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

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

The incubation period of COVID-19 is reported to 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 up to 23 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 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.

The national AHP leadership team in England, led by Suzanne Rastrick, who works closely with other Chief Allied Health Professions Officers (CAHPOs) across the UK, has made clear that, whilst not all procedures undertaken by SLTs may be listed as AGPs in current government guidance, it is essential that SLTs follow RCSLT guidance on PPE.

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 weekly 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.

   o Key areas of focus may include, but are not limited to: changes to service, staff allocation, skill mix and activity plans.

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) The RCSLT would also encourage members to link together via RCSLT networks, e.g. Clinical Excellence Networks (CENs).

h) Set up a buddy system.

i) 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 minimise moving across multiple sites in a day. All SLTs should follow procedures for the safe management of linen (including uniforms) following direct care of COVID-19 positive individuals.

It is also important that there is a back-up plan for staff redeployment 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 an individual’s current COVID-19 status, the PPE requirements, and 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 has been informed that the areas that are listed as AGPs in the government guidance have been approved by all four UK nations as part of a joint pandemic response and based on scientific review. Like all guidance it will be reviewed alongside the evidence-base for this virus.

The RCSLT is actively engaging with the government (at a UK-wide level) for this guidance to be revised. We have asked for speech and language therapy procedures, including swallowing (dysphagia) assessments to be included as AGPs so that SLTs can have access to the appropriate PPE. As the RCSLT considers that dysphagia assessments, along with other procedures listed below, are AGPs, we have been informed by AHP leaders in government that SLTs should refer to RCSLT guidance.
In addition, in the forthcoming government guidance for primary care, which is currently being drafted (20/03/2020), the RCSLT has been informed that the following recommendations will be made:

“As we move from the containment phase, changes will be made to ensure that healthcare workers are protected and all hospitals remain safe, now and in the future. Therefore, different PPE and mask/respirator combinations are now being recommended for different clinical scenarios and settings; this includes consideration of the infection status (confirmed versus possible cases) and the risk of exposure to aerosols containing virus. This risk-based approach and the recommendations have been reviewed and approved by experts including NHS England and NHS Improvement, Public Health England, and the New and Emerging Respiratory Virus Threats Advisory Group (NERVTAG).”

The RCSLT recommends that, prior to face-to-face contact SLTs confirm the individual’s current COVID-19 status, the PPE requirements and the urgency of any assessment or intervention at each planned contact.

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

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 above on new ways of working.)

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.

3.1 PPE for non-suspected COVID-19, asymptomatic and COVID-19 tested negative patients

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 co-hort.
• Dysphagia assessments for non-suspected COVID-19, asymptomatic and COVID-19 tested negative patients not in an intensive care setting, the RCSLT recommends the following PPE: FRSM, gloves, visor, and apron.

• Dysphagia assessments for non-suspected COVID-19, asymptomatic and COVID-19 tested negative patients in a high-risk area where AGPs are being conducted, e.g. ICU, the RCSLT recommends the following PPE: FFP3 and full PPE.

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

3.2 PPE for COVID-19 suspected or confirmed positive patients

For COVID-19 suspected or confirmed positive patients, the RCSLT recommends FFP3 and full PPE. Please see government poster on PPE.

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 produced a poster and a video for how donning and doffing should be done safely.

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 table below is from the government's guidance on PPE and outlines transmission-based precautions for PPE for care of individuals during the COVID-19 pandemic in acute settings.

The list applies to all healthcare workers and support staff/volunteers in exactly the same way.
An aerosol generating procedure (AGP) is a procedure which stimulates coughing and 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: Guidance for infection prevention and control in healthcare settings (pp.27-28), 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.

These 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 (voice prosthesis changes; and open stoma inspection)
   ii. communication management/assessment with laryngectomy patients due to risk of coughing

e) Tracheostomy care and management
   i. with or without mechanical ventilation
   ii. suctioning procedures

f) Non-invasive ventilation (NIV) and high-flow nasal oxygen (HFNO)

g) Respiratory support via:
i. nasal cannulae

ii. face mask

iii. high flow nasal oxygen (HFNO)

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 may 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 in the next 7 days 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 (25/3/2020) re. 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](#).

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 prior to seeing any individual, SLTs check their COVID-19 status. 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).

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 mitigate risks to staff and patients, and to avoid hospital attendance for vulnerable people, or in the case that appropriate PPE cannot be supplied to SLTs, 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).

The need for SLTs to assess patients with tracheostomies who are COVID-19 positive or suspected should be discussed and agreed with the local MDT team on a case-by-case basis.

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.

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.
In these cases full PPE would be required with FFP3 mask. Please see the government poster on PPE.

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 COVID-19 positive or suspected 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.

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 polices.

6.2 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 COVID-19 positive or suspected 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
APPENDIX 1: COVID-19: Guidance for infection prevention and control in healthcare settings

The text in this appendix has been extracted from Government guidance for infection prevention and control in healthcare settings v1.0, published 13 March 2020 (pp.27-28). The latest version can be accessed here.

COVID-19: Guidance for infection prevention and control in healthcare settings

6.5 Aerosol-generating procedures (AGPs)

Aerosols generated by medical procedures are one route for the transmission of the COVID-19 virus. The following procedures are considered to be potentially infectious AGPs:

- Intubation, extubation and related procedures;
- Tracheotomy/tracheostomy procedures;
- Manual ventilation;
- Open suctioning;
- Bronchoscopy;
- Non-invasive ventilation (NIV) e.g. Bi-level Positive Airway Pressure (BiPAP) and Continuous Positive Airway Pressure ventilation (CPAP);
- Surgery and post-mortem procedures in which high-speed devices are used;
- High-frequency oscillating ventilation (HFOV);
- High-flow Nasal Oxygen (HFNO);
- Induction of sputum (see glossary);
- Some dental procedures (e.g. high speed drilling).

For patients with suspected/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. A disposable, fluid repellent [sic] surgical gown, gloves, eye protection and a FFP3 respirator should be worn by those undertaking the procedure and those in the room.

Certain other procedures/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;
- administration of medication via nebulisation.

Note: 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.