



Professional Distinction

Personal Dignity

Patient Advocacy

May 2, 2020

Commissioner Jan Malcolm
Minnesota Department of Health
625 Robert Street N.
Saint Paul, MN 55164

via email only: jan.malcolm@state.mn.us

Dear Commissioner Malcolm:

As the union representing 22,000 nurses in the upper Midwest, MNA recognizes that resuming some healthcare procedures in the midst of a pandemic is a balance between ensuring that patients get the care they've been waiting for with the safety of those patients and the workers who care for them. We want to be able to increase the availability of care to those who seek it and we want to allow nurses and others who have been furloughed to return to meaningful work and ease their worries about how they will provide for their families.

Policy makers must be mindful, as nurses are, about the risks of ramping up elective surgery without being fully prepared. To resume elective surgery, there must be assurances that those patients and the workers caring for them will be safe.

- Prevalence of COVID-19 cases: there must be a sustained reduction in the rate of new COVID-19 cases in the relevant geographic area for at least 14 days before resuming elective procedures.
- PPE and supplies: There must be adequate supplies of Personal Protective Equipment (PPE) to meet pre-crisis CDC standards, medications, blood and bed capacity for planned inpatient surgery as well as outpatient surgery which requires an inpatient stay (which may be an observation status) due to patient's not meeting discharge criteria.
- Staffing: healthcare facilities must have enough trained and qualified staff to safely care for elective surgery as well as COVID-19 patients, taking into account the increased need for breaks and time off to address worker exhaustion.
- Standards of care: health systems must prove they can safely care for elective surgery patients and COVID-19 patients without resorting to a crisis standard of care.

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- Screening and Testing: every employee, patient, visitor and vendor must be tested for fever and COVID-19-like symptoms; to reduce transmission of the virus by asymptomatic or pre-symptomatic people, every patient must be presumed to be a possible COVID-19 case and workers must take appropriate precautions
- Infection prevention: confirmed and presumptive COVID-19 patients and the workers caring for them must be kept separate from other patients and workers.
- Case identification: if a healthcare worker is exposed, they must be informed and placed on paid quarantine immediately for a minimum of 14 days, whether they exhibit symptoms or not.
- Oversight: front line healthcare staff must have a part in decision-making. Healthcare workers need a direct line to the Health Department to report concerns if healthcare facilities cannot meet these minimum criteria. Hospitals must report PPE levels daily to the state, employees and unions representing employees.
- Prioritization of elective cases: must be made based on scientific evidence, clinical judgement and patient need, rather than profit or cost-saving concerns.
- Community Considerations: some considerations for resuming elective surgeries will be different in small hospitals without COVID-19 admissions.

We address the above criteria in detail below

Prevalence and Incidence of Covid-19

The American College of Surgeons, the American Society of Anesthesiologists, the Association of periOperative Registered Nurses, and the American Hospital Association released a joint statement on the resumption of elective surgery.¹ They are in agreement, and we concur, that **“there must be a sustained reduction in rate of new COVID-19 cases in the relevant geographic area for at least 14 days before resumption of elective surgical procedures”**. In the event there is a sustained increase in the rate of new Covid-19 cases in Minnesota, healthcare systems must have a mechanism to reduce or halt elective procedures.

Prior to the resumption of elective surgery, there must be assurances that facilities in the state are safely able to treat all patients requiring hospitalization without resorting to crisis standards of care or transporting patients to other facilities for continued care. If, at any time following resumption of elective procedures, these standards cannot be met, elective procedures must cease.

PPE and Supplies

Prior to the resumption of elective surgery, and in order to continue any elective procedures, there must be adequate supplies of Personal Protective Equipment, including sufficient supplies for a potential surge in Covid-19 patients of a second wave of patients with Covid-19.

¹ https://www.facs.org/-/media/files/covid19/joint_statement_resuming_elective_surgery_after_covid19.ashx (retrieved 4/30/20).

At a minimum, facilities must have (thirty 30) days of PPE and provide “staff training on and proper use of PPE according to **non-crisis level evidence-based standards of care.**²

Without a way to screen for asymptomatic or pre-symptomatic infection, hospitals must treat all patients, visitors, workers and vendors as potentially positive for COVID-19. Healthcare workers must therefore be provided with appropriate PPE for all positive/PUI at pre-crisis CDC standards.

Current facility policies on the use of PPE, including its reuse are endangering nurses, other healthcare providers, and patients. It is irresponsible to further reduce the supply of PPE and risk the health of more Minnesotans at a time when we should be preparing for the surge which has yet to hit in Minnesota. Our members are being required to utilize PPE that is expired, to staple together elastic bands for respirators, to reuse single-use PPE multiple times, to bring in their own PPE including homemade masks, to go without PPE, and to otherwise engage in practices that would have resulted in termination from employment only two months ago.

These practices result in unnecessary harm to nurses, the increased possibility of hospital-acquired infection for patients and it is unconscionable to increase that risk by resuming elective procedures unless non-crisis standards can be continuously implemented.

Facilities must be required to report PPE levels to the state for public dashboards, to employees, and to any labor union representing employees. These reports must occur at least daily and must include:

- The number of days of PPE currently available at the burn rate projected from optimal protection levels (no reuse of PPE identified by the manufacturer as single use, reusable PPE cleaned/disinfected according to manufacturer’s specifications in effect as of 1/1/20, no use beyond expiration date)
- The number of days of PPE currently available at the burn rate projected from protection levels currently used (reuse of PPE intended as disposable or single use, with or without cleaning/disinfecting, use of PPE beyond the manufacturer’s expiration date)
- The number of days of PPE currently available if the high point of the facilities surge plan is reached.

Although not currently classified as PPE, nurses have been demanding hospital scrubs they can change out of at the end of their shift, to prevent bringing the virus out into the community and into their homes. Before resuming elective procedures, healthcare facilities must ensure they have adequate amounts of hospital-provided and laundered scrubs for staff working in all units of the facility.

The supply of blood has tightened during the pandemic. There must be an adequate supply of blood in order to resume elective surgery. The supply must be monitored to assure that sufficient amounts of blood and blood products are available for emergent surgery as well as for other needs.

² Ibid.

Facilities need to be required to identify the quantities of blood and blood products historically used for emergent surgery and rapid replacement through massive transfusion protocol. Prior to resumption of elective surgery, facilities need to be able to assure the state that elective surgery will not reduce the availability of blood and blood products needed for other patients and procedures. Facilities must continue to closely monitor the availability and, if, at any time, a facility cannot provide this assurance, it must be required to immediately cease elective procedures.

Consideration must be given to the decreased ability of patients to be tested for anemia due to the closure or reduction of clinics and pre-procedure assessments must include testing and a treatment plan for anemia that does not result in shortages of blood.

In part due to the number of patients requiring medical intervention and medication during treatment for Covid-19, medications used in elective surgery are in short supply.

As of Friday, May 1, these include;

- Atropine Sulfate Injection
- Bupivacaine Hydrochloride and Epinephrine Injection, USP
- Bupivacaine Hydrochloride Injection, USP
- Cisatracurium Besylate Injection
- Dexmedetomidine Injection
- Etomidate Injection
- Fentanyl Citrate (Sublimaze) Injection
- Hydromorphone Hydrochloride Injection, USP
- Ketamine Injection
- Ketorolac Tromethamine Injection
- Lidocaine Hydrochloride (Xylocaine) Injection
- Lidocaine Hydrochloride (Xylocaine) Injection with Epinephrine
- Methadone Hydrochloride Injection
- Midazolam Injection, USP
- Morphine Sulfate Injection, USP
- Nalbuphine Hydrochloride Injection
- Promethazine (Phenergan) Injection
- Propofol Injectable Emulsion
- Ropivacaine Hydrochloride Injection

Facilities must be able to assure that there will be adequate supplies of drugs before resuming elective procedures.

Adequate staffing

The stress of working in healthcare during a pandemic cannot be underestimated. Before resuming elective surgeries, healthcare facilities must prove they can adequately staff COVID-19 and non-COVID-19 units alike. For staffing to be adequate, stress and exhaustion of healthcare workers must be taken into account.

Staff must be able to take breaks and use benefit time to maintain their own well-being. In addition, any change in schedules to accommodate new increase in cases must occur with direct involvement of frontline healthcare staff.

Standards of Care

Facilities must be able to provide continued assurances that elective procedures will not cause them to implement crisis standards of care. They must be able to provide all patients with pre-pandemic evidence-based standards of care.

Screening and Testing

Every person entering the facility – employee, patient, visitor, delivery and other workers – must be screened for a fever and COVID-19-like symptoms and prevented from entering if present.

Patient drivers must wait in segregated area with social distancing and not need to travel through any staff, patient care, or procedure area to do so.

Representatives from equipment, pharmaceutical and other vendors must not enter the healthcare facility or be present in procedures.

Infection Prevention

Before resuming elective procedures, healthcare facilities must demonstrate to the Department of Health that:

- They are properly cohorting both patients and healthcare workers. Positive and presumed COVID-19 patients should be isolated to one area of the facility. Designated teams of healthcare providers should be assigned to provide care for positive or suspected cases of COVID-19. Providers working in this capacity must never be assigned to patients outside of COVID-19 designated patient care areas.
- They have enough beds in spaces with proper ventilation systems, including negative pressure ventilation, to prevent the spread of SARS-CoV-2 and other infectious diseases.
- ER patients must still be able to be seen separately for screening by staff in full PPE.

Case identification

The United States doesn't have the robust system of public health, contact tracing and strict isolation that other countries have relied upon to prevent transmission of the virus. But those are the only public health tools that address asymptomatic and pre-symptomatic infections.

Therefore, healthcare facilities must:

- Make free, reliable PCR testing widely available to all employees
- Conduct comprehensive surveillance, contact tracing, and case isolation
- Conduct occupational exposure surveillance and enact response plans--if a nurse or other healthcare worker is exposed, they must be placed on paid quarantine immediately for a minimum of 14 days, whether they exhibit symptoms or not.

Prioritization of elective surgery should be in a staged approach, informed by science

- Decisions about prioritization of elective procedures should be made by a team including bedside nurses and should include a nursing assessment of each individual patient.
- Procedures that have an increased likelihood of aerosol generation should continue to be delayed when they are on an elective basis. This includes oral and maxillofacial surgery any other elective aerosolizing procedure.

Oversight

Finally, there must be a check in place to address hospitals that are not meeting these minimum criteria. Nurses have already experienced hospitals stretching or ignoring existing guidance from regulatory, scientific and governing entities. Direct-care nurses must have a role in decision-making and implementation of plans to resume elective procedures as part of the health systems' Incident Command Teams.

Nurses must also have a direct line to the Department of Health, the licensing authority for Minnesota healthcare facilities, to report instances where these minimum criteria are not being met. The hospitals have gotten what they have lobbied for; the nurses have given and given, and now we deserve the same direct line to MDH authorities that the hospitals have.

MNA nurses are eager to “get back to work” and provide patient care to those in need of elective procedures. However, the risks to resuming elective procedures before healthcare systems can prove that workers and patients in all settings can be protected from infection, are deadly. We stress that healthcare systems must meet these minimum criteria before resuming elective surgery.

Sincerely,



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President, Minnesota Nurses Association

Cc: Chris Schmitter
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