16 Common-Sense Tips and Facts for Dealing with COVID-19

BY MARK MOSLEY, MD

Many of these suggestions are not new, but we need new vigilance in the wake of COVID-19.

1. Wash your hands with every entry into and exit from a room.

Wash your hands for 20 seconds. Think of something to say, sing, or pray that takes 20 seconds, or do three rounds of slow, deep meditative breathing. Water with soap may be better, especially if there is a sanitizer shortage. The virus has a lipid layer, so soap or alcohol that is 60% or higher breaks it down.

The temperature of the water doesn't matter. Include the back of your hands and under your nails. Turn the faucet off with your elbow. Washing your hands in front of the patient sends a message of safety and teaches others by example how long to scrub.

You could even teach out loud to the patient for 20 seconds while you wash. Consider foaming your stethoscope with every entry and exit or carry a stack of alcohol pads to wipe down your stethoscope, scissors, pen, etc.

And don't shake hands with patients or staff. Wearing gloves may not help because most people contaminate themselves when taking off gloves.

2. Rarely use tongue depressors.

The virus is spread by droplet, so avoid gagging patients and having them cough in your face. Have the patient turn his mouth up toward the ceiling like he's catching a snowflake out of the sky. Look down into the throat (you may need a stepstool) while holding your breath, and be quick. Face very young children forward on their parents' lap if you must use a tongue depressor. Consider using a mask whose only purpose is prevent large droplet spread.

3. Limit nebulizations.

Nebulizations can aerosolize the virus. All studies show inhalers with aerochambers are as effective. The National Institutes of Health recommend for emergent treatment four puffs minimum, eight puffs for those who use beta-agonists frequently, and 12 for severe patients. (Four puffs equal one nebulization.)

4. Use N95 masks, goggles, and full gown and glove protection for intubation or peritonsillar abscess.

Review the CDC guidelines about how to put on and remove personal protective equipment (PPE); it takes two people to do this. (CDC video: http://bit.ly/2QeDuUZ.) This is critical because most health care workers in past pandemics contaminated themselves when removing PPE.

Use video laryngoscopy instead of direct laryngoscopy. Have as few people in the room as possible during intubation. Go to a negative pressure room to intubate if possible.

5. Don't use chest CT as a screen or diagnosis for COVID-19.

Some reports suggest using a CT scan, but the American College of Radiology says this is nonspecific and should not be done.

6. The infectious control person at your hospital may ask you to begin with influenza screening and a viral panel.

There is the assumption that a patient who is influenza-positive (or positive for another virus) is *unlikely* to have COVID-19 and can be sent home. The *probability* of having two viral illnesses concurrently is lower, but we still need more information, and this assumption may not be prudent.

7. Testing for COVID-19.

It is important to know that a PCR test probably has good specificity, but we are unclear about its sensitivity at this time. As with any test used for screening, we will have many false-positives, particularly in lower-risk populations. It is also important to know that if testing becomes open, that is, not done by just the CDC, many companies will try to create faster, cheaper tests, and each will have variable testing characteristics. This will be much more complicated than determining whether someone has the virus or not.

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8. Staying home from work or school and the 48-hour "quarantine."
Include in the discharge instructions for those with a cough, cold, sore throat, or flu-like illness that they have to be out of school or work for a minimum of 48 hours. If COVID-19 hits your town (and it likely will), this might need to be a 48-hour quarantine recommendation, perhaps until the COVID-19 test comes back. If positive, then patients need to be in a true quarantine for 14 days per CDC recommendations, though they are probably infectious for only 10 days.

9. Besides respiratory transmission, the virus may also be passed by fomite.
The New England Journal of Medicine is about to publish an article that suggests that COVID-19 may be passed by fomite. Even droplets may be able to live on hard surfaces for up to 24 hours or more. We must review our ED practices on what it means to clean a room.

A clean room currently has no definition, no checklist, and no monitoring. In the real world, we rip the sheets off with our bare hands, quickly wipe down only the bed, and put sheets on a wet mattress. We must revisit definitions of cleaning an ED room, create and post a checklist for every room, and regularly monitor the process. Our ED rooms may be the greatest vectors for COVID-19 in our communities, especially for the elderly and those who are immunocompromised or have serious comorbidities. We should make it the highest priority for extra round-the-clock dedicated housekeeping to do this correctly for every patient every time.

10. We need a patient handout with accurate information.
This should cover how to wash your hands correctly, who should be tested, where testing can be done away from the hospital, and what is meant by social distancing.

11. We need a strategy for vulnerable populations.
This includes those experiencing homelessness, those in shelters, and the mentally ill who test positive.

12. We must protect our equipment.
We need a process to protect the N95 masks from being stolen by patients and staff.

13. We need a way of regularly screening ED health professionals for COVID-19 when they have a cold, so we can know if they can stay on the front line.
Human resources will become very important, as will ventilators, BiPAP, and respiratory therapists if this pandemic explodes in our communities.

14. We should avoid misleading statements.
Don't say things like, "COVID-19 is much more lethal than influenza." This is true of relative risk but miscommunicates the absolute risk. The mortality of influenza in the United States is 0.1 percent. The mortality of COVID-19 is currently more than two percent, and it will probably fall to 0.6-0.8 percent as testing increases. So yes, COVID-19 mortality is several times worse than influenza, but mortality is *less than one percent*. And deaths are predominately among elderly and comorbid patients in countries with inadequate ICU capacity and health care infrastructure.

Don't make any statements about the rate of infection. This will initially be dramatically high and scare the bejesus out of everyone as they wrongly project this into the future. But you can't use a point prevalence to make a future prediction. We must be aware that COVID-19 has already been in the United States for weeks, maybe months, and we have been blind to it because we failed to do surveillance testing back in January.

15. We need a central communication platform for ED health professionals.
This will allow us to share ideas about how to adapt in real time to COVID-19 as it hits inner city, rural, community, and remote areas involved in emergency care.

16. Put your scrubs or clothes in the dryer immediately when you get home, and leave them in for 30 minutes before putting them into the dirty clothes hamper.
The heat of the dryer kills viruses and bacteria, and prevents contamination of other clothes. **EMN**

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