

ANNOUNCEMENT:

Joint Commission Statement on Use of Face Masks Brought From Home



The Joint Commission supports allowing staff to bring their own standard face masks or respirators to wear at work when their health care organizations cannot routinely provide access to protective equipment that is commensurate with the risk to which they are exposed. In taking this position, The Joint Commission recognizes:

1. Hospitals must conserve personal protective equipment (PPE) when these items are in short supply to protect staff who perform high-risk procedures.
2. The degree to which privately-owned masks and respirators will increase the protection of health care workers is uncertain, but the balance of evidence suggests that it is positive.
3. No Joint Commission standards or other requirements prohibit staff from using PPE brought from home.
4. Homemade masks are an extreme measure and should be used only when standard PPE of proven protective value is unavailable.

The evidence assessment and policy analysis that is the foundation of this statement may be found on page 2 of this document.

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Health Care Organizations:

Please contact your Account Executive with any questions.

Position Statement: Staff Use of Their Own Personal Protective Equipment in Health Care Settings

Supplies of personal protective equipment (PPE) to protect health care workers from COVID-19 remain inadequate. The Joint Commission, in partnership with five other national organizations, has [called for action](#) at the federal level to address these shortages. We must protect those who are working so heroically to care for people afflicted with COVID-19.

To mitigate these shortages and to address concerns that current recommendations from the U.S. Centers for Disease Prevention and Control (CDC) are inadequate to protect themselves from COVID-19, health care workers are [bringing their own PPE](#) to provide additional protection. Based on reports we are hearing from around the country, health care workers have two main concerns.

Wearing N95 Respirators Instead of Surgical Masks

The CDC [originally recommended](#) that staff should wear N95 respirators instead of surgical masks when caring for patients with COVID-19 or those suspected of having COVID-19. The CDC later [changed their recommendation](#) to use of surgical masks during care that did not generate aerosols (e.g., bronchoscopy, intubation). Although this may have been precipitated by the emergence of PPE shortages, the CDC also justified this based on emerging evidence on the mode of transmission of the SARS CoV2 virus that causes COVID-19:

Early reports suggest person-to-person transmission most commonly happens during close exposure to a person infected with COVID-19, primarily via respiratory droplets produced when the infected person coughs or sneezes. Droplets can land in the mouths, noses, or eyes of people who are nearby or possibly be inhaled into the lungs of those within close proximity. The contribution of small respirable particles, sometimes called aerosols or droplet nuclei, to close proximity transmission is currently uncertain. However, airborne transmission from person-to-person over long distances is unlikely.

However, a [study](#) published a week later reported that the SARS CoV2 virus remains viable (and potentially infectious) when aerosolized with a half-life of approximately one hour. The authors concluded:

Our results indicate that aerosol and fomite transmission of SARS-CoV-2 is plausible, since the virus can remain viable and infectious in aerosols for hours and on surfaces up to days (depending on the inoculum shed). These findings echo those with SARS-CoV-1, in which these forms of transmission were associated with nosocomial spread and super-spreading events.

In addition, [an experimental study](#) showed that standard masks only offer partial protection from aerosolized influenza virus. In light of these studies, it is understandable why health care workers who must come in close contact with COVID-

19 patients (e.g., during auscultation of the heart and chest) would have concerns about the adequacy of surgical masks.

Universal Precautions: Wearing Masks Routinely Throughout the Day

[A recent study](#) provided strong evidence that there is significant risk of transmission of SARS-CoV-2 among asymptomatic or minimally symptomatic patients. Based on this, it is reasonable for health care workers who provide direct patient care to want to take universal precautions by wearing a surgical mask or even an N95 respirator with all patients. Another factor that should be considered is the risk that health care workers may have asymptomatic COVID-19 and could transmit the disease to both patients and other health care workers. Of Spain's 40,000 confirmed coronavirus cases as of March 24, 2020, [approximately 14 percent were medical professionals](#).

Based on this information, it is reasonable for staff to want to wear a mask throughout the day. The value of wearing a mask throughout the day will depend upon the number of COVID-19 patients in the hospital and the community. However, for staff who are at higher risk because of their age, underlying health conditions, or caretaking obligations for high-risk family member, even a small risk of contracting COVID-19 from an asymptomatic patient may make them want to err on the side of caution. Staff in emergency departments are at particularly high risk because of the high number of patients they see who may be asymptomatic carriers of the virus and the fact that they may have to emergently intubate patients and would be at significant risk without a respirator to protect against aerosolized virus. We are aware of a number of hospitals who have gone a step farther and are actually requiring staff to wear masks throughout the day to prevent nosocomial spread from patients to staff and between staff. In addition, staff should always remember that a mask is no substitute for frequent handwashing and social distancing to extent that this is possible.

Summary

The Joint Commission supports allowing staff to bring their own masks or respirators to wear at work when their health care organizations cannot provide them with adequate protection commensurate with the risk of infection to which they are exposed by the nature of their work. Allowing staff to wear masks (or respirators, depending on the degree of risk) throughout the day should help prevent nosocomial spread, although the evidence supporting this is incomplete. At the same time, we strongly support health care organizations' efforts to conserve PPE and to distribute scarce supplies according to CDC recommendations. Most importantly, hospitals must conserve N95 respirators as much as possible to protect staff who perform high risk procedures that aerosolize viral particles (e.g., bronchoscopy, intubation).

We are receiving reports from across the country that some hospitals are prohibiting staff from bringing in their own N95 respirators, surgical masks, and home-made cloth masks. Several justifications have been proposed for this position: it is against hospital policies; the safety of the equipment brought from home is uncertain; having staff wear masks when caring for patients without COVID-19 will scare patients while offering no

protection from COVID-19; and it would be divisive to have some staff wear private PPE when others do not have access to similar equipment. All these concerns have some validity, but they can all be mitigated. In circumstances of PPE shortages, it is better to allow staff the opportunity to enhance their protection, even if the degree of that increased protection is uncertain. That increased protection may offer peace of mind sufficient for staff to attend fully to caring for the patients that so desperately need their help.

The Joint Commission also emphasizes that none of our standards prohibit staff from bringing in their own PPE or wearing PPE throughout the day. Nor do we know of any other organization that recommends against this. The [CDC states](#) that when organizations have reached “crisis capacity,” they may need to rely on “strategies that are not commensurate with U.S. standards of care:”

In settings where facemasks are not available, health care personnel (HCP) might use homemade masks (e.g., bandana, scarf) for care of patients with COVID-19 as a last resort. However, homemade masks are not considered PPE, since their capability to protect HCP is unknown. Caution should be exercised when considering this option.

Clearly, homemade masks are an extreme measure and should be used only when standard PPE of proven protective value is unavailable. The use of homemade masks underscores that we must redouble our efforts to ensure that all health care workers have the proper PPE they need. Scientific studies of SARS-CoV-2 virus transmission and optimal PPE are ongoing, and we will update this statement as further evidence emerges.

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Frequently Asked Questions in Response to The Joint Commission's Position Statement on Use of Face Masks Brought from Home

Why did The Joint Commission feel it was necessary to develop this position statement?

The Joint Commission's Office of Quality and Patient Safety has received numerous complaints from health care workers about inadequate personal protective equipment (PPE). For example, staff have reported:

- Lack of N95 masks for performing aerosolizing procedures
- Having to wear a surgical mask for a prolonged period (up to a week)
- Not being allowed to wear a mask when exposed to a large number of patients who could have COVID-19 (i.e., concerns about caring for asymptomatic and minimally symptomatic when COVID-19 is prevalent)
- Working without routinely wearing masks even after an outbreak occurred among the medical staff from an infected physician

The American College of Emergency Physicians and the American College of Physicians also shared similar concerns voiced by their members. We also have received reports of hospitals citing nonexistent Joint Commission standards to prevent staff from bringing their own PPE to work in shortage situations.

Is The Joint Commission advocating for routine use of N95 masks?

No. Hospitals must conserve N95 respirators as much as possible to protect staff who perform high-risk procedures that aerosolize viral particles. However, there are reports of hospitals not having enough N95 masks for all procedures that aerosolize viral particles. Such procedures include bronchoscopy, endotracheal intubation, positive pressure ventilation (BiPAP and CPAP), nebulizer treatment, sputum induction, airway suction, high frequency oscillatory ventilation, chest physiotherapy, and bronchoscopy. If a hospital cannot provide N95 masks for staff performing these procedures or working in the immediate vicinity, staff should be allowed to bring in their own masks.

The statement says The Joint Commission supports allowing staff to bring their own masks or respirators to wear at work when their health care organizations cannot provide them with adequate protection commensurate with the risk of infection to which they are exposed by the nature of their work. What does this mean?

Hospitals should be allowed to restrict staff from bringing in their own PPE if what they want to bring in is not justified by the person's level of risk of exposure to the SARS-CoV-2 virus. An engineer working in the basement of a hospital or someone working in food services has very low risk of work-related exposure, and it would be appropriate to prohibit these individuals from wearing masks. It also would be appropriate for a hospital to prohibit the routine use of N95 masks for personnel working in an area with no exposure to aerosolized viral particles. In contrast, if a hospital cannot provide N95 masks for staff who perform aerosolizing procedures or who work in close proximity to where aerosolizing procedures are done (e.g., emergency endotracheal intubation or nebulizer treatments in emergency departments), then the hospital should allow staff to bring in an N95 mask instead of just wearing a standard mask.