Standard Operating Procedure: COVID-19 Physiotherapy Delivery (Virtual & In-Clinic)

Accessibility

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Responsible Director	CEO
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Availability	Suitable for public dissemination if redacted

Consultation History

The following committees, groups or individuals will be consulted in the development of this policy:

Name	Date consulted
Leadership Team	22/05/2020
Clinical Governance	22/05/2020

Version History

Version no.	Lead	Date change implemented	Reason for change
V1.0	Joel Booth	n/a	n/a

Document summary
This standard operating procedure outlines Ascenti's approach to delivering care post lockdown, detailing our approach and associated documentation and risk assessments.

1. Introduction

The government has published their COVID-19 recovery strategy and issued advice and guidance to businesses to reinstate services in England. NHS England has signalled the re-opening of non-COVID healthcare pathways and non-urgent and elective care services. The Chartered Society of Physiotherapy has also published detailed advice for Physiotherapists to ensure the safe, appropriate and considered return to face-to-face treatment as part of the government's phase two, permitting a return 1st June 2020.

This document should be read in conjunction with the following documents:

- Emergency Preparedness, Planning and Response: COVID-19 V1.4 26/03/2020
- COVID-19: Recovery Plan V1.1 28/04/2020

This Standard Operating Procedure has been based upon a series of risk assessments detailed in appendix 1.

2. Purpose

This document outlines our approach and delivery along with supporting documentation and underpinning risk assessments. This standard operating procedure underpins our approach to ensure the safe delivery of care during this period where there is sustained community transmission of COVID-19.

3. Scope

This standard operating procedure applies to our outpatient musculoskeletal physiotherapy services and can be used as a resource for our government services and outsourced services.

4. Objectives

- To document our protocols and systems
- To document our risk assessments
- To ensure legal and regulatory compliance
- To ensure compliance with our insurance obligations
- To inform training content

5. Duties & responsibilities

The Leadership Team hold ultimate responsibility and accountability for ensuring the delivery and compliance with this standard operating procedure. Where appropriate, other roles and responsibilities are defined within this document.

6. Definitions

IPC – Infection Prevention Control
PPE – Personal Protective Equipment
SOP – Standard Operating Procedure

7. Procedures and / or processes

We endorse the 'Virtual First' approach, prioritising virtual consultations in the first instance. We support the 3 point face-to-face check; patients should only be booked into face-to-face physiotherapy on the following criteria being met:

- Clinically indicated
- Risk assessment passed (vulnerability and symptoms)
- Consent of patient

7.1 Virtual First

We will operate a 'Virtual First' approach, prioritising virtual consultations in the first instance whenever possible/appropriate. The majority, but not all, of patient's first encounter will be a virtual initial assessment with a physiotherapist. The Physiotherapist will decide the most appropriate clinical pathway for that individual based upon clinical reasoning determining the appropriateness to continue with virtual care, and only referring those patients requiring face-to-face treatment into clinic based appointments. All patients will undergo a COVID-19 screening questionnaire prior to attending clinic. This will be kept under review in line with the evolving situation and official guidance.

7.2 COVID Safety Screening

The patient COVID-19 Safety Screening is designed to ensure patients deemed as requiring in-clinic care are suitable and do not have signs and symptoms of infection.

Vulnerable Patients:

The government has defined certain groups based upon medical need and risk factors who still require shielding and may be at greater risk from contracting COVID-19.

The Extremely Clinically Vulnerable list can be accessed here. Until guidance changes, patients within this category will be not be receiving in-clinic care and continue virtually where possible. Patients will be asked:

- Were you contacted by your GP / NHS health provider and meet government specified criteria for being extremely vulnerable?

Those at an increased risk through age or underlying condition will be prioritised for virtual however if in-clinic care is required they will be informed of the measures being taken to obtain their agreement. They will also be directed into the first daily appointments, where possible. Identifying question for patients will be:

- Are you considered to be at increased risk of developing severe illness from COVID-19 (age <70; underlying conditions)?

Symptoms and Self-Isolation

Patients will be asked a series of COVID-19 specific questions during the screening. These include:

- Do you have a new continuous cough and/or a high temperature?
- Do you have a new or worsening shortness of breath or difficulty breathing?
- Do you have a recent onset of a loss, or change in, your normal sense of taste or smell?
- Do you have new or worsening chills, body aches, headaches and/or sore throat?
- Do you have diarrhoea or vomiting (gastrointestinal upset)?
- Are you, or a member of your household, self-isolating in accordance with the government guidance for Coronavirus? When is your self-isolation due to end (date)?

Patients with any of the above will not be referred for in-clinic care until after their self-isolation ends and when it is safe to do so.

7.3 Clinical Pathways

For patients requiring in-clinic care and who have passed the screening will be directed on the basis of clinical reasoning (training provided) and the following pathway considerations:

- Red flag reported – referral to A&E / emergency services
- Possible red flags or other significant pathology – face-to-face

- Avoiding the need to access primary / secondary care through face-to-face
- Virtual care is unsuitable or not accessible (e.g. communication / access)
- Significant impact: dependency, coping and deterioration
- High levels of pain, disability and distress

7.4 COVID-19 – Patient Safety Protocol

All patients attending in-clinic care will be informed of our COVID-19 protocol, designed to ensure patient and staff safety. The protocol will be delivered via telephone call scripts, email, SMS, website and through posters displayed in clinic. The protocol includes:

1. Only enter 5 minutes (max) before your appointment
2. Remain outside if there are no free waiting area seats
3. Maintain 2m distance from others within waiting room areas
4. Use hand sanitiser before and after your appointment
5. We encourage the use of face coverings as per government guidance
6. Follow the guidance in clinic for social distancing
7. Attend your appointment alone unless a chaperone is essential
8. Your Physiotherapist will be wearing appropriate PPE

7.5 Patient Consent

Patients must be engaged in the rationale for virtual or face-to-face consultations. This is a shared decision making process based upon the benefits, COVID-19 risks and being informed of the controls and measures in place for safety, including the COVID-19 Patient Safety Protocol. Consent provided by the patient must be informed and documented as per company guidance on consent.

- You must document the reasons why you have chosen face-to-face care over virtual
- You must explain the safety measures in place to address risks of COVID-19 for in-clinic care
- You must explain the policy and procedures for attending clinic
- You must explain to the patient that close contact maybe required during the appointment
- Document any questions the patient raises relating to attending in-clinic care
- You must follow company procedures for consent and documenting consent and records of discussions with patient.

7.6 Risk Factors

Patient groups who are required to continue to shield and not access in-clinic care include:

1. Solid organ transplant recipients.
2. People with specific cancers:
    - people with cancer who are undergoing active chemotherapy
    - people with lung cancer who are undergoing radical radiotherapy
    - people with cancers of the blood or bone marrow such as leukaemia, lymphoma or myeloma who are at any stage of treatment
    - people having immunotherapy or other continuing antibody treatments for cancer
    - people having other targeted cancer treatments which can affect the immune system, such as protein kinase inhibitors or PARP inhibitors
    - people who have had bone marrow or stem cell transplants in the last 6 months, or who are still taking immunosuppression drugs
3. People with severe respiratory conditions including all cystic fibrosis, severe asthma and severe chronic obstructive pulmonary (COPD).
4. People with rare diseases that significantly increase the risk of infections (such as severe combined immunodeficiency (SCID), homozygous sickle cell).
5. People on immunosuppression therapies sufficient to significantly increase risk of infection.
6. Women who are pregnant with significant heart disease, congenital or acquired.

People in this group should have been contacted to tell them they are clinically extremely vulnerable.

The following is a non-exhaustive list of risk factors for COVID-19, please consider these as part of risk assessing suitability for in-clinic care:

- Age > 70
- BMI > 40
- Weakened immune system
- Co-morbidities that cause immunosuppression
- Diabetes
- HIV/Aids
- Pre-existing infection
- Alcohol abuse
- Smoking
- Long-term steroid use
- People with known cancer diagnosis and currently having active treatment

7.7 Appointment scheduling

The following strategies will be deployed as reasonable endeavours to facilitate safety controls for in-clinic care:

- Scheduling vulnerable patients for the first appointments of the day
- Spacing / alternating appointment bookings (i.e. virtual-face-to-face), step wise alternate booking sequences to space sessions where possible.

7.6 Staff Safety

7.6.1 Return to clinic checklist

Only staff that are suitable/safe, trained and provided appropriate PPE are to return to clinic. Alternative duties will be sourced for staff who are unable to return to direct patient care. Prior to returning to clinic, a return to clinic checklist will be completed. This checklist includes:

- Health screening: to determine whether they are extremely clinically vulnerable, vulnerable and whether they live in the same household as a vulnerable person.

- The checklist also systematically checks the following areas, to seek understanding and establish compliance in the following areas:

    - Uniform
    - Social distancing / clinic setup
    - Return to clinic guidance
    - PPE & hand hygiene
    - Cleaning and sanitisation
    - Absence reporting
    - Skin condition and dermatitis
    - Annual leave reporting
    - Ordering of supplies (incl. PPE)
    - Incident reporting
    - Patient journey
    - DSE Assessment
    - Well-being
    - Training and competency
    - Commuting and transport

7.6.2 Transport

We are encouraging staff to avoid the use of public transport where possible. We encourage staff to take up alternative forms of travel such as by car, cycling or walking. If there is no other option but to use public transport, they are advised to be alert to following the social distancing and safety measures being put in place. The Network Manager / nominated manager will discuss travel arrangements with staff as part of the returning to clinic checklist, and where appropriate, will review additional measures in consideration of public transport use (e.g. changing start and end times)

7.6.3 COVID-19 Safety Training

All staff returning to clinic will be required to complete COVID-19 Safety Training. This comprises:

- Patient journey
- Virus and transmission information
- Risk factors
- Clinical reasoning
    - Introduction to new service guidelines
    - What is “Virtual First” approach?
    - Factors to consider during and after IA in determining suitability for continued virtual treatment
    - Re-cap of emergency and urgent MSK conditions
    - When in-clinic care may not be indicated
    - When in-clinic care may be indicated
    - Treatment options in the virtual environment
    - New COVID-19 masqueraders which may manifest with MSK symptoms
- Consent
- Risk Factors
- Return to clinic packs
- Social distancing measures
- PPE & Hand hygiene (standard precautions)
- Cleaning and hotspot cleaning
- Dealing with spillages
- Uniform
- Travel to/from clinic
- Absence reporting
- Skin conditions and dermatitis
- Annual leave and travel
- Practical steps

- Incident reporting
- Further support

7.6.4 Return to clinic packs and PPE

Return to clinic packs will be provided to all staff returning to clinic. These Packs containing the following items will be delivered to the clinic to enable the clinic to open. The pack will contain the following items:

Personal Protection Equipment (PPE)	A 6 week supply of nitrile gloves, disposable aprons, face masks (type IIR fluid resistant masks) and eye protection.
Liquid hand soap (x2)	For physiotherapist use only
Antibac Hand Rub (x2)	One for the physiotherapist and one for patient use (if not provided by the facility already)
Sealable clinical waste bag	See PPE guidance
Sanitisation wipes	For cleaning and hotspot cleaning (see cleaning)
Adhesive Black & Yellow Tape	For use in applying local social distancing requirements
Posters	A series of posters (guidance / hygiene)
Resuscitation face shield	In the event CPR is required

All staff are required to read the Social Distancing Clinic Measures and PPE Guidance before using the relevant supplies and before seeing patients in clinic.

Our risk assessments have determined the risks and controls in place in respect of PPE usage, the risk of transmission and control measures in respect of the risks. PPE determined for use with an asymptomatic population supported by additional screening, standard precautions and other controls include:

- Nirtile gloves – single use per patient
- Disposable aprons – single use per patient
- IIR fluid resistant face masks – sessional use
- Eye protection – re-useable (cleaning guidance included in training)

7.6.5 Staff absence, self-monitoring, reporting, isolation and testing

Staff understand that they must not attend clinic or any of our offices and report their absence if:

- They develop a new continuous cough and/or high temperature

- If they are required to self-isolate because they or a member of their household has symptoms of coronavirus
- If they develop any of the other symptoms:

    - Aches and pains
    - Sore throat
    - Vomiting and Diarrhoea
    - Conjunctivitis
    - Headache
    - Loss of taste or smell
    - A rash on skin, or discolouration of fingers or toes

Staff with symptoms will be required to self-isolate and follow the latest testing guidance. HR will maintain an up-to-date Standard Operating Procedure in line with guidance.

7.6.6 Uniform

Uniform guidelines are as follows:

- Uniform must be changed daily
- Uniform must be washed separately to other clothing in a 60 degree wash
- Staff must not travel to/from work in your uniform to reduce the risk of cross-contamination
- Staff should have a 5 day supply of uniform
- Staff must be bare below the elbows, so Ascenti jackets must not be worn whilst treating

7.6.7 Skin Conditions and Dermatitis

Some occupations including healthcare workers are more vulnerable to a skin condition called hand dermatitis. Dermatitis can be due to a number of factors, including frequent hand washing and exposure to an irritant/allergen. Dermatitis can prevent effective hand hygiene being carried out. It is essential staff inform their Regional Network Manager / Clinical Mentor if they are unable to carry out hand hygiene as this is the single most important activity staff can do to reduce the spread of infection.

Good hand care, early detecting and reporting of symptoms will help to reduce the risk of dermatitis.

Good hand care:

- Cover all breaks in skin with a waterproof plaster
- Use the right hand cleansing product at the right time. You must use liquid soap and water when hands are dirty/visibly soiled, potentially contaminated with bodily fluids or caring for a patient with a suspected or known gastro intestinal infection e.g. diarrhoeal illness such as Norovirus, Clostridium difficile.
- Liquid soap and water can have a drying effect on skin, therefore when using this method of hand cleansing always wet hands before applying liquid soap, and rinse well.
- Always ensure hands are completely dry.
- Use moisturising cream before and after work and at home as often as is practical. Moisturiser will replace skins oils and restore the skins protective barrier.

Know the signs: regularly check the skin for any of the following: scaling, cracking, dryness, redness, soreness, blisters, itching, swelling, change in sensation.

Report the signs: early detection and treatment will result in recovery for most people.

- Inform your Regional Network Manager / Clinical Mentor immediately.
- Complete an incident report via DATIX
- Arrange to see your GP for a diagnosis and treatment. If you cannot book a GP appointment straight away consider speaking to your local Pharmacist for advice in the interim.

For more information, please see the Hand Hygiene & Dermatitis Policy.

7.6.8 Annual Leave and Travel

Government guidance regarding travelling overseas will be subject to change over the coming months. It is important that staff continue to check updates to the Annual Leave Policy and report destinations of travel alongside annual leave requests. Some countries may impose restrictions on travel, including quarantine. Staff should check the policies before making arrangements as if the timeframe for quarantine cannot be covered by annual leave, this may be unpaid.

7.6.9 Occupational Health

Ascenti holds a contract with an outsourced Occupational Health provider. Ascenti will continue to make suitable referrals to occupational health in accordance with our existing HR policies and procedures.

7.6.10 Practical steps

In addition to the practical measures detailed, there are further practical steps you can take to reduce transmission, these include:

- Do not shake hands with patients or other members of staff
- Do not use appointment cards
- Do not give out appointment cards
- Do not organise or attend in-person meetings or groups

7.7 Facilities

All facilities will undergo a series of re-opening checks. These include Health & Safety checks and assurances, reviewing cleaning schedules, steps to ensure compliance with insurance and also a series of social distancing checks.

7.7.1 Re-opening Checks

Re-opening checks comprise:

- Check electrics are working in each of our rooms.
- Verify with landlord that a weekly fire alarm test has been carried out.
- Verify with landlord that the emergency lights have had a function test.
- Check that hot water system has been run at 60 degrees for a period of 1 hour and hot water outlets have been drawn off.
- Please confirm that fire door inspections have been made.
- Please check that any shower heads have been cleaned and disinfected.
- Visually inspect the couch(es) and check they are fully functioning with no signs of damage
- Turn all cold taps on within each of our rooms. Once the water is running cold leave running for 2 minutes
- Check heating and ventilation is fully functioning within each of our rooms
- Check each room for signs of water ingress
- Check each room for signs of security breaches
- Ensure the router lights are flashing and you have computer connectivity. If you experience problems please call the I.T helpdesk.
- Please check the date of consumables (e.g. oil and cream) and if out of date order through The Vault.
- Please undertake a stock check of medicines stored and check expiry dates. Please send details of your stock check to governance@ascenti.co.uk, identifying stock levels and reporting (i) drugs to be disposed; (ii) theft / missing stock; (iii) other adverse finding (e.g. spoiled).
- There are no fans being used within the premises.

- Please confirm the status of clinical waste bins (e.g. in place, full, missing).
- Please complete the Social Distancing Assessment and Planning form.

7.7.2 Social Distancing Checklists

All clinics will have a social distancing checklist completed to apply the principles of social distancing and document the controls implemented.

This provides structured guidance to implement suitable controls within your clinic and provides a detailed written record of those controls and measures implemented.

1. Signage and posters

A. COVID-19 'Do not enter if' posters must be placed at the entrance to the facility
B. COVID-19 'Rules' must be placed at the entrance to the facility
C. Hand-hygiene posters must be placed within the waiting areas, entrance to clinic rooms and at the entrance to toilets.

2. Common areas (public) such as waiting rooms, patient access and lifts (measures to keep people at least 2M apart)

A. Space between chairs must be increased within waiting rooms.
B. Consideration should be given to reducing the number of chairs (e.g. remove alternate chairs).
C. Unnecessary items should be removed from waiting areas (e.g. leaflets, magazines, toys)
D. If the facility permits, toilets could be designated for staff and for patients.
E. Passageways and areas around reception should be reviewed and markers (using the tape) placed to provide a visual guide for distancing in reception areas, passage ways and corridors.
F. If there is a lift on site, please check with the premises locally, that appropriate signage on use is in place and that this signage enforces the principles of social distancing.
G. Hand sanitiser should be available to our patients and placed at or near to the entrance of the clinic room. If the local facility has not provided hand sanitiser, then one bottle of the alcohol based hand rub from the PPE pack can be used for this purpose (not both).
H. If feasible, enhance the ventilation of the common areas such as opening windows.

3. Inside the clinic room

A. The PPE supplies must be stored appropriately and securely, including couch roll.
B. The hand-hygiene poster must be placed on the wall within the clinic
C. Increase the distance between your seat and that of the patient, ensuring a minimum distance of 2M.
D. If feasible, enhance the ventilation of the clinic room (such as opening windows). Please be mindful that by opening a window: (1) patient confidentiality is not impacted; (2) security is not put at risk; (3) ventilated air does not reduce the quality of the air within the room.
E. Sanitising supplies, such as universal wipes, hand wash, alcohol based hand rub, are visible and on show within the room during clinic operation and stored securely at the end of the day.

4. Common areas (staff)

A. Agree a schedule for the staggered use common areas used by staff e.g. staff room or shared kitchen for example.

7.7.3 Cleaning and Hotspot Cleaning

In addition to the general cleaning programmes being facilitated and reviewed by the facilities team, it is important that staff consider all of the hotspots and regularly sanitise using the supplies provided to reduce the risk of contact transmission.

Hotspots are those areas that come into contact or are touched by staff and patients. The following schedule details those elements and the frequency of cleaning:

Element	Frequency	Standard of Cleanliness
Door handles	Between patient use	All surfaces should be visibly clean with no blood or body substances, dust, dirt, debris, adhesive tape or spillages.
Arms of chairs	Between patient use	All surfaces should be visibly clean with no blood or body substances, dust, dirt, debris, adhesive tape or spillages.
Bamboo Pen	Between patient use	All surfaces should be visibly clean with no blood or body substances, dust, dirt, debris, adhesive tape or spillages.
Table tops / desks	Between patient use	All surfaces should be visibly clean with no blood or body substances, dust, dirt, debris, adhesive tape or spillages.
Treatment couch (top)	Between patient use	All surfaces should be visibly clean with no blood or body substances, dust, dirt, debris, adhesive tape or spillages.
Treatment couch (underneath)	Daily	All parts (including underneath) should be visibly clean with no blood or body substances, dust, dirt, debris, adhesive tape or spillages.
Pillow (sealed in wipeable	After each patient	All surfaces should be visibly clean with no

cover) and/or covered in couch roll.		blood or body substances, dust, dirt, debris, adhesive tape or spillages.
Injection trolley	Full clean between each procedure	All parts (including underneath) should be visibly clean with no blood or body substances, dust, dirt, debris, adhesive tape or spillages.
Physiotherapy equipment	Clean contact points between patient use	All surfaces should be visibly clean
Physiotherapy visual aids	If patient touches the aids they must be cleaned.	All surfaces should be visibly clean
Hand wash containers / hand rub dispensers / paper towel dispensers	Clean contact points between patient use	All parts of the surfaces of hand soap/paper towel dispensers should be visibly clean with no blood or body substances, dust, dirt, debris, adhesive tape or spillages. Dispensers should be kept stocked.
PPE Dispensers (Gloves & Aprons)	Daily	All parts of the surfaces of the dispensers should be visibly clean with no blood or body substances, dust, dirt, debris, adhesive tape or spillages. Dispensers should be kept stocked
Medical equipment, AED machine, first aid kit, anaphylaxis kit	Clean contact points between patient use One full clean weekly	All parts (including underneath) should be visibly clean with no blood or body substances, dust, dirt, debris, adhesive tape or spillages.

Ventilation and air circulation of the clinic room in between session must be maximised between sessions. This can achieved by leaving the door open as much as possible between session and by opening any windows.

The treatment couch and pillow should be covered with couch roll and the couch roll replaced between each patient. Universal wipes must be used to clean these items between each patient and the area left to dry, prior to covering with couch roll.

Universal wipes are appropriate for cleaning surfaces and non-invasive equipment. These wipes contain a cleaning agent and a disinfectant. This dual action product completes the process of cleaning and disinfecting in one action. Universal wipes are effective against certain bacteria and viruses such as: E.coli, MRSA, Staph aureus, Hepatitis B, Hepatitis C and HIV.

Cleaning products used by staff must not be accessible to the public, especially children or vulnerable adults.

It is the responsibility of staff to ensure sufficient supply of sanitisation supplies and couch roll. These items are ordered via the Vault.

All blood and body fluid spillages must be cleaned immediately using an appropriate spill kit and used as per the instructions.

1. Access to the spill area should be restricted.
2. Prior to cleaning the spill, cover any cuts with a waterproof dressing and put on personal protective equipment (PPE) such as an apron and gloves.
3. The contents of the pack and the spillage should be disposed of in the correct waste stream.
4. Hands must be thoroughly washed and dried on completion of the task.
5. Complete an incident form and submit via Pulse or Datix.

Spillages to carpets or fabric chairs will require steam cleaning/deep cleaning to ensure thorough cleaning has taken place. Disposal of chairs may be required if the spillage can`t be completely removed. **Facilities must be informed at the earliest practical time, no later than 2 hours from the time of spillage**.

7.7.4 PPE Disposal

PPE disposal will be managed in accordance with Health Environment and sustainability Health Technical Memorandum 07-01: Safe management of healthcare waste. The determination of waste stream is subject to the type of premises within which the clinic room is co-located and the absence or presence of infectious contact.

7.8 Incident reporting

Incident reporting continues to be of great importance. It is imperative that any deviation from normal procedure, infection or other adverse events is reported. Please see the Datix page on Pulse for further information on incident reporting. A list of incident reporting types can be found here.

7.9 3rd Party Treatment Panel

All third party treatment suppliers are required to complete an assurance checklist before being approved to receive referrals from us. Satisfactory assurances are being sought including:

- Patient screening
- Social distancing measures / local arrangements
- PPE use and staff training
- Appointment scheduling
- Patient access to hand-hygiene facilities
- Cleaning and hotspot cleaning
- Capacity / staffing level

As part of re-opening and the professional regulatory and insurance compliance requirements, providers are required to complete a risk assessment and a copy of this is required when returning the assurance document to us.

7.10 Suppliers

To support the sustainable return to clinic, all suppliers have been contacted to establish viability, access to supplies, stability of supplies, lead time and ability to resume established and normal supply requirements. This will be periodically checked and managed by the facilities team.

7.11 Further Support

Please continue to check the Coronavirus support pages on Pulse and newsletters for updates. If you require any support or have any questions, please contact your Network Manager / nominate manager in the first instance.

8. Mental capacity

This policy is to be read in conjunction with our mental capacity guidance. The implications of Mental Capacity Act on this policy key principles of the Act:

- Presumption of capacity
- Support to make own decisions
- Right to make seemingly eccentric or unwise decisions
- Best interests
- Least restrictive intervention

9. Implementation

This policy will be disseminated by the method described in the Policy for the Development and Implementation of Policies and Procedural Documents.

9.1 Training implications

This SOP has been used to formulate the content of the COVID-19 Safety Training being provided to all staff prior to returning to clinic. Training is also supported by staff checklists to verify understanding and compliance with the training.

10. Monitoring and audit

This SOP will remain under regular review against changes in updated guidance.

Appendix 1 – Risk Assessments

Appendix A: (Part 1)	Ascenti risk assessment		
Brief details:	COVID-19: Return to Clinic Risk Assessment v1.4		
Business Area/Region/Service:	MSK and PIP	**Person completing RA:**	Joel Booth
Assessment date:	29/4/2020 (updated 12/05/2020)	**Review date:**	01/06/2020
Key to terms:	Likelihood (**L**), Consequence (**C**), Initial Risk Rating (**IR**), Residual Rating (**RR**), Likelihood x Consequence (**IR or RR**)		
Key to risk level:	**Low 1 – 3**	**Moderate 4 - 6**	**High 8 - 12** / **Extreme 15 - 25**

Hazard/what could go wrong?	Possible causes:	Existing controls:	L	C	IR	Additional controls (Gap Analysis)	Residual Risk (RR)	Tolerate (Y/N)
General (both PIP and MSK)								
Staff could be exposed to infection from public transport	• Dependency upon public transport travelling to/from clinic • Greater exposure to general public and heightened probability of encounter	• No standard controls pre-lockdown • Priority travel time for key workers • Uniform policy	3	3	**9**	• Clinic scheduling to avoid peak times on public transport • Change shift pattern • Promote use of alternative forms of transport in staff communications • Reinforce communications to not travel in uniforms, changing into uniform when they arrive at work.	9	Y
Staff may be vulnerable, extremely vulnerable or be from vulnerable households	• Medical condition • Meet vulnerable criteria • Member of household is vulnerable or they are a designated carer	• Vulnerable risk assessment completed prior to closure • PHE guidance • Communication stream	4	3	**12**	• Follow up vulnerable staff risk assessments and put in place local risk assessments • **See vulnerable staff risk assessment**	3	Y

		on PULSE for staff						
Additional groups of staff may fall into shielding category based on risk factors currently being studied	• PHE have launched a review into factors affecting health outcomes from COVID-19, to include ethnicity, gender and obesity – this will be published at the end of May	• PHE study	-	-	-	• Regular reviews of Government / PHE guidance • **See vulnerable staff risk assessment**	TBC	TBC
Staff may be required to travel between clinics and present a transfer of infection between sites	• Scheduling demands	• No standard controls pre-lockdown • Distancing measures and IPC precautions published on PHE/Pulse	3	3	**9**	• Either eliminate or limit in-day travel between clinics or implement additional controls	3	Y
Staff at risk of spreading infection	• Not using PPE • Not following standard precautions • Not following IPC guidance and training • Staff not washing uniforms / or have insufficient quantities of uniform	• Staff training on Infection Prevention & Control • Standard precautions (IPC) • PHE guidance and measures on best practices in place	2	3	**6**	• Staff to be provided PPE packs and guidance (see respective section below)	See respective section for RR	n/a
A situation may present whereby the staff member may need to undertake CPR	• Patient cardiac arrest	• First aid training	1	3	**3**	• Include CPR face-shield in the PPE return to clinic packs (c. £1 per item)	1	Y
MSK								
Staff could have greater exposure to infection from **prolonged** close patient contact	• Direct patient contact (within 2M with physical contact) • Prolonged close contact	• Staff training on Infection Prevention & Control • Standard precautions	4	3	**12**	• Prevent patients attending who meet suspected / confirmed criteria through screening calls, do-not-enter-if posters, patient communications	3	Y

through providing assessment and treatment and from being within the same treatment room with patients.	with patients • Patients attending with suspected / confirmed symptoms • Patients may be unaware of carrying the virus	(IPC) • PHE guidance and measures on best practice in place				• Provide staff with PPE relevant to prolonged contact this is to include: ○ Gloves ○ Aprons ○ IIR surgical mask ○ Access to ABHR and handwashing ○ Eye protection • Staff guidance on how to use PPE, what to do in the event of a patient attending with symptoms, reporting incidents • Enhance IPC guidance • Reduce unnecessary contact (e.g. handshaking) • To reduce time spent within 2M by ensuring only essential patient contact required to deliver care (e.g. undertake subjective assessments from greater than 2M) • Uniform laundry guidance • Provide additional uniforms where required • Continued guidance and monitoring of signs and symptoms of COVID-19 and testing		
Staff could be a source of transmission to patients.	• Direct patient contact (within 2M with physical contact) • Prolonged close contact with patients • Patients attending with suspected / confirmed symptoms • Throughput of patients	• Staff training on Infection Prevention & Control • Standard precautions (IPC) • PHE guidance and measures on best practice in place	2	3	**6**	• Prevent patients attending who meet suspected / confirmed criteria through screening calls, do-not-enter-if posters, patient communications • Provide staff with PPE relevant to prolonged contact this is to include: ○ Gloves ○ Aprons ○ IIR surgical mask	3	Y

						○ Access to ABHR and handwashing ○ Eye protection • Staff guidance on how to use PPE, what to do in the event of a patient attending with symptoms, reporting incidents • Enhance IPC guidance • Laundry guidance • Provide additional uniforms where required • COVID-19 Testing • Guidance on symptoms reporting and absence reporting.		
Staff could come into contact with respiratory droplets from a person with a suspected / confirmed case.	• Patient attends with a cough or cold	• No standard controls pre-lockdown • PHE guidance and measures on best practice in place	3	3	**9**	• Prevent patients attending who meet suspected / confirmed criteria through screening calls, do-not-enter-if posters, patient communications • Provide staff with PPE relevant to prolonged contact this is to include: ○ Gloves ○ Aprons ○ IIR surgical mask ○ Access to ABHR and handwashing ○ Eye protection • Staff guidance on how to use PPE, what to do in the event of a patient attending with symptoms, reporting incidents • Provide sealable clinical waste bags supported by clinical waste collection if needed • Enhance IPC guidance • Laundry guidance • Continued monitoring of signs and symptoms of COVID-19 and testing	3	Y

						• Provide additional uniforms where required		
PIP								
Staff could have **heightened** exposure from close contact or aspect of physical assessment (due to the nature of PIP this is a heightened risk but not prolonged like MSK)	• Direct patient contact (within 2M with physical contact) • Prolonged close contact with patients • Patients attending with suspected / confirmed symptoms	• Staff training on Infection Prevention & Control • Standard precautions (IPC) • PHE guidance and measures on best practice in place	3	3	**9**	• Prevent patients attending who meet suspected / confirmed criteria through screening calls, do-not-enter-if posters, patient communications • Provide staff with PPE relevant to prolonged contact this is to include: o Gloves o IIR surgical mask o Access to ABHR and handwashing o Eye protection • Staff guidance on how to use PPE, what to do in the event of a patient attending with symptoms, reporting incidents • Provide sealable clinical waste bags supported by clinical waste collection if needed • Enhance IPC guidance • Reduce unnecessary contact (e.g. handshaking) • To reduce time spent within 2M by ensuring only essential patient contact required to deliver care (e.g. undertake subjective assessments from greater than 2M) • Laundry guidance • Continued monitoring of signs and symptoms of COVID-19 testing	3	Y
Staff could be a source of transmission to patients.	• Direct patient contact (within 2M with physical contact)	• Staff training on Infection Prevention & Control	2	3	**6**	• Prevent patients attending who meet suspected / confirmed criteria through screening calls, do-not-enter-if posters,	3	Y

	• Prolonged close contact with patients • Patients attending with suspected / confirmed symptoms • Throughput of patients	• Standard precautions (IPC)				patient communications • Provide staff with PPE relevant to prolonged contact this is to include: ○ Gloves ○ IIR surgical mask ○ Access to ABHR and handwashing ○ Eye protection • Staff guidance on how to use PPE, what to do in the event of a patient attending with symptoms, reporting incidents • Enhance IPC guidance • Laundry guidance • COVID-19 Testing • Guidance on symptoms reporting and absence reporting.		
Staff could come into contact with respiratory droplets from a person with a suspected / confirmed case (considering use of peak flow)	• Patient attends with a cough or cold • Assessment requires use of peak flow meter for respiratory assessment	• Staff training on Infection Prevention & Control • Standard precautions (IPC) • Guidance from Atos	3	3	**9**	• Staff not to use Peak Flow meters • Cleaning of equipment between patients • Prevent patients attending who meet suspected / confirmed criteria through screening calls, do-not-enter-if posters, patient communications • Provide staff with PPE relevant to prolonged contact this is to include: ○ Gloves ○ Aprons ○ IIR surgical mask ○ Access to ABHR and handwashing ○ Eye protection • Staff guidance on how to use PPE, what to do in the event of a patient attending with symptoms, reporting incidents • Provide sealable clinical waste bags	3	Y

						supported by clinical waste collection if needed • Enhance IPC guidance • Laundry guidance • Continued guidance and monitoring of signs and symptoms of COVID-19		
Patients / Claimants								
The patient could bring infection into the clinic	• Patient attends with a cough or cold • Patient may be unaware of having infection	• No standard controls pre-lockdown (comms etc. will need to be repurposed) • PHE guidance and AT RISK Group re shielding	3	3	9	• Prevent patients attending who meet suspected / confirmed criteria through screening calls, do-not-enter-if posters, patient communications • Risk assessments for vulnerable patients • Provide staff with PPE relevant to prolonged contact this is to include: o Gloves o IIR surgical mask o Access to ABHR and handwashing o Eye protection • Staff guidance on how to use PPE, what to do in the event of a patient attending with symptoms, reporting incidents • Enhance IPC guidance • COVID-19 Testing • Patients to use ABHR entering and exiting clinic	3	Y
The patient companion / chaperone could bring infection into the clinic	• Companion attends with a cough or cold • Companion may be unaware of having infection	• No standard controls pre-lockdown (comms etc. will need to be repurposed) • PHE guidance and AT RISK Group re shielding	3	3	9	• Prevent chaperones attending who meet suspected / confirmed criteria through screening calls, do-not-enter-if posters, patient communications. Screening chaperones within vulnerable categories • Provide staff with PPE relevant to prolonged contact this is to include: o Gloves	3	Y

						○ IIR surgical mask ○ Access to ABHR and handwashing ○ Eye protection • Staff guidance on how to use PPE, what to do in the event of a patient attending with symptoms, reporting incidents • Enhance IPC guidance • COVID-19 Testing • Companions to use ABHR entering and exiting clinic		
The patient may be extremely vulnerable, vulnerable or be from a vulnerable household	• Medical condition • Meet vulnerable criteria • Member of household is vulnerable or they are a designated carer	• No standard controls pre-lockdown (comms etc. will need to be repurposed) • PHE guidance and AT RISK Group re shielding	3	4	12	• Continue with virtual services • Risk assessment of vulnerable cohorts • Scheduling of appointments e.g. ring fencing vulnerable timeslots at the commencement of the day • Patients to use ABHR entering and exiting clinic	3	Y
Patients could transmit infection between themselves and other patients	• Local arrangements of waiting areas, passageways, lifts etc.	• No standard controls pre-lockdown • PHE guidance and AT RISK Group re shielding	3	3	9	• Local risk assessment of clinic and organise environment to permit social distancing • Regular Hotspot cleaning in clinic • Appointment scheduling/structuring, patient communication/education and adjusting patient expectations • Patients to use ABHR entering and exiting clinic • IPC precaution-spot cleaning • Patients encouraged to heed government guidance on using face coverings within enclosed environments.	3	Y

Appendix A: (Part 1)	Ascenti risk assessment							
Brief details:	COVID-19: Staff at greater risk from COVID-19 (to be read in conjunction with the suite of COVID-19 risk assessments)							
Business Area/Region/Service:	All staff groups		**Person completing RA:**	Joel Booth				
Assessment date:	12/05/2020		**Review date:**	01/06/2020				
Key to terms:	Likelihood (**L**), Consequence (**C**), Initial Risk Rating (**IR**), Residual Rating (**RR**), Likelihood x Consequence (**IR or RR**)							
Key to risk level:	**Low 1 – 3**	**Moderate 4 - 6**	**High 8 - 12**	**Extreme 15 - 25**				

Hazard/what could go wrong?	Possible causes:	Existing controls:	L	C	IR	Additional controls (Gap Analysis)	Residual Risk (RR)	Tolerate (Y/N)
Staff member is 'Clinically extremely vulnerable' –members of staff will have been contacted by the NHS (link)	Staff member will have one or more of the following (disease severity, history or treatment levels will also affect who is in the group). • Solid organ transplant recipients. • People with specific cancers (people with cancer who are undergoing active chemotherapy; people with lung cancer who are undergoing radical radiotherapy; people with cancers of the blood or bone marrow such as leukaemia, lymphoma or myeloma who are at any	• Occupational Health • Vulnerable risk assessment completed prior to closure • PHE guidance on shielding • Communication stream on PULSE for staff • Equality & Human Rights Impact Assessment	3	4	**12**	• Reissue an updated version of the staff screening forms. • Undertake individual risk assessments to ensure staff members are shielded - **they must not work outside of the home.**	4	Y

	stage of treatment; people having immunotherapy or other continuing antibody treatments for cancer; people having other targeted cancer treatments which can affect the immune system, such as protein kinase inhibitors or PARP inhibitors; people who have had bone marrow or stem cell transplants in the last 6 months, or who are still taking immunosuppression drugs • People with severe respiratory conditions including all cystic fibrosis, severe asthma and severe chronic obstructive pulmonary (COPD). • People with rare diseases that significantly increase the risk of infections (such as SCID, homozygous sickle cell). • People on immunosuppression therapies sufficient to							

	significantly increase risk of infection. • Women who are pregnant with significant heart disease, congenital or acquired.							
Staff member is 'Clinically Vulnerable' (link)	Staff member is particularly vulnerable to poor outcomes following coronavirus: Clinically vulnerable people are those who are: • aged 70 or older (regardless of medical conditions) • under 70 with an underlying health condition listed below (that is, anyone instructed to get a flu jab as an adult each year on medical grounds): chronic (long-term) mild to moderate respiratory diseases, such as asthma, chronic obstructive pulmonary disease (COPD), emphysema or bronchitis; chronic heart disease, such as heart failure; chronic kidney disease; chronic liver disease, such as hepatitis; chronic neurological	• Occupational Health • Vulnerable risk assessment completed prior to closure • PHE guidance on shielding • Communication stream on PULSE for staff • Equality & Human Rights Impact Assessment • Patient screening	3	4	**12**	• Reissue an updated version of the staff screening forms. • Undertake individual risk assessments to ensure staff members: o Work from home if possible o If they cannot work from home, they must be offered the safest available on-site role enabling them to stay 2M away from others o If they have to spend time within 2M of others, the individual risk assessment must assess whether this involves an acceptable level of risk. • **See return to clinic risk assessment**	4	Y

	conditions, such as Parkinson's disease, motor neurone disease, multiple sclerosis (MS), or cerebral palsy; diabetes; a weakened immune system as the result of conditions such as HIV and AIDS, or medicines such as steroid tablets; being seriously overweight (a body mass index (BMI) of 40 or above); pregnant women							
Staff may reside within households that have people that are extremely clinically vulnerable or clinically vulnerable	• Member of household is vulnerable or they are a designated carer	• Vulnerable risk assessment completed prior to closure • PHE guidance • Communication stream on PULSE for staff	4	3	**12**	• Reissue an updated version of the staff screening forms.	3	Y
Additional groups of staff may fall into shielding category based on risk factors currently being studied and new scientific data	• PHE have launched a review into factors affecting health outcomes from COVID-19, to include ethnicity, gender and obesity – this will be published at the end of May	• PHE study (to be published at the end of May 2020)	-	-	**-**	• Regular reviews of Government / PHE guidance • Adopt controls for Extremely vulnerable and Vulnerable	TBC	TBC
Inequitable application of control measures based upon prescribed guidance and risk assessment, affecting equality, diversity and	• Published guidance and associated controls measures may be applied differently across the workforce	• PHE study • Government guidance • Equality Act • EDI committee • Equality, Diversity,	3	2	**6**	• Apply an EDI balancing test to all decisions • Update Datix Risk Registers documenting decisions, balance tests, peer review and supporting data / evidence **When applying control measures, the**	3	Y

protected characteristics	• Scientific research highlights additional risk factors requiring greater control measures	Human Rights Impact Assessments				**particular needs of different groups of staff must be considered, upheld and protected.**		

Appendix A: (Part 1)	**Ascenti risk assessment**							
Brief details:	**COVID-19: PPE Risk Assessment (to be read in conjunction with other COVID-19 risk assessments – see Datix Risk Register)**							
Business Area/Region/Service:	MSK and PIP		**Person completing RA:**	Joel Booth				
Assessment date:	06/05/2020		**Review date:**	06/06/2020				
Key to terms:	Likelihood (**L**), Consequence (**C**), Initial Risk Rating (**IR**), Residual Rating (**RR**), Likelihood x Consequence (**IR or RR**)							
Key to risk level:	**Low 1 – 3**	**Moderate 4 - 6**	**High 8 - 12**	**Extreme 15 - 25**				
Hazard/what could go wrong?	**Possible causes:**	**Existing controls:**	**L**	**C**	**IR**	**Additional controls (Gap Analysis)**	**Residual Risk (RR)**	**Tolerate (Y/N)**
Staff contact with patient / claimant								
Inhalation of infected respiratory secretions	• Patient cough / sneezes • Patient with COVID symptoms • We do not routinely use face masks as part of routine MSK physiotherapy and disability assessment	• Patient screening (as per pre-lockdown) • Patient education • Government isolation guidance • There are no aerosol generating procedures in MSK • PIP guidance advising against use of peak flow metres • Occupational Health services	3	3	**9**	• Adherence to government / regulator guidance • Primary care specification for care with non-infected patients is apron, nitrile gloves and IIR fluid resistant face mask (see resources), eye protection (subject to RA) • IIR fluid resistant surgical mask provides high filtration efficacy (Filtration Efficiency: EN14683:2019 Annex B >98%; Breathabillity: EN14683:2019 Annex B <60Pa/cm²; Splash Resistance: > 16kpa. ISO22609:2004; Microbial Cleanliness: 20-25cfu/g ENISO11737-1:2018 <30cfu/g; Biocompatibility: Conforms with	3 – 6	Y

						requirements EN ISO10993-5:2009 and EN ISO10993-10:2013) • PPE training • IPC communication programme • Escalation process for staff who develop signs and symptoms of Covid-19 • Only staff not within vulnerable / extremely vulnerable category (as specified by the government) will be in face-to-face care. • As no aerosol generating procedures are undertaken, guidance specifies there is no specific requirement for eye protection but rather be subject to a local risk assessment (herein) *** PPE should continue to be used whilst there is sustained community COVID-19 transmission**		
Staff member touches face (eyes, nose, mouth) with hands having had contact with an infected person or contaminated surface	• Patient attends with COVID symptoms • Staff behaviour / awareness • Staff adherence to guidelines	• Standard IPC precautions • Hand hygiene policy • Plinth cleaning • Occupational Health	2	3	**6**	• Adherence to government / regulator guidance • Primary care specification for care with non-infected patients is apron, nitrile gloves and IIR fluid resistant face mask (see appendices), eye protection (subject to RA) • Wearing gloves provides a behavioural nudge • Facemask will prevent touching of the nose and mouth (main routes of transmission) • PPE training • Regular hot spot cleaning with sanitation wipes (door handles, seat arms) • Review cleaning schedules of local facilities and frequency	4	Y

						• Escalation process for staff who develop signs and symptoms of Covid-19 • Only staff not within vulnerable / extremely vulnerable category (as specified by the government) will be in face-to-face care. • Disposal process for infected waste *** PPE should continue to be used whilst there is sustained community COVID-19 transmission**		
Ascenti guidance differs to formal government / regulator guidance	• Change in government / regulator guidance • Discrepancy between guidance and Ascenti risk assessment and associated company materials	• Daily review of guidance	2	2	**4**	• Regular IPC reviews • On-going review of policies / procedures / risk assessments / communication programmes	4	Y
Development of skin conditions / dermatitis secondary to increased hand washing, use of ABHR and glove usage	• Increase in hand washing • Increase in glove usage • Increase due to heightened anxiety and vigilance in-and-outside of work	• Hand hygiene policy • Dermatitis checks • Occupational Health • H&S Incident reporting for RIDDOR notification	2	3	**6**	• Source moisturising cream and place on the Vault • IPC Communication programme • Manager guidance • PPE training • Make use of powdered nitrile gloves (if available) • Increase hand surveillance and awareness • Develop Datix triggers to flag dermatitis incident reporting and triggers with H&S	2	Y
Uniform contamination from patient contact posing a risk to staff member and transfer to other patients / claimants	• Undertaking assessment / treatment requires close contact with patient / claimant • Uniform may come into contact with	• Standard IPC precautions • Staff not to travel to/from work in uniform • Uniform policy and	2	3	**6**	• IPC Communication programme • PPE training • Provision of single use aprons • Provide additional uniform where required	3	Y

	contaminated surface • Insufficient sets of uniform • Lack of adherence to guidance	guidance on washing						
Issues with supply of PPE	• Long lead times • Increased demand • Reduced availability • Competition • Mandatory redirection to public sector	• Small panel of established suppliers • Strong relationships with our suppliers • Some stock already secured / within the business	3	4	**12**	• Seek additional suppliers and secure stocks • Internal redistribution of stock • Check with suppliers resuming normal / routine supplies • Monitor PPE 'burn rates' • Order sufficient quantities respective of lead times	8	Y
IPC risks associated with poorly fitting gloves	• Lack of supply • Range of different size glove requirements by staff • Staff may have limited access to a range of sizes	• Profile of historic glove orders (Large 39% / Medium 40% / Small 22%)	2	2	**4**	• Provide a mixture of Large and Medium gloves within the return to clinic packs and facilitate redistribution within first two weeks • Re-establish existing procurement channels to ensure ability to order full range	2	Y
Quality of PPE supplies and IPC products and risk assessment	• Established medical grade industry standards (CE, ISO, EN)	• Internal approval processes • COSSH policy	1	1	**1**	• All products to be vetted using product sheets and checking grades / standards / certifications before procurement • Governance to perform COSHH data sheets in the absence of H&S	1	Y

Appendix – Information Sources used

COVID-19 personal protective equipment (	T2_poster_Recommended_PPE_for_primary	Personal protective equipment (PPE) FAQs	COVID-19_Infection_prevention_and_control
https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/covid-19-personal-protective-equipment-ppe Accessed: 07/05/2020	Accessed 07/05/2020	(the minimum you will require is gloves and an apron, more if your risk assessment suggests it is required.) Chartered Society of Physiotherapy Guidance Accessed: 07/05/2020	COVID-19: infection prevention and control guidance Accessed: 07/05/2020

https://www.cebm.net/covid-19/what-is-the-efficacy-of-eye-protection-equipment-compared-to-no-eye-protection-equipment-in-preventing-transmission-of-covid-19-type-respiratory-illnesses-in-primary-and-community-care/	https://openwho.org/courses/IPC-PPE-EN/items/7a9MooFBPtCZNPJBeqiUdZ	https://www.csp.org.uk/news/coronavirus/clinical-guidance/remote-or-face-face-consultations/implementing-guidance-england	