



**Public Statement to the Institute of Medicine
Committee on Personal Protective Equipment for Healthcare Workers
in the Workplace Against Novel H1N1 Influenza A
August 12, 2009**

Statement by Lisa Maragakis, MD, MPH, The Johns Hopkins Medical Institutions

I am speaking today on behalf of the Society for Healthcare Epidemiology of America (SHEA) and the Infectious Diseases Society of America (IDSA), representing over 9,000 infectious diseases physicians and other professionals who care for patients and direct hospital epidemiology and infection prevention and control programs in our nation's healthcare facilities. Since the emergence of the novel H1N1 influenza strain, our primary goal has been to ensure effective and sustainable delivery of patient care while protecting healthcare workers and patients from influenza acquisition in patient care settings. Today, please consider this statement and our policy recommendations in light of the fact that our members **are among the many front-line healthcare workers** who provide direct, bedside clinical care of patients with suspected or confirmed H1N1 influenza.

SHEA and IDSA have a long history of interest and involvement in the issue of appropriate personal protective equipment for pandemic influenza including the selection of masks or respirators to prevent transmission of influenza. Our organizations have provided scientific expertise to policy makers, conducted relevant research on influenza transmission, and formulated position statements and guideline recommendations in this area. We welcome and appreciate the opportunity to be part of the ongoing dialogue on this important issue.

SHEA recently released a joint position statement, endorsed by the IDSA, the Association for Professionals in Infection Control and Epidemiology (APIC), and the Council of State and Territorial Epidemiologists (CSTE), calling for revision of the CDC Interim Guidance on Infection Control Precautions for Novel Swine-Origin Influenza A H1N1 in Healthcare Facilities. We

undertook this statement to contribute an important perspective on the scientific evidence and clinical experience as the CDC works to provide information to help healthcare providers, public health officials and the general public address the challenges posed by the new virus.

In that statement, we endorsed CDC's initial recommendations on H1N1 as being consistent with evidence available as the virus emerged and reflective of an appropriately cautious approach to containment at a time of ambiguity regarding transmission characteristics and severity of illness in the initial weeks of the outbreak. However, the statement called for amendment of the infection prevention and control guidance in light of additional knowledge and experience concerning the transmission dynamics and severity of the H1N1 outbreak. Available data and clinical experiences suggest that novel H1N1 transmission occurs, like seasonal influenza, via droplet spread. Therefore, it is our expert conclusion that current evidence supports handling H1N1 on the basis of droplet transmission consistent with recommended precautions for seasonal influenza. Our organizations specifically endorse the following precautions for suspected or confirmed cases of novel H1N1 influenza:

- Early recognition and identification of suspected novel H1N1 influenza-infected patients upon presentation to a healthcare setting;
- Placing surgical masks on patients with suspected or confirmed novel H1N1 influenza infection at the point of entry into any healthcare setting;
- Using surgical masks to cover the healthcare worker's nose and mouth to prevent transmission of the influenza virus by droplets or hand contact during routine patient care activities;
- Placing such patients in a single room, if available, or cohorting them with other patients infected with influenza;
- Strict adherence to hand hygiene, respiratory hygiene and cough etiquette; and
- Restricting visitors and healthcare workers with febrile respiratory illnesses.

We recognize that certain medical procedures characterized by the potential for intensive cough induction and the immediately proximity of the operator's face to the source of the cough (such as intubation or bronchoscopy) might produce concentrated aerosols of influenza or other viruses and hence, we can support the CDC's recommendation for the use of higher levels of

respiratory protection, such as fitted respirators, under these limited circumstances. These recommendations recognize that patient care includes a wide range of possible scenarios, and appropriately distinguishes standard care activities from procedures where a possible risk of airborne transmission may exist due to the nature of the procedure. Beyond the types of procedures and close contacts noted in the previous statement, the marginal incremental and theoretical benefits of higher levels of respiratory protection for most routine clinical contacts in the healthcare environment do not justify the additional cost, time, discomfort, and burden of widespread N-95 respirator use for an infection which all scientific authorities agree is primarily transmitted in the community by non-airborne routes.

SHEA and IDSA reiterate that universal adherence to basic infection prevention practices is the critical foundation to ensure healthcare worker safety. In addition to appropriate use of personal protective equipment, healthcare workers must employ rigorous and consistent application of basic infection control and personal hygiene practices at all times, including adherence to hand hygiene and cough etiquette.

Pandemic influenza planning recognizes that transmission of both seasonal and pandemic influenza occurs primarily in the community setting rather than in healthcare settings. Therefore, two other critical control measures are early recognition and separation (isolation) of suspected novel H1N1-infected patients upon presentation to a healthcare facility and restriction of visitors and healthcare workers with febrile respiratory illnesses. Without consistent application of these infection prevention measures in our healthcare institutions, no level of respiratory protection will offer adequate prevention of influenza transmission.

In summary, SHEA and IDSA conclude that the current strain of novel H1N1 has the same transmission dynamics as seasonal influenza and should be managed as such based on the currently available scientific evidence.