Concise Communication

Absence of nosocomial influenza and respiratory syncytial virus infection in the coronavirus disease 2019 (COVID-19) era: Implication of universal masking in hospitals

Shuk-Ching Wong MNurs1, Germaine Kit-Ming Lam MNurs1, Christine Ho-Yan AuYeung MNurs1, Veronica Wing-Man Chan MPH1, Newton Lau-Dan Wong MNurs1, Simon Yung-Chun So MMedSc2, Jonathan Hon-Kwan Chen PhD2, Ivan Fan-Ngai Hung MD3, Jasper Fuk-Woo Chan MD4, Kwok-Yung Yuen MD4 and Vincent Chi-Chung Cheng MD1,2

1Infection Control Team, Queen Mary Hospital, Hong Kong West Cluster, Hong Kong Special Administrative Region, China, 2Department of Microbiology, Queen Mary Hospital, Hong Kong Special Administrative Region, China, 3Department of Medicine, Li Ka Shing Faculty of Medicine, The University of Hong Kong, Pokfulam, Hong Kong Special Administrative Region, China and 4Department of Microbiology, Li Ka Shing Faculty of Medicine, The University of Hong Kong, Hong Kong Special Administrative Region, China

Abstract

Universal masking for healthcare workers and patients in hospitals was adopted to combat coronavirus disease 2019 (COVID-19), with compliance rates of 100% and 75.9%, respectively. Zero rates of nosocomial influenza A, influenza B, and respiratory syncytial virus infection were achieved from February to April 2020, which was significantly lower than the corresponding months in 2017–2019.

(Received 13 June 2020; accepted 5 August 2020; electronically published 17 August 2020)

Methods

Infection control measures for COVID-19

The study was conducted in a healthcare network comprising an acute-care, university-affiliated, teaching hospital and 4 extended-care hospitals with a total of 3,100 beds in Hong Kong. With the outbreak of COVID-19 pneumonia in Wuhan, China, our response plan changed from the alert level to the serious response level on January 4, 2020, and it further elevated to the emergency level on January 25, 2020 in Hong Kong.1 Universal masking was implemented for all HCWs on January 4, 2020 and enforcement began on January 25, 2020. Surgical masks were provided to all HCWs and patients was adopted as a part of proactive infection control measures to combat COVID-19.3 Because published data on the efficacy of universal masking policies to prevent nosocomial transmission of respiratory viruses are limited, we analyzed the incidence of nosocomial influenza A, influenza B, and respiratory syncytial virus (RSV) in a healthcare network in Hong Kong during the COVID-19 era compared with the historical period before universal masking was implemented (ie, the preintervention period).

Compliance of infection control measures

Hand hygiene practice was enforced.

Clinical and laboratory diagnosis of influenza and respiratory syncytial virus

In addition to the diagnosis of COVID-19, nasopharyngeal aspirates or nasopharyngeal swabs were collected from patients with
fever or respiratory symptoms to rule out other respiratory viral infections, including influenza A, influenza B, and respiratory syncytial virus (RSV) using Xpert Xpress Flu/RSV (Cepheid, Sunnyvale, CA) (Supplementary File 1 online). ICNs assessed the laboratory results to identify nosocomial respiratory viral infections, which was defined as patients with onset of fever or respiratory symptoms >48 hours of hospital admission, and they advised appropriate infection control measures to prevent hospital outbreak.

We monitored the incidence of nosocomial acquisition of influenza A, influenza B, and RSV from February 2020 to April 2020, after enforcement of universal masking in the hospitals on January 25, 2020. This period should be within the common seasonal influenza surge in Hong Kong in January–April and July–August, while RSV infection occurs throughout the year in Hong Kong. The corresponding months (February–April) in 2017, 2018, and 2019 were chosen as the preintervention period for comparison.

Statistical analysis

The χ² test was used to compare independent categorical variables between groups. P < .05 was considered statistically significant.

Results

Nosocomial acquisition of influenza A, influenza B, and RSV

The number of patients tested for influenza A, influenza B, and RSV during hospitalization was comparable between the 2 periods (Table 1). Absence of nosocomial influenza A, influenza B, and RSV infection was achieved from February to April 2020 in our healthcare network. The number of nosocomial influenza A, influenza B, and RSV cases per month and per 1,000 patient days per month were significantly lower than during the preintervention period (Table 1).

Compliance of infection control measures

The overall monthly hand hygiene compliance (mean ± SD) from February to April 2020 was 73.3 ± 2.1%, which was comparable to the corresponding figure in the preintervention period (76.9 ± 3.6%) (P = .14). In a 3-week audit from May 18, 2020, to June 5, 2020, 74 ward visits were made by ICNs. The compliance rates of wearing surgical masks among HCWs was 100% (889 of 889) and among adult patients was 75.9% (1,155 of 1,522). Improper wearing of surgical mask was significantly more observed among patients (132 of 1,155, 11.4%) than HCWs (11 of 889, 1.2%) (P < .001). In contrast, significantly more HCWs (29 of 889, 3.3%) touched the external surface of their surgical mask than patient did (18 of 1,155, 1.6%) (P = .01) (Table 2), but none of them performed hand hygiene immediately after touching their mask.

Discussion

For the infection control measures against respiratory viruses other than SARS-CoV-2, it is the general practice for our HCWs to adopt droplet precautions by wearing surgical masks within 1 m of patient contact and by practicing hand hygiene. However, lower
numbers of sporadic cases of nosocomial influenza A, influenza B, and RSV were observed in the preintervention period despite of our infection control practice. In the COVID-19 era, HCWs and patients were additionally required to wear surgical masks at all times in hospitals. Although the hand hygiene compliance of HCWs was comparable before and during the COVID-19 era, the policy of universal masking may be an important contributing factor in achieving zero nosocomial infections of influenza A, influenza B, and RSV.

Universal masking may reduce the shedding of SARS-CoV-2, or other respiratory viruses, from symptomatic and asymptomatic persons and thus reduce the environmental contamination, as illustrated in our recent study. In addition, wearing surgical masks may also prevent the maneuvers of nose picking and eyes touching, a subconscious behavior that poses a risk of self-inoculation of pathogens from the environment via the contaminated hands. This factor is the reason we have highly promoted our institutionally designed sixth moment, “hand hygiene before touching your mucus membrane,” together with the practice of WHO Five Moments for Hand Hygiene.

Universal masking in hospitals in the COVID-19 era deserves further investigation. Given the others enhanced infection control measures for COVID-19 pandemic in 2020 as potential cofounding variables, universal masking appears to be a key measure to control the transmission of respiratory viruses, as well as achieving zero nosocomial transmission of COVID-19, influenza A, influenza B, and RSV in our healthcare network.

### Table 2. Compliance of Wearing Surgical Masks Among Healthcare Workers and Patients

<table>
<thead>
<tr>
<th>Unit</th>
<th>Episodes of HCWs Observed</th>
<th>Episodes of HCWs Wearing Surgical Masks, No. (%)</th>
<th>Episodes of HCWs Wearing Improperly, No. (%)</th>
<th>Episodes of HCWs Touching External Surface of Surgical Masks, No. (%)</th>
<th>Episodes of Patients Observed</th>
<th>Episodes of Patients Wearing Surgical Masks, No. (%)</th>
<th>Episodes of Patients Wearing Surgical Masks Improperly, No. (%)</th>
<th>Episodes of Patients Touching External Surface of Surgical Masks, No. (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicine</td>
<td>394</td>
<td>394 (100)</td>
<td>3/394 (0.8)</td>
<td>10/394 (2.5)</td>
<td>753</td>
<td>568 (75.4)</td>
<td>67/568 (11.8)</td>
<td>2/568 (0.4)</td>
</tr>
<tr>
<td>Surgery</td>
<td>251</td>
<td>251 (100)</td>
<td>5/251 (2.0)</td>
<td>12/251 (4.8)</td>
<td>482</td>
<td>365 (75.7)</td>
<td>60/365 (16.4)</td>
<td>16/365 (4.4)</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>128</td>
<td>128 (100)</td>
<td>2/128 (1.6)</td>
<td>5/128 (3.9)</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Orthopedics</td>
<td>40</td>
<td>40 (100)</td>
<td>0 (0)</td>
<td>1/40 (2.5)</td>
<td>136</td>
<td>105 (77.2)</td>
<td>1/105 (1.0)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>ObGyn</td>
<td>23</td>
<td>23 (100)</td>
<td>1/23 (4.3)</td>
<td>1/23 (4.3)</td>
<td>40</td>
<td>26 (65.0)</td>
<td>1/26 (3.8)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Others</td>
<td>53</td>
<td>53 (100)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>111</td>
<td>91 (82.0)</td>
<td>3/91 (3.3)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Total</td>
<td>889</td>
<td>889 (100)</td>
<td>11/889 (1.2)</td>
<td>29/889 (3.3)</td>
<td>1522</td>
<td>1,155 (75.9)</td>
<td>132/1,155 (11.4)</td>
<td>18/1,155 (1.6)</td>
</tr>
</tbody>
</table>

Note. HCWs, healthcare workers; NA, not applicable because we only observed the compliance of wearing surgical mask in adult patients; ObGyn, obstetrics and gynecology.

*Improper wearing of surgical mask is defined as that the nose or mouth is not fully covered by the surgical mask.

**None of them practice hand hygiene immediately after touching the external surface of mask.

Including adult intensive care unit, clinical oncology, accidental and emergency unit, and mixed ward.

11 HCWs: 9 nurses and 2 supporting staff.

29 HCWs: 9 doctors, 9 nurses, 9 supporting staff, and 2 allied health staff.

References


