air purifiers and negative pressure rooms, administrative controls such as hazard assessments, appropriate staffing and effective training, and finally, use of PPE.

We had reports of employers using carcinogenic chemicals for N95 disinfection (Ethylene Oxide).



Each CDC strategy was less protective and put the workers at greater risk, in response to the equipment and supplies available to the healthcare facility at the time. Unfortunately, employers seemed to immediately default to the strategy with the lowest bar of protection, whether scarcities in PPE supply merited such responses or not.

“Contingency capacity strategies” included compromises made to conserve PPE, such as using expired or non-medical respirators and allowing “limited reuse” of respirators and N95s. It also prioritized the use of N95s and facemasks by medical activity type. “Crisis capacity strategies” included guidance on how to proceed when “no respirators are left” and included the recommendation to exclude higher risk workers from contact with known or suspected COVID-19 patients.⁶

Rutgers University labor expert Dr. Yana Rodgers pointed to a healthcare facility’s costing model which treats PPE as a capital expense and incentivizes administrators of healthcare facilities to shrink their PPE stockpiles.⁷ Rodgers noted healthcare facilities “do not have an economic incentive to encourage employees to use PPE, replace it frequently, or keep much of it in stock.”

Rodgers also identified the lack of PPE as being connected to the Trump administration refusing to invoke the Defense Production Act, in addition to global supply chain shortages. She concluded that what occurred was a market failure, and that the market does not allocate critical healthcare supplies like PPE in an optimal way.⁸

In attempts to make their stockpiles of PPE last longer, employers rationed and held back PPE from employees who needed it, allowing workers to care for COVID-19 patients without the protection they needed.

This resulted in massive exposures to HPAE members and other healthcare workers across the state.



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– DR. YANA RODGERS
Rutgers University labor expert

Reusing equipment

The COVID-19 pandemic resulted in worldwide supply chain disruptions leading to a nationwide shortage of single use, disposable N95 respirators. While occupational safety and infection control specialists had been preparing for the possibility of pandemics for decades (responding to HIV, H1N1, SARS, MERS, and Ebola outbreaks), the COVID-19 pandemic of March of 2020 found a healthcare system completely unprepared and overwhelmed.

6. <https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/index.html>

7. Cohen, Jennifer, and Yana Rodgers. 2020. “Personal Protective Equipment Shortages during the COVID-19 Pandemic.” Rutgers University Working Paper.

8. *Supra*.



S., a Certified Nursing Assistant at Harborage Long Term Care said she had never used an N95 before the COVID-19 pandemic. She was just randomly handed an N95 for COVID-19 patient care and was told “to use it until it broke.” She received no fit testing, no training and no orientation about the protective equipment she had to use. She was just handed whatever random N95 was available and told to use it. She contracted COVID-19 in late April 2020.

By early March 2020, CDC’s interim infection control guidance allowed employers to have healthcare workers extend or reuse their N95s for up to eight hours, or five separate uses during times of severe respirator scarcity. By mid-March, OSHA followed up with temporary enforcement guidelines designed to enhance worker protection under the CDC changes.

OSHA pandemic guidelines for respiratory protection required employers to make every attempt to get better quality respirators, including elastomeric and powered air purifying respirators (PAPRs), before resorting to reuse of N95s. Following the CDC, they authorized the use of non-medical and expired, intact N95s in healthcare settings. Only when those supply possibilities were exhausted could employers resort to reusing or extending the use of respirators.

What happened in response to the CDC interim guidelines was chaotic and inconsistent. Many HPAAE members reported that employers locked up all the N95s in their facilities. Workers had to work without them or access to them was restricted only to personnel performing ‘aerosolizing procedures’ even though COVID-19 transmission risks extend far beyond those procedures.

In some facilities, only the highest-ranking medical professionals received N95s, with nurses, CNAs, transporters, radiology technicians, and house-keepers scrambling for protection. Employees were forced to purchase their own gowns, goggles, face shields, and masks because the employer refused to give them any, citing shortages. Employees had to work with (and are still working with) the same misshapen, contaminated N95s for days and weeks because they could not get a replacement, or receive one that they had been fit tested and approved to use.

Management told healthcare workers to reuse their PPE and N95s until they broke or use them until they were bloody. They were told to wipe them down with chemicals that damaged the filter material of the N95 itself and which were not safe for skin contact. They are still told to store their N95 in a paper bag. For most members, only one bag is provided, and it is used day after day, ignoring how this spreads COVID-19 and other biological contamination from shift to shift.

Management told healthcare workers to reuse their PPE and N95s until they broke or use them until they were bloody.

Employers started bringing in different methods to decontaminate respirators to make them last longer.⁹ Some of these methods were allowed by the FDA and CDC, but many were not. We had reports of employers using carcinogenic chemicals for N95 disinfection (Ethylene Oxide) and of employers using poorly engineered UV light devices that were not engineered or designed to decontaminate N95s.

Some employers have purchased approved decontamination devices utilizing vaporized hydrogen peroxide, but there is no field testing to ensure that decontaminated N95s will still protect employees by maintaining a seal along the face. There has been no fit testing of decontaminated respirators to ensure that these vital devices are effective after reuse and processing.



E., Bergen New Bridge Medical Center: "Staff RNs assigned to rule-out COVID-19 patients were provided one N95 mask per 12-hour shift. Nurses were expected to reuse the same N95 mask throughout the shift. Hair caps, shoe covers, gowns, and gloves were provided. No goggles were available. Face shields were limited in supply and RNs who had face shields were, again, expected to reuse them throughout the shift."

The failures of the employer's Respiratory Protection Program, and the chaos and lack of regulatory oversight around disinfection techniques caused numerous unnecessary exposures.

Reuse of respirators has been the grand enabler of the nation's failure to protect workers during this pandemic. Reuse and decontamination saves the employer money in the short run but endangers worker's lives in real time. After three full months of pandemic, the choice to still be reusing and decontaminating N95s is based on economics, not on the science of worker protection.

Survey respondent members reported:

- More than 3 out of 4 (78%) had to reuse disposable, single-use N95 respirators for COVID-19 patient care
- Almost half (45%) had to reuse the same contaminated, single use N95 for multiple days at a time
- More than a quarter (29%) reported having to use the same contaminated single use N-95 for a week or more
- Almost half (45%) reported receiving no training on how to safely reuse a single use N95
 - Only 1 in 5 received training on how to tell if a single use N95 was at the end of its service life and no longer protected them
 - More than a third (35%) were told to decontaminate their single use N95 respirators themselves
- Almost nine out of ten (88%) were not instructed how to decontaminate a reused N95 respirator
- One out of three had their single use N95s decontaminated by their employer
- More than a quarter (26%) still could not get a new, clean N95 when they needed one

9. HPAE website. Respirator Decontamination Fact Sheet, https://www.aft.org/sites/default/files/covid19_decontamination-filters.pdf

Employers weakened protections and staff threatened

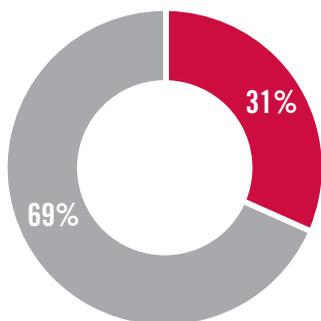
Threatening workers to return to work rather than staying out on quarantine violates infection risk management. New Jersey DOH must require employers to follow consistent procedures for quarantine and isolation of employees who have been exposed and those who have contracted COVID-19 and been sickened.¹⁰ The New Jersey DOH must set up a plan for enforcement to end employer actions that endanger patients, other workers and the surrounding community.



J, from Southern Ocean Medical Center: “Today we learned that we would no longer be contacted or made aware that we were exposed to a positive COVID-19 patient and that we must “assume” we have had contact and monitor and manage symptoms. We were also informed that we would not be following a standard 14-day quarantine (like everyone else), if we developed symptoms; and that, once we were fever free without medication for 72 hours and our symptoms were “tolerable,” we could come back to work. Yet, I have been provided discharge instructions telling me to stay self-isolated at home for 14 days.”

- 69% of respondents were not allowed to take quarantine after exposure
- 20% of healthcare workers surveyed, 1-in-5, said they were sickened with COVID-19
- 24% of survey respondents said they had to return to work while still having symptoms of COVID-19

Only 3 out of 10 workers who said they were exposed to COVID-19 reported being quarantined



M., RN, Inspira Health: “I was shamed for wearing a surgical mask before it became a requirement, yelled at in the ‘huddle’ with manager and co-workers in relation to my asking questions about symptomatic co-workers returning to work without testing and other COVID-19 safety concerns. I was questioned and threatened with being written up for occurrence for calling out from feverish symptoms – no suggestion of screening.”

Some employers did not want to see workers using protective masks in the early days of the pandemic because it sent the “wrong message”¹¹ and might scare people. And some employers went so far as to take away N95s that workers had paid for themselves and brought in from home.¹² All of these actions accelerated exposure to COVID-19, and illness, for healthcare workers.

10. NJ Department of Health. “New Jersey Department of Health (NJDOH) Monitoring and Movement Guidance for Healthcare Personnel (HCP) Exposed to Confirmed Cases of COVID-19.” March 2020, https://www.nj.gov/health/cd/documents/topics/NCOV/Guidance%20for%20HCW%20EXPOSURE%20Monitoring%20and%20Movement%20NJDOH%20DOC%203_9_20_.pdf

11. Worker statement from 22 March 2020.

12. Worker statement from 22 March 2020, different facility from above.



Consequences of PPE program failures

To our knowledge, at least six HPAE members lost their lives to COVID-19 and countless members were sickened. Many are at risk of developing permanent renal, lung and cardiovascular health impacts. Additionally, in performing their job without worker protection, our members placed their immediate families and communities at risk as they traveled home from work each day.

Of those survey respondent members who reported getting sick:

- Two out of three did not have the PPE they needed to provide COVID-19 patient care (66%)
- Nine out of ten never received training on how to decontaminate their PPE (93%)
- Three out of four had to reuse their N95 (77%)
- More than half did not get to use the same kind of N95 they were fit tested for (58%)
- Almost three out of four had to supply and use their own PPE at work (73%)
- Almost half were present during the highest risk aerosolizing procedures performed on COVID-19 patients, without the proper PPE to protect them (45%)
- Just under half were never trained about how to handle a used respirator safely (48%)

THE FAILURES OF OUR SAFETY AGENCIES

During this pandemic, federal and state agencies that should have established strong recommendations and set standards for safety and health abandoned the very standards and protocols meant to protect healthcare workers and their patients. There was a failure on all fronts to acknowledge that the public's health in a pandemic is dependent on the health of their caregivers.

Without the ability to test or to access testing, asymptomatic and symptomatic healthcare workers were forced to continue working despite their risk to others. Our members reported little to no testing, quarantining, or communication from their employer about exposure.

While OSHA released numerous COVID-19 related compliance directives to support worker safety, basic tenets of OSHA's Respiratory Protection and PPE standards were ignored by employers. Rather than in-person inspections to validate complaints, OSHA and PEOSH instead responded to worker complaints by writing letters to employers. When OSHA and PEOSH have chosen to open formal safety complaint proceedings, they have done them solely by phone and email. What agencies do not see, they cannot respond to. HPAE members and staff have filed more than ten OSHA/PEOSH safety complaints against our New Jersey employers as of June 2020.



HPAE ON THE FRONTLINES OF ADVOCATING FOR SAFETY

HPAE stepped up to protect workers and patients from the first days of the pandemic. HPAE leaders immediately recognized the vacuum of federal leadership and guidance, and put together a comprehensive advocacy campaign to protect workers and patients. HPAE leaders fought every day to make sure frontline workers were informed and protected.

Since then, HPAE has:

- Set up a comprehensive web site dedicated to the virus, precautions, protocols and safety standards to follow <https://www.hpae.org/issues/coronavirus-what-you-need-to-know>
- Developed a comprehensive information request for locals to request pandemic response plans from employers
- Across HPAE, members and staff filed ten separate complaints with OSHA and PEOSH when healthcare facilities weakened standards, violated safety practices, and mandated staff to return prior to the recommended 14-day quarantine after exposure
- Monitored and analyzed the latest CDC information to keep members current on guidance and to counter guidance when it weakened standards
- Set up a hotline for members concerns and held regular tele-town halls with members to provide real-time, accurate information to frontline workers
- Made regular public statements to keep the public informed at www.hpae.org/2020



In fact, HPAE became the leading voice in New Jersey advocating for the safety of workers. HPAE, along with other healthcare unions demanded meetings with the New Jersey Department of Health, and the Governor appointed HPAE president Debbie White to sit on the New Jersey Restart and Recovery Advisory Council. <https://nj.gov/governor/admin/recoverycouncil.shtml>

Our demands of New Jersey Governor and Department of Health:

- Address supply shortages and continue to call on the CDC to proactively and effectively target the supply of respirators and use other engineering and administrative controls to reduce the risk of infection to healthcare workers, knowing that our professionals are at the highest risk of infection
- Call on the federal government to release the national stockpile and target supplies to areas where the outbreak has already occurred, incentivizing U.S.-based companies to produce more N95s and better, disposable air purifying respirators, and promoting the use of elastomerics and PAPRs in healthcare settings
- Require hospitals, nursing homes, rehabilitation centers, clinics and other healthcare facilities to provide personal protective equipment in an equitable manner, provide formal training, and ensure sufficient staffing levels at all times
- Provide all healthcare workers – nurses, certified nursing aides, technical staff and service workers including environmental services janitorial staff and dietary workers – who have the potential for direct or indirect exposure to COVID-19 with the same protections <https://www.hpae.org/2020/03/healthcare-unions-demand-protections-for-workers-on-the-frontlines-of-COVID-19-outbreak-in-nj/>



LOOKING FORWARD

Raising the bar on protecting workers, not lowering it

New Jersey needs to begin planning and preparing for the next wave of the COVID-19 pandemic, as well as immediately strengthen its oversight and enforcement powers for future public health crises. We still have a massive shortage of NIOSH approved PPE; the CDC is still changing guidance daily, and now New Jersey and neighboring states have begun their re-opening. It is imperative that New Jersey find a way to stockpile proper PPE, plan for statewide pandemic response coordination, and regulate mandatory pandemic planning for every healthcare facility in the state.

The New Jersey Department of Health's (NJDOH) mission must include the protection of our public health and the regulation of our healthcare institutions during a pandemic. For years, the NJDOH has outsourced responsibility and authority to private groups, such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and to the NJHA.

New Jersey needs and deserves a well-staffed and fully funded NJDOH that will enforce patient and worker safety, hold healthcare operators accountable, and provide strong guidance to effectively safeguard public health.

OSHA requires every business to have comprehensive Emergency Action Plans (EAP) that include responses and protocols for surviving disasters – plans which outline how the business will function during emergencies to protect both employees and the public. In healthcare, this includes pandemic planning and other catastrophic contingencies, for worker and patient safety, outlining how the facility will function during emergencies to protect both employees and patients.

HPAE urges each facility to maintain a stockpile of PPE for a minimum of three months' usage as determined by predictive conditions. Each facility needs a Pandemic and Disaster Emergency Action Plan which meets criteria established by OSHA and by the NJDOH for healthcare facilities. Plans should be reviewed with all staff twice a year and upon new hire. Revisions to plans must be made as determined by the NJDOH with a minimum annual review. Plans should include requirements that employers map out a protocol to inform workers of disease exposure within 24 hours of occurrence, and should include specific protective actions to take for coworkers, patients, and the public.

New Jersey should promote, support and coordinate production, stockpiling, and distribution of healthcare PPE, including N95s and other appropriate respirators, keep and maintain adequate supplies of PPE for workers, and for the general population. Because this illness is transmitted through airborne means as well respiratory aerosols, every worker with potential exposure should have access to N95 respirators.

New Jersey DOH should ensure regular and recurring testing is available for workers on demand in every facility. Healthcare facility employers must be rigorous in monitoring their employees for exposure.

New Jersey needs to begin planning and preparing for the next wave of the COVID-19 pandemic, as well as immediately strengthening its oversight and enforcement powers for future public health crises.

New Jersey says it will have PPE

Governor Murphy's administration has been collecting and distributing PPE to healthcare facilities and trying to regulate the PPE marketplace in New Jersey. The Governor signed executive orders to require reporting of all PPE supplies in the state and to allow for state commandeering of those supplies.¹³

In April, Gov. Murphy ordered 10 million N95s to restock the state's stockpile at a cost of "tens and tens of millions of dollars"¹⁴, while Senators Cory Booker and Bob Menendez secured \$43 million in FEMA money to reimburse the New Jersey Office of Emergency Management (OEM) for PPE purchases.¹⁵ The state of New Jersey has spent at least \$120 million on PPE and other medical supplies, three quarters of which will be reimbursed by FEMA.¹⁶

On May 3rd, Gov. Murphy joined into a multi-state agreement to develop a regional supply chain for PPE and other medical supplies.¹⁷ In late May, the state launched a publicly available PPE supplier registry to help bring transparency to the PPE market.¹⁸ The U.S. Attorney's office for New Jersey is attempting to protect New Jersey healthcare employers from PPE price gouging by suppliers.¹⁹

Gov. Murphy's "The Road Back" reopening plan includes these PPE-related goals: "Ensure hospitals, healthcare systems, and other health delivery facilities have inventories of personal protective equipment and ventilators" and "Build our own state personal protective equipment and ventilator stockpile."²⁰



13. NJ.gov website, page taken down since writing, <https://nj.gov/infobank/eo/056murphy/pdf/EO-111.pdf> and <https://nj.gov/infobank/eo/056murphy/pdf/EO-113.pdf>

14. Stacey Barchenger. "Millions of masks, gloves, and more are on the way. Here's how NJ decides who gets them." USA Today, April 3, 2020, <https://www.usatoday.com/story/news/new-jersey/2020/04/03/who-gets-all-ppe-donations-help-fight-coronavirus-nj/5090563002/>

15. Anthony Vecchione. "\$43M in federal disaster funding to reimburse NJ for PPE purchases." NJBIZ, April 30, 2020, <https://njbiz.com/43m-federal-disaster-funding-reimburse-nj-ppe-purchases/>

16. Brent Johnson. "N.J. buys at least \$120M in medical gear to fight coronavirus, Murphy says." NJ.com, April 25, 2020, <https://www.nj.com/coronavirus/2020/04/nj-buys-at-least-120m-in-medical-gear-to-fight-coronavirus-as-state-finances-crater-murphy-says.html>

17. Press release, Governor's Office, May 5, 2020, <https://nj.gov/governor/news/news/562020/approved/20200503a.shtml>

18. Press release, Governor's Office, May 22, 2020, <https://nj.gov/governor/news/news/562020/approved/20200522b.shtml>

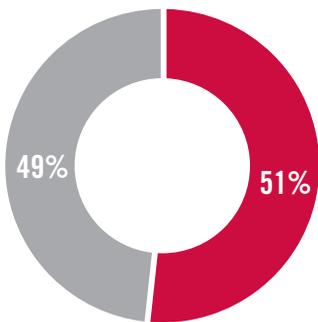
19. "The U.S. Attorney's Office for the District of New Jersey sent a letter to NJHA and its members (attached) outlining federal price-gouging protections in several categories of PPE, ventilators, hydroxychloroquine and other supplies and resources needed in the COVID-19 response. The U.S. Attorney's Office encourages providers to report any alleged violations of the President's anti-price gouging order." <https://www.gnyha.org/wp-content/uploads/2020/04/Coronavirus-Update-No.-31-4.8.20.pdf>

20. The Road Back: Restoring Economic Health Through Public Health, http://d31hzhk6di2h5.cloudfront.net/20200427/db/2d/77/6c/2a8a498ff2edda855c3f456d/The_Road_Back_-_Restoring_Economic_Health_Through_Public_Health.pdf

But will PPE consistently get into the hands of frontline healthcare workers?

By May 14th, the OEM had distributed 42.6 million pieces of PPE, according to a post on Governor Murphy's Facebook page.²¹ In a single week in April, OEM distributed nearly 5 million pieces of PPE to New Jersey healthcare systems according to the NJHA, including 900,000 N95 respirators.²² The state does not disclose how much PPE each healthcare facility receives and that information is shielded from New Jersey's open records law.

The majority of healthcare workers surveyed reported having to perform direct COVID-19 care without appropriate PPE



We do not know when or even if this equipment reaches healthcare workers on the frontlines. Even with replenished inventories of PPE, healthcare employers can continue to resort to CDC-approved contingency and crisis level PPE strategies without ever disclosing if those practices are justified. Healthcare workers and their representatives have no way to rebut claims of scarcity, even when millions of pieces of publicly-funded PPE have been documented as being distributed to their facilities.

Gov. Murphy's administration has taken the right steps to regulate the PPE market during the pandemic state of emergency by requiring PPE disclosures from all New Jersey businesses, centralizing all extra PPE supplies, and maintaining a public registry of the PPE market place. In addition, we urge transparency for distribution and use of PPE throughout NJ's healthcare facilities.



Gov. Murphy's administration has taken the right steps to regulate the PPE market during the pandemic state of emergency.

21. Post by Governor Murphy on Facebook, <https://www.facebook.com/governorphilmurphy/posts/new-new-jersey-office-of-emergency-management-has-now-distributed-more-than-426-/2786873064772029/>

22. NJHA Coronavirus Update #41, April 20, 2020, <https://www.gnyha.org/wp-content/uploads/2020/04/Coronavirus-Update-No.-41.-4.20.20.pdf>

Strengthen and enforce state and federal laws

We learned, as would be expected, that without risk management and safety program implementation, without functional OSHA compliance with respiratory protection and other safety standards, our members become ill, are hospitalized, and sometimes die. HPAE has suffered at least six frontline healthcare member fatalities due to COVID-19 exposures on the job since this outbreak began.²³

Safety and health professionals across the country are expecting an additional surge of COVID-19 infection in the coming months.



Healthcare workers will continue to be exposed to COVID-19 at work, become symptomatic, suffer long term health effects, transmit illness, and potentially die, unless the following occurs:

- **OSHA and PEOSH should use** all consultation and compliance tools at their disposal to enforce fundamental worker safety standards concerning risk management, engineering and administrative controls, and personal protective equipment and respiratory protection. Active enforcement of occupational safety standards in healthcare leads directly to better outcomes and better protection for workers, patients, and the community.
- **Healthcare workers and union representatives must be invited** to the table to collaborate with employers to solve infection control challenges during this and future outbreaks.
- **Healthcare employees must be fully and effectively trained** during working hours by competent instructors about how to maximize infection control and minimize their exposures to COVID-19 during this pandemic, including use of PPE and respirators.
- **Management must invest** in elastomeric respirators and PAPRs for those in the workforce performing highest risk procedures and for those who cannot pass a fit test for an N95.
 - **This needs to be followed up with thorough, effective, demonstrative training offered during working hours.**
- **We need the federal Defense Production Act utilized** to initiate more domestic production of healthcare PPE and NIOSH approved respiratory protection.

23. HPAE COVID-19 Memorial Page, <https://www.hpae.org/memorial/>

New Jersey policy recommendations

From the frontlines, we demand leadership from our government and the agencies tasked with protecting New Jersey's health and safety, including adoption of the following measures:

1 Legislative initiatives:

- a. **S2384 / A4129:** A law to require healthcare facilities to report COVID-19 data related to healthcare workers and certain first responders to the New Jersey DOH. An analysis of the data will help shape legislation, policies, and protocols for future outbreaks.
- b. **S2380 / A3999:** A law to presume that frontline workers who contract the virus got it from workplace exposure for the purposes of employment benefits, including but not limited to workers' compensation benefits.
- c. **S1083 / A2439:** A law to establish minimum registered professional nurse staffing standards for hospitals and ambulatory surgery facilities and certain DHS facilities.
- d. **S2509 / A4169:** A law to protect healthcare professionals from retaliatory action by employers during the ongoing coronavirus disease 2019 pandemic.



- 2 **Establish and maintain a Pandemic PPE Play Book** across the state, including coordinating efforts with Homeland Security, healthcare facilities, laboratories, and PPE distributors to ensure uniformity, widespread testing, contact tracing, and surveillance.
- 3 **Healthcare facilities must apply and implement recommendations** in OSHA's pandemic guidance documents,²⁴ including infection control best practices, OSHA standards and guidance to perform workplace Hazard Assessments, and establish risk management systems to ensure worker protection.
- 4 **Improve communication and coordination** between NJ PEOSH, the New Jersey Departments of Health, Labor, and OSHA to share information about needed oversight and enforcement of safety standards.
- 5 **Ensure that OSHA Pandemic Disaster Planning** recommendations and appropriate safety training are effective, complete, and up to date for all healthcare workers.
- 6 **Ensure a system is implemented** that requires Transparency and Accountability in PPE Supply stockpiles and distribution.
- 7 **Guarantee Supplies of Personal Protection Equipment** – N95 and better filtering facepiece respirators, Elastomeric Respirators, Powered Air Purifying Respirators, gloves, gowns, head, and shoe coverings.
- 8 **Maintain Fit Testing** – <https://actionnetwork.org/letters/urge-nj-lawmakers-to-support-s2384a4129-to-protect-frontlineworkers-and-make-data-public/>

24. <https://www.osha.gov/Publications/3328-05-2007-English.html>



IN CONCLUSION

A message to elected officials and policy makers

Nurses and other healthcare workers have always answered the call – through other outbreaks – HIV-AIDS, swine flu, SARS, MERS, Ebola, the Spanish flu.

But their voices this time are telling us all that the COVID-19 pandemic has been like nothing they ever encountered. All the protections, the support, the information and resources they needed to do their job, to protect us, were missing.

As a result, nurses and other healthcare workers bore the brunt of this pandemic – nationally, more than 92,572 infected and at least 507 dead so far.²⁵ They were caregiver, witness, and victim²⁶ at the same time, dealing with sudden influxes of patients when our country’s experts were still unsure of the best treatments and of the way this disease spread.

But, we knew how to protect frontline workers, and we failed. They were sometimes inadvertently the ones spreading the disease, infecting their own families as well.

The people we count on have been sickened and traumatized, and their trauma and stress will be with us for a long time. If we want them to be at our bedside for the next wave of this pandemic, or for the next disease, we need to listen to their voices.

If anything, this report should serve as a clarion call across our society, all sectors of America, a warning that attention must be paid. Attention must be paid whether the next pandemic is far in our future, just around the corner, or if the one we are currently experiencing continues unabated.

State regulators, policy makers and elected officials have to deal directly and honestly with the risks the virus poses to health care workers. Large healthcare systems in New Jersey were not held even to watered-down CDC guidelines and still lack a requirement to document COVID-19 exposures, or to fully plan for pandemics. In the context of reopening, HPAE is calling for a return to safe practices and a strengthening of state oversight of healthcare facilities to ensure healthcare worker safety and ultimately the safety of patient care.



25. CDC Data Dashboard updated July 06, 2020 reported 92,572 COVID-19 cases among healthcare workers, but only 21% of the 2.1 million COVID-19 patient data collected CDC reported if they were healthcare workers so the case numbers are likely much higher. <https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html>

26. “Lost on the Frontline,” a collaboration between KHN and The Guardian, has identified 729 such workers who likely died of COVID-19 after helping patients during the pandemic. <https://khn.org/news/lost-on-the-frontline-health-care-worker-death-toll-covid19-coronavirus/>



APPENDIX

HPAE COVID-19 Exposure-Illness Survey (Results, data, and methodology)

Were you exposed to COVID-19 in your work-place? (If the answer is No, jump to question 19 on Personal Protective Equipment.)

Yes	54.08% (576)
No	45.92% (489)

**Did you document your exposures?
Select all that apply.**

No	34.79% (207)
Told employer	50.59% (301)
Filed Incident Report	15.97% (95)
Notified Union	14.45% (86)
Kept own log of exposures	29.75% (177)

**How did you find out you had been exposed?
Select all that apply.**

Notified by mgr/admin	36.14% (206)
Notified by colleague	38.25% (218)
Self-discovery	55.96% (319)

Were you quarantined?

Yes	30.98% (184)
No	69.02% (410)

Did you get sick?

Yes	36.47% (217)
No	63.53% (378)

**If yes, what were the symptoms?
Select all that apply.**

Body aches	72.65% (170)
Fatigue	0.00% (0)
Headache	79.06% (185)
Chills	55.13% (129)
Dry cough	3.85% (126)
Chest pains	32.48% (76)
Loss of appetite	44.87% (105)
Diarrhea	46.58% (109)
Fatigue	75.21% (176)
Sore throat	44.02% (103)

Congestion	34.19% (80)
Malaise	47.44% (111)
Gastrointestinal upset	38.46% (90)

Were you tested?

Yes	43.43% (261)
No	56.57% (340)

Where were you tested?

A private medical doctor	24.79% (60)
Healthcare professional at a hospital	75.21% (182)

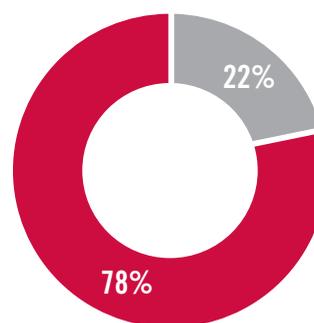
Were you retested (or scheduled to be retested)?

Yes	16.67% (57)
No	83.33% (285)

Result

Negative	68.53% (135)
Positive	31.47% (62)

Over 75% healthcare workers surveyed reported having to reuse their N95 respirator while caring for patients.





Have you been cleared to return to work?

Yes	84.23% (267)
No	15.77% (50)

Did you have to return to work while you were still having symptoms?

Yes	24.30% (69)
No	75.70% (215)

Did you file for workers' comp through employee health?

Yes	24.17% (80)
No	75.83% (251)

PERSONAL PROTECTIVE EQUIPMENT (PPE) – Were you trained about the Personal Protective Equipment (PPE) you need to do COVID-19 care?

Yes	73.57% (774)
No	26.43% (278)

Have you had to work without the right PPE for COVID-19 care? What was missing? Select all that apply.

Gown	38.09% (211)
Gloves	6.14% (34)
Surgical Facemask	19.31% (107)
N95 Respirator	64.80% (359)
Face shield	43.14% (239)
Goggles	50.18% (278)

Have you used your own PPE for work? Select all that apply.

N95	31.33% (214)
KN95	12.15% (83)
Gown	6.59% (45)
Gloves	9.08% (62)
Head covering	61.20% (418)
Surgical Facemask	20.20% (138)
Face shield	20.06% (137)
Goggles	27.96% (191)
Cloth mask	24.74% (169)
Other (please specify)	10.10% (69)

If you were present for aerosolizing procedures, did you have the PPE you needed?

Yes	65.93% (420)
No	34.07% (217)

Were you initially fit tested on an N95 respirator?

Yes	76.62% (790)
No	23.38% (241)

Did you get to use the same brand and size respirator that you were fit-tested to?

Yes	52.88% (496)
No	47.12% (442)

Did you get to use an N95 respirator that's your size?

Yes	71.01% (676)
No	28.99% (276)

Were you assigned a KN95 mask with ear loops?

Yes	19.83% (192)
No	80.17% (776)

Have you been reusing your N95 respirator?

Yes	77.73% (740)
No	22.27% (212)

If yes, for how long?

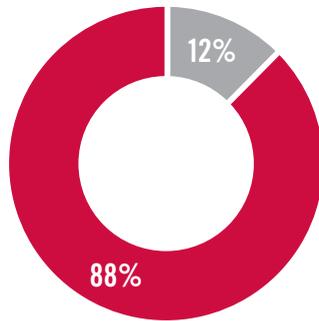
8 hours	5.03% (37)
12 hours	21.09% (155)
Multiple days	44.76% (329)
A week or more	29.12% (214)

Did you receive training about how to handle a used respirator? Select all that apply.

No	45.23% (446)
Putting it on and taking it off (don and doff)	52.23% (515)
Performing a user seal check every time you don	29.21% (288)
Recognizing respirator end of service life (when it is too damaged to use any more)	19.68% (194)



Nearly 9 out of 10 healthcare respondents were never trained how to decontaminate their PPE



Have you been asked to decontaminate your PPE?

Yes	35.13% (345)
No	64.87% (637)

Were trained how to?

Yes	12.32% (94)
No	87.68% (669)

Does your employer decontaminate your respirator?

Yes	34.80% (300)
No	65.20% (562)

Can you get a new N95 when you need one?

Yes	73.85% (706)
No	27.24% (250)

Methodology: In April of 2020, HP AE administered a survey focused on SARS-CoV-2 exposure and health and safety issues at HP AE represented facilities in New Jersey and Pennsylvania. Using Survey Monkey, the survey was distributed electronically to all HP AE members for whom HP AE has a valid email. Not all questions that appeared on the survey were included in this report. Some were omitted, for instance, to preserve confidentiality. 1,085 self-identified HP AE members completed the survey from 4/30/20 to 6/2/20, including employees of the following healthcare facilities: Englewood Hospital and Medical Center, HMM Palisades Medical Center, HMM Jersey Shore Medical Center, Rutgers University RNs and healthcare professionals, Bergen New Bridge Medical Center, Rowan University RNs, University Hospital, Penn-Jersey Region of the American Red Cross, Virtua Memorial Hospital, Temple Hospital Episcopal Campus, VNA Englewood, Inspira Health hospitals in Vineland, Elmer, Bridgeton, and Woodbury, New Jersey, Cooper University Hospital, HMM Southern Ocean Medical Center, Salem Memorial Hospital, Hudson Regional Hospital, CarePoint Bayonne Medical Center, CarePoint Christ Hospital, Sunrise House, Llanfair House, Wanaque, Cornerstone, and the HMM Harborage House long term care facility.

Testimonials

“Exposed & At-Risk is critical to understanding what has happened and is still happening in hospitals throughout the United States in response to COVID-19. It exposes the nasty underbelly of healthcare politics. The summary states, in part, “We know how to protect frontline workers, and we failed.” If we continue to fail, expect an even more critical shortage of essential workers to care for us. The recommendations contained in this report provide a map for all hospitals. Laws laid out in the recommendations address crucial issues, but laws alone will not suffice. They must be backed up with resources tied to enforcement. Only then will we have a chance of preserving the best of our healthcare system and protecting the health of our nation.”



Elayne Kornblatt Phillips RN, MPH, PhD, FAAN

- Associate Professor Emerita of Nursing, Former Clinical Associate Professor and Senior Research Program Officer at the University of Virginia School of Nursing
- Former Director of Research, International Healthcare Worker Safety Center, University of Virginia School of Medicine

“Exposed & At-Risk dramatically exposes an unacceptable truth. This important report documents how New Jersey health care workers, on the front lines of the fight to save lives, are themselves being endangered by the lack of PPE and the failure of the state’s health care employers to take the steps necessary to protect them. And until public health and safety agencies step in to require that they be protected, it will be very difficult to stem this epidemic.”



David Michaels, PhD, MPH

- Epidemiologist and Professor, Department of Environmental & Occupational Health, Milken Institute School of Public Health, The George Washington University
- Former Assistant Secretary of Labor for Occupational Safety and Health (OSHA) 2009–2017
- Author, *The Triumph of Doubt: Dark Money and the Science of Deception 2020*

This report was prepared by the HPAE Public Policy Team: Nate Horrell, Heidi E. Hansen, Ellie Barbarash, Jean Pierce, John Westenberg and Michael Allen, under the supervision of Public Policy Director Bridget Devane and Executive Director Chris Whalen.