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Nurses Support Mandatory Cloth Face Covering Policies as One Measure Among Many to Protect Public Health

Since January 2020, the COVID-19 pandemic has spread rapidly around the world, many millions of people have been infected and hundreds of thousands have died. Several countries have effectively limited or even stopped the spread of the SARS-CoV-2 virus; in contrast, the United States' response has been piecemeal and has largely ignored the available science. Many locations across the United States continue to report record-breaking increases in COVID-19 cases and deaths.

Many states and localities across the United States have issued or are considering issuing mandatory policies requiring people to wear cloth face coverings in public settings. The U.S. Centers for Disease Control and Prevention (CDC) has also recommended the use of cloth face coverings.

Cloth face coverings are an important element, in the context of a broader public health response, in controlling the spread of the virus that causes COVID-19. A cloth face covering, or cloth mask, may include a sewn mask with straps that go around the head or behind the ears or a piece of fabric tied around a person's head.

Nurses support policies requiring the use of cloth face coverings, in the context of a broader public health response, for the following reasons »

» When used in the context of a broader public health response, policies requiring the use of cloth face coverings may help slow the transmission of the virus that causes COVID-19.

» Asymptomatic transmission is a significant concern in how rapidly and easily this virus that causes COVID-19. Mandatory use for those who can wear cloth face coverings, rather than only requiring symptomatic individuals to wear masks, may reduce asymptomatic transmission.

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Considerations for policies requiring use of cloth face coverings »

While many of the countries that have succeeded in preventing widespread transmission have a more common practice of wearing face masks or other cloth face coverings while in public areas, it is important to observe that these same countries have implemented multi-pronged, more comprehensive public health responses to the COVID-19 outbreaks than the United States. The U.S. does not have the widespread testing and rigorous case contact tracing and isolation that has proven key to preventing outbreaks in other countries.

Cloth face coverings are not a substitute for other protective measures. A cloth face covering may protect others from the wearer's respiratory secretions, but it does not protect the wearer. At most, wearing face masks may provide a small additional protection to others (e.g., grocery workers, public, etc.) by reducing the release of infectious particles into the air when the wearer speaks, coughs, or sneezes. Cloth face coverings, in contrast with N95 filtering facepiece respirators commonly used by health care workers, have neither the particle filtration mechanism nor the airtight face seal design to filter at least 95 percent of infectious particles.

Other measures remain important and necessary to reducing and preventing the spread of SARS-CoV-2, including stay-at-home orders and physical distancing policies, workplace protections for nurses and other essential workers, paid sick leave and family leave policies to enable workers to stay home if they feel sick or have tested positive for COVID-19, and other measures. **Policies requiring the use of cloth face coverings in public are not a replacement for physical distancing policies and other measures.**

Physical distancing policies remain the most effective method for reducing the spread of infection. These measures include:

- Stay-at-home orders
- Public health orders to close places where people may congregate in large groups, such as bars, gyms, restaurants, and other locations
- Orders to delay elective procedures when PPE supply and health care capacity are limited

Cloth face coverings should not be used in health care settings. Cloth face coverings are not intended for use by nurses or other health care workers in hospitals or health care settings. Employers are legally and morally obligated to provide the personal protective equipment (PPE) and other precautions that nurses need to be safe at work. PPE for COVID-19 must include a minimum of an N95 respirator plus eye protection, preferably a powered air-purifying respirator (PAPR) or elastomeric respirator, gowns or coveralls, gloves, head and shoe coverings, and temporary scrubs.

A broader public health response to the COVID-19 pandemic, beyond policies requiring the use of cloth face coverings in public, must include »

PUBLIC HEALTH INFRASTRUCTURE » Our public health infrastructure needs sufficient staffing, supplies, and space for robust surveillance, testing, case isolation, and contact tracing to ensure that the virus is effectively contained.

- » Free, reliable polymerase chain reaction (PCR) testing must be made widely available — including to low-income communities and communities of color — regardless of known exposure or symptom status.
- » Comprehensive surveillance, contact tracing, and case isolation is necessary to control the spread of the virus:
  - › Widespread testing for both symptomatic and asymptomatic individuals is needed. There must be ongoing surveillance, such as repeated, random, population surveys of asymptomatic people. Syndromic surveillance should include early detection of comparable indicators (e.g., influenza-like illness) before a diagnosis is made.
  - › Thorough contact tracing must be performed to identify all contacts who could have been infected by each case. Each contact needs to be tracked and isolated.
    - » Case identification, contact tracing, and isolation need to be done within the workplace as well as within the community.
    - » As scientifically trained and holistic caregivers experienced in patient advocacy, nurses are uniquely qualified to provide vital assistance to our public health systems and their skill and expertise should be utilized for contact tracing.
    - » We cannot rely upon technology for contact tracing.
- » Clear and reliable data must be collected and made publicly available.
  - › Reporting by health care facilities to local/state/federal government on admissions/ICU admissions/negative pressure room and ventilator availability/PPE supply must continue and must be made publicly available.
  - › Serological testing, including antibody testing, should be used cautiously to better understand the virus. Serological testing should not be used, at this point, to inform policy making.
  - › Transparent, real-time reporting of testing data, including at least race, occupation, and county, should be made available.
- » There must be strict oversight of the performance, manufacture, and distribution of both PCR and serological tests.

HEALTH CARE CAPACITY AND PREPAREDNESS » Decisions must be made based on the ability to provide needed care, not on profit/cost-saving; health care workers must be protected in order to prevent transmission; health care capacity must be expanded; and health care for all must be assured.

- » **Health care worker safety:** nurses and other health care workers are the foundation of our ability to respond to the pandemic. Their safety is of the utmost importance — for them and their families, for their patients, and for all of us.
  - › The precautionary principle and science must govern decisions about infection control, health and safety, and other policies.
  - › Sufficient and safe PPE must be provided to nurses and other health care workers. The optimal standard of PPE includes powered air-purifying respirators (PAPRs) and coveralls that incorporate head coverings and shoe coverings and gloves. The minimum level of respiratory protection is single-use N95 filtering facepiece respirators. These single-use N95 respirators should not be subjected

to dangerous reuse or decontamination practices. If reusable respirators are needed, employers should turn to PAPRs and elastomeric respirators, which are designed to be safely reused and provide a higher level of protection.

- The supply chain must be made sufficiently robust to produce and distribute needed PPE for both the short and long-term. The Defense Production Act (DPA) must be utilized to its fullest extent to ensure sufficient manufacturing capacity. State governments should also take action to increase PPE production, supply, and distribution to protect nurses, other health care workers, and other essential workers.
- Engineering controls need to be implemented in every health care institution across the country, including hospitals and other health care facilities including clinics and nursing facilities. Ventilation systems, including negative pressure ventilation, are vital to preventing spread of SARS-CoV-2 and other infectious diseases.
- Safe staffing must be guaranteed in all hospitals and other health care facilities.
- Health care facilities must have robust plans to respond to surges in COVID-19 patients including plans for triage, implementing the three-zone model, and expanding health care capacity.
- Health care facilities must have effective occupational exposure surveillance and response plans — if a nurse or other health care worker is exposed, they must be placed on paid quarantine immediately for a minimum of 14 days.
- OSHA must pass an emergency temporary standard to mandate that health care employers put in place measures necessary for SARS-CoV-2 and capacity to enforce the standard. State governments should take action to pass emergency standards to protect health care workers from SARS-CoV-2 exposure and should fully enforce all existing laws and regulations that may apply.

- **Health care capacity for a surge in COVID-19 patients must be ensured:**
  - National, state, and local public hospital and health care infrastructure capacity must be made available.
    - FEMA
    - Army Corps of Engineers
    - National Guard
    - Reverse privatization of the Veterans Health Administration (VHA):
      - Capital assets: the VA Mission Act required the VHA to perform a capital asset review and make recommendations to a newly created Asset Infrastructure Review (AIR) Commission. The justification for this review was to determine where facilities are being underutilized and where they needed to increase capacity. The argument was that underutilized facilities should be closed.
        - Repurpose underutilized facilities: rather than closing underutilized facilities, we can use the AIR Commission findings to repurpose underutilized health facilities to provide national surge capacity for the current pandemic and to ensure that it is available in the future.
      - Fully staff an expanded VHA: improve retention and recruitment by providing competitive wages and benefits.
  - Private sector: the health care sector must be fully prepared to respond safely to future surges. This needs to be the full preparation that should have been in place to begin with. It cannot be a repeat of the reactive, half-measures we saw in the first response. Preparation must include expanding beds, staffing, ventilators and other necessary equipment, medications, PPE supply. Real-time, publicly-reported data on hospital capacity must be made available.

» **Access to health care:** People must be able get treatment they need if they get COVID-19, instead of being out in community and potentially infecting others.

  › Any vaccine or treatment must be provided to all at no charge.

  › Guaranteed no-cost coverage of all treatment, care, and services for people with potential COVID-19 infection whether insured, uninsured, or underinsured.

ENSURING BASIC HUMAN NEEDS ARE MET » Enhanced unemployment benefits and paid sick time and family leave; food security; housing; health care; and other social supports for people who are unemployed or unable to work due to illness or quarantine and isolation measures.

PUBLIC HEALTH AND SAFETY » All workers must have PPE and other needed health and safety protections including an OSHA emergency temporary standard on infectious diseases and enforcement capacity. Health and safety protections must be in place for people in institutions that are at high risk for outbreaks of COVID-19 including skilled nursing facilities, prisons and jails, encampments, and immigration detention centers.

Sources »

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