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(ARCHIVED) Universal Mask Use in Health Care Settings and Retirement Homes

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Introduction

As one measure to prevent COVID-19, universal masking has been instituted in care settings in Ontario. Medical masks (herein referred to as masks) can function either as source control (being worn to protect others) or part of personal protective equipment (PPE) (to protect the wearer). Wearing a mask is not a substitute for physical distancing or other preventative measures. Masking is one of many control measures that work together to prevent the spread of infection. Other measures include vaccination, screening, ventilation, hand hygiene, physical distancing and environmental cleaning. Within this document, we outline different scenarios that apply to healthcare workers consistently wearing masks while at work in all health care settings.

Principles of Universal Masking

When universal mask use by staff is indicated as a means of source control, this involves the wearing of a mask by all staff and visitors, at all times. To facilitate judicious and effective use of masks as part of source control, the following are recommended as best practices:

- Universal masking is one measure to prevent transmission of COVID-19. Persons wearing a mask must also practice physical distancing, maintaining at least two metres (six feet) of separation to prevent exposing others to their respiratory particles including droplets.
- A single mask for source control may be worn for an extended period (e.g., donned or put on at the beginning of the shift, and continued to be worn) as long as the mask is not manipulated or removed, is not visibly soiled, damp, damaged or difficult to breathe through.
- The mask is to be donned when entering the facility/home and removed when eating/drinking or leaving the facility/home at the end of the shift/day.
- PPE type (medical mask or fit tested N95 respirator) is dependent on the risk assessment and/or specified precautions, requirements or recommendations.

- Extended use or re-use of masks/N95 respirators as PPE should only be considered in consultation with the IPAC professional and/or the outbreak management team in order to mitigate the risk of transmission that may occur with extended use or re-use. Extended use is preferable to re-use.
- After use, masks are to be handled in a manner that minimizes the potential for cross-contamination.
- If a mask must be re-used, keep it from being contaminated by storing it in a clean paper bag, or in a cleanable container with a lid. This is preferable to placing a used mask on an open surface or paper towel.
- Paper bags are to be discarded after each use. Reusable containers are to be cleaned and disinfected after each use. Bags and containers are to be labelled with the individual's name to prevent accidental misuse.
- Hand hygiene is to be performed before putting on and after removing or otherwise handling masks.

Universal Masking Scenarios

*Perform hand hygiene before and after every resident interaction.

*Scenarios assume that a personal risk assessment will be conducted before every patient/resident interaction.

Scenarios - with universal masking	**Any personal protective equipment?***	**Change my mask?**	**Change my gown, gloves and eye protection?**	**Re-use of mask?**
Direct patient/resident care and no Additional Precautions	☐ Yes ☑ No Mask only for source control	If wet, contaminated, or hard to breathe through, or removed	Not applicable	Only in extreme shortage. Perform hand hygiene before and after touching mask and store mask in clean paper bag
Direct care (< 2m) for patient/resident on Droplet/Contact Precautions	☑ Yes ☐ No Requires gown, gloves, eye protection and mask	Yes, upon leaving room	Yes, upon leaving the room	No
Direct care for multiple patients/residents on Droplet/Contact Precautions who are in the	☑ Yes ☐ No	Yes, upon leaving cohorted area (as	Change gloves and clean hands	No

Scenarios - with universal masking	Any personal protective equipment?*	Change my mask?	Change my gown, gloves and eye protection?	Re-use of mask?
same ward room or cohort (as defined by local IPAC expertise)	Requires gown, gloves, eye protection and mask.	defined by local IPAC expertise)	between each resident ^Gown, mask, eye protection removed upon leaving the cohorted area	
Enter patient/resident room on Droplet/Contact Precautions and > 2 m from resident (e.g. drop off meal tray, observe patient or their monitor without direct contact)	☑ Yes ☐ No Mask (have access to PPE if care needs change while in room).	If wet, contaminated, or hard to breathe through, or removed	Not applicable, unless risk assessment warrants PPE	Only in extreme shortage. Perform hand hygiene before and after touching mask and store in clean paper bag

Note: Extended use or leaving PPE on when moving between residents is not best practice in IPAC and is only be used as part of a strategy to conserve PPE during a shortage, and in consultation with IPAC team.
*PPE type is dependent on the risk assessment and/or specified precautions, requirements or recommendations i.e., medical mask, fit tested N95 respirator, eye protection, gowns and gloves.[1]

Definitions

Universal Masking: Wearing a medical mask at all times to protect others from the wearer.

Personal Protective Equipment: Personal protective equipment, commonly referred to as "PPE", is equipment and clothing worn to minimize exposure to hazards and prevent illnesses and infection to the worker. For the purposes of this document, PPE consists of a mask, gloves, gown and eye protection, and is chosen as part of personal risk assessment.[2]

Personal Risk Assessment: An evaluation of the interaction of the health care provider, the client/patient/resident and the client/patient/resident environment to assess and analyze the potential for exposure to infectious disease.[3]

Source Control: Personal practices that help prevent the spread of bacteria and viruses to others (e.g., covering the mouth when coughing, wearing a mask).[3]

Extended Use: Refers to the practice of wearing the same item of personal protective equipment for repeated encounters with several patients, without removing it between the encounters. Extended use may be implemented when multiple patients with the same infection are placed together in dedicated waiting rooms, clinics or hospital units during supply shortages and in consultation with the IPAC team.[4]

Re-use: Reuse should only be considered under extreme shortages. Reuse involves the practice of using the same item of personal protective equipment for multiple encounters with patients but removing it ('doffing') between at least some of the encounters. The item of personal protective equipment is stored in between encounters and re-used.[4]

Conservation (strategies): Strategies employed to extend the supply of personal protective equipment.[4]

Contamination: The presence of an infectious agent on hands or on a surface, such as a counter, clothing, gowns, gloves, bedding, toys, surgical instruments, care equipment, dressings or other inanimate objects.[3]

Cohorting: Grouping two or more clients/patients/residents who are either colonized or infected with the same microorganism to a geographic area, with staffing assignments restricted to the cohorted group of patients.[3]

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