

Second Personal Protective Equipment Survey of UK Nursing Staff Report:

Use and availability of PPE during the
COVID-19 pandemic

SURVEY

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Percentages may not always total 100% due to rounding.

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Executive summary

The Royal College of Nursing has undertaken two surveys of health and care staff to identify their experiences and ongoing issues with the supply of and access to Personal Protective Equipment (PPE) during the COVID-19 pandemic. This report details the findings of the second survey (May 2020).

Although there has been some improvement since April 2020 when we previously asked health and care staff about their experiences of supply, distribution and access to PPE, there are still shortages of essential PPE in all settings, and health and care staff are still reliant on PPE items being donated or home-made in some cases. It is unacceptable for health and care staff to be exposed to avoidable risk to their own safety. Our findings also highlighted a stark and deeply-worrying contrast in the experience and safety of black, Asian and minority ethnic (BAME) respondents. Urgent action needs to be taken to clearly identify and tackle this issue decisively for the safety and wellbeing of BAME staff both now and in the future.

Given our existing concerns about particular settings and staff groups, we have analysed the results through two specific lenses: PPE availability and training across all staff and all settings, and PPE availability and training specifically for BAME staff compared to white British staff. We have focused on the main issues our members have raised: a lack of availability and training in general, and a disproportionate impact on staff from a BAME background.

Health and care staff continue to feel under pressure to care for people without having the correct PPE and having to reuse single use items. This means they are compromising their own safety to provide care for other people. Staff in care homes are less likely to have access to the PPE they need, even though there is a widespread level of infection within those settings. For those working in high risk environments, many respondents had not been adequately fit tested for their filtering face piece respirator. This is unsafe for both the individual and the member of staff who is providing care for them.

Key findings include:

- over a third of respondents felt pressure to care for individuals with possible or confirmed COVID-19 without adequate protection. This is significantly worse for BAME nursing staff where over half (56%) felt pressure to work without the correct PPE
- one in five respondents in non-high-risk areas are concerned about the supply of eye/face protection, with a further 12% concerned there are not currently enough for them to use. The situation is worse for BAME respondents where one in four said there was not enough eye/face protection or enough fluid-repellent surgical masks for them to use during their shift
- twice as many BAME respondents said there were not enough surgical masks, disposable plastic aprons and disposable gloves than white British respondents
- a third of respondents have not received training on what standard PPE to wear and when they should wear it. Training is more prevalent in hospital settings, than care home and community settings
- those working in a care homes were most likely to report that they felt pressured to care for individuals with possible or confirmed COVID-19 without adequate protection (41%) than those working in a hospital (38%) or the community (24%).

We urge all employers of health and care staff across all settings, and all UK governments, to review these findings and act immediately to resolve these issues to prevent further exposure to risk. This is particularly vital given the extent of the impact of the pandemic on care homes and amongst individuals from BAME groups. Our findings show that staff in these groups and settings are not being protected adequately in comparison to their peers and disproportionately affected by COVID-19 in comparison to their peers. This cannot continue.

Personal Protective Equipment (PPE)

We are the largest trade union and professional body for nursing, representing 450,000 nursing staff across the UK. Throughout the pandemic we have consistently raised concerns on behalf of health and care staff relating to a lack of adequate PPE for all types of frontline services.

To date, we have undertaken two surveys of all health and care staff experiences, across all settings, on accessing and using PPE during COVID-19. The first was in mid-April and the second, of which the findings are detailed in this report, was in early May. This was in response to the widespread concerns around the supply, distribution and safety of PPE throughout the COVID-19 pandemic. A summary of the first report in April is also available¹.

Access to high quality PPE, that is appropriate to the level of care and type of setting, is essential to ensuring the health and safety of health and care staff across the UK. It is critical to the stability of the psychological contract between staff working across health and social care sector and their employers. The onset of the COVID-19 pandemic has exposed global shortages in the supply of PPE. A lack of sufficient PPE can expose health and care staff to unnecessary risk and serious harm. In some cases, this may have led to staff members contracting COVID-19, becoming unwell and tragically losing their lives.

The COVID-19 pandemic, much like other global health emergencies, has highlighted the detail of existing and persistent inequalities that structure the way that our societies and the way that work across health and social care is both organised and experienced.

The available evidence shows there is a disproportionate negative impact from the pandemic on those from BAME backgrounds. Recent reports on the number of deaths due to COVID-19 among health care workers state that just under two-thirds (63%) have occurred in people from a BAME background².

While the factors leading to a disproportionate impact upon BAME groups are likely to be complex and multi-layered, it is important to consider the potential links with PPE shortages. Given that decision makers are aware of the increased risk for staff members from BAME

backgrounds, it is absolutely vital that access to PPE is swiftly improved to provide crucial protection against infection.

Our survey and findings

The RCN developed and distributed two online surveys to all RCN members exploring respondent's experiences of PPE across all settings in health and social care. These were carried out in April and May 2020, with some adjustments to the second survey to reflect changing context.

Both surveys were framed around UK-wide guidance on the recommended use of PPE. We explored how far respondents working in specific settings had access to PPE as well as information about infection control and the associated training needed to do their job safely. We also explored issues such as where PPE had been sourced and any issues experienced with the PPE. We asked respondents about the pressure they may have experienced to reuse single-use PPE, or to treat individuals without the correct PPE, and how far concerns had been raised or addressed.

Building on our original PPE survey, the second survey was updated by taking into account emerging issues reported by our members, such as overall confidence that employers are doing enough to protect staff, the quality of supplied PPE items and specific issues with fit-testing.

This second survey was emailed to all RCN members and publicised through social media platforms. The survey was open from Thursday 7 May until Monday 11 May 2020. All the questions were closed and quantitative in nature, but respondents were directed to an open form on the RCN website at the end of the survey where they could share more about their experiences if they wished. There were 5,023 completed responses, and all the analysis in this report is presented at UK level.

As we want to urgently understand the disproportional impact that COVID-19 is having on BAME staff, we have focussed our analysis on the responses from those with a BAME

background, in comparison with those from a white British background. Overall, there were 4,418 combined responses from BAME (728) and white British (3,690) respondents to the second PPE survey. To have disaggregated those respondents in the BAME category would have produced too small numbers for meaningful comparison. However, data emerging from pandemic has pointed to specific risk for BAME communities which necessitates aggregating their responses to better understand their collective lived experience in the context of the current COVID-19 pandemic.

A major finding from our surveys is the variation in experience in their access to PPE between different groups. Staff from BAME groups were more likely to report that they did not have access to adequate supplies of PPE compared to their colleagues from white British groups. Ensuring that robust and transparent risk assessments for staff are undertaken as well as regular equality analysis are key to understanding why this is the case, and to identify the steps needed to resolve this disparity urgently. Too many staff still feel pressure to provide care for individuals when they do not have the necessary adequate protection to keep themselves safe. This disparity could lead to staff feeling pressure to provide care when they do not have adequate protection to keep themselves safe. It is unacceptable for any employer to put staff in a position where they are required to compromise their safety to care for others.

BAME staff working in high-risk areas and requiring the use of PPE such as FFP3 masks are less likely to have been fit-tested for their PPE in comparison to their white British colleagues. This will mean that staff are more likely to be using equipment, which is not correctly fitted, and this could place them at risk of avoidable exposure where rates of infection are likely to be higher. This is a clear and concerning indicator of differential treatment between staff in BAME groups and their white British colleagues. It is vital that it is understood as unjustifiable unequal treatment, and that this disparity is immediately identified and addressed by all employers in partnership with staff and their representative bodies.

Staff members from BAME groups felt less confident in their employer's ability to protect

them from exposure to COVID-19 in comparison to the white British counterparts. Almost a quarter of staff did not feel confident at all, compared to around 1 in 10 white British staff. Given the knowledge we have about the risks for BAME groups, it is vital that employers take immediate and additional steps to protect their staff and ensure they feel safe at work. Managers should be encouraged to have supportive and confidential conversations with BAME staff about any underlying health conditions.

Finally, although a high proportion of respondents reported that they have raised concerns to their managers, these concerns were not always addressed. BAME staff were less likely to have their concerns addressed in comparison to their white British counterparts. This situation is likely to be an additional source of worry and deepening concern for BAME staff as clear support and care from the employer may appear invisible and intangible. Other staff are reluctant to raise concerns for fear of it having a negative impact on their future career. These findings suggest that urgent work is needed by employers in close partnership and collaboration with trade unions to develop inclusive workplace cultures that are characterised by openness and transparency and where staff are supported to deliver professional candour and where those concerns are heard and responded to.

Intelligence from our members and media reports suggest shortages are greater in some health and care settings. Therefore, it is also important to explore whether there was any difference in respondents' experiences in different types of settings. We have highlighted any notable differences between care settings where sample sizes enable comparisons.

These surveys are intended as a snapshot, exploring the experiences of nursing staff across the UK at a certain point in time during the COVID-19 pandemic. Where relevant, we have compared the results presented here with those of the previous PPE survey carried out by the RCN carried out between 10-13 April 2020. However, these comparisons should be treated with caution due to the difference in overall response rates³.

Findings: Nursing staff working in non-high-risk environments⁴

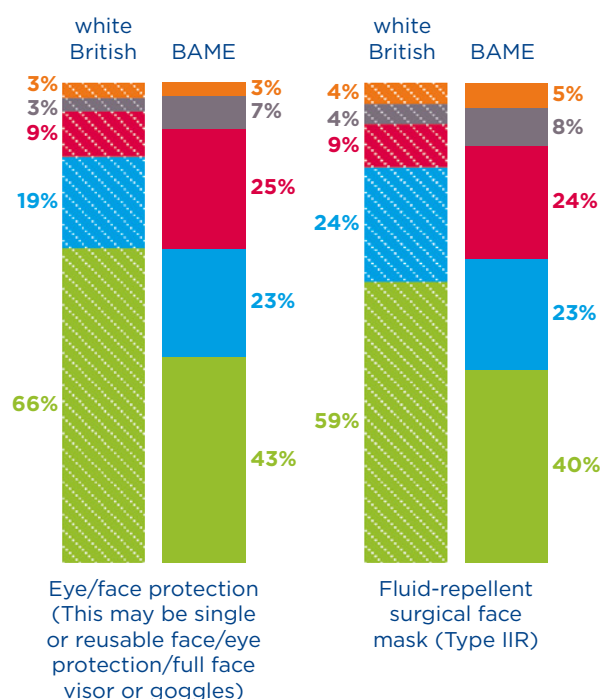
For the purposes of this survey, 'non-high-risk environments' include any roles which does not involve taking part in high risk procedures such as aerosol-generating procedures (AGPs), or; working in a 'high-risk areas' such as, intensive/critical care units or the 'hot zone' of an emergency department.

Supply of PPE

Overall, access to PPE items has improved since the last survey. However, almost a quarter (24%) of respondents register concern about the supply of face masks for their next shift, with a further 11% saying there are already not enough for them to use. One in five respondents are concerned about the supply of eye/face protection, with a further 12% registering concern that that are not enough of those items for them to use.

Examining responses by ethnicity reveals some stark differences. Just over two in five (43%) BAME respondents said they had enough eye protection or enough fluid-repellent surgical face masks (40%) for the duration of their shift. This is in comparison to figures of 66% and 59% of white British respondents, respectively.

Do you have enough of the following standard personal protective equipment (PPE) items for the duration of your shift?



- I have enough to use in my workplace
- I have enough at the moment but am concerned about the supply for my next shift
- There is not enough for me to use
- I don't know
- Not needed

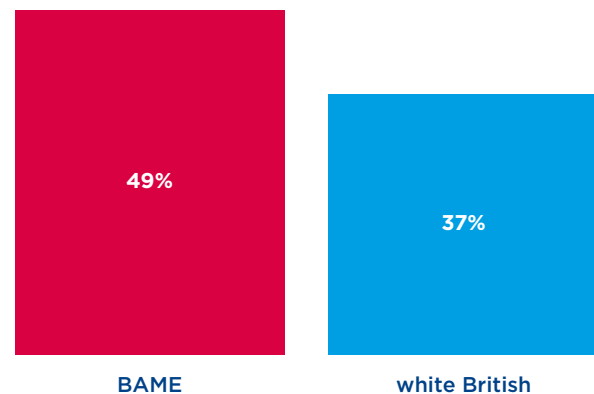
By contrast, one in four (25%) of BAME respondents said there was not enough eye/face protection or enough fluid-repellent surgical masks (24%) for them to use during their shift. This compares to around one in ten (9%) of white British respondents reporting there were not enough of those items.

The overall situation remains the same across both surveys in relation to disposable plastic aprons and disposable gloves. Twice as many BAME respondents said there were not enough surgical masks, disposable plastic aprons and disposable gloves for use in comparison to white British respondents.

Almost two in five respondents have been asked to reuse single-use standard PPE items (39%), this figure highlights that there has been no improvement on the previous survey. Respondents working in the community were less likely to be asked to reuse single-use items of PPE (31%), than those working in a hospital (43%) and a care home (44%).

Significantly, almost half (49%) of BAME respondents said they had been asked to reuse single-use items of PPE compared with over a third (37%) of white British respondents.

Have you been asked to reuse single use equipment?



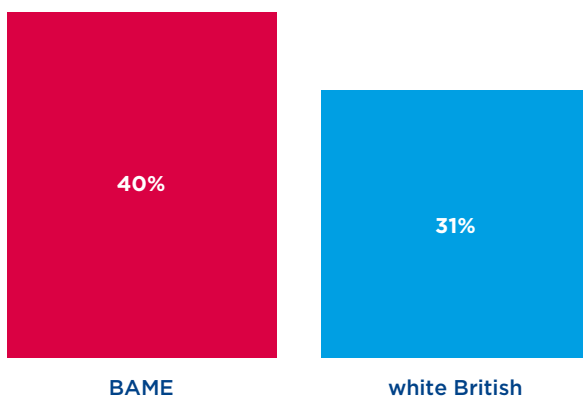
PPE Training

Staff using PPE should be trained in what PPE to wear and when also how to put it on (donning), remove it (doffing) and dispose of it safely. However, a third of respondents (33%) have not received training on what standard PPE to wear and when they should wear it, and over a third (35%) have not received any training on the donning, doffing and disposing of standard PPE. However, access to both types of training have improved since the last survey.

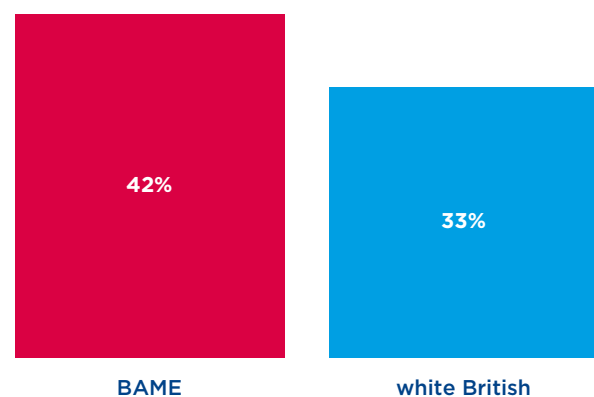
Those working in a hospital setting were more likely to receive both training on what PPE to wear and when to wear it (72%), and on donning, doffing and disposing (69%) of it compared to those working in the community (60% and 61%) or in a care home (58%).

BAME respondents were less likely than white British respondents to have received training in the appropriate standard PPE to use and when it should be used, or training in donning, doffing and disposing of standard PPE.

Respondents who have not received training on what standard PPE to wear and when you should wear it



Respondents who have not received training on donning, doffing and disposing of standard PPE



Issues with using PPE

Respondents from both groups highlighted issues with the physical impact and resultant discomfort caused by having to wear PPE. 54% of BAME and 55% of white British respondents stated that their PPE irritates or hurts their skin, ears, eyes, nose and mouth. White British nursing professionals (77%) were more likely to report that their PPE increases their body temperature and makes them sweat, compared with BAME nursing professionals (55%).

However, BAME nursing professionals were more likely to report ill-fitting PPE (too short, too long, too loose, too tight) 46% compared with 36% of white British respondents.

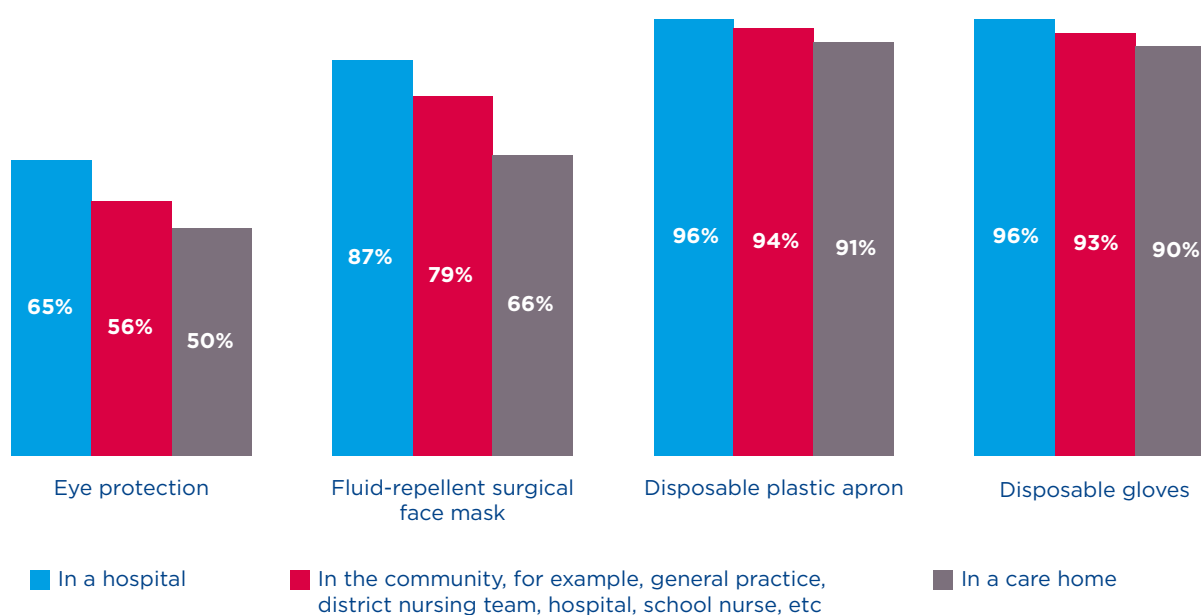
It is recognised that wearing PPE for long periods can also create additional wellbeing pressures and health and safety risks for nursing staff. For example, PPE is extremely uncomfortable to wear and when combined with factors such as shift length, ability to take breaks and access to hydration as well as work intensity as a result of patient acuity can lead to heat stress, fatigue and heat-related illness, which places a risk to both nursing staff and those they are looking after.

Sources of PPE

As in the previous survey, we wanted to continue exploring the source of PPE items, as there had been reports of appeals being made by health and care organisations to the general public for donations of PPE. Whilst it is the case that the employer supplied most PPE items to staff across all care settings, there are some areas of difference that are worth noting. For example, nearly a quarter (23%) of eye/face protection was donated, with a further 12% being home-made or purchased directly by staff for use. BAME nursing staff (15%) were less likely to be using donated eye/face protection, compared with white British respondents (26%). Though BAME respondents were three times more likely to have purchased their own fluid-resistant (Type IIR) surgical mask, 6% compared with 2% of white British respondents.

There was also a difference in where supplies of PPE came from across the different care settings. Those working in care homes were the least likely to have all items of PPE supplied by their employer. The greatest disparities between settings were for items of eye protection and face masks, where those working in care homes and the community were much more reliant on items being donated, purchased directly by the member of staff or home-made.

Percentage of PPE items supplied by the employer in each health care setting



Findings: Nursing staff in high-risk environments⁵

This section covers analysis of the questions asked to nursing staff working in environments where high risk procedures are being carried out, these include: aerosol-generating procedures (AGP) in a clinical or community setting; care of a ventilated patient; intensive/critical care units and in the 'hot zone' of an emergency department.

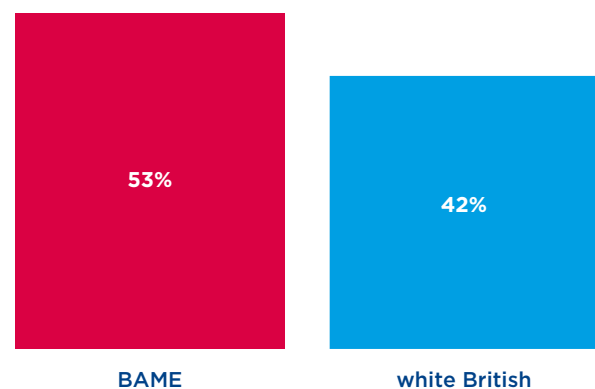
Supply of PPE

Overall, access to PPE items had improved since the last survey. However, almost one in five respondents (19%) told us there were not enough respirator masks for them to use, with a further 35% concerned about the supply for their next shift. Nearly a quarter (23%) of respondents said there were not enough gowns for them to use, with a further 34% concerned about the supply for their next shift.

Respondents from a white British background were significantly more likely to report there being enough eye/face protection items (66%) and filtering face piece respirators (FFP3 or FFP2/N95) (44%), than for respondents from a BAME background (43% and 25%, respectively).

BAME respondents were nearly three times more likely to report that there was not enough eye/face protection for the duration of their shift, 21% in comparison to 8% of white British respondents. Similarly, BAME respondents were more than twice as likely to report that there were not enough filtering masks, 35% compared with 15% of white British. Almost double the amount of BAME respondents reported not having enough disposable fluid-repellent coverall/gowns to use during their shift, 37% compared with 19% among the white British respondents.

BAME respondents are more likely to be asked to reuse single use PPE when working in a high-risk environment



It is of concern that our survey results indicate that more than two in five (44%) respondents are still being asked to reuse single use equipment, although this has improved since the last survey where over half (51%) said that this had been their experience.

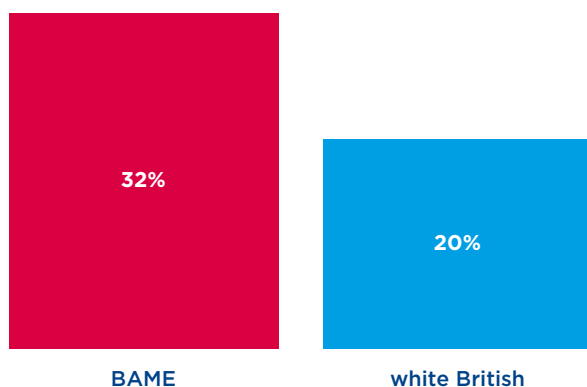
Though the situation is worse for BAME respondents who are more likely to be asked to reuse single-use PPE when working in a high-risk environment – over half (53%) saying they had been asked to reuse single-use PPE compared with 42% of white British respondents.

PPE Training

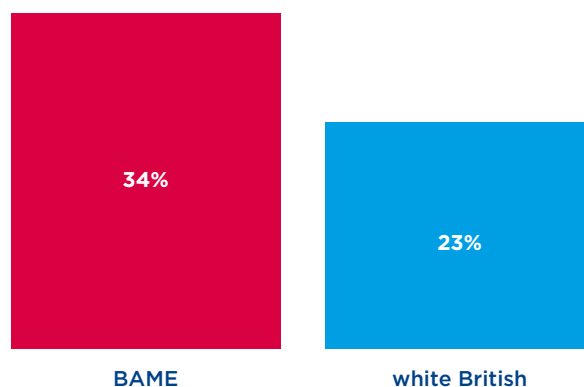
Almost one in four of survey respondents (23%) have still not received training on what PPE to wear and when to wear it, and over a quarter (26%) have still not received training on donning, doffing and disposing of their PPE. Though access to both types of training have improved since the last survey.

White British frontline staff are considerably more likely to have received training on high-risk PPE than those from BAME backgrounds, for whom around one in three report not having received essential training on how to use these aspects of high-risk PPE.

Percentage of respondents who have not received training on what PPE to wear, as recommended for supporting aerosol-generating procedures (AGPs) or other high-risk procedures, and when you should wear it



Percentage of respondents who have not received training on donning, doffing and disposing of PPE, as recommended for supporting aerosol-generating procedures (AGPs) or other high risk procedures?



Issues with using PPE

In our latest survey, we introduced new questions exploring issues with respondents and their PPE. 82% told us it increases their body temperature and made them sweat; nearly three quarters (73%) told us it irritates/hurts their skin, ears, eyes, nose, mouth; 40% told us it doesn't fit properly and 30% said it didn't consider their specific individual needs. We also asked people how long they could wear their filtering face piece respirator before it becomes uncomfortable. Over a quarter (27%) said it became uncomfortable in less than an hour, with a further 26% could wear it comfortably for over an hour but less than two. This is of particular concern given the length and shifts, shortages of staff and intensity of work as a result of patient acuity.

As with those working in a non-high risk environment, white British respondents were more likely to cite physical issues with PPE than among the BAME respondents. 74% of white British compared to 67% of BAME respondents reported that their PPE irritates or hurts their skin, ears, eyes, nose and mouth. 86% of white British reported that their PPE increases their body temperature and makes them sweat, compared to 65% of BAME respondents. However, similarly to the findings in non-high risk environments PPE was less likely to fit for BAME respondents, 46% reported this issue compared with 38% of white British respondents.

Fit testing filtering face piece respirators

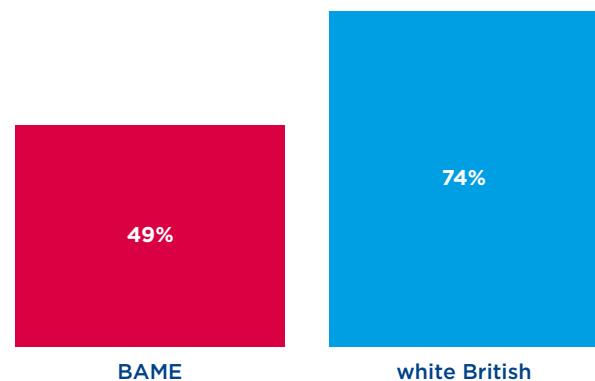
We also wanted to explore the issue of fit testing for filtering face piece respirators (FFP3 or FFP2/N95) nursing staff are currently wearing or have worn. Overall a third (32%) had not been adequately fit tested, and the most common reasons were due to there being too many different brands/types of mask to be able to fit test them all, or that their employer had not scheduled fit testing.

There was a substantial difference when exploring ethnicity, only half of BAME respondents (49%) said they had been adequately fit-tested for the filtering face piece respirators (FFP3 or FFP2/N95), whereas almost three quarters of white British respondents had been adequately fit-tested (74%).

Although access to fit testing for white British respondents has improved slightly (our previous survey revealed that 68% of white British respondents reported having had their filtering facepiece respirator mask fit tested), for BAME respondents, the situation had worsened, in the previous survey 53% reported they had been fit-tested suggesting inequalities in accessing fit testing have broadened.

Additionally, where fit-testing has not occurred there appears to be a disparity about some of the reasons for this: 41% of BAME respondents did not know why they had not been fit-tested, and 13% were not aware they should have a fit-test for filtering face piece respirators. This compared to 24% of white British respondents not understanding why they hadn't been fit-tested, and only 5% of white British respondents not realising this was necessary.

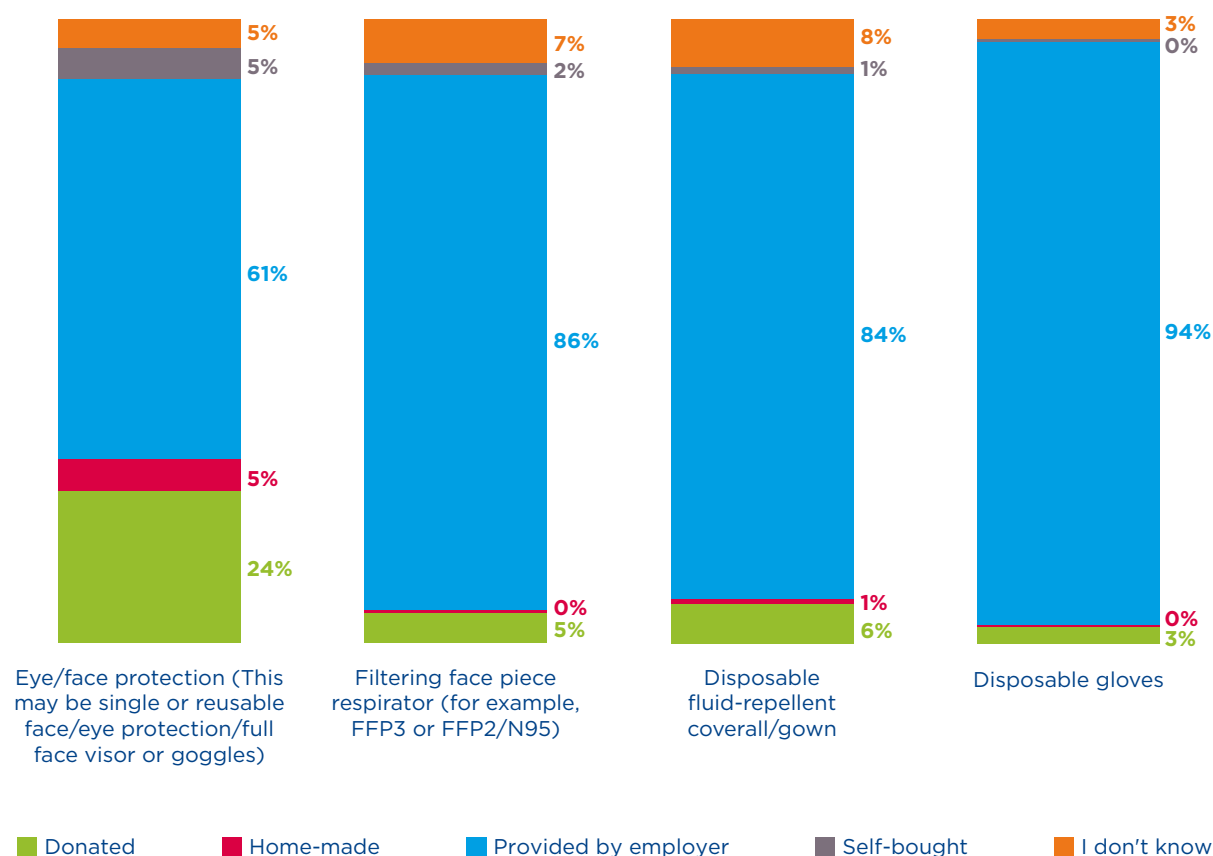
Have you been adequately fit tested for the model(s) of filtering face piece respirator (FFP3 or FFP2/N95), you currently wear/have worn?



Sources of PPE

For all high-risk PPE equipment, the majority were being supplied by the employer. However, nearly a quarter (24%) of eye/face protection was donated, with a further 10% home-made or self-bought.

Where did your PPE, as recommended for supporting AGPs or other high-risk procedures, come from?



Findings: All nursing staff regardless of working environments

Pressure to work unsafely

Over a third of respondents (34%) said they felt pressure to care for an individual with possible or confirmed COVID-19 without adequate protection. This has improved since the last survey was conducted a month ago where 50% had felt the same pressure.

Critically, more than half (56%) of those in the BAME group said they felt pressure to care for an individual with possible or confirmed COVID-19 without adequate protection, as outlined in the PPE guidance for both non-high-risk and high-risk scenarios, compared with 29% of their white British counterparts.

Those working in a care homes were also most likely to report that they felt pressured to care for individuals with possible or confirmed COVID-19 without adequate protection (41%), than those working in a hospital (38%) or the community (24%).

Quality of PPE

New questions were introduced about the quality of the PPE being supplied. Over one in three respondents (34%) told us they have been supplied with damaged/easily damaged PPE (items that have holes, are scratched, tear easily etc). This was similar for both white British and BAME respondents. In addition of those that have been supplied with poor quality equipment, more than three quarters (78%) have had to use them. BAME respondents (81%) were slightly more likely to have had to use them than white British respondents (78%).

There were slight differences when asked about being supplied with damaged or easily damaged PPE across the different settings. It was less likely in community settings (28%) than in hospitals and care homes (both 36%).

Just under one in three respondents (30% overall) have had to use PPE items which are past their expiry date, with slightly more white British respondents having to do so (31%) than BAME respondents (26%). However, BAME respondents were far less likely to know whether PPE had expired, 39% compared with 29% of white British respondents.

Infection prevention and control

Since the last survey, UK government guidance⁶ has been updated to include recommendations that staff who are wearing PPE are trained to recognise dehydration, fatigue and exhaustion while wearing the required PPE. We introduced a question to explore the extent to which this guidance had been applied to nurse professionals and 83% of respondents revealed that they had not had this information or training.

Respondents generally had access to enough general infection control supplies, and this had improved since the last survey. However, 32% did not have enough hand cream. More than one in five were concerned about the supply of disinfectant wipes for their next shift (22%), and a similar number had the same concerns about alcohol-based hand rub (21%).

The lack of access to hand cream was a greater issue for those working in care homes where only 36% had enough to use, compared to 43% in the community and 50% in hospitals.

Raising concerns

Overall, four in five respondents (80%) had concerns about their PPE - 58% had raised their concerns, but 23% had not. Of those who had raised their concerns (n=2,930):

- 27% said these were addressed fully
- 46% said these were addressed partially
- 27% said these were not addressed.

This is an improvement from the previous survey where only 21% of concerns had been addressed and the percentage of respondents who did not have any concerns has doubled since the last survey.

Responses regarding whether people had concerns and if they were raised were similar across all three settings. However, those working in the community were more likely to have those concerns addressed in full (34%) compared to those working in care homes (28%) or hospitals (24%).

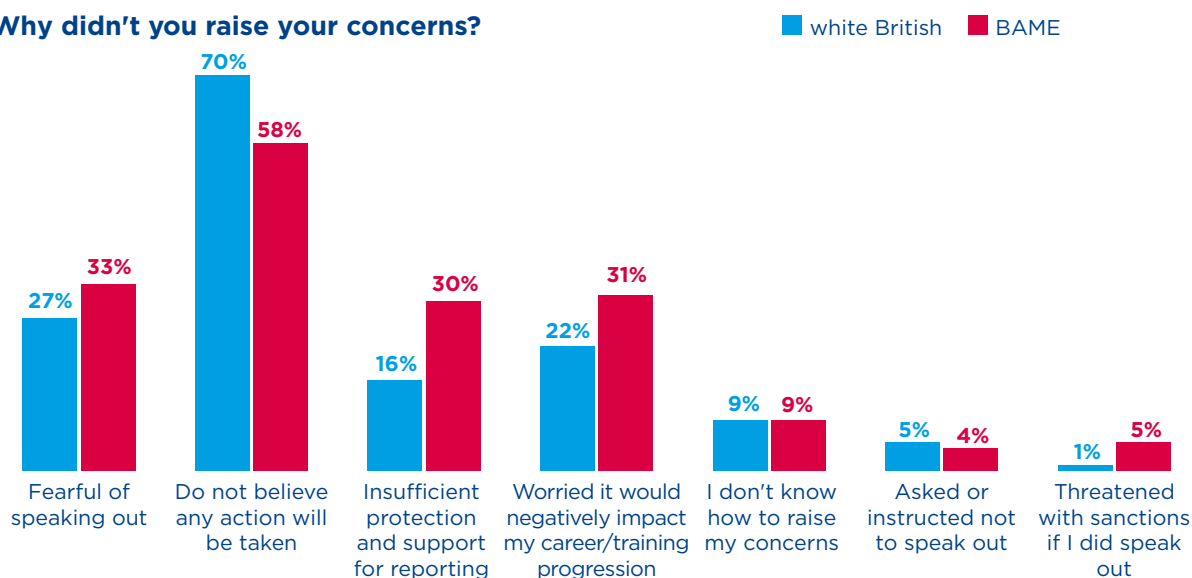
Respondents in the BAME group were both more likely to raise concerns about PPE to their employer (67% having done so compared with 56% white British), and less likely to have had these concerns addressed – one in three BAME respondents' concerns (31%) had not been addressed compared with one in four among the white British group (25%).

These results are similar to those of the previous PPE survey, when despite almost four in five BAME respondents raising concerns about PPE (compared to two-thirds of white British respondents), BAME nursing professionals were less likely to have had these concerns addressed – 31% of BAME respondents compared to 25% of white British respondents.

In this survey we asked an additional question about why people who had concerns did not raise them. Most commonly this was because they did not believe any action would be taken (68%). More than one in four (29%) were fearful of speaking out, nearly a quarter (24%) were worried it would negatively impact on their career or training progression and one in five said there was insufficient protection and support for reporting.

Though around one in three BAME respondents highlighted their fear of speaking out, insufficient protection and worry for the impact this might have in their careers as important factors for not reporting their concerns. These specific reasons could indicate broader issues for employers about how the workplace culture could appear unsupportive and non-inclusive to BAME nursing staff.

Why didn't you raise your concerns?



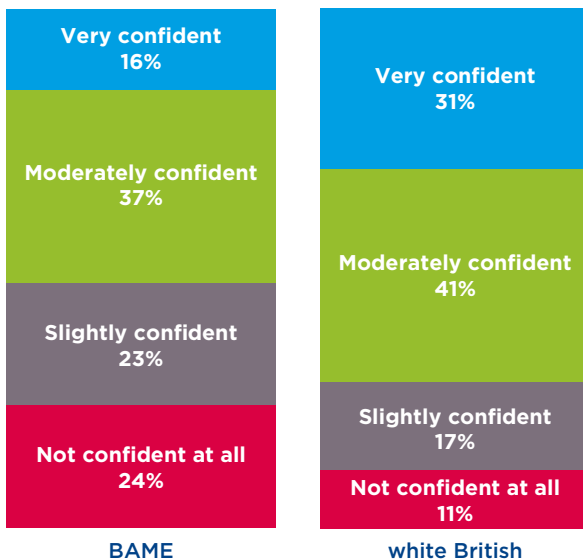
Feeling safe to work

For the first time, we asked respondents to report on how confident they are that their employer is doing enough to adequately protect them from COVID-19 in their place of work. Overall, 28% of respondents were very confident that their employer is doing enough to adequately protect them from COVID-19 in their place of work, and a further 40% were moderately confident. Those working in care homes were least likely to feel confident that their employer was doing enough to adequately protect them, with one in five selecting they weren't confident at all.

Overall, how confident are you that your employer is doing enough to adequately protect you from coronavirus infection in your place of work?



Overall, how confident are you that your employer is doing enough to adequately protect you from coronavirus infection in your place of work?



When looking at the difference by ethnicity, BAME respondents were far less confident that their employer was doing enough to protect them adequately from COVID-19 in their place of work compared to white British respondents. Only 15% of BAME respondents felt very confident in their employers compared with 30% among the white British group. Furthermore, almost a quarter of BAME respondent did not feel confident at all in their employers, compared with only 11% of white British respondents.

Next steps

The time for action is now. As we move towards the expansion of service provision and the reopening of additional services, the demand for PPE will increase. Issues with supply, training and access to PPE cannot continue, putting more individuals and staff at unacceptable levels of risk. This is a pivotal moment for governments across the UK to demonstrate reciprocity for the extraordinary contribution to the health and wellbeing of the UK made by BAME and all nursing staff. It is important not only for the current workforce, but also to assure and encourage those considering nursing career in the UK both now and in the future as we emerge from the COVID-19 pandemic.

Too often, policy makers wait for certainty of causation before acting to resolve issues. In this case, they cannot wait for analysis and investigation into the wide range of factors which will have led to the disproportionate impact on BAME staff. There is already enough evidence to show that staff are being affected. Workplace experience and treatment is a likely factor contributing to the increased risk which BAME frontline staff are facing during this pandemic.

We will continue to monitor the provision of PPE to health and care staff closely and raise concerns on their behalf. We will also continue to speak up for all health and care staff regardless of ethnicity to ensure they receive adequate PPE and training to undertake their roles safely, and put pressure on governments in all parts of the UK and employers of health and care staff to respond urgently to all issues raised.

We will repeat this survey regularly to ensure that any ongoing issues with PPE are identified and addressed urgently and monitor overall changes. Where we do not see progress or improvements being made in response to the concerns of frontline staff, we will take firm and decisive action to ensure that the needs of all health and care staff are met. We will support any members who have exhausted all options for accessing PPE, reducing risks and raising concerns, and who have had to refuse to treat as a last resort. Additionally, we continue to use the lived experience of the diversity of our membership to shape our policy asks on behalf of RCN members across the UK.

Employers must:

- **Resolve outstanding issues with PPE supply.** Ensure that all nursing staff, regardless of practice setting, have access to the necessary PPE of the required standard to ensure the safety of health care workers and the people they care for. Staff should not be asked to reuse single-use PPE items. Employers should obtain necessary adjustments in terms of the provision of PPE for staff who have physical disabilities and other requirements.
- **Facilitate staff to use PPE effectively.** Train all staff in what PPE to wear and when, and in donning, doffing and disposing of it safely. Employers should recognise the importance of FIT testing and ensure that there is suitable provision to test all staff who require it. Ensure that staff have access to hand cream and other supplies, and are made aware of the importance of maintaining skin health.
- **Continuously assess the impact on staff.** Carry out comprehensive and continuous equality analysis including impact assessments on staffing issues relating to COVID-19, including reviewing the allocation of shifts, and access to PPE and to fit testing for BAME workers. This includes ensuring compliance with the working time regulations and that all staff have adequate rest breaks during and between shifts. Alongside this, they should update their risk assessment processes to explicitly include ethnicity in their vulnerable and at-risk groups.
- **Provide support to staff who need it.** Ensure that all staff are aware of the support and counselling services that available to them to maintain and promote wellbeing. Importantly, ensure that, where available, staff can self-refer to occupational health service for advice and support
- **Support staff to raise concerns and respond to them effectively.** Ensure that staff know how to raise concerns about their safety including completion of incident forms, are not subject to detriment for

raising concerns and that concerns are acted on. Ensure that there is a process in place for responding to concerns raised by frontline staff, and that where appropriate concerns can be raised to commissioning bodies or national organisations for additional support.

- **Support staff to self-isolate and shield where necessary.** Confirm that staff will receive full pay during any COVID-19 related absences, including periods when individuals are self-isolating, shielding off sick for COVID-19 related reasons.
- **Record all health care worker deaths.** Ensure that they have the correct processes in place to maintain an accurate register of staff deaths. This must include collecting data relating to ethnicity, nationality and other protected characteristics.

for disparity amongst BAME groups have been established in England and Wales. In Northern Ireland and Scotland, the governments should take forward these reviews so that there is a comprehensive understanding of the levels of risk and causation are fully understood, regardless of geographical location. The official reviews do not displace the responsibilities of employers to comply fully with their health and safety obligations and wider duty of care to, regardless of their race or nationality.

- **Provide funding and support to ensure all staff are paid when self-isolating and shielding.** Support all employers to ensure that staff will receive full pay during any COVID-19 related absences, including periods when individuals are self-isolating, shielding off sick for COVID-19 related reasons.

The Health and Safety Executives in each country should:

- Investigate suspected breaches of health and safety legislation relating to a lack of provision of PPE resulting in harm to staff and intervene where necessary. We will work locally with employers to resolve issues, but if necessary will raise concerns directly with the relevant Health and Safety bodies.

Governments in all parts of the UK should:

- **Resolve outstanding issues with national PPE supply.** Ensure that every possible step is taken to provide enough PPE to every health and care setting where it is required, with a particular focus on protecting those who are exposed to the highest risk. It is essential that the issues with PPE are resolved in advance of any expansion of service provision to prevent patients, the public and staff members being exposed to unnecessary risk.
- **Support investigations into BAME disparity in all parts of the UK.** Continue to support the ongoing independent reviews which are investigating the reasons

Resources for health and care staff

The RCN has produced advice guidance to support staff during this time.

Personal Protective Equipment: Are you Safe?

A short guide to support decision making about PPE access and raising concerns.

Refusal to Treat

Guidance for supporting the consideration of withdrawing care.

Appendix 1: Profile of respondents

Workplace

Country breakdown

- England: 78%
- Northern Ireland: 5%
- Scotland: 11%
- Wales: 6%

Employer

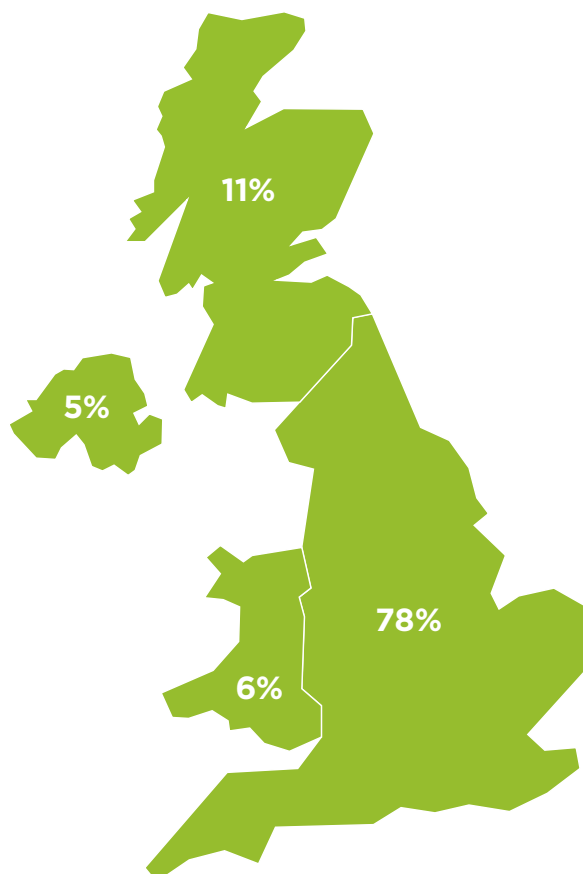
- NHS: 80%
- Non NHS: 20%

Employment status

- Permanent: 87%
- Bank: 6%
- Agency: 4%
- Temporary: 3%

Setting

- Hospital: 61%
- The community: 23%
- Care home: 11%
- Non-hospital urgent and emergency care, for example, call centre, walk-in centre, home visits, etc: 1%
- Prison/police custody: 1%
- Other (please specify): 3%



Demographics

Ethnicity

- 73% of respondents are of white British background (including English, Northern Irish, Scottish and Welsh)
- 14% of respondents are of a BAME background
- 9% of respondents are of white Irish (3%) and white other (6%) backgrounds
- Finally, 4% of respondents answered 'other' and prefer not to say

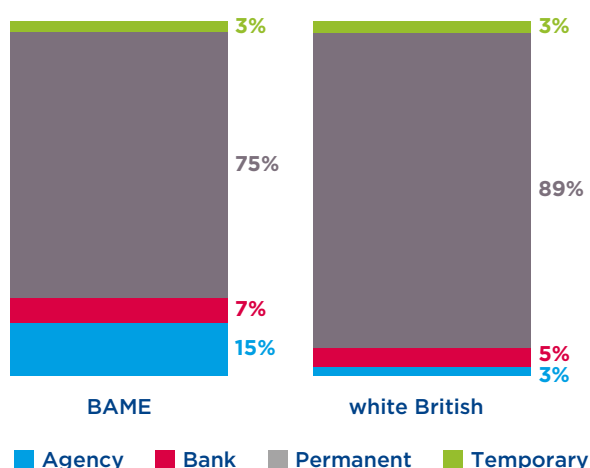
Gender

- 90% identify as female
- 8% identify as male
- 0% identify as non-binary
- 2% preferred not to say
- 0% Other

Disability

- 92% of respondents identify as not having a disability
- 6% of respondents identify as having a disability
- 2% preferred not to say

Which of these would best describe your current employment?



72% of BAME respondents are employed by an NHS organisation, 10% less than the white British respondents (82%).

BAME respondents were less likely to describe their current employment as 'permanent' (75%) than white British respondents (89%). BAME respondents were also more likely to be employed by an agency (15%) than white British respondents (2%).

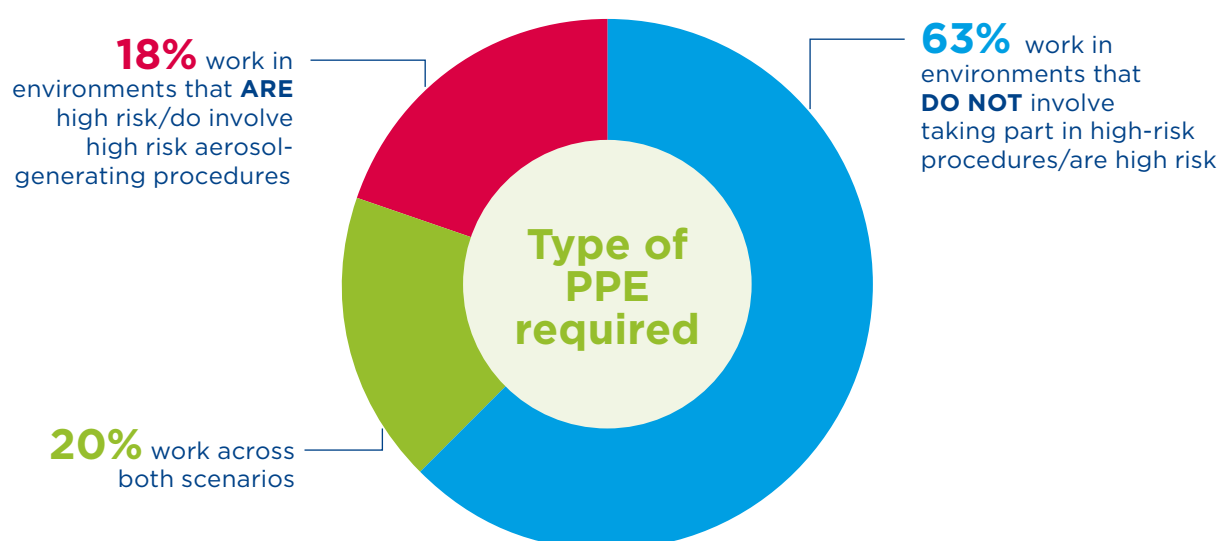
Amongst respondents who reported working for organisations other than the NHS, almost half in both groups work in care homes. 32% of BAME respondents reported working in an independently-run hospital setting compared with 12% of white British respondents. Only 10% of BAME respondents work in independently-provided services in the community, compared with 27% of white British respondents.

Among those who are employed by an NHS organisation, 84% of BAME respondents work in a hospital setting compared with 67% white British respondents. 12% of BAME respondents work in NHS settings in the community, compared with 28% of white British respondents.

Gender and ethnicity breakdown

Finally, 12% of BAME respondents identify as male compared with 7% of white British respondents. 86% of BAME and 93% white British respondents identify as female, respectively.

Appendix 2: Full results



Access to standard PPE

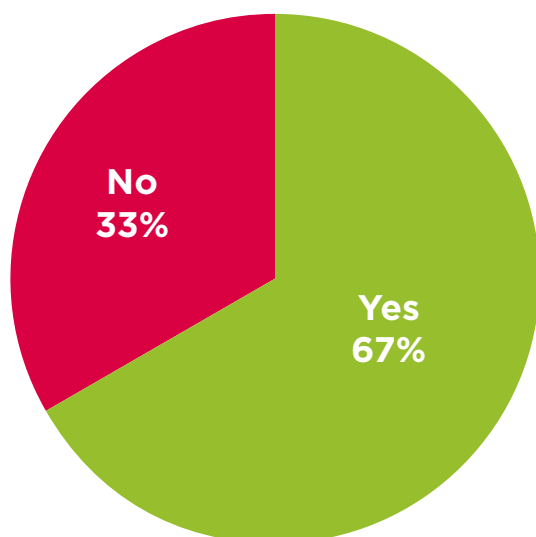
Do you have enough of the following standard PPE items for the duration of your shift?

	I have enough to use in my workplace		I have enough at the moment but am concerned about the supply for my next shift		There is not enough for me to use		I don't know		Not needed	
Eye/face protection (This may be single or reusable face/eye protection/full face visor or goggles)	2,541	62%	820	20%	512	12%	141	3%	121	3%
Fluid-repellent surgical face mask (Type IIR)	2,291	55%	985	24%	471	11%	204	5%	184	4%
Disposable plastic apron	3,417	83%	552	13%	119	3%	36	1%	11	0%
Disposable gloves	3,540	86%	481	12%	82	2%	26	1%	6	0%

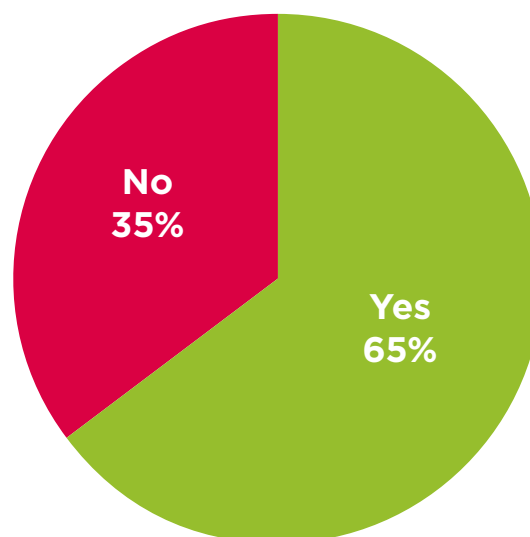
Are you experiencing any of the following issues with your PPE? (New question)

Increases my body temperature and makes me sweat	73%
Irritates or hurts my skin, ears, eyes, nose, mouth	54%
It does not fit (too short, too long, too loose, too tight)	38%
It does not consider my specific individual needs (for example, having a disability, wearing glasses, having a beard, religious and cultural practices)	29%

Have you received training on what PPE to wear and when you should wear it?



Have you received training on donning, doffing and disposing of standard PPE?



Pressure to reuse equipment

During this COVID-19 pandemic, 39% of respondents have been asked to re-use single use equipment.

Where did your standard PPE come from?

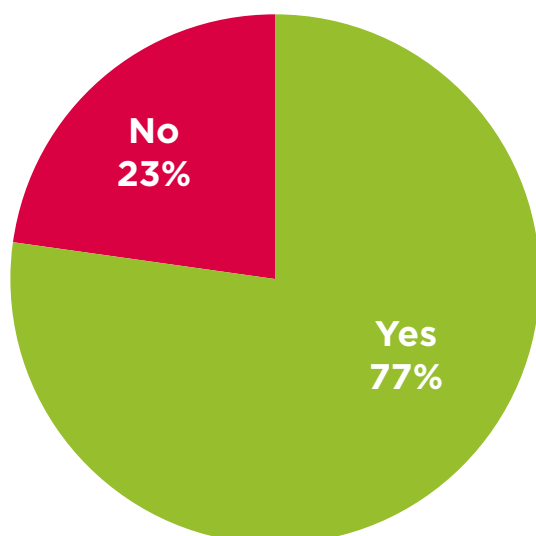
	Donated		Home-made		Provided by employer		Self-bought		I don't know	
Eye/face protection (This may be single or reusable face/eye protection/full face visor or goggles)	1,276	23%	306	6%	3,301	60%	332	6%	264	5%
Fluid-repellent surgical face mask (Type IIR)	304	7%	46	1%	3,662	81%	146	3%	372	8%
Disposable plastic apron	117	3%	12	0%	4,024	94%	26	1%	95	2%
Disposable gloves	122	3%	2	0%	4,045	94%	38	1%	83	2%

Working in high-risk environments

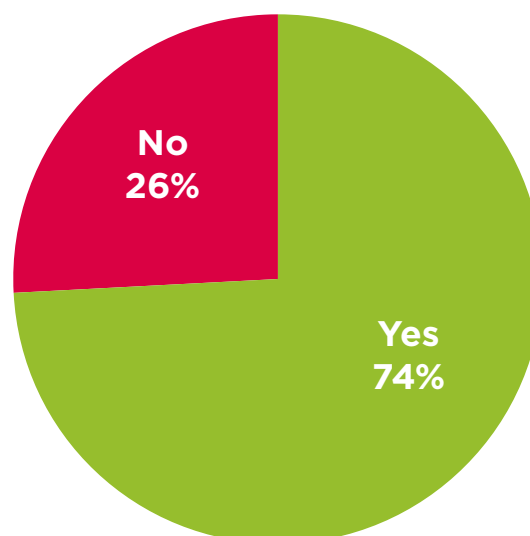
Do you have enough of the following PPE items, as recommended for supporting AGPs or other high-risk procedures, for the duration of your shift?

	I have enough to use in my workplace		I have enough at the moment but am concerned about the supply for my next shift		There is not enough for me to use		I don't know		Not needed	
Eye/face protection (This may be single or reusable face/eye protection/full face visor or goggles)	1128	60%	504	27%	197	11%	46	2%	7	0%
Filtering face piece respirator (FFP3 or FFP2/ N95)	744	40%	654	35%	360	19%	77	4%	47	3%
Disposable fluid-repellent coverall/gown	698	37%	636	34%	433	23%	75	4%	40	2%
Disposable gloves	1541	82%	291	16%	37	2%	13	1%	0	0%

Have you received training on PPE (as recommended for supporting AGPs or other high-risk procedures) to wear and when you should wear it?



Have you received training on donning, doffing and disposing of PPE (as recommended for supporting AGPs or other high-risk procedures)?



Pressure to reuse equipment

During this COVID-19 pandemic, 44% of respondents have been asked to re-use single use equipment.

Have you been adequately fit tested for the model(s) of filtering face piece respirator (FFP3 or FFP2/N95), you currently wear/have worn? *(Reworded question to take into account having to be fit tested for different models)*

Yes	69%
No	32%

Why has your mask not been fit tested? *(New question)*

Too many different brands/types of mask to fit test all	35%
I have not been scheduled to be fit tested by my employer	34%
I do not know why it hasn't happened	29%
My employer does not have sufficient fit testing equipment available	20%
There is no one trained to fit test	13%
I have been offered fit checking, but not fit testing	12%
I was not aware it had to be fit tested	7%

How long can you wear your filtering face piece respirator (FFP3 or FFP2/N95) before it becomes uncomfortable? *(New question)*

Less than 1 hour	27%
1 hour, but less than 2 hours	26%
2 hours but less than 3 hours	22%
3 hours but less than 4 hours	15%
4 or more hours	9%

Are you experiencing any of the following issues with your PPE? *(New question)*

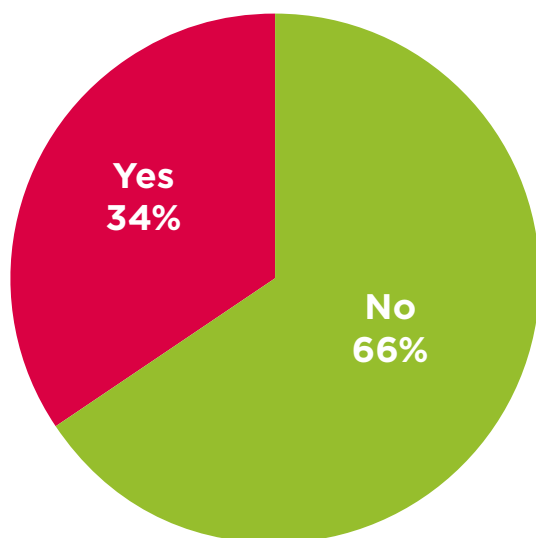
It does not fit (too short, too long, too loose, too tight)	41%
Irritates or hurts my skin, ears, eyes, nose, mouth	73%
Increases my body temperature and makes me sweat	82%
It does not consider my specific individual needs (e.g. having a disability, wearing glasses, having a beard, religious and cultural practices)	30%

Where did PPE items, as recommended for supporting AGPs or other high-risk procedures, come from?

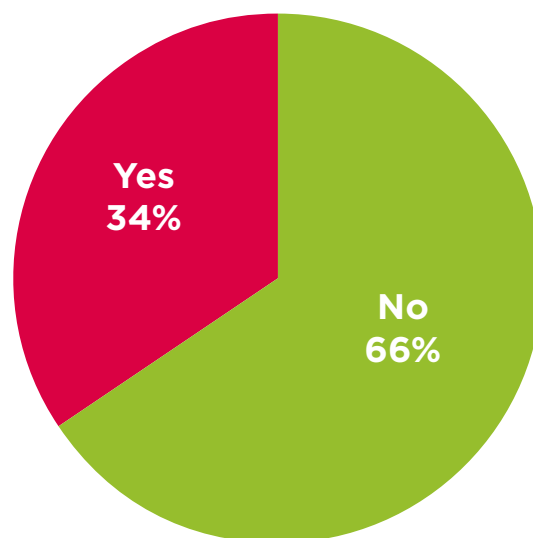
	Donated		Home-made		Provided by employer		Self-bought		I don't know	
Eye/face protection (This may be single or reusable face/eye protection/full face visor or goggles)	609	24%	131	5%	1520	61%	128	5%	113	5%
Filtering face piece respirator (for example, FFP3 or FFP2/N95)	98	5%	10	1%	1719	86%	40	2%	139	7%
Disposable fluid-repellent coverall/gown	126	6%	16	1%	1691	84%	20	1%	154	8%
Disposable gloves	51	3%	5	0%	1814	94%	8	0%	61	3%

Questions asked to all respondents

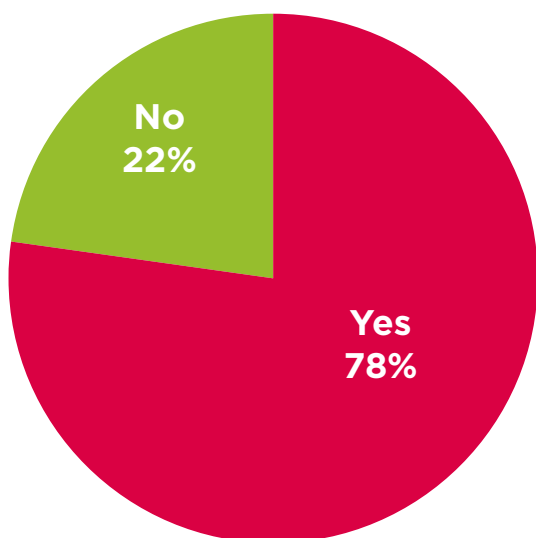
Have you felt pressured to care for a patient with possible or confirmed COVID-19 without adequate protection, as outlined in the current PPE guidance?



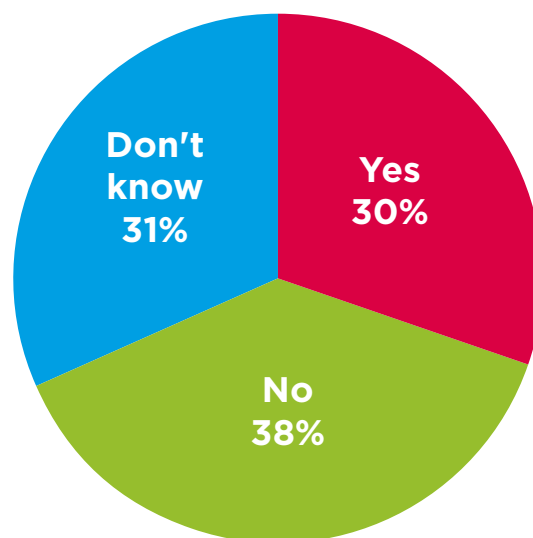
During the COVID-19 pandemic, have you been supplied with damaged/ easily damaged PPE (for example, items that have holes, are scratched, tear easily etc)? *(New question)*



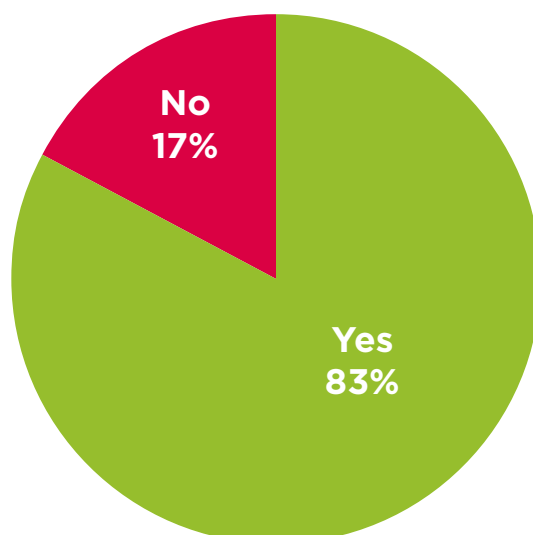
If yes, did you have to use these items? *(New question)*



During the COVID-19 pandemic, have you had to use PPE items which are past their expiry date? *(New question)*



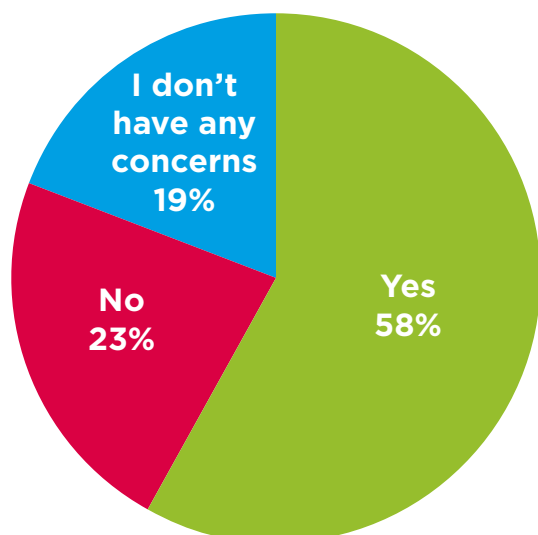
Have you been given information and training to recognise dehydration, fatigue and exhaustion while wearing your required PPE? *(New question)*



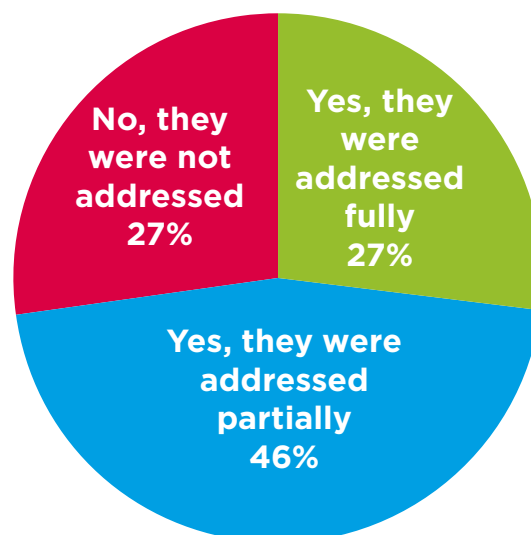
Do you have access to the following general infection control supplies?

	I have enough to use in my workplace		I have enough at the moment but am concerned about the supply for my next shift		There is not enough for me to use		I don't know		Not needed	
Alcohol-based hand rub (ABHR)	3,469	69%	1,074	21%	418	8%	47	1%	15	0%
Hand wash/soap	4,185	83%	610	12%	160	3%	43	1%	25	1%
Clinical waste disposal bag	4,114	82%	554	11%	188	4%	110	2%	57	1%
Detergent/disinfectant	3,583	71%	633	13%	280	6%	376	8%	151	3%
Disinfectant wipes for equipment cleaning	3,158	63%	1,116	22%	611	12%	112	2%	26	1%
Hand creams	2,321	46%	532	11%	1,587	32%	468	9%	115	2%

During the COVID-19 pandemic, have you raised any concerns you have had about PPE to your employer?



If you raised concerns, were they addressed?



What method did you use to raise your concerns? Select all that apply

Raised it verbally with my manager	91%
Raised it in writing with my manager	16%
Raised it formally with someone more senior (for example, nursing director, managing director, etc)	15%
Raised it with the RCN or other trade union workplace representative	5%
Filled in an incident form/near miss form or equivalent	5%
Raised it with RCN Direct or equivalent	2%

If you had concerns, but did not raise them, why not? (New question)

Do not believe any action will be taken	68%
Fearful of speaking out	29%
Worried would negatively impact my career/ training progression	24%
Insufficient protection and support for reporting	21%
I don't know how to raise my concerns	8%
Asked, or instructed not to speak out	5%
Threatened with sanctions if I did speak out	2%

Overall, how confident are you that your employer is doing enough to adequately protect you from coronavirus infection in your place of work? (New question)

Very confident	28%
Moderately confident	40%
Slightly confident	19%
Not confident at all	14%

References

- 1 Royal College of Nursing (2020) *Personal Protective Equipment: Use and Availability During the COVID-19 Pandemic*, London: RCN. <https://www.rcn.org.uk/professional-development/publications/rcn-ppe-survey-COVID-19-uk-pub-009235>
- 2 Kirby, Toby. *Evidence Mounts on the Disproportionate Effect of COVID-19 on Ethnic Minorities*. [https://www.thelancet.com/journals/lanres/article/PIIS2213-2600\(20\)30228-9/fulltext](https://www.thelancet.com/journals/lanres/article/PIIS2213-2600(20)30228-9/fulltext). Published online May 8, 2020
- 3 In total, 13,605 people responded to the previous PPE survey. Of these, 10,263 were respondents from a white British background and 1,624 were respondents from a BAME background.
- 4 Overall, there were 4,135 respondents within this category: 3,052 responses came from people from a white British background and 612 from respondents of BAME background. The number of respondents working in each setting are: A hospital – 2,274; the community (for example, general practice, district nursing team, hospice, school nurse, etc – 1,106; care homes – 525)
- 5 Overall, 1,882 respondents answered these questions: 1,324 from a white British background and 279 from a BAME background worked in these environments. Due to small sample sizes we were unable to carry out meaningful analysis on those who work in high risk environments by setting: A hospital – 1,581; the community; (for example, general practice, district nursing team, hospice, school nurse) etc – 169; a care home – 78.
- 6 Public Health England (2020) *COVID-19: Infection Prevention and Control Guidance*, NHS: London. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/886668/COVID-19_Infection_prevention_and_control_guidance_complete.pdf

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