

OSHA Complaint

Albany Medical Center

1. Employer is not providing suitable respiratory protection. Respirators provided do not consistently protect employees. Respirators are not consistently and rapidly available when needed. N95s and PAPR hoods are not maintained and inspected properly. Employees are forced to use N95s that no longer achieve a fit. Employees are not properly trained in the inspection and maintenance of PAPR equipment.
2. Employer has, since the Spring of 2020 and continuing, reprocessed (“decontaminated”) N95 respirators using a variety of means. The employer has done this in contradiction to:
 - A. CDC guidance that such processes only be resorted to under crisis conditions. For much if not all of the period of time that the facility has been reprocessing N95s, crisis conditions have not been met. At this time, crisis conditions do not exist in the hospital. The employer has stated that they have over a ninety day supply of equipment.
 - B. The manufacturer’s guidance. AMC is using 3m N95 equipment. 3M states clearly in its technical bulletins (accessed November 24, 2020 that “3M does not recommend decontaminating FFRs”).
 - C. The requirement to seek out and incorporate other respiratory protection before resorting to reprocessing. Elastomeric respirators and other equipment recommended by OSHA and the CDC are available for use via a number of means; yet AMC is not availing themselves of them. Only if the other equipment is not available can the employer then consider decontamination/ reprocessing. NYSNA has widely publicized the role that elastomerics and other equipment can play in the conservation of equipment and protection of staff, and offered to work with employers, like AMC, to help secure this equipment. AMC has not availed themselves of this.
 - D. Despite failure rates identified during the course of routine fit testing.
3. The employer is failing to adhere to specific guidelines for the use of reprocessed respirators, including but not limited to:
 - A. Continuing to use reprocessed respirators during non-crisis time periods.
 - B. Not properly monitoring the reprocessing and failing to identify and remove dirty and compromised N95s from the supply chain, as per CDC etc.
 - C. Not controlling the storage and distribution reprocessed N95s such that they are subjecting them to further contamination and damage.
 - D. Not conducting modified fit test that the CDC calls for when N95s have been reprocessed; failing to insure that reprocessed N95s retain their protective capability.
 - E. Re-using N95s up to 20 times, way beyond the maximum 5 donning and doffing set by CDC and way beyond the functional life of them when they are exposed to an oxidizer (hydrogen peroxide.)
 - F. Directing staff to stop putting their names on N95s to be reprocessed, contrary to guidance that workers reuse the same equipment, when reuse is in place

4. When the employer realized, via routine respirator fit testing, that reprocessed N95s being used to conduct tests were subject to high failure rates, after just 2-3 reprocessing cycles, this information was ignored, with no adjustments to the use of reprocessed N95s by staff.
5. In certain areas, such as the OR, the employer does not have consistent policies and protocols on the use of respiratory equipment that is linked to assessed hazards and specific patient care tasks.
6. In all areas, accessing PPE is time-consuming and difficult. In a hospital setting, sudden changes in patient status can routinely result in the need for N95s on an immediate basis. Not possible when have to go to the Pyxis, count the equipment, type in the info, then get your N95 and rush back to the patient.
7. Regarding PAPR equipment in particular, the employer's training materials do not instruct on how to inspect the equipment, how to check air flow or battery levels. Two instances recently of PAPRs being used on a unit without filters installed.

Additionally, the employer, starting September 2020 and continuing, has:

8. Failed to properly identify and assess COVID-19 hazards, and failed to apply hierarchy of control protocols to arrive at protective measures, such as administrative and engineering controls, to protect staff.
9. Exposed dozens of staff to Covid-19 as a result of lack of hazard controls, including by failing to properly identify (test) patients before admitting them to non-covid units in the hospital, cohorting these patients in units with non-covid patients. Since March 2020, over fifty staff have been exposed, according to OSHA Log entries, which may be under-reported. The majority of these incidents have taken place recently. In at least one incident another patient was exposed by the patient in question and soon after contracted COVID-19. The employer restricts testing to "symptomatic" patients only, even though it is well documented that the virus is transmitted by asymptomatic and pre-symptomatic individuals. This restriction is also in contradiction to industry practice during this time.
10. Failed to provide properly functioning negative air isolation rooms, a key engineering control. Rooms on Covid units, such as E5, do not maintain proper pressure relationships needed for safe negative air isolation. Rooms in the Ed are routinely mis-used and not available for patients needing them, or, when used for isolation patients, protocols are not in place and followed to maintain pressure relationships. The lack of anterooms, recommended by the FGI and ASHRAE, contributes to these problems. As a result, SARS-CoV-2 is escaping into hallways and other care areas, exposing staff, patients and visitors, and staff are unable to perform safe donning and doffing procedures for PPE, likewise creating conditions for the spread of SARS-CoV-2 in the facility.
11. Failed to follow recommended cleaning and disinfecting protocols needed to protect against the spread of SARS-CoV-2, and other pathogens, to staff, patients and visitors. This is taking place at the South site and other locations in the hospital. During the week of November 9th the employer failed to conduct terminal cleaning on a room where a COVID 19 patient had been cared for.
12. Failed to uphold proper housekeeping standards, allowing the presence of mice, cockroaches, water and mold, on unit E2 and other units. Vermin is especially present on night shifts. On unit D3N a pathogen issue related to plumbing has been allowed to continue unabated for years, with environmental services staff directed to pour bleach down drains twice daily as a stop-gap measure that covers up the odors.
13. Failed to have protective measures and protocols in place during the transport of patients, including COVID-19 PUI and positive patients, moving them in and out of elevators and hallways without adequate protection.

14. Failed to keep in place contact tracing and notification procedures. Employer in the past had a system of logging staff who enter patient rooms, for example, but has abandoned that system. Employer fails to notify staff of COVID-19 exposures.

These issues are in violation of OSHA regulations, CDC guidance related to SARS-CoV-2/COVID 19 and prevailing healthcare industry practices in New York State. Dozens of staff and many patients have been needlessly exposed to SARS-CoV-2 and other dangerous pathogens.