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How COVID-19 Might Finally Improve Compliance

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When the Post-COVID-19 World Arrives, Infection Preventionists Will Be Waiting

In this issue, we take stock. We take stock of the lessons learned and how they can be applied in the future. Our cover story, by Jan Dyer on page 16, examines how environmental services (EVS) teams dealt with coronavirus disease 2019 (COVID-19), and how—with the help of infection preventionists (IPs)—these much unheralded teams will need to operate in the future.

Then, 2 members of our Editorial Advisory Board (EAB)—Rebecca Leach, RN, BSN, MPH, CIC; and Mary Jean Ricci, MSN, RNBC—apply their wealth of infection control experience to a phrase that everybody hears these days: hand hygiene (page 20). Why has this simple practice been so difficult to maintain historically, and how can we ensure that healthcare workers and others continue proper hand hygiene after the immediate crisis? Leach and Ricci have answers. Hand hygiene is also one of the many, many infection control topics tackled by another EAB member, Sharon Ward-fore, MS, MT(AASCP), CIC, in our coverage of a webinar she conducted that looks at what IPs have just been through and what they’re about to encounter in the near future (page 27). EAB member Linda Spaulding RN, BC, CIC, CHEC, CHOP, looks at how the systemic problems in long-term care facilities (remember, these were the main COVID instigators) can be fixed without spending huge amounts of money (page 24). Hint: Don’t hook IP programs to 1 person to the extent that when that person leaves, the program folds. Build a culture of IP.

EAB member Saskia v. Popescu, PhD, MPH, MA, CIC, writes about how IPs can ensure that we never again get caught flat-footed when it comes to having enough personal protective equipment on hand (page 30). EAB member Kevin Kavanagh, MD, on page 32 asks a question that could possibly echo in the Halls of Congress: Why do we not have a national reporting system for all dangerous pathogens?

So much to ponder, so much to learn. Help us help you battle COVID-19 and all the other deadly pathogens. Please contact Editorial Director Alexandra Ward at award@mhhlifesciences.com with any questions or for opportunities to contribute.

Stay safe and thank you for reading.

Mike Hennessy, Sr
Chairman and Founder

CHAIRMAN’S LETTER
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You Don’t Want Me Visiting During Your Hospital Stay

BY FRANK DIAMOND

I haven’t been on vacation since March 11. In fact, I haven’t gone anywhere. It’s just that my name hasn’t come up that much because you may have been preoccupied by another problem given a distinctive label on that day—a designation that will make it live on in infamy. That, and the fact that it kills people. I won’t name it (Cough! Cough! COVID!). It gets far too much attention as is, to the point where the rest of us pathogens can’t get any press. That’s a mistake. They don’t call me a superbug for nothing. I can put a hurting on you. I can kill you, too.

Before 2000, I was uncommon in the United States. I’ve become much more common since, and though health experts don’t know just how many people I infect each year, they can say with certainty that I am a major cause of infections in healthcare settings.

I am difficult to treat. I’ll attack anyone, but especially the elderly and very young—the vulnerable. People on ventilators or hooked up to catheters need to watch out, as well.

You’ll never in a million years guess what the best method is for preventing my spread. But here’s a spoonerism: “Wand sashing.” Wand sashing with soap and water or alcohol-based bub. (Fun fact: the spoonerism for hand hygiene is hand hygiene.)

I got my reputation and part of my name by becoming resistant to the most effective antibiotics out there. These antibiotics, created in the 1980s, beat back bacteria that other antibiotics can’t treat. These drugs usually win, but not against me. Hey, if you want to be the best, you’ve got to beat the best.

When I spread, I’m able to share my antibiotic-resistant qualities with healthy bacteria in your body. Symptoms vary, depending on the type of bacteria carrying me and what part of your body I happen to be attacking. Oh, yes. I have my choice of targets.

If you’ve got fever, chills, and fatigue, I can be anywhere in your body. Shortness of breath means that I’ve caused pneumonia. Pain when urinating? That’s me triggering a urinary tract infection. Pain and swelling of the skin? Yep. Skin infection. Belly pain? Liver or splenic infection. Stiff neck and reduced consciousness? That can be meningitis.

If your healthcare provider suspects I’m visiting, she or he will take a blood count, chest X-ray, urine tests, cultures for blood or sputum, and antibiotic sensitivity tests. One, some, or all of these.

Treatment may include fever-reducing medicines, vital signs monitoring, IV fluids, being hooked up to a ventilator, if need be, and they might try another antibiotic.

The bottom line is something you’ve heard almost as much as you’ve heard the phrase “wand sashing” (well, maybe not lately, because all you hear about these days is wand sashing), but here’s the best way society can avoid me: Avoid misusing and overusing antibiotics. Got it?

Who am I?
Ernest Hemingway described courage as “grace under pressure.” A study of the psychological challenges to—and changes in—nurses on the frontlines fighting coronavirus disease 2019 (COVID-19) uses the term “growth under pressure.” The 20 nurses in the study, when first assigned to COVID-19 patients, felt a lot of anxiety brought on by fatigue, discomfort (often caused by the wearing of personal protective equipment [PPE] for hours), and helplessness caused by heavy workloads and fear of either catching the disease or becoming an asymptomatic carrier and bringing it home to their loved ones.

But then, according to the study in the American Journal of Infection Control, the nurses gradually developed coping mechanisms that included making lifestyle adjustments (trying to keep to their exercise schedules, for instance), performing acts of kindness, and receiving support from other members of the care team.

Investigators wrote that the “nurses adopted avoidance, isolation, speculation, humor, self-consciousness, and other psychological defenses to psychologically adjust to the situation.”

This, in turn, led to “growth under pressure, which included increased affection and gratefulness, development of professional responsibility, and self-reflection.”

**Early Intervention**

Investigators concluded that psychological counseling for nurses caring for patients with COVID-19 would be most effective if given early on in the experience. They also cited the importance of establishing “early support systems, such as adequate supplies of protective materials, reasonable allocation of human resources, elderly and infant care services for nurses’ families, pre-job training, and interpersonal interaction among nurses to facilitate nurses’ adaptation to the antiepidemic tasks,” the study states.

The study, which used the Colaizzi's phenomenological method to qualitatively analyze the psychological experiences of the nurses, was conducted in China at the First Affiliated Hospital of Henan University of Science and Technology from January 20 to February 10, 2020 by investigators who work for that institution. It’s a small study and just how much of it can be extrapolated to other healthcare institutions in other countries at other times during the pandemic is unclear because “the medical system and culture of different countries varies,” the authors admit.

However, the novelty of COVID-19 makes reports from the frontlines valuable, they argued, and the study contains tables of quotes that the nurses gave to the psychologist who conducted the interviews.

The psychologist asked 3 main questions: What do you feel about the COVID-19 patients? How do you cope with those feelings? What lessons have your learned from the pandemic?

**Adult Diapers**

What the investigators described as “sub-questions” were also asked. They included: How did you feel when you agreed to the assignment? Were there any changes in the job and in your life? What are your thoughts and feelings about fighting COVID-19?

Here are some examples of how the nurses answered, under the general themes.

Significant amount of negative feelings in the beginning:

- “After putting on protective clothing, nursing duties are awkward to carry out. Protective clothing needs to be worn for 8 hours or more without drinking water and eating food and urinating was done with adult diapers.”
- “After all, it is a new disease and the patient’s condition is unpredictable. I am always worried about what to do if the patient’s condition deteriorates in the next second.”
- “I am the only child and my mother cries every day and fears that I will be infected, and I worry more about them...”

Coping and self-care styles:

- “We encourage each other. It doesn’t feel like I’m fighting alone, I’m not afraid.”
- “In fact, the chance of medical staff infection is very low and the protection of negative pressure wards is better than other departments.”
- “When using diapers, I tell myself you’re young enough to become a baby [laughs].”
- “I write a diary and sometimes write letters.”
- “The progressive breathing relaxation method recommended by my colleague is good, I often use it.”
New Method Needed to Determine Infection Preventionist Staffing Levels

BY FRANK DIAMOND

Just what infection preventionists (IPs) do and how much time they spend doing it remains somewhat of a mystery because of a lack of evidence-based guidelines on this matter, according to a study in the American Journal of Infection Control.\(^1\) The way in which IPs spend their “time varies significantly from hospital to hospital and is driven in part by regulations, by the priorities of hospital administration and supervisors of IP, and by the strengths and interests of the IP,” according to the study.

But the common method used to determine IP staffing—using a ratio of IPs to the number of beds or the number of patients—might not be the best way of determining just how many IPs an institution needs.

“After entering the negative pressure ward, I saw that both the patient and the doctor were protected. So, I felt safe and relieved.”

“Every time I take care of the patients, they will take the initiative to put on a mask. I feel particularly safe in my heart. After treatment, they will keep saying ‘thank you’ and it feels good.”

“Patients are very cooperative with our work. Although some patients have emotions due to illness, they show great respect to us.”

“My family calls or sends WeChat greetings every day, and I feel very happy.”

Some of the study’s findings will sound all too familiar to nurses dealing with patients with COVID-19 throughout the world. For instance, a lot of anxiety felt by the nurses at first had to do with having to reuse PPE and wear that PPE for long shifts. The nurses’ fear peaked when they entered the negative pressure ward for the first time. “They were mainly concerned about the unknown conditions of the patients, severe emergencies, and the patients’ psychological state,” the study stated.

Investigators compared their findings with other studies that show how epidemics can traumatize caregivers. The nurses in their study “grew psychologically” under the pressure of coping with COVID-19. They re-examined their values and found motivation by being grateful for the support they received from family, friends, and colleagues.

“The sense of responsibility brought by professional ethics in an epidemic, encouraged nurses to actively participate in antiepidemic tasks and boosted their professional identity and pride…,” the study states. “Our finding of the existence of positive emotions in our nurses such as confidence, calmness, relaxation, and happiness, which simultaneously or gradually appeared with negative emotions, was in contrast to the results of several studies that describe only the presence of a large amount of negative emotions during outbreak stress.”\(^2\)

REFERENCE
The WISN method is a human resource management tool that determines how many health workers of a particular type are required to cope with the workload of a given health facility and assesses the workload pressure of the health workers in that facility, the study states.

Investigators wanted to find out just what the correct staffing levels should be for acute care hospitals. To that end, they used the WISN method, dividing the work IPs do into 3 categories: control activities, support activities, and additional activities. The control activities are directly tied to infection prevention and performed by all IPs; support activities were also performed by all IPs but did not necessarily have to do with infection prevention directly; and additional activities were performed by only a few IPs.

The investigators calculated how many IPs with an available working time of 6332 hours it would take to handle a workload that should take 6338.25 hours to complete in an acute care hospital with 182 beds and 69,331 annual admissions.

Investigators calculated the total available working time by deducting the total number of leaves of absences and days not worked from the total number of possible days someone could have been working in a year. The formula: 

\[
AWT=\left\{A(B+C+D+E)\right\} \times F
\]

where A is the total number of working days in 1 year, B is the number of public holidays, C is the number of annual leaves including earned, casual leaves etc, D is the number of sick leaves, E is the number of other leaves, and F is the number of working hours in 1 day, the study states.

What the investigators called core infection control work consumed 78% of an IP’s time. In the study, IPs were defined as nurses with at least 1 year of experience in infection control.

“Support and additional activities consumed the remaining 22% time,” the study states. “Active surveillance required 44% time and education consumed 32% time. WISN ratio of available staff and required staff was 0.75.” In other words, there needs to be 4 IPs on staff, not 3 as would have been the case if common ratio calculations were used in this particular scenario.

Active surveillance consumed most of the IP workload; 44% out of the total available time adding up to about 14 hours a week. And most of that surveillance was conducted on central line associated blood stream infections (CLABSIs).

The investigators listed 8 control activities; those activities performed by all IPs. They were:

1. Environmental air sampling
2. Environmental surface sampling
3. Taking medical samples to microbiology laboratories
4. Distributing reports about patients to inpatient units that might include treatment suggestions
5. Analyzing patient reports from data taken from hospital information systems
6. Data management in general
7. Submitting daily incident reports
8. Rounds in the inpatient units

The common method used to determine IP staffing — using a ratio of IPs to the number of beds or the number of patients — might not be the best way of determining just how many IPs an institution needs.

That last one, rounds, comprised 9 specific activities, the investigators said, ranging from monitoring compliance of infection prevention protocols to bedside teaching. Support activities included roughly 7 miscellaneous tasks that are usually performed by IPs. The additional activities were performed by only a few IPs.

The authors cite a “mega survey” conducted by the Association of Professionals in Infection Control and Epidemiology (APIC) that showed a median IP staffing ratio of 1.25 IPs per 100 patients in acute care hospitals in the United States.

“Most countries do not address even the minimum benchmarks of infection control nurse staffing adequately,” the study states. “In such a scenario, the WISN method helps to take prioritized decisions. The method [lays out] all the activities that ought to be performed along with their frequencies and times taken.”

This should help hospitals create a “customized” infection control program. In addition, WISN allows hospital personnel other than those with an IP program to take up some of the duties. “This can be done by initially calculating the staffing requirement based on workload,” the study states. “Thereafter, allocation of certain duties to other categories of staff (non-nursing IP) can be considered based on requirement and policy of the hospital and/or the state.”

The study concluded that “staffing for infection control can no longer be made on the basis of bed numbers or patient census but rather must reflect the scope of the program, characteristics of the patient population and the workload involved, techniques for applying scientific knowl-
Infection Preventionists Prepare to Ride the Second Wave of COVID

BY SASKIA V. POPESCU, PHD, MPH, MA, CIC

Has the second wave begun or are we still experiencing the first wave? Or has the first wave been so rough that it’s blending into the second wave?

For many, it seemed like the first wave of COVID-19 cases was mild and didn’t feel as chaotic as what we saw across some U.S. cities, while others experienced deeply traumatizing, overwhelmed hospitals. That so many of us were in different periods of the outbreak often lends itself to many thinking we’re through the first wave … or even the pandemic. Cheer down. As we’re seeing in many states, that’s just not the case. For many, this is the first wave.

Those of us in healthcare and infection prevention must focus on sustainable efforts to combat COVID-19. How do we maintain readiness and response without burnout? There’s no solid answer to this, but a big piece really goes into the establishment of plans and education.

For those scaling down, what are your indicators for scaling back up? Sometimes the hardest thing is recognizing when we need to start looking again at personal protective equipment (PPE) re-use efforts, surge capacity, and all the other aspects of pandemic response that had to be implemented initially.

The good thing is that we have knowledge on our side, both in terms of lessons learned and hopefully having some more processes already in place; processes that don’t need to be created or revised. Having COVID-19 plans, like information on extended use of N95 masks, or duration of isolation, available online on intranets can be immensely helpful.

Another piece to this is reiteration of training and screening. While most are using universal masking practices for all hospital employees, how confident are we in their compliance or habits? Now is the time to do educational roadshows on PPE and isolation precautions. They don’t have be long, but it’s a nice way to stop by units not treating COVID-19 patients and discuss proper masking practices. (For instance, wearing PPE all day is rather novel for most of us.)

Moreover, this is the time to chat with staff about hospital plans and address questions they might have. Using those quiet moments to invest in sustainable COVID-19 infection prevention goes a long way and helps to reduce the long-term burden on the infection preventionists. Giving staff the skills to not only be safe, but also critically think through infection prevention situations, is critical to their safety and that of the patient.

In the beginning, we were rapidly trying to do training and education, acquire PPE, and develop educational materials and processes. Now is the time to regroup and refine our practices, like ensuring staff understand when isolation precautions for COVID-19 patients can be discontinued, or where the information is available to give to patients being sent home, but still requiring isolation. These are just a few lessons learned and a handful of things that can help guide us to a more sustainable approach to COVID-19.

REFERENCES AVAILABLE AT INFECTIONCONTROLTODAY.COM

Ethical Principles Critical to Protecting Healthcare Workers

BY ANDREW BLASI & KATHERINE NUNNER

The International Council of Nurses (ICN) estimated in June that at least 450,000 healthcare workers had been infected with COVID-19 to date. This is just one reason why it is so important for healthcare institutions, from large municipal hospitals to community clinics, to provide safe work environments for healthcare workers to perform their essential duties, including upholding regulations regarding occupational safety. A safe work environment is but one of several vital areas highlighted during this pandemic where the business of healthcare is greatly strengthened through the implementation of and adherence to...
ethically. Conducting business matters responsibly, with accuracy and honesty at the forefront without taking unfair advantage or entertaining a conflict of interest. The pandemic is likely to serve as a turning point in our societies’ focus on responsible business conduct, particularly in healthcare, as some unscrupulous actors take advantage of emergency health resources and economic upheaval for immediate benefit.

5. Respecting the environment, minimizing negative impacts as well as proper collection, storage, and disposal of biomedical waste.

6. Upholding patients’ rights, including respect of personal values and beliefs as well as such areas as dignity, privacy, and confidentiality. Each of these important considerations have been on display amidst the pandemic, along with ethical approaches to research activities and ensuring persons enrolled in clinical research are informed of the risks and benefits.

7. Safeguarding information and using data responsibly, maintaining appropriate administrative, technical, and physical protections while adhering to data standards that consider new and emerging technologies.

8. Preventing discrimination, harassment, and bullying, through a positive and respective environment for everyone with a zero tolerance for anything less.

9. Protecting and empowering staff, through a safe working environment as previously mentioned. Ensuring healthcare workers are fully trained and provided the tools they need to do their jobs safely will be a major commitment for every healthcare organization following the COVID-19 pandemic.

10. Supporting ethical practices and preventing harm, such as formal policies and procedures for areas with ethical concerns, ideally considering accepted international best practices. All healthcare organizations should ensure mechanisms are in place to address current and future ethical concerns that may arise.

Rapid uptake of EPIHC around the world will undoubtedly aide our health systems’ resurgence from the present crisis, strengthening protections for healthcare workers and those they serve in their everyday work.

ANDREW BLASI is a former foreign service fellow to the US Ambassador in London and director at C&M International. Katherine Nunner is a senior consultant at C&M International. They serve as advisors to the Ethical Principles in Health Care (EPIHC) secretariat in collaboration with the International Finance Corporation (IFC), a member of the World Bank Group.

For many states with a growing number of coronavirus disease 2019 (COVID-19) cases, a real issue has been the challenge of understanding exposures. With surging cases in Arizona, California, Texas, and Florida, this means that exposure risks for healthcare workers are growing in the community. For those of us in healthcare, this adds to the challenge of identifying when healthcare workers become sick. Checking against exposures we know might have happened, this can be problematic. How many of us truly know when we’ve been exposed? The knowledge we have in healthcare can be both a gift and burden. We know who has COVID-19, but once we leave the hospital, that knowledge of potential exposures likely goes right out the window.

A study from the Centers for Disease Control and Prevention (CDC) Morbidity and Mortality Weekly Report (MMWR) has shed light on how many people truly know where their exposure to SARS-CoV-2 occurred. Interviewing 364 participants during March 9-27 across Colorado, the researchers found some interesting sources for these COVID-19 cases. The authors noted that “among the 265 (73%) participants without known contact with a laboratory-confirmed COVID-19 patient, 30% (79 of 265) reported contact with a person they knew who had fever or respiratory symptoms. The most commonly reported activities in the 2 weeks before becoming ill included attending gatherings of >10 persons (116; 44%), traveling domestically (76; 29%), working in a healthcare setting (75; 28%), visiting a healthcare setting not as a healthcare worker (61; 23%), and using public transportation (57; 22%).”

Low-Risk Exposures to COVID-19 Can Sometimes Pack Deadly Punch

BY SASKIA V. POPESCU, PHD, MPH, MA, CIC

Moreover, nearly 30% reported contact with at least one person who had laboratory-confirmed COVID-19. A majority of this group reported that their exposure was related to a household member, whereas 25% noted that exposure to a confirmed case occurred in the workplace. These two types of exposures represented the majority of those reported from people with known exposures to confirmed cases. Of those with workplace exposures, a majority stated that this contact occurred in healthcare settings (60% were in healthcare personnel), followed by public administration or military.

While these findings are important, perhaps the most concerning is that so many of newly diagnosed cases aren’t aware where their infection stemmed from—where the exposure occurred. This is an increasingly important trend as infection preventionists work to respond to surges of COVID-19 cases. While healthcare worker exposures can and do occur, so many also occur out in the community. It’s easy to assume the greatest risk is in the hospital, where cases occur. This is also where the greatest protection occurs though—the near universal masking, presence of enhanced isolation precautions, and intense focus on isolation precautions. It’s when we leave the hospital or go to get a coffee in the cafeteria, our behaviors can become lax. We opt to take breaks from masking, exhausted from it all. Communicating these risks are important though. Since it’s so easy to focus on those high-risk exposures, we may not realize how frequent those small moments occur. It’s helpful to remind staff about the risk in the community and how they can protect themselves while still living their lives. Discussing risk spectrums and harm reduction measures can go a long way and help staff stay safe beyond the walls of the healthcare facility, which is ultimately our goal.
APIC President Connie Steed Talks About What COVID Has Wrought
Connie Steed, MSN, RN, CIC, FAIC: “Our goal at APIC, which is the goal of all IPs, is to have healthcare without infection. That’s an arduous task, but that is our vision and goal. And the infection preventionists’ role will help drive that vision.”

Hospital Airflow Plays a Crucial Role in Infection Prevention
Stephanie Taylor, MD: “In general, airflow has been managed by the engineers, by the architects, by the facility managers, and not so much by the clinicians. There is a lot you can do in indoor air management to decrease transmission of infections.”
WATCH: https://bit.ly/3eaFXJd

How Healthcare Will Change After COVID-19
Jaan Sidorov, MD, the CEO of PA Clinical Network and the former medical director of Geisinger Health Plan talks about the many changes infection preventionists and other healthcare professionals will most likely face.

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Notable Quotables

“Even before COVID-19, there was a study done where 8 out of 10 healthcare workers wanted to receive better hand hygiene training. Proper hand hygiene training is the No. 1 way to reduce the spread of illnesses and viruses including COVID-19. Given these unprecedented times, it’s more important than ever to reinforce and control the spread of not only COVID-19, but on any other illnesses.”

—DEBORAH CHUNG, HEALTHCARE MARKETING MANAGER FOR ESSITY NORTH AMERICA
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Napoleon said (supposedly), “An army marches on its stomach.” In other words, they can’t fight if they aren’t fed. In a sort of twist, it could be said that a hospital—fighting a deadly pandemic—depends vitally on the people who clean the floors and baseboards, curtains, mattresses, elevator buttons, and handrails.

The frontline healthcare workers rely on that “other” frontline. In the Lompoc Valley Medical Center newsletter, Environmental Services Director Deanna Hall called her staff “behind-the-scenes heroes protecting our physicians, nurses, respiratory therapists, patients, and employees by stopping the spread of infectious disease.”

Local Level
The US Centers for Disease Control and Prevention (CDC), the American Hospital Association, and state hospital associations have issued guidelines for dealing with the pandemic, but as the Occupational Safety and Health Administration’s (OSHA’s) Pandemic Influenza Preparedness and Response Guidance for Healthcare Workers and Healthcare Employers says, “Although a pandemic will be a nationwide event, it will be experienced on a local level.” That is, individual hospitals would have to work out what was best for them, their staff, and their patients.

As the virus began its devastating sweep, hospital associations and other groups began updating protocols that were generally intended for influenza outbreaks or less common events like Ebola and severe acute respiratory syndrome (SARS). Then it became more and more evident that coronavirus disease 2019 (COVID-19) was not like influenza. It couldn’t even rightly be compared to SARS, even though they’re related.

“I’ve been in environmental services for 17 years and I have never seen anything like this,” Glen Rogers, assistant director of environmental services at the University of Iowa Healthcare, tells Infection Control Today.

“The coronavirus is changing all of our lives,” said the California Hospital Association’s Coronavirus Response page. The California Department of Public Health “All Facilities Letters” revealed the changing focus: From application processes and notices of stakeholder meetings on January 17 to health updates and interim guidance on COVID-19 beginning January 23.

Some hospital associations adapted others’ existing protocols. The COVID-19 updates from the California Department of Public Health “All Facilities Letters” revealed the changing focus: From application processes and notices of stakeholder meetings on January 17 to health updates and interim guidance on COVID-19 beginning January 23.

Still, the swiftness and severity of the virus spread meant some hospitals were scrambling to adjust. “The entire pandemic came on too quickly, so we were initially slow to get going,” Sharon Ward-Fore, MS, MT(ASCP), CIC, a Chicago infection prevention consultant and member of Infection Control Today’s Editorial Advisory Board, said.

The Missouri Hospital Association
Board. “We had assigned those robots to ICT’s Editorial Advisory a member of the pandemic,” says Leach, who is also robots that we were utilizing prior to already had a fleet of UV disinfection discharge cleaning.”

on, as well as performing the terminal and spaces, nursing station, med room, and so units who focuses on cleaning the shared one dedicated EVS person for the cohort member potential exposures. “We have Leach says, to conserve PPE and limit staff since mid-March,” when they had their incident command at our organization and has been “going ever since. We’ve had hospital started preparing in late January, HonorHealth in Scottsdale, Ariz., says her the infection prevention coordinator at environmental services leaders need to do to ensure facilities return to their pre-crisis state?

Extreme Demands
Overall, Leach says, “Dealing with the pandemic for my infection prevention department has been tiring, inspiring, challenging, and collaborative. The demands on our time have been extreme, as most IPs would likely agree. The preparation and training before our patients arrived was very consuming, and once we started getting patients and our first wave, that was all we worked on. We were on call 24/7, working 12- to 14-hour days in the hospital, and then working from home at night and sometimes through the night and through weekends. The days all blended together.”

Support and collaboration help, though. “I feel supported by my hospital,” Leach says. “Other members from other departments help with some of our tasks and duties to ease the burden. I think for IPs, we are the subject matter experts in a pandemic, so we will be relied on heavily, and since you typically have a limited number of IP staff, you feel stretched.”

Rogers also emphasizes the importance of a supportive and collaborative environment. Hours fluctuate constantly in EVS, he says, but he cites the amount of time spent focusing on the pandemic. “Luckily we have a great management team here that we could rely on to keep the day-to-day operations going as we worked on pandemic-specific issues.”

On the other hand, the hospital staff are prey to the same things the general public are: anxiety and fear of contracting the virus. Ward-Fore says the pandemic “caused a drain on staffing, by illness and fear. All the education in the world could not help those that refused to work due to fear.” But she adds, “Having enough PPE and using it as we normally would have helped alleviate the fear.”

It also helps to have flexibility. As Rogers recalls, “Some of the new protocols presented challenges for staff, but we then used them as learning opportunities.”

Months of long days without let-up take a double toll: both professional and personal. Leach says, “At first I didn’t even have time to think about how the pandemic was affecting me, my kids, my family, my friends. It was exhausting, I had moments of total meltdown and times when I was so proud of what I do for a living. I think it finally hit me that my personal life has changed and my kids and family were experiencing this in a totally different way than I was about 2 months into the pandemic. I realized how much loss I was feeling and how much stress and grief I was holding in, just to get through the days and be supportive and effective in my work. I was totally compartmentalizing my own personal experience so that I could

The Association for the Health Care Environment held a webinar to provide guidance in “transitioning back to normal, albeit a new normal.” On the discussion list: What do environmental services leaders need to do to ensure facilities return to their pre-crisis state?
do my job. I think I’m still figuring out how I feel about things and sorting through my emotions. I think those of us working in IP right now have a unique perspective on resiliency during a pandemic.”

“A sustained crisis” is how OSHA describes an influenza pandemic. It contrasts such a pandemic with mass casualty and weapons of mass destruction events, which are “typically a surprise.” By contrast, a pandemic may come and go in waves, taxing morale and mental health of the people who must face it again and again. As of this writing, many parts of the country are still on the uphill part of the climb in the crisis, and others are relapsing after beginning to reopen. Arizona, where Leach is located, saw an alarming surge in cases and hospitalizations in mid-June. Chicago, where Ward-Fore is, was not out of the woods as it “cautiously” reopened around the same time: The chart of daily COVID-19 deaths was admittedly heading down, but in a very spiky way. And Rogers’ home, Iowa, despite a downward trajectory, has ongoing virus hotspots.

Second Wave
And a second, perhaps even harder, wave is expected to hit in the fall. The more intensive protocols may not be needed forever, but certainly their time is not done. “At this point,” Leach says, “we know that this work will continue through the year, so we have to think about burnout of the IP staff and how we can sustain our work through other methods that are not dependent on us being there at all times.”

Every disaster brings lessons. Hard-won though they may be, they can inform the way forward. In May, the Association for the Health Care Environment held a webinar to provide guidance in “transitioning back to normal, albeit a new normal.” On the discussion list: What to do with rooms outfitted with special equipment, or the space that’s been converted to COVID care? What do environmental services leaders need to do to ensure facilities return to their “pre-crisis state”?9

“We’ll continue with this process now, likely until we get to a place where we can stand down our COVID cohort units,” Leach says. “We also have enhanced cleaning procedures within our public areas as we re-opened for elective surgery and procedure to ensure more frequent disinfection of countertops, door handles, and other high-touch places in those common spaces where patients and visitors are coming through. We’ll likely keep up the UV disinfection protocol for COVID patients after the pandemic is over. I hope we sustain the frequent cleaning of shared spaces and waiting rooms as well, but that will depend on staffing.”

“How has your hospital been handling COVID-19? How are you celebrating your environmental services team? Have any IP success stories? Let us know! Connect with us online at InfectionControlToday.com or find us on social media @ICT_Magazine

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Let’s assume that hand hygiene compliance has increased during the coronavirus disease 2019 (COVID-19) pandemic. Now the challenge for infection preventionists (IPs) and others on the frontlines of infection control and prevention: Sustain those gains. But how?

Employ the concepts of behavioral change, including informal leaders, social pressures, cultural norms, and immediate and personal feedback. Informal leaders are people within a work area who are respected and seen as individuals who can be trusted and followed.

Informal leaders can either undo an intervention or change it if they don’t accept it, or they can vastly move a program forward if they are brought in as a stakeholder from the beginning. Social pressures and cultural norms exist on a large scale down to a small scale, such as a profession, hospital, unit within a hospital, and even a shift within the unit. These norms dictate acceptable behaviors, and social pressures can change the norms to reflect changes in what is acceptable for that particular culture. Finally, personal feedback can help reinforce the behavior that is desired by noticing and praising the person when it’s done. Also, personal feedback that is done through consideration can also be used to help identify when a norm or behaviors don’t meet expectations and to help the person understand what behavior is expected. Successful feedback needs to be timely, specific, and focus on the actions or behavior that is observed.

IPs could perform informal surveys of staff perceptions of hand hygiene in this time and use that information to help find the reasons why people are doing the right thing. Studies have shown that to enact social change, only about 25% of a group needs to adopt the change and move the rest of the group forward.

Monitoring Systems
In the past, when there have been major national health threats, such as anthrax attacks and Ebola, the federal government earmarked funding for grants and programs that would be used for public health efforts or for hospitals to obtain training or personnel to focus on preparedness efforts. If funding becomes available for healthcare facilities as a result of increased government grants or programs, it would be ideal to use some of those funds to invest in technology that would improve hand hygiene compliance, such as the electronic monitoring systems.

Another option is telemedicine, using electronic communication to decrease the number of times staff have to come in and out of the patient rooms, therefore removing one of the known barriers to hand hygiene compliance. But ultimately technology cannot solve all the barriers for hand hygiene compliance and, to truly have sustained change, a cultural shift must occur within the facility.

Role modeling, timely feedback, consistent monitoring, and data reports all help support the clean hands culture that is needed in healthcare facilities. At this time, months into the COVID-19 pandemic, some of the behavior change will start to normalize. Before habits return to pre-COVID ways, IPs have the opportunity to build on the renewed importance of hand hygiene in healthcare and start to build the foundations of a new hand hygiene campaign in their facilities.

Leadership involvement is key, as well as finding those informal leaders in the unit level who can be local champions and the role models needed to help drive overall behavior. The core of much of what an IP does requires them to become change agents. A strong change agent needs to be curious, persistent, and collaborative. There are many examples of research on how to influence behavior change and how to
utilize some of the informal leaders, social pressure, and feedback to create that culture shift within an organization. An IP does not receive formal education on behavior change science, but it would be beneficial to seek out some of these resources and perhaps work with local and national professional organizations to offer course work, online classes and other avenues to include these topics into the IP trainings.

Secret Shopper
Behavior change during a pandemic is related to several factors: risk assessment, personal fears, social factors, informational campaigns, and cultural expectations. Social factors in a healthcare setting are peer pressure, role modeling, and social comparisons with other units or departments. Also, patients are more acutely aware of the role of hand hygiene in a pandemic and are another source of social pressure to perform.

Hand hygiene has always been the most common way IPs have talked about preventing the spread of infection, and that is true with COVID-19. The first item listed on the US Centers for Disease Control and Prevention (CDC) website on how to prevent the spread is hand hygiene and it has been consistently educated to the public. During this time, as the pandemic is making disease transmission and the chain of infection come to life for everyone, hand hygiene is again being seen as everyone’s responsibility.

One challenge to understanding how hand hygiene habits changed in healthcare during COVID-19 is the ability to accurately measure and report compliance data. Hand hygiene is most typically monitored via secret shopper observations. During times of pandemics, the staff who would typically be doing these observations, such as nursing supervisors, ancillary staff, and IPs may be pulled into other duties or not available. Monitoring and observing for hand hygiene may not be a top priority when other patient care concerns are paramount.

Also, secret shopper observations have an inherent flaw in observational bias and Hawthorne effect, which have been recognized as a well-known shortcoming of data reported using that type of data collection. These limitations create a gap in knowledge to understand whether compliance actually increased.

Changing the culture won’t be easy. It’s been tried again and again and points back to the most basic of questions: Why do healthcare workers not perform hand hygiene, even when they understand the importance of that task to prevent the transmission of infections? Many studies have looked at common reasons why hand hygiene opportunities are missed including: inconvenient placement of dispensers/sink; broken dispenser/sink; distractions; perception of lack of time; inappropriate glove use; skin irritation; workflows do not provide opportunity; and frequent entry and exit of the patient care area.

Healthcare facilities have struggled to achieve and sustain high compliance rates of hand hygiene, despite the awareness and knowledge of its importance for centuries. Semmelweis was the first hand hygiene champion in 1858, and was met with disdain at first, eventually gaining some acceptance before being sent to a mental institution. Studies have found that, on average, compliance is usually around 50%, with some healthcare workers having more than 100 opportunities for hand hygiene during a normal work shift.

Reminder Capabilities
Electronic hand hygiene monitoring systems have been shown to provide more reliable data and also can improve compliance rates. These systems help remove the Hawthorne effect and observation bias associated with secret shopper programs. Also, some have reminder capabilities that would help notify staff when they have nearly missed a hand hygiene opportunity. Another benefit of these programs is the data analytics and ability to share nearly real-time data with staff and leadership. One of the biggest barriers for IP programs to adopt electronic monitoring is the cost associated with establishing and sustaining these programs.

Often IP does not have a budget, and the costs can be substantial, therefore the approval to spend the funds must be made from top leadership of the organization.

To enact social change such as better hand hygiene, only about 25% of a group needs to adopt the change and move the rest of the group forward.

During a time of pandemic, many hospitals are actually struggling financially because the usual elective patients are not coming to the hospital. Therefore, there is even less room in budgets to invest in an electronic program. The process for establishing the cost-benefit analysis of these electronic systems can improve hand hygiene compliance and therefore improve the ability to respond to future outbreaks and keep patients and staff safe.

Given so many reasons why hand hygiene is not performed, as an IP it is important to acknowledge these barriers and attempt to address them within the organization to ensure that healthcare workers can feel supported to do the right thing and be given the type of environment that supports hand hygiene. Part of this includes developing a safety culture within the organization that will encourage compliance with all infection prevention protocols and initiatives.

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REFERENCES AVAILABLE AT INFECTIONCONTROLTODAY.COM
Handwashing Is a New Normal Possible?

BY MARY JEAN RICCI MSN, RNBC

Can something as simple as handwashing prevent the spread of coronavirus disease 2019 (COVID-19)? Today, handwashing is as important as ever. Prevention becomes essential to stopping the spread of the virus because there is no vaccine to prevent it and no treatment for anyone experiencing the illness.

Mitigation is the only tool we have at our disposal to fight this novel virus. Science has consistently proven that handwashing is the only way to prevent viral and bacterial diseases. Healthcare providers know that hand hygiene protocols reduce the rates of healthcare-associated infections (HAIs), yet providers continue to miss opportunities to perform hand hygiene. COVID-19 will have a lasting impact on hand-hygiene practices if we reevaluate what outcome we want to achieve with the provision of education on hand hygiene.

Coronavirus is spread by droplets. So anytime we talk or sneeze or cough, there are droplets that come from our mouth and nose. The virus is on our face, hands from covering our sneeze by habit, or even with the use of tissues. The virus can land on surfaces. If a contaminated surface is touched then one is at risk for contracting the virus via hand contact with their face, nose, eyes, and mouth. During the COVID-19 pandemic, handwashing becomes even more important. How can healthcare providers serve as credible educators for the general population, on the critical issue of hand hygiene, when healthcare providers are not consistently practicing hand hygiene? How can we prevent the transmission of disease when we neglect to provide patients with an opportunity to properly wash their hands?

Healthcare workers now have an increased need to wash hands. Hand hygiene should be completed prior to donning and after doffing personal protective equipment. Healthcare providers are also wearing masks for the duration of their shift in healthcare facilities. Hand hygiene should be performed after adjusting their mask as well.

Healthcare workers have many reasons for not performing hand hygiene. Edmonds, et al includes some of the following reasons for not washing hands: inconvenience, I forgot, I was wearing gloves, lack of education, hands full, skin breakdown, frequent entry into room, and hand hygiene products have a strange odor or leave a film on hands.1 The reasons for lack of hand hygiene are only important if we use the noncompliance reasons to improve systems such as: promoting hand hygiene, trialing new products, or changing behaviors of healthcare providers.

To-Do List

What can professional development educators and infection control specialists do to encourage hand hygiene? We need to consider what outcome we would like to achieve with hand hygiene compliance.

Have professional development educators and infection control specialists consider the objective of hand hygiene education. Is the objective of hand hygiene education to increase the compliance rates of hand hygiene or is the objective of hand hygiene to prevent the transmission of disease?

If the objective of hand hygiene is to prevent the transmission of disease, then our educational content needs to be redesigned. We need to transform our education programs and campaigns. Education needs to include content related to how easily germs are spread and transmitted in the hospital environment, how healthcare employees contaminate the environment, how the environment is contaminated with social media devices, how staff contaminate themselves, how patients can contaminate their environment.

We need to create educational programs for patients, families, and visitors, as well as staff. Education can no longer be “wash in and wash out.” Professional development educators and infection control specialists need to design educational programs that create a lasting behavior change in all constituents.

The only education that should remain consistent is the procedure for washing hands. The procedure2 for handwashing, according to the US Centers for Disease Control and Prevention (CDC), should be adopted in all healthcare facilities.

The procedure is:

1. Wet your hands with clean, running water (warm or cold), turn off the water, and apply soap.
2. Lather your hands by rubbing them together with the soap. Lather the...
backs of your hands, between your fingers, and under your nails.

3. Scrub your hands for at least 20 seconds. Twenty seconds can be measured by singing the song “Happy Birthday” or the “ABCs” song from beginning to end twice.

4. Rinse your hands well under clean, running water.

5. Dry your hands using a clean towel or air dry them.

Now is the time to change our educational methods. We need to change our content. We need to get the message out that the goal of hand hygiene is to prevent the transmission of disease. We need to ask staff if they have stopped the spread of your germs today? We cannot just put the handwashing flyer reminder somewhere out there in healthcare facilities. We need to change the signage and location of the information frequently, so the message remains on the minds of the providers. The message needs to be innovative. We need to create educational interventions that promote a change in personal behavior.

Patients, Too

A major educational deficit that remains in the healthcare system is patient hand hygiene. How often do we encourage patients to perform hand hygiene while in the healthcare facility? Do we have signage to encourage patient handwashing? Is hand sanitizer available to our nonmobile patients? Do we offer an opportunity for patients to wash their hands before and after meals? After using a bedpan or commode, has the patient been provided with access to soap and water? Is the opportunity available in your healthcare facility for a patient to perform hand hygiene after coughing or sneezing? Are patients offered a chance to wash their hands after a procedure outside their room? Is hand sanitizer or soap and water available to the patient after a physical, occupational, or speech therapy session? Have we taught patients to complete hand hygiene after touching a wound or dressing?

Now is the time to provide education to patients encouraging the patients to ask for an opportunity to wash their hands while a patient in the healthcare facility. We need to educate patients to speak up for access to hand hygiene to prevent the transmission of disease. Access to soap and water or hand sanitizer is a necessity for patients in the healthcare facility. Professional development and infection control specialists can make a difference in the health of our patients. Emphasizing patient hand hygiene can only serve to decrease the infection rates in patients and stop the transmission of disease.

Our methodology for collecting hand hygiene compliance data needs to change. We need to ask ourselves tough questions. Do we truly empower our hand hygiene observers to conduct in-the-moment education with staff? Can all employees stop the line? Do we truly create a culture of do no harm? With the increased necessity for hand hygiene, is now the time to invest in technology to measure hand hygiene compliance? Do we need to begin to measure hand hygiene compliance in the patient population?

In this time of the global pandemic, patients are afraid to return to healthcare settings for routine care, elective procedures, and even emergent life-threatening procedures. Can we convince the public to return to the healthcare system for elective or life sustaining treatment with improved hand hygiene?

COVID-19 has changed the world in which we live. Can we respond with increased rigor to prevent the spread of disease? Would you feel safer as a patient or a healthcare worker if we stopped transmitting disease?

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REFERENCES AVAILABLE AT INFECTIONCONTROLTODAY.COM

For more on the latest infection control and prevention literature, visit InfectionControlToday.com
How to Build Cost-Effective Infection Prevention Programs at Long-Term Care Facilities

BY LINDA SPAULDING, RN, BC, CIC, CHEC, CHOP

It’s 5 pm on a Friday. Five residents are presenting with diarrhea, nausea, and vomiting. The director of nursing (DON) has already left for the weekend. The facility’s infection preventionist’s last day was Wednesday and no one has been hired yet. The DON tells the staff to call the medical director who orders stool cultures for *Clostridiodes difficile*, and foodborne illness.

By 7 pm, 10 residents have the same symptoms.

The staff report back to the DON. The DON is not sure what to do but knows that the facility’s former IP is still in town. She calls her. The former IP says that it might be norovirus and that the state Department of Health’s (DOH) after-hours number should be called. The number is in the infection control manual for reportable diseases. The IP also says there is a policy for norovirus, but no one knows where to find it.

This is an example, based on real events, of an infection prevention and control (IPC) program that has not outlived a person. Staff did not know what to do and the DON did not know she should call the DOH. Nobody knows what report forms are required to report the outbreak to the DOH and they don’t know the phone number of the DOH epidemiology branch to report the outbreak. This facility’s IP practices were dependent on a single person, not facility practice.

A strong, well-run IPC program costs more time than money. An initial investment toward training a facility’s IP and instituting a well-developed program is well worth the money and will save funds in the long run (which also means saving lives) for long-term care facilities (LTCFs). The right approach means not having to break the bank to install an effective IPC program.

How can this be done? Does a LTCF need a full-time certified IP on staff? No. What it needs is a well-developed program that belongs to the facility and not to a person. People come and go. There is no reason to redevelop your IPC program every time a person leaves the facility.

Building a strong infrastructure is the key to a good long-standing program.

A well-developed IPC program helps to proactively manage and reduce any risk associated with healthcare-acquired infections (HAIs). IPC needs to be a balanced approach addressing risk of infection, not just looking at the treatment of infections. By using the risk approach to preventing infections, money is saved with the decrease in antibiotic cost, decrease in cost of personal protective equipment (PPE), decrease in mortality and morbidity, decrease in nursing care, and a decrease in the risk of bad publicity.

In the time of coronavirus disease 2019...
Infection control needs to be a balanced approach that addresses the risk of infection, and not just the treatment of infection. Money is saved when this approach is used.

Not Business as Usual
There has been little change in IPC programs after severe acute respiratory syndrome (SARS), Middle East respiratory syndrome (MERS), and H1N1 influenza. These epidemics struck, and then many healthcare organizations quickly went back to what they were doing previously. All healthcare facilities should have programs that are designed around the facility needs and performance measures. And, as mentioned, they should be facility-driven, not person-driven. IPC programs should be based on trigger points for infection risk within a particular facility, and not based on a person’s knowledge of infection prevention. With a strong program in place, any person should be able to come into a facility and pick up monitoring IPC where the last employee left off. LTCFs must manage these challenges, measure performance, and manage the changes that should come out of the worst pandemic this world has seen since the influenza pandemic of 1918.

Does Anybody Care?
The unfortunate truth is not all problems fit within a standard. The message to staff is no one cares. The message to management is “we didn’t get cited so it must be OK.” It has been this way for years, but it does not have to be.

Water Management
The plant management director’s last day was Wednesday, but he has not finished implementing the water management program that was required to be in place in November. It is now January. The hospital hired a new director for this department.
in December. CMS surveyors want to see the facility’s water management plan. The quality department director calls the new director in plant management and asks him to bring the water management plan to her. The director states he doesn’t have a water management plan. The new director and old director never talked about it. Again, this facility was not in control of its practices and policies did not outlast the person. Another example of a system breakdown with change management.

CMS now requires facilities to have a water-management plan. This affects plant operations again, but it also affects every employee, resident, and visitor. The water-management plan is designed to identify any area of risk within the facility that can cause bacteria to grow in the water that residents drink or bathe in. The same water is aerosolized when the residents are bathed, exposing the healthcare worker (HCW) who is bathing the resident.

The aerosolization of the water is then breathed into the lungs of the resident and the HCW. This can lead to Legionella infections of the lungs. Any area throughout the waterline where there is standing water can lead to growth of Pseudomonas, Legionella, and other water-borne bacteria leading to an increased risk of infections.

If the facility has piped-in oxygen and the oxygen tanks that pump in the oxygen to the building are not maintained, they can become contaminated. If shower heads are not cleaned or changed on a rotating basis, the shower heads can become a source of infection. Aerators on sinks have been linked to many outbreaks of Pseudomonas infections. How a toilet plunger is carried through the facility can contaminate the environment with coliform bacteria.

These are just some examples of how IPC is part of a plant operation department. Employees of this department need to know the policies and procedures for mitigating risk.

Once these are in place, all future employees should be following the same practices, not reinventing the practice. Any policy and procedure in this area should provide guidance for a new employee on how the process is done unless they can provide documentation of updated standards, guidelines, or regulations that justify a change in practice.

This is just a start to creating an effective IPC in an LTCF, but it’s a good start. The important thing is: Start!

LINDA SPAULDING, RN, CIC, BC, CHEC, CHOP, is an infection prevention consultant and founder of InCo and Associates International.

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Navigating the New Normal in Infection Prevention

BY FRANK DIAMOND

You had questions, she had answers. Infection prevention consultant Sharon Ward-Fore, MS, MT (ASCP), CIC, held sway recently in a wide-ranging, hour-long *Infection Control Today* webinar presentation that touched on a host of issues that infection preventionists (IPs) will need to be familiar with as society moves out of the shadow of coronavirus disease 2019 (COVID-19) and into the light of a new normal.

“Infection prevention basically remains the same,” said Ward-Fore, who is also a member of *Infection Control Today*’s Editorial Advisory Board. “The same tools will work: surveillance, rounding, auditing, tracking, tracing, teaching, coaching, being the calming voice when chaos reigns. Be watchful of what is happening locally and elsewhere, maintain this heightened sense of awareness through vigilance.”

Ward-Fore spoke to an audience of fellow IPs and other healthcare professionals during the webinar, hosted jointly by ICT® and Metrex. As society finds its bearings, IPs on will need to monitor workforce availability, facility considerations, testing capacity, personal protective equipment (PPE), infection prevention protocols, and regional considerations.

**Second Wave**

“We know a second wave is coming,” Ward-Fore said. “We don’t know when or how bad it might be. So be prepared. Prepare by assessing your medical supplies, your equipment, and your PPE frequently, and don’t forget your staff. Make sure your staff is doing OK.”

Second Wave

“I know a second wave is coming,” Ward-Fore said. “We don’t know when or how bad it might be. So be prepared. Prepare by assessing your medical supplies, your equipment, and your PPE frequently, and don’t forget your staff. Make sure your staff is doing OK.”

It will also be necessary to again train other professionals the way IPs have historically trained them about infection prevention, because a lot of the old rules had to be set aside when COVID-19 surged. For instance, the PPE shortage led some hospitals to say that gowns need not be worn for patients with bacterial infections such as extended spectrum beta-lactamase-producing (ESBL) organisms, vancomycin-resistant *Enterococcus* (VRE), and methicillin-resistant *Staphylococcus aureus* (MRSA).

“This is a little different from our normal contact precautions for these kinds of organisms,” said Ward-Fore. “How do we justify the use of PPE when the pandemic is over for things like MRSA and VRE? When now we’re saying it’s OK to not use it?”

Ward-Fore suggested that IPs should be “tracking transmissions and strain typing, because right now the cat is out of the bag, so to speak, and how do we go back to our normal standard infection prevention protocols without a lot of pushback? The way we do that is starting to collect data now so that we have some information for what lies ahead. When everyone says, ‘We didn’t wear our PPE during the pandemic, why do we need to wear it now?’, IPs will have an answer.”

IPs will also need to monitor PPE donning and doffing. “It’s up to you to audit practices and give real-time feedback,” said Ward-Fore. Ward-Fore brought her real-world experience to bear on guidelines by the US Centers for Disease Control and Prevention (CDC) and the World Health Organization (WHO). At one point she featured a WHO slide showing 11 steps for good hand hygiene (Figure 1).

“This WHO diagram demonstrates how hand hygiene should be performed every time,” Ward-Fore said. “It’s almost like performing a surgical scrub. When it’s performed this way, meticulous and thoughtful, it can really make a difference in staff and patient safety. The challenge now, as it has been in the past, is how do we build in the time to perform like this...
for every patient encounter? If any of you figure that out, please let me know.”

That’s not to say she didn’t find WHO and CDC guidance useful. In fact, just the opposite. Ward-Fore praised guidelines created by both organizations and relied on them throughout her presentation.

For instance, when it comes to workforce availability, Ward-Fore said that IPs in the post-COVID world should always keep in mind the second wave. As soon as IPs spot a symptomatic worker, they should make sure that worker’s face is covered, inform the worker’s supervisor, and send the worker home.

“When the CDC has a lot of guidance around this in the Interim US Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to COVID-19,” said Ward-Fore. “It’s a mouthful, but it’s a really great resource that will help you figure out what to do with your staff and how to conduct a risk assessment to find out the different ways that you can manage your staff through a positive exposure or potential exposure.”

A good resource for staffing questions can be found on the CDC website under Strategies to Mitigate Healthcare Personnel Staffing Shortages, said Ward-Fore. “Lots of great tools and checklists to kind of help you maneuver through this quagmire of so many different questions with so many different answers.”

Waiting Rooms

Try to maintain low patient volumes throughout the facility in the reopening phase. Place chairs 6 feet apart in waiting areas. “Now I’d like you all to close your eyes and visualize what some of your waiting rooms look like [currently],” Ward-Fore said. “I see a waiting room where patients are sitting shoulder to shoulder and back to back. Even in the best of times, this really is not a good setup. Think about the cold and flu season. People are right next to each other spreading and shedding. We need to think about ways to reduce crowding in waiting rooms.”

The post-COVID-19 healthcare facility should be full of visual reminders for patients, staff, and visitors, said Ward-Fore. Patient screening will become a more important aspect of care. “Infection preventionists have known the importance of patient screening for quite a long time,” Ward-Fore said. “As an IP that covered the ED, basic everyday patient screening and triage was very, very important.”

When diseases like pertussis or measles were circulating, IPs would ask the patient if he or she had traveled recently and, if so, where. Screening questions were developed to help identify Candida auris when that popped up a few years ago.”

Treatment protocols should be based on what’s relevant to a particular healthcare institution: hospital, primary care, etc.

Figure 1. How to Handwash

WASH HANDS ONLY WHEN VISIBLY SOILED! OTHERWISE, USE HANDRUB!

Duration of the entire procedure: 40-60 sec.

1. Wet hands with water
2. Apply enough soap to cover all hand surfaces.
3. Rub hands palm to palm
4. Right palm over left dorsum with interlaced fingers and vice versa
5. Palm to palm with fingers interlaced
6. Backs of fingers to opposing palms with fingers interlocked
7. Rotational rubbing of left thumb clasped in right palm and vice versa
8. Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa
9. Dry thoroughly with a single use towel
10. Use towel to turn off faucet
11. Rinse hands with water

…and your hands are safe.

practice, urgent care center, or mini-clinic. “When I was an IP, I worked in the emergency department and I developed this thing I called the respiratory hygiene algorithm for the ED staff,” Ward-Fore said. “And it was simply a list of communicable diseases like mumps, measles, pertussis.”

She needed to determine: What actions needed to be taken? Did patients need to go into negative airflow rooms? Were droplet precautions needed?

“And it was just the way to simplify how patients move through triage,” said Ward-Fore. “It provided a quick guidance on symptoms, presentation, masking, a need for additional precautions. So, think about how you might be able to develop your protocol and make it simple.”

**EVS Monitoring**

IPs will also, as always, have to monitor the environmental services (EVS) staff. “Practices drift,” Ward-Fore said. “Staff may be in a hurry. And sometimes staff think more is better. And I actually saw this at my former institution where the staff thought if you use 3 squirts, then 10 squirts is better. So be sure that you’re monitoring this regularly, and train, train, train and audit to make sure everyone’s following the same protocol.”

Clean from top to bottom, clean to dirty, clockwise or counterclockwise. “Clean before disinfection,” Ward-Fore said. “I can’t tell you enough how important this is. If there is bioburden on a particular item, a medical device or a patient tray in their room, unless you remove that bioburden the disinfectant is not able to touch those surfaces. It’s really important to clean before disinfection.”

In the healthcare infection prevention and control FAQs for COVID-19, the Centers for Disease Control and Prevention suggested the following surface disinfection protocol:

- Understand product instructions for use
- Clean before disinfection
- Complete required contact time for disinfection
- Communicate facility protocol to entire staff
- Identify cleaning owners
- Specify cleaning frequency
- Determine cleaning order

IPs should know who is responsible for cleaning what. But more than that, everybody should know who’s responsible for cleaning what.

“This is a process that seems to break down fairly regularly,” said Ward-Fore. “When I covered surgical services, this happened fairly often. People would point the finger at each other and say, ‘Oh, well anesthesia cleans this but EVS cleans that.’”

IPs also need to specify how often something should be cleaned. Waiting rooms and other areas where patients tend to congregate for a long time should be cleaned more frequently.

Make sure there’s a plan to thoroughly clean and disinfect all patient care items. Exam rooms are different than public waiting rooms and not all waiting rooms or exam rooms are the same.

“What you really need to do also is try and limit the amount of supplies and equipment in the room to make it easier to clean,” said Ward-Fore. “Keep your supplies stored in cabinets or drawers. That’s actually why they’re there. And be sure you can close them. There’s no need for seven days’ worth of linen or enough IV bags on the counter for an entire week’s worth of surgeries. IPs, does this sound familiar? Probably.”

Finally, IPs should be aware of who among their fellow healthcare workers seems stressed out. “Recognize the toll this prolonged heightened awareness may take on staff physically and emotionally,” said Ward-Fore. “The staff worldwide have been trouper but how long can they maintain that? So be cognizant of that. Let each other know that you have each other’s backs and that you’re there for each other.”

**REFERENCES AVAILABLE AT INFECTIONCONTROLTODAY.COM**

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**5 Takeaways from the Webinar**

1. A second wave is coming. In fact, by the time you read this, it might already be here. “So be prepared. Prepare by assessing your medical supplies, your equipment, and your PPE frequently, and don’t forget your staff.”

2. Infection preventionists will need to monitor the donning and doffing of personal protective equipment more than ever. “IPs, it’s up to you to audit practices and give real-time feedback. This is really important.”

3. Patient screening will become a more important aspect of care. “Infection preventionists have known the importance of patient screening for quite a long time...” For instance, “IPs would ask the patient if he or she had traveled recently and, if so, where. Screening questions were developed to help identify *Candida auris* when that popped up a few years ago.”

4. IPs will also, as always, have to monitor the environmental services (EVS) staff. “Practices drift. Staff may be in a hurry... So be sure that you’re monitoring this regularly, and train, train, train and audit to make sure everyone’s following the same protocol.”

5. Infection preventionists need to take note of who among their fellow healthcare workers might be under a lot of stress. “The staff worldwide have been trouper but how long can they maintain that? So be cognizant of that.”
Supply chain issues are a larger, more systemic aspect of healthcare and national preparedness. Although IPs may not be able to fix them individually, there are ways we can ensure the safety of our hospitals.

Preparedness

Shortages extend beyond masks and gowns, but also into tubing, Foley catheter kits, disinfecting wipes, hand hygiene products, disposable laryngoscope blades, and much more. COVID-19 is a marathon, not a sprint, and ultimately represents the bigger issue of hospital preparedness and how we integrate critical aspects, like supply chain and surveillance. It is important to note that the battle to reduce and even prevent COVID-19 must continue as healthcare experts keep a lookout for a second wave. Instead of a stop-go-stop-go approach, it’s important we approach this from the perspective of perseverance and resolve.

One of the first ways we can work toward more sustainable efforts is to first focus on daily PPE counts. This is something most likely to do with larger international and national supply chains from manufacturers and distributors but, overall, this is a good measure to establish as a standard infection prevention and control (IPC) practice.

Moreover, are IPs simply evaluating what’s available day to day or are they also considering what will be needed in a surge? In many cases, the relationship between IP and the supply chain department is passive and fluctuates with emergencies or new products. What if, though, we worked to have a more proactive relationship that involved weekly meetings regarding the level of supplies, like PPE? Right now, many of us are getting daily reports on the number of supplies we have and how many usage days that translates to.

Working with the supply chain department to set up more continuous, proactive check-ins that are measured by days of supplies on hand and how that would fluctuate with varying surges can be immensely helpful. This also involves scaling or descaling PPE-focused efforts. For many, guidance from the US Centers for Disease Control and Prevention (CDC) is what actions are based on. When the CDC declares something an emergency, that is often the trigger point for most hospitals and healthcare facilities.

Perhaps, though, a more proactive approach is needed: indicators for scaling up PPE conservation efforts and then triggers for descaling. Continued monitoring of outbreaks locally and internationally can go a long way. Travel-based screening and education about existing outbreaks, like the current Ebolavirus outbreak in the Democratic Republic of the Congo, requires us to keep tabs on what’s going on in the world. An outbreak anywhere is an outbreak everywhere and although some countries might have enhanced surveillance measures, COVID-19 has taught us that we are all uniquely vulnerable. While it might not change the outcome for millions, monitoring and helping guide preparedness efforts earlier could change the outcome for thousands of employees and patients.
This requires support and a collaboration between infection prevention, administrative leaders, and key stakeholders like supply chain, laboratory services, and others.

**Alternatives to N95s**

In addition, IPs can possibly utilize more sustainable PPE. Full-face respirators have become more common with the COVID-19 pandemic. These offer an alternative to N95 respirators and, in some cases, combine eye protection. A benefit to these devices is that they are re-usable and able to be cleaned and disinfected between use. Like powered air purifying respirators (PAPRs), they offer a long-term alternative for extended use that is often more comfortable for staff. More importantly, they allow staff to re-use them with disinfection protocols that change the traditional disposable notion of PPE. Although IPs have traditionally thought of PAPRs for only emergency preparedness situations, perhaps full-face respirators offer a middle ground that can change pandemic preparedness in healthcare.

Face shields are another piece to this puzzle. More research is being conducted on the feasibility of using face shields in several environments—for all triage staff as protective measures, but also as a potential alternative for community mask use. While these offer protection for eyes, respiratory protection will still be required for those in isolation requiring a mask (eg, surgical or N95). The use of face shields in the community as an alternative to face masks is an increasing topic of conversation. Changes cannot be made to current PPE protocols at the moment, but it will be interesting to see where this research leads.

Supply chain issues are a larger, more systemic aspect of healthcare and national preparedness. Although we may not be able to fix them individually, there are ways we can account for them and ensure the safety of our hospitals and healthcare facilities. Those aforementioned efforts shouldn't focus solely on PPE, though.

**Time Is Now**

A big piece to this is also about the collective efforts of IPs and hospitals. IPs are often under-represented when it comes to hospital preparedness and, often, many healthcare colleagues don't even realize IPs exist, let alone the work IPs do. Now is the time for IPs to use their voice. Work with the Association for Professionals in Infection Control and Epidemiology's Policy Group to help drive legislation and accountability locally and nationally. Engage with local leadership, hospital consortiums, and policy makers. Infection prevention voices and representation are critical to help not only drive change, but also spread awareness of the very real issues we see and manage daily. Moreover, work with local public health officials and departments.

Our public health personnel are some of our greatest allies. We often interact with them regarding reporting of communicable diseases, and they often offer committee feedback and training, and serve as a wealth of knowledge to understand how we all work together. IP representation on public health steering groups and committees is immensely helpful and not only gives us a voice, but also ensures that there is awareness for the intricacies of how healthcare operates. Moreover, continued engagement with public health agencies enhances the relationship that we are fundamentally reliant on.

Combatting COVID-19 will require a considerable amount of dedication, resources, and coordination. It will take time and there will be setbacks as IPs navigate through a pandemic. Infection prevention efforts, though, are so critical and extend beyond hospital and healthcare walls. We often act as the intersection between healthcare, public health, and emergency preparedness. Utilizing our knowledge and incorporating some of the lessons learned, especially about PPE and response, will be critical for not only COVID-19, but also future infectious disease outbreaks and events.

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REFERENCES AVAILABLE AT INFECTIONCONTROLTODAY.COM
The United States has long lacked the needed infrastructure for the reporting of resistant organisms. Outbreaks have largely gone undocumented and, in many cases, ignored. Nursing homes largely flew under the radar for infectious disease reporting and accountability.

The healthcare industry cites the burden of reporting and lack of resources as justification for its inaction. Infection preventionists (IPs) are stretched to the limit with both reporting and patient responsibilities with an unwillingness of facilities to prioritize infectious disease prevention in their operating budgets. In addition to financial concerns, accountability was also at the heart of the inertia in implementing the infrastructure needed for a comprehensive national reporting system for dangerous pathogens.

All of this changed with coronavirus disease 2019 (COVID-19). After decades of reluctance to implement a national reporting system, we witnessed almost overnight the formulation of case definitions and comprehensive national reporting from all healthcare facilities. One must ask the question: Why has this not been done for other dangerous pathogens?

Intense concern has been focused on nursing homes. On May 6, 2020, the US Centers for Medicaid and Medicare Services (CMS) issued an interim final rule regarding COVID-19 cases among residents in nursing homes. Nursing homes are now required to report COVID-19 resident and staff infections to the US Centers for Disease Control and Prevention’s (CDC’s) National Healthcare Safety Network (NHSN) and to the other facility residents along with their families and/or representatives. The regulation states: “Inform residents, their representatives, and families of those residing in facilities by 5 pm the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or 3 or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other.”

Health Watch USA™ has called for a national tracking system for both employees and patients/residents of all facilities for all dangerous pathogens.

Inadequate System

Of the CDC’s 5 urgent bacterial threats only one—Clostridioides difficile—has required reporting, but participation is only mandated for hospitals, and only those which participate in Medicare’s prospective payment system. Thus, critical access hospitals are not included. Carbapenem-resistant enterobacteriaceae (CRE) is not required to be reported on a national basis, even though its bloodstream infections have close to a 50% fatality rate. Candida auris and carbapenem-resistant Acinetobacter are also not required to be reported. Of the CDC’s 11 Serious Threats, only methicillin-resistant Staphylococcus aureus is required to be reported, and only in hospitals. Nursing homes, surgery centers, dialysis centers, critical access hospitals, along with private physician offices are not required to report in a national system.

States may have additional requirements and a few states have comprehensive mandatory reporting laws. This is the case for the state of Kentucky, which implemented a comprehensive reporting law in October 2016 which mandates all healthcare facilities to report outbreaks of dangerous pathogens to the NHSN and to confer rights of the Kentucky Health Department to access NHSN data.

There are a few important points which need to be explained:

State health departments only have...
delayed access to NHSN data. Healthcare facilities need to give them permission, or permission granted by state law, for state health departments to have access to the actionable current data.

- The definition of an outbreak is defined by the CDC as an infection rate above a facility’s baseline. The baseline is defined by the facility, so it is in the eye of the beholder. The Kentucky regulation closes this loophole by defining an outbreak as “2 or more cases, including HAs (healthcare-associated infections), that are epidemiologically linked or connected by person, place, or time, or a single case of an HA not commonly diagnosed.”

- A healthcare facility is defined as any place, building or agency which is operated, or designed to provide medical diagnosis, treatment, nursing, rehabilitative, or preventive care and includes alcohol abuse, drug abuse, and mental health services.

A long list of dangerous pathogens and definitions is also specified. One shortcoming of the law is that public reporting and report verification is prefaced by “may,” which means it may not happen.

However, this type of a comprehensive system, whether through statute or regulation, is lacking on the national level.

Broad Net

A comprehensive reporting system is not just needed for infections solely caused by dangerous pathogens but also for co-infections which all too commonly affect those inflicted with COVID-19. It is known that when death occurs with viral pneumonia that there is often a bacterial co-infection. Bacterial co-infections occurred in up to 95% of fatal cases with the Spanish flu. The most common organisms were Staphylococcus aureus, Streptococcus pneumonia, and Hemophilus influenzae. Secondary infections were identified in 50% of COVID-19 fatalities. Obviously, if these co-infections are caused by antibiotic resistant bacteria, then one would expect the fatality rate to increase.

During the March 11 Senate HELP committee hearing on COVID-19, Sen. Mitt Romney asked CDC Director Robert Redfield, MD, why the CDC has not established an accurate real time data site for hospitalization and treatment data at the CDC. Redfield responded: “…the reality is there is an archaic system a non-integrated public healthcare system. Each public health department has their own systems. This nation needs a modern highly capable data analytic system that can do predictive analysis. I think it is one of the many shortcomings that have been identified … It is time to get that corrected.”

After decades of reluctance to implement a national reporting system, when COVID-19 came we witnessed almost overnight the formulation of case definitions and comprehensive national reporting from all healthcare facilities.

CMS’s COVID-19 Focused Survey of Nursing Homes also requires screening of all staff at the beginning of their shift for COVID-19, including temperature and signs of illness. Deborah Birx, MD, the White House’s Coronavirus Response Coordinator, called for testing all nursing home residents and staff in the immediate term. The CDC’s Anthony Fauci, MD, agreed with Birx and took the recommendation a step further.9

“aragraph 2: In the long range we will have to have infection control capabilities in nursing homes that are really mature and really unassailable,” Fauci said. “We have to do the kind of surveillances and have to have the capability of when you identify someone you get them out of that particular environment so that they don’t spread the infection throughout. General testing for all, I think, is a good start, but you look where are you going to go in the future. There has to be a considerable degree of surveillance capability.”

It is of utmost importance to screen healthcare staff and patients for dangerous pathogens along with the establishment of a national tracking system. In addition, an economic and healthcare safety net for healthcare workers needs to be established.

No Paid Sick Leave

Some frontline workers do not even have paid sick leave. Healthcare workers and, through them, their families are also at risk of acquiring a myriad of drug-resistant dangerous pathogens. Active screening of workers, along with the provision of health benefits and an economic safety net, needs to be enacted.

A dangerous pathogen is a dangerous pathogen; we should not discriminate on our approach to COVID-19. The frequency
Air Purifier Said To Be Able To Impede COVID-19

The Air Pro RX air purifier, recently granted 510(k) premarket notification by the US Food and Drug Administration, should be utilized in high-risk areas in healthcare settings during the coronavirus disease 2019 (COVID-19) pandemic, according to the device’s manufacturer, Molekule.

“Air Pro RX uses Molekule’s patented Photo Electrochemical Oxidation (PECO) technology, and has demonstrated greater than 5-log, or 99.999% reduction, of RNA virus MS2 at 24 hours as a proxy virus for SARS-CoV-2,” the company said in a press release.

The device is currently being used in Mercyhealth hospitals in Wisconsin and Illinois.

“Air Pro RX does not require any installation and begins cleaning the air immediately after start-up,” Molekule said.

“It comes with a pre-filter, which is optimized for large particle capture, and a PECO-Filter, which is optimized to destroy bacteria, viruses, and other airborne contaminants. Air Pro RX is also easily cleaned and compatible with standard wipe-down disinfection protocols used in hospital facilities.”

Jaya Rao, MoleKule’s co-CEO and co-founder, said that “it’s critical now more than ever to consider new air purification technology and how it moves medical facility air quality standards forward and protects their patients.”

https://molekule.com

Test in the Works Said to Cut Down on COVID-19 False Negative Rates

The majority of tests for coronavirus disease 2019 (COVID-19) approved by the US Food and Drug Administration for Emergency Use Authorization (EUA), are single-pathogen tests. The problem with those, according to the Beverly, Massachusetts-based company LexaGene, is that while single-pathogen tests have high sensitivity, some of them might also have a high false-negative rate for COVID-19 cases. LexaGene is looking to get EUA approval for what the company describes as “a gold standard, multiplex test” that will limit the false-negative rate. Isothermal nucleic acid amplification which is used in one of the current tests, “doesn’t require sample prep and performs a genetic reaction, which is fast, but risks an inhibited sample and a false negative result.”

The LexaGene test applies an RT-qPCR-based method to analyze test samples for up to 27 pathogens and can do this in about an hour. If a patient is ill but tests negative for COVID-19, they can conceivably find out whether it’s the flu.

Furthermore, according to the company, the test does this automatically. Trained lab technicians need not be involved. A company spokeswoman says that the test “also has the unique ability to accept test assays from third parties and test for new, mutated pathogens without needing to replace or update the entire device. This means that when a pandemic occurs, there is a smaller chance of delays in getting testing where it is needed.”

https://lexagene.com

Tool Allows Physical Therapy to Continue in a Pandemic, Makers Say

Nursing homes and other long-term care facilities (LTCFs) have come into focus during the coronavirus disease 2019 (COVID-19) pandemic. One of the big needs in such facilities is therapy for patients. However, because of social distancing and the fact that LTCFs have been a nexus of the coronavirus, hands-on therapy might not be an option. Now there’s “a cloud-based platform that turns any computer with a webcam into a data-driven therapy tool that can be used within skilled nursing rehab gyms, at patients’ bedsides, at home post-discharge.” That’s how Restore Skills describes itself. (The company and the product it’s selling have the same name.) It creates more practice opportunities in the therapy gym. In addition, says Restore Skills, it can be used for out-of-gym activities and can be a great motivator for patients.

“At a time when nursing homes are even more severely understaffed and patients are isolated in their rooms,” Restore Skills turns every member of the LTCF care team into a “skill-building superstar—from activities directors to CNAs and nurses.”

The company states that “it is the only therapy software of its kind available that uses a traditional laptop webcam, forgoing the extra cost of advanced technology.”

https://restoreskills.com
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