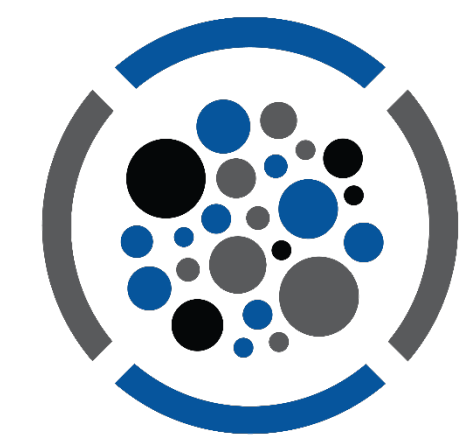


# The Impact of COVID-19 Response on Infection Prevention Programs and Practices in Southeastern United States



Duke Center for  
Antimicrobial Stewardship  
and Infection Prevention

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## Background

- Early assessments of SARS-COV-2 preparedness revealed resource shortages, use of crisis capacity strategies, and gradual adoption of universal masking policies in hospitals.
- Our initial survey highlighted several differences in community hospital preparedness for SARS-CoV-2.
- We performed a follow-up survey one year after the initial survey to assess changes in infection prevention policies in our diverse network of community and academic hospitals.

## Methods

- Survey Timing:** April 2021, in follow-up to our initial survey from April 2020 (ref).
- Survey Distribution:** electronically using Qualtrics (Qualtrics, Provo, UT) to infection preventionists.
- Setting:** 56 community hospitals in Duke Infection Control Outreach Network (DICON) and 2 academic hospitals (Duke/UNC Medical Center).
- Content:** 26 questions related to personal protective equipment (PPE) availability, policies related to restarting surgeries, testing, universal masking, eye protection, daily screening, and staffing challenges.

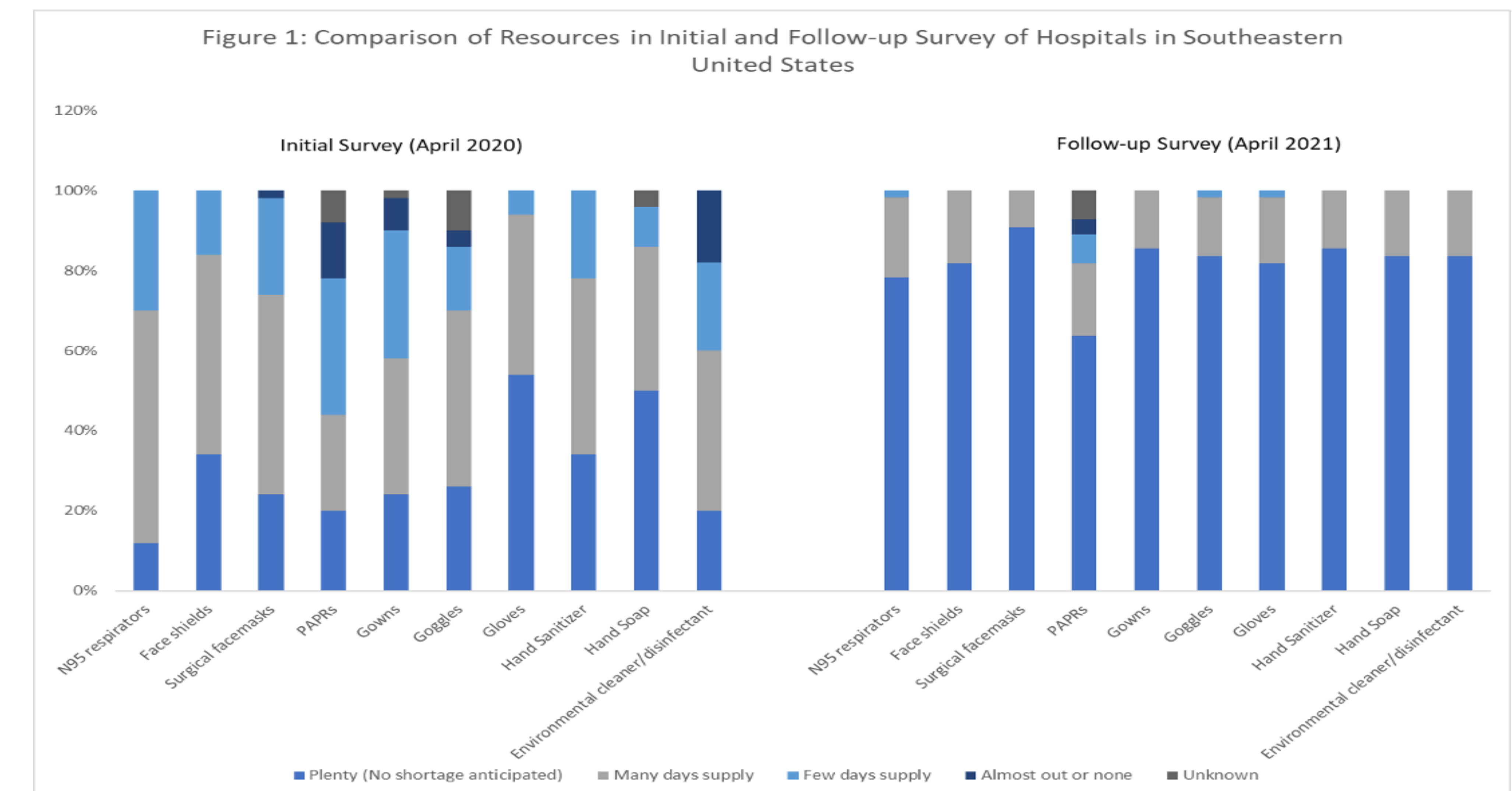
**Table 1: Comparison of survey responses related to infection prevention policies and practices in a large network of hospitals**

Survey Sections	Initial Survey (April 2020) * n (%)	Follow-up survey (April 2021) * n (%)
<b>PERSONAL PROTECTIVE EQUIPMENT AND SCREENING</b>		
Reprocessing of N95 respirators	36 (72%)	19 (32.7%) **
Universal masking of staff, patients, visitors	38 (76%)	50 (100%) **
Universal eye protection	NA	7 (13.2%)
Eye Protection		
• in high settings	NA	7 (13.2%)
• In ED, or in when patient is unmasked		39 (73.5%)
Universal employee screening	45 (90%)	52 (100%)
<b>SURGERIES/PROCEDURES</b>		
Suspended elective Procedures	43 (86%)	36 (94%)
Enhanced PPE for surgical procedures if pre-op testing not performed	NA	8 (15%)
Enhanced PPE for surgical procedures for suspected or confirmed COVID19 cases	NA	8 (15%)
Change from test based to time-based strategy for removal of isolation	NA	50 (92.4%)
<b>TESTING</b>		
In-house testing	34 (68%)	47 (81%) **
Weekly testing capacity >100 tests	NA	22 (40%)
Universal pre-admission testing	NA	32 (59.2%)
Pre-operative testing		
• for all or most surgeries	43 (86%)	43 (78.2%)
• for some surgeries		10 (18.2%)
Testing asymptomatic patients prior to discharge to long-term-care facility	17 (34%)	37 (67.3%) **
<b>STAFFING</b>		
Infection prevention furloughs, staffing cuts, reassignments	NA	14 (25.5%)
Use of agency nursing	NA	45 (81.8%)

\*\*statistical significance, \* denominators are different for different questions and for different surveys

## Results

- 55 hospitals responded to our follow-up survey (response rate of 95%).
- Hospitals reported significant improvement in PPE and resource shortages on the follow-up survey compared to our initial survey as shown in Figure 1, P<0.05.
- Changes in policies and practices related to PPE, screening, elective surgeries, testing, and staffing on our serial surveys have been summarized in Table 1.



## Conclusions

- Our follow-up survey revealed improvement in resource availability, increase in testing capacity, uniformity in infection prevention policies, but also highlights the increase in infection prevention staffing shortages and use of agency nursing.

**References:** Advani et al .Assessing severe acute respiratory coronavirus virus 2 (SARS-CoV-2) preparedness in US community hospitals: A forgotten entity. Infect Control Hosp Epidemiol. 2021 May;42(5):600-603. doi: 10.1017/ice.2020.1238.