National Nurses United
The National Voice for Direct-Care RNs

WASHINGTON DC
8455 Colesville Road
Suite 1100
Silver Spring MD 20910
phone: 800-287-5021
fax: 240-235-2019

OAKLAND
155 Grand Avenue
Suite 100
Oakland CA 94612
phone: 800-504-7859
fax: 510-663-1625

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Mr. Mark Pallansch, Director
Division of Viral Diseases
National Center for Immunization and Respiratory Diseases (NCIRD)
1600 Clifton Road NE
Atlanta, GA 30329

Subject: **CDC's Interim Infection Prevention and Control Recommendations for Patients with Confirmed 2019 Novel Coronavirus (2019-nCoV) or Persons Under Investigation for 2019-nCoV in Healthcare Settings**

Dear Director Pallansch:

National Nurses United (NNU), representing more than 150,000 members, is the largest union of registered nurses in the United States. As such, we are concerned that our members are afforded their right to a safe and healthful workplace and are fully protected by their employers from hazardous exposures that may occur in the course of providing patient care.

While the novel coronavirus, provisionally 2019-nCoV, now SARS-CoV-2, is a newly identified virus, this is not a novel situation. Unfortunately, the world has seen several similar infectious disease events in recent decades—Severe Acute Respiratory Syndrome (SARS), Middle East Respiratory Syndrome (MERS), H1N1 influenza, Ebola, Zika, and others—and this is unlikely to be the last. Each successive event has underlined the importance of a strong public health infrastructure and the need for our healthcare facilities to be prepared.

NNU's members provide patient care in a variety of settings, including clinics and hospitals, which are most likely to see patients who may have a 2019-nCoV infection, now called COVID-19. Healthcare facilities must maintain protective infection control and prevention plans to prevent occupational exposure to staff and to stop the spread of this novel coronavirus. The Centers for Disease Control and Prevention (CDC) often serves as a resource to healthcare facilities on infectious diseases and we appreciate the CDC's publication of interim guidance for infection control and prevention in healthcare facilities on the novel coronavirus.

While the CDC addresses many important elements in their guidance, there are significant issues that will put nurses and other healthcare workers, their patients, and ultimately our communities at increased risk of exposure. We are writing to urge the CDC to strengthen their Interim Infection Prevention and Control Recommendations for Patients with Confirmed 2019 Novel Coronavirus (2019-nCoV) or Persons Under Investigation for 2019-nCoV in Healthcare Settings immediately in the following ways:

1. **CDC should remove all references to the outdated "six foot rule."**

Section 1 of the interim guidance addresses measures to screen and isolate patients to prevent the spread of novel coronavirus in healthcare facilities. Prompt recognition and isolation of possible COVID-19 cases is a significant element in preventing further spread. CDC's guidance rightly recommends that source control procedures be implemented and that patients with symptoms of respiratory infection should not be allowed to wait with other patients.

Instead, CDC states that patients who have symptoms of any respiratory infection should be placed in a "separate, well-ventilated space that allows waiting patients to be separated by 6 or more feet...." Recent advancements have allowed much more thorough characterization of respiratory droplet size, mass, settling and evaporation time, and other factors that influence particulate behavior. This research indicates that with respiratory symptoms such as sneezing or coughing a wide range of aerosols are created, some of which travel through and remain in the air for some time.[1]

During flu season there are many patients presenting to healthcare facilities with respiratory symptoms. CDC's guidance would have these patients waiting in the same space as patients with possible COVID-19 cases, effectively exposing them to this novel virus and encouraging its continued spread. The "six foot rule" is archaic and the CDC should strike all reference to it from their infection control and prevention guidance. The CDC should instead recommend that patients identified as possible COVID-19 cases be placed in an isolation room immediately, preferably one with negative pressure.

2. **CDC should rectify their definition of "hand hygiene," which currently violates OSHA's Bloodborne Pathogens Standard.**

Section 2 addresses isolation precautions, including personal protective equipment (PPE), and other work practice controls. Under "Hand Hygiene," the CDC explicitly recommends that healthcare workers should perform "hand hygiene using ABHS [alcohol-based hand sanitizer] before and after all patient contact, contact with potentially infectious materials, and before putting on and upon removal of PPE, including gloves." The CDC adds handwashing with soap and water as an afterthought, "Hand hygiene in healthcare settings also can be performed by washing with soap and water for at least 20 seconds...." Especially when dealing with a novel virus about which little is known, this is an irresponsible recommendation. Hand sanitizer only removes some—not all—of certain kinds of bacteria and viruses whereas handwashing with soap and water is significantly more protective.

Further, the CDC's promotion of hand sanitizer does not meet the level of protection required by the Occupational Safety and Health Administration's (OSHA) Bloodborne Pathogens Standard (29 CFR 1910.1030), which mandates that hand hygiene be performed with soap and water after removal of gloves or other PPE and after contact with blood or other potentially infectious materials. Hand sanitizer is allowed as a backup for situations when handwashing with soap and

[1] For example, see: Lee, J., D. Yoo, et al. (2019). Quantity, Size Distribution, and Characteristics of Cough-generated Aerosol Produced by Patients with an Upper Respiratory Tract Infection. *Aerosol and Air Quality Research*, 19: 840-853.
Xiao, S., Y. Li, et al. A study of the probable transmission routes of MERS-CoV during the first hospital outbreak in the Republic of Korea. *Indoor Air*, 28(1): 51-63.

water is not feasible, but OSHA still requires that hands be washed with soap and water as soon as feasible (29 CFR 1910.1030(d)(2)(iv)).

In addition, CDC should note the recent letter the U.S. Food and Drug Administration (FDA) sent to GOJO Industries Inc., maker of PURELL hand sanitizer products. FDA took issue with several claims made in marketing materials about the efficacy of PURELL against bacteria, viruses, and preventing the spread of infectious diseases:[2]

> FDA is currently not aware of any adequate and well-controlled studies demonstrating that killing or decreasing the number of bacteria or viruses on the skin by a certain magnitude produces a corresponding clinical reduction in infection or disease caused by such bacteria or virus.

The CDC's promotion of hand sanitizer use for COVID-19 is irresponsible and should be remedied immediately.

3. CDC should strengthen their PPE recommendations for healthcare workers providing care to known or suspected COVID-19 cases.

Section 2 and the Appendix address the PPE to be worn by healthcare workers providing care to patients with confirmed or suspected COVID-19. It is important that the CDC has recognized the need for respiratory and eye protection, among other elements, to prevent healthcare worker exposure to this novel virus. However, there are several issues with CDC's recommendations on PPE.

First, the CDC guidance does not address the compatibility issues posed by wearing goggles with an N95 filtering facepiece respirator. Goggles can disrupt the seal of the facepiece respirator, undermining the protection that must be provided. OSHA's Technical Manual strongly recommends that "full-facepiece respirators be worn where either corrective glasses or eye protection is required…."[3] OSHA also notes that the full-facepiece respirator may be more comfortable and less cumbersome than the combination of a half-facepiece respirator and goggles. In hospitals and other healthcare settings, powered air-purifying respirators (PAPRs) and other full facepiece respirators are better options in these situations when both eye and respiratory protection are needed. CDC should remedy their guidance to recommend PAPRs or other full-facepiece respirators when both respiratory and eye protection are needed.

Second, the CDC's recommendation for simple isolation gowns may be inadequate. Since the current outbreak began, our knowledge of SARS-2/COVID-19 has evolved rapidly; but there is still much we do not know including how long this novel coronavirus may persist on surfaces. A recent review of the literature on the persistence of coronaviruses on inanimate surfaces found that several human coronaviruses can persist on inanimate surfaces for up to nine days.[4] The CDC's recommended PPE ensemble leaves healthcare workers' necks, heads, lower legs, and shoes

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[2] U.S. Food and Drug Administration, Division of Pharmaceutical Quality Operations III (January 17, 2020). *Warning Letter: Case # 599132*. Retrieved from https://www.fda.gov/inspections-compliance-enforcement-and-criminal-investigations/warning-letters/gojo-industries-inc-599132-01172020.

[3] U.S. Occupational Safety and Health Administration. *OSHA Technical Manual, Section VIII: Chapter 2, Respiratory Protection*. Retrieved from https://www.osha.gov/dts/osta/otm/otm_viii/otm_viii_2.html.

[4] Kampf, G., D. Todt, et al. Persistence of coronaviruses on inanimate surfaces and its inactivation with biocidal agents. *Journal of Hospital Infection*, In press.

uncovered. This may be insufficient to protect healthcare workers from exposure and may not effectively prevent the spread of novel coronavirus.

4. **CDC should improve recommendations on staffing to protect nurses, other healthcare workers, and patients.**

Section 2 addresses considerations for patient placement. While the CDC outlines several important recommendations, including limiting the personnel and visitors who enter an isolation room, they neglect an important consideration that nurses assigned to care known or suspected COVID-19 cases should not have other patient assignments. As noted above, this is a novel virus about which little is known, including the potential role in transmission of contaminated objects or surfaces. Ensuring that the nurse assigned to a known or suspected COVID-19 case has a one-to-one assignment prevents possible exposure to other patients via contaminated objects or surfaces. Additionally, the one-to-one assignment recognizes the significant time required to safely don and doff PPE, thus providing a higher level of protection for the nurse as well.

We request that CDC act promptly to clarify and update their guidance to reflect the concerns outlined above. If you have questions regarding these matters or would like to arrange a meeting, please contact Jane Thomason at 510-433-2771 or jthomason@nationalnursesunited.org.

Sincerely,

Bonnie Castillo

Bonnie Castillo, RN
Executive Director

cc: Mr. Robert Redfield, MD, Director, Centers for Disease Control and Prevention

Members of the U.S. Senate Committee on Health, Education, Labor, and Pensions

Members of the U.S. Senate Homeland Security and Governmental Affairs Committee

Members of the U.S. House Committee on Education and Labor

Members of the U.S. House Committee on Oversight and Government Reform

Mr. Richard Trumka, President, AFL-CIO