Electronic Testimonial Submission

No Reply - Cook County Health <WP-Notifications@cookcountyhealth.org>
Thu 4/23/2020 3:21 PM
To: Santana, Debbie <dsantana@cookcountyhhs.org>

Type of Message

Message

Message

I've been a registered nurse for 13 years, and have been an employee of CCHHS for almost 11. I've worked full time at Stroger's ER for over 8 years and part time at Provident's ER for the past 2.5.
I was appalled to learn of the closing of Provident's ER from it being mentioned in passing in a Crain's Chicago Business report on Dr Mason being fired.
Our union met with County Human Resources on Sunday April 5 and we pleaded with them to reconsider. Our union wasn't against remodeling, but there had to be a better way. We asked how this wasn't a violation of the Emergency Medical Treatment and Labor Act, which forbids the transferring out of unstable patients.
Management said they were worried about safety, because a staff person got Covid-19. Every hospital who treats Covid-19 patients has had staff catch the virus, and none of them have been shut down.
If the County is so concerned about safety, what about the almost 500 Covid-19 positive people at the Cook County jail?
What about the safety of the community? In my years there, many have been brought there needing immediate lifesaving medical intervention. An ER is not a fast food restaurant where you can turn the lights off and put up a closed sign when a mouse is found in the freezer.
This closing occurred on the same weekend when disproportionate deaths of African Americans by Covid-19 was reported on. Imagine the increased stress the community had to endure to be informed that some people are dying at a greater rate and their own ER is being shut down.
This would not have occurred at Illinois Masonic in Lincoln Park, Northwestern Memorial in Streeterville, or even U of C in Hyde Park. There already is a 14 year difference in life expectancy between Washington Park and Hyde Park, and that was before the pandemic. This community already needed more healthcare, not reductions. The life expectancy gap between Streeterville and Englewood is 30 years, these gaps should already have been a public health emergency.
I worked at the ER on the day it was reopened. I'm relieved that nothing tragic occurred during the two week closing. I'm grateful to the community organizations and nurses who publicly campaigned against the closing.
Regarding the upgrade, the walls got painted, it was cleaned, and the number of beds inside the ER was reduced from 16 to 10. My co-workers also heard there will be less nurses working in the ER for each shift. How will these reductions benefit the community?
To my knowledge, no frontline nurse or community member was consulted in the closing or the re-opening - the practice of doing things without discussion beforehand has to end immediately.
Moving forward, there needs to be a serious conversation with all the stakeholders and the responsible elected officials. This virus has put a spotlight on chronic medical inequities, and decisive urgent action must be taken. A date for such a meeting must be set up.

Name

Dennis Kosuth

MICU COVID UNIT

Myles, Denise <dmyles3@cookcountyhhs.org>

Wed 4/29/2020 6:30 AM

To: Santana, Debbie <dsantana@cookcountyhhs.org>
Cc: Daniel Ritter <dritter@nnoc.net>

My name is Denise Myles and I have been working in MICU since February 2011 on night shift as the Charge Nurse. The acuity of the patients in the unit is at the highest level I've seen in my career as a nurse. We are constantly assisting with intubation, patients on paralytics, sedated vasoactive therapy and patients who need to receive CRRT(which is dialysis provided by registered nurses in MICU). All of these procedures are complex labor intensive and dangerous if not performed by highly trained staff. The patients who are not intubated are afraid, anxious and restless with increasing respiratory rates and decreasing oxygen saturation's. Normal oxygen saturation is 90-100%. Covid patients oxygen saturation can decrease to 80's with respiratory rate ranging from high 40's to low 50's. When we try to reposition patients the oxygen saturation can decrease to the 50's. This is a stressful situation for nurses because we need to reposition and rotate patients to prevent pressure injuries and to promote excellent hygiene for our patients. Our intubated patients are receiving sedation and paralytics and require at least 2 to 3 staff members to provide care. Aside from our ordinary nursing duties registered nurses have assumed additional roles and are now functioning in roles of respiratory therapist, passing dietary trays and housekeepers. The nurses leave work each day physically and emotionally drained with the added non-nursing duties. The nurses deserve non-nursing duty pay during this pandemic.This pay will not help the workload but will help to increase morale of staff and keep RNS from seeking employment elsewhere during crisis.

I would like to keep the registered nurses free of Covid-19, I am asking the board to provide the nurses highest level of PPE. We need fresh N95 masks and respirators, face shields, hair covers, shoe covers and gowns that protect against viruses and are water resistant. Management has denied nurses hair covers and shoe covers. The isolation gowns which are currently being provided by management are not approved to protect against viruses per FDA and water soaks thru them when we bathe and care for our patients. We deserve better. Fulfil your obligation to us by keeping us safe. Our patients need to stay healthy.

Sincerely,
Denise Myles
Critical Care Nurse 2

TO WHOM IT MAY CONCERN:

Hello, my name is John Stewart and I am a nurse at Stroger Hospital. I work as a rapid response nurse, we assist patients around the hospital when critical care support is needed on the medical floors. In the past month or so we have seen a large increase in workload volume due to patients requiring increasing amounts of critical care outside of the intensive care unit. Due to the need for increasing amounts of oxygen associated with COVID-19, we as rapid response nurses partner with the patient's primary nurse to follow these patients very closely. We try to limit our contact to preserve PPE and minimize contamination but we recognize the current literature recommendations that frequent assessment is necessary in a deteriorating patient. We try to uphold the highest standards of care so we assess patients frequently and thoroughly as we try to prevent sentinel events such as "failure to rescue." Often, we have to follow these patients and assess them hourly or more frequently to see if they are improving or declining. We, as nurses, have a legal obligation for frequently assessing these patients and providing safety and security for their lives. We do not have the luxury of coming to the patient's room once a day as other professions do. We are required legally and morally as registered nurses to follow up and address patient needs throughout the duration of our shift. Our job is completed at the patient''s bedside, not from afar.

We have recently experienced a lack of support from respiratory therapists on medical floors due to increased amounts of ventilators in ICU. This is concerning especially since this is primarily a respiratory virus. This means more frequent nurse assessment. When a patient is required to go to ICU from the medical floor, we have had a lack of support from the patient transportation department. The wait times for the transportation department are simply too long for a patient who requires intensive care which means nurses are responsible for transporting these patients on our own. We always advocate for proper and timely patient care so we have assumed the extra workload for our patients. All of these things mean that we as nurses are being more exposed to COVID-19 than others in the hospital, we are experiencing an increase in workload while many other departments are easily able to pawn their work off on nurses. Another thing I have witnessed is individuals from other professions having nurses enter a COVID-19 patient's room to give them a phone so that the individual can speak to the patient from outside the room. We have had to take out the garbage because of lack of housekeeping.

We have adjusted to these added responsibilities seamlessly because we as registered nurses know our ultimate responsibility is not to our managers or the Cook County Board, our ultimate responsibility is to our patients. We have gone above and beyond our roles within the institution. We are asking for the implementation of additional pay to account for us taking on the additional workload associated with the current pandemic. We feel we are worth the additional pay because we have repeatedly assumed extra responsibilities to help our patients throughout this pandemic and are the only hospital without additional hazard pay within the medical district.

Respectfully,

John Stewart

My name is Martha Foy and I work as a Clinical Nurse I in Stroger Hospital on 7 South. After I was diagnosed with COVID-19, I am able to share with you, 1st hand, the fear one experiences and the painful symptoms such as chest pains and the struggle to breath. I work on the chemotherapy unit, and my concern for immunocompromised patients has grown tremendously. Management has chosen to ignore the importance of contact tracing which has placed our patients, our families, and our colleagues at risk of contracting and spreading the virus. I was exposed to the virus by my coworker who tested positive for COVID-19. Management never told me that I was working in close proximity with someone who had tested positive for COVID-19, so I continued to work with patients with immune systems that have limited ability to fend off the virus. The CDC has stated that the virus can be transmitted by someone who is asymptomatic and I was possibly shedding the virus and exposing my patients. I should have been quarantined and tested until we were sure that I was not putting anyone risk, but that is not management's policy. My colleague, not management, informed me that they had tested positive. I was asymptomatic at the time, so management's policy is to not test exposed employees. To protect my patients and family I went to the Illinois Department of Public Health to receive a test. I received the call from IDPH on 3/29 that I tested positive for COVID-19. For management to continue to place vulnerable patients at risk goes against everything a healthcare provider stands for. Their stance that they do not need to contact trace is simply wrong. About 1 week ago I received a follow up call from IDPH and was told that contact tracing is necessary and does not violate HIPPA.

The only way to protect our immunocompromised patients and those patients with underlying health issues is to make it a requirement to wear the proper PPE prior to entering the rooms of the least vulnerable. *Management has a responsibility to not only protect their employees but to protect the patients who have placed their trust in the hospital they have chosen to be treated at*. To provide them with anything less is an injustice and is morally and ethically wrong. Although we are not actually accepting COVID-19 patients to the Chemotherapy Unit, we have had patients who have been sent to us that were not suspect to have COVID-19 but later turned out to have symptoms, these are our silent carriers. When symptoms do surface, or an x-ray shows the possibility of the patient having the virus, anyone having worked on this patient is now exposed and has exposed our least vulnerable such as the chemotherapy patients that are immunocompromised. Two nurses on the chemotherapy unit, including myself, tested positive for COVID-19 and others on the same unit have experienced symptoms and have not been tested. One of our Nurses unknowingly brought it home and their elderly family member ended up in ICU with the virus. Does an immunocompromised patient need to pass away from complications brought on by the virus before management steps up and protects these patients from harm? I've been told by management that "you will not carry the virus on your shoe or hair, it's a respiratory virus," management either does not have a clear understanding of the severity of the virus and how it's spread or they are just turning a blind eye and risking the lives of their employees and our patients. I ask that protecting our nurses and patients become a priority before more lives are affected or lost because of the virus.

Sincerely,

Martha Foy
Clinical Nurse I

Mildred Austin

Pediatric Emergency Registered Nurse
John H. Stroger, Jr. Hospital
04/29/2020

CCH Board
John H. Stroger, Jr. Hospital
1969 Ogden Avenue
Chicago, IL 60612

Dear Union Representative:

I am writing this letter to highlight concerns regarding the unsafe environment that pose risks to the nurses and other healthcare workers in the John H. Stroger, Jr. emergency department (ED). The current layout and process in which COVID-19 patients are placed in the ED has become increasingly hazardous. Patients that are under investigation and who have tested positive for the virus have been placed in the resuscitation area, rooms 15-18. These patients are intermingled with patients that are not under investigation or who have not tested positive for the virus. Also, these rooms are separated by curtains.

Infection control protocols state that patients with a possible or known communicable disease be placed in isolation rooms that are clearly marked with signs that are visible to alert others not to enter without proper infection control practices. If this area is going to be used for COVID-19 patients, they should be co-horted and the doors remain closed at all times until you enter or leave the area.

Other areas of concern include the pediatric ED area, rooms 19-22. Pediatric patients are being exposed to COVID-19 on the Green team. When they are stabilized, they are then transported back to the pediatric ED 19-22 where they will likely expose the patients in that area.

Patients that test positive for the virus or who are under investigation are placed in designated rooms. These rooms have doors and may have ventilation systems in place to prevent the spread of the virus in the department. If a patient placed in these rooms tests positive for the virus, they are not immediately moved to the COVID-19 unit on the nursing floors until a bed is available, hence exposing the ED to the virus even further.

The ED has the second highest rates of positive COVID tests amongst the nursing staff. This is not a safe setting for anyone that works in this department. If you have a high percentage of nurses that have tested positive, the inappropriate placement of these patients, the continual exposure to other patients and staff members, and the inability to transfer COVID-19 positive patients to designated nursing units in a timely manner, this ED will become a petri dish that continues to harbor the virus and increase rates of transmission.

Mail - Santana, Debbie - Outlook

Thank you for taking the time to read this letter of concern. This issue needs to be addressed immediately so that more nurses and staff members do not risk exposure to this harmful virus and possibly spread it to others.

Mildred Austin

Testimony for Cook County Health Board Meeting, April 30, 2020

Good morning Directors, Chairman, and thank you for the opportunity to provide testimony.

My name is Marti Smith and I serve as the Midwest Director for National Nurses Organizing Committee. I represent the more than 1300 Registered Nurses who care for the patients and detainees here at Cook County Health.

The COVID-19 pandemic is exposing the cracks in our society in many ways – many of them healthy. We are now having substantive discussions about the erosions in our social safety net and the abysmal care we have provided to our elderly, and those are very necessary conversations to have.

However, during a time when we have the greatest shared interests; a long-term nursing shortage, coupled with a dire and immediate need for more nursing resources, CCH has chosen to treat its nurses with reckless disregard.

Throughout this pandemic, NNOC has been engaged at every level of government about provision of appropriate protections for healthcare workers. Because the SARS-CoV-2 virus is novel, or previously unknown to us, much is unknown about it, about the disease it causes, and much is unknown about the long-term sequelae of infections.

At CCH, we have met with every level of management, including senior administration and elected officials about inadequate protections, including PPE, provided to nurses and healthcare workers. At the same time, we have nurses and healthcare workers getting sick at work. We track these infections at every single facility we represent.

Stroger Hospital has the second highest number of RN COVID infections in our union.

We represent more than 150,000 Registered Nurses across the United States.

The only facilities with more infections at this point is the entire New York Harbor VA System.

Cook County Health has squarely placed its infection prevention protocols in the hands of the CDC, which on the face of it, sounds good. There are three issues with this – first, the CDC is in the hands of a Trump appointee in the same way the EPA is, and in the EPA, science doesn't exist. In the new CDC, bandanas and scarves will serve as protection for nurses when masks run out. Nurses have all taken microbiology and epidemiology. We all know that is not based on science, and we are being asked to place our lives in the hands of an agency that is making recommendations based on scarcity.

Second, the CDC guidance should serve as a MINIMUM level of precautions. There is absolutely nothing that would prevent CCH from taking greater precautions based on peer-reviewed

scientific evidence. Evidence that we have provided to Cook County Health, and that we are attaching to this testimony for your review.

Third, our objective outbreak numbers indicate you have a problem with the number of infections in your facilities. You should be taking a very hard look at Cermak and at Stroger, where both staff and patients are literally dying from COVID that was transmitted within your walls.

Please – if you want nurses to ever apply to work here again. If you want to work collaboratively with your labor partners. If you would like to put a stop to the deaths among your own staff, please, provide virus impermeable coveralls that cover all exposed skin.

Provide hair covers and shoe covers. Provide N95 masks for all nurses caring for COVID patients and patients suspected of having COVID. You have these items in your stores. If you need more, we will work with you to find them.

Thank you.

ATTACHMENTS

Journal of Infectious Disease, published April 16, 2020

Airborne or Droplet Precautions for Health Workers Treating Coronavirus Disease 2019?

https://academic.oup.com/jid/advance-article/doi/10.1093/infdis/jiaa189/5820886

Cases of coronavirus disease 2019 (COVID-19) have been reported in more than 200 countries. Thousands of health workers have been infected, and outbreaks have occurred in hospitals, aged care facilities, and prisons. The World Health Organization (WHO) has issued guidelines for contact and droplet precautions for healthcare workers caring for suspected COVID-19 patients, whereas the US Centers for Disease Control and Prevention (CDC) has initially recommended airborne precautions. The 1- to 2-meter (≈3–6 feet) rule of spatial separation is central to droplet precautions and assumes that large droplets do not travel further than 2 meters (≈6 feet). We aimed to review the evidence for horizontal distance traveled by droplets and the guidelines issued by the WHO, CDC, and European Centre for Disease Prevention and Control on respiratory protection for COVID-19. We found that the evidence base for current guidelines is sparse, and the available data do not support the 1- to 2-meter (≈3–6 feet) rule of spatial separation. Of 10 studies on horizontal droplet distance, 8 showed droplets travel more than 2 meters (≈6 feet), in some cases up to 8 meters (≈26 feet). Several studies of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) support aerosol transmission, and 1 study documented virus at a distance of 4 meters (≈13 feet) from the patient. Moreover, evidence suggests that infections cannot neatly be separated into the dichotomy of droplet versus airborne transmission routes. Available studies also show that SARS-CoV-2 can be detected in the air, and remain viable 3 hours after aerosolization. The weight of combined evidence supports airborne precautions for the occupational health and safety of health workers treating patients with COVID-19.

Journal of the American Medical Association, published this week:

Exposure to a Surrogate Measure of Contamination From Simulated Patients by Emergency Department Personnel Wearing Personal Protective Equipment

- Experienced healthcare workers performed care tasks commonly required by patients with COVID (e.g., airway management and ventilatory support) in a simulation. A non-visible fluorescent compound was used as a marker of contamination- applied surfaces and secretion areas on the manikin-patient.
- Healthcare workers wore N95 respirators, eye protection, isolation gowns, and gloves.
- 7 of 8 participants had fluorescent markers (contamination) on their exposed skin, primarily neck.
- All participants had fluorescent markers (contamination) in their hair.
- Half had fluorescent markers (contamination) on their shoes.

"Despite personal protective equipment, fluorescent markers were found on the uncovered skin, hair, and shoes of participants after simulations of emergency department management of patients experiencing respiratory distress. The findings suggest that the current recommendations for personal protective equipment may not fully prevent exposures in emergency department settings. Clothing that covers all skin may further diminish exposure risk."

https://jamanetwork.com/journals/jama/fullarticle/2765377

Updated 4/20/20

Airborne Precautions Must be Maintained for COVID-19 to Protect Nurses and Other Healthcare Workers and to Prevent Spread in our Communities

Much is still unknown about COVID-19 and the virus that causes it, SARS-CoV-2. **In emerging infectious disease events like COVID-19, it is of the utmost importance that healthcare employers and public health agencies follow the precautionary principle**—we cannot wait until we know for certain that something is harmful before action is taken to protect people's health. Further, evidence is emerging that airborne transmission is a significant consideration for SARS-CoV-2/COVID-19.

Healthcare employers must implement the fullest protections, including isolating both possible and confirmed COVID-19 cases in negative pressure rooms, providing protective PPE, and providing safe staffing, in order to ensure that healthcare workers maintain their right to a safe and healthy workplace and to prevent the continued spread of SARS-CoV-2.

While much is still unknown regarding SARS-CoV-2, the available evidence indicates the need to maintain airborne precautions:

For airborne transmission to occur, three criteria must be met: (1) virus must be emitted by infected persons, (2) virus must be able to survive and travel through environment, (3) receptor must be susceptible.

1. **SARS-CoV-2 is emitted by infected persons via exhalation, coughs, and sneezes.**

   a. **Human exhalations, sneezes, and coughs create a wide range of sizes of droplets, including very small particles that may remain airborne or travel through the air.**[i]

   b. **An article published in JAMA reported on what is known about disease transmission via respiratory "droplets."**[ii]**Pathogen-carrying gas clouds are emitted when people breath, cough, and sneeze and can travel up to 23-27 feet.**

   Droplet transmission was originally defined in 1897, large and small droplets defined in 1930s. This model of infectious disease transmission has not been updated since. And yet, the CDC and WHO maintain use of this paradigm despite more recent research.

   More recent research over the past few decades performed with instrumentation that better measures particle sizes and movement has determined that human exhalations, coughs, and sneezes (the things that supposedly create large droplets under old model) are actually made of multiphase turbulent gas clouds (a puff) that entrains ambient air and traps and carries clusters of particles of a wide range of sizes.

   This includes viral particles in people who are sick.

   c. **Patients with SARS-CoV-2 emit virus when they breath, sneeze, and cough.**

   - One study examined viral loads and isolates for patients hospitalized with COVID-19. The majority of patients in this study presented with upper respiratory tract symptoms. Viral loads from upper respiratory tract samples were extremely high (more than 1000 times higher than SARS). Live virus was isolated from upper respiratory tract tissues.[iii]

     Michael Osterholm, PhD, MPH, director of the Center for Infectious Disease Research and Policy at the University of Minnesota, said, "The findings [of this study] confirm that COVID-19 is spread simply through breathing, even without coughing… They also challenge the idea that contact with contaminated surfaces is a primary means of spread," (emphasis added).[iv]

   i. **One study examined viral presence and load in the exhaled breath of patients with lab-confirmed influenza, seasonal coronaviruses, or rhinovirus. They found viral presence in exhaled breath, even without**

cough, for all types of viruses in both droplet (>5 micron) and aerosol (<5 micron particles).[v]

2. **SARS-CoV-2 remains viable when suspended in the air and can travel through the air.**
   a. Doremalen et al. reported that SARS-CoV-2 remained viable in aerosols throughout the duration of their experiment- three hours.[vi]

   b. Fears et al. reported that SARS-CoV-2 remained infectious after 16 hours suspended in aerosols. They reported, "Collectively, this preliminary dataset on the aerosol efficiency and persistence of SARS-CoV-2 suggest that this virus is remarkably resilient in aerosol form, even when aged for over 12 hours, and reinforces the conclusions reached in earlier studies of aerosol fitness by others."[vii]

   c. Several studies have sampled the air in rooms where patients with COVID-19 are placed. They have found SARS-CoV-2 in the air samples:

      i. One study measure air samples in rooms where patients with COVID-19 were cared for in a hospital in China. Several air samples were positive for the virus. Air outlets were also positive for the virus.[viii]
      ii. Another examined air samples in isolation rooms of patients with COVID-19 in Singapore. Air sampling of two COVID-19 patients (both day 5 of symptoms) detected SARS-CoV-2 PCR positive particles of sizes >4 µm and 1-4 µm. In a single subject at day 9 of symptoms, no SARS-CoV-2 PCR-positive particles were detected.[ix]
      iii. Another study looked at the presence of virus in air samples taken in patient rooms in a hospital in Nebraska where patients with SARS-CoV-2 were isolated. They found that SARS-CoV-2 was found in a majority of air samples taken at greater than 6 ft from patient. SARS-CoV-2 was found in a majority of hallway air samples. SARS-CoV-2 was found in the air samplers worn by sampling personnel even when the patients did not cough.[x]

3. **Nurses and other healthcare workers are left vulnerable when they are not provided PPE that they need. Airborne precautions have prevented healthcare workers infections in other countries.**
   a. Hong Kong has more effectively contained the outbreak of COVID-19 than many other countries. One study reports a description of infection control measures adopted during response to COVID-19 in Hong Kong. 42 of 1275 patients evaluated were identified as having COVID-19 in first 42 days of the outbreak. 11 of 413 (2.7%) healthcare workers caring for these patients had unprotected exposure requiring a 14-day quarantine. No healthcare workers were infected, no nosocomial transmission observed. Environmental surveillance of viral particles conducted- in breathing zone of patient, wipe samples from surfaces in patient rooms.[xi] Infection control measures implemented include:
      i. 36 patients immediately isolated upon admission in AIIRs, 6 in non-AIIR
      ii. **Standard, contact, droplets, and airborne precautions for suspected or confirmed cases**

iii. Stepped up use of PPE during aerosol generating procedures
iv. Surgical masks worn by all HCWs, patients, and visitors in clinical areas implemented since day 5
v. Promotion of hand hygiene by HCWs and patients

b. Another study examined the infection rate in two groups of departments.[xii] Three departments were in the "mask group" because they utilized N95 respirators and also frequently performed hand hygiene (respiratory, ICU, and Infectious Disease). Three departments were in the "non-mask group" because early in the outbreak they hadn't implemented precautions- staff did not wear masks and disinfected and cleaned hands "occasionally."
   i. "Mask group" reported statistically significantly fewer infections than the "non-mask group." None out of 278 staff in "mask group" infected compared to 10 out of 213 staff in "no mask group" were infected.
   ii. Found similar results in two other hospitals- staff wearing N95s and frequently conducting hand hygiene were not infected.

c. A third study reported on healthcare worker protections implemented in China during three phases.[xiii]
   i. First stage- this was an unknown disease and healthcare workers were not protected. At this time, the infection rate ranged from 3.5% to 29% among healthcare workers in different hospitals in the epicenter of Wuhan according to previous reports, when the initial source of the novel coronavirus still remained unknown.
   ii. Second stage- inadequate protection for healthcare workers due to supply shortages. During this period of time, the number of confirmed cases in China was still increasing rapidly. By February 11, 2020, a total of 1,716 health care workers were confirmed with COVID-19, including five deaths.
   iii. Third stage- disease severity acknowledged and full protection of healthcare workers. "The highest level of precaution, so called "full precaution," is mandatory for high-risk exposure, a disposable surgical cap, test-fit N95 masks or respirators, gloves, goggles or face shield, gown and fluid-resistant shoe covers. We would like to point out that the key element of full precaution is the complete coverage of the head and facial skin…" No healthcare worker infections reported in this third period.

Additional considerations that underline the need for airborne precautions for healthcare workers caring for patients with SARS-CoV-2:

- It has been well-established that SARS-CoV-2 virus occurs in high levels in patients' feces.[xiv],[xv],[xvi],[xvii]It has also been well-established in the scientific literature that toilet flushes aerosolize fecal material, even after two or more flushes.[xviii] Nurses and other healthcare workers may frequently be required to flush patient waste (e.g., from bedpans or bedside commodes) or may otherwise be exposed via aerosols created when patients flush toilets.

A 2011 literature review observes:
"It may be concluded from the peer-reviewed studies discussed above that flush toilets of various designs spanning at least 50 years of production in Europe and the U.S. have been shown to produce substantial quantities of aerosol, that these aerosols are capable of entraining microorganisms at least as large as bacteria, that such bioaerosols will be produced during multiple flushes after toilet contamination, that sufficiently small microbe-laden droplets will evaporate to form droplet nuclei bioaerosols the size of which can be consistent with that associated with respirable penetration, and that these droplet nuclei bioaerosols may remain viable in the air for extended periods and travel with air currents."

- Given the clinical progression of COVID-19, aerosol-generating procedures may need to be performed at any time during patient care. Nurses and other healthcare workers must be appropriately protected.
    - Reports of the clinical progression of COVID-19 indicates that aerosol-generating procedures may need to be performed <u>at any time</u> as patients become more ill. For example, a report of clinical outcomes for 52 critically ill patients with COVID-19 observed that a high proportion of patients required high flow nasal cannula (63.5%) or mechanical ventilation (71%), both aerosol-generating procedures.[xix] This underlines the importance and necessity of ensuring that nurses and other healthcare workers are protected at all times, or that airborne and contact precautions are always observed.

The SARS Commission Report should serve as a cautionary and instructive tale for the current SARS-CoV-2/COVID-19 outbreak.

- Many features of the response current SARS-CoV-2 outbreak are reminiscent of the SARS outbreak response in 2003. The SARS Commission's Final Report is a detailed account of what happened that very clearly underlines the need to apply the precautionary principle in these kinds of situations and to protect nurses and other healthcare workers from exposure.
- In particular, we draw your attention to the chapter titled "A Tale of Two Cities," which compares the success of British Columbia in preventing a SARS outbreak to the wide spread of SARS in Ontario.[xx] From the SARS Commission Final Report:

British Columbia: *"There was no further spread. A combination of a robust worker safety and infection control culture at Vancouver General, with better systemic preparedness, ensured that B.C. was spared the devastation that befell Ontario." (*4)

British Columbia's success was described as resulting from the following:

*"We always start with the highest level of precaution…We don't use droplet precautions in our hospital, never have, because we've always believed that droplets have been aerosolized so we only have one category, that's airborne, and you always start with the highest level of precaution and then as the clinical situation becomes clearer, you step back on your precautions…" (*254)

The report's authors noted:

"Some of the same Ontario hospital leaders who argued against the N95 respirator required to protect nurses and who actually denied there was a safety law that required the N95 to be

fit tested still insist that science, as it evolves from day to day, comes before safety. ***If the Commission has one single take-home message it is the precautionary principle that safety comes first, that reasonable efforts to reduce risk need not await scientific proof.*** *Ontario needs to enshrine this principle and to enforce it throughout our entire health system."* (13)
"*What we do need is a common-sense approach to worker safety in hospitals coupled with a measure of scientific humility in light of the terrible and sometimes fatal failures in scientific advice and hospital safety systems during the SARS outbreak… It is better to be safe than sorry."* (1047)

---

[i] Respiratory symptoms such as coughing and sneezing create a wide range of particle sizes. Particles can also be created by breathing and talking. The fate of these particles is complex and dependent on many factors, including liquid in the particle evaporating and shrinking particles to 50% of their original size within a second of release, some particles impact onto surfaces, some particles remain suspended in air for long periods of time, some particles are dispersed by air currents, other particles settle on surfaces due to gravity. Inhalation of aerosols can occur near the point of generation and further from the point of generation (after aerosols have diffused). There are no hard and fast rules for safe distances.
Jones, R.M. and L.M. Brosseau, *Aerosol transmission of infectious disease.* Journal of Occupational and Environmental Medicine, 2015. **57**(5): p. 501-8.
[ii] Bourouiba, Lydia, "Turbulent Gas Clouds and Respiratory Pathogen Emissions: Potential Implications for Reducing Transmission of COVID-19," JAMA, March 26, 2020, https://jamanetwork.com/journals/jama/fullarticle/2763852.
[iii] Wolfel, Roman, et al. (March 8, 2020), "Clinical presentation and virological assessment of hospitalized cases of coronavirus disease 2019 in a travel-associated transmission cluster," medRxiv, published online at https://www.medrxiv.org/content/10.1101/2020.03.05.20030502v1.
[iv] Van Beusekom, Mary, (March 9, 2020), "Study highlights ease of spread of COVID-19 viruses," *CIDRAP*, published online at http://www.cidrap.umn.edu/news-perspective/2020/03/study-highlights-ease-spread-covid-19-viruses.
[v] Leung, Nancy H. L. et al. " Respiratory virus shedding in exhaled breath and efficacy of face masks," Nature Medicine, April 3, 2020, https://www.nature.com/articles/s41591-020-0843-2
[vi] Doremalen et al., "Aerosol and Surface Stability of SARS-CoV-2 as Compared with SARS-CoV-1," NEJM, April 16, 2020,https://www.nejm.org/doi/full/10.1056/NEJMc2004973.
[vii] Fears, Alyssa C. et al. "Comparative dynamic aerosol efficiencies of three emergent coronaviruses and the unusual persistence of SARS-CoV-2 in aerosol suspensions," medxRiv, April 18, 2020, https://www.medrxiv.org/content/10.1101/2020.04.13.20063784v1.
[viii] Guo, Zhen-Dong et al., "Aerosol and Surface Distribution of Severe Acute Respiratory Syndrome Coronavirus 2 in Hospital Wards, Wuhan, China, 2020," Emerging Infectious Diseases, April 10, https://wwwnc.cdc.gov/eid/article/26/7/20-0885_article.
[ix] Chia, Po Ying et al. " Detection of Air and Surface Contamination by Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) in Hospital Rooms of Infected Patients" medRxiv April 9, 2020, https://www.medrxiv.org/content/10.1101/2020.03.29.20046557v1.full.pdf
[x] Santarpia, Joshua L et al., "Transmission Potential of SARS-CoV-2 in Viral Shedding Observed at the University of Nebraska Medical Center," medRxiv (pre-print), March 26, 2020, https://www.medrxiv.org/content/10.1101/2020.03.23.20039446v2.
[xi] Cheng, C.C. et al., (March 5, 2020), "Escalating infection control response to the rapidly evolving epidemiology of the Coronavirus disease 2019 (COVID-19) due to SARS-CoV-2 in Hong Kong." Infection Control and Hospital Epidemiology, March 2020, p 1-24https://www.cambridge.org/core/journals/infection-control-and-hospital-epidemiology/article/escalating-infection-control-response-to-the-rapidly-evolving-epidemiology-of-the-coronavirus-disease-2019-covid19-due-to-sarscov2-in-hong-kong/52513ACC56587859F9C601DC747EB6EC
[xii] Wang, Xinghuan et al. "Association between 2019-nCoV transmission and N95 respirator use" J Hospital Infection, March 3, 2020, https://www.journalofhospitalinfection.com/article/S0195-6701(20)30097-9/fulltext

[xiii] Chen, Weiyun et al " To Protect Healthcare Workers Better, To Save More Lives," Anesthesia & Analgesia, March 30, 2020, https://journals.lww.com/anesthesia-analgesia/Abstract/publishahead/To_Protect_Healthcare_Workers_BetterTo_Save_More95724.aspx.
[xiv] Viral RNA found in stool samples. Pan, Yang, et al. (Feb 24, 2020). "Viral load of SARS-CoV-2 in clinical samples." The Lancet, published online, https://www.thelancet.com/journals/laninf/article/PIIS1473-3099(20)30113-4/fulltext.
[xv] Zhang, Wei, et al. (Feb 4, 2020). "Molecular and serological investigation of 2019-nCoV infected patients: implication of multiple shedding routes." J Emerging Microbes & Infections, 9(1), https://www.tandfonline.com/doi/full/10.1080/22221751.2020.1729071#.Xk0snlo7ZWY.twitter.
[xvi] Gu, Jinyang et al. "COVID-19: Gastrointestinal manifestations and potential fecal-oral transmission," *Gastroenterology*, Article in Press, https://www.gastrojournal.org/article/S0016-5085(20)30281-X/fulltext
[xvii] Xiao, Fei et al. "Evidence for gastrointestinal infection of SARS-CoV-2," *Gastroenterology*, Article in Press,https://www.gastrojournal.org/article/S0016-5085(20)30282-1/fulltext
[xviii] Johnson, David L. et al. (2011), "Toilet Plume Aerosol Occupational Hazards to Healthcare Facility Workers: A Review of the Literature with Suggestions for Future Research," available online at https://www.semanticscholar.org/paper/Toilet-Plume-Aerosol-Occupational-Hazards-to-%3A-A-of-Johnson/d669435d4d06ef10d4c183c22ce6d7965d2c4cc5#citing-papers.
[xix] Yang, Xiaobo et al. (Feb 24, 2020), "Clinical course and outcomes of critically ill patients with SARS-CoV-2 pneumonia in Wuhan, China: a single-centered, retrospective, observational study." The Lancet Respiratory Medicine, published online,https://www.thelancet.com/journals/lanres/article/PIIS2213-2600(20)30079-5/fulltext.
[xx] Campbell, Archie, The Honourable Mr. Justice (Dec 2006), "The SARS Commission Final Report," online athttp://www.archives.gov.on.ca/en/e_records/sars/report/.

Santana, Debbie

From: Dian Palmer <DPalmer328@msn.com>
Sent: Thursday, April 30, 2020 7:41 AM
To: Santana, Debbie
Cc: Larry Alcoff; dpalmer@seiu73.org; Trumaine Reeves; Tyson Roan
Subject: Re: Address the Board

Dear CCH Board,

Thank you for taking the time to read this letter on behalf of the SEIU Local 73 CCH members.

We have attempted to negotiate with the Bureau of Human Resources (BHR) regarding three (3) important issues concerning our members The issues are as indicated below:

1. Hazard Pay for the tremendously dangerous work that our members do everyday.

We attempted to negotiate with the chief negotiator from BHR Orlando Brown. Mr Brown stated that our members signed up for this work and for the inherent dangers that came with the job and they were compensated accordingly.

I disagree. Who signs up for a pandemic that comes along every 100 or more years. Who signs up and commits not only their own lives but the lives of their spouses, children, parents and their unborn. And in their last hour on earth they have to go it alone. With no one to hold their hand or whisper a prayer.

All that we ask is for a little appreciation. But, we were met with a resounding no.

2. Additional 80 hours of sick time and expanded FMLA for Covid-19 caused absences.

Cook County has afforded every other Employee these temporary benefits other than CCH employees.

We ask only for the same consideration for CCH front line workers. No more no less.

3. Expand the criteria for universal testing of all CCH employees.

We believe a baseline of testing will allow the city, county and state a better opportunity to assess the health of our communities and flatten the curve. It allows us to make better decisions to protect workers, their families and their patients. But CCH, after telling us that it has more than adequate capacity to do the testing and process the results in its lab, stated that they were not prepared to agree to test every worker whether showing symptoms or asymptomatic.

After 2 and 1/2 hours of discussions Mr. Brown unilaterally declared an impasse.

I ask for your assistance in these terribly upsetting and destructive times. Our members are doing the best they can under the circumstances. They are afraid not only for them selves, but also for their families and the lives they are entrusted to care for.

We are asking you to stand with our members, your employees to provide them with the support and safety they need to provide the care and service for their patients

One word from you would make all the difference.

Sincerely

Dian Palmer
President
SEIU LOCAL 73

Please acknowledge the receipt of my letter.

Sent from my iPhone

On Apr 29, 2020, at 6:50 PM, Santana, Debbie <dsantana@cookcountyhhs.org> wrote:

Dear Dian -

Because the meeting will be held remotely, only testimony submitted electronically before the meeting will be read by staff at the meeting. You can submit it directly to me anytime before 8:30 tomorrow morning. I'm attaching the meeting notice that provides the information on that subject for your reference.

Please let me know if you have any other questions.

Thanks,
Deb Santana

Deborah Santana
CCHHS Secretary to the Board
1950 W. Polk Street, Room 9106
Chicago, Illinois 60612
312/864-0907
dsantana@cookcountyhhs.org

http://www.cookcountyhealth.org

COOK COUNTY
HEALTH

From: Dian Palmer <dpalmer328@msn.com>
Sent: Wednesday, April 29, 2020 6:37 PM
To: Santana, Debbie <dsantana@cookcountyhhs.org>

My name is Genevieve Lewis and I am an RN working in the Neonatal Intensive Care Unit.

Our nurses are doing a job that carries a risk to our lives, our families and our community. The hospital should, at least, provide us with proper protection and they are not doing this. Several of our Neonatal nurses including myself were bullied and intimidated by management to remove our level 4 coveralls, which do confer protection from viruses.

We had to invoke our union rights, and refuse to remove our coveralls, when working with suspected Covid-19 patients.
We are a public safety net hospital. We should take the lead in stopping and controlling Coronavirus. Instead, our hospital administrators are being negligent and irresponsible. We shouldn't have to fight management and the virus. Management must stop harassing RNs who are simply trying to protect themselves and their families from this virus.

We have attempted to follow the chain of command and our contract to solve this issue. We have filed grievances on this matter and unfortunately our workplace safety grievance hearing has been delayed for weeks because management has been unprepared to address our concerns, Managements keeps asking for additional dates which tells me and the RNs I work with that our health and safety is not the priority. With each passing day, RNs lives are put at risk. Stop the delays and give us the PPE that actually stops viruses and allows us to do our jobs.

Sincerely,

Genevieve Lewis
Clinical Nurse I