HOSPITAL EMPLOYEE HEALTH

THE PRACTICAL GUIDE TO KEEPING HEALTHCARE WORKERS HEALTHY

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INSIDE

RELIAS MEDIA

Spring of Fear: ED Staff Face Surging Coronavirus

'In dire circumstances, you do dire things'

By Gary Evans, Medical Writer

Emergency physicians and other frontline clinicians are trying to hold the line against an accelerating coronavirus pandemic in the United States, even as they fear for their own safety and that of their families and colleagues. As this report was filed, the healthcare system was facing a major test as a surge of COVID-19 patients were presenting at some hospitals and were grimly anticipated in others.

A shortage of personal protective equipment (PPE) — particularly N95 respirators — ratcheted up the anxiety, as did the accumulating media reports of healthcare worker deaths, illness, and home quarantine. The epicenter of the coronavirus outbreak in the United States is New York City, which reported 45,707 cases of COVID-19 and 1,374 deaths as of April 1.

"I get very anxious when I am about to go into work," says **Avir Mitra**, MD, an emergency medicine physician at Mount Sinai Beth Israel Hospital in New York City. "The night before, I start getting anxious."

> "THE LAST THING WE WANT A MONTH FROM NOW — WHEN THIS SITUATION IS EVEN WORSE THAN IT IS TODAY — IS HALF OF THE ED DOCTORS SICK."

Some ED physicians worry more when they leave work and head home. **Torree McGowan**, MD, FACEP, an emergency physician at St. Charles Medical Center in Bend, OR, is starting to see the first wave of coronavirus infections in her area.

"I am definitely concerned," she

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MEDICAL WRITER: Gary Evans
EDITOR: Jill Drachenberg
EDITOR: Jonathan Springston
EDITORIAL GROUP MANAGER: Leslie Coplin
ACCREDITATIONS MANAGER: Amy M. Johnson, MSN, RN, CPN

EDITORIAL QUESTIONS:
For questions or comments, call **Gary Evans** at (706) 424-3915.

tells *Hospital Employee Health*. "My husband is immunosuppressed, so I shower and change clothes before I leave work. I am trying very hard to stay away from my family, and we are strictly socially isolating. I am not going anywhere but work, home, and then the bare minimum that we need to do [in the community]."

Healthcare workers are particularly concerned about a change in the CDC recommendations, which said wearing a surgical mask for COVID-19 patients was acceptable if N95 respirators were unavailable.[1] *(See CDC recommendations, page 55.)*

"The initial recommendation when this was coming out of China was N95s [or equally effective respirators]," McGowan says. "Now, we are being told surgical masks, but there is a lot of concern about whether that is being driven by the science or the shortage of N95s."

A Temporary State

The CDC recommendations allow wearing a surgical mask for general care of coronavirus patients, while still requiring respirators for aerosol-generating procedures. Those wearing surgical masks should still don gloves, gowns, and eye protection. The patient should be masked for source control of the virus.

"This is a temporary state of affairs," **Michael Bell**, MD, deputy director of the CDC Division of Healthcare Quality Promotion, said at a recent meeting at the agency. "The intent would be that once the supply chain [issues] are resolved, we would go back to recommending respirator protection once it is available. This is a pivot that we are making so we are not painted into a corner. We don't want to wait until everything is gone and there isn't anything left for those high-risk procedures. Now is the time to do this."

As of April 2, the CDC reported 213,144 cases and 4,513 deaths in the United States. The World Health Organization global count surpassed 500,000 cases with more than 16,000 deaths.

"If you look at the vast outbreak in China, it peaked and started to resolve in three or four months," Bell said. "We are now in month two. We probably have two or three more months of work to do in terms of accommodating this. Everything we do we have to try to be nimble, making sure what we have said so far doesn't get in the way, and getting ready for what happens next."

A last-ditch and widely ridiculed CDC recommendation calls for healthcare workers to use "scarves or bandanas" with a face shield if no masks of any kind are available.[2]

"That's crazy," Mitra says. "The last thing we want a month from now — when this situation is even worse than it is today — is half of the ED doctors sick."

Expressing similar concerns, a group of physicians posted a petition demanding action. It garnered more than 1.2 million signatures as this story was filed.[3]

"As a physician, I do not know how long it takes to make an N95 mask, but I do know how long it takes to train a physician, a nurse practitioner, a physician assistant, a respiratory therapist, or nurse," the petition states. "We are the supply chain that needs to be protected."

In addition to masks, hand hygiene, gloves, gowns, and face shields or goggles were being emphasized to protect healthcare personnel in the absence of a vaccine and effective treatment. Triage and

case identification protocols were in place, but given the shortages of coronavirus tests and waning PPE supplies in many areas, the general perception was that a critical moment was at hand.

As this story was filed, at least two U.S. clinicians were in critical condition with COVID-19, according to the American College of Emergency Physicians, while 14 doctors have died fighting the ongoing coronavirus outbreak in Italy. In the U.S., there were media reports of dozens of healthcare workers who were infected or in self-quarantine. Two unrelated deaths of healthcare workers were reported in Georgia, although it was not immediately clear if they acquired the virus at work or in the community.

"The reason this hits home and is a such a concern to us is centered around what we don't know," says **Hamad Husainy**, DO, FACEP, an emergency physician at Helen Keller hospital in Sheffield, AL. "A lot of young doctors like myself — I'm 38 years old and I've been in practice for 10 years — haven't seen something like this."

An Insidious Virus

Indeed, most U.S. healthcare workers have not experienced anything quite like this novel coronavirus in their careers. Certainly, some have dealt with two other coronaviruses, SARS in 2003 and MERS, which has established a sporadic presence in the Middle East since it emerged in 2012. There also was the 2009 influenza A H1N1 pandemic and the Ebola outbreak in 2014-2015.

From the U.S. perspective, none of these prior threats possessed the combination of morbidity and mortality posed by SARS-Cov-2, a highly transmissible respiratory virus that experts estimate has about 10 times the mortality rate of seasonal flu. This coronavirus can spread insidiously — from people who exhibit mild illness or appear asymptomatic — yet cause severe disease and death in the elderly and those with underlying medical conditions.

"I'm younger, so I feel like I would probably be OK [if infected], but it is still scary," Mitra says. "There are people [I work with] who are older. Say I have a patient and I ask a nurse, 'Can you go in and hang this medicine?' I feel terrible if the nurse is older, [thinking] 'Am I putting them in harm's way?' We all feel scared and anxious about this."

Concerned that healthcare system may be overrun, emergency clinicians echoed the national sentiment that people avoid becoming patients by staying home and practice social distancing when out. There has been some disconnect in this message, however, as several states and cities moved to enforce lockdowns to stop large gatherings of people. New York City went into lockdown — with essential services exempted — in mid-March, as the city that never sleeps fell silent.

"We definitely have coronavirus patients coming in. We are testing patients and a decent amount of them are positive," Mitra says. "We have older patients coming in who need to get admitted, and quite a few are going to the ICU. So far at our hospital, we are just kind of at capacity. I have not seen us go over capacity yet. I really do think in the next two weeks we will."

As in other hospitals, the policy at Beth Israel called for reusing N95 respirators, covering them between patients with examination masks that are then discarded.

"At my hospital, we still have PPE, but they have started rationing it," says Mitra. "They are giving us one N95 mask to use for the week and they are asking us to put it in a brown paper bag between shifts, which to me seems a little bit unsafe."

Confusion, Frustration

Companies were stepping in to make more masks and respirators, and it was hoped the situation would be resolved in the near term. There was a concerning undercurrent in these discussions that some healthcare workers may not report for duty if they are expected to work without proper PPE. The purchase of N95 masks and other PPE by the public also frustrated some medical workers on the frontlines desperate for supplies.

"A surgical mask is one thing. That is not unreasonable for a person to wear, and a lot of countries do that," Mitra said. "But I don't think somebody who is quarantining right now needs to be wearing an N95 mask. That type of activity should be banned. Whatever manufacturing [capacity] we have should be going to healthcare workers so we are able to care for other people's parents and grandparents when they get sick."

There was a sense of confusion and mixed messaging on both PPE and coronavirus testing, which has gone through a series of exasperating changes, from largely unavailable, announced, and delayed, then rolled out as if anybody could be tested. A shortage of testing reagents, swabs, and viral transport media followed in some areas, exacerbated by concerns of using scarce PPE during testing that is needed for frontline staff.

"We ramped up testing, but then we got an update from the NYC department of health saying we should not be testing anymore unless the patient is admitted to the hospital," Mitra said. "Sinai has a two-hour test, which is very helpful, but we are reserving that for patients that are admitted to the hospital so we can figure out whether they have it and put them in the right type of bed."

There were ongoing discussions about the appropriate time to test and the sensitivity of results, as COVID-19 has an incubation period of about two to 14 days, with the average onset of symptoms at day five.

"One of my good [physician] friends just got a fever yesterday. He's out," Mitra said. "Several of the residents are on seven-day quarantines because they have fevers. Every day the policy is shifting about what to do with them if they are sick. Should you test them or not? Of the people who happened to get sick when the policy was to test them, a couple of them are confirmed positives. Some of the others are just presumed positive and they are at home."

Temperature Check

At McGowan's hospital in Oregon, all personnel must take their temperature when they report for duty. Those with a temperature above 100.4°F cannot work. Those with no fever, but respiratory symptoms, must wear a mask.

"My hospital is allowing people to wear a mask at all times if they prefer," she says. "Every healthcare worker, from the doctors to the housekeepers, has their temperature check when they come. If you have respiratory symptoms, you are required to wear a mask the entire time you are in the hospital. None of our patients are allowed visitors except under very limited circumstances."

Elective surgeries are being cancelled to preserve PPE so it will be available for caregivers who are working with COVID-19, she says. However, this was not happening in all areas, and 300 clinicians at the University of Pittsburgh Medical Center (UPMC) wrote an open letter to administration calling for the end of nonemergency surgeries. UPMC had not responded to a request for comment as this report was filed.

"While the rationale to continue forward with elective cases and visits at outpatient clinics is that there are very few positive cases in Allegheny County, the reality is that testing is limited, thus the real number of total

CDC Guidelines for Reuse of N95 Respirators

Discard those used in aerosol procedures

With reuse of N95 respirators in effect at many hospitals, the CDC has issued recommendations that begin with the caveat "there is no way of determining the maximum possible number of safe reuses for an N95 respirator as a generic number to be applied in all cases."[1] Manufacturers may offer some guidance, and the CDC cited several recommendations regarding reuse and discarding N95 respirators:

- Discard N95 respirators following aerosol-generating procedures, contamination with blood, respiratory, or nasal secretions, and after close contact with patients with an infectious disease requiring contact precautions.
- Reduce surface contamination of respirators by placing a cleanable face shield or surgical mask over the respirator.
- Hang used respirators in a designated storage area or keep them in a clean, breathable container such as a paper bag between uses. Ensure respirators do not touch, and that each is clearly labeled with the wearer's name.
- Wash hands thoroughly with soap and water or an alcohol-based hand sanitizer before and after touching.
- Avoid touching the inside of the respirator. Perform hand hygiene if contact is made.
- Use a pair of clean gloves when donning a used N95 respirator. Discard gloves after the N95 respirator is donned and adjusted. ■

REFERENCE

1. Centers for Disease Control and Prevention. Pandemic planning: Recommended guidance for extended use and limited reuse of N95 filtering facepiece respirators in healthcare settings. Available at: https://bit.ly/39k0AQV

cases in our community is virtually unknown and likely to be rapidly increasing," the clinicians wrote. "Additionally, it is well known by now that those affected, especially the young, can be shedding COVID-19 for several days before exhibiting any signs/symptoms such as fever, cough, or shortness of breath."[4]

Indeed, McGowan has adopted the view that all patients must be presumed positive. "The best recommendation I have seen right now is assume that everybody you are around is infected, and assume that you are infectious because we think this is spreading from people who have very minimal symptoms or are asymptomatic."

Testing supplies also were an issue at her hospital, and the practice of only testing patients who were admitted with COVID-19 symptoms was in effect.

"We are setting up tents to isolate our respiratory complaints from nonrespiratory," she says. "There is a lot of stress among the frontline caregivers. This is all evolving so rapidly. We are getting different information about the science that is coming out looking at how long can this survive in the air and on surfaces. The recommendations for the PPE seem to be driven more by the shortages of PPE rather than what we think is actually best for protection. That's concerning, and it is creating a lot of stress for caregivers."

However, healthcare workers in areas where there are few or no reported cases may develop a sense of complacency. "I will say in general for our staff, it hasn't become as real as it has in other parts of the country," Husainy says. "They seem to be a little complacent. I hope when this is all said and done they can look at me and say, 'You were wound a little too tight.'"

Given the lean stock of N95s, masks are worn over respirators that may be used indefinitely, he explained. "With regard to PPE, we really have not been well-prepared," Husainy says. "We have literally two boxes of N95 masks in the entire hospital. We are being asked to take one and use it until further notice, until it gets visibly soiled or breaks. In dire circumstances, you do dire things."

The hospital plans to use powered air-purifying respirators (PAPR), which can be cleaned and reused, in the ED if suspect coronavirus cases begin presenting. "Right now, we are reserving them for the emergency medical staff," Husainy says. "In the ICU, these patients already have been delineated as who is at risk and who is not. In the ED, people come in and you have to find that out. It's a reality that we are going to run out of N95 respirators. My prediction is that our only option is going to be to use the PAPRs when we have to intubate somebody or place a patient on a ventilator."

Husainy urges his co-workers to remain on guard, reminding them that some healthcare workers were infected before there was recognized transmission in the community.

"We have to be as vigilant today as we will be when this ED is full of these patients," he says. ■

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4. University of Pittsburgh Medical Center residents. An open letter to UMPC, March 21, 2020. Available at: https://bit.ly/33MGDRJ

Crossing the Fine Line Between Fear and Courage

'It is a level of risk we have probably never in our careers faced'

Altruism that has been observed in various forms is the only time one can show courage is when one acts in the face of fear. This is what healthcare workers responding to the coronavirus pandemic are essentially doing, says **Wendy Dean**, MD, a psychiatrist and co-founder of Moral Injury of Healthcare.

"We have the same fears that everybody else has," she says. "We worry for our safety, our families, and our patients. Not usually in that order. Typically, we are worried about our patients first, our families second, and ourselves last."

Hospital Employee Health asked Dean, who has studied the concept of moral injury to healthcare workers as they attempt to protect and treat patients under difficult "normal" conditions, for more insight in the following interview.

HEH: Can to speak to what the healthcare workers' general mindset is in a pandemic situation?

Dean: We have been kind of acculturated to manage the risk and the fear of the work that we face. We face all kinds of infectious risks all the time. The difference is that typically when we are facing those they are known entities. We know what the algorithms are for treatment or for mitigation. The difference for coronavirus is that we don't know any of that. That does heighten our fear a little bit, or in some cases a lot, depending on what role people are filling in the hospital. I think for ED, primary care docs, infectious disease, critical care personnel, and first responders, it is a level of risk we have probably never in our careers faced — except some of the folks who responded to Ebola. It is an outsized risk, and as with anything else we are more comfortable dealing with the known — even if it is high risk — than dealing with the unknown. But we are going to face down that risk and do our jobs because that is what we have trained to do.

"THE MANTRA REALLY HAS GOT TO BE IF YOU DON'T HAVE PPE, YOU DON'T GO IN. I THINK THAT IS ABSOLUTELY ANATHEMA TO MOST PHYSICIANS, FIRST RESPONDERS — THAT IS NOT HOW WE ARE RAISED IN THIS PROFESSION."

HEH: What to think has been the effect of reports of infections and deaths in emergency clinicians?

Dean: It is very sobering. It's not unexpected. It is makes the whole theoretical concept become very real, very quickly. It also heightens the concern about PPE [personal protective equipment]. I think a lot of physicians, especially in those frontline specialties, are concerned about a scarcity of PPE. [Occupational infections] heighten the fact that PPE is going to be critical if we are going to avoid decimating our healthcare providers. I think this pandemic is moving much quicker than any of our bureaucratic systems can move.

HEH: If the healthcare system is overrun, there may have to be ethical decisions about which patients receive care. This has reportedly been the case in Italy, where the healthcare system has been overwhelmed by the coronavirus.

Dean: If you look at where our trend line is, we are following Italy right now. The way to fall off Italy's curve is to isolate, have strict social distancing, and everyone stay home. If we don't that, Italy is going to be our reality. We have as a society been averse to rationing in any way. We pretty much practice on [the model] of providing optimal care for every patient. That's our training, that's our culture, and so the idea that we will have to deny care to patients based on certain criteria will be exceptionally difficult. The other part of this that is going to be very hard is when you are facing a scarcity of PPE, as we saw in the Ebola epidemic. When physicians rushed in without PPE, they contracted the disease and were taken out of the healthcare workforce — either temporarily or they died. In either case, they couldn't take care of anyone. The mantra really has got to be if you don't have PPE, you don't go in. I think that is absolutely anathema to most physicians, first responders — that is not how we are raised in this profession. That will be extremely hard for people. ■

CDC Guidance for Use of Facemasks During Crisis

Homemade masks as a last resort

The CDC's recommendation for optimizing the supply of facemasks include "contingency" and "crisis" capacity. These are steps hospitals can take if they are no longer at "conventional" capacity, when standard measures remain in effect. These guidelines, which are subject to change with the coronavirus pandemic, were current as of March 25.[1]

The CDC defines contingency capacity as practices that may be used temporarily during periods of expected facemask shortages. Crisis capacity may call for stopgap measures "that are not commensurate with U.S. standards of care," the CDC states. Hospitals with conventional capacity should use facemasks according to product labeling and local, state, and federal requirements.

Contingency Capacity Methods:

• Selectively cancel elective procedures and nonurgent appointments that typically require facemask use by healthcare personnel (HCP).

• Remove facemasks for visitors in public areas.

• Consider removing facemasks in all public areas in healthcare facilities. Facemasks can be provided to symptomatic patients upon check in. Store all facemasks in a secure and monitored site.

• Extend use of facemasks by wearing the same facemask for repeated close contact encounters with several different patients.

Under extended use conditions:

• Discard the mask if it becomes soiled, damaged, or difficult to breathe through.

• Avoid touching facemasks. Perform hand hygiene if contact occurs.

• Leave patient care areas before removing masks.

Crisis Capacity Methods:

• Cancel all elective procedures and nonurgent appointments that typically require HCP facemask use.

• Use masks beyond the manufacturer-designated shelf life during patient care activities.

• Implement limited re-use of facemasks by using the same facemask for multiple encounters with different patients but removing it after each encounter.

• Facemasks that fasten with ties may not be able to be undone without tearing and should be considered only for extended use. Facemasks with elastic loops can be considered for re-use.

• Leave patient areas to remove facemasks. Fold masks so that the outer surface is held inward and against itself to reduce contact with the outer surface during storage. Store folded masks in a clean sealable paper bag or breathable container between uses.

Prioritize facemasks for selected activities such as:

• Essential surgeries and procedures;

• During care activities that may result in splashes or sprays;

• During prolonged face-to-face or close contact with a potentially infectious patient;

• Performing aerosol-generating procedures, if no respirators are available.

If facemasks are not available:

• Exclude HCP at higher risk for severe illness from COVID-19, such as those of older age, with chronic medical conditions, or those who may be pregnant, from caring for patients with confirmed or suspected COVID-19 infection.

• Consider designating HCP who have clinically recovered from COVID-19 to provide care for additional patients with COVID-19. Those who have recovered from COVID-19 may have developed some immunity, but this is unconfirmed.

• Use a face shield that covers the entire front and sides of the face with no facemask.

• Consider using patient isolation rooms for risk reduction.

• Portable fans with high-efficiency particulate air (HEPA) filtration can increase the effective air changes per hour of clean air to the patient room, reducing risk to individuals entering the room without respiratory protection.

• Consider use of ventilated headboards. These draw exhaled air from a patient in bed into a HEPA filter, decreasing risk of HCP exposure to patient-generated aerosol.

• HCP may use homemade masks (including scarves or bandanas) for care of patients with COVID-19 as a last resort. However, homemade masks are not considered PPE, since protective capabilities are unknown. Exercise caution if considering this option. Homemade masks should be used in combination with a face shield that covers the entire front and sides of the face. ■

REFERENCE

1. Centers for Disease Control and Prevention. Strategies for optimizing the supply of facemasks. Available at: https://bit.ly/3amSCYq

Table 1. Epidemiologic Risk Classification for Asymptomatic Healthcare Personnel Following Exposure to Patients with Coronavirus Disease (COVID-19) or their Secretions/Excretions in a Healthcare Setting, and Their Associated Monitoring and Work Restriction Recommendations

Epidemiologic Risk Factors	Exposure Category	Recommended Monitoring for COVID-19 *(until 14 days after last potential exposure)*	Work Restrictions for Asymptomatic HCP
Prolonged close contact with a COVID-19 patient who was wearing a facemask (i.e., source control)			
HCP PPE: None	Medium	Active	Exclude from work for 14 days after last exposure
HCP PPE: Not wearing a facemask or respirator	Medium	Active	Exclude from work for 14 days after last exposure
HCP PPE: Not wearing eye protection	Low	Self with delegated supervision	None
HCP PPE: Not wearing gown or gloves[a]	Low	Self with delegated supervision	None
HCP PPE: Wearing all recommended PPE (except wearing a facemask instead of a respirator)	Low	Self with delegated supervision	None
Prolonged close contact with a COVID-19 patient who was not wearing a facemask (i.e., source control)			
HCP PPE: None	High	Active	Exclude from work for 14 days after last exposure
HCP PPE: Not wearing a facemask or respirator	High	Active	Exclude from work for 14 days after last exposure
HCP PPE: Not wearing eye protection[a]	Medium	Active	Exclude from work for 14 days after last exposure
HCP PPE: Not wearing gown or gloves[a,b]	Low	Self with delegated supervision	None
HCP PPE: Wearing all recommended PPE (except wearing a facemask instead of a respirator)[b]	Low	Self with delegated supervision	None

HCP: healthcare personnel; PPE: personal protective equipment

[a]The risk category for these rows would be elevated by one level if HCP had extensive body contact with the patients (e.g., rolling the patient).
[b]The risk category for these rows would be elevated by one level if HCP performed or were present during a procedure likely to generate higher concentrations of respiratory secretions or aerosols (e.g., cardiopulmonary resuscitation, intubation, extubation, bronchoscopy, nebulizer therapy, sputum indication). For example, HCP who were wearing a gown, gloves, eye protection, and a facemask (instead of a respirator) during an aerosol-generating procedure would be considered to have a medium-risk exposure.

Adapted from the Centers for Disease Control and Prevention: https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html#table1

CDC Defines 'Low-Risk' Occupational Exposures to Coronavirus

A move to avoid arbitrary furloughs over minor breaks

The CDC recently issued guidelines allowing healthcare personnel (HCP) to continue working if they incur only "low-risk" exposures to patients with COVID-19. With some reported cases of large numbers of HCP furloughed after exposures, the CDC is moving to preserve the workforce in situations where HCP are exposed to infected patients through minor breaks in protocol or personal protective equipment (PPE).[1]

"As we look at the progress of this outbreak, there is going to be greater and greater numbers of [HCP] exposed. Not necessarily high-risk exposures like doing an induced sputum or something like that, but nonetheless a non-negligible exposure," said **Michael Bell**, MD, deputy director of the CDC Division of Healthcare Quality Promotion, at a recent meeting at the agency.

Furloughs Present Risks

The result of routinely furloughing these workers with minor exposures for two weeks could be inadequate staff to care for patients. Thus, the CDC has designed contingency planning guidelines that would allow asymptomatic healthcare workers to still work if they have a "low-risk" exposure to a coronavirus patient. *(For more information, see table, page 56.)* These include allowances for asymptomatic HCP to continue to work after options to improve staffing have been exhausted.

"Facilities could consider allowing asymptomatic HCP who have had an exposure to a COVID-19 patient to continue to work after consultation with their occupational health program," the CDC stated. "These HCP should still report temperature and absence of symptoms each day prior to starting work. Facilities could have exposed HCP wear a facemask while at work for the 14 days after the exposure event if there is a sufficient supply of facemasks."

If these workers develop even mild symptoms consistent with COVID-19, they must stop all patient care, notify their supervisor, and leave work, the CDC suggested. The thinking, in part, is to maintain the critically needed healthcare workforce rather than use arbitrary and extensive furloughs.

What Is 'Low Risk'?

Examples of low risk include occupational exposure to a COVID-19 patient without wearing eye protection, a gown, or gloves. Wearing a surgical mask instead of an N95 respirator while exposed to a coronavirus patient also is categorized as a low risk. Of course, individual circumstances could affect these situations greatly, and the CDC recommendations are nonregulatory and optional.

The guidelines stated the CDC has "removed [the] requirement under 'self-monitoring with delegated supervision' for healthcare facilities to actively verify absence of fever and respiratory symptoms when HCP report for work. This is now optional." The CDC also simplified risk exposure categories based on the most common scenarios involving source control measures, use of PPE, and the duration of contact with the patient.

"[Community transmission] means previously recommended actions (e.g., contact tracing and risk assessment of all potentially exposed HCP) are impractical for implementation by healthcare facilities," the CDC guidelines stated. "In the setting of community transmission, all HCP are at some risk for exposure to COVID-19, whether in the workplace or in the community. Facilities should shift emphasis to more routine practices, which include asking HCP to report recognized exposures, regularly monitor themselves for fever and symptoms of respiratory infection, and not report to work when ill."

Create Employee Screening Plan

Infection preventionists and their employee health colleagues should develop a plan for how they will screen for symptoms and evaluate sick workers. This could include requiring healthcare workers to report absence of fever and symptoms prior to starting work each day.

"I think this will make a large difference," Bell said at meeting of the CDC's Healthcare Infection Control Practices Advisory Committee (HICPAC). "The issue of [allowing] symptomatic personnel to work is not currently on the table. It is

something, however, I think a great deal about because during cold and flu season it is a reality that many healthcare workers come to work with a minor sniffle or a scratchy throat."

There may come a time during this outbreak where shorthanded facilities should consider letting workers with mild symptoms be allowed to work while wearing a mask.

"This is at odds with the very concrete statement that people often make of 'don't come to work when you're ill," he said. The problem with that blanket policy — and one of the explanations for the longstanding problem of presenteeism — is that many healthcare workers have limited sick leave, must use vacation days, or are not paid if they are out sick.

"I think our [HICPAC] committee is going to have to weigh in," Bell said. "Not just for this outbreak, but looking forward. Do we want to see a change in our culture about how we manage healthcare personnel with very mild symptoms?"

The CDC will continue to grapple with these problems in healthcare, but the shift to community mitigation will dominate the coming months, he added.

"With regard to the healthcare system, right now the focus is on protecting a very critical asset to the nation," Bell said. "At a certain point, healthcare personnel are going to be more likely to get this infection at the grocery store than they are at the hospital." ■

REFERENCE

1. Centers for Disease Control and Prevention. Interim U.S. guidance for risk assessment and public health management of healthcare personnel with potential exposure in a healthcare setting to patients with coronavirus disease 2019 (COVID-19). Available at: https://bit.ly/2VIt9Eu

OSHA Allows 'Enforcement Discretion' During COVID-19

CMS also drops routine surveys to focus on coronavirus

Responding to respirator shortages during the outbreak of novel coronavirus, the Occupational Safety and Health Administration (OSHA) has issued a memorandum allowing "enforcement discretion" by compliance officers citing the Respiratory Protection standard (29 CFR § 1910.134).

"OSHA recommends HCP employers follow existing CDC guidelines, including taking measures to conserve supplies of these respirators while safeguarding HCP," the agency memo stated. "One such measure is that healthcare employers may provide HCP with another respirator of equal or higher protection, such as N99 or N100 filtering facepieces, reusable elastomeric respirators with appropriate filters or cartridges, or powered air-purifying respirators (PAPR)."[1]

OSHA instructed its field offices to exercise enforcement discretion on the annual fit-testing requirement as long as employers:

- Make a good-faith effort to comply with 29 CFR § 1910.134.
- Use only NIOSH-certified respirators.
- Use CDC and OSHA methods to optimize the supply of N95s and prioritize their use.
- Perform initial fit tests with each employee using the same model, style, and size respirator that the worker will be required to wear.
- Inform HCP the annual fit testing of N95 filtering facepiece respirators is suspended to preserve

and prioritize the supply of respirators.

• Explain the importance of performing a fit check at each donning to ensure an adequate face seal, in accordance with the procedures outlined in 29 CFR § 1910.134, Appendix B-1.

• Conduct a fit test if there are any physical changes to the employee that may affect respirator fit (e.g., facial scarring, dental changes, cosmetic surgery, or obvious changes in body weight) and explain to workers that if their face shape has changed since their last fit test, they may no longer be getting a good facial seal with the respirator.

• Remind HCP to inform their supervisor or their respirator program administrator if the integrity and/or fit of their N95 is compromised.

CMS Targets COVID-19

The Centers for Medicare & Medicaid Services (CMS) is suspending routine inspections to focus on issues related to infection control and COVID-19 in hospitals, nursing homes, and other accredited sites, a CMS official announced.

"[We are] suspending nonemergency surveys across the country so our surveyors can focus on the most serious health and safety threats like infectious disease," said **Daniel Schwartz**, MD, MBA, chief medical officer of the CMS Survey and Certification Group. "Our colleagues in the accrediting agencies will follow us on this policy as well." Hospital, dialysis centers, and other facilities with a history of infection control deficiencies still are in line for surveys, he added.

In a March 4 memorandum, CMS said its action allows "inspectors to turn their focus on the most serious health and safety threats like infectious diseases and abuse. This shift in approach also will allow inspectors to focus on addressing the spread of the coronavirus disease 2019 (COVID-19)."[2]

According to CMS, effective immediately, surveys are limited to the following, which are listed in priority order:

• All immediate jeopardy complaints and allegations of abuse and neglect;

• Infection control complaints, including facilities with potential COVID-19 or other respiratory illnesses;

• Statutorily required recertification surveys such as nursing homes, home health, and hospice.

• Any revisits necessary to resolve current enforcement actions;

• Initial certifications;

• Surveys of facilities with a history of infection control deficiencies at the immediate jeopardy level in the last three years;

• Surveys of facilities, hospitals, and dialysis centers with a history of infection control deficiencies at lower levels than immediate jeopardy.

If a CMS inspector identifies or suspects COVID-19, they are to work closely with CMS regional offices in coordination with the CDC. CMS has deployed an infection preventionist to the CDC to assist with guideline development. ■

REFERENCES

1. Occupational Safety and Health Administration. Temporary enforcement guidance — Healthcare respiratory protection annual fit-testing for N95 filtering facepieces during the COVID-19 outbreak, March 14, 2020. Available at: https://bit.ly/2WWd0fp
2. Centers for Medicare & Medicaid Services. Suspension of survey activities, March 4, 2020. Available at: https://go.cms.gov/2W7iDXu

CE OBJECTIVES

After reading each issue of *Hospital Employee Health*, the nurse will be able to:

1. Identify particular clinical, administrative, or regulatory issues related to the care of hospital employees;
2. Describe how the clinical, administrative, and regulatory issues particular to the care of hospital employees affect healthcare workers, hospitals, or the healthcare industry at large;
3. Cite solutions to the problems faced in the care of hospital employees based on expert guidelines from relevant regulatory bodies, or the independent recommendations of other employee health professionals.

COMING IN FUTURE MONTHS

- Should healthcare workers recovered from coronavirus be considered immune?
- Grief work: Death of a colleague during pandemic
- A national survey on personal protective equipment supplies
- Preparing for the seasonal return of novel coronavirus

HOSPITAL EMPLOYEE HEALTH

CE INSTRUCTIONS

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CE QUESTIONS

1. **The CDC recommendations allow wearing a surgical mask for general care of coronavirus patients, while still requiring respirators for:**

   a. transport of patients.
   b. patients that cannot wear a mask.
   c. aerosol-generating procedures.
   d. initial triage.

2. **Torree McGowan, MD, FACEP, said all personnel at her hospital must undergo a temperature check when they report for duty. They cannot work if their temperature is above:**

   a. 98.6°F.
   b. 99.5°F.
   c. 100°F.
   d. 100.4°F.

3. **Hamad Husainy DO, FACEP, said a lot of the fear and uncertainty about COVID-19 is based on:**

   a. the unknown.
   b. lack of vaccine.
   c. lack of proven treatment.
   d. complacency.

4. **Wendy Dean, MD, said current coronavirus trends in the U.S. outbreak are following along the same epidemic line as:**

   a. South Korea.
   b. Italy.
   c. Iran.
   d. China.