

The LTCCV19 surveyed the leadership of 25 community LTCFs to assess needs and identify areas of potential assistance; 18 facilities responded, and to date, the VAGLAHS LTCCV19 has engaged in targeted support with 11 facilities. VAGLAHS staff completed twice daily telephone calls with the community facilities' administrators for real-time feedback on new cases of COVID-19 in residents and staff. For 7 facilities with testing limitations, the VAGLAHS LTCCV19 deployed registered nurses to assist in collecting specimens from veteran residents and to perform universal SARS-CoV-2 surveillance testing, and train community staff on specimen collection. Veterans with COVID-19 from community LTCFs have been admitted to the acute-care VA hospital for medical care, then to the CRU if their community LTCFs were not able to house them upon recovery. VAGLAHS staff trained in infection control were dispatched to community LTCFs to review on-site practices and strategize areas for improvement, including those listed by Guar *et al.*¹

As Guar *et al.*¹ emphasize, to combat this pandemic we must fortify areas of our society at higher risk of both outbreak and severe disease, such as LTCFs. The SARS-CoV-2 virus clearly does not recognize institutional boundaries, and institutions with the resources and capacity to assist in this fortification can play a substantial role in protecting vulnerable members of our community, ultimately reducing the burden of the ongoing COVID-19 pandemic.

Acknowledgments. We thank Lauren Barrera and Rachelle Davis for their work coordinating and conducting outreach activities, and VAGLAHS staff for adaptability and dedication to caring for veterans in unprecedented ways

during the COVID-19 pandemic. The views expressed in this article are those of the authors and do not necessarily represent the views of the Department of Veterans Affairs.


Financial support. No financial support was provided relevant to this article.

Conflicts of interest. All authors report no conflicts of interest relevant to this article.

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Are we forgetting the “universal” in universal masking? Current challenges and future solutions

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To the Editor—Many US hospitals have recently adopted policies mandating universal masking of all staff, visitors and patients. Universal masking is particularly important in preventing transmission to and from individuals who are asymptomatic or pre-symptomatic for coronavirus disease 2019 (COVID-19).¹ The Centers for Disease Prevention and Control (CDC) estimates that ~35% of severe acute respiratory coronavirus virus 2 (SARS-CoV-2) cases are asymptomatic.² In addition, healthcare professionals (HCPs), patients, and visitors with atypical or very mild symptoms may more readily transmit SARS-CoV-2 in healthcare facilities without masking policies.³ Risk of exposure to SARS-CoV-2 in nonclinical areas within healthcare facilities may be overlooked.

The incidence of COVID-19 among HCPs decreased significantly after our health system adopted a universal masking policy. Unmasked exposure to another HCP rather than exposure to

known infected patients resulted in most of the COVID-19 cases among staff after implementation of this policy.⁴ We recently surveyed 50 community hospitals within the Duke Infection Control Outreach Network and found that 90% of these hospitals had also adopted universal masking policies. However, we also determined that actual compliance with universal masking policies was suboptimal, particularly among staff outside of clinical care settings, including administrative offices, shared work rooms, and break rooms. Poor compliance in these shared spaces led to known exposures in some of these hospitals, leading to employee furloughs, a substantial burden of contact tracing, and unnecessary anxiety for exposed individuals. Here, we discuss our perception and understanding of the etiology of poor compliance with universal masking policies in healthcare settings, and we discuss proposed solutions as well.

Inaccurate risk perception

Overall, HCP compliance with protective measures such as universal masking often correlates with the level of risk they

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Cite this article: Advani SD, *et al.* (2021). Are we forgetting the “universal” in universal masking? Current challenges and future solutions. *Infection Control & Hospital Epidemiology*, 42: 784–785. <https://doi.org/10.1017/ice.2020.333>

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perceive. Individuals are more likely to comply with recommended prevention measures if they perceive themselves to be at higher risk of harm in a particular situation or setting.⁵ HCPs commonly perceive their risk of contracting COVID-19 from an infected patient to be higher than the risk of exposure to an asymptomatic coworker. Ironically, HCPs spend more time in close proximity to their coworkers than infected patients. A recent study demonstrated that <5% of exposed HCPs tested positive for SARS-CoV-2 despite exposure to an infected patient without adequate personal protective equipment (PPE), although most HCP attribute greater risk to this type of exposure.⁶ The propensity among HCPs to perform inaccurate risk assessments has been seen with other basic infection prevention measures such as hand hygiene.⁷

Inconsistent messaging from public health authorities

Earlier this year, public health authorities pointed out a lack of evidence related to the use of universal masking by the general public to prevent acquisition of SARS-CoV-2. Later, a member of the World Health Organization (WHO) stated in June 2020 that asymptomatic spread of SARS-CoV-2 is 'very rare.' The WHO quickly modified and clarified this statement by stating that asymptomatic spread is incompletely understood even though it actually occurs, contributing to ongoing confusion. Furthermore, a few high-ranking political leaders and millions of citizens routinely ignore the current recommendation to use face coverings in indoor settings and when in close proximity with others. Inconsistent, contradictory and unclear advice from public health authorities has contributed to widespread confusion about the utility of universal masking in preventing the spread of SARS-CoV-2 (response efficacy).⁵

The CDC recently updated their exposure guidelines and issued a new "frequently asked question" on May 29, 2020, recommending the use of eye protection when caring for patients in areas of "moderate to substantial community transmission [of SARS-CoV-2]," even if COVID-19 is not suspected.^{8,9} In our opinion, this guidance is confusing and adds an unnecessary emphasis on the use of additional PPE by HCPs when in direct contact with patients and does not place emphasis on the need for universal masking of patients when staff are in close proximity to patients.

COVID-19 fatigue

COVID-19 fatigue, a term that describes drift in following preventative measures as this pandemic goes on, is an important cause of poor compliance with policies related to universal masking.¹⁰ This "fatigue" among HCPs may be potentially related to their long work hours, required interactions with other team members throughout the day, the burden of wearing additional eye protection and uncomfortable or poor-quality masks.

Future strategies related to universal masking

For effective behavioral change, wearing a mask must become a habit for HCPs in all shared spaces inside and outside the workplace, outside of their immediate household and when appropriate physical distancing is not possible.¹¹ We need to work closely with HCPs to better understand the root causes for poor masking compliance and to identify and remove barriers to doing the right

thing. Simple solutions such as educational campaigns on the rationale for masking, creation of a mask committee comprised of key stakeholders from various worker types to serve as champions, making physical changes to the environment to facilitate distancing, offering better quality masks, as well as suitable and accessible alternate locations that allow for physical separation to occur while HCPs are unmasked during breaks, will likely lead to improved compliance.

Finally, we need clear, simple, and consistent messaging from public health authorities for successful implementation of universal masking policies. Our goal should be to focus on the simple message of universal masking to prevent the transmission of SARS-CoV-2. Healthcare epidemiologists and public health professionals need to learn the art of salesmanship during these times because the message itself, though important, is only as good as the leader that presents it to the public.¹²

Acknowledgments. None.

Financial support. No financial support was provided relevant to this article.

Conflicts of interest. All authors report no conflicts of interest relevant to this article.

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