RCSLT guidance on personal protective equipment (PPE) and COVID-19

1 May 2020

CONTEXT

The RCSLT is aware that this is a time of unprecedented challenge for the NHS and is working hard to ensure that it keeps abreast of the changing environment and requests for support and guidance from the speech and language therapy profession.

The RCSLT has been working closely with government leads to help inform this guidance. It is our understanding that all government guidance which is referenced in this paper is UK-wide. Members are encouraged to keep up-to-date with the latest government advice, which can be found here.

A coronavirus is a common type of virus: COVID-19 is a new strain of coronavirus first identified in Wuhan City, China.

On 31 December 2019, Chinese authorities notified the World Health Organization (WHO) of an outbreak of suspected pneumonia, which was later classified as a new disease: COVID-19.

On 30 January 2020, WHO declared the outbreak of COVID-19 a 'Public Health Emergency of International Concern' (PHEIC).

On 11 March 2020, COVID-19 was categorised a pandemic.

The incubation period of COVID-19 is reported to be between two-to-14 days. This means that if a person remains well 14 days after contact with someone with confirmed coronavirus, they are *unlikely* to have been infected. However, it is important to note

that an individual can be asymptomatic and a carrier of the virus and therefore be able to contaminate others.

Based on current knowledge, the main symptoms of COVID-19 are a cough, a fever and, in severe cases, shortness of breath and pneumonia. Other symptoms members are identifying include anosmia (loss of smell), ageusia (loss of taste) and gastrointestinal problems, e.g. diarrhea and vomiting. Please see the ENT UK website for further guidance.

As it is a new virus, the lack of immunity in the population (and, as yet, the absence of an effective vaccine) means that COVID-19 has the potential to spread extensively. The current data seem to show that we are all susceptible to catching this disease, which includes the general public, patients and healthcare staff. Data from Wuhan City, China, suggests that individuals shed the virus for an average duration of 20 days after symptom onset and the RCSLT is aware that data may change this position.

The purpose of this guidance is to support RCSLT members to make informed decisions about safe ways of working when undertaking procedures which may require personal protective equipment (PPE) during the COVID-19 pandemic.

1. RCSLT, NATIONAL AND LOCAL GUIDANCE

We understand that there is confusion locally as to which guidance should be followed. We would like to reassure SLTs of the support we have nationally from other professional associations for SLTs to refer to RCSLT specific guidance. This is essential in light of the current government definition of aerosol generated procedures (AGPs) as discussed below.

Please note: Social distancing and minimal contact with others in line with government guidance must also be observed within the healthcare context, wherever possible, in order to reduce virus transmission. The RCSLT therefore advises that prior to considering PPE, SLTs carefully weigh the risk-benefit of face-to-face assessments and consultations. Such contact should only be undertaken for urgent care where no alternative is possible, or the alternative places the patient at higher risk of a new serious adverse event (see also sections on caseload prioritisation and new ways of working, including telehealth).

In addition to following RCSLT guidance, we acknowledge that SLTs will need to consider local Trust policies and remain up-to-date with government guidelines.

The RCSLT guidance on PPE is being updated on a regular basis in line with the evolving situation.

The Health and Care Professions Council (HCPC) continues to update its guidance as well. You can find the latest information from the HCPC here.

All other RCSLT information about COVID-19 can be found here. RCSLT members are invited to share examples of resources that are being developed locally to implement this guidance.

At the end of this guidance there is a list of useful resources, which can also be found on the RCSLT website.

This RCSLT guidance is being updated regularly to reflect the current situation. If you have any feedback, please contact info@rcslt.org.

2. RISK ASSESSMENT, CLINICAL JUDGEMENT AND NEW WAYS OF WORKING

The uncertain times that COVID-19 has brought have resulted in the need for new ways of working for SLTs.

The RCSLT recommends the following for SLTs:

a) Ensure risk assessments and redeployment opportunities are in place for pregnant staff and those with any underlying health conditions, in line with government guidelines, the Royal College of Obstetricians and Gynaecologists and local Trust policies.
b) Use your expertise and clinical judgement.
c) Have daily huddles with colleagues (regardless of setting) – this can be in person or remote; platforms include (check with local IT colleagues) Zoom, Microsoft Teams.
    - Key areas of focus may include, but are not limited to: changes to service, staff allocation, skill mix, activity plans and cohorting arrangements for 'clean' vs COVID-19 wards.
d) Receive training and/or support to ensure you are still able to practice safely and effectively if your employer asks you to move into a new area or role. The HCPC has guidance on this.
e) Use your professional judgement to assess what is safe and effective practice in the context in which you are working during the pandemic.
f) Engage and link in with others across the profession and multidisciplinary teams.
g) Consider using clinical incident reporting systems, e.g. Datix, to raise concerns about unsafe levels of PPE availability.

h) The RCSLT would also encourage members to link together via RCSLT networks, e.g. Clinical Excellence Networks (CENs).
i) Set up a buddy system.
j) Ensure that everyone is looking out for each other. This may be for personal support, co-working or supervision. It is important for services to be aware that some SLTs are working in small units so it is essential to use networks to reach out to staff across the system, e.g. daily catch ups.

The RCSLT is aware that there may be a requirement to cohort SLTs to fewer locations to reduce the spread of staff across a large number of wards in hospitals and other locations.

SLTs should work to avoid moving across multiple sites in a day.

All SLTs should follow procedures for the safe management of linen, including uniforms. Where uniform is not worn and 'scrubs' unavailable, SLTs should change clothes and shoes on arrival into and before leaving work. Clothes should be taken home and washed immediately. Shoes worn for clinical work should remain at work. See section 3.3 below, as well as the government's guidance on Reducing the risk of transmission of COVID-19 in the hospital setting.

For SLTs working to support patients with communication needs, the RCSLT recommends referring to sections 2.1 and 2.2 in this guidance. The RCSLT also recommends that SLTs refer to government guidance on social distancing if risk assessment identifies that face-to-face contact is essential and where appropriate PPE is provided. Please refer to the following tables on the government's webpages on COVID-19: infection prevention and control:

- Table 1: Recommended PPE for healthcare workers by secondary care clinical context
- Table 2: Recommended PPE for primary, outpatient, and community care
- Table 4: Additional considerations for COVID-19

It is also important that there is a back-up plan for staff re-deployment to other areas in case of the need for staff to self-isolate or where staff are re-deployed.

If staff are being re-deployed to perform other tasks it would be appropriate to consider those SLT tasks which could be carried out by another healthcare professional under speech and language therapy guidance. This is in line with HCPC guidance.

The RCSLT has developed and is constantly updating FAQs, guidance and training resources, which can be found here. There are also valuable specialty specific resources being shared through CENs through Basecamp.

2.1 Telehealth

Telehealth is the remote provision of healthcare services using technology. In some Trusts, preparations are being made to offer video consultations, using an NHS England approved web-based service, where possible.

This is being tested and piloted within some NHS Trusts and the RCSLT will be asking members to share examples so that other services can also develop new approaches.

Please see the RCSLT's guidance for telehealth.

2.2 Prioritisation of caseloads

The RCSLT recommends that, prior to face-to-face contact, SLTs confirm

a) an individual's current COVID-19 status

b) the PPE requirements

c) the urgency of any assessment or intervention at each planned contact.

In light of this extraordinary situation, it may be necessary to use a risk assessment/red, amber, green (RAG) rating to prioritise the caseload.

RCSLT supports the need for local discussion on what is truly urgent patient need for any face-to-face contact.

Ideally, this should be done in partnership with colleagues in your multidisciplinary team, taking account of local policies and procedures, particularly related to infection control. This may change the priorities of the overall caseload and the timing of interventions on an individual case-by-case basis.

3. PERSONAL PROTECTIVE EQUIPMENT (PPE)

The RCSLT's primary goal is to keep you, our members, safe.

We recognise that, as we learn more about the virus, advice may change. It is therefore important that an SLT representative in your service is engaged on a daily basis with local health and safety teams. These may include infection prevention and control and internal COVID-19 communication teams, to ensure that the role of speech and language therapy is understood and supported. It is critical that any SLT representative liaises with the whole speech and language therapy service to agree issues to be raised and that responses are communicated to the team.

The RCSLT has been in contact with NHS England about the COVID-19 pandemic guidance and has raised concerns that the aerosol generated procedures (AGPs) listed **do not include all those procedures that the RCSLT considers as being AGPs (see section below on AGPs and Appendix 1)**.

The RCSLT, along with other AHP professional associations, recently provided a list of procedures and elements of care along with the evidence for why these should be included into government guidance on PPE.

The RCSLT remains extremely concerned that the procedures listed in this guidance, particularly dysphagia assessments, are not listed as AGPs in the government guidance.

The RCSLT has written a letter to the Secretary of State for Health and we are following up with government leads on this.

We are also aware that it states in the new guidance that *AGPs are undergoing a further review at present* (see point 2 in Table 2: Recommended PPE for primary, outpatient and community care by setting, NHS and independent sector).

As the RCSLT considers that dysphagia assessments, along with other procedures listed below, are AGPs, we recommend our members should refer to RCSLT guidance alongside government guidance, particularly as section 7 of the new government guidance on PPE (2 April 2020) states:

"Ultimately, where staff consider there is a risk to themselves or the individuals they are caring for they should wear a fluid repellent surgical mask with or without eye protection, as determined by the individual staff member for the episode of care or single session."

For example, the RCSLT considers a swallow assessment an AGP as it elicits a cough, which causes sputum to become airborne and thus capable of entering through the mouth, nose and eyes.

Government guidance on Transmission characteristics and principles of infection prevention and control highlights that all secretions (except sweat) and excretions should be regarded as potentially infectious in patients with known or suspected COVID-19, as research has shown the presence of live COVID-19 in the stools and conjunctival secretions of confirmed cases. Please see section 4 for more detail**.**

3.1 Issues for consideration

The RCSLT recommends that prior to face-to-face contact, SLTs confirm the

a) individual's current COVID-19 status;

b) PPE requirements;

c) urgency of any assessment or intervention at each planned contact.

This will ensure that the use of PPE will not be diverted from areas of greatest need.

Whilst the RCSLT recognises that PPE is in short supply, this guidance is provided to meet appropriate infection control measures and protect patients and healthcare professionals.

We are aware of the risks of SLTs transmitting the virus to vulnerable patients when undertaking the procedures outlined in this guidance.

Given the shortage of PPE, it is critical that SLTs work with their MDT colleagues to consider if there are any tasks that can be undertaken by another colleague who has access to appropriate PPE (please see section 2 above).

The RCSLT recognises that the status of any patient and the way the virus is spreading may change. As a result, this guidance is being reviewed on a weekly basis to take on board feedback and any changes to circumstances.

When undertaking dysphagia assessments this should include risk assessment for other carers involved in supporting eating and drinking. This should inform their PPE requirements. Please see sections 3.1, 3.2, 3.3 and 3.5 below for more information.

The RCSLT further recognises that for some individuals, the appearance of others in PPE may be distressing. These groups may include individuals with a learning disability, individuals with dementia, or individuals with other conditions that make it difficult for them to understand the need for PPE. SLTs should assess the urgency of any contact with individuals for whom the use of PPE would be distressing, whether these contacts could be postponed, or delivered in a different way.

To humanise the staff wearing PPE, it could be helpful to place e.g. photographs of who is wearing the PPE or writing their name and roles on the apron.

SLTs may be instrumental in developing accessible resources to help individuals understand the reasons why people are wearing PPE.

3.2 Government guidance on PPE and risk assessment for PPE

The government has significantly strengthened its advice on PPE, please refer to the tables below which are found on the government's webpages on COVID-19: infection prevention and control:

- Table 1: Recommended PPE for healthcare workers by secondary care clinical context
- Table 2: Recommended PPE for primary, outpatient, and community care
- Table 4: Additional considerations for COVID-19

This includes PPE for patients who are in the extremely vulnerable group undergoing shielding.

Please note that there is a difference between a surgical mask and a fluid–resistant mask (FRSM) and so it is essential that SLTs ensure that they have the correct mask. This would normally be an FRSM for non-AGP procedures and an FFP3 for AGP procedures (see section 10 of the government guidance on PPE).

In addition, in **note 4** in Table 4: Additional considerations for COVID-19 the government states that:

"Risk assess refers to utilising PPE when there is an anticipated/likely risk of contamination with splashes, droplets of blood or body fluids. Where staff consider there is a risk to themselves or the individuals they are caring for they should wear a fluid repellent surgical mask with or without eye protection as determined by the individual staff member for the care episode/single session."

The government also states in **note 3** in Table 4: Additional considerations for COVID-19 that:

"Single use refers to disposal of PPE or decontamination of reusable items e.g. eye protection or respirator, after each patient and/or following completion of a procedure, task, or session; dispose or decontaminate reusable items after each patient contact as per Standard Infection Control Precautions (SICPs)."

The government guidance (section 7) follows on to say:

"Risk assessment at organisational level requires that organisations consider healthcare-associated COVID-19 risk at local level and according to the local context. Organisational risk assessment and local guidance should not replace or reduce the ability of the health and social care worker to use appropriate PPE while providing care to patients or residents.

Local acute provider risk assessment may assist in determining higher risk areas and identify specific areas of a hospital where sessional use of PPE is required (for example, certain wards, clinical areas)."

3.3 PPE for seeing patients who are NOT currently a possible or confirmed COVID-19 case

This includes patients who may have been positive COVID-19, are in recovery and have been tested as negative. However, SLTs are asked to be aware that we still do not have enough evidence about ongoing risks for this cohort.

- For all AGP procedures undertaken **in any setting**, listed in Appendix 1, in section 4 below and in line with the latest government guidance (see Tables 1, 2 and 4), **the RCSLT recommends the following PPE: FFP3 respirator, long sleeved disposable gown, gloves and disposable eye protection (full PPE).**

- For non-AGP procedures and direct patient care within 2 metres e.g. communication assessment and interventions, and in line with government guidance **(see Table 4: Additional considerations for COVID-19), the RCSLT recommends the following PPE: FRSM, disposable gloves, disposable apron and risk assessment for eye protection.**

However, **please see sections 4, 5 and 6 below** for advice on specific procedures.

3.4 PPE for possible or confirmed COVID-19 patients

- For all AGP as listed in Appendix 1 and in section 4 below and in line with the latest government guidance (see Tables 1, 2 and 4), **the RCSLT recommends**

full PPE: FFP3 respirator, long sleeved disposable gown, gloves and disposable eye protection.

- For non-AGP procedures and direct patient care within 2 metres e.g. communication assessment and interventions, **SLTs are asked to refer to government guidance on PPE recommendations in Tables 1, 2 and 4.**

However, please see sections 4, 5 and 6 below for advice on specific procedures.

3.5 Fit testing and fit checking PPE

It is vital that SLTs get **fit tested** for face masks such as FFP3. Whilst the fit testing procedure is the same regardless of the mask being fitted, the pass/fail result is specific to the mask type the person is fitted with.

There are now a variety of masks coming in to NHS Trusts. A fit test pass on one mask type does not guarantee a pass on a different mask type due to the different designs and shapes of mask types. The exception here is the Cardinal Health/Medline masks which are interchangeable.

If the model of FFP3 mask that has been fit tested should change or is not avalailable, a repeat fit test on a different mask is required before use.

Once an SLT has been fit tested on a particular mask type or types, a **fit check** should be performed every time the mask is used at the point of care.

3.6 Donning and doffing of PPE and disposal

If working in COVID-19 positive areas, training and team support is necessary. All staff having clinical contact with patients should be fit-tested if necessary for appropriate PPE in line with government guidance.

In addition, clinicians must be aware of and trained in the procedures for **donning and doffing** PPE in such a way as to safely mitigate the risk of contamination, and they should be familiar with decontamination and safe waste disposal procedures. Ideally these procedures should be performed in a negative pressure room with air changes as recommended by infection control regulations and detailed by local Trust and national policy. The government has information on:

- Donning and doffing for AGPs

- Donning and doffing for non-AGPs

In areas that have been assessed as high risk, it is appropriate to ensure the use of a buddy **to support the donning and doffing of PPE.**

In addition, SLTs need to be aware of local COVID-19 patient cohorting arrangements.

The government's guidance on Reducing the risk of transmission of COVID-19 in the hospital setting highlights that advice from the local waste management team should be sought prospectively on how to manage disposal of PPE. This applies to both acute and community settings.

3.7 Transmission-based precautions for PPE

The government has published summaries outlining PPE recommendations for health and social care workers working in different settings. Please see the government's guidance on PPE (section 5).

4. GOVERNMENT (UK) AND RCSLT GUIDANCE ON AEROSOL GENERATING PROCEDURES (AGPs) AND HIGH-RISK PROCEDURES AND ELEMENTS OF CARE UNDERTAKEN BY SLTs

An aerosol generating procedure (AGP) is a procedure which results in the release of airborne particles. AGPs can create a risk of airborne transmissions of infections that are usually only spread by droplet transmission. It is of note that infection can be by infected droplet contact with mucous membranes (i.e. by breathing in through mouth or nose, by droplets into the eyes, or by droplets picked up on the hands being transferred to mouth, nose or eyes by touching the face).

The transmission of COVID-19 is thought to occur mainly through respiratory droplets generated by coughing and sneezing, and through contact with contaminated surfaces. During AGPs there is an increased risk of aerosol spread of infectious agents irrespective of the mode of transmission (contact, droplet, or airborne), and airborne precautions **must** be implemented when performing AGPs, including those carried out on a suspected or confirmed case of COVID-19 in line with the government's guidance.

The RCSLT strongly advises SLTs to read the government guidance on COVID-19: personal protective equipment (PPE) (section 8), which outlines the full list of AGPs. The relevant section can also be found in Appendix 1 of this document.

While not all procedures that are undertaken by SLTs are listed in the government guidance as AGPs, the RCSLT has worked with members to identify a range of procedures and elements of care which the RCSLT considers to be AGPs and therefore require assessment for appropriate PPE.

The rationale for this is that the clinical evaluation of swallowing, videofluoroscopic swallowing studies, tracheostomy and laryngectomy care, and cough reflex testing all **result in the induction of sputum**. Sputum is identified in the government guidance (section 8.1) as a high risk secretion which can carry the virus. The other procedures listed below are also considered high risk, either due to the patient having excessive and/or pulmonary secretion or inducing the patient to cough due to e.g. severe respiratory infection.

These procedures and elements of care include (please note that this is not an exhaustive list):

a) Clinical evaluation of swallowing (dysphagia assessments which may include delivery of mouth care)

b) Videofluoroscopic swallow study (VFSS)

c) Cough reflex testing

d) SLT-led laryngectomy care and management, including:

    i. surgical voice restoration (SVR), including voice prosthesis changes, checking voice prosthesis leakage, cleaning voice prosthesis (voice prosthesis changes; and open stoma inspection)

    ii. stoma care, including placement of tracheostomal baseplates, buttons or laryngectomy tubes

    iii. management of other aspects of laryngectomy care, including electrolarynx use or oesophageal speech due to risk of coughing

e) Tracheostomy care and management

    i. with or without mechanical ventilation

    ii. suctioning procedures

f) Respiratory support via:

    i. nasal cannulae

ii. face mask

iii. non-invasive ventilation (NIV)

iv. high flow nasal oxygen (HFNO). Please note that assessment of confirmed and suspected patients on HFNO **should be avoided where possible** due to the higher risk of transmission. This is in line with the government's specialty guide for the role and use of non-invasive respiratory support in adult patients with coronavirus (confirmed or suspected).

g) redeployment tasks, e.g. insertion of nasogastric tubes (NGTs). This is in line with the Royal College of Surgeon's guidance on NGTs and PPE. Please visit the RCSLT's website for a protocol on NGT insertion procedure.

It is essential for SLTs to note the recent guidance from the British Laryngological Association (BLA) which states that all therapist-led endoscopy should cease and the RCSLT would support this position. However, given that the situation is continuing to evolve and SLTs may be re-deployed to new roles, this position on endoscopy will continued to be reviewed. We are aware that ENT UK have successfully lobbied PHE regarding PPE for performing 'all ENT-related procedures' and this RCSLT guidance will be amended regularly to reflect the change to national guidance and *any* practice implications for SLTs.

We are aware that the role of the SLT in the care of COVID-19 survivors is still evolving and this guidance will be updated to reflect changing caseloads, clinical priorities, roles and ways of working.

ENT UK also has useful information that SLTs will need to refer to, which can be found here.

It is important to note that ENT UK has released an additional update (25/03/2020) regarding wearing FFP3 for the duration of a clinic and/or ward round to carry out exams.

5. ACUTE SETTINGS

Speech and language therapy plays a vital role in acute and critical care, and SLTs may therefore encounter individuals with and without COVID-19 in these settings.

The RCSLT is aware that there may be a requirement to cohort SLTs to fewer locations to reduce the spread of staff across a large number of wards in the hospital and other locations.

NHS England has published a clinical guideline for the management of critical care patients during the coronavirus pandemic which can be found here. The Intensive Care Society (ICS) has also published guidance for those working in acute and critical care, which can be found here. The British Thoracic Society and the Royal College of Physicians has produced collaborative guidance for everyone working on a ward with suspected or proven COVID-19 cases, and particularly for multi-professional teams, which can be found here. A quick reference guide ward poster to support this can be found here. In addition, the government has published a specialty guide for the role and use of non-invasive respiratory support in adult patients with confirmed or suspected coronavirus, which can be found here.

Speech and language therapy adds value in the rehabilitation phase, after the acute phase of COVID-19, alongside multi-professional colleagues. This includes assessment and management of individuals with conditions that are directly, or indirectly, related to COVID-19, the result of critical care interventions, respiratory disease or underlying or co-existing comorbidities.

As highlighted above, it is critical that an SLT representative is present at daily meetings to discuss health and safety, infection control and patient care.

It is imperative that SLTs are aware of the COVID-19 status of the patient prior to seeing them. **The RCSLT recommends that a risk assessment of the necessity of assessment and patient location is carried out, following local Trust policy and medical team advice.**

5.1 Clinical evaluation of swallowing (dysphagia assessments which may include delivery of mouth care)

The RCSLT recommends the following:

- Undertake risk assessments and prioritise the caseload for all individuals before undertaking clinical evaluation of swallowing.
- Look at new ways of working as highlighted in the section above.
- Encourage patients to self-feed where possible.

- Where face-to-face assessments cannot be avoided, SLTs should have access to appropriate PPE as outlined in the PPE section above.
- Use laryngeal palpation if essential and using appropriate PPE (see section on PPE above).

For the delivery of mouth care, please refer to the government's guidance on Mouthcare for patients with COVID-19 or suspected COVID-19.

5.2 Videofluoroscopic swallow study (VFSS)

Due to risk of transmission in moving the individual to the radiology suite, the RCSLT recommends the following:

- Each VFSS should be risk assessed in line with the requirement to meet the needs of patients and local policies. Do not undertake VFSS with patients with confirmed COVID-19.
- Delay any procedures for unconfirmed cases who are awaiting test results.

5.3 Laryngectomy/surgical voice restoration (SVR) prosthesis changes

As neck breathers, laryngectomy patients may be at higher risk for developing COVID-19. During the current pandemic, when undertaking a voice prosthesis change or other communication assessment, SLTs must be equipped and wear full PPE in line with ENT recommendations, local Trust policies and government guidance. Full PPE should be worn regardless of whether the laryngectomy patient's COVID-19 status is positive, suspected or negative.

If appropriate PPE cannot be supplied to SLTs by local Trusts for laryngectomy patient care, SLTs must not undertake voice prosthesis changes or inspection of voice prosthesis/open stoma.

To avoid unnecessary hospital attendance and to reduce risks to clinicians and patients, it is recommended that speech and language therapy services instruct laryngectomy patients regarding home-management of voice prosthesis dislodgement using a tracheosesophageal puncture stent and leakage, using either plug insert devices for the appropriate voice prosthesis (which should be supplied to patients along with instructions for use), and/or the use of thickener powder with full instructions for use, along with information supplied to GPs regarding prescription. Laryngectomy patients

should be informed that they must contact their SLT service in the first instance and not attend unplanned.

For more information, please see ENT UK's website and the British Association of Head and Neck Oncologists' guidance on the reinsertion of TEP voice prostheses.

5.4 Tracheostomy

Tracheostomy procedures are officially identified as AGPs (see Appendix 1 below).

Full PPE is required for all tracheostomy interventions. Speech and language therapy input is essential to the tracheostomy MDT and the need for SLTs to assess patients with tracheostomies who are possible or confirmed COVID-19 cases should be discussed and agreed with the local MDT team on a case-by-case basis.

It is important for SLTs to work with medical, nursing and physiotherapy colleagues to identify where they can add value, e.g. performing suctioning, tracheostomy care.

Guidelines are published on the ENT UK website and will also be available from the BLA website. Please also refer to the National Tracheostomy Safety Project.

In these cases full PPE would be required with FFP3 mask. Please see the government's Table 1: Recommended PPE for healthcare workers by secondary care clinical context.

Access to patients who have longstanding tracheostomy will continue at the moment to reduce pressure in the system.

For more information, please see the Government's advice on infection prevention and control and the RCSLT's information on local influencing.

5.5 Head and neck cancer/oncology treatment

These patients are very productive of secretions whilst they are 'on-treatment' and immediately post treatment. Therefore full PPE would be required with FFP3 mask to carry out any swallowing interventions with this caseload. Given the circumstances it is each SLT's responsibility to effectively triage and enable indirect care where possible.

NB: many patients may have excessive oral and/or pulmonary secretions and appropriate PPE should be selected on a case-by-case basis.

5.6 Cervical auscultation

Cervical auscultation should not be used on confirmed COVID-19 positive cases, in line with practice by respiratory physicians.

This is due to the fact that COVID-19 can survive on surfaces for up to five days. Cervical auscultation carries a risk of transmission of the virus due to the proximity of the stethoscope to the SLT's face.

SLTs should carefully consider whether the benefits of the use of cervical auscultation with patients who are **not possible or confirmed COVID-19 cases** outweigh the risks of transmission.

6. COMMUNITY / OUTPATIENT SETTINGS

The RCSLT recognises that the majority of individuals in community and outpatient settings have not been tested for COVID-19.

It is recognised that a range of assessments or procedures that may require PPE will be needed for people referred to speech and language therapy in community and outpatient settings. **The RCSLT recommends that SLTs refer to sections 2, 3, 4 and 5 above to understand the rationale for different requirements for settings and procedures and to help inform decision making on PPE requirements in community and outpatient settings.**

It is critical that SLTs undertake a risk assessment of individuals and develop safe protocols to meet their needs and to help with prioritisation of caseloads. Assessments that may prevent hospital admission and expedite discharge from the intensive care unit (ICU) or hospital may be deemed a priority.

Where there is the potential for preventative measures to reduce hospital admission, and the risk of COVID-19 in the individual is low, it is recommended that these individuals are prioritised.

The RCSLT further recommends that:

a) Non-urgent appointments are reviewed/postponed.

b) Patients enquiring with concerns relating to COVID-19 are directed to appropriate national government guidelines.

c) Clinicians call ahead of seeing any urgent patients to:

   i. ask if they are self-isolating or have any symptoms of COVID-19

   ii. discuss with the individual whether or not they are happy to be seen given that most individuals may be in vulnerable/at risk groups; where an individual is not able to give informed consent, it is essential that local policies with respect to consent and best interest are followed

   Concerns about visiting an individual based on the above should be discussed with line managers and agreement made regarding the best course of action. For example, this may include safe swallowing advice being provided over the telephone in line with a local dysphagia telephone management standard operating procedure (SOP). This includes advice about safe positioning, pacing, extra 1:1 support, etc. It may also include additional dietary/fluid modification measures with close monitoring.

d) All visits that are going ahead are undertaken in line with government (UK-wide) guidance on infection control and with appropriate PPE as highlighted in the section on PPE above.

6.1 Community videofluoroscopic swallow study (VFSS)

In line with the guidance with respect to working in an acute setting, as the risk of transmission in moving the individual is too high, the RCSLT recommends the following:

- Each VFSS should be risk assessed in line with the requirement to meet the needs of patients and local policies.
- Do not undertake VFSS with patients with confirmed COVID-19.
- Delay any procedures for any unconfirmed cases for those who are awaiting test results in line with local policies.

6.2 Cervical auscultation

As stated in section 5.6 above, cervical auscultation should not be used on confirmed COVID-19 positive cases, in line with practice by respiratory physicians.

This is due to the fact that COVID-19 can survive on surfaces for up to five days. Cervical auscultation carries a risk of transmission of the virus due to the proximity of the stethoscope to the SLT's face.

SLTs should carefully consider whether the benefits of the use of cervical auscultation with patients who are **not possible or confirmed COVID-19 cases** outweigh the risks of transmission.

7. EXTERNAL SOURCES OF INFORMATION ON COVID-19

Wellbeing resources

- Intensive Care Society

Critical care

- Intensive Care Society

Paediatrics and neonatal care

- Royal college of Paediatrics and Child Health
- Paediatric Intensive Care Society

ENT conditions

- ENT UK
- British Association of Head & Neck Oncologists
- British Laryngological Association

Lung conditions

- British Lung Foundation
- British Thoracic Society

Residential care, supported living and home care guidance

- Government guidance

Dietetics

- British Association of Dietetics

Please see the RCSLT website for a more substantial list of resources.

APPENDIX 1: Government guidance on COVID-19 personal protective equipment (PPE), section on aerosol generated procedures

The text in this appendix has been extracted from Government guidance on COVID-19 personal protective equipment (PPE), updated on 10 April 2020. The latest version can be accessed here.

COVID-19 personal protective equipment (PPE)

8. PPE guidance by healthcare context

8.1 Aerosol Generating Procedures

The highest risk of transmission of respiratory viruses is during AGPs of the respiratory tract, and use of enhanced respiratory protective equipment is indicated for health and social care workers performing or assisting in such procedures. The evidence review will continue to be updated in light of emerging evidence for this new pathogen.

A long sleeved disposable fluid repellent gown (covering the arms and body), a filtering face piece class 3 (FFP3) respirator, a full-face shield or visor and gloves are recommended during AGPs on possible and confirmed cases, regardless of the clinical setting. Subject to local risk assessment, the same precautions apply for all patients regardless of case status in contexts of sustained COVID-19 transmission. Where an AGP is a single procedure, PPE is subject to single use with disposal after each patient contact or procedure as appropriate.

The following procedures are currently considered to be potentially infectious AGPs for COVID-19:

- intubation, extubation and related procedures, for example manual ventilation and open suctioning of the respiratory tract (including the upper respiratory tract)
- tracheotomy or tracheostomy procedures (insertion or open suctioning or removal)
- bronchoscopy and upper ENT airway procedures that involve suctioning
- upper gastro-intestinal endoscopy where there is open suctioning of the upper respiratory tract
- surgery and post mortem procedures involving high-speed devices
- some dental procedures (for example, high-speed drilling)
- non-invasive ventilation (NIV); Bi-level Positive Airway Pressure Ventilation (BiPAP) and Continuous Positive Airway Pressure Ventilation (CPAP)
- High Frequency Oscillatory Ventilation (HFOV)
- induction of sputum
- high flow nasal oxygen (HFNO)

For patients with possible or confirmed COVID-19, any of these potentially infectious AGPs should only be carried out when essential. Where possible, these procedures should be carried out in a single room with the doors shut. Only those healthcare staff who are needed to undertake the procedure should be present.

Certain other procedures or equipment may generate an aerosol from material other than patient secretions but are not considered to represent a significant infectious risk. Procedures in this category include administration of pressurised humidified oxygen, entonox or medication via nebulisation.

NERVTAG advised that during nebulisation, the aerosol derives from a non-patient source (the fluid in the nebuliser chamber) and does not carry patient-derived viral particles. If a particle in the aerosol coalesces with a contaminated mucous membrane, it will cease to be airborne and therefore will not be part of an aerosol. Staff should use appropriate hand hygiene when helping patients to remove nebulisers and oxygen masks.

Chest compressions and defibrillation (as part of resuscitation) are not considered AGPs; first responders (any setting) can commence chest compressions and defibrillation without the need for AGP PPE while awaiting the arrival of other clinicians to undertake airway manoeuvres.

APPENDIX 2: List of contributors

Please see below an alphabetical list of key RCSLT experts who have contributed.

We would particularly like to thank **Sarah Wallace, Justin Roe and Lee Bolton for their time and help with the drafting of this document.**

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