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

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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.

The aim of this guidance is to support all RCSLT members, regardless of where they work or who they are employed by (eg public sector, charity sector or independent sector) to make informed decisions about safe ways of working during the COVID-19 pandemic. This guidance is intended to support members with navigating:

- Government guidance and infection prevention and control (IPC) recommendations for all settings and setting-specific guidance (across the UK);
- RCSLT guidance to inform local policies and procedures, including a risk assessment framework; and
- local policies and guidance.

RCSLT insurance policy provides cover as follows:

The policy would provide cover in the unlikely event the SLT had followed the UK government guidance in respect of PPE and guidance re: testing/self-isolating but was somehow still professionally negligent.

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
- Public Health England: COVID-19: infection prevention and control
- Health Protection Scotland: Infection prevention and control (IPC) guidance in healthcare settings

You can sign up to receive the latest UK 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
- Northern Ireland: Follow the guidance of the Public Health Agency

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 regularly updating FAQs, guidance and training resources, which can be found here. This includes examples of infection prevention and control 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 Clinical Excellence Networks (CENs) on Basecamp and through professional networks on the RCSLT website. 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; eg 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. If you have any feedback, please contact 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

Transmission of SARS-CoV-2 can occur through various routes:

1. Direct contact
2. Indirect contact within the immediate environment, including care equipment
3. Airborne via droplets and aerosols from the respiratory tract directly onto mucosal surfaces or conjunctivae (WHO, 2020, WHO, 2020a; PHE 2020).

Transmission can occur through infected secretions such as saliva and respiratory secretions or respiratory droplets expelled when an infected person coughs or sneezes. Respiratory droplets and droplet emissions when coughing or sneezing are considered important routes of COVID-19 transmission (WHO, 2020; PHE 2020). All secretions (except sweat) and excretions should be regarded as potentially infectious in individuals with known or suspected COVID-19 (PHE, 2020).

A review of the scientific evidence can be found in the RCSLT report Aerosol generating procedures, dysphagia assessment and COVID-19 and in the *International Journal of Language and Communication Disorders* (Bolton et al, 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 is related to the following factors:

- Viral load or shedding
- The amount of viable virus shed
- Droplets being expelled

- Contact with others
- The infection prevention and control procedures in operation

Public Health England highlights 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 transmissability of the virus (Arons et al 2020). However, while there are some reports of asymptomatic transmission (Chau et al 2020) published reports of cases are low. Similarly, the WHO has reported unpublished data from member states which found that asymptomatic transmission was “less likely” (WHO 2020).

A report by 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).

3. Government guidance on reducing the risk of transmission of COVID-19

3.1 Government guidance for health and care settings

The government has produced UK-wide guidance *COVID-19: Guidance for the remobilisation of services within health and care settings Infection prevention and control recommendations* (published 20 August 2020).

This will be referred to throughout this document as the Government IPC guidance.

The RCSLT would like to bring the following paragraphs to the attention of members:

"The IPC principles in this document apply to all health and care settings, including the independent/private sector, mental health and learning disabilities, primary care areas, care homes, care at home, maternity and paediatrics (this list is not exhaustive, **please refer to specific country resources for setting specific guidance)**."

"NB. The guidance does NOT apply to Adult Social Care settings in England and these providers should refer to existing guidance already in place. DHSC/PHE will continuously review this guidance and update as needed."

The guidance is based on the best available evidence and recommends:

- key IPC measures;
- use of local and national prevalence and incidence data to guide returning services; and
- patients to be managed in three pathways (High, Medium and Low) to help guide the implementation of measures to provide safe and effective care locally.

3.1.1 Infection prevention control precautions

Standard infection prevention control precautions are expected to be followed in all pathways and care settings to reduce the risk of transmission and include:

- messaging information for all patients/individuals, staff and visitors;
- hand hygiene facilities including instructional posters;
- good respiratory hygiene;
- PPE;
- safe management of the environment;
- frequent decontamination of care equipment;

- maintaining physical distancing of 2 metres at all times (unless wearing PPE due to clinical or personal care); and
- use of face coverings and facemasks by patients/individuals, visitors and by staff in non-patient facing areas.

Advice on face coverings and facemasks by patients/individuals, visitors and by staff in non-patient facing areas (as outlined in government IPC guidance) is as follows:

- “use of face coverings by all outpatients (if tolerated) and visitors when entering a hospital or GP/dental surgery
- use of a surgical facemask (Type II or Type IIR) by all inpatients in the medium and high-risk pathways if this can be tolerated and does not compromise their clinical care, such as when receiving oxygen therapy, to minimise the dispersal of respiratory secretions and reduce environmental contamination
- extended use of facemasks by all staff (England /Scotland) in both clinical and non-clinical areas within the healthcare setting
- all visitors should wear a face covering in healthcare settings
- where visitors are unable to wear face coverings due to physical or mental health conditions or a disability, clinicians should consider what other IPC measures are in place, such as physical distancing, to ensure sufficient access depending on the patient’s condition and the care pathway.

Where possible and clinically appropriate remote/virtual consultations rather than face-to-face should be offered to patients/individuals.”

Sessional use of PPE has been minimised in this government guidance.

Transmission Based Precautions (section 8, page 25) are additional measures to be used when caring for individuals with a suspected or known infection such as COVID-19.

The level of cleaning required is dependent upon the COVID-19 status of the patient and the level of risk regarding contamination. The RCSLT recommends that SLTs refer to the COVID-19 infection prevention and control guidance which outlines the types of products to be used in these scenarios.

3.1.2 Care pathways and settings

Section 4 (page 10-14) of this government document highlights high, medium and low risk pathways to support local decision making for the management of patients and recommends screening and triaging to enable early recognition of COVID-19 cases.

The guidance applies to inpatient, outpatient, community and primary care settings, however, these do not reflect the work of SLTs in early years, schools and other settings (see section 3.3 below).

The RCSLT is aware that approaches being used to manage the risk of transmission of COVID-19 are not consistent across hospital, community and other settings including outpatient settings and so has provided additional guidance in section 4 below.

3.2 Government guidance for primary and community settings

3.2.1 England: Primary and community healthcare

The government has published recommendations for primary and community healthcare providers in England. The guidance states:

- "Providers of primary and community health services should ensure that measures are in place so that all settings are, where practicable, COVID-secure, using social distancing, optimal hand hygiene, frequent surface decontamination, ventilation and other measures where appropriate.
- Where a setting cannot be delivered as COVID-19 secure through all other means, **a local assessment may conclude that primary and community healthcare staff (both in clinical and non-clinical roles), when not otherwise required to use personal protective equipment, should wear a face mask;** worn to prevent the spread of infection from the wearer*.
- Where a COVID-19 secure environment cannot be maintained, patients and members of the public entering primary and community healthcare premises should be advised to use face coverings in line with government advice.

*The recommendation is for a Type I or Type II face mask worn to prevent the spread of infection from the wearer. If Type IIR face masks are more readily available, and there are no supply issues for their use as personal protective equipment, then these can be used as an alternative to Type I or Type II masks. The extended use of face masks does not remove the need for other key bundles of measures to reduce the risk of transmission of SARS-CoV-2, including social or physical distancing, optimal hand hygiene, frequent surface decontamination, ventilation and other measures where appropriate. Reliance on individual (as opposed to bundles of) measures to reduce the risk of virus transmission is not sufficient**."**

See: New recommendations for primary and community health care providers in England

3.2.2 Scotland: Social, community and residential care

Health Protection Scotland has published guidance for **social, community and residential care** (but excluding care home settings) which states that:

"Physical distancing of at least 2 metres should be followed in all areas of the facility. Where there is risk that 2 metre physical distancing cannot be maintained, for example when providing direct care or consultations, the use of PPE in accordance with guidance (The tables in appendix 6 and appendix 7) aims to reduce the risk of exposure."

"Health and social care staff can wear a fluid resistant surgical mask (FRSM) along with other appropriate PPE where the person they are visiting or otherwise attending to is neither confirmed nor suspected of having COVID-19, if they consider doing so is necessary to their own and the individual's safety."

"When carrying local risk assessments the following aspects and the outcomes should be considered and documented:

- Is the task/activity being done essential?
- Can the task/activity be done in a different way so that 2 metre distance can be maintained?
    - Yes – do this and document a justification that describes why the process has changed from usual practice, make sure your usual Health and Safety considerations are applied (if relevant).
    - No – then adapt the task to ensure physical distancing is adhered to as far as possible and document this.
        - Minimise the time spent at less than 2 metres
        - Maintain 2 metre distance for breaks, such as lunch and toilet breaks
        - Maximise the distance, where the 2 metres distance cannot be kept, always ensure the greatest distance between people is maintained
    - Apply environmental changes to minimise contact such as physical barriers, markings or changing placement of equipment or seating.
    - Consider changes in working practices (stagger times at which work is done or breaks are taken; restructure work flows to allow for physical distancing to be implemented).

Ensure that all infection prevention and control measures are implemented fully."

See: Covid-19 Information and Guidance for Social, Community and Residential Care 21 August 2020

3.2.3 Scotland: Primary care

Health Protection Scotland has also published guidance for primary care which states that in **primary care settings:**

"It is essential that the clear recommendation of the 2m rule outlined in the physical distancing guidance is adhered to. Staff when not otherwise required to use PPE, should wear a Fluid Resistant Surgical facemask (FRSFM). Where the 2m rule cannot be followed despite all possible steps being taken to try to maintain this; in those circumstances a risk based approach should be used."
See: HPS Website - COVID-19 - Guidance for primary care

3.2.4 Wales: Housing, health and social care

Public Health Wales has published examples to inform the implementation of the updated IPC guidance in housing, health, social care and support settings, which states that:

"The current UK COVID-19 IP&C guidance highlights the need for a risk assessment approach to implementation for settings where direct care is being delivered. However, other community settings will need to interact with clients/service users and in order to protect their staff, all organisations are advised to undertake and document appropriate individual and organisational level risk assessments in relation to the implementation of current IP&C guidance to protect against spread of COVID-19."

See: Housing, health, social care and support settings: Examples to inform implementation of the updated Infection Prevention and Control guidance – COVID 19

3.2.5 Northern Ireland: Community settings

The Public Health Agency has published a one-page document which provides guidelines for HSC Trust staff to follow to reduce the risk of COVID-19 transmission when they visit community settings and move between settings. This states:

"In order to limit the spread of COVID-19, the overall intention remains to reduce footfall into any community setting."

"The latest visiting guidance issued on 6 July 2020 requires staff visiting care settings to wear a face mask, which must be applied before entering the setting and worn for the duration of the visit to the facility."

See: Key principles for HSC Trust staff visiting community settings

3.3 Government and RCSLT guidance for SLTs working in early years and educational settings

Whilst the government has not published formal guidance for health professionals who work in early years and education settings, we have been informed by Public Health England that SLTs working within the NHS should use their local NHS trust guidance which will reflect the health and social care guidance. Given this steer, we would recommend that SLTs working in the NHS across the UK also follow their local NHS trust guidance.

For those SLTs not employed by the NHS, based on government guidance for other settings, evidence about the way the virus is transmitted, and the risks to the SLT and others if the virus is transmitted, the RCSLT recommends that SLTs working in early years and education settings adhere to the IPC measures put in place by the setting as well as relevant measures outlined in government guidance when working with children and young people. Key measures include:

- social distance of 2 metres;
- optimal hand hygiene;
- frequent surface decontamination;
- ventilation; and
- other measures where appropriate.

3.3.1 Risk assessment for working in early years and educational settings

Along with following NHS trust guidance and other local setting guidance and policies, where these exist, the RCSLT recommends that SLTs undertake a risk assessment for individual children and young people. Using the RCSLT risk assessment framework (Annex 1), this may conclude:

A. No need for any PPE as it is possible to meet the requirements for a COVID-19 secure environment as outlined in 3.3 above and a risk assessment does not identify a need for a higher level of PPE.
B. PPE required as cannot maintain/meet COVID-19 secure environment (eg 2 metre distance) and/or other risks are identified. Please refer to section 5 in this guidance. Given the risk of transmission, the RCSLT recommends a type I or type II face mask is used in all settings if the SLT is within 2 metres of the individual (see below re visors and face shields). However, this is a recommendation and exceptions can be made as long as other IPC measures are in place and the process to record and agree the approach outlined below (i-iv) is followed.

SLTs will need to record:

i. The overall SLT service policy for IPC measures and PPE which would be informed by:
   - local IPC policies where these exist (for their employing organisation and/ or setting e.g. school);
   - section 3.3 and 3.3.1 above; and
   - an overarching risk assessment.

ii. The outcome of individual risk assessments and decisions re PPE, using the risk assessment framework in Annex 1.

iii. The rationale for any variation from the overall SLT policy for IPC and PPE and that these have been agreed with:
   a. the setting where that variation is being implemented. Where this is in the child's home, this variation should be agreed with the parents/ carers; and
   b. IPC leads for the organisation (where applicable).

   For example, there are situations where a visor instead of a mask may be useful for certain therapeutic activities (eg standardised assessments). However, visors should only be worn instead of masks with agreement from those listed above and following careful risk assessment.

iv. Their work schedule in detail so that, in line with government and local policy on track, trace and test:
   a. they can be contacted; and
   b. the contacts that the SLT has had can also be traced.

Visors or face shields are not a substitute for a fluid resistant surgical mask. Although they block initial forward movement of air, aerosolised droplets move around the visor and can disperse over wide areas (Verma, Dhanak & Frankenfield, 2020), and can result in an intense downward jet (Viola et al, 2020 *pre-print*). This downward jet could pose a particular hazard when the wearer is in a more elevated position; eg sat or stood above a child. See section 5 below for more details on PPE and AGPs.

England:
A letter from Children's Minister Vicky Ford to children and young people with SEND, their families and carers, and those who work to support them (2 September) highlights exemptions for the use of face coverings for individuals with communication needs and staff providing specialist interventions and therapies. In the letter, these **exemptions do not apply to the wearing of face masks (PPE)** by visiting specialists including therapists. The expectation is for visiting specialists to be aware of PPE requirements. Read the full letter here.

While RCSLT members have raised concerns that it is not clear in this letter if the above sentence applies to SLTs, the following paragraph is in the government guidance for special schools:

“Specialists, therapists, clinicians and other support staff for pupils with SEND should provide interventions as usual. Supply teachers, peripatetic teachers or other temporary staff can move between settings. They should ensure they minimise contact and maintain as much distance as possible from other staff. Such specialists will be aware of the PPE most appropriate for their role.”

RCSLT members who are not employed by the NHS have asked for clarification for a number of scenarios (please note that this is not an exhaustive list). Scenarios might include the following:

SLT employed by only one school: As well as following IPC policies and procedures for that school, SLTs should risk assess for individual children and procedures to be undertaken using the risk assessment framework in Annex 1. This may impact on PPE requirements.

SLT contracted by one school only (ie only working on one site per week): If they move around to other schools week to week, SLTs would still be considered as visitors and should follow the guidance in sections 3.3 and 3.3.1 above.

SLT contracted by more than one school but not moving between sites on the same day: SLTs would still be considered as visitors and should follow the guidance in sections 3.3 and 3.3.1 above.

4. RCSLT guidance to help inform local discussions in specific settings

It is essential that SLTs refer to the government IPC guidance as highlighted in section 3.1.1 above.

The aim of this section is to provide additional support to SLTs working across a range of settings.

For example, in the use of assessment and therapeutic resources, RCSLT members have reported that a useful way to manage IPC is through the use of laminated resources, or perspex sheets which can be placed on top of an assessment (which cannot be laminated), and can be wiped down in between individual sessions.

4.1 Inpatients

While government guidance suggests segregation of staff to COVID-19 and non-COVID-19 wards/areas this 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 (eg SLTs visiting non-COVID-19 individuals first and using appropriate PPE to see COVID-19 individuals later); and
- social distancing when in any environment.

4.2 Outpatients

IPC strategies for outpatients are described in section 4.3 of the government IPC guidance. There may be local differences in approach to assessing the COVID-19 status and vulnerability of an individual prior to attending an outpatient appointment. It is therefore essential that local policies are followed.

To reduce the risk of transmission, SLTs should follow local 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 local booking in systems; and
- making use of AGP designated areas when required.

4.3 Privately run clinics/home clinics

As well as providing speech and language therapy services in a range of other settings, SLTs working in independent/private practice may run 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); and
- 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 the following:

- 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

4.4 NHS 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).

In addition to following government IPC guidance, 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; and
- working with and through parents and carers.

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.

4.5 Home visits

Home visits may not be practical as a result of the following:

- Individual or parent/carer concerns, which cannot be allayed, about the risk of transmission of the virus
- Access to appropriate level of 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
- Lone working issues related to staff safety
- Difficulties making contact to arrange a home visit and to check their 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 the following:

- Working outside or 'through the window' if this is appropriate/practical, taking into account 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
- Preparing for visits by providing communication accessible resources (eg leaflets, social stories, videos) on why PPE is being worn and considering approaches to personalisation where possible – see section 5.3 in this guidance
- Consideration of equipment taken into the house versus use of what is available in the home in line with local ICP
- 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
- Following advice in the government IPC guidance on the decontamination of surfaces (sections 7.3, 9.3 and10.3)

Moving from house to house in the community may necessitate greater caution with increased risk of surface infection (eg 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 the use of PPE);
- minimise the number of rooms entered;
- ventilate the room; and
- ask relatives to be in another room, or if this is not appropriate, to maintain a 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.

4.6 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.

The risks and considerations listed under home visits (section 4.5 above) may also apply to care homes, nursing homes and supported living accommodation. However, additional 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 are still infectious;
- Individuals discharged from hospital into care homes who may later test positive for COVID-19; and
- 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 to mitigate risks may include:

- the use of telehealth;

- the use of the Eating, Drinking and Swallowing Competency Framework (EDSCF) and elearning for supporting the wider workforce;
- minimising the number of SLTs visiting a care home where several residents require face-to-face visits, or cohorting SLTs to specific homes; and
- working outside or using 'through-the-window' interventions, where the individual and their carer sit inside as close to the window as possible and the SLT stands outside and they 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, where technology is not appropriate and/or they are shielding. Confidentiality requirements would need to be met.

Reducing the levels of distress in an individual caused by the SLT wearing PPE can be found in section 3 of a resource developed by PHE for care workers working in care homes: COVID-19: PPE – resource for care workers working in care homes during sustained COVID-19 transmission in England

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.

4.7 Education and early years settings

The Governments across the UK have each issued operational guidance for education and early years settings on actions they should take to reduce the risk of transmission (see Annex 5). These measures include the following:

- Minimising contact with individuals who are unwell, including through adhering to relevant test and trace systems
- Minimising contact and mixing, by altering as much as possible:
    - the environment (such as classroom layout)
    - timetables (such as staggered break times)
- Protocols for what to do if a child/member of staff has COVID-19 symptoms
- Enhanced cleaning, hand washing and respiratory hygiene

When working with children and young people, consideration should be given to the key IPC measures highlighted in 3.1.1 above, RCSLT guidance in section 3.3, and to the specific guidance by governments across the UK (see Annex 5). The following measures could also be considered to reduce risk:

- Working with the child/young person outside or in a well ventilated area
- 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, eg to health premises after visiting education settings
- Use of PPE as appropriate (see section 5)

SLTs should adhere to any guidance provided by suppliers of standardised assessments while wearing PPE. For example, guidance for undertaking receptive language assessments when wearing face masks.

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 and RCSLT guidance in Section 3.3.

4.7.1 Children who are clinically extremely vulnerable

We are aware that as more is now known about COVID-19, in the future far fewer children and young people will be advised to shield. There are different operational arrangements across the UK to update shielded patient lists, and SLTs should be aware of local processes.

For children with tracheostomies, examples of IPC considerations and advice on ways to support them back to school can be found at the National Tracheostomy Safety Project.

4.8 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.

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 the reduce risk of transmission; and
- 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 (2 September)

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.

5. PPE and AGPs

The RCSLT recommends that SLTs read the following sections in the Government IPC guidance:

- Section 5: Standard Infection Prevention Control Precautions (SICPs): all pathways or settings (p15)
- Section 6: Aerosol Generating Procedures: procedures that create a higher risk of respiratory infection transmission (p19)
- Section 7.4: Low risk pathways - Aerosol Generating Procedures (AGPs): procedures that create a higher risk of respiratory infection transmission (p23)
- Section 9.4: Medium risk pathways - Aerosol Generating Procedures (AGPs): procedures that create a higher risk of respiratory infection transmission (p29)
- Section 10.4 High risk pathways - Aerosol Generating Procedures (AGPs): procedures that create a higher risk of respiratory infection transmission

The short list of medical procedures classed as 'Aerosol Generating Procedures' can be found in section 6. While no direct reference is made to dysphagia assessment/ procedures in this list, the RCSLT and expert consensus, with the support of other professional associations, considers dysphagia assessment to be an aerosol generating procedure (Bolton et al, 2020). This is as dysphagia assessment requires direct prolonged contact, with a particular focus on the upper airway, and carries an inherent risk of contact with infectious saliva and secretions and of inducing aspiration-related coughing.

Furthermore, Section 8 of the government document describes droplet and airborne routes of transmission of COVID-19 and the additional transmission-based precautions required in such cases. Patients with dysphagia by nature of their condition have excessive secretions and respiratory complications predisposing them to coughing or drooling.

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. There are a number of products on the market which are designed for public use but not for practitioners.

See Section 5.1 of the government IPC guidance 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).

While 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.

See Annex 6 for a description and illustration of different types of face masks and protection.

Please also note that face coverings are not classified as PPE. Face coverings are instead largely intended to protect others, not the wearer, against the spread of infection because they cover the nose and mouth, which are the main confirmed sources of transmission of virus that causes coronavirus infection (COVID-19).

See: Face coverings: when to wear one, exemptions, and how to make your own.

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, for example, RAG ratings).

Prior to using the risk assessment framework it is essential that SLTs read Section 2 in this 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; and
- AGPs which may induce forceful or prolonged coughing or sneezing.

For SLTs working in independent practice, the Association of Speech and Language Therapists 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 guidance

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

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, and whether this contact could be postponed or delivered in a different way.

To humanise the staff wearing PPE, it could be helpful to, for example, place photographs or write the name and role of who is wearing the PPE on the apron, in line with the ‘Hello my name is’ campaign. Ways to support personalisation for children may include, for example, use of 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. There is currently one type of clear face mask that has been approved for use. However, SLTs are asked to note that "the product has not been tested by regulators in the same way as a type IIR or type II surgical face mask" – see NHS England statement on this mask, ClearMask™

RCSLT have also released a statement on ClearMask™

Visors or face shields are not a substitute for a fluid resistant surgical mask. Although they block initial forward movement of air, aerosolised droplets move around the visor and can disperse over wide areas (Verma, Dhanak & Frankenfield, 2020) and can result in an intense downward jet (Viola et al, 2020 *preprint*), a particular hazard when the wearer is in a more elevated position (e.g. sat or stood above a child).

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

5.4 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.

A number of UK short life working groups led by NHS Estates are undertaking further work on theatre, endoscopy, dental ventilation requirements and fallow periods following Aerosol Generating Procedures (AGPs) which will be published on completion.

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.

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.

6. 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.

- SLTs are asked to refer to the following sections of the Government IPC Guidance:
  - Section 3: Governance and responsibilities. This covers the need for risk assessment for staff who are vulnerable.
  - Section 11: Occupational health and staff deployment for staff who are considered high risk.
- The following resources may be useful:
  - 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 (eg Datix) to raise concerns about unsafe levels (eg 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; and
- 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 the following:
   - 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; eg 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. Local infection control teams may also give specific advice regarding clothing.

7. 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.

7.1 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.

It is important that SLTs can work flexibly to meet patient need in a rapidly changing situation. For example, they may need to switch from face-to-face appointments to telehealth in the event of a local lockdown, change in infection status or change in access to a setting.

7.2 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.

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. Does the local area have high / increasing case rates?
2. What is the risk to the individual if the SLT service is not delivered face-to-face?
3. 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?
4. If direct/face-to-face contact is indicated, consider the risks in Table 1.
5. 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.
6. You do not have to select a level of risk from every section, the tables are there to guide decision making.
7. 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).

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

	Factors indicating higher risk	[□]	[□]	Factors indicating lower risk
Symptoms	**Any of these symptoms:** • **High temperature or fever** • **New, continuous cough** • **A loss or alteration to taste or smell**			**No symptoms**
Current COVID-19 status and history of the individual and/or household members[1]	**Suspected or confirmed COVID-19 positive, or unknown COVID-19 status** **Confirmed diagnosis of COVID 19** **Waiting for a COVID 19 test result**			**Where known, individual has been identified as COVID-19 negative**
	Recently positive, recovering or recovered			**No COVID-19 symptoms or history or contact with a known case**
	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** **Contact with someone with a confirmed diagnosis of COVID-19, or been in isolation with a suspected case in the last 14 days**			**Not self-isolating** **No known contact with someone with a confirmed diagnosis of COVID-19**

[1] See Section 2: COVID-19 and routes of transmission for summary of scientific evidence on viral shedding

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**
International travel	**Travelled internationally to a country that has not been agreed as safe for travel by the government**			**No international travel / travel to a country that has been agreed as safe for travel by the government**
Proximity to the individual to deliver the assessment or intervention	**Intervention requires close and sustained proximity to the individual (refer to Government/local guidance), e.g. cervical auscultation, videofluoroscopy, endoscopy, speech sound assessments, dysphagia assessment, oral hygiene, intra and extra oral stimulation, tactile interventions (please note that this is not an exhaustive list)**			**Intervention does not require close and sustained proximity to the individual or parent/carer (refer to Government/local guidance)**
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**
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[2]**
Neck breathers	**Tracheostomy, laryngectomy**			**Non-neck breather**
Airway sensitivity	**Diagnosis or intervention that is likely to increase the risk of coughing e.g. chronic cough, laryngeal pathology or surgery, inducible laryngeal**			**Diagnosis or intervention that is likely to reduce the risk of coughing e.g. chronic silent**

[2] See RCSLT report on Aerosol generating procedures, dysphagia assessment and COVID-19

	obstruction (ILO), hypersensitivity, recent intubation			**aspiration, known impaired laryngeal sensitivity**
Use of equipment	**Equipment cannot be decontaminated in line with local infection and control guidance e.g. videofluoroscopy, cervical auscultation, endoscopy, other equipment**			**Equipment can be decontaminated in line with local infection and control guidance e.g. videofluoroscopy, cervical auscultation, endoscopy, other equipment**

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

Consider the following factors (list not exhaustive):				
	Factors indicating higher risk	**[□]**	**[□]**	**Factors indicating lower risk**
Ability to predict potential for coughing	**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**
Aspiration	**Overt**			**Silent**
Secretions that have the potential to become airborne	**Visible drooling or suspicion of retained upper airway secretions with potential need for suctioning**			**No excess secretions**
Cough frequency or force	**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)**
Sneezing	**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 settings, managers and infection prevention control teams, or with local health protection teams if available.

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

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:

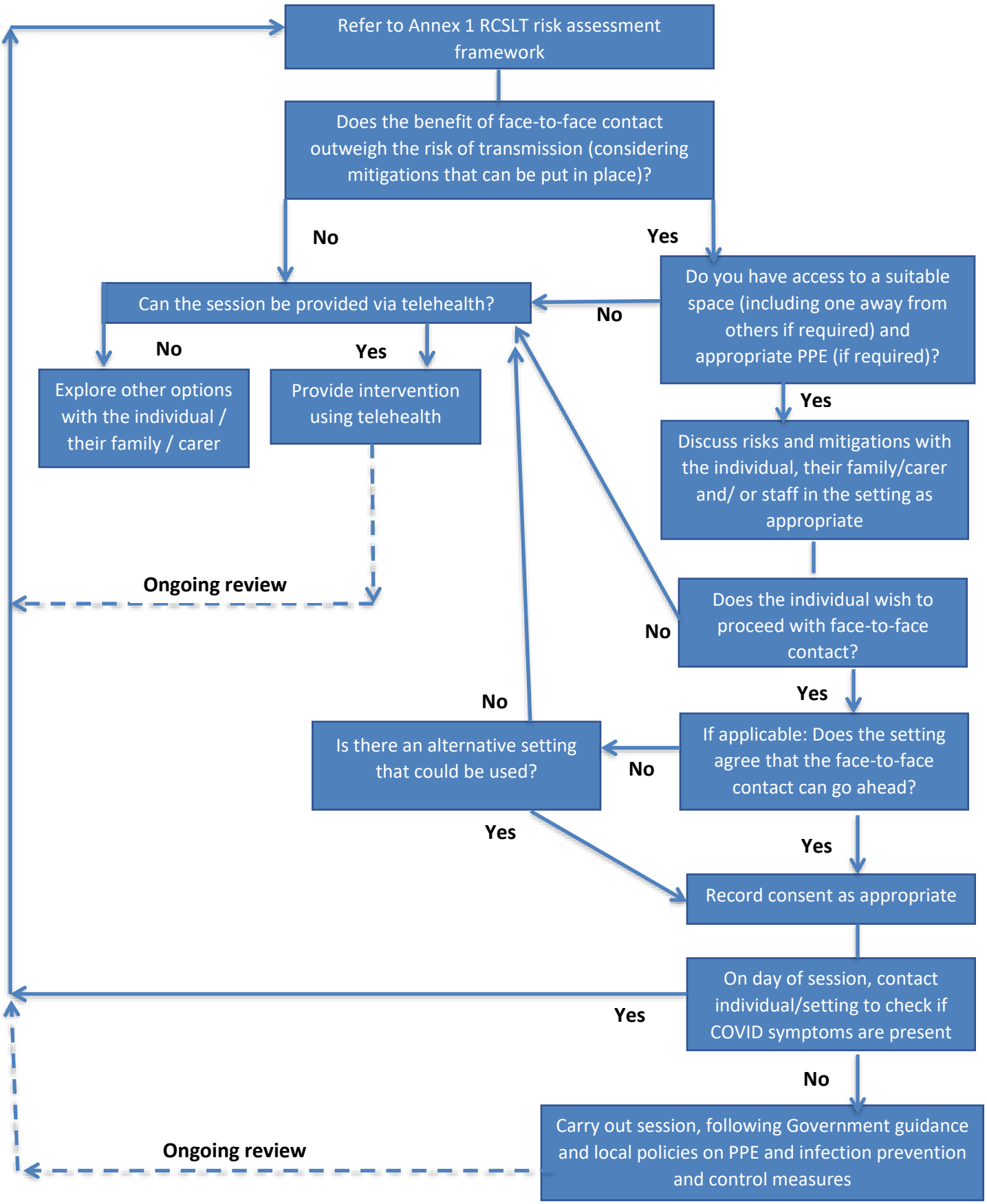
- Donning and doffing for AGPs
- Donning and doffing for non-AGPs

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.



Annex 5: Government guidance for education and early years settings

England:

Guidance for full opening: schools - GOV.UK

Guidance for full opening: special schools and other specialist settings

Actions for early years and childcare providers during the coronavirus (COVID-19) outbreak

Safe working in education, childcare and children's social care settings, including the use of personal protective equipment (PPE)

Scotland:

Coronavirus (COVID-19): guidance on re-opening school age childcare services

Wales:

Operational guidance for schools and settings from the autumn term (version 3)

Guidance for supporting vulnerable and disadvantaged learners

Northern Ireland:

New School Day - Version 2 - 13 August 2020

Northern Ireland Re-opening School Guidance - Special Schools

Annex 6: Types of face masks/protection

Type *All masks should be labelled as tested and certified medical devices*	**Example image**	**Details**
Surgical masks • Type I • Type II		Helps to stop the spread of saliva or respiratory secretions **exhaled by the person wearing it**. This helps stop the spread of the virus and other potentially harmful bacteria.
Fluid–resistant surgical mask (FRSM) • Type IIR		Includes an additional splash resistant layer which protects against fluid transfer if the wearer coughs or sneezes.
FFP2 respirators (*Note: N95 is equivalent American standard mask filtering 95% of airborne particles*)		Prevents the wearer from inhaling particles and vapours (minimum of 94% filtration percentage and a maximum of 8% leakage to the inside). This is a fluid resistant mask and so protects the wearer from droplets when someone close to the wearer coughs or sneezes.
FFP3 respirators		Prevents the wearer from inhaling particles and vapours (minimum filtration of 99% and a maximum leakage of 2% to the inside). Fluid resistant and closer fitting to the face.
Face visor/shield		Can be used alongside a mask if blood and/or body fluid contamination to the wearer's eyes or face is likely – for example, during aerosol generating procedures.

ClearMasks™		Clear-fronted mask, making the mouth and face visible to facilitate communication with those who rely on lip-reading and use facial expression to support communication; this includes people who are d/Deaf, have a learning disability, autism and dementia. Provides splash protection. *(Note: Currently the product has not been tested by regulators in the same way as a type IIR or type II surgical face mask – see NHS England statement and RCSLT statement)*

The FFP score stands for 'filtering face piece' and comes from the European standard EN standard 149:2001

Images taken from 3M Healthcare, Medline Industries and ClearMask™

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