

Position Statement (revised June 22, 2020): Preventing Nosocomial COVID-19 Infections as Organizations Resume Regular Care Delivery

The Joint Commission supports the following positions for healthcare organizations to prevent nosocomial COVID-19 infections as they are resuming routine care.

Healthcare organizations should continue to follow CDC recommendations for universal masking of staff, patients, and visitors. If there are situations where a patient cannot wear a mask (e.g., under 2 years of age, respiratory compromise, or examination of the nose, mouth, lips, and perioral area) personnel providing care within 6 feet of the patient should don a medical mask. In areas where there is moderate to substantial transmission of COVID-19 in the community (or as indicated by standard precautions), personnel should also wear eye protection in addition to wearing a mask. If there are no COVID-19 cases in the community for several weeks, organizations should work with public health authorities to re-evaluate the need for universal masking based on their community's risk of new cases; if the organization stops universal masking, it should be prepared to immediately re-institute universal masking if new cases emerge.

When caring for patients with known or suspected COVID-19 infection, healthcare personnel should wear filtering facepiece respirators (e.g., N95 respirators) or higher-level respirators for all aerosol generating procedures or surgical procedures that might pose higher risk for transmission (e.g., that generate potentially infectious aerosols or involving anatomic regions where viral loads might be higher, such as the nose and throat, oropharynx, respiratory tract).

Healthcare organizations should no longer be operating under crisis standards of care when they resume elective procedures and ambulatory care; use of contingency strategies for gowns, eye protection, or facemasks is acceptable practice, as long as the level of personal protective equipment (PPE) used is appropriate for the elective procedures or ambulatory care provided. In areas that experienced a large surge in the number of COVID-19 cases, many hospitals and healthcare organizations were unable to follow their usual policies and procedures and had to resort to "crisis standards of care." The effectiveness of crisis strategies is uncertain, and they may pose a risk for transmission of infectious diseases between healthcare providers and patients or other safety concerns. Therefore, the volume of care delivered under crisis standards should be limited, and an expansion of services to elective procedures and ambulatory care would be inappropriate until patient care activities are back within routine standards. Selective contingency strategies may still be needed for a period of time, but organizations should make every effort to minimize the use of contingency strategies, and when used the level of personal protective equipment (PPE) should be appropriate for the elective procedures or ambulatory care provided (e.g., ANSI/AAMI PB70 level 2 gown for procedures with low risk of contamination).

During times of respirator shortages, it is acceptable for healthcare organizations to use contingency conservation strategies for filtering facepiece respirators (e.g., N95 respirators) to ensure an adequate supply of respirators for all aerosol-generating procedures.

Re-opening for elective procedures and following recommendations highlighted in this document will greatly increase the demand for respirators. To ensure adequate supplies, organizations may need to continue to use approved conservation strategies. Failure to use conservation strategies could limit the availability of respirators for those situations in which their use is critical to protect healthcare workers.

Patients undergoing elective surgery (or other aerosol-generating procedures) should be tested for COVID-19 shortly before the scheduled procedure.

We support the recommendations of the [American Society of Anesthesiologist and the Anesthesia Patient Safety Foundation](#) for preoperative screening and [testing for current COVID-19 infection](#). We recognize that some organizations will not have adequate testing supplies to accomplish this currently. This is a serious concern; ensuring adequate supplies to test all patients before elective surgery should be a national priority to protect patients and healthcare workers.

Prior to testing, patients should be screened for COVID-19 symptoms; patients with COVID-19 symptoms should be sent immediately for evaluation. When possible, there should be universal testing for COVID-19 among patients without symptoms. This is necessary because patients with incubating COVID-19 could be asymptomatic immediately prior to an elective procedure and then develop overt COVID-19 infection. If the infection is severe, this could lead to [complications during the post-procedure period](#). Moreover, if patients with asymptomatic or presymptomatic COVID-19 undergo surgery, this poses a high risk of transmission of COVID-19 to the operative team. Patients who are found to have active disease (positive COVID-19 test) should not undergo their planned procedure until the infection has resolved. Ideally, testing should be done as close as possible to the time of the procedure while ensuring there is adequate time to obtain the results. Some states require testing to be done within 72-96 hours of the procedure. Patients should be advised to self-quarantine between the time of testing and the day of their procedure to minimize the chance of becoming infected during the window between testing and the procedure.

Because of the risk of false-negative COVID-19 tests, clinicians caring for patients undergoing elective surgery (or other aerosol-generating procedures) whose pre-procedure test for COVID-19 is negative should still use a respirator (e.g., N95 mask, PAPR); the use of respirators should continue until the organization determines that the risk of a clinician acquiring COVID-19 from a patient with a false-negative COVID-19 PCR test is very low.

Because of sampling technique, sample site, the test performed and the timing of the test, there is a significant risk of false negative COVID-19 tests. Therefore, we support the recommendations of the [American Society of Anesthesiologist and the Anesthesia Patient Safety Foundation](#) and [others](#) who call for use an N95 mask by all operating room staff during aerosol-generating procedures (AGP) such as intubation and extubation, nebulizer treatments, etc. If it is not possible to have all staff who are in the room during and after an AGP wear an N95 mask, then staff not wearing an N95 mask may enter the room following an AGP after the [CDC-recommended time for air clearance](#) (99% efficiency) to occur within the room.

If the incidence of COVID-19 is very low in the population of patients cared for by an organization, it may no longer be necessary to take the precaution of using an N-95 mask for AGPs if an asymptomatic patient has tested negative for COVID-19 immediately prior to a procedure. However, this should be done cautiously. Although the risk of exposure and transmission from a single patient with COVID-19 is low, the cumulative risk grows greatly when many clinicians provide care to hundreds or thousands of patients. Although the risk depends on many factors, the incidence of COVID-19 in the community and the rate of false negative COVID-19 PCRs are the primary risk determinants. Organizations considering using medical masks instead of N95s for AGPs should carefully read the accompanying FAQ for this position statement that presents clinicians' risk of exposure to a patient with COVID-19 and the risk of contracting COVID-19 under different community incidence rates and different COVID-19 PCR false negative rates.



Organizations should check with state and local health departments for more specific requirements. For example, some states have established requirements regarding the type of pre-operative/pre-procedure testing for SARS-CoV-2 that must be done and the time period in which it must be done (e.g., no more than three days prior to the surgery or procedure).