**COVID-19**

**Optimizing the Supply of Facemasks During COVID-19 Pandemic - Policy**

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**Policy**

It is the policy of this facility to optimize the use of facemasks consistent with current CDC guidance.

**Purpose**

To provide strategies or options for the facility to optimize supplies of facemasks when the facility is experiencing limited supply.

“Surge capacity refers to the ability to manage a sudden, unexpected increase in patient volume that would otherwise severely challenge or exceed the present capacity of a facility. While there are no commonly accepted measurements or triggers to distinguish surge capacity from daily patient care capacity, surge capacity is a useful framework to approach a decreased supply of facemasks during the COVID-19 response. To help healthcare facilities plan and optimize the use of facemasks in response to COVID-19, CDC has developed a [Personal Protective Equipment (PPE) Burn Rate Calculator](https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/burn-calculator.html). Three general strata have been used to describe surge capacity and can be used to prioritize measures to conserve facemask supplies along the continuum of care.

* [**Conventional capacity**](https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/face-masks.html#conventional-capacity)**:** measures consisting of engineering, administrative, and personal protective equipment (PPE) controls that should already be implemented in general infection prevention and control plans in healthcare settings.
* [**Contingency capacity**](https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/face-masks.html#contingency-capacity): measures that may be used temporarily during periods of expected facemask shortages. Contingency capacity strategies should only be implemented after considering and implementing conventional capacity strategies. While current supply may meet the facility’s current or anticipated [utilization rate](https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/burn-calculator.html), there may be uncertainty if future supply will be adequate and, therefore, contingency capacity strategies may be needed.
* [**Crisis capacity**](https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/face-masks.html#crisis-capacity): strategies that are not commensurate with U.S. standards of care but may need to be considered during periods of known facemask shortages. Crisis capacity strategies should only be implemented after considering and implementing conventional and contingency capacity strategies. Facilities can consider crisis capacity strategies when the supply is not able to meet the facility’s current or anticipated [utilization rate](https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/burn-calculator.html).”1

“Decisions to implement contingency and crisis strategies are based upon these assumptions:

1. Facilities understand their facemask inventory and supply chain
2. Facilities understand their facemask [utilization rate](https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/burn-calculator.html)
3. Facilities are in communication with local healthcare coalitions, federal, state, and local public health partners (e.g., public health emergency preparedness and response staff) to identify additional supplies.
4. Facilities have already implemented other [engineering and administrative control measures](https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/conventional-capacity-strategies.html) including:
   * Use physical barriers and other engineering controls
   * Limit number of patients going to hospital or outpatient settings
   * Use telemedicine whenever possible
   * Exclude all HCP not directly involved in patient care
   * Limit face-to-face HCP encounters with patients
   * Limit visitors to the facility to those essential for the patient’s physical or emotional well-being and care (e.g., care partner, parent).
   * Cohort patients and/or HCP

* Facilities have provided HCP with required education and training, including having them demonstrate competency with donning and doffing, with any PPE ensemble that is used to perform job responsibilities, such as provision of patient care

**Once availability of facemasks returns to normal, healthcare facilities should promptly resume conventional practices.**Determining the appropriate time to return to conventional strategies can be challenging. Considerations affecting this decision include:

1. The anticipated number of patients for whom a facemask should be worn by HCP providing their care
2. The number of days’ supply of facemasks currently remaining at the facility
3. Whether or not the facility is receiving regular resupply with its full allotment”1

**Protocol for Optimizing the Supply of Facemasks:**

Complete a review of current and future needs for PPE’s. Utilize a process to determine PPE Burn Rate.

* [PPE Burn Rate Calculator](https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/burn-calculator.html) – This is a sample spreadsheet-based model that provides information for healthcare facilities to plan and optimize the use of PPE for response to coronavirus disease 2019 (COVID-19).

Conventional Capacity:

* Use facemasks according to manufacturer’s recommendation (label) as well as local, state, and federal requirements,
  + Use FDA-cleared surgical masks when exposure to splashes and sprays are anticipated
  + Facemasks not regulated by FDA (i.e. procedure masks) may not provide protection against splashes and sprays.

Contingency Capacity:

* Secure facemasks in public areas and distribute to visitors in accordance with your visitor COVID-19 policy
* Extended Use of facemasks (defined as wearing the same facemask for repeated close contact with several residents without removing the facemask between residents)
* Employees should discard facemask when removed and at the end of each day of work
  + Remove and discard facemask if soiled, damaged, or difficult to breathe through
  + Employee must be careful not to touch or adjust facemask.
    - If the facemask is touched or adjusted, immediately perform hand hygiene
  + Employee should leave the resident care area if the facemask needs to be removed
* Facemasks will be reserved for use by employees, rather than residents
  + Instruct symptomatic residents to use tissue or other barriers (i.e. cloth facemasks) to cover mouth and nose

Crisis Capacity:

* Use the facemasks beyond manufacturer’s-designated shelf live
  + Contact manufacturer for recommendations
  + Inspect product for integrity prior to use. If evidence of degraded materials or visible tears, discard product
* Implementation of re-use of facemasks (the practice of using the same facemask by one employee for multiple encounters with different residents, removing after each encounter. The employee should not touch the outer surface of the mask during care. Removal of mask should be accomplished carefully, in accordance with facility procedure.
  + Remove and discard if soiled, damaged, or hard to breathe through
  + If facemask cannot be re-used (provider is unable to undo dies without tearing) it should be considered for extended use rather than re-use
  + Facemasks with elastic ear hooks may be more appropriate for re-use
* Employee should leave the resident care area when the facemask needs to be removed.
  + Remove mask carefully, folding so the outer surface is held inward and against itself reducing contact with the outer surface during storage. Store between uses in a clean, sealable paper bag or breathable container.
* Prioritizing Facemasks:
  + Essential procedures
  + Activities when splashes and sprays are anticipated
  + Activities with prolonged face-to-face or close contact with potentially infectious resident is unavoidable
  + Facemasks will be used when respirators are not available during care of residents with COVID-19 or other infections in which a respirator is indicated such as when performing aerosol generating procedures when moderate to substantial community transmission of COVID-19 is occurring.

When Facemasks are Not Available:

* Exclude employees with higher risk of severe illness from COVID-19 from contact with residents with known or suspected COVID-19. (i.e. employees over 60 years old, chronic medical conditions, pregnant employees, etc.)
* Employees who have recovered from COVID-19 may be assigned to care for residents with known or suspected COVID-19
* Use of a face shield that covers the entire face to the chin or below and sides and not facemask
* Employees may use cloth masks “as a last resort for care”1 of a resident with COVID-19 or other infections in which a respirator is indicated.

**References**

1 Centers for Disease Control and Prevention. Coronavirus Disease 2019 (COVID-19). Strategies for Optimizing the Supply of Facemasks, Updated Nov. 23, 2020: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/face-masks.html>

Centers for Medicare & Medicaid Services. COVID-19 Long Term Care Facility Guidance. April 2, 2020. <https://www.cms.gov/files/document/4220-covid-19-long-term-care-facility-guidance.pdf>