



NUHW WORKPLACE SAFETY POLICY POSITIONS FOR THE COVID-19 PANDEMIC

NUHW is committed to making sure our members can safely care for our patients. When confronting a novel virus like severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), which causes the illness known as coronavirus disease 2019 (COVID-19), data, research, and guidance from public health, infectious disease, and occupational health and safety authorities and researchers is rapidly evolving and, in some areas, still limited.

The policies recommended in this document reflect the minimum precautions and protocols that must be in place to keep healthcare workers safe, given current available information. NUHW's guidelines will be updated in response to new research and to respond to emerging issues among healthcare workers.

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1. Universal Mask Policy and Eye Protection for Patient Care

All healthcare employers should provide a mask (which covers the mouth and nose) to all people who enter a healthcare facility including patients, employees, physicians, trainees, and visitors regardless of whether they have respiratory symptoms or not. Instituting a universal mask policy helps decrease [asymptomatic spread of COVID-19](#), (which the [CDC's Director states](#) is occurring) and keeps employees healthy so they can continue their essential work.

Employers should provide each employee with a new mask at the beginning of each shift. If the mask becomes soiled or wet at any point throughout the shift, the employer should provide a replacement. The mask should be discarded at the end of each shift prior to leaving the facility.

Immediate implementation of universal masking is particularly important in long-term care facilities (LTCFs), given the high-risk status of their residents. All employers must comply with [CDC's LTCF-specific guidance](#) which states that facilities in areas with community spread (such as the entire state of California) should implement universal use of masks for all healthcare workers.

A universal mask policy is a minimal and rudimentary precaution. It is not a replacement for appropriate personal protective equipment (PPE) that is donned and doffed by healthcare workers each time they deliver patient care to or work in areas occupied by a person under investigation (PUI) for COVID-19 infection or patients confirmed to be COVID-19 infected.

Eye Protection for All Direct Patient Care:

To provide a physical barrier for the eyes and to deter healthcare workers from touching their eyes, eye protection should be worn for the direct care of all patients (PUIs, confirmed COVID-19 patients and uninfected patients). Eye protection must take the form of goggles or a face shield. Goggles must fit snugly against the face and should be indirectly vented to prevent fogging. Face shields must seal against the forehead at the top (i.e. have a crown), extend below the chin, and fully wrap around the face extending to the ears on both sides. Neither prescription glasses nor safety glasses are adequate eye protection, because they do not seal to the face and provide protection to all sides of the eye area. Prescription glasses can be worn under goggles or a face shield. Goggles can interfere with N95 respirator fit when worn together. Therefore, a face shield is the preferable form of eye protection to wear with an N95 respirator.

While the [CDC](#) recommends eye protection in areas with moderate to substantial community transmission but considers it optional in areas with minimal to no community spread, NUHW believes workers in all communities should be wearing eye protection for patient care.

2. Personal Protective Equipment (PPE)

Our healthcare workers are on the frontlines of an unprecedented public health crisis. Their health and safety must be prioritized to ensure that our healthcare system can care for all the patients impacted by the COVID-19 pandemic. Therefore, healthcare workers must be protected to the fullest extent possible.

[Cal/OSHA's](#) "regulations require protection for workers exposed to airborne infectious diseases such as the 2019 novel coronavirus disease (COVID-19), first identified in December 2019." Cal/OSHA's Aerosol Transmissible Diseases (ATD) Standard was adopted in 2009 ([Title 8 CCR §5199](#)) to protect employees from airborne infections due to their

work activities. [Per the ATD Standard](#), “for protection against ATDs, NIOSH-certified respirators with a rating of at least N95 must be used.”

However, in the face of “extreme supply shortages,” [Cal/OSHA](#) does permit healthcare facilities to provide employees otherwise required to wear an N95 respirator with surgical masks. (They must first exhaust all other suggested alternatives to surgical masks listed as “Optimization Strategies to Extend Respirator Use” in their [“Interim Guidance on COVID-19 for Health Care Facilities: Severe Respirator Supply Shortages”](#)). [CDC guidance](#) allows for this same downgrading of PPE when respirator supplies are inadequate.

Along with other unions and advocacy organizations, NUHW opposes this weakening of PPE standards by both Cal/OSHA and the CDC. Decisions about PPE for healthcare workers should be dictated by scientific evidence and the safety of caregivers--not supply chain failures. NUHW insists that all employers must provide PPE for airborne precautions, in addition to PPE for contact and droplet precautions, to all healthcare workers who care for patients with suspected or confirmed COVID-19 infections:

- NIOSH-certified N95 respirator or other respirator with equivalent or higher protection, gown, eye protection — goggles or face shield which covers the front and sides of the face — and gloves.
- Powered air-purifying respirators (PAPRs) with high-efficiency particulate air filters are required for employees who perform aerosol-generating procedures on PUIs or confirmed COVID-19 patients.

NUHW insists that employers take immediate steps to secure an adequate supply of respirators (N95 or higher) and PAPRs for all aerosol-generating procedures, along with PPE for droplet and contact precautions, to allow for the protection of healthcare workers. If the supply of disposable filtering facepiece respirators is inadequate, NUHW urges all employers to pursue acquisition of elastomeric respirators and PAPRs, which are reusable, as a more sustainable way to confront PPE supply challenges. Furthermore, NUHW requests that employers provide the union with a daily inventory of PPE available at all care sites staffed by NUHW members.

*****Update: On August 6, 2020 Cal/OSHA updated it’s [“Interim Guidance on COVID-19 for Health Care Facilities: Severe Respirator Supply Shortages”](#) stating that “California health care providers are no longer experiencing an extreme respirator shortage” and that employers covered by the ATD Standard must provide occupationally exposed employees with NIOSH-certified particulate respirators. NUHW welcomes this stronger guidance from Cal/OSHA and continues to expect that all healthcare employers adhere to the respiratory requirements laid out in the ATD Standard.*

Read on for further details on Cal/OSHA’s ATD Standard:

[Cal/OSHA](#) has determined that COVID-19 is an airborne infectious disease which is covered by Cal/OSHA’s Aerosol Transmissible Diseases (ATD) Standard (Title 8, [Section 5199](#).) This means that all workers providing care to PUIs or confirmed COVID-19 infections should use airborne precaution PPE. COVID-19 also requires contact and droplet precautions. Accordingly, PPE must include an N95 respirator, gown, eye protection, and gloves.

Per Cal/OSHA’s ATD Standard, all employees must be medically cleared and fit-tested to wear an N95 or other respirators provided by the employer. Fit testing must be performed at least annually.

PPE guidelines under the ATD Standard apply to all employees involved in the care of PUIs or confirmed COVID-19 patients in all healthcare settings (inpatient, outpatient, home health care, LTCFs, jails and prisons). This includes staff involved in patient transport and environmental services.

Per the ATD Standard, powered air-purifying respirators (PAPRs) with high-efficiency particulate air filters are required for employees, like respiratory therapists, who perform aerosol-generating procedures on PUIs or confirmed COVID-19 patients.

Donning of PPE upon entry and doffing of PPE upon exit of PUI or confirmed COVID-19 patient rooms should be done using the “buddy system” which provides observation by a trained coworker (who should be at least 6 feet away from the coworker who is donning and doffing). Time spent donning and doffing PPE is compensable, and should be done on the clock.

Home health setting: In the home health care setting, where employers cannot ensure that a patient's private home is equipped with engineering controls like proper ventilation, employees must wear respiratory protection when there is an airborne infectious disease with community spread like COVID-19.

3. Scrub Provision

At the beginning of each shift, facilities should make scrubs (or equivalent garment substitute) available for all healthcare workers who will be caring for PUIs or confirmed COVID-19 patients. Scrubs should also be available for workers who will be in contact with equipment and surfaces that were exposed to a PUI or COVID-19 patient or who will clean a room that was occupied by a PUI or COVID-19 patient. At the end of the shift, employees should return scrubs for laundering by the facility and change into their own clothes to return home. Wearing employer-provided scrubs should be voluntary but supply should be adequate for all employees in contact with PUIs or confirmed COVID-19 cases who want to wear them.

4. Source Controls

All employers should implement source controls, as outlined by the [Cal/OSHA ATD Standard](#). This includes placing a mask on all patients (including home health patients) unless not possible for medical reasons (i.e. facial injury etc.). While priority should be given to masking PUIs and confirmed COVID-19 cases, providing a mask for all patients offers the greatest protection to healthcare workers given the prevalence of [asymptomatic transmission](#).

5. Engineering and Work Practice Controls

All employers should implement the [“Engineering and Work Practice Controls” outlined in Cal/OSHA’s ATD standard](#). Engineering controls include airborne infection isolation rooms or areas (AIIRs), local exhaust ventilation, high efficiency particulate air (HEPA) filtration, and ultraviolet germicidal irradiation (UVGI).

Work Practice Controls should include source control measures (e.g., masks on all PUIs and confirmed COVID-19 cases), isolation precautions, procedures for safely moving patients through a facility, handwashing, PPE donning and doffing procedures, the use of anterooms, as well as cleaning and disinfecting contaminated surfaces, PPE, articles, and linens. Employees should also perform as many tasks as possible in areas that are at least 6 feet away from PUIs or confirmed COVID-19 patients (e.g., do not remain in a patient’s room to do charting, etc.)

Employers should also implement policies to allow for social distancing in the workplace. When possible, employees should maintain at least 6 feet between themselves and all patients, coworkers, and other visitors to facilities. Employees should not congregate in break rooms and management should not hold huddles or other team meetings if there is not adequate space to maintain at least 6 feet between employees. [Per guidance from the Centers for Medicare and Medicaid](#)

[Services \(CMS\)](#), visitors should be discouraged from gathering in common waiting rooms and visitor areas, and from unnecessary travel within the hospital. The facility should designate limited entry points for all visitors.

Instead, employers should provide spaces — which are regularly cleaned and disinfected-- that can accommodate this 6-foot social distancing protocol for all employee breaks, meals, huddles, and meetings. For staff who work in non-clinical, office-based settings, adequate space must be made available to allow for adequate social distancing throughout the workday.

6. Employee Screening

Screen all staff daily with, at a minimum, a temperature check and a symptom checklist at the beginning of the work day, outside of the entrance to the workplace. Signs and symptoms that must be assessed are cough, fever, shortness of breath, sore throat, body aches, chills, headache, runny nose, diarrhea, conjunctival hyperemia, and [anosmia, hyposmia, or dysgeusia](#) in the absence of other respiratory disease (allergic rhinitis, etc.). Employees should also be asked about community exposures (i.e. whether they live with someone who is under investigation for or has contracted COVID-19).

7. Screening of Patients and Visitors

[Per CMS' recommendation](#), hospitals should limit visitors for COVID-19 patients and patients under investigation, and should place limitations on all other visitation including restricting the number of visitors per patient, or limiting visitors to those that provide assistance to patients. All healthcare settings should screen all patients and visitors for COVID-19 with a temperature check, symptom checklist, travel screen, and exposure screen prior to entering patient care areas (just as for employees, outside of the entrance of the facility before entering areas occupied by staff and patients). Staff assigned to screen patients and visitors should be provided an N95 mask, gown, gloves, and eye protection (see Section 2 for detailed PPE guidance).

If a patient or visitor screens positive, they should be masked or placed in a manner that eliminates or minimizes contact with employees who are not wearing respiratory protection until the patient is moved to an airborne infection isolation room/area. Employers must ensure that patients are moved to an airborne infection isolation room/area in a timely manner.

All long-term care facilities should follow [guidance from CMS](#) to “restrict visitation of all visitors and non-essential health care personnel, except for certain compassionate care situations, such as an end-of-life situation.”

8. Cohorting of Patients and Staff Assignments

Hospitals should plan for dedicated areas or wards for cohorting of COVID-19 patients. Staff teams for cohorted COVID-19 patients should not be providing care to other patients, including PUIs, who should not be cohorted with COVID-19 patients nor treated by the same care team, [per WHO guidelines](#). If dedicated wards are being used, dedicated environmental services staff should be assigned. Access to wards with cohorted COVID-19 patients should be restricted to designated staff teams. Meal trays should be delivered outside of the ward, and distributed by nursing staff within the ward. Dietary workers should not circulate within COVID-19 wards, or enter the rooms of COVID-19 patients to distribute or retrieve trays or items.

Per the [Cal/OSHA ATD Standard](#), all PUIs and COVID-19 patients should be treated in airborne infection isolation rooms (AIIR) (also referred to as negative pressure rooms) or rooms that have been adequately converted for these purposes.

Per [CDC guidelines](#), long term care facilities should place COVID-19 patients in single rooms with their own bathrooms. Nursing homes should dedicate healthcare staff teams to treat COVID-19 patients.

[Per WHO guidelines](#) (see “Infection prevention and control during health care when novel coronavirus (nCoV) infection is suspected”), limit the number of persons present in the room to the absolute minimum required for the patient’s care and support. Have a plan in place to “batch” or combine tasks to minimize the number of times that staff members must enter a room, and the number of personnel who enter a room. Dedicated portable imaging and other diagnostic equipment should be used.

If confirmed or possible COVID-19 patients must be transported, have nurses prepare patients for transport, provide patients with a mask, and meet transporter outside of the room to minimize exposure; have nurses receive patients outside of the room if possible. Use transport routes that minimize exposure to other workers and patients. If transporter must enter the room, disinfect bed rails and provide transporter with appropriate PPE, per NUHW recommendations for personnel providing direct care.

Per the [CDC’s recommendation](#), dedicated medical equipment (e.g., stethoscope, blood pressure cuff, thermometers, etc.) should be used when caring for PUIs or confirmed COVID-19 patients. Disposable equipment is also appropriate if available. All non-dedicated, non-disposable medical equipment used for the care of PUIs or confirmed COVID-19 patients should be cleaned and disinfected according to manufacturer’s instructions and facility policies before use on another patient. See section 14 for guidance on cleaning and disinfecting equipment.

To the extent possible, portable radiographic equipment should also be dedicated to use with COVID-19 patients. If there is not enough equipment to do so, this equipment should be disinfected according to manufacturer’s instructions after each use with a PUI or COVID-19 patient.

Follow [CDC guidelines for signs](#) on and labeling of patient room doors when transmission-based precautions (i.e., contact and airborne precautions) are in place. Signage should be in all of the primary languages spoken by support staff, including EVS and dietary workers, to signal to all personnel that extra precautions are needed.

9. Testing

To protect staff, patients, and the wider community, NUHW requests that employers provide all healthcare workers with access to rapid, point-of-care testing for COVID-19. (Healthcare workers who are assigned the task of administering tests should be provided PPE.)

If testing capacity is currently inadequate to test all employees and obtain results rapidly, then NUHW requests that management work immediately to procure more tests and increase testing capacity.

10. Contact Tracing

When a facility discovers that an employee, patient, or visitor has contracted COVID-19 or come under investigation for COVID-19, employers will conduct immediate contact tracing to identify exposed individuals, notify such individuals, and evaluate the risk of each exposure. This evaluation should include a determination of:

1. Time and date of exposure.
2. Location of exposure.
3. Circumstances of exposure (i.e., activities that the employee was engaged in at the time of the exposure).
4. Proximity of contact (i.e., distance from PUI or confirmed COVID-19 patient?).
5. Duration of exposure.
6. PPE worn by the employee at the time of the exposure.

7. How PPE was being used (e.g., continuous use, reuse, decontamination procedures, etc.) and the PPE's condition (e.g., expired, non-medical grade/repurposed from industrial sources, homemade, etc.).
8. If the employee was wearing an N95, the date of most recent fit testing.
9. Date of training provided to the employee on donning and doffing of PPE.
10. Whether the patient, visitor, or staff member was wearing a mask (i.e., source control).

When an employer conducts contact tracing and identifies that a NUHW member or members came into contact with a PUI or confirmed COVID-19 patient (which includes cleaning a room occupied or recently vacated by the patient), the employer shall notify the member or members and NUHW. The employer shall submit to NUHW the name of the employee and written documentation of the above risk evaluation as well as verification that the employer has notified the employee. If it is determined through contact tracing that an employee was not wearing adequate PPE at the time of exposure, see section 11 for guidance.

11. On-the-Job Exposure to Suspected or Confirmed COVID-19 Cases

When an employee is in contact with a patient, visitor, or staff member who is suspected or confirmed to have COVID-19 *without wearing adequate PPE or if there was a possible breach of PPE*, the employee should be sent home on precautionary leave to quarantine for a minimum of 14 days (with full pay and benefits) and provided testing by the employer.

The same protocol applies to employees who come into contact with a patient room, surfaces or equipment potentially contaminated by a PUI or confirmed COVID-19 patient *when not wearing the appropriate PPE or if there was a possible breach of PPE*.

12. Healthcare Workers Who Develop COVID-19 Symptoms

If a healthcare worker develops symptoms of COVID-19 (even with no known exposure to a PUI or confirmed COVID-19 patient), they should be put on paid leave and tested (testing should be provided by the employer). A detailed contact tracing should be performed immediately to identify coworkers who came into close contact with the sick healthcare worker.

Coworkers who came into contact with this symptomatic coworker and *were not wearing appropriate PPE* at the time of the exposure should be put on precautionary leave to quarantine for a minimum of 14 days (with full pay and benefits) and provided testing. The hospital must notify NUHW of any such exposures.

13. Return-to-Work Determinations

[Per CDC guidelines](#), employees who had a symptomatic infection (but who did not have a severe to critical illness and are not severely immunocompromised) should be permitted to return to work only after at least 10 days have passed since symptoms first appeared and at least 24 hours have passed since last fever without the use of fever-reducing medications and symptoms (e.g., cough, shortness of breath) have improved.

Healthcare workers with severe to critical illness or who are severely immunocompromised (see CDC's definitions of these categories [here](#)) should return to work according to the following criteria:

- At least 10 days and up to 20 days have passed since symptoms first appeared
- At least 24 hours have passed since last fever without the use of fever-reducing medications and
- Symptoms (e.g., cough, shortness of breath) have improved
- Consider consultation with infection control experts

For asymptomatic infections: Per [CDC guidance](#), employees “who are not severely immunocompromised and were asymptomatic throughout their infection may return to work when at least 10 days have passed since the date of their first positive viral diagnostic test.” Employees “who are severely immunocompromised but who were asymptomatic throughout their infection may return to work when at least 10 days and up to 20 days have passed since the date of their first positive viral diagnostic test.”

Finally, [per the CDC](#) if local infectious diseases experts raise concerns that an immunocompromised healthcare worker may be infectious for longer than 20 days the CDC’s two-test strategy can be considered under the guidance of these infectious disease experts.

14. Accommodation Policy for High-Risk Employees

Employees who are pregnant or considered to be at high-risk for developing severe illness if they contract COVID-19, due to age or underlying medical condition, should be offered alternatives to assignments with confirmed COVID-19 cases or wards or to ED triage areas for possible COVID-19 patients. Those who request such medical accommodation should be placed in other clinical work areas or should be offered assignments in non-patient care areas or areas with limited risk of exposure, with no changes to pay and benefits. This should apply to all staff, including environmental services, dietary, and other non-clinical staff. Employees requesting medical accommodation may be protected by the Americans with Disabilities Act (ADA). Employers and employees may wish to consult relevant resources from the U.S. Equal Employment Opportunity Commission (EEOC), including “[What You Should Know About COVID-19 and the ADA, the Rehabilitation Act, and Other EEO Laws](#),” and “[Pandemic Preparedness In The Workplace And The Americans With Disabilities Act](#).”

Regardless of the work area to which high-risk employees are assigned, they should have access to the PPE they request to limit their exposure risk.

15. Training

All employers should provide staff with training on all COVID-19 protocols that are needed for the safe and effective execution of healthcare workers’ duties. New training should be provided immediately if new protocols emerge or old protocols are updated as more information about this pandemic becomes available.

Training should cover the following topics, [as recommended by Cal/OSHA](#): signs and symptoms of COVID-19; modes of transmission of COVID-19 and source-control procedures; tasks and activities that may expose employees to COVID-19; appropriate uses of methods (and these methods’ limitations) for preventing or reducing exposure to COVID-19 including appropriate engineering and work practice controls, decontamination and disinfection procedures, and use of personal and respiratory protective equipment; selection of PPE, its types, proper uses and limitations, location, donning and doffing, handling, cleaning, decontamination and disposal; proper use of respirators; what to do if an exposure incident occurs; and the facility’s surge plan.

In particular, PPE training should be provided to all employees who provide direct patient care (e.g., nurses, certified nursing assistants, respiratory therapists, behavioral health therapists, and imaging technologists) and others who might come in contact with patients or their environment (e.g., environmental services, dietary services, maintenance workers). This includes training on how to don and doff PPE, followed by an in-person competency check and one-on-one refresher trainings as needed and upon employee request.

Under no circumstances should nursing staff be relieved or covered by non-nursing staff. Unlicensed employees should not be required to perform duties that are the responsibility of licensed professionals (MDs, NPs, RNs, LVNs etc.) as they do not have the appropriate level of training.

Any employee assigned to the labor pool and assigned duties outside of their classification must receive adequate training, PPE and scrubs (see Section 4), if appropriate.

16. Disinfecting Equipment

Per the [CDC's recommendation](#), dedicated medical equipment should be used when caring for PUIs or confirmed COVID-19 patients. This should include portable radiographic equipment and other diagnostic equipment, to the extent possible.

All non-dedicated, non-disposable medical equipment used for care of PUIs or confirmed COVID-19 patients should be cleaned and disinfected in accordance with the CDC's standard practices for high-level disinfection and sterilization of semi-critical and critical medical devices, as described in the [CDC Guideline for Disinfection and Sterilization in Healthcare Facilities, \(2008\)](#).

17. Environmental Services - Infection Control, PPE, and Cleaning Products

We recommend the [CDC's guidelines](#) for infection-control procedures for the rooms of COVID-19 patients, with modifications for appropriate PPE. In addition, we recommend that these procedures be followed for PUIs as well as confirmed patients, and for the rooms of all patients (even if not under investigation or positive for COVID-19) who have undergone aerosol-generating procedures.

Daily cleaning (cleaning of rooms still occupied by patients): In general, only essential personnel should enter the rooms of patients with COVID-19. Healthcare facilities should consider assigning daily cleaning and disinfection of high-touch surfaces to nursing personnel who will already be in the room providing care to the patient. If this responsibility is assigned to environmental services (EVS) personnel, they should wear the same level of PPE that NUHW recommends for any staff member--that is, airborne, contact, and droplet precaution PPE, which must include an N95 respirator (or a respirator with higher protective qualities), gown, eye protection, and gloves. PPE should be doffed safely upon leaving the room, immediately followed by performance of hand hygiene. EVS personnel should be properly trained on safe donning and doffing procedures.

Terminal cleaning (cleaning of rooms following patient discharge): The amount of time before EVS workers should enter a room for terminal cleaning depends on the ventilation of that room, which affects the risk of airborne pathogens remaining in the air. We currently do not know how long SARS-CoV-2 remains infectious in the air. If hospitals are following [CDC guidelines](#), typical treatment rooms are ventilated at a minimum of 6 "air changes per hour" (ACH), which requires 69 minutes before 99.9% of pathogens are removed from the air, and workers can safely enter with appropriate PPE. The [CDC recommends](#) that airborne infection isolation rooms (AIIR), also referred to as negative pressure rooms, are ventilated at a minimum of 12 total air changes per hour, which requires 35 minutes of wait-time before 99.9% of pathogens are considered to be removed, and EVS workers can safely enter for terminal cleaning while equipped with appropriate PPE. [Cal/OSHA's ATD standard](#) cites the same CDC guidelines for time elapsed before personnel should enter the room.

If the ventilation specifications in a room are unknown, EVS staff are best protected against exposure by waiting 69 minutes before entering rooms for terminal cleaning. If a facility is unable to exhaust air in the manner described by the

CDC guidelines, appropriate engineering controls are described on [PDF page 16 of CalOSHA's California Workplace Guide to the ATD standard](#).

Appropriate PPE for EVS workers doing terminal cleaning (once the wait time has elapsed for sufficient ventilation) is a surgical mask, gown and gloves. Eye protection is needed if splashes or sprays during cleaning and disinfection activities are anticipated or otherwise required based on the selected cleaning products. Shoe covers are not recommended at this time for personnel caring for patients with COVID-19. (The [CDC recommends](#) all of the above-listed PPE except surgical masks, but NUHW recommends surgical masks as well.) Any staff entering the room *before* the appropriate wait time has elapsed should be wearing the maximum recommended PPE, including an N95 respirator, gown, eye protection, and gloves, as if the patient is in the room.

Note that the CDC's recommendations for terminal cleaning only applies to the rooms of confirmed COVID-19 patients. However, to best protect our members, NUHW extends this recommendation to the rooms of PUIs and any patient who has undergone an aerosol-generating procedure.

Communication with employees: Hospitals may be modifying engineering controls — like local exhaust ventilation — to minimize the spread of SARS-CoV-2. All workers, including EVS workers, should be made aware of any such changes, and be informed of whether the hospital is changing EVS protocols as a result. NUHW staff and members can consult the CDC's "[Air changes/hour \(ACH\) and time required for airborne-contaminant removal by efficiency](#)" table for the safe amount of wait time before EVS workers enter, depending on the ACH in a room.

Cleaning products: EVS workers should be equipped with [EPA-registered disinfectants](#) qualified for use against SARS-CoV-2 and should be properly trained on product use. The list contains over 200 products, and hospitals should follow the [California Department of Public Health recommendations](#) to select for asthma-safer products with the active ingredients hydrogen peroxide (without peroxyacetic acid), citric acid, lactic acid, ethyl alcohol, isopropyl alcohol, sodium bisulfate, or products authorized by the U.S. EPA's [Design for the Environment](#). Hospitals should avoid products that contain bleach (sodium hypochlorite), quaternary ammonium compounds (benzalkonium chlorides), peroxyacetic acid (peracetic acid), and glutaraldehyde. If non-EVS staff are assigned daily cleaning duties, they, too, must be properly trained.

Medical waste: Per [Cal/OSHA regulations](#), linen or laundry room workers should be provided with disposable gloves for the handling of contaminated laundry, and per NUHW recommendation, all employees should be provided with surgical masks. [CDC guidance](#) states that medical waste (including laundry and trash) that results from the treatment of PUIs or confirmed COVID-19 patients can be processed in accordance with routine procedures. However, the [CDC's Guidelines for Environmental Infection Control in Health-Care Facilities](#) also states that laundry originating in isolation areas should be segregated and handled with special practices. NUHW's recommendations, as detailed in Section 2, reflect the Cal/OSHA ATD standard, which calls for the treatment of SARS-CoV-2 as an airborne pathogen, which warrants the use of isolation rooms and all related practices. Therefore, NUHW recommends that linens from PUIs and COVID-19 patients be processed according to the hospital's procedures for handling contaminated laundry originating in isolation areas, as the CDC is not prescriptive about specific procedures.

18. Dietary Services

Dietary workers responsible for food preparation should wear a mask and gloves while handling and preparing food.

Dietary workers responsible for patient meal deliveries should not enter patient care areas. Instead, dietary workers should drop off meal tray carts outside patient care areas for medical staff to retrieve and bring into the hospital unit or patient care area and then deliver to patients.

Medical staff should also retrieve the meal trays from patient rooms upon completion of meals. (For PUIs and confirmed COVID-19 patients, meals should be provided using disposable meal trays, plates, cups and utensils which are then placed in appropriate garbage bags by medical staff.)

19. Radiology Services

The [CDC recommends](#) that all non-urgent outpatient procedures, including imaging and fluoroscopy, be rescheduled. Radiography and CT may be used to assess PUIs and COVID-19 patients. As stated earlier, to the extent possible, portable radiographic equipment should be dedicated for use with COVID-19 patients. If there is not enough equipment to do so, this equipment should be disinfected according to manufacturer's instructions after use with PUIs and COVID-19 patients.

According to guidance from [the American Society of Radiologic Technologists](#), examinations for all patients should be kept to a minimum, limited to only those essential for patient care. When performing chest radiographs on PUIs or COVID-19 patients, who may cough or breathe forcefully, staff should be wearing PPE to protect against airborne transmission (see Section 2 - PPE). This applies at the bedside and in the radiology department. Transporting patients should be kept to a minimum, and examination should be performed at the bedside whenever possible. If examinations must be conducted in the radiology department, radiologic technologists should follow all contact, droplet, and airborne precautions. Standard hand hygiene and recommended doffing of PPE should be performed after every patient encounter.

After use by a PUI or COVID-19 patient, radiology rooms and equipment should be disinfected by EVS or by properly trained radiology personnel, according to terminal cleaning standards, including the appropriate wait time before other staff or patients enter the room (see Section 18 - EVS).

20. Alternative Work Models

When it will not compromise patients' health, alternatives to in-person services should be implemented to decrease potential exposure for healthcare workers and patients. This includes the use of telehealth technology and rescheduling elective or non-urgent procedures if needed to decrease the strain on facilities confronting COVID-19 related demands. Care that's typically provided in patients' homes should be provided via telehealth whenever possible.

If it will not compromise patient care, all departments that can do so should convert to remote working from home. This includes call centers where employees provide telehealth services. It also includes medical social workers and mental health clinicians who attend to patients in emergency departments. Employees providing care remotely, whether telephonically, via video, or online classes, should not be required to physically report to work, and should work from home.

21. Recommendations for Mental Health Care Workers

Mental health care appointments, including consultations with patients in the emergency department (ED) or hospital, should be conducted over phone or video whenever possible. Clinicians who provide telehealth appointments or services should do so from home, and should not be required to come into healthcare facilities. If providers must provide in-person appointments or care, they should be afforded space that allows for adequate social distancing, furnished with a surgical mask and gloves for themselves and for the patient in order to limit the risk of exposure. Sanitizing supplies, including disinfecting wipes and hand sanitizer, should be readily available.

Mental health providers and social workers who work in hospital settings should be afforded the same access to PPE as NUHW recommends for all other hospital workers. If mental health workers must enter the ED or hospital, or otherwise care for PUIs or confirmed COVID-19 cases, they should be given full and appropriate PPE, and receive appropriate PPE training, per NUHW recommendations.

Non-hospital settings, like outpatient clinics and medical office buildings, which must remain open to receive a limited number of in-person patients on an emergency or walk-in basis, should maintain the minimum possible number of mental health care workers on-site in order to minimize exposure. Employers should work with NUHW to designate staff for these assignments. Social distancing measures should be in place at all times, including in waiting rooms, during consultations and during appointments. As at a hospital, patients must be screened at the entrance of the facility.

22. COVID-19 Related Communication from Employers

Management should provide regular communications, via email, physical postings, and team meetings (held in spaces large enough to accommodate social distancing) about any updates or changes to COVID-19 policies and precautions, as well as schedules or resources for PPE training, testing availability, surge capacity planning, and plans for designating COVID-19 wards or triage areas. Regular communication is key to protecting caregivers and patients.

All staff, including non-nursing staff such as EVS, dietary workers, imaging techs, and laboratory workers, must be notified in advance if they are going to come into contact with PUIs or confirmed COVID-19 patients. Appropriate PPE precautions must be communicated.

23. Non-Patient Care Areas

Suspend patient and visitor foot traffic into non-patient care areas, such as medical records and the cafeteria.

24. Presumptive Workplace Exposure for All COVID-19 Diagnoses

In light of widespread shortages of PPE, shortages of tests, restrictive testing criteria, transmission via contaminated workplace surfaces and equipment, and [asymptomatic transmission](#), any employee who tests positive for COVID-19 or who has a clinical diagnosis of COVID-19 based on symptoms should be presumed to have endured a workplace exposure.

25. Mental Health Services for All Healthcare Workers

Healthcare workers are on the frontlines of an unprecedented public health crisis that confronts them with intense pressure, stress, uncertainty, and, in many cases, trauma in the workplace. Many healthcare workers are also the primary caregiver of children or other relatives when they return home. Finally, healthcare workers are at high risk for COVID-19 infection, which can take both a physical and mental toll. In sum, the impact of this pandemic on healthcare workers is profound.

Employers must provide access to high-quality mental healthcare services to employees at no cost. All employees--regardless of job classification or healthcare setting--should be eligible and services should continue to be available into the future. The mental and physical wellbeing of healthcare workers must be the priority in every healthcare institution.

26. Whistleblower Protections and Healthcare Workers' Right to Object To and Refuse Assignments

This section provides information on the right of employees to object to and refuse assignments as well as file complaints with Cal/OSHA. NUHW members should consult with their NUHW representative and/or steward regarding complaints and/or objections to and refusals of assignments.

Employees maintain all rights under federal and state law as well as the collective bargaining agreement to complain about the safety of the workplace, to object to assignments, and to refuse to work under appropriate circumstances and to be free from retaliation for any such conduct. Among the legal protections for such conduct are:

Right to Object to Assignments: When an employee determines that a workplace assignment could compromise or risk the health and/or safety of themselves, their patients, or their coworkers, they have the right to object to the assignment. Employees can also object to assignments due to the following reasons:

1. Understaffing
2. Unsafe healthcare worker-to-patient ratio
3. Not oriented to unit
4. Did not receive adequate training for the assignment
5. The assignment could be done remotely but management will not allow
6. Lack of proper disinfection supplies

Employees will complete an Objection to Assignment (OTA) form to document that they are accepting an assignment under protest and only because they have been instructed to do so by their supervisor on pain of discipline. Employees will submit the OTA to their supervisor and their union representative as well as keep a copy for their own records.

Whistleblower Protections and the Right to File a Cal/OSHA Complaint: California Labor Code Section 1102.5 provides broad whistleblowing protections for employees. Under this statute, an employer may not retaliate against any whistleblowing employee who complains or supplies information about what they reasonably (whether ultimately found true or not) believe to be a violation of any federal or state law or any local, state or federal rule or regulation. A whistleblower is anyone who reports legal violations or supplies information to any government entity or to any management employee with “authority” over the employee or who has authority on behalf of management “to investigate, discover or correct” the problem.

In California, [employees can file a complaint about a workplace hazard with Cal/OSHA](#). The employee can choose to give their name which Cal/OSHA will keep confidential, unless the employee requests otherwise. Cal/OSHA will then conduct an investigation.

Additionally, violations of Labor Code section 1102.5 may be enforced by complaint to the California Labor Commissioner or through private civil suit.

Right to Refuse Hazardous Work: Whenever possible, employees should consult their NUHW representative and/or steward before refusing a work assignment. Although there are substantial legal protections for such refusal, and workers should never place themselves in danger, this is a serious step and can result in employee discipline. Ultimately, a government agency, court or labor arbitrator will decide if the decision was correct if the employer disputes it and takes disciplinary action. The employee may well be out of work for a substantial time before legal resolution.

[Cal/OSHA provides the following guidance to employees regarding refusing hazardous work:](#)

“It is illegal for your employer to punish you for refusing to perform hazardous work if both of the following are true:

1. Performing the work would violate a Cal/OSHA health or safety regulation.
2. The violation would create a ‘real and apparent hazard’ to you or your coworkers.

When these conditions are met, you have the right to refuse to perform the work. But before you refuse, you should take the following steps:

1. Tell your supervisor about the hazard and ask that it be corrected.
2. Explain that you are willing to continue working if the hazard is corrected or you are assigned other work that is safe.
3. State that you believe a health or safety regulation is being violated.
4. Contact your union shop steward, if you have one.
5. If the problem is not fixed, call Cal/OSHA and file a complaint.”

Protection Against Retaliation: [Per Cal/OSHA](#), “it is also illegal for your employer to threaten, discharge, demote, or suspend you for reporting hazards to your employer, filing a complaint with Cal/OSHA, or otherwise exercising your rights to a safe and healthful workplace. If your employer discriminates or retaliates against you for exercising these rights, you have the right to file a complaint with the California Labor Commissioner, also called the Division of Labor Standards Enforcement. The Labor Commissioner may be able to recover wages owed to you and help you get your job back. In most cases, you must file your complaint within six months of the retaliation.”

27. Housing for Healthcare Workers

Given the high rates of transmission between employees, lack of testing, and inadequate PPE supplies, employers should provide safe, high-quality nearby housing accommodations (e.g. hotels) for employees who choose not to return home to limit exposures to their family and community. Providing this option is particularly important given that many healthcare workers have family members who are in the high-risk category for severe illness (older age, underlying illness, etc.) Accommodations nearby to facilities should also be provided for healthcare workers to take rest breaks in the event of extended hours during a surge scenario. Costs for these accommodations as well as meal provision should be covered completely by the employer.