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INSIDE

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Some Health Departments, Hospitals Ignore CDC COVID-19 Testing Changes

"Our county health departments resoundingly said, 'Pound sand'"

By Gary Evans, Medical Writer

The public health agency with arguably the most admired and emulated approach to combatting infectious disease outbreaks worldwide finds its latest advice on COVID-19 testing widely criticized and openly disregarded. Amid the worst pandemic in a century, the Centers for Disease Control and Prevention (CDC) is dispensing advice to those who say they will not follow it.

How did we get here? Painfully. In a move suspected by some as politically driven, the CDC recently revised SARS-CoV-2 testing guidelines, deemphasizing the need to test asymptomatic people who have been in contact with a confirmed or possible case of COVID-19 as of Aug. 24, 2020: "If you are in a high COVID-19 transmission area and have attended a public or private gathering of more than 10 people (without widespread mask wearing or physical distancing): You do not necessarily need a test unless you are a vulnerable individual or your healthcare provider or state or local public health officials recommend you take one," the CDC guidelines state.[1] (*See "CDC's Controversial Testing Changes."*)

After the uproar, CDC Director **Robert Redfield**, MD, issued a statement that said testing of asymptomatic contacts could be "considered" and offered an explanation for the change.

"We are placing an emphasis on testing individuals with symptomatic illness, individuals with a significant exposure, vulnerable populations including nursing homes or long-term care facilities, critical infrastructure workers, healthcare workers and first

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responders, or those individuals who may be asymptomatic when prioritized by medical and public health officials," Redfield stated. "Testing is meant to drive actions and achieve specific public health objectives. Everyone who needs a COVID-19 test can get a test. Everyone who *wants* a test does not necessarily *need* a test; the key is to engage the needed public health community in the decision with the appropriate follow-up action." (Italics are Redfield's.)

Open Rebellion

Despite the qualifiers and caveats in the guidance, the infection control and public health community was not having it. Retreating from the cardinal public health principle of contact tracing was met with criticism and open rebellion.

"I don't think it will have much impact at all, and the reason is states are going to ignore the CDC guidance," says **Will Humble**, MPH, executive director for the Arizona Public Health Association. "Our county health departments resoundingly said, 'Pound sand.' We are going to keep testing, we are going to encourage testing of asymptomatic contacts, and when they are positive, we are going get them in [quarantine], and we are going try to continue to find their contacts."

After a surge of COVID-19 cases undermined contact tracing efforts in June and July, Arizona has gotten back up to speed.

"Now we are finally in a position where our counties do case investigations and do follow-ups and have effective contact tracing," he says. "I just don't see discouraging [testing] now that we have that in place. This makes zero sense to us."

Connie Steed, MSN, RN, CIC, FAPIC, director of infection prevention and control at Prisma Health in Greenville, SC, said her organization is continuing to offer drive-by testing for the community.

"Testing continues to be encouraged in our community because I think public health and infection preventionists still feel that testing is helpful," she says. "We have drive-by by testing that is done, most times, seven days a week for our community. We are going to continue that. We are not going to deemphasize it."

Steed is president of the Association for Professionals in Infection Control and Epidemiology (APIC), which was one of 265 organizations that signed a letter to the White House Coronavirus Task Force calling for the testing changes to be reversed. (*See "Infection Control, Public Health Groups Call for Action on CDC Testing Change."*)

"Forty percent of infections are asymptomatic," she says. "That means that there is a large volume of individuals that we don't know about, so they can be a significant source of transmission. So public health does contact tracing and those [who] are exposed need to be tested so we can effectively quarantine. The hospitals ensure isolation. We really feel it is important to continue encouraging testing."

Testing also is decentralized in many states and counties, making it less likely that some sweeping change seen as counterintuitive will be broadly adopted, Humble adds.

"The key question is whether the CDC guidance will change the behavior of the managed health care plans," Humble says. "If they stop paying for testing based on this

guidance, I think it could have a real impact — but [I] don't see health plans stopping payment.

Sometimes You Have to 'Fall on Your Sword'

Beyond the logistics, the CDC's public health credibility has been hurt by this decision, says Humble, who has been involved in public health for three decades.

"As a career public health guy, my perspective from the very beginning is that the CDC has an untarnished brand," he says. "They were the most trusted brand within the federal government. We knew we could trust the CDC for evidence-based recommendations and analysis. That has changed over the last six months. I think, among public health people, the reputation of the agency is tarnished."

Change in CDC leadership could eventually restore confidence in the agency, as the rank and file staff and career scientists remain respected, Humble says. As is the standard practice with changes in U.S. presidents, CDC Director Redfield was appointed by the Trump Administration. President Trump has publicly called for a reduction in SARS-CoV-2 testing.

"To me if you are in a senior leadership position, if you are Redfield, there are certain moments in time where you say, 'This is worth falling on my sword for.' Enough is enough and you have to take a stand," Humble says. "And we haven't — at least publicly — seen that from them. Maybe there has been a lot of pushback behind the scenes that we never knew about. That happens behind closed doors and you never see it. [What you do] see is such a puzzling decision by the CDC. It flies in the face

CDC's Controversial Testing Changes

In contrast to recent guidelines — which emphasized the importance of contact tracing because 40% of cases are asymptomatic — the Centers for Disease Control and Prevention (CDC) issued this guidance on Aug. 24, 2020:

"If you are in a high COVID-19 transmission area and have attended a public or private gathering of more than 10 people (without widespread mask wearing or physical distancing): You do not necessarily need a test unless you are a vulnerable individual or your healthcare provider or state or local public health officials recommend you take one."[1]

A negative test does not mean you will not develop an infection from the gathering or contract an infection at a later time.

• You should monitor yourself for symptoms. If you develop symptoms, you should evaluate yourself under the considerations set forth above.

• You should strictly adhere to CDC mitigation protocols, especially if you are interacting with a vulnerable individual. You should adhere to CDC guidelines to protect vulnerable individuals with whom you live.

• If you are tested, you should self-isolate at home until your test results are known, and then adhere to your healthcare provider's advice.

After the move was widely criticized by medical and public health officials, **Robert Redfield**, MD, CDC director, issued a statement saying testing could be "considered" for all close contacts of confirmed or probable cases.

In his statement, Redfield summarized testing recommendations and mitigation strategies as follows:

• Testing may be considered for all close contacts of confirmed or probable COVID-19 patients.

• Those contacts who test positive (symptomatic or asymptomatic) should be managed as a confirmed COVID-19 case.

• Asymptomatic contacts testing negative, or who are not tested, should strictly adhere to CDC mitigation protocols.

• If testing is not available, symptomatic close contacts should self-isolate and be managed as a probable COVID-19 case.

• Anyone who has been in close contact with a confirmed or probable COVID-19 patient should follow the following mitigation strategies:

- Monitor symptoms.
- Take special precautions to protect the vulnerable.
- Wear a mask.
- Stay at least six feet apart.
- Wash hands.
- Talk to a healthcare provider or public health to determine if a test is needed.

REFERENCE

1. Centers for Disease Control and Prevention. Overview of testing for SARS-CoV-2 (COVID-19). Updated Aug. 24, 2020. https://www.cdc.gov/coronavirus/2019-ncov/hcp/testing-overview.html

of everything we know about this virus."

Asked if the decision was the result of political pressure, Humble answers, "I can't say that because I don't know 100% for sure. What I can say is this decision is not evidence-based. That much I know."

Steed says the change has caused confusion, given the CDC's recent emphasis on testing asymptomatic contacts.

"The question that many of us have is where is that coming from?" she says. "Because if you look as recently as July, they were pushing this testing — then all of a sudden this changes several weeks later? That kind of change puts things in question. Some of us are concerned that this is being done not because CDC is necessarily thinking this is what is best. It may be that there is another influence there. [Testing reduction] has been a constant theme from the administration and it could have — in my perception — had some influence."

Universal masking in hospitals helps protect against asymptomatic cases, and everyone is generally having temperature checks and asked about possible contacts with COVID-19 cases. Mask use by the public became politicized early in the outbreak and remains a divisive issue despite clear scientific evidence that they afford some protection in close conditions. In a discussion of whether masks should be mandated by law, a legal scholar addressed the larger issue of insulating the CDC from political influence in future outbreaks.[2]

"The CDC was marginalized because the president and the White House contradicted [the] CDC's science-based advice and even refused to allow [the] CDC to issue certain guidelines like school opening guidelines," says **Lawrence Gostin**, JD, of the O'Neill Institute for National and Global Health in Washington, DC. "We need to return to a landscape where political officials support science and key public health agencies like [the] CDC. COVID shows that we need national uniform legal standards and [the] CDC is best positioned to use science as the basis for new powers."

Mixed Messages

Testing, or lack thereof, may have hobbled the U.S. response since the outbreak began. The CDC previously cited potential transmission from asymptomatic cases in emphasizing the importance of testing the contacts of those with COVID-19.

The CDC action could, in part, be a real-world acknowledgement of the lack of rapid testing nationwide, but it drew a strong reaction because there was a general perception that testing methods were improving, and it would become easier to test contacts of suspected or confirmed COVID-19 cases.

"This has me and many other people in infectious disease and public health scratching our heads, because we were moving as a society to expanding testing," says **William Schaffner**, MD, a professor of preventive medicine at Vanderbilt University in Nashville. "As testing becomes more available, less expensive, and the results can be returned more quickly, we were moving to greater use of tests — [not] reducing testing."

One problem is that the tests — depending on the test used and conditions under which it is given — may result in a false negative, or less often, a false positive. "False negative tests provide false reassurance, and could lead to delayed treatment and relaxed restrictions despite being contagious," writes **Robert H. Shmerling**, MD, senior faculty editor of Harvard Health Publishing.[3] "False positives, which are much less likely, can cause unwarranted anxiety and require people to quarantine unnecessarily."

For example, the commonly used polymerase chain reaction (PCR) test with a nasal swab results in a range of false negatives from 2% to 37%. The reported rate of false positives with this test is 5% or lower, Shmerling noted.

"The outside of the incubation period for [SARS-CoV-2] is 14 days," Schaffner says. "That is a very long period of time. We have all been trying to think of strategies that are valid and science-based to try to abbreviate that. We recognize that there is no perfect answer, but could we still reduce that duration and provide some assurance that the risk is very low?"

One of the strategies is to do more testing to address the situation with false negative tests.

"There might be a way to do testing more frequently, and if they are negative for several days, I would think that would reduce the risk that this contact is going to become positive," Schaffner says. "I thought we as a public health community were moving in that direction, trying to find testing as a means of providing some assurance that people could come out of quarantine a bit earlier. That is in conjunction with trying to move us back into a more functional society. This set of [CDC] advisories would appear to put the brakes on that."

Another troubling aspect of the testing change is that the CDC presented no new data indicating spread from asymptomatic carriers

is less of a concern than emphasized previously.

"I haven't seen any new data, but of course we understand a person who is a contact and quarantined is not likely to be a transmitter," Schaffner says. "[As a result of this change] we will be identifying fewer positive individuals."

Asked if that translates to more transmission, he said, "Of course — exactly."

'Indefensible'

The Society for Healthcare Epidemiology of America (SHEA) "vehemently" disagreed with the CDC testing changes, calling for an "immediate revision of these guidelines to underscore the criticality of testing and contact tracing as a primary means of combating the pandemic."

On the contrary, the country needs "dramatically increased testing," SHEA emphasized in

Infection Control, Public Health Groups Call for Action on CDC Testing Change

Letter to VP Pence and White House Coronavirus Task Force

Many of the nation's leading infection control and public health groups signed a letter to the White House Coronavirus Task Force asking that recent revisions to COVID-19 testing guidelines be rescinded.

Groups endorsing the call for action included the American Public Health Association, the Association for Professionals in Infection Control and Epidemiology, the Infectious Diseases Society of America, and the Society for Healthcare Epidemiology of America.

Signed by more than 200 organizations and medical societies, the letter protests changes to the Centers for Disease Control and Prevention's (CDC) testing guidelines, which downplay the need for testing asymptomatic contacts of COVID-19 cases.

"We believe the revision does not reflect the best available science and the best interest of the public's health and has resulted in confusion among public health and medical professionals and the public," the letter states. "We ask the Department of Health and Human Services (HHS) to reverse the revision."[1]

The letter's key points include the following:

• "By [the] CDC's own estimation, about 40 percent of infections are asymptomatic, meaning people who do not know they are infected are a significant source of transmission. Identifying individuals infected with COVID-19 — even if they are asymptomatic — is critical to support appropriate isolation and quarantine measures, identification of contacts, to limit spread, and to provide the comprehensive view of community spread needed to inform effective public health responses."

• "Testing of asymptomatic individuals may also be critical for certain high-risk workplaces, such as in nursing homes, and to support safe reopening of schools."

• "By downplaying the importance of testing for asymptomatic individuals, especially those who have been exposed to the virus, these guidelines could precipitate further community spread. We are further concerned that changes to the testing guidelines could reduce insurance coverage for COVID-19 tests by incorrectly calling into question the medical appropriateness of testing on asymptomatic individuals."

• "In a moment when we are continuing to see COVID-19 surges in hot spots across the country and a desire to safely open schools and businesses, we need more testing, not less. The decision may delay the ability of communities to safely reopen and extend the social and economic toll of the pandemic on our communities."

• "Given the shortages in testing supplies and personnel, we support prioritizing testing for symptomatic individuals. However, our goal as a nation should be to expand testing capacity to allow for testing of all recommended individuals, including asymptomatic people who have been in close contact with an infected individual. The solution to testing shortages is not to limit the number of people who are tested but to expand the availability of tests."

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1. American Academy of Family Physicians. Joint letter to Vice President expressing concern on recent COVID-19 testing guidance changes from CDC. Sept. 3, 2020. https://www.aafp.org/dam/AAFP/documents/advocacy/prevention/crisis/LT-WhiteHouse-COVID19TestingGuidelinesConcerns-090320.pdf

a statement. "While the exact timing of such testing in relation to exposure can be debated, broad scale testing is critically important because COVID-19 has been proven to be transmitted frequently by asymptomatically and pre-symptomatically infected persons."

While acknowledging "the constraints of current testing capabilities," SHEA said the CDC is retreating from a basic principle of public health during outbreaks.

"The revised CDC guidelines are in direct contradiction to evidence-based public health guidelines for identifying new cases of an epidemic disease, aggressively tracing contacts of new cases, and isolating and testing contacts known to be exposed," SHEA stated. "These principles are cornerstones of the public health management of an infectious disease epidemic."

SHEA urged the CDC to rescind the revised guidelines immediately and "include exposed contacts as individuals who need not only quarantine but also testing."

In a tweet, **Tom Frieden**, MD, former director of the CDC, called the revision "indefensible."

"If an asymptomatic contact tests positive, their contacts can be identified, warned, and quarantined," Frieden said.[4] "Not testing asymptomatic contacts allows COVID to spread. The CDC guidance is indefensible. No matter who wrote it and got it posted on the CDC site, it needs to be changed."

Anthony Fauci, MD, a member of the White House Coronavirus Task Force and director of the National Institute of Allergy and Infectious Diseases, told CNN he was literally unconscious during a surgical procedure when the testing revisions were made.[5]

"I was under general anesthesia in the operating room and was not part of any discussion or deliberation regarding the new testing recommendations," said Fauci. "I am concerned about the interpretation of these recommendations and worried it will give people the incorrect assumption that asymptomatic spread is not of great concern. In fact, it is." ■

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Nurses Still Reporting PPE Shortages, Fear of Reusing Single-Use N95s

'I never thought I would consider leaving nursing'

The chronic problem with adequate stocks of personal protective equipment (PPE) for nurses continues as the coronavirus pandemic heads into the dreaded fall and winter months. Many nurses feel unsafe because of the shortages — and the continued reprocessing and reuse of N95 respirators, which are designed for single use only — according to the American Nurses Association (ANA).

Overall, 42% of responding nurses still are experiencing widespread or intermittent PPE shortages. Slightly more than half (51%) of nurses had treated a positive or suspected COVID-19 patient in the last two weeks. Nurses in long-term care, hospice, and staff nurses in general were most likely to be experiencing PPE shortages, the ANA reported.[1]

"The top on our list has been and remains ensuring a sufficient supply of the highest level of PPE," **Ernest J. Grant**, PhD, RN, FAAN, president of the ANA, said during a press briefing. "This is an imperative

continued on page 116

A Breakdown of ANA Survey Findings

Frequent respirator reuse, sometimes for prolonged periods

A recent survey of 21,503 nurses by the American Nurses Association (ANA) revealed the following key findings on personnel equipment and practices during the COVID-19 pandemic.[1] Some of the findings were compared to answers to similar questions in an ANA survey in May 2020.

- Fifty-one percent of nurses surveyed treated a patient testing positive for COVID-19 or was suspected of having COVID-19 in the past two weeks.
- Nurses are most likely to treat COVID in hospitals of all sizes.
- Forty-two percent of all respondents have experienced shortages of personal protective equipment (PPE) (down slightly from 45% in a May ANA survey).
- Of those experiencing shortages, 16% said the shortages were widespread (down from 21% in May).
- Twenty-six percent experienced intermittent shortages of PPE (up from 24% in May).
- The greatest shortages were claimed in long-term care, hospice, and with staff nurses.
- Fifty-three percent of nurses say the PPE situation is the "same" or "worse" since May, while 42% or nurses say it has improved.
- Shortages varied greatly based on type of PPE, with N95s in shortest supply.
- Thirty-seven percent say they are "out" or "short" of N95 masks (down from 42% in May).
- The greatest N95 shortages were in long-term care, home health, and hospice.
- Shortages in other PPE were lower: goggles, 25%; face shields, 23%; gowns, 22%; elastomeric respirator, 18%; and surgical masks, 16%.
- Although two-thirds of nurses say their N95 fit appropriately, 24% say it did not.
- Sixty-eight percent of nurses say their facility requires re-use of N95 masks, with 88% saying re-use is "required" or "encouraged."
- The number of facilities requiring re-use rose from 62% in May to 68% in August, while "required" or "recommended" rose from 79% in May to 88% in August.
- Nurses in hospitals of all sizes and staff nurses are most likely to say their facility requires re-use of N95 masks.
- For those reusing N95 masks, 62% feel very or somewhat unsafe, which represents a 3% increase from the May survey.
- Thirty-five percent feel very unsafe with reused masks (up 1% since May).
- Twenty-seven percent feel somewhat unsafe with reused masks (up 2% since May).
- Those feeling most unsafe work in large/medium hospitals and are staff nurses.
- Nurses re-using N95 masks are re-using them many times.
- Fifty-eight percent of nurses say they re-use N95 masks five days or more (up 15% since May).
- Fourteen percent say they re-use N95s more than two weeks.
- Re-use of N95 five days or more happened most often in long-term care, ambulatory, home health, and hospice facilities.
- A similar number of nurses said their facility was decontaminating N95 masks (38%) than said they were not (41%). This represents a slight downward shift from May, when 43% were decontaminating and 38% were not decontaminating.
- Most likely to decontaminate are large/medium and small hospitals and staff nurses.
- Fifty-five percent of nurses who said their facility was decontaminating N95 masks felt somewhat or very unsafe by the practice, which is up slightly from 53% in May.
- Most likely to feel unsafe with decontamination are nurses in large/medium hospitals, military/VA, and, especially, staff nurses.
- The most popular method of decontamination was ultraviolet light, followed by vaporized hydrogen peroxide. Half of nurses were not sure of the method used.

REFERENCE

1. American Nurses Association. PPE Survey #2 Final Report. Sept. 1, 2020.

continued from page 114

and nonnegotiable. It is troubling that six months — *six months* — into the COVID-19 pandemic, nurses continue to report that PPE shortages persist. Reuse practices of single-use PPE are on the rise."

From July 24 through Aug. 14, 2020, 21,503 nurses responded to the ANA's survey on PPE availability, reuse, and contamination practices. Nurses from a variety of settings were asked to report their experiences from the previous two weeks. Not all nurses responded to all questions, so the percentages reflect those responding to individual questions. Based on the survey results, the ANA calls for:

- the full use of the Defense Production Act to increase the domestic production of PPE;
- passage of the Medical Supply Chain Emergency Act of 2020;
- expanded investment in testing and public health infrastructure.

"The key findings are alarming," Grant said. "Over half — 58% — said they are reusing single-use PPE like N95 masks for five or more days. [In addition], 68% say the practice of reusing single-use PPE like N95 masks is required by their facility's policy."

These practices and the overall shortages continue to put nurses under mental and emotional stress. Nurses say they feel unsafe and they are concerned about exposing their families.

"The conversations that are occurring with my colleagues include, 'I'm not sure I can do this much longer' or 'I never thought would consider leaving nursing,' said **Jennifer Gil**, BSN, RN, a staff nurse at ANA and a clinical nurse in the emergency department at Thomas Jefferson University Hospital in Philadelphia. "These comments are occurring every day. I never thought that would happen, or even that those words would come out of my mouth."

Saying it was a moral and strategic imperative for the nation to protect its nurses, Grant said reusing single-use N95 masks was begun as a crisis response and should not become accepted practice.

ALTHOUGH THE PANDEMIC CAUGHT THE HEALTHCARE SYSTEM LARGELY UNPREPARED, IT IS TIME TO START THINKING OF LESSONS LEARNED BEFORE THE NEXT ONE HITS.

"The ANA does not support this as a standard practice," he said. "We understand it has to be done because of the continued shortage, but there needs to be a better way. We need to reach a point in this pandemic where nurses do not have to function in a crisis mode. We need make certain that we have enough PPE."

Grant cited the example of a nurse in Texas who was assigned five N95 respirators in March and was reusing them months later. "That gives you some idea of the anxiety nurses feel — this is why they feel uncomfortable and unsafe having to reuse these," he said. "Yes, they have undergone decontamination, but there is the protentional that as they are continuingly [reprocessed] there could be breakdown in the structure that may allow the virus to penetrate."

Disturbingly, 14% of responding nurses, said they re-use N95s for more than two weeks.

"[That is] beyond the [Centers for Disease Control and Prevention] contingency limit of five additional days," says **Tener Veenema**, PhD, MPH, MS, RN, FAAN, a professor of nursing at Johns Hopkins School of Nursing. "That is very concerning. Masks may be contaminated with other things than SARs-COV-2. [Methicillin-resistant *Staphylococcus aureus*] and *C. diff* are in hospitals. Things splash on masks — blood, saliva, body fluids. All of these things were the rationale for the single-time use."

The health of nurses has such a direct effect on patient health that it makes sense to spend the money needed to ensure adequate PPE and staff retention, she says.

"All efforts to ensure the protection and sustainment of this workforce are a sound investment that will translate into positive health outcomes for all of us," Veenema said. "Science saves lives."

Although the pandemic caught the healthcare system largely unprepared, it is time to start thinking of lessons learned before the next one hits, she says.

"Think of this pandemic, in all honesty, as a harbinger of what is to come," Veenema said. "This will not be the last infectious disease outbreak that we are forced to deal with. It's really critical that we be forward-thinking.

"This is a [biological] event has really rendered the U.S. vulnerable across a number of different levels — public health, economics, and

security. This is a critical opportunity to think how we can do things better. PPE is one of those issues that can be addressed and corrected," she said.

For example, an alternative respirator that has been highly recommended by the National Academy of Sciences is the elastomeric filtering facepiece respirator, which is reusable and can be cleaned, disinfected, and stored, she said.

Although these survey results are specific to nurses, other healthcare support staff, environmental services, and nutrition workers may have access to adequate PPE. "We also need to be looking at the design and engineering of new innovative types of PPE that provide nurses and other healthcare workers with better comfort and tolerability while maintaining high filtration efficacy that doesn't require fit testing," Veneema says. "[We need] affordable, adequate inventories and a robust vendor supply chain to ensure the continuation [of PPE]." ■

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COVID-19 Precautions Could Blunt Flu Season

The 'razor's edge' of double outbreaks

Commonly recommended precautions against COVID-19 — including masking and social distancing — have blunted transmission against seasonal flu in some countries in the Southern Hemisphere, an epidemiologist reports.

"In some areas of the Southern Hemisphere — South Africa and Australia in particular — they have had very mild flu seasons," said **Leonard A. Mermel**, DO, ScM, AM (Hon), FSHEA, FIDSA, FACP, medical director of Epidemiology and Infection Control at Rhode Island Hospital in Providence. "Masking, staying at home, avoiding large crowds, not going to work when sick — some of these things that are happening with COVID-19 are going to tamp down transmission of influenza."

The role of vaccine efficacy in this flu reduction was not discussed at a recent press conference held by the Infectious Diseases Society of America. That may become more clearly understood in the U.S. 2020-2021 flu season, which has created a similar vaccine but does not see the compliance levels with masking reported in other countries.

"We have not rounded the corner in terms of COVID-19. Although there are some positive signs in terms some states getting some things under control," said **Jeanne Marrazzo**, MD, MPH, FIDSA, an infectious diseases professor at the University of Alabama at Birmingham. "Overall, we are still on a razor's edge with regard to COVID-19."

> OVERALL, WE ARE STILL ON A RAZOR'S EDGE WITH REGARD TO COVID-19.

Mutable influenza is infamous for its unpredictably, thus the old adage, "If you have seen one flu season, you have seen one flu season."

"The reasons for that are myriad, but really relate to our ability to predict the antigenic components of the virus," said Marrazzo. "Can we get ahead of the game and choose the appropriate constituents for the vaccine?"

Vaccine Components

The Centers for Disease Control and Prevention recently announced that the components for the 2020-2021 egg-based vaccines include:

- hemagglutinin (HA) derived from an influenza A/Guangdong-Maonan/SWL1536/2019 (H1N1) pdm09-like virus;
- influenza A/Hong Kong/2671/2019 (H3N2)-like virus;
- influenza B/Washington/02/2019 (Victoria lineage)-like virus, and (for quadrivalent egg-based vaccines);
- influenza B/Phuket/3073/2013 (Yamagata lineage)-like virus.

"Sometimes we [match the viruses] well, sometimes not so well," Marrazzo said. "For example, last year we had two waves of influenza A that were pretty significant. A lot of people die from the flu every year. The other concern is that last year, for example, some places experienced somewhat unexpected outbreaks of influenza B, which had a predilection for kids. So here in Alabama and a lot of other places,

we had to shut down some schools because of influenza."

There are some testing panels that can detect both flu and SARS-CoV-2 rapidly, but ensuring an adequate supply could be an issue, Mermel said. This is a critical issue because both flu and COVID-19 present with similar symptoms of fever, cough, and fatigue. However, COVID-19 also can cause a loss of taste and smell.

"A differentiated complication is that COVID can form blood clots in veins and arteries," he said. "In terms of the spectrum of illness, both can be asymptomatic, mild to quite severe."

Although the signs from the Southern Hemisphere may bode well, both speakers stressed it is absolutely critical to get a flu vaccine this year — even for those who typically avoid it. "The big concern this year is that we are going to see what could be a perfect storm of accelerated COVID-19 activity, as people gather more inside, and as they become continually fatigued with the mask wearing, the social distancing, and the hand hygiene — [then] they are exposed to seasonal influenza," Marrazzo said.

There is the possibility of coinfection or that influenza could weaken the immune system enough to make a COVID-19 particularly serious. "We really can't be complacent about this," she said. "People really need to take the flu vaccine seriously. It does work — it prevents symptomatic illness, hospitalizations, and mortality. If there is ever a year to get your flu vaccine and get your kids vaccinated, this is the year.

"It can be a very serious disease. Nine million to 45 million individuals in the United States are infected with seasonal influenza every year, leading to 140,000 to 800,000 hospitalizations, and, in the United States, 12,000 to 60,000 deaths," Mermel said.

There are similar findings with flu and COVID-19 adversely affecting disadvantaged communities, so a flu immunization effort should target these populations. ■

OSHA Fines Facility $28,000 for Failure to Protect Workers from COVID-19

Lack of respirators, no fit-testing log

The Occupational Safety and Health Administration (OSHA) has cited a healthcare facility $28,070 for failing to protect healthcare workers from COVID-19.

Hackensack Meridian Health Residential Care in North Bergen, NJ, was issued "two serious citations and one other-than-serious violation for failing to protect employees from exposure to the coronavirus," OSHA reported.[1]

Based on a coronavirus-related inspection, OSHA cited the facility for a serious violation of failure to provide respirators to resident-care employees for a period of time in March 2020.

"Employees were caring for residents who were exhibiting symptoms of coronavirus," the agency stated. "OSHA also cited the employer for failure to conduct respirator fit testing, effective training, and compliant medical evaluations, during the period after the employer began providing respirators to the employees and requiring their use."

The less serious violation was for failure to establish a record for qualitative fit tests of employees.

"Employers must take appropriate steps to protect the safety and health of their employees during the pandemic," OSHA said in a statement. "OSHA will continue to field and respond to complaints and take steps needed to address unsafe workplaces, including vigorous enforcement action for all standards that apply to the coronavirus, as warranted."

OSHA requires proactive measures to protect workers from the coronavirus, such as social distancing measures and the use of physical barriers, face shields, and face coverings when employees are unable to physically distance at least six feet from each other.

"OSHA guidance also advises that employers should provide safety and health information through training, visual aids, and other means to communicate important safety warnings in a language their workers understand," the agency noted. ■

REFERENCE

1. U.S. Department of Labor. U.S. Department of Labor Cites Hackensack Meridian Health in North Bergen, New Jersey, For Failing to Protect Employees from Coronavirus. Sept. 11, 2020. https://www.dol.gov/newsroom/releases/osha/osha20200911-0

Parent Hospitalized After COVID-19 Outbreak in Daycare

Asymptomatic toddlers transmitted virus

One parent was hospitalized after 12 children acquired COVID-19 in childcare facilities, the Centers for Disease Control and Prevention (CDC) reported.[1]

Transmission was documented from the children to at least 12 (26%) of 46 non-facility contacts who were listed as confirmed or probable cases. Transmission was observed from two of three children with confirmed, asymptomatic COVID-19, the CDC noted.

"SARS-CoV-2 infections among young children acquired in childcare settings were transmitted to their household members," the CDC concluded.

"Testing of contacts of laboratory-confirmed COVID-19 cases in childcare settings, including children who might not have symptoms, could improve control of transmission from childcare attendees to family members."

Although transmission from children 10 years of age and older has been documented, the outbreak shows that children in "daycare" can also spread infection. "To better understand transmission from young children, contact tracing data collected from three COVID-19 outbreaks in childcare facilities in Salt Lake City, UT, from April 1 through July 10, 2020, were retrospectively reviewed to explore attack rates and transmission patterns," the CDC reported.

> "SARS-COV-2 INFECTIONS AMONG YOUNG CHILDREN ACQUIRED IN CHILDCARE SETTINGS WERE TRANSMITTED TO THEIR HOUSEHOLD MEMBERS," THE CDC CONCLUDED.

Contact tracing data show that children can play a role in transmission from childcare settings to household contacts. Having SARS-CoV-2 testing available, timely results, and testing of contacts of persons with COVID-19 in childcare settings regardless of symptoms can help prevent transmission, the CDC concluded.

"CDC guidance for childcare programs recommends the use of face masks, particularly among staff members, especially when children are too young to wear masks, along with hand hygiene, frequent cleaning and disinfecting of high-touch surfaces, and staying home when ill to reduce SARS-CoV-2 transmission," the agency noted. ■

REFERENCE

1. Lopez AS, Hill M, Antezano J, et al. Transmission dynamics of COVID-19 outbreaks associated with child care facilities – Salt Lake City, Utah, April-July 2020. *MMWR Morb Mortal Wkly Rep* 2020; Sept. 11. doi: http://dx.doi.org/10.15585/mmwr.mm6937e3. [Online ahead of print].

HOSPITAL INFECTION CONTROL & PREVENTION

CME/CE INSTRUCTIONS

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CME/CE QUESTIONS

1. **The Centers for Disease Control and Prevention (CDC) recently revised its SARS-CoV-2 testing guidelines, deemphasizing the need to test which of the following?**

   a. Cruise line passengers
   b. Healthcare workers compliant with personal protective equipment
   c. Asymptomatic people who have been in contact with a confirmed or possible case of COVID-19
   d. Babies born to mothers with COVID-19

2. **Approximately what percentage of COVID-19 patients are asymptomatic?**

   a. 10%
   b. 25%
   c. 33%
   d. 40%

3. **A joint letter demanding the CDC reverse recent changes to COVID-19 testing guidelines said the revisions could:**

   a. encourage people to quarantine for no reason.
   b. reduce insurance coverage for COVID-19 tests on asymptomatic individuals.
   c. lead people to falsely claim symptoms to get tested.
   d. drive the outbreak underground with only hospitalized cases counted.

4. **The Occupational Health and Safety Administration cited a healthcare facility $28,070 for failing to protect healthcare workers from COVID-19. Which of the following was cited in the case?**

   a. Use of substandard masks labeled N95 respirators
   b. Failure to provide workers with N95 respirators for a period of time
   c. Lack of alcohol hand rubs in hallways and nurses' stations
   d. Failure to mask coughing patients for source control