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| **SOP - for the wearing of face masks** | **DOCUMENT TITLE:** | **Standard Operating Procedure - for the wearing of face masks** | |
| **Name of Originator/Author /Designation & Specialty:** | Liz Watkins, DDIPC | |
| **Local / Trust wide** | Trust wide | |
| **Statement of Intent:** | To describe the process for the wearing of face masks throughout the Trust | |
| **Target Audience:** | All staff | |
| **Version:** | 1 | |
| **Name of Group and Date when Recommended for Ratification** | Infection Prevention and Control Group |  |
| **Name of Division and Date of Final Ratification:** | DIPC | *Date*  20 June 2022 |
| **Review Date:** | June 2023 | |
| **Contributors:**  ***Individuals involved in developing the document*.** | **Designation:**  Mary Sexton : DIPC | |
| **The electronic version of this document is the definitive version** | | |

**CHANGE HISTORY**

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| --- | --- | --- |
| **Version** | **Date** | **Reason** |
| 1 | 20/06/2022 | New SOP |
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A translation service is available for this document. The Interpretation/Translation Policy, Guidance for Staff is located on the intranet under Trust-wide Policies.

**THE DUDLEY GROUP NHS FOUNDATION TRUST**

**THE WEARING OF FACE MASKS THORUGHOUT THE TRUST STANDARD OPERATIONAL POLICY**

**1 STANDARD OPERATING PROCEDURE SUMMARY**

This SOP provides information on the requirement to wear face masks throughout the Trust in both clinical and non-clinical environments for staff, patients, and visitors. As is the nature of emerging infectious diseases, advice can change rapidly in line with an evolving situation nationally and internationally.

**2 STANDARD OPERATING PROCEDURE DETAIL**

**2 BACKGROUND INFORMATION**

2.1 Guidance for COVID-19 advised the wearing of Personal Protective Equipment including type IIR fluid resistant surgical facemasks for all patients, staff, and visitors. This was implemented in all hospital areas including both clinical and non-clinical areas.

**3. RECOMMENTATION FOR ALL HEALTH CARE STAFF:**

Health and care staff should continue to wear facemasks as part of personal protective equipment required for transmission-based precautions when working in COVID-19/ respiratory care pathways, and when clinically caring for suspected/confirmed COVID-19 patients

Staff may continue to wear type IIR fluid resistant surgical face masks as a personal preference, and these will continue to be provided.

**3.1 Areas of higher Risk Inpatients and Day cases**

* Emergency Department
* Renal Unit and Ward
* SDEC
* Wards C4 and C5
* ITU
* Critical Care
* Neonatal Unit

The above areas are classed as areas of higher risk for patient care.

All staff and patients in the above areas will be required to wear face masks.

[Communications - Mask Wearing](http://thehub/communications/NewsPages/Mask%20Wearing.aspx)

**3.2 Inpatient COVID-19 testing**

There are no changes to the COVID-19 testing for inpatients this continues to be required on admission day, day 3, day 7 and 48 hours prior to discharge if transferring to another care provider and if patients become symptomatic

COVID-19 contacts should be swabbed on notification of contact status and again on day 5 and if patients become symptomatic.

[Communications - COVID-19 staff information page](http://thehub/communications/NewsPages/COVID-19%20staff%20information%20page.aspx)

**3.3 All Staff**

Staff should also be enabled to wear masks if this is their personal preference in any area.

All staff should have a review of their COVD-19 risk assessments to document their level of risk.

All staff will still be required to undertake twice weekly lateral flow testing. If staff produce a positive result then to the staff isolation SOP should be followed.

[Communications - COVID-19 staff information page](http://thehub/communications/NewsPages/COVID-19%20staff%20information%20page.aspx)

**3.4 Outbreaks of Infection e.g., suspected or confirmed respiratory outbreaks including COVID-19 and influenza etc.**

The Trust also recommends that staff should wear type IIR fluid resistant surgical face masks in suspected of confirmed outbreaks of infection.

**3.5 Aerosol Generating Procedures**

The advice and guidelines regarding AGPs have not changed. Staff will still need to don FFP3 masks.

Staff should be FFP3 fit tested before donning an FFP3 Masks.

FFP3 mask fit testing should be arranged locally in your department via a fit tester or the fit testing team.

Masks are available via procurement.

PPE should be donned immediately prior to entry of the room and removed immediately upon exit

**3.6 Corridors**

Staff do not need to routinely wear face masks when using main hospital corridors. Corridors in wards are subject to the specific guidance for that clinical area. For example, if walking through ED then a type IIR fluid resistant surgical facemask will be required.

**3.7 Transporting patients**

Staff need to wear type IIR fluid resistant surgical face masks when transporting patients of the ward and in public areas e.g., to imaging etc

**3.8 Recommendation For inpatients:**

Inpatients with suspected or confirmed COVID-19 should be provided with a facemask on admission and continue to wear this for the duration of their isolation.

This should be worn in multi-bedded bays and communal areas, e.g., waiting areas for diagnostics, if this can be tolerated and is deemed safe for the patient. They are not usually required in single rooms, unless, e.g., a visitor enters.

Patients with suspected or confirmed COVID-19 transferring to another care area should wear a facemask (if tolerated) to minimise the dispersal of respiratory secretions and reduce environmental contamination.

All other inpatients are not necessarily required to wear a facemask unless this is a personal preference. However, in settings where patients are at high risk of infection due to immunosuppression e.g., oncology/haematology, patients may be encouraged to wear a facemask following a local risk assessment.

All other patients can wear facemask if they wish to do so. These will continue to be provided

The requirement for patients to wear a facemask must never compromise their clinical care, such as when oxygen therapy is required or where it causes distress, e.g., paediatric/mental health settings.

The Trust recommends that staff review patients with immunosuppression to include those patients who are on high dose steroids and rheumatology patients including clinically vulnerable patients. E.g., those patients who would qualify for COVID-19 medication. These patients should be encouraged to wear a face mask.

**3.9 Patients visiting Outpatients:**

Patients with respiratory symptoms who are required to attend for emergency treatment should wear a facemask/covering, if tolerated, or offered one on arrival.

All patients attending for lung function tests, Respiratory clinic and SDEC with respiratory symptoms will wear a facemask.

All other patients are not required to wear a facemask unless this is a personal preference.

**3.10 Community Settings**

Staff will need to risk assess their patients for any respiratory illness and continue to wear face mask for those deemed to be at high risk of infection due to immunosuppression e.g., oncology and haematology patients

**3.11 Offices and non-clinical areas**

Staff in offices and non clinical areas will not be required to wear face masks but may need to don face masks when moving to clinical areas.

Staff will need to observe signage on the ward or speak to the person in charge before entering the clinical area.

**3.12 Visitors:**

Visitors to ward areas are not required to wear face masks

In inpatient settings where patients are at high risk of infection due to immunosuppression, e.g., oncology/haematology, ED, and SDEC and areas listed above, visitors will be required to wear a facemask.

During outbreaks of infection, visitors will be required to wear facemasks. These should be provided on entry to the clinical area.

If visitors refuse to wear a facemask then a local risk assessment will be required, and this must be documented in the notes of the patient they are visiting.

The Trust proposes to return to open visiting on 20th June 2022 from 11am to 8pm with a maximum of 2 visitors per patient.

The visitor booking system will be ceased but advice will be given to visitors who will still need to vigilant for symptoms of COVID-19

**4 Definitions/aBBREVIATIONS**

AGP – Aerosol generating procededures

**5 REFERENCES:**

Classification: Official

Publication Approval reference C1657

**Standard Operating Procedure Consultation Form**

**(This page to be deleted from the document prior to adding to HUB Trust Central document page)**

Please ensure that you receive either a confirmation or comments from a stakeholder (via an email) before you add their details to the consultation section on the procedural document

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| **What is the title of the procedural document:** | | | | | | | |
| **Standard Operating Procedure - for wearing of type IIR fluid resistant surgical face masks** | | | | | | | |
| **Date of Submission:** | **20.06.2022** | | | **Author** | **Liz Watkins** | | |
| **Is there a similar/same document already in existence / if so will this document replace this one or is it in addition?** | | | | | | | |
| New document | | | | | | | |
| **In addition to the central HUB page for procedural documents will it need to be linked to any other pages? Please list below** | | | | | | | |
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| **Please detail below which speciality on the procedural documents page you would like the guideline to be stored under.** | | | | | | | |
| **Guidance, IPC page** | | | | | | | |
| **Consultation: Please list the stakeholders who have been consulted in the development of this document and the date they confirmed agreement of its content. This is any member of staff/groups who will be part of or affected by this. If this was a group please list attendees:** | | | | | | | |
| **Name** | | | **Designation** | | | | **Date Confirmed Agreement** |
| **SPECIALISTS / GROUP/S** | | | | | | | |
| Mary Sexton | | |  | | | | 20/06/2022 |
| IPCG Meeting | | |  | | | | 30/7/22 |
| **DIVISIONAL MANAGEMENT CONSULTATION** | | | | | | | |
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| **CLINICAL GUIDELINES GROUP**  **(all clinical guidelines and SOPs involving doctors MUST go through this group prior to ratification**) | | | | | | | |
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| **PHARMACY CONSULTATION**  **(if medication referred to in guideline, pharmacy must be consulted)** | | | | | | | |
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| **OTHER** | | | | | | | |
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During the development or review of the Procedure, consideration must be given to the actual or potential impact on equality. Due care is given to ensure that they do not contravene the article of the Human Rights Act or could be interpreted as containing any matters of a discriminatory nature, including but not limited to age, disability, sex, race, religion or belief, gender reassignment, marriage, or civil partnership, pregnancy, or maternity.



**Check List**

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*Prior to submission of the Standard Operating Procedure please ensure you can answer yes or N/A to all of the questions below.*

|  |  |
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|  | **Yes/No** |
| 1. **Title** |  |
| Is the title clear and unambiguous? | Y |
| 1. **Front Sheet Completion** |  |
| Is the colour banding strip peach? | Y |
| Is the Author identified (name, designation, and Specialty)? | Y |
| Is it clear whether it is a local guideline or a Trust wide one? | Y |
| Is the Target Audience identified? | Y |
| Is the document version controlled? | Y |
| Is the name of the Group and date when recommended for ratification documented? | Y |
| Is the name of the division and Date of ratification documented? | Y |
| Have the people contributing to the document been identified on the Front cover Sheet as per designation and not individual names? | Y |
| Has the change history been fully completed? | Y |
| 1. **Body of the document** |  |
| Has the contents page been fully completed, and the numbering reflects the document content pages? | Y |
| Is there a footer on each page recording; document title, date of issue, version number, page number and total number of pages in font Arial 10pt? | Y |
| Is the document written in Arial 12pt font? | Y |
| Does the document contain individual designations and NOT names? | Y |
| Does the numbering run in sequence? | Y |
| Does the document follow trust format of; Introduction, Statement of Intent/Purpose, Definitions, Process, Training/Support, Equality and References for the main body? | Y |
| The meaning for any definitions or abbreviations used is clearly stated? | Y |
| Is there identified training or support which includes the process for follow up of non-compliance clearly cited? | Y |
| Are procedural documents relating/supporting this document hyperlinked? | Y |
| Are references cited in full and comply with the Harvard referencing? | Y |
| Does the document require changes to clinical documentation? | Y |
| If yes, has the digital Trust Clinical Approvals Group been informed? | Y |
| 1. **Consultation** |  |
| Is the consultation form completed? | Y |
| If the document includes prescribing or administering of medicines, has pharmacy been consulted? | N/A |
| If it relates to medical Practice, has the Clinical Guidelines Group been consulted? | Y |

**Appendix 1**

**Standard Operating Procedure**

**Equipment (if applicable)**

*Record any equipment required for the procedure in the chart below*

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| **STANDARD OPERATING PROCEDURE DETAIL** | | |
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