

# We should allow family presence for hospitalized patients in isolation for coronavirus disease 2019 (COVID-19)

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*To the Editor*—In our field, we rapidly implement preventative measures during outbreaks or epidemics. However, we may keep such measures longer than needed once the epidemiologic situation has changed. Among the many reasons for differential speeds in implementation and de-implementation of preventative measures, one can cite fatigue, lack of evidence, competing priorities, and even fear. Here, I postulate that one measure that may have been appropriate early on in the pandemic but needs to be revisited is allowing family presence for hospitalized patients in isolation for coronavirus disease 2019 (COVID-19).

## Why were these restrictions implemented?

### *Visitors could become infected*

Infection control professionals are charged with mitigating the risk of infection spread among healthcare personnel, patients, and visitors. Visitors could potentially become infected while in the room of a person isolated because of COVID-19. However, the risk of transmission of infection to visitors can be greatly mitigated. In many places visitors are required to be vaccinated, healthcare facilities have engineering controls (increased air exchanges), and personal protective equipment (PPE) is available. These measures have proven safe for healthcare workers throughout the pandemic. Furthermore, patients admitted because of COVID-19 are unlikely to be at the peak of infectiousness, and visitors may have already had COVID-19 as part of the same transmission chain and may be unlikely to be reinfected soon after recovery.

### *Visitors may be infected and transmit disease to other people present in the healthcare setting*

Visitors may unknowingly carry an asymptomatic or presymptomatic severe acute respiratory coronavirus virus 2 (SARS-CoV-2) infection. However, that is true for all visitors, regardless of the COVID-19 status of the visited patient. This is why universal infection controls are in place (eg, universal masking).

### *Implementation may be burdensome*

Educating visitors on donning and doffing of PPE may add to the chores of already busy healthcare workers. However, we currently do this for visitors to patients on isolation for other reasons (eg, tuberculosis and *C. difficile*). This protocol is not unique to COVID-19. However, hospital administration may need to provide extra support for this added task.

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### *Contribution to community spread*

At this point in the pandemic, most country governments have started transitioning to a mitigation strategy in which some degree of transmission is considered acceptable. Potential transmission from patients to visitors is unlikely to meaningfully impact community transmission.

### *Limited PPE supply*

The beginning of the pandemic was characterized by a problematic shortage of PPE and other supplies. Fortunately, the availability of PPE has increased tremendously in the United States. Discussions with supply chain departments will need to be undertaken to ensure that adequate stock is available.

## Why should these restrictions go away?

### *Visitor restrictions adversely affect patients and their families well-being*

Visitor restrictions may lead to incomplete grief and emotional distress by patients, families, and healthcare workers. They are a barrier to high-quality communication and decision making; they may perpetuate inequities; and they may be associated with poor clinical outcomes.<sup>1</sup>

### *Restricting family presence may lead to longer stays and delayed decisions to limit treatment prior to death*

A recent study showed a ~3 days longer hospital stay after implementation of policies preventing visitors and a hazard ratio of ~2 for a longer time to care parameters including do not resuscitate, do not intubate, and comfort care.<sup>2</sup> Given that engaging patients and families has been advocated for the prevention of healthcare-associated infections, it is not unreasonable to speculate that some of the increases in HAI reported nationwide<sup>3</sup> may, in part, be associated with restrictive visitation policies.

## The way forward

Safe family presence can be achieved. Several centers have successfully achieved safe policies to allow visitors to patients with COVID-19 in special circumstances, such as end of life, delivery and birth, and for pediatric patients. One remaining question is whether visitors need to be offered a fit tested N95.

Fit testing is an employment-based requirement to ensure that workers who are repeatedly exposed to airborne diseases do not develop occupational infections. The Centers for Disease Control and Prevention and other health departments have advocated for N95 respirators and KN95 mask use in the community without the need for fit testing.<sup>4</sup> Requiring fit testing could become an operational barrier preventing family

members at the bedside, and it is not clear that is strictly needed.

In summary, I believe it is time to expand visitation to all COVID-19 patients. The risk benefit ratio has shifted toward allowing visitors for all patients regardless of their COVID-19 status. Fortunately, most of the reasons visitor restriction policies implemented are no longer present, and allowing visitors for patients in isolation because of COVID-19 is beneficial for patients, family members, and the healthcare system as a whole.

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## Response to “Severe acute respiratory coronavirus virus 2 (SARS-CoV-2) surface contamination in staff common areas and impact on healthcare worker infection: Prospective surveillance during the coronavirus disease 2019 (COVID-19) pandemic”

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*To the Editor*—We read with great interest the recent paper by Zhang et al,<sup>1</sup> which demonstrated severe acute respiratory coronavirus virus 2 (SARS-CoV-2) RNA contamination in staff common areas in an acute-care hospital. Many investigators have assessed the frequency and level of environmental contamination (ie, surfaces and air) in rooms housing patients with coronavirus disease 2019 (COVID-19).<sup>2,3</sup> However, to our knowledge, this is one of few studies to evaluate SARS-CoV-2 contamination outside patient rooms in units or hospitals providing care for patients with COVID-19. Given the finding of SARS-CoV-2 RNA in common areas of the hospital, this paper is likely to generate substantial concern among healthcare personnel (HCP). Therefore, we would like to provide some comments and context for this important finding regarding the likelihood that viable SARS-CoV-2 is present in common areas in an amount sufficient to pose a risk to HCP.

First, the recovery of SARS-CoV-2 RNA in areas remote from patient care locations is not surprising based on earlier reports that have assessed the potential spread of microbes using surrogate molecular markers. Jiang et al<sup>4</sup> pioneered the use of cauliflower DNA to map the potential spread of microbes by placing toy balls

contaminated with cauliflower DNA for 1 hour in a daycare center room. They demonstrated rapid contamination of multiple surfaces and objects in the room, some spread to other rooms, and importantly, spread to the homes of some children. Oelbert et al<sup>5</sup> placed cauliflower DNA on a single telephone in a pod in a pediatric intensive care unit and demonstrated rapid spread to 58% of surfaces sampled in the pod, to 18% of surfaces sampled in 5 other pods, and to 30%–80% of surfaces sampled in the nursing station, physician charting area, and the changing room.<sup>5</sup>

Second, as noted by Zhang et al, SARS-CoV-2 can survive on environmental surfaces for hours to days. However, SARS-CoV-2 is an enveloped virus and environmental survival is limited. In laboratory studies, viable SARS-CoV-2 persisted for a median of 2 days (range, 30 minutes to 7 days) on surfaces, depending on the type of surface.<sup>6</sup> Survival is enhanced at lower temperatures and humidity.

Third, as noted by Zhang et al, the finding of SARS-CoV-2 RNA does not necessarily equate to the presence of viable virus. The review by Kanamori et al<sup>2</sup> reported 4 studies in hospitals in which environmental contamination was simultaneously assessed by SARS-CoV-2 and viral culture. Among these studies, 3 reported detection of SARS-CoV-2 RNA on surfaces (ie, 7.7%–75% of surfaces sampled), but no study detected viable virus by culture.<sup>2</sup> Gonçalves et al<sup>3</sup> reviewed 37 studies that assessed surfaces for SARS-CoV-2 contamination. Viral viability was assessed in multiple studies but was not confirmed in any study (methods: swab, 6 studies; gauze pads, 1 study; and RT-qPCR 6 studies). Viable virus

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