Department of Health complaint re: Albany Medical Center

From: [redacted]

I am currently employed on the Oncology/Hematology floor at Albany Medical Center, where I care for immunocompromised cancer patients, many of whom are receiving life-saving cancer treatments that severely impact their immune systems.

I trust that you will follow your policy regarding hospital complaints and keep my name confidential. I am concerned about retaliation so please do not share my name with the facility as I wish to remain anonymous.

The Oncology/Hematology floor has experienced 2 COVID-19 outbreaks. The first began Thanksgiving week and included 12 staff and 8 patients. The second is ongoing and has included 12 staff since 1/1/21 and multiple patients. Current total affected counts as of 1/18/21 are approximately 28 infected staff and 17 infected patients. There are only a handful of RNs on my unit who have not tested positive.

Please note that the first outbreak was chronicled in the New York Times in this article: https://www.nytimes.com/2020/12/17/nyregion/nurses-coronavirus-new-york.html?smid=em-share

I am imploring the Department of Health to take action now to protect the lives and health of the cancer patients that I care for and the RNs and care partners providing that care.

Contributing conditions that have not changed between outbreaks include: lack of N-95 mask fit testing for all unit staff, lack of N-95 mask availability for all unit staff, lack of training on and adequate availability of PAPRs. The previous congregate living policy, which requires COVID-19 precautions for 14 days for all congregate living patients regardless of initial test results, has been suspended. [redacted]

Two hospital-wide policies have been changed recently. The first was a policy which went into effect December 22nd, 2020. This policy requires PAPRs or N-95 masks for staff in the care of all patients (including COVID negative patients) with certain characteristics/procedures, such as tracheostomy, bipap/cpap, and high flow nasal canula. Additionally, CPR and intubation are considered aerosolizing procedures and anyone participating in a code should have an N-95 mask or PAPR per the new policy. The second policy is the COVID testing of all admitted patients, which went into effect on Monday, 1/11/21. Per the algorithm, however, asymptomatic patients and pre-procedure tested patients do not have to have their tests results come back negative before being brought to the floor. They can be put into a semi-private, non-negative pressure room, with a roommate, on a non-covid floor. As we have had both asymptomatic and pre-procedure patient tests come back positive in the recent past, this is a concern.

Currently, the unit continues to operate normally, with admissions, transfers, and roommates in semi-private rooms with shared bathrooms, despite multiple staff and patient infections since 1/1/21. Those patients cared for by confirmed positive staff have been placed on COVID precautions for 10 days and are being tested (frequency unknown). However, other patients, to my knowledge, are not undergoing serial swabbing every 3 days, as was done in the initial outbreak in November. Staff is not undergoing every 3 day swabbing. Staff continues to float to

other units, including COVID units, and returning to the home unit. Multiple patients have tested positive after being housed in a room with another positive patient. Epidemiology announced on 1/14 that the rooms of positive patients would no longer be treated with Tru-D afterward, an ultraviolet light treatment used until now. Per Epidemiology, it is not necessary.

After the aforementioned aerosolizing procedure policy went into effect, a list was generated of types of patients not allowed to come to this unit due to a lack of fit-testing and access to proper PPE. [redacted]

On [redacted], 2 codes occurred on the unit. All code staff had proper PPE, however, this unit's floor staff did not, as they still have not been fit tested for N-95 masks and PAPRs were not available. Thus, both these codes created exposure events for all staff in the rooms not wearing proper PPE. Said staff actively participated in compressions. On [redacted], 2 patients came back positive, including one of the patients who had coded.

These are but a few examples of improper patient placement, lax infection control policies, and exposure events occurring on a regular basis on this unit. More specific information is available upon request. Concerns regarding patient placement and infection control have been expressed to Epidemiology, Nursing Supervision, and the Unit Manager. Typically, these have been met with no changes on this unit and dismissiveness.