

How to protect healthcare workers from the COVID-19 pandemic in a practical way

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ABSTRACT

Protecting healthcare workers is a critical component of a successful COVID-19 pandemic response. This is a difficult undertaking due to the resource-intensive nature of infectious disease protection, budgetary constraints, and global shortages of personal protective equipment (PPE). Protecting healthcare workers (HCWs) requires practical, easy-to-implement methods. To generate a narrative overview of worker protection strategies relevant to COVID-19, we cross-reference the "Systems, Space, Staff, and Stuff" paradigm from disaster management with the "Hierarchy of Controls" approach to infection prevention from the Center for Disease Control and Prevention (CDC). HCW protection can be improved by using different forms of PPE, managing dangers, and restructuring how people work. A thorough PPE strategy can find new or underutilised solutions to HCW protection using the disaster management paradigm of "systems, space, staff, and material."

Keywords: Healthcare workers, COVID-19, Infection control, PPE optimization, Respiratory protection

Introduction

SARS-CoV-2 is a highly infectious Coronavirus that causes COVID-19, a serious and life-threatening sickness predominantly of the respiratory tract, and is disseminated largely through droplet and airborne transmission. It's difficult and intimidating to adequately prepare a healthcare facility to respond to this outbreak [1]. The original SARS-CoV (SARS) outbreak in 2002-2003 disproportionately affected healthcare professionals, which has been linked to poor infection control practises. This article is designed to serve as a reference and summary of current infection control best practises, standards, and laws, as well as their applicability to SARS-CoV-2. The global shortage of Personal Protective Equipment (PPE) that has evolved as this virus has spread over the world emphasises the necessity for such guidelines. As a result, we present an overview of traditional worker protection tactics, suitable alternate solutions or adjuncts, and lastly minimum criteria that are only applicable for crisis operations for each topic [2].

Standard precautions are a set of basic best practises established by the Centers for Disease

Control (CDC) for use when workers are exposed to bloodborne pathogens or other potentially infectious materials [3]. Hand hygiene, use of PPE (gloves, eye protection, etc.), respiratory hygiene/cough etiquette, sharps safety, safe injection practises, sterile instruments and devices, and clean and disinfected environmental surfaces were developed as a result of the uncertainty of the HIV/AIDS epidemic in the 1980s. These behaviours should be at the heart of any safe healthcare environment.

Notwithstanding the standard precautionary measures list over, extra safeguards ought to be carried out regarding the Hierarchy of Controls, a pattern that coordinates mediations in the working environment by various levels of adequacy in forestalling work environment injury and openness. These levels incorporate Elimination, Substitution, Engineering Controls, Administrative control, and PPE. Disposal is the recognizable proof and expulsion of pointless risks; while replacements supplant what is happening with a less perilous one. Designing control is the utilization of outside obstructions of frameworks to lessen openness to medical services laborers (HCW) like the utilization of actual boundaries (eg, putting a glass or plastic

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windows in banquet rooms), nook, and seclusion (eg, utilization of airborne detachment spaces for spray creating strategies). Authoritative controls are approaches and practices intended to diminish HCW openness to dangers. Despite the fact that it is the most apparent, PPE is the most un-compelling sort of assurance in the pecking order since it requires dynamic, fruitful use with respect to the HCW and is consequently likewise the most defenseless to human mistake [4]. Regardless of this, it is the last "safeguard" in a specialist assurance methodology.

In this article, we present good judgment, promptly appropriate direction on different themes in customary areas of catastrophe the executives and arranging, using the "Stuff, Space, Staff, and Systems" worldview while molding this direction into the order of controls diagram that has proactively been presented. In doing as such, we will introduce Space and Staff issues and arrangements first, as these components track onto the initial four best levels of the Hierarchy, then progress to Stuff issues which for the most part revolve around PPE, with a running conversation of ideal Systems changes coordinated all through. A few sources, including from the CDC express that disposal of an irresistible illness risk isn't commonly imaginable. Notwithstanding, we contend here that there are a few select situations where "valid" end is conceivable. We propose that the normal meaning of "actual expulsion of a risk" is excessively thin, and end is all the more fittingly perceived as "complete evacuation of a perilous collaboration between a danger and a laborer." This might happen by expulsion of the specialist from vicinity to the risk or expulsion of the risk from the work environment. At the point when perceived thusly, we recommend that telemedicine visits are an illustration of genuine end as opposed to managerial controls in light of the fact that in spite of the fact that it is "fundamentally impacting the manner in which individuals work" it likewise totally eliminates the perilous cooperation between the medical services laborer and the risk (the COVID-19 patient). Additionally, limiting superfluous admittance to the medical services offices is an illustration of end since it can forestall a contaminated, yet asymptomatic guest from interfacing with medical services laborers, delivering that likely peril (ie, disease) totally disposed of Albeit hastily. These are changes to the manner in which individuals work, since they are totally eliminating the hazardous

connection, they are truth be told at the zenith of the progressive system of controls as opposed to among the most un-successful methodologies.

Essentially, instances of Substitution are restricted since irresistible sicknesses present intrinsic risks that can't be supplanted with less perilous ones (ie, a less risky infection). Nonetheless, at times, it could be smarter to comprehend the peril not as the irresistible illness itself, but instead as the gamble producing cooperations that the HCW embraces with it. One such model is Bilevel positive strain ventilation (BiPap) which is believed to be a spray producing method that establishes a continuous high-risk climate for adjacent HCWs. In the event that a clinic suggests endotracheal intubation be utilized rather than BiPap since this is thought to just be a transient gamble during the inception of the system, yet not a continuous gamble of aerosolization for the rest of the patient's ventilation, this should have been visible as an example of Substitution or as a regulatory control contingent upon the specific situation. On the off chance that, speculatively, the clinic carries out a severe, widespread prohibition on BiPap to forestall any chance of its utilization on a COVID-19 patient this is Substitution; while assuming the new conventions are composed to help HCWs when intubation is desirable over BiPap, then, at that point, this is an Administrative Control. Our objective isn't to conclusively classify every conceivable wellbeing intercession, but instead to utilize the Hierarchy of Controls to describe the dangers that HCWs experience and utilize that comprehension to drift towards a more secure work environment.

Restricting Access

The initial phase in every medical care office's progress from routine activities to pandemic reaction ought to be to confine its tasks just to fundamental capacities. Insignificant or elective systems ought to be dropped, and routine office visits ought to be conceded. Admittance to the office ought to be confined to just those filling fundamental roles. This will be a baffling and disagreeable strategy for patients and their families. Notwithstanding, decreasing by and large traffic through the medical services office lessens potential open doors for medical care laborers to become tainted and for offices to become sullied [5]. It additionally empowers medical care laborers to progress from their normal tasks to committed pandemic reaction

exercises. Guest admittance to the medical care office ought to be diminished, with the conceivable exemption of painstakingly chosen conditions like pediatrics, work and conveyance, or end of life circumstances. Guests and laborers entering the office ought to be assessed for conceivable irresistible side effects before passage (eg, screening polls and temperature screenings), and if positive, denied section and alluded for fitting self-confinement. Insightful correspondence with patients and their families about the significance of such approaches will be fundamental for their fruitful execution.

Furthest degree conceivable, telehealth innovation ought to be utilized to disconnect patients, suppliers, and offices from potential openings. Routine mobile office visits ought to be changed to tele-visits, and for long term settings, progressing expert discussions to remote visits ought to be done assuming direct contact with the patient and care group isn't in any way essential. Telemedicine checking inside medical care offices ought to be utilized at whatever point conceivable to forestall superfluous patient-HCW contact. Additionally, far off electronic correspondence with patients ought to be executed whenever the situation allows. As an optional technique, these strategies may likewise be applied to patients hospitalized for non-COVID reasons, as their gamble of new disease may really be expanded while long term because of HCWs high combined chance of openness to SARS-CoV-2 and the chance of asymptomatic transporters among the staff. Diminishing the quantity of insignificant patient connections will likewise have the additional advantage of diminishing PPE use during the pandemic.

Perhaps the least expense and most effectively executed intercessions is to quickly require all patients and staff to wear careful veils while on premises. This obviously gives a sensible benchmark level of security against respiratory beads however can likewise fill in as a component for source control by keeping spread from people tainted with SARS-CoV-2. A critical part of individuals contaminated may have negligible side effects or be totally asymptomatic while unconsciously spreading the infection. Requiring veil use can significantly diminish asymptomatic spread of a bead transmission sickness. Without a doubt, when local area predominance of the infection arrives at adequately undeniable levels, medical services offices ought to expect that a huge part of patients introducing because

of reasons other than COVID-19 side effects or testing will likewise be transporters of the infection.

Barrier shielding can be used in a variety of conditions at a healthcare institution, but they're especially useful when droplets or aerosols are likely to be present. Plastic barriers (with or without integrated gloves) between HCWs administering accelerated testing and the patient, as well as so-called "aerosol boxes," which are reusable plastic shields to cover the patient's face and shoulder during intubation, have been proposed.

Consider establishing discrete, well-defined sections within each facility to measure the level of hazard and to define when and where employees should operate. Such zones should be clearly labelled as hot/warm/cold or red/yellow/green, with the transitions between them marked conspicuously and plainly. Colored tape borders on walls and floors, as well as high visibility lettering on doors, are some examples of how such a system could be implemented. Such identifiers should be made understandable in the languages of local workers and patients. In some settings, corresponding badging for personnel may be suitable to swiftly and easily detect anyone entering unauthorised areas.

Conclusion

Despite previous experience with SARS-CoV-1, delivering the best personal protective equipment to all healthcare professionals has proven to be a difficult goal to achieve in practise. However, we have highlighted significant factors and failure points as a result of our assessment. Traditional PPE may be unavailable due to cost, availability, or supply chain disruption due to the nature of the epidemic. In such circumstances, practical options should be carefully evaluated, with a return to infection control's basic principles in mind. These solutions can be off-the-shelf consumer products adapted for healthcare or equipment from other industries that meets the same minimal protection needs. Finally, while personal protective equipment (PPE) has recently garnered a lot of attention due to national shortages, process and system modifications should be the major tools for preventing avoidable threats to HCWs and waste PPE. The most effective technique is to eliminate or contain dangers while lowering the number of workers exposed.

References

1. Maltseva N, Borzova E, Fomina D, et al. Cold urticarial-What we know and what we do not know Allergy. *Eur Acad Allergy Clin Immunol* 76, 1077-1094 (2021).
2. Maurer M, Metz M, Bindslev Jensen C, et al. Definition, aims, and implementation of GA(2) LEN urticaria centers of reference and excellence Allergy. *Eur Acad Allergy Clin Immunol* 71, 1210-1218 (2016).
3. Ramos-Casals M, Stone JH, Cid MC, et al. The cryoglobulinaemias. *Lancet* 379, 348-360 (2012).
4. Bracken SJ, Abraham S, MacLeod AC. Autoimmune theories of chronic spontaneous urticarial. *Front Immunol* 10, (2019).
5. Koepfel MC, Bertrand S, Abitan R, et al. Urticaria caused by cold. *Ann Dermatol Venereol* 123, 627-632 (1996).