

# RCSLT guidance on reducing risk of transmission, use of personal protective equipment (PPE) in the context of COVID-19

Published: 12 June 2020

Updated: 26 June 2020

## Contents

<b>1. Context and background</b> .....	3
<b>2. COVID-19 and routes of transmission</b> .....	5
2.1 COVID-19 symptoms .....	5
2.2 COVID-19 transmission .....	5
2.3 Children and transmission of COVID-19 .....	6
<b>3. Practical and operational considerations</b> .....	7
<b>4. Reducing the risk of transmission of COVID-19</b> .....	9
4.1. New ways of working .....	9
4.1.1. Telehealth .....	10
4.1.2. Upskilling of others .....	10
4.2 Face-to-face contact .....	10
4.2.2 Cohorting or bubbles .....	10
4.3 Changing working practices .....	11
4.3.1 In-patient settings .....	11
4.3.2 Out-patient clinics .....	12
4.3.4 Community clinics .....	13
4.3.5 Home visits .....	14
4.3.6 Care homes, nursing homes and supported living accommodation .....	15
4.3.7 Education and early years settings .....	16

4.3.8 Justice settings .....	18
4.3.9 Undertaking AGPs .....	19
<b>5. Use of personal protective equipment (PPE) .....</b>	<b>19</b>
5.1 Risk assessment and consideration for PPE .....	20
5.2 Government guidance on PPE .....	21
5.3 Challenges when using PPE.....	22
<b>Annex 1: Risk assessment framework .....</b>	<b>23</b>
<b>Annex 2 - Fit testing and fit checking PPE.....</b>	<b>35</b>
<b>Annex 3 - Donning and doffing of PPE and disposal .....</b>	<b>36</b>
<b>Annex 4 - Decision making flowchart.....</b>	<b>37</b>
<b>Acknowledgements .....</b>	<b>38</b>

## 1. Context and background

The RCSLT is aware that this is a time of unprecedented challenge for all health, social care, education and other services 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.

Since the outbreak of the coronavirus pandemic, the RCSLT has worked with members to support the delivery of care in the context of government guidance and professional consensus on managing the risk of transmission of COVID-19.

With the initial outbreak of the pandemic a precautionary approach was adopted by the RCSLT and many of our medical colleagues. This included:

- a. Assuming the COVID-19 status of individuals as positive and our PPE guidance reflecting this
- b. Identifying and, where appropriate, avoiding procedures that are higher risk of viral exposure and/ or considered an AGP (even if not listed in the official government guidance)
- c. Focusing on acute care where a surge phase was experienced against a background of PPE supply chain issues

As our understanding continues to evolve with the emerging science, and in the context of the restoration of some services which were paused during the peak of the pandemic, this guidance has been updated and replaces the previous RCSLT personal protective equipment (PPE) guidance published on 1 May 2020.

The purpose of this guidance is to support **all** RCSLT members, **regardless of where they work or who they are employed by (e.g. public sector, charity sector or independent sector)** to make informed decisions about safe ways of working during the COVID-19 pandemic. The RCSLT recognises that as we learn more about the virus, local and national advice may change.

It is therefore important that, in addition to following RCSLT guidance, SLTs consider **their current working practices, employment context, local policies** and remain up-to-date with government and other relevant guidance signposted in this document, including those listed below:

- Health and Care Professions Council (HCPC): [regulation in light of COVID-19](#)
- UK-wide official guidance: [COVID-19: infection prevention and control](#)
- UK-wide official guidance: [COVID-19 personal protective equipment \(PPE\)](#)

- Health Protection Scotland: [Infection prevention and control \(IPC\) guidance in healthcare settings](#)

You can sign up to receive the latest Government updates [here](#).

Where the organisation you work for has a local infection prevention and control team, an SLT representative in your service should engage with the team.

For RCSLT members who have concerns with respect to assessing and treating specific individuals and do not have access to a local infection prevention and control team, including members working in the independent sector, information on who to contact locally for guidance and advice on health protection can be found below:

- England: [Find your local health protection team](#)
- Scotland: [Contact your local NHS board's public health department](#)
- Wales: [Contact your Health Protection Team](#)

The RCSLT is making enquiries about the relevant contacts for Northern Ireland and will provide information when it is available.

Key RCSLT guidance which should be read in conjunction with this guidance includes:

- [Restoring services and keeping everyone safe: framework to support decision-making](#)
- [COVID-19: Maximising the contribution of the speech and language therapy workforce](#)
- [COVID-19 speech and language therapy rehabilitation pathway](#)
- [Report on aerosol generated procedures, dysphagia assessment and COVID-19](#)

The RCSLT has developed and is constantly updating FAQs, guidance and training resources, which can be found [here](#). This includes examples of infection control and prevention policies and consent forms. These may be particularly useful for SLTs who may not otherwise have access to this information.

There are also valuable specialty specific resources being shared through CENs through Basecamp. RCSLT members are invited to share examples of resources that are being developed locally to implement this guidance.

In order to continue to support the profession, it is essential that all RCSLT members (including those working in independent practice) contact the RCSLT if there are any issues not covered by this guidance. There are a number of routes that members can

take; e.g. using the enquiries hotline and email address: **0207 378 3012** and **info@rcslt.org**.

**This RCSLT guidance is being updated regularly to reflect the current situation. Changes to this version has been highlighted in yellow for ease of reference. If you have any feedback, please contact [info@rcslt.org](mailto:info@rcslt.org).**

## 2. COVID-19 and routes of transmission

### 2.1 COVID-19 symptoms

Current NHS guidance recognises the main symptoms of COVID-19 as a new, continuous cough, a high temperature and a loss of, or change to, sense of smell (anosmia) or taste (ageusia). Other symptoms reported include shortness of breath, difficulty breathing, fatigue, muscle aches, headache, sore throat, congestion or running nose, nausea or gastrointestinal problems including diarrhoea and vomiting ([CDC, 2020](#)).

### 2.2 COVID-19 transmission

Based on the available evidence, transmission of COVID-19 is primarily through respiratory droplets and contact routes ([WHO, 2020](#); [PHE 2020](#)). Respiratory droplet emissions when coughing or sneezing are considered important routes of COVID-19 transmission ([WHO, 2020](#); [PHE 2020](#)).

This evidence, and other related COVID-19 transmission scientific evidence, was reviewed in the RCSLT report [Aerosol generating procedures, dysphagia assessment and COVID-19](#) (Bolton et al, 2020).

All secretions (except sweat) and excretions should be regarded as potentially infectious in individuals with known or suspected COVID-19 ([PHE, 2020](#)).

The incubation period of COVID-19 is typically between 5 and 6 days but may be up to 14 days ([WHO, 2020](#)). Thus, if a person remains well 14 days after contact with someone with confirmed coronavirus, they are unlikely to have been infected.

Symptomatic adult patients present a higher risk of transmitting the virus than those who do not develop symptoms ([WHO, 2020](#)). Those with severe COVID-19, such as those who are critically ill, have a significantly higher viral load and shed the virus for longer ([Liu et al, 2020](#), [Zhou et al, 2020](#), [WHO, 2020](#)). Transmission of COVID-19 however is not only related to viral load or shedding but will also reflect the amount of viable virus shed, droplets being expelled, contact with others and the infection control

procedures in operation. Public Health England highlight that most people will not be infectious until they experience symptoms ([PHE, 2020](#)).

Some individuals testing positive for COVID-19 are asymptomatic or have very mild symptoms. COVID-19 has been identified amongst pre-symptomatic and asymptomatic populations and this is likely to be a factor in the transmissibility of the virus ([Arons et al 2020](#)).

However, while there are some reports to date of asymptomatic transmission ([Chau et al 2020](#)) published reports of cases are low. Similarly, the World Health Organization has reported unpublished data from member states investigating asymptomatic transmissions which found that asymptomatic transmission was “less likely” ([WHO 2020](#)). Unpublished modeling data estimate the possible percentage of asymptomatic cases that may transmit COVID-19 to be 40% (range was unreported) (WHO Q&A).

Currently, the proportion of asymptomatic cases remains unclear with one systematic review meta-analysis indicating that 15% of cases were asymptomatic (95% CI 12-18%) while the proportion of cases was lower (8% (95% CI 3-18%) in aged-care settings. Study quality was poor however and more data is required to clarify these numbers ([WHO 2020](#)).

In [a recent report](#) the WHO indicated that: “Current evidence suggests that most transmission of COVID-19 is occurring from symptomatic people to others in close contact, when not wearing appropriate PPE.”

### **2.3 Children and transmission of COVID-19**

Children make up between 1 and 5% of confirmed cases ([Munro et al, 2020](#)). A systematic review has indicated that children and young people appear 56% less likely to contract COVID-19 from others who are infected ([Viner et al, 2020](#)).

Children generally present with mild symptoms or are asymptomatic, and critical illness appears very rare (~1%). However, the role of children in passing the disease to others is unknown, in particular given large numbers of asymptomatic cases. ([Munro et al, 2020](#)).

### **2.4 Testing for COVID-19**

There are two types of test for coronavirus:

- a) Swab tests, which test if a person currently has coronavirus.
- b) Antibody tests, which test if a person has had the virus in the past.

## Swab tests

All RCSLT members, including those working in independent practice, can ask for a swab test through the [NHS website](#) if having symptoms of coronavirus.

The NHS offers free swab tests to:

- anyone in England and Wales who has symptoms of coronavirus, whatever their age
- anyone in Scotland and Northern Ireland aged 5 and over who has symptoms of coronavirus

Groups defined as essential workers, or those that live with them, can access priority testing if they have symptoms.

Adult care homes can apply for testing kits to test the residents and staff, even if no-one has coronavirus symptoms.

## Antibody testing

The government is currently providing laboratory-based tests to NHS and care staff in England in the first phase of their antibody testing programme. The UK Government is buying tests on behalf of the devolved administrations, and each devolved nation is deciding how to use its test allocation.

It is important to note that there is no strong evidence yet to suggest that those who have had the virus develop long-lasting immunity which would prevent them from getting the virus again. Therefore, the value of antibody tests is currently limited to answering the question of whether someone has had the virus or not, and providing data and a greater understanding on the spread of the virus.

### 3. Practical and operational considerations

It is important that RCSLT members use their professional and clinical judgement to assess what is safe and effective practice for themselves, individuals and others, in the context in which they are working during the pandemic. The RCSLT recommends that the following are considered to support practice:

- a) **Safe management procedures.** Regardless of location of work, and where appropriate, all SLTs should follow procedures for safe management. This includes:
  - Ensure risk assessments and redeployment opportunities are in place for staff who are clinically vulnerable, or extremely clinical vulnerable, including staff who are pregnant or have any underlying health conditions, in line with

government guidelines, the [Royal College of Obstetricians and Gynaecologists](#) and local employer policies.

- Consideration of staff who are in groups with an increased risk of severe illness, including those who are older, male, or in black, Asian and minority ethnic (BAME) groups. Risk assessment guidance and tools are available from:
  - NHS Employers: [Risk assessments for staff](#)
  - Welsh Government: [COVID-19 workforce risk assessment tool](#)
- See also the report from PHE on [Disparities in the risk and outcomes of COVID-19](#).
- Information on the steps NHS England are taking to address the impact of COVID-19 on BAME staff in the NHS, including links to BAME networks, can be found [here](#).

b) **Have regular meetings, catch ups or huddles with colleagues using networks available** (regardless of setting) – this can be in person or remotely using videoconferencing platforms such as Zoom or Microsoft Teams (and subject to your local IT recommendations). It is important to engage and link in with others across the profession and multidisciplinary teams for personal support, co-working or supervision. It is important to be aware that some SLTs are working in isolation or in small units so it is essential to use networks to support staff across the system. Key areas of focus may include, but are not limited to:

- changes to service
- staff allocation and skill mix
- activity planning
- clinical incident reporting systems (e.g. Datix) to raise concerns about unsafe levels (e.g. of PPE availability)
- **ASLTIP local groups**
- buddy systems
- cohorting arrangements for 'clean' vs COVID-19 wards or for visiting care homes where there are multiple referrals
- school visits and approaches to reduce footfall across sites where possible

c) **Redeployment.** If staff are being re-deployed to perform other tasks it would be appropriate to consider:

- Which SLT tasks could be carried out by another healthcare professional under speech and language therapy guidance. This is in line with HCPC guidance
- [HCPC guidance](#) if your employer asks you to move into different areas of roles

- If there is a back-up plan for staff re-deployment to other areas in case of the need for staff to self-isolate.
- The need for training and/or support to ensure you and your colleagues are still able to practice safely and effectively
- Links with other SLTs via RCSLT networks, e.g. Clinical Excellence Networks (CENs)
- RCSLT COVID-19 guidance on [maximising the contribution of the speech and language therapy workforce](#)
- Insurance requirements to ensure there are no gaps in indemnity coverage, the Government has introduced additional powers to provide clinical negligence indemnity arising from NHS activities related to the Coronavirus outbreak, where there is no existing indemnity arrangement in place. [More information](#)

**d) Clothing.** Regardless of location of work and where appropriate, all SLTs should follow procedures for the safe management of linen, including uniforms. Government guidance on [COVID-19: infection prevention and control guidance](#) has a short section on staff uniforms which can also be applied to everyday clothing.

**e) Social distancing from colleagues.** In keeping with current government guidance, social distancing and minimal contact with others must be observed within the healthcare context, wherever possible, in order to reduce virus transmission.

If SLTs are unable to physically distance from other colleagues **in line with Government/local guidance on social distancing measures**, it is advised that local infection control guidelines are followed; e.g. if there is a requirement to wear a face covering to reduce the transmission of the virus.

This applies to office settings as well as clinical environments, where local policies on infection prevention and control should be followed.

#### 4. Reducing the risk of transmission of COVID-19

This section considers approaches being adopted to reduce the risk of transmission of COVID-19 in a range of sectors and settings. [Annex 1](#) provides more information about using a risk assessment framework to inform decisions about the selection of PPE.

##### 4.1. New ways of working

The uncertain times that COVID-19 has brought have resulted in the need for new ways of working for SLTs. Approaches to the delivery of care and new ways of working are outlined in the RCSLT's [Restoring services and keeping everyone safe: Framework to support decision-making](#).

#### **4.1.1. Telehealth**

The unprecedented circumstances surrounding the outbreak of COVID-19 have led many SLTs to undertake consultation, assessment and intervention remotely via telehealth. In some cases this is an extension of existing practice, in others completely novel. In response the RCSLT has updated its [telehealth guidance](#) which is now open access.

However, we acknowledge the limitations of telehealth, including for disadvantaged groups who do not have easy access to digital technologies. SLTs should ensure they evaluate the impact of telehealth, including consideration of health inequalities **and outcomes**.

#### **4.1.2. Upskilling of others**

SLTs should also consider whether it would be appropriate to provide training/coaching to another member of the workforce or a parent/carer who is already in close physical contact with the individual, to enable them to deliver the assessment or intervention, while the SLT provides support and supervision **in line with Government/local guidance on social distancing measures**, or via telehealth.

### **4.2 Face-to-face contact**

SLTs should use their clinical judgement and the risk assessment framework (Annex 1) to determine whether face-to-face contact would be the most appropriate way to meet the needs of the individual and to assess the level of PPE required.

#### **4.2.2 Cohorting or bubbles**

In order to reduce the risk of transmission, members are reporting that a number of strategies are being implemented locally. These include cohorting/creating segregated pathways/bubbles, for example:

- Cohorting individuals on wards/areas depending on COVID-19 status (see below)
- Core staff being designated to specific individuals and groups to minimise crossover and seeing different people
- Schools and **early years** settings where education staff are operating in bubbles (smaller groups with a consistent member of staff)

Additional feedback from members indicates that approaches are being used to cohort individuals into groups in a range of settings. This includes:

- Hospital inpatient settings
- Inpatient mental health and youth justice provisions
- Secure settings
- Respite care
- Inpatient facilities for children and young people with learning disability and/or autism or complex medical needs
- End of life provision
- Some special schools

Examples include:

1. Wards/areas designated for known non-COVID-19 individuals. These wards may be referred to as e.g. 'green zone'. Different strategies include individuals being
  - Asked to self isolate 14 days prior to elective surgery
  - Tested prior to admission (e.g. 48 or 72 hours, depends on local agreement)
2. Wards/areas designated for confirmed or potential COVID-19 individuals. Criteria may include:
  - Those individuals who are suspected positive
  - Those awaiting test results
3. Wards/areas designated for individuals who were COVID-19 positive but have now tested negative.

### **4.3 Changing working practices**

The RCSLT is aware that approaches being used to manage the risk of transmission of coronavirus are not consistent across hospital, community and other settings including outpatient settings. The descriptions below provide examples of some of the approaches being used.

#### **4.3.1 In-patient settings**

Inpatient settings are commonly using the cohorting approaches described above. However, we are aware that approaches being used to segregate staff to COVID-19 and non-COVID-19 wards/areas may not be practical for speech and language therapy and other professions in some in-patient settings due to numbers of staff available.

In this scenario, other ways of managing access to individuals will need to be put in place for SLTs and other professionals who are part of a peripatetic workforce. In order to mitigate the risk on patient flow and delaying interventions, options include:

- Fewer SLTs allocated to COVID-19 protected areas.
- Supporting the upskilling of other staff where feasible.
- Organising caseloads throughout the day – e.g. SLTs visiting non-COVID-19 individuals first and using appropriate PPE to see COVID-19 individuals later.
- Social distancing when in any environment.

In addition, the government has published guidance on [reducing the risk of transmission in hospital settings](#).

SLTs should use the risk assessment framework in [Annex 1](#) to support clinical decision-making for safe practice and PPE requirements, in line with Government guidance.

#### **4.3.2 Out-patient clinics**

Some individuals may be cohorted and there may be differences in approach to assessing the COVID-19 status and vulnerability of an individual prior to any outpatient appointment. It is therefore essential that local policies are followed.

To reduce the risk of transmission, SLTs should follow their hospital/clinic guidance on risk stratification and where possible consider ways to minimise infection spread by, for example:

- Working in teams
- Working on sites according to their COVID-19 status
- Avoiding moving across multiple sites in a day
- Working in designated clinical spaces
- Following new local booking in systems
- Making use of AGP designated areas when required.

In addition, the government has published guidance on [reducing the risk of transmission in hospital settings](#).

SLTs should use the risk assessment framework in [Annex 1](#) to support clinical decision-making for safe practice and PPE requirements, in line with Government guidance.

#### **4.3.3 Privately run clinics/home clinics**

As well as providing SLT services in a range of other settings, SLTs working in independent/private practice may run SLT services through a variety of other bases including (but not limited to):

- Their own homes
- Rented space in a shared building. SLTs should liaise with the building management/leaseholder to get up-to-date information about infection control for communal areas.
- Privately owned buildings/clinics.

When undertaking a face-to-face session it is important to determine the PPE requirements (see [Annex 1](#)).

Practical approaches to reduce the risk of transmission may include:

- Staggered contacts to allow for the clearing of the environment in line with local policies
- Collaboration with other services using the building to ensure safe entrance and exit
- Consideration of waiting areas
- Managing people coming in and out of the building
- Working in a well ventilated room
- Working with and through parents and carers
- Consideration of equipment use and clearing in line with infection prevention and control policies

For examples of infection prevention and control policies which can be adapted for local use, please see the [RCSLT website](#).

#### **4.3.4 Community clinics**

Some services may be offering the use of community clinics or other community spaces to carry out face-to-face contact to assess an individual's communication and/or swallowing needs when it is not possible to use other locations or methods, for example to assess a young child or where a family experiences digital poverty. Parents and individuals may also prefer to attend such a facility. In these circumstances it is not possible to cohort those attending. A risk assessment should be undertaken for each individual taking into account the urgency and the requirement to be seen face to face, and to determine the PPE requirements (see [Annex 1](#)).

Practical approaches to reduce the risk of transmission may include:

- Staggered contacts to allow for the clearing of the environment in line with local policies
- Collaboration with other services using the building to ensure safe entrance and exit
- Consideration of waiting areas

- Working in a well ventilated room
- Working with and through parents and carers
- Consideration of equipment use and clearing in line with infection prevention and control policies

SLTs should use the risk assessment framework in [Annex 1](#) to support clinical decision-making for safe practice and PPE requirements, in line with Government guidance.

#### **4.3.5 Home visits**

Home visits may not be practical as a result of:

- Individual or parent/carer concerns, which cannot be allayed, about the risk of transmission of the virus
- Shortages in PPE if undertaking a procedure that may be considered higher risk following use of the risk assessment framework
- Concerns about shielding for a member of the household (please note: section 8.10 of [Government guidance](#) outlines the PPE requirements for individuals who meet the requirement for shielding)
- Lone working issues related to staff safety
- Difficulties making contact to arrange a home visit and check COVID-19 status if the individual is not contactable by phone

If consent is granted (**including through best interest decisions**), the risk assessment framework (Annex 1) should be used to help assess a home visit. Practical approaches to care may include:

- Use of social distancing measures
- Undertaking speech and language therapy sessions in a well ventilated area to reduce risk whilst ensuring confidentiality is adhered to
- Working outside or 'through the window' if this is appropriate/practical, taking into account of the need to respect confidentiality
- Working with and through parents and carers
- Where appropriate, using telehealth and working with and through other members of the MDT to reduce the number of professionals in the home
- Use of the correct infection prevention and control (IPC) measures and PPE, if providing direct, face-to-face intervention.
- Where appropriate, consideration of fit testing (Annex 2) and how donning and doffing of PPE will be undertaken in line with IPC measures (Annex 3)
- Consideration of communication constraints whilst wearing a mask - see section 5.3

- Preparing for visits by providing communication accessible resources (e.g. leaflets, social stories, videos) on why PPE is being worn and considering approaches to personalisation where possible - see [section 5.3](#)
- Consideration of equipment taken into the house versus use of what is available in the home in line with local infection control procedures
- Where there is an AGP to be performed in the home environment, if the individual has COVID-19 it is highly likely that family members will already have been exposed, especially where they are providing intimate care. This means that the risk of transmission is significantly reduced for those family members. The family should be advised that ideally a window should be open during and for an hour afterwards to enable aerosols to settle, followed by wiping surfaces, e.g. with bleach-based surface wipes/household cleaner, and that these are precautionary measures.

**Moving from house to house in the community** may necessitate greater caution with increased risk of surface infection (e.g. kneeling down to assess or repositioning). To address this, it may be appropriate to:

- Plan your visits throughout the day so that higher risk home visits are undertaken towards the end of the day (this includes consideration of use of PPE)
- Minimise the number of rooms entered
- Ventilate the room
- Ask relatives to be in another room, or if this is not appropriate, to maintain safe social distance.

SLTs should use the risk assessment framework in [Annex 1](#) to support clinical decision-making for safe practice and PPE requirements, in line with Government guidance.

#### **4.3.6 Care homes, nursing homes and supported living accommodation**

Care homes, nursing homes and other supported living accommodation will have local policies regarding external visitors and arrangements for health professionals and residents. It is therefore important to find out what these are prior to planning a visit to inform ways of working and PPE protocols.

As well as the risks and considerations which are listed under home visits ([Section 4.3.5](#) above) which may also apply to care homes, nursing homes and supported living accommodation, other risks include:

- Staff coming into the setting with COVID-19 who may be asymptomatic and have not been tested or have had a false negative test
- Individuals who are discharged into the setting, are recovering from COVID-19 and still infectious

- Individuals discharged from hospital into care homes who may later test positive for COVID-19
- Multiple individuals who share a living space and who may not understand social distancing, lack capacity or have behaviours which challenge (for example, individuals with dementia or learning disability)

Practical approaches to care may include:

- the use of telehealth
- the use of [the Eating, Drinking and Swallowing Competency Framework \(EDSCF\)](#) and e-learning for supporting the wider workforce
- minimising the number of SLTs visiting care home where several residents require face-to-face visits, or cohorting SLTs to specific homes
- working outside or 'through-the-window' interventions, where the individual and their carer sit inside as close to the window as possible and SLT stands outside and are on the phone to each other. This can add to the consultation/assessment process and be useful where individuals do not have access to technology, technology will not be appropriate and/or are shielding. Confidentiality requirements would need to be met.

If an individual is distressed by you wearing PPE, please see e.g. Section 3 in PHE's [COVID-19: PPE – resource for care workers working in care homes during sustained COVID-19 transmission in England](#) for examples on how to reduce the level of distress.

SLTs should use the risk assessment framework in [Annex 1](#) to support clinical decision-making for safe practice and PPE requirements, in line with Government guidance.

#### **4.3.7 Education and early years settings**

##### **Government guidance**

Across the UK, governments have set different dates for the reopening of education and early years settings, and issued nation-specific guidance on the measures which settings need to take to minimise the risk of transmission. Measures which are common across the UK include:

- Minimising contact with individuals who are unwell, including through adhering to relevant test and trace systems
- Cleaning hands more often than usual
- Ensuring good respiratory hygiene
- Cleaning frequently touched surfaces often
- Minimising contact and mixing by altering, as much as possible, the environment (such as classroom layout) and timetables (such as staggered break times)
- Protocols for what to do if a child/member of staff has COVID-19 symptoms

Children and young people who have been classed as clinically extremely vulnerable due to pre-existing medical conditions have been advised to shield and are not expected to attend school or college, and should continue to be supported at home as much as possible.

The responsible authorities have been asked to undertake risk assessments for pupils with statutory entitlements to support (EHC plans, Co-ordinated Support Plans or Statements of SEN) to determine the children whose needs can be as safely or more safely met in the educational environment. These risk assessments need to balance a number of risks, including (but not limited to):

- The potential health risks to the individual from coronavirus, bearing in mind any underlying health conditions/clinical vulnerability
- The risk to the individual if some or all elements of their statutory provision temporarily cannot be delivered in the normal manner or in the usual setting
- The potential impact to the individual's wellbeing of changes to routine or the way in which provision is delivered

SLTs who work in education and **early years** settings are advised to read the relevant Government guidance.

England:

- [Coronavirus \(COVID-19\): implementing protective measures in education and childcare settings](#)
- [Supporting children and young people with SEND as schools and colleges prepare for wider opening.](#)

Scotland:

- [Coronavirus \(COVID-19\): re-opening schools guide](#)
- [Coronavirus \(COVID-19\): physical distancing in education and childcare settings](#)

Wales:

- [Keep Education Safe: Operational guidance for schools and settings \(COVID-19\)](#)

Northern Ireland:

- [Guidance to support safe working in educational settings](#)

### **Local arrangements**

**Leaders in each local setting may approach the reopening of settings differently.**

This includes decisions around:

- Risk assessments
- When to re-open, and to which groups of children, and how many
- Policies regarding local infection prevention measures
- External visitors being allowed into the setting

It is therefore essential that SLTs are aware of local decisions and also help to inform approaches to the provision of services. This would include engaging parents and carers.

If SLTs are permitted to go into education and **early years** settings, the following measures could be considered to reduce risk:

- Working with the child/young person outside
- Maintaining social distance **in line with Government/local guidance on social distancing measures** or more
- Working with children in their small groups ('bubbles') and minimising movement across settings as much as possible, in line with local procedures.
- Working with and through staff remotely and/or face to face to support the delivery of assessments and interventions
- Using video or remote access to other professionals for joint appointments where more than one professional is required
- Reviewing the equipment taken into the setting, taking into account the equipment that is already available in the setting, and following local infection control procedures
- Allocating staff in line with local policies
- Following local policies for movement in between settings and any restrictions on returning, e.g. to health premises after visiting education settings.
- Use of PPE as appropriate (see [section 5](#))

SLTs should use the risk assessment framework in [Annex 1](#) to support clinical decision-making for safe practice and PPE requirements, in line with Government guidance.

#### **4.3.8 Justice settings**

The RCSLT is aware there are specific challenges around supporting individuals in some settings within the justice system and is working with members to identify how these can be overcome. The RCSLT will update this section to reflect approaches to remove barriers to care.

Given the range and complexity of justice sector settings, RCSLT members are asked to review the guidance for other areas as provided above to identify:

- Local arrangements to reduce the risk of transmission

- Local infection, prevention control policies and PPE requirements in line with government guidance and the RCSLT risk assessment framework (Annex 1)

SLTs who work in justice settings are advised to read the relevant Government guidance, including.

- [COVID-19: prisons and other prescribed places of detention guidance](#) (England)
- [Probation Roadmap to Recovery](#) (England and Wales)
- [COVID-19: prisons and other prescribed places of detention guidance in Northern Ireland](#)

SLTs should use the risk assessment framework in [Annex 1](#) to support clinical decision-making for safe practice and PPE requirements, in line with Government guidance.

#### **4.3.9 Undertaking AGPs**

It is recommended that AGPs are undertaken in a well ventilated room or area to reduce the risk of transmission. Natural ventilation can be achieved by opening a window or door. **Clearance of infectious particles after an AGP is dependent on the ventilation and air change within the room. In an isolation room with 10-12 air changes per hour (ACH), a minimum of 20 minutes is considered pragmatic. In a single room with 6 ACH this would be approximately one hour (see Government [guidance on COVID-19 infection prevention and control for more information](#)).**

In addition, if undertaking an AGP in, for example, a care home, the procedure should be undertaken away from other residents rather than in communal areas.

It is important to follow local infection and prevention control guidance on environmental decontamination and Government [guidance on COVID-19 infection prevention and control](#).

Decontamination procedures after a community visit should include cleaning reusable or non-disposable equipment using warm water and a household cleaner followed by disinfection using a chlorine-based product prior to leaving the home, and supporting the individual or carer to clean and disinfect any surfaces in the area.

See also Government guidance on [cleaning in non-healthcare settings](#).

SLTs should use the risk assessment framework in [Annex 1](#) to support clinical decision-making for safe practice, in line with Government guidance.

## **5. Use of personal protective equipment (PPE)**

PPE is an essential element of infection prevention and control, and it is important that SLTs understand the different types of PPE that are approved for use in line with health and safety standards and their appropriate use.

Types of PPE include:

- Filtering Face Piece class 3 (FFP3) respirator (fit testing required)
- Filtering Face Piece class 2 (FFP2) or N95 respirators if [FFP3 is not available \(fit testing required if used instead of FFP3\)](#)
- Fluid-resistant surgical mask (FRSM)
- Surgical mask or simple 'face covering'
- Eye and face protection – this could be a surgical mask with integrated visor / a full face shield / visor polycarbonate safety spectacles or equivalent
- Fluid-repellant long-sleeved gown
- Disposable plastic apron
- Disposable gloves

See [Section 10 of the Government Guidance on PPE](#) for more information on the different types of PPE and their uses. [For more advice on what to look for when selecting and using PPE, please see HSE guidance on Risk at Work - Personal protective equipment \(PPE\).](#)

[Whilst manufacturers may have different styles of PPE, Government guidance on donning and doffing \(for \[AGPs\]\(#\) and \[non-AGPs\]\(#\)\) has illustrations of different PPE, including masks, eye protection and aprons.](#)

Please note that there is a difference between a surgical mask and a fluid-resistant surgical mask (FRSM) and so it is essential that SLTs ensure that they have the correct mask. The risk assessment framework ([Annex 1](#)) will support SLTs to identify the appropriate level of PPE required.

### **5.1 Risk assessment and consideration for PPE**

While the RCSLT recognises that PPE is in short supply in some areas of the UK, this guidance is provided to meet appropriate infection control measures and protect individuals and healthcare professionals. As well as being at risk themselves, the RCSLT is aware of the risks of SLTs transmitting the virus to vulnerable individuals when undertaking the procedures outlined in this guidance.

Given the shortage of PPE in the public sector and in some areas of the UK, the RCSLT advises that, prior to considering PPE, SLTs carefully weigh the risk-benefit of face-to-

face assessments and consultations ([Annex 1](#)). In addition, SLTs who work as part of an MDT can consider a flexible approach to meeting the needs of individuals.

This will ensure that **where members are working as part of an MDT in the public sector**, the use of PPE will not be diverted from areas of greatest need.

The RCSLT has worked with members to co-produce the risk assessment framework in [Annex 1](#).

The purpose of the risk assessment framework is to support clinical judgement and conversations around the weighting of the risk and the implication for practice and PPE requirements. SLTs or services may wish to develop their own more detailed risk assessment with e.g. RAG ratings.

Prior to using the risk assessment framework it is essential that SLTs read [section 2](#) in the guidance to understand what is currently known about transmission of the virus.

The tables in the risk assessment framework in [Annex 1](#) aim to support decision making for appropriate PPE in light of:

- Factors which may increase the risk of transmission of the virus
- AGPs which may induce forceful or prolonged coughing or sneezing.

**For SLTs working in independent practice, ASLTIP provides training on how to conduct a risk assessment.**

## **5.2 Government guidance on PPE**

Guidance on infection prevention and control, including the use of PPE, has been issued jointly by the Department of Health and Social Care (DHSC), Public Health Wales (PHW), Public Health Agency (PHA) Northern Ireland, Health Protection Scotland (HPS), Public Health Scotland, Public Health England and NHS England, **and thus covers the whole of the UK**. It is important that all SLTs familiarise themselves with this live document on a regular basis: [COVID-19: Infection prevention and control \(IPC\)](#).

The RCSLT recommends that SLTs refer to the tables below:

- [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 individuals who are in the [extremely vulnerable group undergoing shielding](#).

For information about fit testing, fit checking, donning and doffing and disposal of PPE, please refer to:

- [Annex 2: Fit testing and fit checking PPE](#)
- [Annex 3: Donning and doffing of PPE and disposal](#)

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.

### **5.3 Challenges when using PPE**

The RCSLT recognises that for some individuals, the appearance of others in PPE may be distressing. This may include younger children, as well as individuals with conditions that may make it difficult for them to understand the need for PPE, including autism, learning disability, and dementia. 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 the name and role on the apron, in line with the 'Hello my name is' campaign. Ways to support personalisation for children may include use of e.g. a favorite cartoon character.

SLTs may be instrumental in developing accessible resources to help individuals understand the reasons why people are wearing PPE, such as social stories and videos.

Furthermore the RCSLT recognises that the use of face masks or coverings poses challenges when working with people with a range of communication difficulties, including the deaf community and those with hearing impairment, who may rely on lip reading to communicate.

We are supportive of investigating the procurement and use of clear face masks where appropriate as part of PPE provision. We are aware that a number of clinical trials are underway and that clear masks ([e.g. surgical mask with a clear piece over the mouth](#)) will need to fulfill health and safety requirements.

Given the nature of the pandemic, SLTs are advised to follow government guidance on appropriate PPE.

## Annex 1: Risk assessment framework

### Guidance on risk assessing coronavirus exposure for SLTs and the selection of appropriate PPE

The purpose of the risk assessment framework is to support clinical judgements and conversations around the weighting of the risk and the implication for their own practice and PPE requirements. SLTs or services may wish to develop their own more detailed risk assessment with e.g. RAG ratings.

Prior to using the risk assessment tables below it is essential that SLTs read [Section 2](#) of this guidance to understand the current evidence about the transmission of the virus.

#### Pre-risk assessment questions/**considerations**

Before providing face-to-face interventions to individuals (children or adults) with suspected or confirmed COVID-19, or where the COVID-19 status is unknown, SLTs should consider the following:

1. What is the risk to the individual if the SLT service is not delivered face-to-face?
2. Can individuals be supported and outcomes met safely and effectively by delivering care differently, e.g. telehealth/videoconferencing, working collaboratively with other members of the workforce or parents/carers?
3. If direct/face-to-face contact is indicated, consider the risks in Table 1.
4. Refer to the risks in Table 1 and Table 2 if you are undertaking a procedure which may produce forceful and/or prolonged coughing or sneezing.
5. You do not have to select a level of risk from every section, the tables are there to guide decision making.
6. If, as a result of the risk assessment, PPE will be required, consider measures to reduce the risk of the individual being distressed by you wearing it (see e.g. Section 3 in PHE's [COVID-19: PPE – resource for care workers working in care homes during sustained COVID-19 transmission in England](#)).

Once you have completed Tables 1 and 2, refer to Table 3 for potential PPE requirements and government guidance: [COVID-19: Infection prevention and control](#).

**Table 1: Factors associated with potential COVID-19 transmission risk**

	Factors indicating higher risk	[ ]	[ ]	Factors indicating lower risk
Current COVID-19 status and history of the individual and/or household members <sup>1</sup>	Suspected or confirmed COVID-19 positive, or unknown COVID-19 status			Where known, individual has been identified as COVID-19 negative
	Recently positive, recovering or recovered			No COVID-19 symptoms or history
	Conditions being treated as infectious, e.g. Paediatric Multisystem Inflammatory Syndrome temporally associated with SARS-CoV2 (PIMS-TS)			No conditions being treated as infectious and associated with COVID-19
Isolation status of individual or any member of their household	Self-isolating			Not self-isolating
Time since onset of symptoms (discuss with the individual, carer, and/or MDT)	Within two weeks of symptom onset (most infectious)			More than two weeks since symptom onset

<sup>1</sup> See [Section 2](#): COVID-19 and routes of transmission for summary of scientific evidence on viral shedding

	Factors indicating higher risk	[ ]	[ ]	Factors indicating lower risk
Proximity to the individual to deliver the assessment or intervention	Intervention requires <b>close and sustained proximity to the individual (refer to Government/local guidance)</b> , e.g. cervical auscultation, videofluoroscopy, endoscopy, speech sound assessments, dysphagia assessment, <b>oral hygiene, intra and extra oral stimulation, tactile interventions (please note that this is not an exhaustive list)</b>			<b>Intervention does not require close and sustained proximity to the individual or parent/carer (refer to Government/local guidance)</b>
Ability of the individual to understand and follow social distancing and hygiene measures	Young children			Non-ambulant individuals
	Individuals who may not understand or be able to follow social distancing and hygiene measures e.g. some individuals with learning disabilities, autism, mental health conditions or dementia			Individuals can understand or be helped to understand, and are able to follow social distancing and hygiene measures
Vulnerability of the individual, member of household	Individuals with known immunocompromising factors or shielding			No known immunocompromising factors, or not shielding
Behavioural challenges (when not undertaking an AGP)	Known behavioural challenges resulting in e.g. spitting, biting, combative			No known behavioural challenges resulting in e.g. spitting, biting, combative

	Factors indicating higher risk	[ ]	[ ]	Factors indicating lower risk
Care setting is high risk for exposure to infectious AGPs	COVID-19 designated ICU/HDU			Designated low risk COVID-19 clinical area
	Setting with suspected or confirmed individuals on non-invasive ventilation (NIV); continuous positive airway pressure (CPAP); or high flow nasal oxygen (HFNO)			Working in a non-COVID-19 area without AGPs occurring
	Working in other high risk COVID-19 clinical areas where AGPs may be occurring			Schools and other non-clinical settings including individuals' homes
Assessment or intervention involves potential for aerosol generation	Swallowing, voice and communication assessment and therapy where the risks of exposure as a result of loud voice (e.g. singing, Lee Silverman Voice Therapy (LSVT)), forceful blowing (e.g. expiratory muscle strength training (EMST)) and/or production of coughing (e.g. cough reflex testing) cannot be mitigated			Swallowing, voice or communication assessment and therapy where the risks of exposure as a result of loud voice, forceful blowing and/or production of coughing can be mitigated or contact is unlikely to produce aerosols <sup>2</sup>
Neck breathers	Tracheostomy, laryngectomy			Non-neck breather

<sup>2</sup> See RCSLT report on [Aerosol generating procedures, dysphagia assessment and COVID-19](#)

	Factors indicating higher risk	[ ]	[ ]	Factors indicating lower risk
<b>Airway sensitivity</b>	<b>Diagnosis or intervention that is likely to increase the risk of coughing e.g. chronic cough, laryngeal pathology or surgery, inducible laryngeal obstruction (ILO), hypersensitivity, recent intubation</b>			<b>Diagnosis or intervention that is likely to reduce the risk of coughing e.g. chronic silent aspiration, known impaired laryngeal sensitivity</b>
<b>Use of equipment</b>	<b>Equipment cannot be decontaminated in line with local infection and control guidance e.g. videofluoroscopy, cervical auscultation, endoscopy, other equipment</b>			<b>Equipment can be decontaminated in line with local infection and control guidance e.g. videofluoroscopy, cervical auscultation, endoscopy, other equipment</b>

**Table 2: For AGPs, what is the likelihood of the individual producing forceful or prolonged coughing or sneezing?**

<b>Consider the following factors (list not exhaustive):</b>				
	<b>Factors indicating higher risk</b>	<b>[ ]</b>	<b>[ ]</b>	<b>Factors indicating lower risk</b>
<b>Ability to predict potential for coughing</b>	High risk of prolonged or forceful coughing, e.g. initial assessment where reason for referral is coughing on oral intake; review patients where a cough has previously been observed and is anticipated			Low risk of prolonged or forceful coughing, e.g. swallow review where aspiration risk has already been established and/or mitigated; paediatric feeding assessment unlikely to produce cough
<b>Aspiration</b>	Overt			Silent
<b>Secretions that have the potential to become airborne</b>	Visible drooling or suspicion of retained upper airway secretions with potential need for suctioning			No excess secretions
<b>Cough frequency or force</b>	Increased cough frequency or force, e.g. chronic lung disease in adults, nasendoscopy in chronic cough / ILO patients			Reduced cough frequency or force, e.g. neuromuscular disease, young children (0-2 years)
<b>Sneezing</b>	Nasendoscopy			No risk of sneezing
	Nasal regurgitation			
	Allergy			

### **Selecting PPE**

In making decisions about the level of PPE required, SLTs should use the risk assessment framework and discuss with local managers and **infection prevention control teams**, or **with local health protection teams if applicable**:

- Approaches to mitigate any identified risks for each factor
- The level of PPE required (see also Table 3)

The RCSLT is aware that government guidance continues to change and so it is essential that members keep up-to-date with [Government Guidance](#).

**Table 3: Potential scenarios and PPE requirements**

Potential scenarios	Government guidance	PPE requirements (taken from Government guidance)
<b>Hospital in England</b>	<p>All staff in hospitals in England will be provided with surgical masks which they will be expected to wear from 15 June. All visitors and outpatients must wear face coverings at all times.</p> <p>(See <a href="#">DHSC announcement, 5 June</a>)</p>	Surgical mask
<p><b>In any setting, where the potential risk (of whether the individual meets the case definition for a possible or confirmed case of COVID-19<sup>3</sup>) cannot be established prior to a face-to-face assessment</b></p>	<p>Where the potential risk to health and social care workers cannot be established prior to face-to-face assessment or delivery of care (<b>in line with Government/local guidance on social distancing measures</b>), the recommendation is for health and social care workers in any setting to have access to and where required wear aprons, FRSMs, eye protection and gloves.</p> <p>(See UK Government guidance: <a href="#">COVID-19: infection prevention and control guidance</a>, Section 5.7)</p>	<p>FRSM (fluid resistant surgical mask)</p> <p>Apron</p> <p>Eye protection</p> <p>Gloves</p> <p>NB Visors provide barrier protection to the facial area and related mucous membranes (eyes, nose, lips) and are considered an alternative to goggles.</p>

<sup>3</sup> A possible or confirmed case of COVID-19 is defined as an individual with a new continuous cough or high temperature or a loss of, or change in, normal sense of taste or smell (anosmia) – see Section 2.2. [here](#)

Potential scenarios	Government guidance	PPE requirements (taken from Government guidance)
<b>AGPs on possible and confirmed cases regardless of setting</b>	<p>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.<sup>4</sup> (See UK Government guidance: <a href="#">COVID-19: infection prevention and control guidance</a>, Section 5.8.1)</p> <p>In line with Table 2 and the risk of producing forceful and/or prolonged coughing or sneezing members should refer to Table 2, in order to make <u>a stratified risk assessment</u> to inform the need for a higher or lower level of PPE.<sup>5</sup></p>	<p>FFP3 (A filtering face piece class 3 respirator)</p> <p><b>FFP2/N95 if FFP3 is not available</b></p> <p>Long-sleeved disposable fluid repellent gown (covering the arms and body) or disposable fluid repellent coveralls</p> <p>A fullface shield or visor</p> <p>Gloves</p>
<b>Individual's home or usual place of residence</b>	<p>For provision of direct care to any member of a household where there is one or more possible or confirmed case.<sup>6</sup></p> <p>(See UK Government guidance: <a href="#">COVID-19: infection prevention and control guidance</a>, Section 5.8.10)</p>	<p>FRSM</p> <p>Apron</p> <p>Eye protection</p> <p>Gloves</p>

<sup>4</sup> Sustained community transmission is occurring across the UK.

<sup>5</sup> See RCLT report on [Aerosol generating procedures, dysphagia assessment and COVID-19](#)

<sup>6</sup> A possible or confirmed case of COVID-19 is defined as defined as an individual with a new continuous cough or high temperature or a loss of, or change in, normal sense of taste or smell (anosmia) – see Section 2.2. [here](#)

Potential scenarios	Government guidance	PPE requirements (taken from Government guidance)
<p><b>Primary care, ambulatory care and other non-emergency outpatient settings (including hospital outpatient clinics)</b></p>	<p>For primary care, ambulatory care and other non-emergency outpatient settings (including hospital outpatient clinics) PPE should be used for any direct care of possible and confirmed cases.<sup>8</sup> Such PPE may be indicated for work in such settings regardless of case status, subject to local risk assessment.</p> <p>For health and social care workers working in reception and communal areas but not involved in direct patient care, every effort should be made to maintain social distancing of 2 metres. Where this is not practical use of FRSM is recommended.</p> <p>(See UK Government guidance: <a href="#">COVID-19: infection prevention and control guidance</a>, Section 5.8.9)</p>	<p>FRSM</p> <p>Plastic aprons</p> <p>Eye protection</p> <p>Gloves should be used for any direct care of possible and confirmed cases.<sup>8</sup> Such PPE may be indicated for work in such settings regardless of case status, subject to local risk assessment</p>
<p><b>Community and social care settings, including care homes, prisons, mental health and other overnight resident facilities</b></p>	<p>For direct care of possible or confirmed cases<sup>7</sup> in facilities such as care homes, mental health inpatient units, learning disability and autism residential units, hospices, prisons and other overnight care units</p>	<p>FRSM</p> <p>Apron</p> <p>Eye protection (risk assess for eye protection)</p> <p>Gloves</p>

<sup>7</sup> A possible or confirmed case of COVID-19 is defined as defined as an individual with a new continuous cough or high temperature or a loss of, or change in, normal sense of taste or smell (anosmia) – see Section 2.2. [here](#)

Potential scenarios	Government guidance	PPE requirements (taken from Government guidance)
<b>Care to vulnerable groups undergoing shielding</b>	For delivery of care to any individual meeting criteria for shielding (vulnerable groups) in any setting.  (See UK Government guidance: <a href="#">COVID-19: infection prevention and control guidance</a> , Section 5.8.14)	As a minimum, single use disposable plastic aprons gloves  FRSM must be worn for the protection of the patient.  Additional PPE should be applied as per recommendations stated by context and / or risk assessment
<b>In any setting, for an individual that is not currently a possible or confirmed case<sup>7</sup></b>  <b>This includes:</b>  <b>Community children's settings (clinics, education and <b>early years</b> settings), clients' own homes</b>	If a distance of 2 metres (or in line with Government/local guidance) <b>can</b> be maintained, and risk assessment indicates no other higher risk factors	Government guidance does not specify PPE requirements, <b>however, the RCSLT is aware that local guidance may differ from Government guidance</b>
	If a distance of 2 metres (or in line with Government/local guidance) <b>cannot</b> be maintained  (See UK Government guidance: <a href="#">Table 4: Additional considerations, in addition to standard infection prevention and control precautions</a> <b>N.B. This guidance applies to both the NHS and independent sector</b> )  <b>Government PPE requirements link to Government guidance that states that there is currently sustained community transmission occurring across the UK.</b>	As a minimum:  Single use gloves  Single use apron  Risk assess to determine whether additional PPE is required.

Potential scenarios	Government guidance	PPE requirements (taken from Government guidance)
<p><b>In any setting, where staff consider there is a risk to themselves or the individuals they are caring for</b></p>	<p>Government guidance states:            Ultimately, where staff consider there is a risk to themselves or the individuals they are caring for they should wear PPE            (See UK Government guidance: <a href="#">COVID-19: infection prevention and control guidance</a>, Section 5.7)</p>	<p>FRSM            With or without eye protection as determined by the individual staff members</p>

## Annex 2 - Fit testing and fit checking PPE

It is vital that SLTs are **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 available, 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.

The Health and Safety Executive website contains useful information on [fit testing basics](#) and [guidance on fit testing masks](#) which includes a video.

The RCSLT acknowledges that there are significant barriers during this coronavirus pandemic, including:

- Obtaining FFP3 respirators (e.g. limited distribution, supply chain issues)
- Assessment of risk by the individual SLT vs perceived risk by the organisation
- Access to fit testing (the RCSLT is actively working with ASLTIP and other stakeholders to identify potential ways forward to support access to fit testing)

The HSE has stated that FFP2 and N95 respirators (filtering at least 94% and 95% of airborne particles respectively) offer protection against COVID-19 and may be used if FFP3 respirators are not available. **These require fit testing if used instead of an FFP3.**

### Annex 3 - Donning and doffing of PPE and disposal

All staff having clinical contact with infected individuals should have access to appropriate PPE in line with government guidance.

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

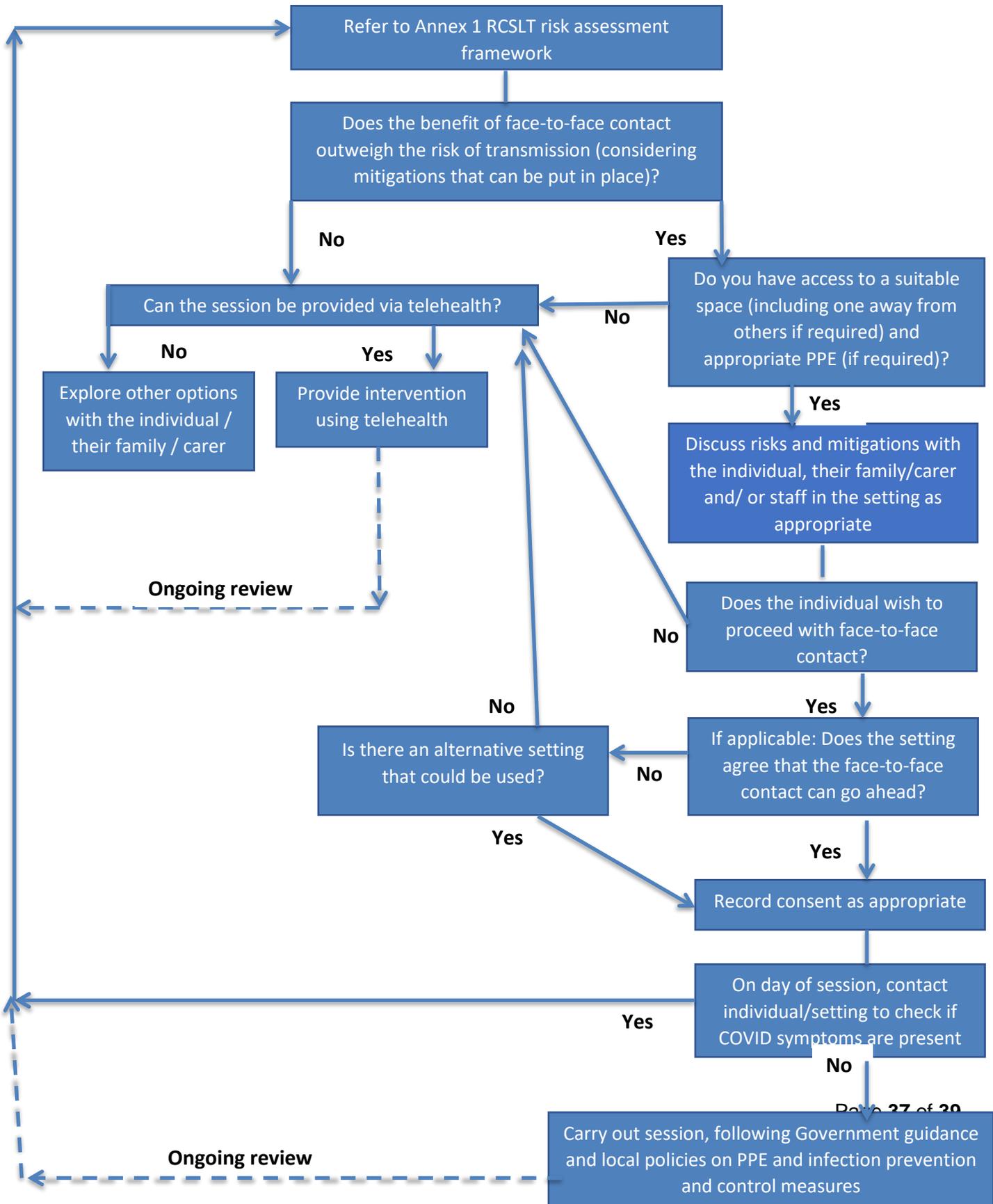
- [Donning and doffing for AGPs](#)
- [Donning and doffing for non-AGPs](#)

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.

The government has also published guidance on [cleaning in non-healthcare settings](#) which includes information on waste disposal.

## Annex 4 - Decision making flowchart

This flowchart can be used by any speech and language therapist to support decisions around working with any individual, in any setting.



## Acknowledgements

As well as thanking our members working across a range of clinical groups, settings and those working in independent practice for their feedback, we would particularly like to thank the following members for their time and input in drafting this guidance:

Lee Bolton, Clinical Lead SLT/Improvement Coach, Imperial Health Charity; Pre-doctoral Research Fellow, Imperial College London

Sam Bowman (Condie) Consultant Speech and Language Therapist and Founder of Talkabout Speech and Language Therapy

Professor Marian Brady, Nursing, Midwifery and Allied Health Professions Research Unit, Glasgow Caledonian University

Sarah Buckley, Practice Manager, Sarah Buckley Therapies Ltd; Acting Vice-Chair ASLTIP

Dr Margaret Coffey, Clinical Service Lead, SLT (Head and Neck/ENT), Honorary Clinical Research Fellow, Imperial College London

Claire Fuller, Consultant Speech and Language Therapist, Integrate Therapy, North Wales

Helen Gill, Director, Time4Talking Ltd.; SEND Lead, James Montgomery Academy Trust

Gemma Jones, Clinical Lead SLT, Cardiff and Vale University Health Board; Highly Specialist SLT Critical Care, Cwm Taf Morgannwg University Health Board

Hannah Lewthwaite, SLT, Clinical Expert Pathway Lead for Dysphagia, Solent NHS Trust

Claire Mills, Clinical Specialist SLT in Critical Care; NIHR Clinical Doctoral Research Fellow, University of Leeds

Alex Stewart, NIHR Clinical Doctoral Research Fellow, Specialist Speech and Language Therapist, Great Ormond Street Hospital/UCL

Wendy Taggart, Manager of Adult SLT Services, Gilford Health Centre, Gilford, Co Armagh

Sarah Wallace, Consultant SLT (Critical care and dysphagia), Wythenshawe Hospital, Manchester University NHS Foundation Trust; Chair RCSLT Tracheostomy Clinical Excellence Network; NIHR Research Associate

Elizabeth Williamson, Consultant Speech and Language Therapist, The Speech Group London