

UNMH: Validation Tool: Elastomeric Masks

Employee _____ Dept. _____

Instructions: This validation tool must be completed in order for individual to access elastomeric masks.

Validation Key: O = Observed practice. S = Simulated demonstration. V = Verbalizes understanding.

Criteria	Competent		Verification Method
	Yes	No	
<ul style="list-style-type: none"> Locate clean masks and filters in SPD containers. Check out mask. 			V
<ul style="list-style-type: none"> Inspect mask Check to ensure filter is not soiled or damaged – if so, discard and obtain new filter Attach both filters with a quarter turn 			O, S
<ul style="list-style-type: none"> Appropriately don mask Appropriately conduct positive and negative pressure seal check 			O, S
<ul style="list-style-type: none"> Secure a surgical mask over the Respirator exhalation port 			O, S
<ul style="list-style-type: none"> Appropriately Doff mask Place respirator interior side down in designated bucket 			S
<ul style="list-style-type: none"> Don new gloves and surgical mask if transporting patient (to PACU etc...) 			S
<ul style="list-style-type: none"> Remove and dispose of surgical mask from EMR while wearing gloves. Perform hygiene of gloved hands. Clean exterior of mask with 1st wipe being careful not to wipe inside cartridge or saturate the filter material. 			S
<ul style="list-style-type: none"> If elastomeric has been doffed for the last time in the day....remove filters and continue wiping all outside surfaces of Filter. (If not, then keep filters on.) Place on clean chux 			S
<ul style="list-style-type: none"> With 2nd wipe, clean inside of mask and wipe down straps Place in level 2 container and take to SPD for additional cleaning/disinfection. 			S
<ul style="list-style-type: none"> Document mask checked back in Return filters to storage area 			V

I have completed these requirements and understand the information presented regarding Elastomeric donning, doffing and cleaning levels.

Employee signature _____ Date _____

Batcave/Unit Based Educator/Unit Director/Supervisor

Printed Name: _____ Date _____

Signature: _____

Plan: This section to be completed only if an improvement plan is needed.

Needs additional supervised experience Y/N

Limit scope of practice Y/N

Needs further review Y/N

Initiate disciplinary action Y/N