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COVID-19: Nine Out of 10 HCP Recover Without Hospitalization

CDC reports 27 deaths as healthcare workers fight on

By Gary Evans, Medical Writer

In what is considered an underestimate, the Centers for Disease Control and Prevention (CDC) recently reported that more than 9,000 healthcare workers in the United States have been infected with novel coronavirus and 27 have died.

Despite the severity of a spectrum of cases, 90% of the healthcare workers recovered without hospitalization. In addition to overcoming fear to treat patients, the healthcare workforce is proving resilient in the face of the COVID-19 pandemic.

“We always knew that healthcare workers would be essential to combatting pandemics, but I think you can see with this one, it is more

true than many of us had anticipated,” **Robert Redfield**, MD, director of the CDC, said at recent meeting. “This virus is clearly one of the most infectious respiratory viruses that we have ever had to deal with.”

In CDC surveillance data from Feb. 12 to April 9, healthcare personnel (HCP) accounted for 9,282 of 49,370 COVID-19 case reports with occupational information.¹ The information was gathered from CDC surveillance forms.

The numbers and percentages vary depending on the detail provided in individual reports.

“This [report] is likely an underestimation because HCP status was available for only 16% of reported cases

“THIS VIRUS IS CLEARLY ONE OF THE MOST INFECTIOUS RESPIRATORY VIRUSES THAT WE HAVE EVER HAD TO DEAL WITH.”

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nationwide,” the CDC stated. “HCP with mild or asymptomatic infections might also have been less likely to be tested, thus less likely to be reported. The total number of COVID-19 cases among HCP is expected to rise as more U.S. communities experience widespread transmission.”

Although only 6% of the infected workers were at least age 65 years, 37% of deaths occurred in this older age group. In addition, 38% of those infected had underlying risk factors including asthma, chronic obstructive pulmonary disease, diabetes, cardiovascular disease, and an immune-compromised condition.

“Older HCP or those with underlying health conditions should consider consulting with their healthcare provider and employee health program to better understand and manage their risks regarding COVID-19,” the CDC recommended. “The increased prevalence of severe outcomes in older HCP should be considered when mobilizing retired HCP to increase surge capacity, especially in the face of limited PPE [personal protective equipment] availability.”

One approach is to assign these workers to lower-risk duties like administrative tasks, the CDC noted.

Almost Half Exposed in Community

Breaking down the cases reveals 55% of medical workers reported healthcare exposures, with the remainder citing household (27%), community (13%), or exposures in multiple settings (5%). The data reflect the “potential for exposure in multiple settings, especially as community transmission increases. Further, transmission might come from unrecognized sources, including

presymptomatic or asymptomatic persons,” the CDC reported.

The numbers overall are fairly consistent with what is reported in other countries, says **Torreo McGowan**, MD, FACEP, an emergency physician at St. Charles Medical Center in Bend, OR.

“Unfortunately, the more you are exposed and the higher the levels of exposures, the higher the risks of infection,” she says. “Healthcare workers are around very sick people who are shedding a lot of virus on a regular basis. But only about half the healthcare workers in the study had their [exposure] at work. We have to be careful outside the hospital, not just within it.”

As the boundaries blur, it will be more challenging to make the distinction between community and occupational transmission to healthcare staff. More benign strains of coronavirus cause colds of unknown origin, but the severity of this infection raises issues of occupational health and workers’ compensation.

“When we have healthcare workers who get sick with a cold, we are not always sure if they picked it up from work or from the community,” McGowan says. “As this virus spreads more in communities, [the source of transmission] probably won’t matter as much once we have ways to treat this — especially when we get a vaccine in place. There is a whole other question of workers’ compensation and workplace injuries that is completely different. From a medical standpoint, it probably doesn’t matter, but from a financial and liability standpoint, that is a different conversation.”

Among those who reported contact with a confirmed COVID-19 patient in a healthcare setting, details of the exposure and whether

the worker was wearing PPE could not be determined. Among HCP patients with data available, the median age was 42 years. Among HCP patients with data available on age and health outcomes, 6,760 were not hospitalized. However, 723 were hospitalized, and 184 were admitted to an intensive care unit (ICU).

Although 92% of the healthcare workers reported at least one symptom among fever, cough, or shortness of breath, the remaining 8% did not report any of these symptoms. Preventing asymptomatic transmission was one of the justifications for the recent CDC recommendation for all healthcare workers to wear surgical masks while on duty. (*See related story in this issue.*)

“Assuring source control among all HCP, patients, and visitors in healthcare settings is a promising strategy for further reducing transmission,” the CDC stated. “Even if everyone in a healthcare setting is covering their nose and mouth to contain their respiratory secretions, it is still critical that, when caring for patients, HCP continue to wear recommended PPE.”

Given the shift to community spread, contact tracing after occupational exposures is likely to be fruitless.

“Additional measures that will likely reduce the risk for infected HCP transmitting the virus to colleagues and patients include screening all HCP for fever and respiratory symptoms at the beginning of their shifts, prioritizing HCP for testing, and ensuring options to discourage working while ill such as flexible and nonpunitive medical leave policies,” the CDC concluded.

Redfield said COVID-19 is peaking in the United States, but will

likely increase again in the colder days ahead and coincide with seasonal flu.

“It is very probable that by late fall 2020, winter 2021, that we will be back in the throes of fighting a substantial outbreak against this virus,” he said. “Hopefully, this time we will be able to stay in the mode of high containment because of astute early diagnosis, contact tracing, isolation, things that [HCP] will be a critical component of.”

Q&A

The CDC sent the following responses to *Hospital Employee Health* via email from report authors **Sherry Burrer**, MD, and **Matthew Stuckey**, PhD, MPH. Both serve on the CDC’s COVID-19 Response Health Systems Worker Safety Task Force.

HEH: Based on this report, would you recommend that hospital employee health departments identify older workers and others with underlying risks of COVID-19 complications and consider removing them from care of these patients?

CDC: We stress that older HCP or those with underlying health conditions should consult their healthcare provider and employee health program to better understand and manage their risks regarding COVID-19. Healthcare facilities can consider limiting exposure of HCP at high risk of severe illness to patients with confirmed or suspected COVID-19. Another consideration is preferential assignment of older HCP or those with underlying health conditions to lower-risk settings such as telemedicine, administrative assignments, or clinics for non-COVID-19 patients. During severe PPE supply limitations, one method may be to exclude HCP at higher risk for severe illness from COVID-19

from caring for patients with confirmed or suspected COVID-19 infection.

HEH: Did you see any signs of increased infection severity or outcomes in African American HCP?

CDC: Because of missing data, all analyses are descriptive, and no statistical comparisons were performed. While we were able to present data on health outcomes (hospitalizations, ICU admissions, and deaths) by age, additional work is needed to confirm findings about the impact of other potentially important factors, such as disparities in race and ethnicity or underlying health conditions.

HEH: The report does not include information on what PPE was used. Would the HCP have been expected to wear PPE for suspected coronavirus cases during this surveillance period?

CDC: During this period, HCP were recommended to follow the guidance in place by CDC regarding PPE and caring for confirmed and suspected COVID-19 patients: gloves, isolation gown, eye protection, and an N95 respirator or higher-level respirator — or a facemask, if respirators are not available.

HEH: How does the growing presence of COVID-19 complicate identification of occupational infections? Can you comment on whether there will be a point where it will be less meaningful to make this distinction, or is it always important to try to determine if occupational infections are occurring?

CDC: It is important to determine if occupational infections are occurring so we can better understand which specific HCP groups are most affected and how the exposures are happening. This information would inform interventions and guidance. However, done alone, contact tracing after recognized occupational

exposures likely will fail to identify many HCP at risk for developing COVID-19. This is a consequence of asymptomatic transmission and the fact that determining work-relatedness becomes more challenging as community transmission increases. Our analysis indicated that HCP reported exposures at work, at home, and/or in the community, highlighting the potential for exposure in multiple settings.

HEH: Does the CDC recommend that healthcare workers be assessed for fever when they report to work?

CDC: Additional measures in healthcare settings may reduce the risk for infected HCP transmitting the virus to colleagues and patients regardless of the source of HCP infection. These include screening all HCP for fever and respiratory symptoms at the beginning of their shifts, prioritizing HCP for testing, and ensuring options to discourage working while ill (e.g., flexible and nonpunitive medical leave policies).

HEH: How can healthcare facilities address asymptomatic workers?

CDC: Given the evidence for presymptomatic and asymptomatic transmission, assuring source control and covering the nose and mouth [with masks] among all HCP, patients, and visitors in healthcare settings is a promising strategy for further reducing transmission.

'More Questions Than Answers'

The thought of asymptomatic healthcare workers spreading coronavirus to patients and co-workers is one of the more daunting aspects of responding to the pandemic.

"After reading this, I feel I have

more questions than answers," says **Hamad Husainy**, DO, FACEP, an emergency physician at Helen Keller Hospital in Sheffield, AL. "How many of us have it [asymptomatically] and are walking around spreading it to other people?"

Ultimately, better testing capabilities are needed to understand transmission to healthcare workers in the hospital and community.

"WITH THE LACK OF REAL-TIME TESTING AND THE LACK OF OVERTLY SENSITIVE TESTING, WE REALLY CAN'T ACCURATELY REPRESENT REAL TIME WHAT THE SITUATION LOOKS LIKE. WE WILL GET THERE."

"It is something from an epidemiological standpoint that we don't have a really great handle on yet," Husainy says. "With the lack of real-time testing and the lack of overtly sensitive testing, we really can't accurately represent real time what the situation looks like. We will get there."

That said, historical respiratory virus testing has had questionable accuracy, with a rapid test for flu typically yielding an accuracy rate of 58%.

"That is a little bit better than a coin flip," Husainy says. "We have an ELISA [enzyme-linked immunosorbent assay] test with a

3.5-hour turnaround that has a much better sensitivity, but we are talking about something that has been around a long time. Most places aren't even using that test, because nobody wants to wait in urgent care or a hospital or get a call back with results. For flu, really the recommendations in emergency medicine are if you suspect flu and it's flu season, they have the flu. We rarely test for it."

In an important difference, antiviral treatment for flu is available and may be administered empirically. A similar situation may result with the first treatments for novel coronavirus.

"You can imagine if a drug company gets FDA [Food and Drug Administration] approval for a treatment or reduction of symptoms of coronavirus, people are just going to give it for the mere suspicion [of infection]," he says. "In the short term, that does have some utility, as long as there are appropriate studies on the drug to make sure it is not harmful."

In the interim, assume everyone is infected — including yourself, McGowan recommends.

"That's how everyone is operating because it is the people without symptoms who are really spreading this," she says. "People are being fairly careful now if they start to get sick. The best research we have right now is that you are contagious about two or three days before you start to have symptoms. Once we get better testing, we could try to limit these exposures." ■

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One COVID-19 Patient Exposed 43 Healthcare Personnel

Three cases thought to be first U.S. occupational infections

An unsuspected case of COVID-19 — hospitalized as the pandemic was beginning in the United States — exposed 43 healthcare personnel (HCP) and caused what are thought to be the first occupational infections with the virus, the Centers for Disease Control and Prevention (CDC) reported.¹

On Feb. 26, the first U.S. case of community-acquired COVID-19 was confirmed in a patient at “hospital B” in Solano County, CA. Initially, the patient had been evaluated at a different facility, “hospital A,” the CDC reported.

“At that time, COVID-19 was not suspected, as the patient denied travel or contact with symptomatic persons,” the CDC noted. “During a four-day hospitalization, the patient was managed with standard precautions and underwent multiple aerosol-generating procedures, including nebulizer treatments, bilevel positive airway pressure ventilation, endotracheal intubation, and bronchoscopy.”

Several days later, the patient tested positive for SARS-CoV-2, the virus that causes COVID-19.

“Among 121 hospital A HCP who were exposed to the patient, 43 (35.5%) developed symptoms during the 14 days after exposure and were tested for SARS-CoV-2,” the CDC noted. “Three had positive test results and were among the first known cases of probable occupational transmission of SARS-CoV-2 to HCP in the United States.”

Other healthcare workers could have been infected with the virus but were not picked up in the testing, the CDC acknowledged. Workers were tested through nasopharyngeal and oropharyngeal specimens, but serological testing was not performed. Likewise, additional infections might have occurred among asymptomatic-exposed HCP who were not tested.

“It is possible that additional infections may have occurred among the 40 symptomatic healthcare personnel who tested negative, due to potential limitations in test sensitivity and timing,” says lead author **Amy Heinzerling, MD**, an officer in the CDC Epidemic Intelligence Service. “It also is possible that their symptoms were caused by other respiratory infections or by noninfectious causes

such as seasonal allergies. Most of these 40 healthcare personnel had mild symptoms, and none required hospitalization.”

The three infected staff members performed more physical examinations of the patient and had longer exposures during nebulizer treatments without wearing personal protective equipment (PPE).

“Because transmission-based precautions were not in use, no HCP wore PPE recommended for COVID-19 patient care during contact with the index patient,” the CDC concluded. “Healthcare facilities should emphasize early recognition and isolation of patients with possible COVID-19 and use of recommended PPE to minimize unprotected, high-risk HCP exposures and protect the healthcare workforce.” ■

REFERENCE

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CDC Issues Return to Work Guidelines for Healthcare Personnel

Testing preferred, but there is another option

The Centers for Disease Control and Prevention (CDC) has issued guidelines for healthcare personnel (HCP) to return to work after suspected or confirmed COVID-19 infection.¹

Employee health professionals should consider their local situation with the coronavirus in using one of the two options recommended by the CDC: a test-based method or a non-test-based method

“Use the test-based strategy as the preferred method for determining when healthcare personnel may return to work in healthcare settings,” the CDC recommended.

Test, or No Test

However, since testing has been an issue since the pandemic began, the CDC includes a non-test method as well.

The test-based method calls for exclusion from work until these three conditions are met:

- Fever resolves without use of fever-reducing medications;

- Respiratory symptoms (e.g., cough, shortness of breath) improve;

- Two negative results from at least two consecutive nasopharyngeal swab specimens collected 24 hours apart (total of two negative specimens).

The non-test-based method calls for exclusion from work until:

- At least 72 hours have passed since resolution of fever without the use of fever-reducing medications and improvement in respiratory symptoms;

- At least seven days have passed since symptoms first appeared.

“HCP with laboratory-confirmed COVID-19 who have not had any symptoms should be excluded from work until 10 days have passed since the date of their first positive COVID-19 diagnostic test, assuming they have not subsequently developed symptoms since their positive test,” the CDC recommended. “If HCP had COVID-19 ruled out and have an alternate diagnosis (e.g., tested positive for influenza), criteria for return to work should be based on that diagnosis.”

After returning to work, HCP

should wear a medical facemask for source control at all times until all symptoms are completely resolved or until 14 days after illness onset — whichever is longer. Then, HCP should revert to their facility policy regarding universal source control during the pandemic.

A facemask for source control does not replace the need to wear an N95 or higher-level respirator when indicated. Of note, N95 or other respirators with an exhaust valve might not provide source control.

Workers returning to work from COVID-19 infection should be restricted from contact with severely immunocompromised patients until 14 days after onset. They should self-monitor for symptoms and seek re-evaluation from occupational health if respiratory symptoms recur or worsen, the CDC recommended. ■

REFERENCE

1. Centers for Disease Control and Prevention. Return to work for healthcare personnel with confirmed or suspected COVID-19. Updated April 13, 2020. <https://bit.ly/2W5AyMF>

CDC Recommends Universal Masking

In another new normal of the COVID-19 pandemic, all healthcare personnel (HCP) should wear surgical masks throughout their entire shift, the Centers for Disease Control and Prevention (CDC) recommends.¹

Moreover, patients should be actively screened for fever before

entering the facility and wear their own mask or be provided one to receive care. The recommendations come amid a shortage of personal protective equipment (PPE), but these are voluntary measures for hospitals to meet as their local situation warrants. Sometimes called “universal masking,” the practice

was used in some hospitals during the 2003 sudden acute respiratory syndrome (SARS) outbreak. As opposed to that predecessor coronavirus, SARS-CoV-2 can spread with apparent ease from asymptomatic people.

“To address asymptomatic and presymptomatic transmission,

implement source control for everyone entering a healthcare facility (e.g., healthcare personnel, patients, visitors), regardless of symptoms,” the CDC recommended.

Medical face masks should be reserved for healthcare personnel, but visitors and patients can wear cloth face coverings. If they arrive without one, they can be provided a mask if supplies are available, the CDC noted.

“As community transmission intensifies within a region, healthcare facilities could consider forgoing contact tracing for exposures in a healthcare setting in favor of universal source control for healthcare personnel and screening for fever and symptoms before every shift,” the CDC stated.

HCP should receive job-specific training on PPE and demonstrate competency with selection and proper use, including donning and doffing the equipment. Universal masking may be as much about addressing fear in the healthcare workforce as science, **Ann Marie Pettis**, RN, BSN, CIC, FAPIC, president-elect of Association for Professionals in Infection Control and Epidemiology (APIC), said at a recent press conference.

“As this ramps up, our staff is getting understandably more and more fearful,” said Pettis, director of infection prevention at the University of Rochester in NY. “We’re probably

going to institute universal masking. In other words, every time staff come into work, we are going to offer them a new mask each day whether they are taking care of COVID patients or not. Again, it’s not scientific, but we have to give them the feeling that they are safe because their families are so worried about them coming to work.”

While acknowledging the ongoing PPE shortage, CDC guidelines still call for N95 respirators when treating suspected or confirmed COVID-19 patients.

“Facilities that do not have sufficient supplies of N95s and other respirators for all patient care should prioritize their use for activities and procedures that pose high risks of generating infectious aerosols and use facemasks for care that does not involve those activities or procedures,” the CDC recommended. “Once availability of supplies is reestablished, the guidance states that the use of N95 and higher-level respirators should resume.”²

“What is this really about? It is about the almost unconscionable U.S. national shortage of N95 respirators,” says **Daniel Lucey**, MD, MPH, FIDSA, FACP, an infectious diseases physician at Georgetown University Medical Center in Washington, DC.

Although the universal masking policy has been adopted at his facility, an emergency physician tells *Hospital*

Employee Health the rationale behind it is questionable.

“A surgical mask is a false sense of security,” says **Hamad Husainy**, DO, FACEP, of Helen Keller Hospital in Sheffield, AL. “It blocks large particles, but studies have been done showing the longevity of this virus in the air and on surfaces. Also, the [small] size of this virus. I understand there is a PPE shortage and that is one of the issues that goes into this, but it should be an N95 mask.”

Because asymptomatic cases are probably driving transmission, Husainy wears an N95 respirator while on duty.

“New York, New Orleans, New Jersey, Italy — those places went ‘boom,’” he says. “That didn’t just happen. The way that so many people got sick so quick in all these places was the asymptomatic carriers.” ■

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Three National Surveys Document PPE Shortages

ANA: 85% of nurses polled fear for family safety

Three different national surveys revealed widespread shortages of personal protective equipment (PPE) and other critical hospital supplies, a situation the president of the American Nurses Association (ANA) compared to going into battle without armor.

“Our military does not send troops into battle without the equipment they need to stay safe,” ANA President **Ernest J. Grant**, PhD, RN, FAAN, said in statement. “As a former volunteer firefighter, I would never have been required to respond to a fire without the proper gear.”¹

On March 20, the ANA began to survey nurses nationwide about their access to PPE and other work environment concerns. According to findings from more than 20,000 respondents:

- 76% reported being extremely concerned about PPE;
- 66% reported being out or short of N95 respirators;
- 62% were out or short of full-face shields;
- 61% were out or short of surgical masks;
- 69% reported concerns about working short-staffed.

“Further, we hear disturbing reports that employers have retaliated against nurses and other healthcare workers for raising legitimate concerns about their personal safety and the safety of patients,” Grant stated. “Protecting the safety and health of nurses and other frontline workers is directly related to safeguarding the public and stemming the spread and impact of the virus.”

According to the ANA survey,

85% of nurses responding said they worry about keeping their families safe from infection.

“At this point, we can’t even measure the toll the pandemic will take on the mental health of nurses in the long term,” Grant said.

APIC, Inspector General Surveys

The Association for Professionals in Infection Control and Epidemiology (APIC), which conducted a national survey of infection preventionists (IPs), is demanding the federal government act to protect patients and frontline healthcare workers.

“This is simply unacceptable,” said APIC CEO **Katrina Crist**, MBA, CAE. “Shortages of critical PPE and disinfection supplies are jeopardizing our ability to safely treat patients and protect healthcare workers, who put their lives on the line every day.”

APIC issued a call to action along with its survey results at a March 27 press conference. “APIC is urging the federal government to act now,” Crist said. “We are asking for clear communication. We need clarity on when the supplies are coming — when and where. In addition to asking the federal government to use all of the powers at their disposal to increase the supply — especially of respirators — we need clear communication.”

Similar findings were revealed in a Department of Health and Human Services Office of Inspector General (OIG) report of a phone survey conducted in late March.

“Hospitals reported that widespread shortages of PPE put staff and patients at risk,” the report stated. “Hospitals reported that heavier use of PPE than normal was contributing to the shortage and that the lack of a robust supply chain was delaying or preventing them from restocking PPE needed to protect staff. Hospitals also expressed uncertainty about availability of PPE from federal and state sources and noted sharp increases in prices for PPE from some vendors.”²

Likewise, the OIG report found a demand for clear and consistent communication, as “inconsistent guidance from federal, state, and local authorities posed challenges and confused hospitals and the public.”

Hospitals reported that it was sometimes difficult to remain current with CDC guidance, which has been evolving as the dynamics of the pandemic change, the OIG report noted. Respondents to the OIG survey cited “conflicting guidance from different government and medical authorities, including criteria for testing, determining which elective procedures to delay, use of PPE, and getting supplies from the national stockpile. Hospitals also reported concerns that public misinformation has increased hospital workloads (e.g., patients showing up unnecessarily, hospitals needing to do public education) at a critical time.”

Although more rapid tests are coming to the market, the OIG survey reflected some of the confusion and mixed messaging on coronavirus testing, which has gone through a series of exasperating

changes, from largely unavailable, announced, and delayed, and 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 by frontline staff.

“Hospitals reported that they were unable to keep up with COVID-19 testing demands because they lacked complete kits and/or the individual components and supplies needed to complete tests,” the OIG report revealed. “Additionally, hospitals reported frequently waiting seven days or longer for test results. When patient stays were extended while awaiting test results, this strained bed availability, PPE supplies, and staffing.”

The testing issue also created a bottleneck in the continuum, as some long-term care facilities refused to take in hospital discharges

until they produced a negative COVID-19 test.

“Hospitals reported needing items that support a patient room, such as intravenous therapy poles, medical gas, linens, toilet paper, and food,” according to the OIG survey. “Others reported shortages of no-touch infrared thermometers, disinfectants, and cleaning supplies. Isolated and smaller hospitals faced special challenges maintaining the supplies they needed and restocking quickly when they ran out of supplies.”

The APIC survey of IPs was conducted between March 23 and March 25, netting 1,140 responses in all states and the District of Columbia. Of those, 233 reported their facilities were out of respirators, and an additional 317 said they were “almost out.” Nearly half of the respondents said they do not have enough face shields, and 13% are completely out. Regarding mask supply, nearly

one-third of respondents are almost out or completely out.

“The federal government must act now to produce more PPE and coordinate distribution where it is needed most,” said APIC President **Connie Steed**, MSN, RN, CIC, FAPIC. “Every minute wasted puts more lives at risk. We are asking healthcare providers to risk their own health and their families’ health to care for us.” ■

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The Risk of COVID-19 to Pregnant Healthcare Personnel

With limited data, err on the side of caution

Are there recommended work restrictions for pregnant healthcare personnel (HCP) during the COVID-19 pandemic?

The Centers for Disease Control and Prevention (CDC) is somewhat equivocal on the issue, essentially saying no heightened risk has been clearly established, but the known risk from similar viruses and influenza warrants caution.¹

“Information on COVID-19 in pregnancy is very limited,” the CDC stated. “Facilities may want to consider limiting exposure

of pregnant HCP to patients with confirmed or suspected COVID-19, especially during higher-risk procedures (e.g., aerosol-generating procedures) if feasible based on staffing availability.”

That said, pregnant women are currently not considered at increased risk for severe illness from COVID-19.

“However, pregnant women have had a higher risk of severe illness when infected with viruses from the same family as COVID-19 and

other viral respiratory infections, such as influenza,” the CDC stated.

Thus, pregnancy is a gray area, with the COVID-19 risk to expectant mothers not as clearly established as it is to those age 65 years and older, and those of any age with underlying health conditions such as heart and lung disease or diabetes. ■

REFERENCE

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FDA: Do Not Use Antibody Tests to Diagnose COVID-19

Fauci warns of going down 'misleading path'

While antibody tests are broadly seen as a way to determine immunity and exposure to the pandemic coronavirus, the Food and Drug Administration (FDA) recently warned that tests should not be used as the “sole basis to diagnose COVID-19.”¹

“The FDA is not aware of an antibody test that has been validated for diagnosis of SARS-CoV-2 infection,” the agency wrote in a letter to healthcare providers. “While the FDA remains open to receiving submissions for these tests for such uses, based on the underlying scientific principles of antibody tests, the FDA does not expect that an antibody test can be shown to definitively diagnose or exclude SARS-CoV-2 infection.”

The FDA recommendations for healthcare providers include:

- Continuing to use antibody tests, as appropriate, while aware of their limitations;
- Using antibody tests as information about whether a person may have been exposed, rather than as a diagnostic tool;
- Being aware that not all marketed serological tests have been evaluated by the FDA. FDA-authorized tests are listed on the Emergency Use Authorization (EUA) page.² Tests offered under a policy outlined in the FDA’s COVID-19 Diagnostic Policy Guidance are listed on the FDA’s frequently asked questions page. Such tests have not been reviewed by the FDA, unless an EUA has also been submitted and reviewed by FDA.

While antibody testing is a work in progress, it has the potential to answer questions key to fighting the

pandemic. One of them is whether those who survive infection with SARS-CoV-2 generate sufficient antibodies to be immune for some time.

“That is certainly the hope,” says **William Schaffner**, MD, an infectious disease physician and professor of preventive medicine at Vanderbilt

“THERE HAVE BEEN INTERNATIONAL INCIDENTS WHERE A COUNTRY HAS ORDERED MILLIONS OF THESE TESTS FROM ANOTHER COUNTRY, ONLY TO FIND THAT THEY DON'T WORK.”

University. “If you look at the human coronaviruses — the ones that cause the common colds — you do get strain immunity, but it begins to wane fairly quickly after about a year. But that kind of immunity would be terribly important in blunting a resurgence of this virus in the fall. It might be a bridge to the time we can get a vaccine deployed.”

Anthony Fauci, MD, director of the National Institutes of Health’s National Institute of Allergy and Infectious Diseases, also recently

commented on this issue in an interview.

“Right now, we don’t think that this [SARS-CoV-2] is mutating to the point of being very different,” Fauci said. “We are making a reasonable assumption that this virus is not changing very much. If you get infected in February or March — and then recover — then next September or October, I believe that person is going to be protected. We are not 100% sure. But I think that is a reasonable assumption.”

However, Fauci took a cautious tone regarding the antibody tests now coming on the market. The tests certainly have great promise to affect the coronavirus response, but the antibody diagnostics must be carefully validated before they are widely distributed, he emphasized.

“There have been international incidents where a country has ordered millions of these tests from another country, only to find that they don’t work,” he said. “We have to validate these tests — that’s absolutely critical. Otherwise, you will go down a path that will be very misleading.” ■

REFERENCES

1. Food and Drug Administration. Important information on the use of serological (antibody) tests for COVID-19 — letter to health care providers. April 17, 2020. <https://bit.ly/3aPu21K>
2. Food and Drug Administration. Emergency Use Authorizations. Industry hotline: Coronavirus COVID-19 diagnostic tests and shortages. <https://bit.ly/2VMBKWb>

Group Issues Guidance on PPE Pressure Injuries

Seeking relief without compromising protection

The bruised faces of healthcare workers have become a badge of courage, the price they are willing to pay for wearing respirators, masks, and other personal protective equipment (PPE) over long work shifts caring for COVID-19 patients.

The National Pressure Injury Advisory Panel (NPIAP), an independent, not-for-profit professional organization, has issued some general guidance to help healthcare workers — with the caveat that PPE effectiveness must not be compromised.

“The same mechanical forces (i.e., pressure and shear) that cause pressure injuries in our patients are now causing pressure injuries in fellow healthcare providers wearing PPE masks, face shields, and goggles

for long periods of time,” the NPIAP stated. “N95 respirator masks have a particularly high risk for injury due to requirements for a tight fit. Skin injury can also occur as a result of friction and the accumulation of moisture under the mask.”¹

Using a liquid skin protectant may help prevent friction injuries without interfering with the fit of the N95 mask. “The NPIAP does not recommend the use of petroleum jelly, mineral oil, or any other compound that could enhance slippage and affect the function of the mask,” the guidance stated.

Another helpful measure is periodically relieving the pressure of the mask, washing hands before and after.

“Reduce pressure by removing

the mask from your face for 15 minutes every two hours outside of areas of patient contact,” the NPIAP recommended. “If this time frame is not practical, attempt to lift the mask by the sides for five minutes every two hours. Any pressure relief will be helpful. Wash hands before and after touching mask.”

Skin abrasions can be treated with topical moisturizers, and “thin occlusive dressings may be used to protect open wounds if they do not interfere with the mask seal,” the panel concluded. ■

REFERENCE

1. National Pressure Injury Advisory Panel. NPIAP position statements on preventing injury with N95 masks. 2020. <https://bit.ly/34UKe0m>

Worker Bill of Rights in Pandemic

California union demands action to shore up frontlines

A union representing 15,000 healthcare workers in California has issued a “bill of rights” demanding the levels of testing and personal protective equipment (PPE) needed to provide a safe workplace in the coronavirus pandemic.

Saying healthcare workers comprise 12% of the COVID-19 infections in California, the National Union of Healthcare Workers (NUHW) demanded action by medical centers and systems.

“We have developed this policy agenda based on guidance from

public health officials, research into best practices at healthcare facilities, and conversations with NUHW members,” the union stated.¹ In addition to PPE and testing, the healthcare worker rights include:

- Providing training on all COVID-19 protocols, including new training or refreshers immediately when protocols change;
- Providing free access to high-quality mental healthcare services;
- Providing safe, high-quality, temporary nearby housing for healthcare workers who choose not to return home to limit exposure to their family members;

• Giving workers input in decisions on staffing, PPE, infection control protocols, surge planning, and changes that affect their work;

• Giving workers additional paid time off to care for themselves or their families, presumptive eligibility for workers’ compensation for COVID-19 illness, and childcare support to continue working during the COVID-19 pandemic. ■

REFERENCE

1. National Union of Healthcare Workers. COVID-19 Healthcare Workers’ Bill of Rights. <https://bit.ly/2VMqsRH>



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CE QUESTIONS

- 1. According to the Centers for Disease Control and Prevention (CDC), 6% of healthcare workers infected with COVID-19 were age 65 years or older. What percentage of the total deaths did this age group comprise?**
 - a. 10%
 - b. 22%
 - c. 37%
 - d. 51%
- 2. The CDC reported that a range of 2-5% of healthcare workers infected with COVID-19 were:**
 - a. admitted to an ICU.
 - b. had blood clots.
 - c. had not been tested.
 - d. had fatal infections.
- 3. As community transmission intensifies within a region, the CDC says healthcare facilities could drop which of the following in favor of universal source control for healthcare workers and screening for fever and symptoms before every shift?**
 - a. Drive-through testing for symptomatic patients
 - b. Mandatory furloughs for exposed workers
 - c. Contact tracing for exposures in the healthcare setting
 - d. N95 respirator use for aerosol generating procedures
- 4. The Food and Drug Administration specifically said novel coronavirus antibody tests should not be used:**
 - a. to determine healthcare worker immunity for returning to work.
 - b. as the sole basis to diagnose COVID-19.
 - c. to establish priority for vaccination or treatment.
 - d. to determine whether to wear a respirator or a surgical mask.

CE OBJECTIVES

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

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 health care 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.