COVID-19 GUIDANCE FOR HEALTHCARE IN SECURE ENVIRONMENTS: RECOVERY

August 2020

Practical advice for clinicians

This advice aims to provide practical answers for clinicians working in secure environments. It has been informed by national guidance and by primary care clinicians with expertise in the context of secure environments. It does not supersede advice from PHE, NHS England and NHS Improvement, HMPPS or local operational guidance. Healthcare professionals in Scotland, Wales and Northern Ireland will have specific governance arrangements but principles of care will be relatable.

Further (non-COVID-19) resources for healthcare in secure environments can be found in the RCGP Spotlight on Healthcare in Secure Environments Toolkit.

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Introduction

The UK is now entering the **recovery phase** of the COVID-19 pandemic, and it is recognised that the response required in this phase is complex. New epidemiological evidence continues to emerge, UK government guidance, underpinned by a recovery strategy, continues to evolve, and expectations of care delivery by the NHS are changing.

COVID-19 is expected to impact or exacerbate, both directly and indirectly, existing health and social inequalities, which frequently affect people in contact with the criminal justice system. It is particularly important, therefore, that clinicians working in secure environments should seek to provide equivalence of care to people living in these closed, high risk settings, many of whom are vulnerable. This advice aims to provide practical answers against a backdrop of change. It has been informed by national guidance and by primary care clinicians with expertise in the context of secure environments. It does not supersede advice from PHE, NHS England and NHS Improvement, HMPPS or local operational guidance. Healthcare professionals in Scotland, Wales and Northern Ireland will have specific governance arrangements but principles of care will be relatable.

Further (non-COVID-19) resources for healthcare in secure environments can be found in the RCGP Spotlight on Healthcare in Secure Environments Toolkit.

What's new?

This guidance has been extensively updated and includes new information covering remote consulting and telemedicine, PPE, testing and contact tracing, COVID-19 risk stratification, changes to shielding arrangements, long term conditions, resuscitation, prescribing for End of Life care, release planning and prescribing. There are also links to new patient resources, to assist at induction and to facilitate difficult conversations relating to COVID-19.

SECTION A: COMMUNICATION, TRIAGE AND REMOTE CONSULTATIONS

A1: COMMUNICATION

- Principles of good communication remain fundamental to providing safe, effective, trauma-informed care and professional engagement, during the restoration and recovery phase of the COVID-19 pandemic.
- **Active listening with compassion** is required to obtain a good history and functional assessment, identify new symptoms, trends and signs of deterioration.
- **Clarity of explanation and care planning with explicit safety netting advice** is also needed. Barriers to effective communication due to language, learning difficulties or low literacy, should be overcome with appropriate communication aids, including telephone interpreting services (e.g. language line), written information in other languages, easy read and pictorial information. COVID-19-specific patient resources have been developed for the secure environment.
- Specific guidance for communication in remote consultations and triaging has been developed. It is important that all clinicians who are unfamiliar with this way of working receive training to equip them,

since some tools used for good face-to-face communication e.g. visual and vocal cues to signal active listening (nods, 'uh, huh', 'ok') may not have their usual effect, particularly if there is a visual time lag or poor connection. For further information relating to remote consultations, see A3 and infographic H2.

- Key points in video-based communication:
  - o Eye contact: look at the camera, not the patient's face on the screen
  - o Use facial expression to show interest.
  - o Keep gestures and body movements slow
  - o Keep vocal cues to a minimum.
  - o Pacing cues/interruptions should be agreed at the start of the consultation (e.g. hand up)
  - o Clear signposting, summarising and safety netting

A2: TRIAGE   Contents ¬

- **Efficient primary care triage by appropriately trained healthcare staff is essential and should involve senior clinicians**.
- Since restrictions to face-to-face primary care were introduced in the community, in order to reduce COVID-19 transmission, a system of 'total triage' has been developed. Various models of clinician-led or digital patient-led triage have been used. It is important to explain to new residents that models for care delivery will be different from the community and may vary from one secure setting to another.
- In most secure environments, digital patient-led options are currently unavailable however, models including **clinician-led telephone triage** and **paper-based patient questionnaires** have been used for residents wishing to access healthcare in lockdown.
- Where possible, **telephone triage is advisable** in secure environments, throughout the pandemic recovery period, particularly at sites where there are suspected or confirmed COVID-19 cases or where there is an outbreak. However, It is important to **ensure triage methods are suited to the needs of the resident**; people with communication difficulties may require face-to-face contact or communication aids (see A1).
- Without in-cell phone access, telephone triage is more challenging to provide, but remains achievable; wing-based telephones can be used at specified times or a room on the wing can be identified from which to make calls, to facilitate confidentiality. **Calls should NOT be recorded**.
- Telephones should always be cleaned between users.
- Where telephone triage is limited, 'clinically extremely vulnerable' (high risk) and 'clinically vulnerable' (moderate risk) patients, should be prioritised in order to minimise their face-to-face contact with other residents or staff.
- **Secondary care telephone triage:** In the community, and in some parts of the UK prison estate, a telephone triage system has been commissioned between primary care providers and local hospitals, in which GPs can request telephone advice and guidance from a consultant, in order to reduce A&E attendance and reduce referrals. Where commissioned, secondary care telephone triage in the secure estate has the potential to reduce escorts.

A3: REMOTE CONSULTATIONS   Contents ¬

- Where triage has identified the need for further assessment, new hybrid models for delivering clinical care to patients without face to face contact are being developed in the community. These include **telephone and video consultations**.
- In secure settings, in response to the pandemic, in-cell telephone access is being increased and telemedicine solutions are being developed, utilising NHS static PCs and approved mobile devices with an HMPPS-approved software option (*Visionable*). These solutions will **enable remote consultations** and also **improve patient safety** by providing **mobile access to SystmOne**, for clinical encounters on the wings or in SSU.
- **Face-to-face** appointments should continue where clinically necessary and where there are barriers to effective remote communication due to co-morbidities or disabilities e.g. confusion, hearing/sight

difficulties. All residents being seen for a face-to-face appointment (whether on the wing or in healthcare) should be **screened for COVID-19 symptoms and supported to wash their hands before leaving their cell**. Social distancing measures should be adhered to in all communal areas, including healthcare waiting rooms. If face-to-face appointments are required for **shielded** patients or those in **protective isolation** due to suspected or confirmed COVID-19, a **home visit** should be done.

- **Guidance on remote consultations** has been developed and it is important that all clinicians receive training to equip them with this unfamiliar way of working.
- **Scope of remote consultations** (T – telephone, V – video, ANP- advanced nurse practitioner, N – nurse, NMP – non-medical prescriber)

Remote consultation type	Locations	Type	Remote Staff	Comments
Primary care triage	Prison wing/cell > HCC	T	GP/ANP/N (on-site – HCC based, patient on wing)	Optimise use of face to face (F2F) consultations.
Secondary care triage	Prison (GP) > hospital	T	Hospital based consultant	May avoid A&E, reduce referrals and reduce escorts
Primary care consultation	Prison > prison	T/V	GP/ANP	Allows cross-site cover/patient access when on-site staff limited
	Prison > community		GP/ANP/NMP	Pt access/remote prescribing possible when prison-based clinician off-site
Secondary care consultation	Prison > community	T/V	Visiting psychiatrist (offsite)	Pt access/remote prescribing possible when prison-based clinician offsite
	Prison > hospital		Hospital based clinician	Reduce escorts. Less suitable for some specialties. May need follow up F2F.
Mental Health Act assessment	Prison > secure hospital	V	Secure hospital psychiatrist	When transfer to secure hospital needed and F2F assessment not possible
Pre-release liaison with community services: primary care, substance misuse(SM) or mental health (MH)	Prison > community	V (T)	Community practitioner Primary care: GP/ANP SM/MH: allocated key worker	Increase likelihood of engagement and reduce risk post-release

- Principles of safe video consulting in general practice during COVID-19 have been jointly published by RCGP/NHS and there is specific separate operational guidance for prison video consultations, published on Future NHS Collaboration Platform.
- **Core requirements of remote telephone and video consultations (VCs)**
  - Clinical consultations must remain confidential and **no recordings** should be made
  - Chaperone required in all telephone consultations requiring external connections; should be member of healthcare team, unless emergency and no HCP available. On-site healthcare consultations (wing/cell > HCC) will not require a member of healthcare to chaperone.
  - Chaperone required in all video consultations; should be member of healthcare team, unless emergency and no HCP available
  - Chaperone must dial in to telephone (external) or video consultation, on behalf of patient.
  - VCs must only take place using software approved by HMPPS (*Visionable* or *Involve)*
  - All designated VC chaperones in prison should hold an individual named software account
- **Practical considerations**
  Before a clinic:
  - Identify a single point of contact (SPOC) e.g. admin email address for coordination of remote consultations.

- A log of all remote consultations should be kept by the administrative team (see SOP published on [Future NHS Collaboration Platform](#) for exemplar).
- Where possible, set aside a remote clinic consulting room for telephone and video consultations, ensuring the telephone has a hands-free option, so that both patient and chaperone can hear the remote caller. If possible, set up a second screen in the room, so that the patient video is on one screen and notes can be recorded on the other, simultaneously.
- If possible, set up a dedicated Telephone/Video clinic list, with an allocated chaperone.
- If setting up a remote clinic list for a single off-site clinician, consider allocating 5 minutes between appointments to write up plan/prescription from previous patient and review notes of next patient, as it will not be possible to write notes on SystmOne electronic healthcare record (EHR) during the consultation (unless there is a 2nd screen).
- Ensure that contact details are available for each remote consultation (telephone number, email) so that there can be clear communication channels before, during and after consultations, where necessary (e.g. unplanned delay, lost connection).
- If language interpretation/other communication aids are required, and communication needs cannot be met with TC/VC, a face-to-face consultation should be requested.

During a clinic:
- Bring patients over to waiting room ideally 10 minutes before their allocated appointment time and check that they continue to give their consent for the remote consultation.
- If either party involved a in remote consultation is likely to be delayed, it will be important to get in touch with the caller at the other site to warn them as soon as possible.
- The patient's EHR should be opened by the chaperone before the start of the consultation.
- **Patient consent** should be obtained: 1st VC requires signed written consent form (available in SOP, on NHS Futures platform); subsequent VCs require consent to be recorded in S1 notes. Notes can be made in EHR during the consultation, if 2 screens are available, or after the consultation has ended.
- SystmOne can be accessed securely by remote clinicians (hospital and community-based), provided the external organisation has a data sharing agreement with the NHSE commissioner. Hospital departments interacting regularly with secure estate are more likely to access S1 EHR.

After a clinic:
- It is the remote clinician's responsibility (and not the chaperone's) to write an accurate detailed clinical record of the consultation, to make prescribing recommendations or provide a remote prescription, in line with [NHS remote prescribing guidance](#) (see [section E](#)) and to arrange any further investigations and follow up. The chaperone may document a brief outline of the remote consultation on SystmOne but they will not be expected to document the full details.
- Remote clinicians must communicate details of the consultation to the prison healthcare team and the patient. Immediate action required should be communicated in writing (e.g. by email) to the prison healthcare team within 24h of the consultation. This should be followed up with a formal letter. For further guidance on remote prescribing see [section E](#).

- **Future considerations**
- At present, video calls for prison use are restricted to 1:1 calls only, with an accompanying chaperone. With secure software, there is potential for facilitating group work through video conferencing, with appropriate security approval. This could prove beneficial for e.g. substance misuse recovery work (e.g. *Breaking Free*) and other online groups e.g. AA/NA which are now running in the community.
- One aim of the NHS Long term plan, to [implement digital access to healthcare](#) for all patients, has rapidly progressed in community primary care during COVID-19; [Online consultations](#) and total triage have met patient need while limiting the spread of COVID-19. During recovery and beyond COVID-19, a hybrid model of consultations will persist in the community. It will therefore be important to continue with digital innovations in secure environments, in order to limit disparity of digital access to healthcare and reduce the risk of disengagement with community services after release due to unfamiliarity with methods used.

VIDEO CONSULTING

Video consultations can potentially replace some of the non-verbal communication (NVC) cues lost during a telephone consultation, but evidence suggests that it is not equivalent to face to face. This evidence-based guide illustrates the preparation necessary and the nuance modifications to consultation style required to navigate some of the potential pitfalls of video consultation (VC).

Set Up

SUITABILITY ✓
- Follow up consultations
- Patient is known to GP
- Chronic disease

SUITABILITY !
- Undifferentiated urgent care
- If exam needed
- Tech confidence

Are you offering preferential access to the more tech savvy?

Prepare Yourself
Have you got access to notes (ideally second screen)?
Have you a phone number for the patient?
Think: which consultations are appropriate?

Prepare the Environment
Remove distractions for you and the pt
Camera at eye level—head and hands visible
Close windows—Reduce background sounds
Check lighting—not from behind
Mute telephone & set do not disturb

Eye Contact
Look at camera when talking
Look at screen & camera when listening
Signpost what you're doing when you need to look away

Practice must have agreed processes in place to support video consultations:
- Patient information for VC
- Emergency procedures
- Consultation coding....

IS IT RIGHT TO GO ON?

Consent
Consent for video consulting
Confirm confidentiality in place & no party is recording

4 Cs

Hello, can you hear me?
Hello, can you see me?

Communications Check
Optimise technology set up
Troubleshoot problems

Confirm Identity
Ask patient's name / DOB / Service number
Confirm back up telephone number

Confirm Participants
Check who else is there & make introductions (even if off screen)
Confirm patient location

Patient's Part
Get the Story

The 4 Cs may interfere with the normal methods for starting a consultation.
Ready yourself before starting the consultation.

Opening Questions
With an open mind...
Tell me more...
What happened?

EMPHASISE
non-verbal communication
ACKNOWLEDGE visual cues

PAY ATTENTION
Look & sound interested.
Try not to interrupt; unlike face to face, encouraging sounds may upset the conversation due to even tiny audio delays.
Acknowledge visual cues.

GIVE RECEIPTS
Verbally acknowledge what the patient says.
Emphasise NVC to show you're listening.

ICE !
Problem lists may not be offered
Agenda easily missed

Doctor's Part
Summarise

SAFETY FIRST
Clinical errors are more likely working remotely

EXAMINE
(where appropriate)
Visual cues
Pain, posture, pallor...
Know the Limitations

AFFIRM
Check your understanding of the problem & the context.
Clarify you have the whole picture.

Cross The Bridge
Data Gathering — Management Plan

LIFESTYLE ADVICE
Giving advice may be overlooked, or not received and understood by patient.
Check understanding!
Share online resources.

!
Specifically seek psycho-social context
Check health understanding
How do you follow up unstable patients?

Shared Part
Agree the Plan

I was just considering...
THINK ALOUD

EXPLAIN
Clearly & using patient's own language
Chunk & Check
Watch for NVC cues from patient
Check understanding

BEWARE
Rushing or skipping summaries.
Missing information due to reduced non-verbal communication.

OFFER
Realistic options
Genuine choice
Time for questions
Further information

IN DIFFICULTIES !
Tell patient what you're not sure about, and let them help you.
IS FACE TO FACE NEEDED?

Close
Is it OK to Stop?

RECAP
Assessment, diagnosis
Management plan
Decisions
Follow-up

Maintain relationship for next time.
Invite the patient to close the consultation.
End clearly.

FURTHER ACTIONS
Prescription
Investigations
Referral?
Records & Notes

HOUSEKEEPING
Look After Yourself
Check your tech
Are you ready for the next patient?

REFLECT !
Did you maintain the relationship?
Is the patient safe?
Is there a plan going forward?

B1: COVID-19 TRANSMISSION

- Occurs mainly through: **droplet** (coughing, sneezing) and **contact** (contaminated surface) spread.
- The risk of aerosol spread (contact, droplet or **airborne**) is increased during aerosol generating procedures (AGPs).
- All secretions (except sweat) and excretions, including diarrhoeal stools from patients with known or suspected COVID-19, should be regarded as potentially infectious.

B2: GENERAL PRINCIPLES OF INFECTION PREVENTION AND CONTROL

- Details of both standard infection control precautions (SICPs) and additional transmission based precautions (TBPs) are set out in **COVID-19: Infection Prevention and Control (IPC) guidance**, issued and updated jointly by DHSC, Public Health Wales (PHW), Public Health Agency (PHA) Northern Ireland, Health Protection Scotland (HPS) and Public Health England.
- **The Health Protection (Coronavirus) Regulations 2020**: underpin public health measures in law.
- **General measures to prevent coronavirus spreading** should be followed by all residents and staff.
    - **Hand hygiene**: more frequent **hand washing** (20 secs) or use of hand rub gel e.g. on entry/exit, at keys and radio collection points, avoid face touching
    - **Respiratory and cough hygiene**: 'catch it, bin it, kill it'
    - **Social distancing:** all residents and staff should aim to remain at least 2 metres apart at all times, in all areas. Where contact <2m is necessary for essential health and social care and security duties, PPE will be required.
    - **Health Education:** i) **Verbal and visual reminders**: e.g. staff prompts, floor marking tape for food and medicines queues, posters, **in-cell TV and radio** messages ii) **Written and pictorial patient information**: FAQs: What can I do to keep myself safe from coronavirus while I'm in prison? – A guide for prison residents; Understanding COVID-19 in secure settings (pictorial); information in other languages
    - **Regular cleaning and disinfecting of objects and surfaces**: use standard cleaning equipment. Ensure communal areas e.g. showers, phones cleaned as frequently as possible, including before and after use.

B3: POPULATION MANAGEMENT

B3i: NATIONAL FRAMEWORK FOR PRISON REGIMES AND SERVICES

- In order to meet requirements for social distancing, shielding and household isolation during COVID-19 lockdown, prisons have been operating under an **Exceptional Regime Management Plan (ERMP)** in which key regime priorities (meals, access to healthcare and medication, safety and welfare services, provision of family contact) have continued but association, group activities (work, gymnasium, education) and social visits have stopped.
- In order to further reduce infection spread, the secure estate has been compartmentalised by introducing **cohorting** arrangements and limiting **inter-prison transfers (IPTs)**.
- As the UK enters the COVID-19 recovery phase, the government has set out its strategy to lift restrictions, linked to 5 levels of virus circulation and transmission risk (COVID-19 Alert levels 1-5).
- **A 5-stage conditional recovery plan has been developed for prison regimes and services** (including healthcare) which aligns with the 5 different potential phases of the pandemic (see COVID-19: National Framework for Prison Regimes and Services published 02 June 2020.)

- 5 different levels of regime and 5 different levels of healthcare (and other services) will be delivered according to a **5-stage conditional Exceptional Delivery Model**.
- Individual prison transitions between EDM recovery stages will depend on:
    - community virus circulation and transmission risk (local)
    - prison virus circulation and transmission risk (local and national)
    - rates of staff absence (due to COVID-19 infection or contact)
- Transitions may be in either direction and may not mirror the timings of developments outside secure environments due to:
    - increased risk of infection spread in closed settings
    - vulnerability of population
    - increased risk of COVID-19 seeding into secure environments through new residents, staff and other visitors as community restrictions ease
- Regimes may transition directly back to (stage 4) lockdown on the advice of Outbreak Control Teams, where an outbreak is identified, or when advised centrally by HMPPS.
- Transitions towards opening additional elements of the regime have begun, planned by individual establishments and authorised through HMPPS COVID-19 Gold Command channels.

B3ii: COHORTING

- An outbreak of COVID-19 in a closed environment has the potential for high levels of morbidity and mortality and it is important to:
    - reduce virus seeding and
    - protect people most at risk of severe illness with the virus
- On the advice of PHE, prisons have introduced a **cohorting process** in order to isolate specific groups of residents from the main population, and so reduce the risks of an outbreak with high levels of severe illness, multiple hospital admissions, and deaths.
- Ideally, residents in each of the 3 cohorts should be located in **single cells or alone in multiple occupancy cells,** however, residents may share cells ('double up') if this is necessary.
- Each of the 3 cohorts is usually located in a distinct area, known as a **cohort unit**, however, some establishments are implementing cohorting as a **process,** identifying different ways of isolating cohorted individuals, to suit the local architecture and availability of accommodation.
- Close partnership working is required between healthcare and prison teams in order to identify and appropriately locate residents**.**
- Where possible, prison staff working in RCU, PIU, SU should not be cross-deployed to other areas and healthcare duties should be arranged to minimise staff footfall between different areas.

- **REVERSE COHORT UNIT (RCU)/ REVERSE COHORTING**
- **What?**
- Temporary separation for at least 14 days to:
    - Monitor for emerging symptoms
    - Protect from infection in the main population
- Ideally, locate in **single cells/alone** in multiple occupancy cells. If single occupancy cannot be achieved, people arriving on the same day can share a cell and become a **household** (unless high risk CSRA status)
- Group residents for daily regime according to date of arrival.
- People arriving on subsequent days should not mix with arrivals from previous days. If unavoidable and a new arrival has to join a household already part-way through the reverse cohorting process, the 'clock' should be reset and the 14-day reverse cohort period restarted for the entire household.
- **Who?**
- Newly received residents
- On return from hospital if:
    - Over-night stay (or longer) – see also PIU (below)

- o Prolonged day-case treatment e.g. chemotherapy, dialysis, radiotherapy (NB may already be shielding)
  - o **Attendance at A+E
  - o **Routine OPD visit

  **depends on local risk assessment/ advice from hospital IPC team
- <u>Cell-sharing contacts</u> of symptomatic residents
- <u>Contacts identified by test and trace scheme</u> (contacts may isolate without relocating)
- <u>Attending court trial</u> unless 1-day only with no breach to social distancing
- **When to end Reverse Cohorting (RC)?**
- <u>If remain asymptomatic:</u>
  - o Single occupancy: after 14 days
  - o Multiple occupancy: 14 days after arrival of last member to join the household
  - o Attending court: 14 days after final day of court appearance
  - o Contact (asymptomatic) of confirmed COVID-19 case: 14 days after confirmed case's test date
  - o Contact (asymptomatic) of suspected COVID-19 case: 14 days after suspected case's symptom onset <u>unless</u>: suspected case tests negative (can stop isolating)
- <u>If become symptomatic:</u> start self-isolation for at least 10 days in PIU – see below
  A resident should be assessed by a member of healthcare, by asking questions and checking their temperature, before RC process can end.

- **PROTECTIVE ISOLATION UNIT (PIU)/ SELF-ISOLATION**   Contents ¬
- **What?**
- Temporary separation for <u>at least 10 days</u> to:
  - o Prevent infection spread
  - o Monitor for new symptoms/deterioration
- Locate in **single cells/alone** in multiple occupancy cells.
- Test for COVID-19 (**ALL symptomatic** residents should now be **tested** - see B5).
- Minimise non-essential staff contact with suspected and confirmed COVID cases in PIU.
- **Who?**
- <u>Symptomatic</u> residents (untested/test result awaited/test positive/test negative)
- <u>Residents returning from hospital with COVID-19</u>
- <u>Household/other contacts</u> of suspected/confirmed cases who <u>become symptomatic</u>
- <u>Asymptomatic residents who test positive</u> (at present asymptomatic people are only tested as part of specific research/surveillance programmes)
- **When to end self-isolation?**
- **After 10 days** if:
  <u>Suspected and confirmed cases</u> (<u>not</u> admitted to hospital with COVID-19)
  - o **48h free from i) fever (without medicine to reduce fever) ii) vomiting/diarrhoea**
  - o **free from i) nausea ii) loss of appetite iii) sneezing or rhinorrhoea**
  - o **follow up test negative (confirmed cases only)** NB if remains test positive, follow PHE HPT advice
- **After 14 days** if:
  <u>Confirmed cases returning from hospital following admission with COVID-19</u>
  <u>Households where suspected/confirmed cases and asymptomatic members choose to remain together</u>
- NB cough/loss of sense of smell may persist for weeks and should not be a reason to continue isolating if other symptoms have resolved and other conditions for ending self-isolation are met.
  A resident should be assessed by a member of healthcare, by asking questions and checking their temperature, before protective isolation measures can end.

- **SHEILDING UNIT (SU)/SHIELDING**
- **What?**
- Shielding is an evolving process. It is advisory. Currently, shielding involves separation from others to prevent infection and minimise risk of severe illness with COVID-19.
- Locate in **single cells/alone** in multiple occupancy cells
- **Who?**
- Clinically extremely vulnerable (CEV) residents (at high risk of severe illness from COVID-19) in line with national guidance and/or local guidance during any specific COVID-19 outbreak (See also C2ii)
- Residents who fall into the Clinically vulnerable (moderate risk) category have also been shielded in some establishments, following advice from local HPTs, where virus transmission levels have been high and where residents have multiple risk factors e.g. age, BMI, multiple co-morbidities.
- Residents should be supported by healthcare staff in their decision making. Those who choose to remain unshielded should sign a disclaimer and be encouraged to follow all other IPC guidance.
- If residents with clinical vulnerabilities change their mind at any point, and choose to start, to stop or to restart shielding, they should be supported in their choices.

- **FUTURE SHIELDING ARRANGEMENTS – timings/arrangements differ across 4 nations of UK**
- **6th July – 31st July:**
    - Food and medicines in-cell (28 days IP if judged safe on IP assessment)
    - Any necessary medical care delivered in-cell
    - Exercise and **mix outdoors with a small group of people who are shielding, ensuring social distancing** (2 metres apart)
    - Safe arrangements for showers and telephone calls
- **From 1st August:**
    - Shielding will be paused in the community but will continue to be offered in prisons, to reflect the high risk nature of closed settings
    - All residents with clinical vulnerabilities (moderate and high risk) should be advised to remain cautious and:
        - Stay in cell where possible
        - Stay at least 2 metres apart from all staff and other residents when out of cell
        - Take particular care with hand washing/respiratory hygiene and cleaning/disinfecting surfaces and objects touched by others
    - Residents with clinical vulnerabilities may change their mind and choose to start, to stop or to restart shielding. They should be supported in their choices.

B4: PPE

- PPE is one element of effective COVID-19 IPC. Other measures: see B2, B3, B5.
- **Changes to PHE/PHW/HMPPS guidance**: PPE for all essential security, health and social care duties <2m. (further details, see table p13)
- **Fit testing:** must be arranged and IPC Appendix 2 guidance re-facial hair followed prior to use of FFP3 respirators, to ensure effective respiratory protection.
- **PPE types**:
  Type 3: FFP3 respirator, gloves, eye/face protection, disposable fluid repellent gown
    - AGP suspected/confirmed COVID-19 case (including resuscitation/self-harm response)
    - Escort/bedwatch suspected/confirmed COVID-19 case
  Type 2: Fluid-resistant surgical mask, gloves, eye/face protection-risk assess, disposable plastic apron
    - Healthcare, social care or security task (non-AGP) <2m from resident/staff
    - Cell/room visit to possible/confirmed COVID-19 case >2m
    - Escort/bedwatch NOT suspected/confirmed COVID-19 case
- **Single vs sessional use**:
  Single use: Type 3 PPE; Type 2 PPE apron/gloves
  Sessional use: Type 2 PPE: mask/eye protection; change if move areas/rest break/damaged/after AGP

- **How to put on (don) and take off (doff) PPE correctly:** If possible, buddy to supervise
    - Order to put on: Apron/gown>surgical mask>eye protection>gloves
    - Order to take off: Gloves>apron/gown>eye protection>surgical mask

- **Patient use of PPE**:
- FRSM should be worn by suspected/confirmed in <u>clinical</u> and <u>communal areas</u> and when being <u>transported</u> unless clinical care compromised (e.g. receiving oxygen via face mask)
- Face coverings/masks are compulsory for all patients <u>attending hospitals</u>.
- **PPE for escorts/hospital attendance/bedwatch:**
- PPE should be immediately accessible to escort staff to facilitate transfer to hospital
- **Face coverings or face masks must be worn by all visitors to hospitals.** A FRSM should be provided for the resident and PPE should be worn by escort staff in line with PHE guidance.
- **Bedwatches:** PPE should be worn by prison staff, in line with PHE guidance. Hospitals may also request more distant security observations for bed watches, to comply with their IPC policies during the COVID-19 pandemic.Prison staff will NOT BE ALLOWED INTO ICUs on bed watch duty. There is an IPC issue and a risk of getting in the way of staff delivering one-to-one specialist care.
- **PPE and Risk of Deliberate-Self Harm**: FRSMs, plastic gloves and aprons may all pose a potential safety risk to residents by:
    - **Cutting:** metal strips from masks
    - **Ligature:** mask straps, gloves or aprons
    - **Choking/ingestion:** gloves
- **Reducing risk of DSH from PPE:**
    - **Correct disposal** of used PPE by staff
    - **Store unused PPE** away from residents
    - **Individualised assessment of DSH risk** from PPE
- It is important to balance the risk of giving PPE to a symptomatic resident who is at high risk of DSH or attempted suicide with the risk to other residents and staff of COVID-19 transmission, if PPE is not worn. In cases where PPE creates an unacceptable risk of DSH to a symptomatic resident, the resident should be carefully isolated, non-essential contact should be kept to a minimum and PPE should be worn by all staff and visitors (e.g. chaplaincy) at points of essential contact.
- All used PPE must be disposed of as clinical waste, adhering to waste disposal and IPC guidance.
- **Decontamination** and other considerations**:** Providers may decide to advise all staff (including doctors) to change into easily washable uniform on site and remove it before going home.

Recommended PPE for staff (clinical and non-clinical) in custodial settings and in community offender accommodation (COVID-19)

- Staff must minimise any non-essential and avoidable contact with any staff member or prisoner/resident when Coronavirus Covid-19 is circulating in the community. Where this cannot be practicably done, due to, e.g. the built environment, essential planned tasks e.g. searches, medication supervision or drug testing a risk assessment must be undertaken to include mitigation measures, including the provision of PPE as outlined in the table (See current HMPPS Covid Standard Operating Procedures, SOP).

- For unplanned interventions, where the 2 metre social distancing cannot practicably be achieved, PPE should be readily accessible in appropriate locations throughout the settings, for immediate use. Unplanned interventions e.g. assaults/fights, self-harm/suicide, restraint, falls, sudden onset of illness, overdose (See current SOPs).

- Reusable eye/face protection must be decontaminated according to manufacturer, supplier or infection control guidance.

- For bedwatches this is the minimum. A risk assessment of exposure needs to be undertaken (See current SOPs).

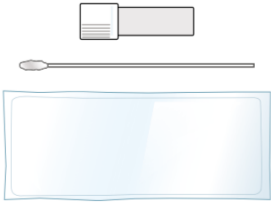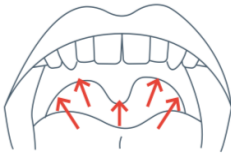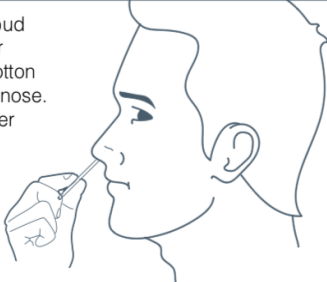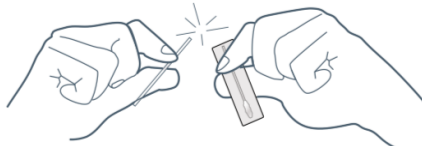- Aerosol generating procedures (AGPs) are listed in current **Guidance COVID-19 personal protective equipment (PPE)**
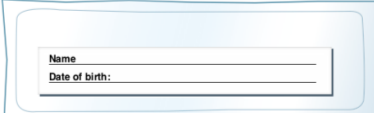
Context	Disposable Gloves	Disposable Plastic Apron	Disposable Fluid Repellent Coverall/ Gown	Fluid Repellent (Type IIR) Surgical Mask	Filtering Face Piece Respirator (FFP2/3)	Eye/ Face Protection
Within 2m of defined AGP (Refer to SOP on ambulance escort and bedwatches)	✓ Single use*	✗	✓ Single use*	✗	✓ Single use*	✓ Single use*
Essential, unavoidable and sustained health, social or security related tasks where 2 metre social distancing cannot practicably be achieved e.g. Escorts, Bedwatches, CPR, 1st Aid, Self-harm, overdose	✓ Single use*	✓ Single use*	✗	✓ Single/sessional use**	✗	✓ Risk assess sessional use**
Entry to cell/room to possible or confirmed case use single use PPE Risk assess eye protection). (Drop offs made with no entry into the cell/room, sessional gloves & aprons may be used. Risk assess eye protection).	✓ Single use*	✓ Single use*	✗	✓ Single/sessional use**	✗	✓ Single/sessional Use**

* Single use refers to disposal of PPE after each patient/prisoner/resident and or following completion of a procedure or task.

** Sessional use refers to a period of time when the member of staff is undertaking duties in a specific setting/exposure environment. Session ends when the member of staff leaves the setting/exposure environment.

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B5i: TESTING

- **Who will be tested?**
  i)   Symptomatic: ALL residents/staff
  ii)   Asymptomatic: different programmes of asymptomatic testing are being introduced by in prisons for different purposes including research, surveillance and with the aim of reducing virus transmission at points of entry, transfer and release from the secure estate.
- **Who will not be tested?**
  i)   Symptomatic people who decline testing
  ii)   Symptoms suggest non-COVID-19 illness
  iii)   Asymptomatic contacts of suspected/confirmed cases, unless they become symptomatic (or testing is arranged as part of another programme of research/surveillance/transition testing)

- **TAKING A TEST**
- Arrangements for taking swabs will vary; underlined healthcare teams will take some tests, private testing companies will be involved with other programmes, and underlined self-testing will be introduced at other sites.
- Healthcare staff should familiarise themselves with underlined PHE guidance for taking swab samples in order to guide patients taking self-tests, if needed (NB self-test kits advise anterior nasal swabbing)
- underlined Consent must be obtained before testing: explain procedure (include uncomfortable, gagging, tears)
- S**pecific COVID-19 swab** (viral medium, not charcoal) must be used.

- **SELF-TESTING (PHE guidance)**

1 Prepare to take throat sample

Please wash your hands carefully before you start.

Then unpack the kit onto a clean surface.

A. First take the throat swab. Open the swab packet which contains the small bottle and pull out the swab.

B. Wipe the soft tip of the swab around the back of your throat as shown in the diagram. Stand in front of a mirror. Open your mouth wide and stick out your tongue – you will see an arch at the back of your mouth. Try to swipe the soft tip of the swab across the five areas in the picture as below.

Rub the swab several times across the very back of your throat, behind the arch. This may make you gag but should not be painful.
Ensure you also swab the sides of the arch where your tonsils protrude.
Try to avoid swabbing your tongue and teeth.

2 Next, take the nose sample

A. Place the tip of the cotton bud gently JUST inside one of your nostrils and gently wipe the cotton bud around the inside of your nose. Please repeat this for your other nostril using the same swab.

No force is needed and you do not have to push far into your nostril.

B. Once you have taken the swab, place the soft tip of the swab into the collection tube and break off the plastic end (at the breaking off point where the swab stick is thinner). Replace the lid on the bottle.

Please avoid touching the cotton bud tip with your hands (before or after the swabbing) to avoid contamination.

3 Finally, pack the samples

A. Wash your hands again.

B. Write your name, date of birth and today's date on the outside of the small collection tube with the swab. This is very important. Your GP may include sticky labels.

Name
Date of birth:

C. Place the small tube inside the large white screw topped lid contained and close the lid tightly. Place the white top container into the cardboard box.

D. Make sure the request form details are correct and place inside the box.

- **Step 1-Throat**: Rotate tip of swab 5 times (10 seconds) at back of throat, <u>behind</u> soft palate, then rotate it 5 times (10 seconds) over each tonsil/tonsillar area. <u>Do not touch tongue, teeth or gums</u> with swab. Gag reflex likely to be triggered
- **Step 2 - Nasopharyngeal (HCP)**: Using same swab, aim tip of swab towards the ear (tragus) and insert along floor of nose until resistance met at back of nose. Repeat other nostril. Tears stimulated.
- **Step 2 - Nose (self-test)**: Using same swab, place tip just inside one nostril. Rotate swab 5 times (10 seconds) then repeat for other nostril.
- **Step 3 -** Put swab into viral medium, break off tip where marked/thinner, replace lid. Correctly label swab and complete <u>COVID-19 primary testing form (E28)</u>. Double bag sample and send to designated local laboratory without delay (by courier).

- **WHAT DOES A TEST RESULT MEAN?**
- **[Test results should be interpreted](#)** in light of both:
    - **pre-test probability**: the likelihood of having COVID-19, which will depend on local community infection rates, history of exposure to COVID-19, symptoms and signs, likelihood of alternative diagnosis
    - **sensitivity and specificity** of test; current tests have high specificity and moderate sensitivity
- **[Test results](#):**
    - **positive test result:** very likely that someone has COVID-19. Tests have been found to remain positive after infectious period has ended.
    - **negative test result:** moderately likely someone does not have COVID (2-3 people in 10 who test negative will be infected) so cannot be used to rule out COVID-19 infection, particularly if someone has symptoms and a history of exposure to COVID-19. Interpretation of results in asymptomatic people uncertain at present.

- **WHAT ACTION SHOULD BE TAKEN/NOT TAKEN)?**
- Testing will not replace/shorten self-isolation (PIU/RCU)
- **While awaiting test results:**
    - Suspected case (resident/staff) should immediately start protective isolation ('self-isolation')
    - **Household members of suspected case (resident/staff) should self-isolate**. This includes:
        - resident's cell sharing partner
        - resident's community household members (and support bubble) if in contact with suspected case within 48h of the onset of their symptoms
        - staff member's household members (and support bubble)
    - Contact tracing (see B5ii) should be initiated by prison COVID-19 lead
- **When a test result is positive:**
    - Contact tracing (see B5ii) should be initiated by prison COVID-19 lead if process not started
    - Prison staff complete Form C1(resident)/Form C(staff) (see HMPPS Contact Tracing guidance)
    - <u>Confirmed case</u> (resident/staff) should continue protective isolation for *at least 10 days (*see [B3ii](#) self-isolation)
    - <u>Household members and [other contacts](#)</u> (see B5ii) should continue self-isolating for 14 days.
    - If during this time a **contact becomes symptomatic, they become a suspected case** and:
        - HPT should be notified
        - test should be taken
        - isolation should continue for *at least 10 days (*see [B3ii](#) self-isolation)
- **When a test result is negative:**
    - Continue protective isolation of symptomatic resident for *at least 10 days (*see [B3ii](#))
    - Household contacts and other contacts may stop isolating
    - If a **contact becomes symptomatic** after stopping isolation**,** they **become a suspected case**:
        - HPT should be notified
        - test should be taken
        - isolation should re-start and continue for *at least 10 days (*see [B3ii](#) self-isolation)

- Contact tracing has been introduced in the UK as part of the public health strategy to prevent and control the transmission of COVID-19. It is an **important part of reducing the risk of an outbreak in secure environments.**
- **Who is a contact?** A contact is a person who has been exposed (<u>without PPE</u>) to the confirmed or suspected 'index case' between <u>48h before and 7 days after</u> onset of symptoms (or date test taken, if index case asymptomatic) through:
    - o **<u>Direct contact</u>**: exposure < 1m for 1minute or longer
        - ▪ face to face (coughed on, talked to)
        - ▪ physical contact (skin to skin)
    - o **<u>Proximity contact:</u>** 1-2m for >15 minutes
        - ▪ extended close contact (e.g. during exercise/association/groups/sharing cell/office)
        - ▪ travel in small vehicle with/in a plane near
    - o **<u>Household contact (staff only):</u>** significant time spent in same household
        - ▪ live and sleep in same home
        - ▪ students in accommodation with shared kitchen
        - ▪ sexual partner
        - ▪ cleaned the house
- **Who is <u>not</u> a contact?** A person who has been:
    - o exposed to index case (within specified time frame) but wore appropriate PPE
    - o exposed to index case (within specified time frame) but maintained social distancing (>2m)
    - o exposed to index case outside specified time frame (ie >48h before or >7 days after)
    - o contact of an asymptomatic contact (including household and work colleague)

- **MANAGING CONTACTS**
- PHE HPT (regional) should be notified of ALL suspected and confirmed cases by:
    - o healthcare if resident or healthcare staff member
    - o governor if prison staff member

    and will work with prisons to identify contacts of suspected and confirmed cases.
- **While awaiting test results**
    - o <u>Household members</u> of suspected case (resident/staff) should self-isolate
    - o Other <u>contacts</u> of suspected case may be notified (if suspected case wishes) and advised to:
        - ▪ maintain stringent social distancing, hand hygiene and observe for symptoms
        - ▪ avoid people at moderate or high risk of serious illness from COVID-19
- **When case confirmed (resident/prison or health staff/visitor)**
    - o <u>Household members</u> continue to isolate (14 days from start of index case's symptoms or date test done if index case asymptomatic)
    - o All other <u>contacts</u> (residents/staff) should self-isolate for 14 days
- **Asymptomatic contacts** of suspected or confirmed cases **will not be tested** (unless they become symptomatic)
- **All <u>contacts</u>** who become **symptomatic** become **suspected cases** and:
    - o HPT should be notified
    - o COVID-19 test should be taken
    - o isolation should continue for *at least 10 days (*for details, see <u>D2v</u>)
- **When index case tests negative**
    - o <u>Household members</u> and other <u>contacts</u> may stop isolating.

C1:   CLINICAL CARE DELIVERY DURING RECOVERY

- During Lockdown, across the UK, face-to-face patient access has been restricted to limit the spread of COVID-19. In secure environments, **restricted regime, cohorting and reduced inter-prison transfer** arrangements have contributed to smaller than predicted numbers of outbreaks, severe illness, hospital admissions and deaths from COVID-19, while restricting patient access.
- Where clinics have stopped or been severely restricted in order to meet lockdown requirements, **telephone appointments** (triage/consultations) have been introduced effectively in sites where residents have in-cell phones. **Paper-based questionnaires** and **wing visits** have been used where telephone access has been limited to shared wing phones.
- In-cell telephone access is being increased across the secure estate and telemedicine solutions are being developed, bringing the potential to improve access to primary and secondary care services in prison and to facilitate patient contact with community services pre-release, during and beyond COVID.
- As the UK enters the COVID-19 recovery phase, the government has set out its strategy to lift restrictions, linked to 5 levels of virus circulation and transmission risk (COVID-19 Alert levels 1-5).
- **A 5-stage conditional recovery plan has been developed for prison regimes and services** (including healthcare) which aligns with the 5 different potential phases of the pandemic (see COVID-19: National Framework for Prison Regimes and Services published 02 June 2020.)
- As the risk of virus transmission reduces, healthcare services will be incrementally reintroduced, following a **5-stage conditional Exceptional Delivery Model** aligned to the 5 different levels of regime.
- Face-to-face patient contact will increase, with IPC measures in place (appropriate PPE, social distancing, hand hygiene, patient screening for COVID-19 symptoms prior to attending healthcare).
- During the recovery period, where an outbreak occurs locally or nationally in the secure estate or community transmission levels increases, regimes and healthcare delivery restrictions will be reintroduced.

C2:   MANAGING ENTRY INTO PRISON

C2i: RECEPTION AND SECONDARY SCREENING

- **Screening for physical and mental health conditions, learning disabilities and substance misuse** is an essential part of healthcare provision and findings should be recorded on the **SEAT** (SystmOne assessment templates). It should continue at every level of the 5-stage conditional recovery plan, for every new resident, received from the community or another establishment. It is important to be aware that medical conditions may be diagnosed for the first time and more advanced illness may present in reception throughout the recovery phase (see C3).
- **The risk of self-harm should also be assessed on entry**, based on:
  - history of previous self-harm and attempted suicide
  - current presentation
  - collateral information (from liaison and diversion services, court or police custody; recorded in the PER (person escort record).

  An ACCT process should be initiated to provide support, where the need is identified.
- **SCRA**: Additional information has been uploaded onto NHS Summary Care Records (SCRA) during COVID-19, enabling clinicians to view diagnoses, vaccinations and other key patient information, in addition to acute and repeat prescriptions, where consent for record sharing has previously been agreed. This has the potential to improve patient safety and continuity of prescribing, assisting with the medicines reconciliation process.
- **COVID-19 risk stratification:** should be reviewed on all patients, in the first few days in custody (see C2ii and E2) using SEAT template, SCR(A), SystmOne (Summary/Medication/Vaccinations).

Community GP practices, CMHTs, pharmacies, substance misuse services and secondary care specialists should be contacted (phone/email) to obtain information necessary for risk stratification and continuity of care.

- **Screening for COVID-19 infection**: All new receptions should continue to be screened for COVID-19 and IPC measures followed, during the recovery phase. The number of new receptions will increase as community restrictions lift and court trials resume. This will increase the risk of COVID-19 seeding into secure environments. In addition, some new arrivals may have been temporarily accommodated in hostels or hotels provided as part of the government 'Everyone In' scheme or in multiple-occupancy approved premises, with varying degrees of cohorting, social distancing and self-isolating and increased risk of virus transmission.

- **Referral for further assessment following screening:** It is important to have **clear pathways for further assessment and treatment** where medical problems are identified by screening. It is also important to underline follow up on outstanding hospital appointments, identifying where new local referrals will be required and contacting hospitals to establish what level of service is being offered and expected waiting times. A record should be kept of all referrals and patients given safety netting advice to contact healthcare if their symptoms deteriorate or new symptoms develop while waiting to be seen at hospital.

- **During the highest levels of lockdown** (levels 5 and 4), particularly with staff absence, triage should be carried out by a senior clinician (see A2) and urgent clinical care prioritised. New hospital referrals should continue, if specialist assessment is required.

- **During the recovery phase**, face-to-face access will increase. **Systems of triage used during lockdown (levels 5 and 4) should be evaluated**. As new possibilities for remote access (in-cell telephones/video calls) become available in each site, clinical pathways should be revised to incorporate TC/VC access (see A3). Lessons from community primary care digital access should be taken into account, where transferable into the secure context. New pathways and systems should be monitored and evaluated.

- **Mental health and substance misuse issues** may have deteriorated during lockdown. People may have become involved in domestic violence or a in cycle of debt, money lending, violence and exploitation linked to substance misuse.

- **Mental health referrals and prescribing in reception:** It is important that mental health referrals are initiated in reception where primary care screening has identified a new or ongoing problem that may require further assessment and support from the mental health team. Residents should be advised that Mental Health Teams (MHT) will continue to screen and triage patients at every level of lockdown and recovery, to identify where urgent assessment is necessary, but that screening may be paper-based (or by telephone where available) if face-to-face contact is restricted.

- Where there is written confirmation of antidepressant or antipsychotic prescribing in the community (available from the patient or their SystmOne record/SCR(A)), this should be prescribed in reception to avoid/minimise dose omissions. Where prescribing information is not available, this should be followed up urgently by pharmacy teams, as part of the medicines reconciliation process.

- **Substance misuse assessment and prescribing in reception**: During lockdown, heroin quality has been poorer due to reduced imports and new dealers. Face-to-face access to community substance misuse services has been severely restricted and dependence and withdrawal have had to be diagnosed by telephone, without testing people who report symptoms. Supervised consumption services have been suspended in many community pharmacies, with 14 days unsupervised OST being dispensed for patients. Reports are emerging of increased urine drug tests showing non-prescribed methadone. All of these factors significantly increase the risk of drug related death and the importance of a cautious OST prescribing approach, following arrival in prison.

- Substance misuse screening, initial assessment and urine drug screening should be done in Reception at all levels of lockdown and recovery. If supervised consumption cannot be confirmed, new residents should be initiated on OST induction regimes and dose escalation managed cautiously, in response to withdrawal observations, in order to avoid overdose.

- Location of new residents with substance misuse issues will need to be agreed locally, and take into account IPC cohorting measures and individual patient risk (e.g. patient at high risk of alcohol withdrawal may need inpatient unit location but other new residents may have withdrawal observations facilitated in RCU rather than in usual areas allocated for residents with substance misuse issues)
- **Patient information:** Changes to care delivery and cohorting arrangements should be clearly explained to new residents, using communication aids where needed (e.g. telephone interpreting services (e.g. language line), written information in other languages, easy read and pictorial information and COVID-19-specific patient resources).
- It should be made clear to new residents that restrictions are not intended to be punitive and that during the recovery phase, the level of healthcare services available (and the way they are delivered) will change in parallel with regime changes, depending on the level of virus transmission in the local community and in the local and national prison estate.

C2ii: COVID-19 RISK STRATIFICATION Contents ¬

- Since the onset of the pandemic, evidence has been emerging about risk factors for becoming seriously ill with COVID-19 and risk stratification has become increasingly complex. It is likely that in the coming months, a more nuanced COVID-19 risk assessment approach will be developed, providing more individualised risk advice and support for patients. Until then, it is it advised that people in secure environments should be **stratified into low, moderate or high COVID-19 risk categories, within the first few days in custody so that those with clinical vulnerabilities can be offered advice to reduce their risk of infection with COVID-19**. There is a letter template on SystmOne that should be printed and given to people identified to be in the high risk (clinically extremely vulnerable) group.
- The **SEAT template, SCR(A), Summary, Medication, Vaccinations** and **Communication/letters** sections on SystmOne provide useful (although potentially incomplete) sources to inform COVID-19 risk stratification.
- At this stage, most patients will be aware whether or not they should be taking additional precautions to protect themselves from COVID-19, but there will be some people who may not have been identified and others who have developed new medical conditions since NHS letters were initially sent. (See Appendix E2 for further guidance.)
- **Current risk categories:**
  - **HIGH RISK** (**Clinically Extremely Vulnerable)**
    SNOMED CT code for high risk category 1300561000000107 - High risk category for developing complication from coronavirus disease caused by severe acute respiratory syndrome coronavirus infection (finding)
    Read Code Y228a
  - **MODERATE RISK (Clinically Vulnerable)**
    SNOMED-CT code for moderate risk category 1300571000000100 - Moderate risk category for developing complication from coronavirus disease caused by severe acute respiratory syndrome coronavirus infection (finding)
    Read Code Y228b
  - **LOW RISK**
    SNOMED-CT code for low risk category 1300591000000101 - Low risk category for developing complication from coronavirus disease caused by severe acute respiratory syndrome coronavirus infection (finding)
    Read Code Y228c
- Public Health England undertook a review of surveillance data and published a report of the disparities in risk and outcomes from COVID-19 in June 2020. The report identified additional risk factors:
  - Age and gender: older; male
  - Geography and deprivation: urban; deprived (also data suggests rough sleeping)
  - Living in a care home

- o Ethnicity: BAME background
- o Occupation: nurse, social care work, driver (taxi/bus/coach), security guard, sales and retail assistants, construction and processing plants
- Following up the PHE report, recommendations have been made to address the impact of COVID-19 on BAME communities. An expert working group has also produced a Risk Reduction Framework for NHS Staff at risk of COVID-19 infection.
- Shielding arrangements for the clinically extremely vulnerable (high risk) group changed from **6th July** in prisons (see B3ii/shielding).
- From **1st August**, shielding will be paused in the community but will continue to be offered in prisons, to reflect the high risk nature of closed settings.
- **It will be important to continue to identify and keep a record of all current residents at moderate and high risk from COVID-19 in order to offer appropriate IPC guidance and advise of the risk of severe illness with COVID-19 infection.**

C2iii: SAFE PRESCRIBING

GENERAL PRINCIPLES
- Guidance for safe prescribing in secure environments can be found in Safer Prescribing in Prisons (2nd edition, Jan 2019) and RCGP Spotlight on Healthcare in Secure Environments Toolkit.
- General principles of safe prescribing and good medicines governance (medicines reconciliation, appropriate medicines handling (including CDs), In Possession (IP) risk assessment, timely generation of prescriptions and availability of medicines) should be followed at every stage of the 5-stage conditional recovery plan.
- NICE COVID-19 guidance (Rapid Guidelines and Rapid Evidence Summaries) and NHS England COVID-19 guidance for health and justice services provide additional information to support changes to prescribing and medicines handling during the pandemic.
- **Medicines handling:** medicines brought into reception (new patient/transfer) should be handled in line with IPC guidance.
- **Continuity of medicines:** it is important to minimise dose omissions at every stage of lockdown and recovery. Access to urgent and critical medicines should continue to follow local SOPs, although these may need to be adjusted where there are changes to medicines access pathways during COVID-19. The **SCR(A)** will support prescribing in reception and medicines reconciliation, where details are up to date.
- **In-possession (IP) risk assessments:** should be completed in reception and at other points, when required (e.g. following closure of ACCT). Multi-disciplinary team discussion may be required to inform IP risk review post-ACCT closure, particularly if a resident has a history of repeated self-harm.
- Where safe and appropriate during the pandemic:
  - o prescribe regular medicines 28 days IP (generate up to 4 x 28 day repeat prescriptions)
  - o provide symptomatic relief, antibiotics and other necessary medicines IP
- IP medicines can be given out by unregistered staff where necessary. Support to self-medicate can be provided by officers or social care workers.
- **Supervised consumption (STT)** should continue for:
  - o medicines at high risk of abuse and diversion
  - o residents unsuitable for IP medicine (according to IP risk assessment).
- STT medicines must be distributed by registered healthcare professionals, wearing appropriate PPE. The resident's mouth should be checked, in line with usual practice.
- **Door-to-door delivery** of STT medicines will be required for residents who are shielded or in protective isolation due to suspected/confirmed COVID-19, including substance misuse medicines. It may also be necessary for other residents requiring supervised consumption during lockdown levels 5 and 4.
- **Socially distanced supervised medicines queues** should be facilitated for residents requiring STT, where cohorting allows this, during the recovery phase.

- **Remote prescribing:** There will be increased opportunities for face-to-face clinical/medication reviews during the recovery phase of the pandemic, however, remote consultations (primary and secondary care) are likely to continue during and beyond the COVID-19 pandemic. Remote prescriptions should be in line with NHS remote prescribing guidance for health and justice sites. Of particular note:
    - **Verbal orders will not be accepted** by the dispensing pharmacy except in very urgent exceptional circumstances and never for CDs
    - **For hospital appointments usual prescribing and access to medicines continue**:
    - Where a medicine is usually prescribed by the hospital (e.g. Hepatitis C/HIV) and it is prescribed following a remote outpatient appointment) the hospital should prescribe AND arrange for the medicine to be posted or sent via homecare to the prison (just as they would do for community patients who are housebound). We would not expect a member of HMP or healthcare staff to collect the medicine from the hospital.
    - Where there is shared care with the GP, the usual information is shared by the hospital and the GP prescribes with arrangements for review and monitoring.
- **On transfer** to another establishment, **7 days** of medication should be supplied.
- **On release**, **28 days** medicines should supplied or provided by FP10 (**OST** up to **14 days** supplied or on FP10MDA – see section C12ii for further details.)

SPECIFIC MEDICINES
- **Warfarin** should be switched to DOACs wherever possible, according to Clinical guide for the management of anticoagulant services during the coronavirus pandemic.
- **NSAIDS:** NICE COVID Rapid Evidence Summaries (RES) have been published on NSAID use (acute and long term). A CEBM review on NSAIDs in acute respiratory infection (not including COVID-19) concluded that NSAIDs do not significantly reduce total symptoms or duration of respiratory infections and that they should be used with caution, taking into account pre-existing medications and conditions.
- NICE concluded that stopping or switching NSAID treatment when prescribed for long-term conditions could have a negative impact on some people, however, use may be inappropriate for others, since COVID-19 can lead to cardiovascular and renal complications (BMJ Best Practice)
- **Dexamethasone:** Preliminary findings of the RECOVERY trial were published on 22 June 2020. It was found that low dose dexamethasone reduces deaths in patients hospitalised with COVID-19 by 1/3rd if ventilated and by 1/5th if receiving oxygen. There was no benefit seen for patients not receiving respiratory support. At present, there is no specific guidance regarding the use of dexamethasone in patients with COVID-19 in health and justice sites.
- **ACE inhibitors and ARBs for treatment of high blood pressure**: MHRA have issued a statement, advising of the importance of continuing treatment.
- **Sick Day Rules for ACE inhibitors, ARBs, diuretics, metformin, NSAIDs**: patients with fever or diarrhoea/vomiting are at risk of dehydration and AKI (see p49 linked document).
- **Vitamin D supplements**: An NHS coronavirus update about vitamin D has been published, advising people to consider taking 10 micrograms vitamin D daily due to lack of exposure to sunlight during COVID-19. This is supported by NICE ES28.
- Vitamin D supplements are likely to benefit residents in secure environments all year round, where there is very limited access to the outdoors. They are also important to prevent vitamin D deficiency in people with dark skin (e.g. African, African-Caribbean or south Asian background) or who wear clothes that cover up most of their skin. Multivitamins containing vitamin D can be bought from the canteen. They will not be prescribed by the healthcare team unless there is a proven deficiency necessitating higher replacement doses.

SUBSTANCE MISUSE MEDICINES (see also C2i)
- Prescribing for substance misuse continues to be a significant risk reduction measure and a core component of the recovery journey for people who use substances.
- (PHE/DHSC published COVID-19 guidance on provision of services for people who use drugs or alcohol in April 2020.

- It is important to be aware, when prescribing for substance misuse in reception, that face-to-face access with community substance misuse services has been severely restricted during lockdown so dependence and withdrawal have often had to be diagnosed by telephone, without testing people who report symptoms.
- Supervised consumption services have been suspended in many community pharmacies, with 14 days unsupervised OST being dispensed for patients.
- **If supervised consumption cannot be confirmed, OST induction regime should be initiated** for new residents and dose escalation managed cautiously, in response to withdrawal observations, in order to avoid overdose.
- Once the resident is stabilised on OST, consider writing 2-3 x28 day scripts.
- **If operational issues prevent the safe supply of methadone, consider using buprenorphine**. Oro-dispersible buprenorphine (e.g. Espranor) is less likely to be diverted and more quickly administered than crushed buprenorphine tablets.
- [Injectable buprenorphine (Buvidal)](#) administered on a weekly or monthly basis has been introduced to [Scottish prisons](#) during the COVID-19 pandemic to:
    - Provide safe continuous management of dependence in a group at high risk of infection transmission and developing severe illness with Covid-19 infection.
    - Ensure OST continuity where there is an outbreak in a prison
    - Reduce the need for daily contact with front line healthcare and prison staff,
    - Reduce the risk of COVID-19 transmission to other vulnerable patients in prisons.
- COVID-19: guidance for substance misuse and homelessness services in Wales recommends considering Buvidal to promote continuity of supervised OST consumption. It has therefore been agreed that Buvidal may be introduced into pre-release planning pathways in prisons in Wales, where its use is agreed between patient and community services following release (to Wales). Buvidal use is not currently recommended in secure environments in England. NHS guidance to support transfers of care from Scotland and Wales is available.
- **Naloxone training**: consider providing naloxone training **at induction/first appointment** with substance misuse services. Consider sharing naloxone training with all residents **on in-cell TV.**
- **Assisted withdrawal** (with regular observation) should be optimised for patients with a history of **alcohol** or **benzodiazepine dependence** prior to custody.
- **Assisted withdrawal from gabapentinoids** for residents identified as being at increased risk of drug-related death remains an important prescribing safety choice during COVID-19, particularly where OST service provision is suspended. Follow up medication reviews and support could be over the phone. Where staffing levels or restriction of movement make support of patients going through gabapentinoid assisted withdrawal unfeasible, dose reductions may need to be suspended.

MENTAL HEALTH MEDICINES
- Follow NICE guidance and principles set out in Safer Prescribing in Prisons (2nd edition, Jan 2019) and [NHS Health and Justice: Mental Health Prescribing: Safer use of Mental Health Medicines (2017)](#)
- RCPsych COVID-19: providing medication provides advice for managing mental health medicines during the pandemic, including antidepressants, anxiolytics and antipsychotics, depot guidance.
- **Careful consideration is required before initiating tapering and withdrawal from antidepressant, anxiolytic or antipsychotic medicines** during the COVID-19 recovery phase. Some residents may have experienced a deterioration in their mental health during lockdown, due to the threat of COVID-19 infection, reduced contact with families, regime restrictions and reduced medicines' monitoring. Other residents may be more at risk of relapse or recurrence of affective and psychotic illness as restrictions begin to lift, interactions increase, and access to illicit drugs, debt and threats of bullying and violence escalate.
- Advice should be taken from the onsite mental health team and local visiting psychiatrists about patients whose mental health appears to be deteriorating, and the prescriber should be contacted if changes need to be made to specialist-initiated medicines.

C3:   SCREENING AND IMMUNISATIONS

- **National Screening Programme** services which were suspended during levels 5 and 4 of lockdown (bowel, AAA, cervical, breast) will be reintroduced in level 3 of the recovery phase.
- **NHS Health checks**, stopped during level 5 and 4 of lockdown, will be reintroduced in level 3 of the recovery phase. A catch-up programme will be required.
- **Seasonal vaccinations** should continue during the pandemic, at all levels of lockdown. It will be important to ensure adequate supplies of influenza vaccine to facilitate timely protection for residents who will be at high (and moderate) risk of severe illneaa with COVID-19.
- **BBV testing and Hepatitis C treatment initiation** should continue throughout the pandemic, where staffing levels permit.

C4:   LONG-TERM CONDITIONS, ADVANCED DISEASE, FRAILTY AND END OF LIFE CARE

C4i: LONG-TERM CONDITIONS

- It is important to be aware that **medical conditions may be diagnosed for the first time and more advanced illness may present in reception** throughout the recovery phase.
- A CEBM publication: Supporting people with LTCs during national emergencies identifies indirect factors that drive suboptimal care of LTCs and populations and conditions more at risk. Drivers include:
    - o Diversion of health care resources
    - o Interruption to routine care and medication supply
    - o Increased stress, changes in food supply, diet and activity
    - o Disruptions to transport
- Particular conditions and populations more at risk include:
    - o Cardiovascular disease (hypertension, stroke, acute MI)
    - o Diabetes (diabetes complications)
    - o Older people
    - o People living with deprivation
- NHS figures have shown a reduction in community GP appointments booked since the onset of the pandemic, thought to be related to fear of COVID-19 but also likely to be linked to transport difficulties and, for some people, lack of access to smartphones, limited credit and unfamiliarity with the technology. Other community services have been restricted and hospitals have deferred many non-urgent outpatient appointments and provided telephone appointments for others during the lockdown period, in order to meet demand for COVID-19 cases and to meet IPC requirements.
- The CEBM publication identifies risk mitigation strategies for managing LTCs. Planning and response strategies involve: collaboration, communication and continuity planning.
- In secure environments, during the recovery phase, collaboration and communication between prison and health teams (at national, regional and local levels) will continue to be central to delivering appropriate and effective care which patients can access in a timely way. Continuity planning is set out in the 5-stage recovery model.
- It will be important to ensure that care provision during the recovery phase includes:
    - o proactive LTC reviews with safety netting advice
    - o identifying a point of contact for patients with LTCs (with advice on when/how to contact)
    - o clear identification (LTC registers) and tracking
- **Optimal management of LTCs in secure environments during the recovery phase will improve not only longer term morbidity and mortality from LTCs but also reduce morbidity and mortality from COVID-19** since tight control of e.g. diabetes will reduce the likelihood of severe illness with COVID-19.
- **Management of long-term conditions:** NICE COVID-19 rapid guidelines provide information on management of long-term conditions during COVID-19. Further advice should be requested from a

patient's specialist if needed. If newly arrived in custody, and not yet referred or seen in a local hospital, advice should still be sought from a local specialist if required.

- **Diet and activity:** Healthy menu options should be encouraged for all residents, to reduce the risk of developing and slow the rate of progression of LTCs. Gyms have been closed and out-of-cell activity has been restricted during lockdown but it remains important to encourage exercise and to maintain mobility of people with physical limitations, including those who are older and frail and at risk of falls.
- In-cell workouts have been promoted through national prison radio and WayOut TV. Links to further in-cell workouts and to exercises for people with reduced mobility can be found on the <u>RCGP Spotlight on Healthcare in Secure Environments Toolkit</u>.
- **Group work and education**: It will be important to reintroduce respiratory and cardiac rehabilitation programmes and diabetes education (e.g. DESMOND) during the recovery phase. In the community, some group work has been re-introduced online.
- Currently, online access and group work cannot be facilitated in prisons. Provision of printable educational resources (including pictorial, to cater for lower literacy and non-English speaking), access to support telephone lines, and streaming long-term condition health education on National Prison Radio and WayOut TV will be important to consider in providing support for residents living with LTCs in the months ahead.

C4ii: ADVANCED DISEASE AND FRAILTY

- **COVID-19 risk stratification**: It will be advisable to continue to identify all new receptions and to keep a record of all residents in the COVID-19 **'moderate'** (clinically vulnerable) or **'high'** (clinically extremely vulnerable) groups (<u>C2ii</u>) throughout the recovery phase, in order to:
    - o **plan appropriate individualised pathways of care** and
    - o **easily identify people who will need the highest levels of protection from infection with COVID-19 during any further local outbreaks**.
- **Frailty Assessment:** an **objective, holistic assessment of frailty** is recommended for all residents who are identified to have advanced disease and those at risk of severe illness with COVID-19. The outcome of the frailty assessment should be recorded on SystmOne.
- Residents who require assistance with mobility should have a PEEP (Personal Emergency Evacuation Plan) in place, which will be recorded on NOMIS, however a PEEP should <u>not</u> be used for the purpose of determining clinical frailty.
- The **Clinical Frailty Scale (CFS)**, when used in line with <u>NICE NG 159 COVID-19 rapid guideline: critical care in adults.</u> and taken together with age and co-morbidities, can help to inform clinical discussions around <u>ethical care</u> escalation decisions, including whether or not a patient would benefit from admission to critical care, were they to become ill with COVID-19.
- The CFS should not be used in younger people, people with stable long-term disabilities (for e.g. cerebral palsy), learning disabilities or autism. Comorbidities and underlying health conditions should be considered in all cases, involving relevant specialists if needed e.g. for people with dementia.
- **Advanced Care Planning and shared-decision making:** Treatment Escalation Plans (TEPs) should be discussed early with residents with advanced disease who are not already on an end of life pathway. Discussions should include holistic care plans, including suitability for **critical care.**
- Shared-decision making should involve families, where possible. A **Family Liaison Officer** (FLO), appointed by the secure establishment, may be helpful for this purpose.
- **Advanced Decisions to Refuse Treatment (ADRT)** should be identified and discussed with patients. Where a resident has an ADRT in place, it is important to clarify their wishes if they were to become ill with COVID-19. If a patient draws up an ADRT, they may revoke or replace it, providing they retain capacity.
- **DNACPR** is a specific decision relating to CPR in the event of cardiac arrest. It is important to identify residents with pre-existing DNACPR notices and to make ALL staff aware of them. It is also important to identify those for whom CPR would not be considered appropriate, in order to have honest and early

discussions with them about what would happen, were they to arrest if infected with COVID-19. Even if a patient does not agree with the DNACPR decision made, they should still be involved in discussions.

C4iii: END OF LIFE CARE

- Care should be underpinned by the 6 ambitions of the Dying Well in Custody Charter for residents who are already on an end of life pathway and those whose choice is to remain in the secure environment until the time of their death, whether or not their death is related to COVID-19.
- Care should **be individualised, holistic and co-ordinated, competent and compassionate**. It should be regularly reviewed and every effort made to keep the resident as comfortable and free from distress as possible. This will involve security considerations around an 'open door' policy, potential adaptations to a resident's room, identifying escalating care needs and anticipatory prescribing.
- Meeting social care needs will require good collaboration with local authority and prison colleagues.
- Guidance for patients with COVID-19 has been collated by Northern Care Alliance NHS Group and the Association for Palliative Medicine of Great Britain and Ireland. It provides suggestions for simple, non-pharmacological and pharmacological measures that can be initiated for patients with palliative needs around COVID-19. See also NICE rapid guideline [NG163]: managing symptoms (including at the end of life) in the community (April 2020) and Table 1
- Further links relating to DNACPR, advance decisions (ADRT), palliative and end of life care can be found in the RCGP Spotlight on Healthcare in Secure Environments Toolkit.

C5: MANAGING ACUTE ILLNESS AND INJURY: NON-COVID-19

- **Acute illness and injury should be managed in a timely way throughout the pandemic, regardless of the level of lockdown.**
- If a patient is unwell or injured and a face-to-face assessment is felt to be clinically necessary, it should be facilitated, either in the healthcare clinic or on the wing. For patients without COVID-19 symptoms, they can be seen in healthcare (if possible, in a 'cold' room, separated from any 'hot' areas used by patients with COVID-19 symptoms). If an escort to healthcare cannot be facilitated or the resident has symptoms suggestive of COVID-19, a wing visit should be done. Some secure environments may have the facilities to set up a specific 'hot' clinic (potentially in/near the protective isolation unit).
- Clinical assessment should be done wearing recommended PPE.
- Where acute illness or trauma require hospital assessment, transfer should be arranged in a timely way. **Discussion with the hospital should occur ahead of transfer**, whether or not the resident has COVID-19 symptoms.
- **On return from hospital,** see B3iii for cohorting arrangements.

C6: MANAGING ACUTE ILLNESS: COVID-19

AT ALL TIMES, FOR PATIENT-FACING WORK, WEAR APPROPRIATE PPE

C6i: IDENTIFY, ISOLATE, TEST AND TRACE (see also B5)

- A resident suspected of having COVID-19 infection who is well enough to remain in the secure environment should be placed in **protective isolation (self-isolation) for at least 10 days** (see B3ii)
- **Test and Trace**: The resident should be **tested for COVID-19** (B5i) Suspected and confirmed cases of COVID-19 should be notified to local Public Health England (PHE) Health Protection Teams (HPT) by prison or immigration removal centre (IRC) healthcare teams as soon as possible and a process of **contact tracing** should be initiated by the prison.
- HPTs will contact PHE's National Health and Justice Team and Centre Health and Justice leads in response to cases in prisons and PPDs. The HPT Team and PHE National Health and Justice Team will decide whether or not to declare a formal outbreak. If an outbreak is declared, the national contingency plan for outbreaks in PPD should be followed. Clinicians should attend outbreak control team meetings (OCTs) where possible, balanced against their other commitments.

- Keeping a resident's family informed of a resident's protective isolation and health is important and secure establishments may appoint FLOs to assist with this. Any health-related details will require the resident's consent before they are shared.
- Local cohorting arrangements for protective isolation should be followed. They may change during the recovery phase, depending on capacity, numbers of symptomatic residents, increasing numbers from court and any changes in inter-prison transfer arrangements.
- **The symptomatic resident should wear a surgical face mask at any time they may potentially come into contact <2m with others, in order to reduce the risk of COVID-19 spread**. This should include transfer to a PIU area, escort to and from hospital, and any time in a clinical or communal area. Once transferred from one destination to the next, the surgical mask should be disposed of carefully in clinical waste and hand hygiene should be followed (see also B4). If any surfaces have been touched by the symptomatic person, they should be cleaned.
- Suspected and confirmed COVID-19 cases should stay in a **single cell (or alone in a higher occupancy cell)**.
- Careful **multi-professional team discussion** will be required (if necessary, taking advice from local PHE) when deciding on the location for symptomatic residents with nursing, medical or social care needs or those on a shielding unit. Risk to the clinically vulnerable resident who is a suspected case will need to be balanced against the vulnerabilities of others who are co-located.
- Staff will need to monitor more closely residents with suspected or confirmed COVID-19 who are clinically vulnerable (moderate or high risk) since they are at greater risk of becoming seriously ill and requiring rapid transfer to hospital.
- **Household members** (residents who have been sharing a cell with a suspected COVID-19 case) should be **placed in isolation. The isolation period will be for 14 days** unless either the contact becomes symptomatic or the suspected (index) case tests negative (see Contacts section for further details B5ii)
- **Some residents may not report symptoms** because they:
  - have not noticed them
  - are reluctant to report them, due to anxiety, a wish to remain in shared accommodation, thoughts of suicide, deliberate-self harm or even a wish to infect others.
- If a resident is observed by another resident or a member of staff to be unwell but is not reporting symptoms, it is important to tactfully assess, isolate and test, where appropriate.
- Support should be provided through the ACCT process if the need is identified.

C6ii: INITIAL ASSESSMENT   Contents ¬

- Initial assessment should include assessment of breathlessness. **Use clinical judgment through careful history taking and questioning**. Consider all causes of cough, breathlessness and fever
- Examine patients where clinically indicated. Check oxygen saturations and temperature. In some circumstances, it may be appropriate to perform a limited examination. BP and auscultation should be used when crucial for decision making. If limited examination has been performed, this should be documented **(O/E LE).**
- NB if taking drugs affecting the immune system (e.g. oral prednisolone), a resident may have an atypical COVID-19 presentation and may not develop a fever.
- **NEWS2 score** should only be used alongside full clinical assessment since it is validated for assessment in hospital, not the community. NB Pulse oximetry: Sats <92% (<88% in COPD) on air indicates serious illness.

⚠ **Red flags**

Covid-19:
- Severe shortness of breath at rest
- Difficulty breathing
- Pain or pressure in the chest
- Cold, clammy, or pale and mottled skin
- New confusion
- Becoming difficult to rouse
- Blue lips or face
- Little or no urine output
- Coughing up blood

Other conditions, such as:
- Neck stiffness
- Non-blanching rash

Red Flags infographic – from BMJ

- **Immediate admission to hospital should be facilitated where clinically necessary** (see)
- **Where a resident has mild symptoms only at presentation**: they should be advised to:
    - **self-isolate for at least 10 days**
    - **follow safety netting advice (Red Flags, delayed deterioration c.7 days)**
    - **drink regularly** (c. every 20 minutes) and **wash their hands regularly**
    - **use symptomatic relief** supplied free of charge, using usual protocols (see Table 1)
- Consider using simple picture prompts or written information with translation, if required. Check understanding by asking them to repeat back the information.

C6iii: MONITORING
- Residents in protective isolation should have regular opportunities to **discuss any anxieties**. This may not require a member of healthcare staff but it is important that an anxious resident is neither 'fobbed off' nor given unscientific/incorrect advice (as far as is currently known).
- Residents will not require regular observations by healthcare staff unless indicated for other clinical reasons. **Closer monitoring** will be necessary for patients with:
    - **Advanced long-term condition**
    - **COVID-19 risk (moderate/high)**
    - **Signs of clinical deterioration**
- **Clinical deterioration**
- Residents with suspected COVID-19 may be initially well but deteriorate after around 7 days.
- **Pulse oximetry can be used to detect signs of early deterioration**. Sats <92% (<88% in COPD) on air indicates serious illness.
- Remember other causes for clinical deterioration: increasing cough (e.g. COPD exacerbation, asthma), persisting fever (e.g. sepsis of other cause, UTI, cellulitis), increasing breathlessness (pneumonia, pulmonary embolus, tension pneumothorax)
- **After 10 days:** suspected/confirmed case isolation may end, if assessment by healthcare confirms:
    - **48h free from i) fever (without medicine to reduce fever) ii) vomiting/diarrhoea**
    - **free from i) nausea ii) loss of appetite iii) sneezing or rhinorrhoea**
    - **follow up test negative (confirmed cases only)**
- NB if follow up COVID-19 test is positive, PHE HPT advice should be sought.
- **Post-admission with COVID-19, 14 days** isolation will be required on return from hospital (see)

C6iv: HOSPITAL ADMISSION
- **Immediate admission to hospital should be facilitated where clinically necessary:**
- Secure environments provide primary healthcare. Where a patient is assessed to require clinical admission this should be facilitated. It may be for:
    - Medicines that cannot safely be provided in the secure environment (local decision) e.g. oxygen, IV antibiotics, IV fluids or subcutaneous
    - Possible access to critical care
    - Hospital or hospice-based end of life care, if this cannot be provided on site
- PPE should be immediately accessible to escort staff to avoid delay to transfer.
- The hospital and ambulance should be told before transfer that a patient has suspected COVID-19.
- **Readmission**: If a patient's condition deteriorates following discharge from hospital or the level of care that a secure environment is able to provide does not meet a resident's clinical needs, further admission should be arranged.

C6v: SYMPTOM MANAGEMENT IN COVID-19 (including EoL)
- Symptom control guidelines for COVID-19 can be found in NICE NG163: managing symptoms (including at the end of life) in the community (April 2020) and Table 1

- The level of care that can be offered by each secure environment will vary, depending on the resources available (e.g. 24h nursing care, respiratory physiotherapy, IV or s/c medicines, oxygen, social care). This will influence the timing of hospital admission and discharge.
- **Community-acquired pneumonia**: if suspected, use pulse oximetry track for deterioration
- Management should follow NICE COVID-19 rapid guideline [NG165]: managing suspected or confirmed pneumonia in adults in the community (April 2020)
- Do NOT offer antibiotics if pneumonia likely to be due to COVID-19 virus or symptoms are mild. Provide safety netting advice. Prescribe antibiotics if at high risk of complications due to age, frailty, co-morbidities, or severe illness with previous lung infection.
- Recommended antibiotics are:
  - **1st line** (oral): **doxycycline** 200 mg day 1, then 100 mg od for 5/7 total (not in pregnancy)
  - **Alternative/2nd line**: **amoxicillin** 500 mg 3 times a day for 5 days.
  - for penicillin allergy: NICE guidance (NG138) for Pneumonia (community acquired)
- IV antibiotic prescribing decisions will be made locally, depending on agreed enhanced primary care provision.
- **Oxygen is a key part of managing more severe symptoms associated with COVID-19.** Provision will be subject to local agreement, depending on staff capacity and skill mix, oxygen cylinder procurement, delivery and return, and collaborative risk assessment with prison/security teams.
- For **end-of-life breathlessness**, if available, consider a **trial of oxygen therapy**. Continue if it alleviates breathlessness.
- **Do NOT offer oral steroids** unless indicated for another condition e.g. asthma
- **Post-discharge symptom management:** Patients who have been admitted to hospital are likely to be discharged earlier than usual, due to pressure on beds. Healthcare teams should work with their local hospital trusts to ensure that a patient's healthcare needs can be met in prison when they are discharged back.
- Other prison residents cannot be expected to provide social care.
- If a patient's condition deteriorates following discharge from hospital or the level of care that a secure environment can provide does not meet a resident's clinical needs, further admission should be arranged.

C6vi: RECOVERY FOLLOWING COVID-19
- It is important to recognise that, while most people may experience mild symptoms from COVID-19 and recover within 7-14 days, increasing numbers of people, especially post-hospital admission, report persisting symptoms including:
  - Fatigue
  - Breathlessness
  - Post-viral cough
  - Muscle weakness
  - Difficulties with memory and confusion
  - Sleep-related problems including insomnia and nightmares
  - Flashbacks, anxiety, depression
- It will be helpful to keep a record of:
  - Residents who were admitted to hospital with COVID-19
  - Residents who were not admitted with COVID-19 but who have symptoms persisting beyond 14 days

as they may require reasonable adjustments and additional multi-disciplinary support for their rehabilitation. Support for recovery should be tailored to the individual.

SYMPTOM MANAGEMENT: COVID-19 INCLUDING PALLIATIVE AND END OF LIFE MEDICINES					
INDICATION	NON-PHARMACOLOGICAL	1st LINE DRUG	DOSE/NOTES	2nd LINE DRUG	DOSE/NOTES
Fever Offer pharmacological treatment only if other symptoms also present	Keep room cool Wear loose clothing Cool face with flannel/cloth Fluids – up to 2 litres/d **Avoid portable fans** (risk infection spread)	**Paracetamol (PO)**	0.5-1g every 4-6h PRN, max 4g/24h	**Paracetamol (PR)**	0.5-1g every 4-6h PRN, max 4g/24h
		Ibuprofen (PO)	400mg tds; lowest effective dose, shortest period needed		
Cough Treat only if cough distressing See NICE NG165 if suspected/confirmed pneumonia	Avoid lying on back if possible (cough ineffective)	**Codeine (PO)** Codeine linctus (15mg/ml) or codeine phosphate tablets (15mg, 30mg)	15-30mg every 4h PRN (max qds); increase to 30-60mg qds PRN (max 240mg/24h) Avoid if risk sputum retention e.g. bronchiectasis. Short-term only unless EoL	**Morphine (PO)** Morphine sulfate solution (10mg/5ml)	2.5-5mg (IR) every 4h PRN; increase to 5-10mg every 4h PRN. If patient already taking regular morphine, increase regular dose by 1/3rd **NB constipation risk;** consider regular stimulant laxative
Breathlessness Identify and treat reversible causes e.g. pneumonia, heart failure If accompanying anxiety, see below	Keep room cool Calm and reassure: touch, talk, explain Encourage relaxation techniques and breathing techniques - pursed lip (nose in 5 secs, mouth out 5 secs) Air across the face: open window, avoid fan Positioning – see diagrams from BLF	**Morphine (PO)** Morphine sulfate (10mg/5ml) (IR) or (MR)	(IR) 2.5-5mg every 2-4h PRN; if already on opioids 5-10mg or 1/12th of 24h dose every 2-4h PRN (MR) 5mg bd; increase PRN (max 30mg/24h)	**Oxycodone (PO)** (IR) or (MR) **ONLY if e-GFR <30 ml/min**	Dose equivalence (see BNF Prescribing in Palliative Care and local guidance)
		Morphine (SC) Morphine sulfate (10mg/ml)	(SC) 1-2mg every 2-4h PRN (if more than bd and if skills/availability use: syringe driver morphine sulfate 10mg/24h, increasing stepwise to 30mg/24h)	**Oxycodone (SC)** **ONLY if e-GFR <30ml/min**	Dose equivalence (see BNF Prescribing in Palliative Care and local guidance)
		Oxygen	**Trial** - in line with NICE NG163 and NHS guidance; **continue if beneficial**		
Anxiety	Explore anxieties Calm and reassure: touch, talk, explain Encourage relaxation techniques and breathing techniques Adjust lighting	**Lorazepam (PO)** (S/L off-label use)	0.5–1mg qds PRN, max 4mg/24h (0.25-0.5mg, max 2mg/24h if elderly, debilitated)	**Levomepromazine(PO)**	Start 6mg every 2h
		Midazolam (SC)	2.5-5mg every 2-4h PRN; if>bd and skills/available use: **syringe driver;** start 10mg/24h, increasing stepwise; reduce to 5mg/24h if eGFR <30	**Levomepromazine (SC)**	Start 12.5-25mg, hourly PRN (6.25-12.5 mg elderly) Infusion 12.5-100mg/24h (up to 200mg/24h if specialist input)
Delirium Identify and treat reversible causes	See RCPsych Delirium management advice for patients with confirmed or suspected COVID-19 in the acute trust setting	**Haloperidol** (PO/SC)	0.5-1 mg ON and every 2 hours PRN Increase dose by 0.5- 1mg PRN to max 10 mg/d (max 5 mg/d elderly). Infusion 2.5-10 mg/24 hours	**Levomepromazine** (PO) (SC)	See above
Nausea Identify and treat reversible causes	See Scottish Palliative care guidelines	**Haloperidol** (PO/SC)	1.5mg od-bd to 5-10mg/d (divided doses) Infusion 2.5-10 mg/24 hours	**Levomepromazine** (PO) (SC)	6mg ON, up to 12.5-25mg bd 6.25mg ON, up to 12.5-25mg bd

Table1: Symptom Management in COVID-19 (including EoL) – see also link-enabled version

SYMPTOM MANAGEMENT: COVID-19 INCLUDING PALLIATIVE AND END OF LIFE MEDICINES - Continued

		Step 3 / Alternative	Dose equivalence (see BNF Prescribing in Palliative Care and local guidance)
Pain Identify and treat reversible causes Consider type of pain Explore anxieties/other psychological issues	Prescribe in line with Pain Management Formulary for prisons **End of Life:** Follow **WHO 3 step pain ladder** for cancer pain. **Step 1** Non-opioid (paracetamol, NSAID)	**Step 3 Morphine** (PO) Morphine sulfate (10mg/5ml) See BNF morphine, BNF Prescribing in Palliative Care and local formulary Initial dose: 5-10mg every 4h. Titrate to achieve adequate pain relief	**Step 3 Oxycodone (PO)** (IR) or (MR) ONLY if e-GFR <30 ml/min Dose equivalence (see BNF Prescribing in Palliative Care and local guidance)
Start analgesia early, to prevent pain developing. Prescribe regular (not PRN) use in EoL cancer pain	**Step 2** Opioid - weak (codeine, tramadol) **Step 3** Opioid – strong (morphine) **Adjuvant analgesia** (antidepressant, antiepileptic) can be prescribed at any step	**Step 3 Morphine** (SC) Morphine sulfate (10mg/ml) See BNF morphine, BNF Prescribing in Palliative Care and local formulary Initial dose: 5-10mg every 4h. Titrate to achieve adequate pain relief	**Step 3 Oxycodone (SC)** ONLY if e-GFR <30 ml/min Dose equivalence (see BNF Prescribing in Palliative Care and local guidance)
Colic	**Hyoscine butylbromide (SC)** (20mg/ml) See BNF hyoscine, BNF Prescribing in Palliative Care and local formulary. 20mg SC PRN 4hrly up to every 1hr (60-300mg/24 hours)	**Glycopyrronium (SC)**	200mcg every 4hr up to every 1hr. 0.6-1.2mg/24h
Noisy breathing/ Respiratory Secretions	**Hyoscine butylbromide (SC)** (20mg/ml) See BNF hyoscine, BNF Prescribing in Palliative Care and local formulary. 20mg SC PRN 4hrly up to every 1hr (20- 120mg/24 hours)	**Glycopyrronium (SC)**	200mcg every 4hr up to every 1hr. 0.6-1.2mg/24h
Opiate Substitute Treatment See York Pathway	**Keep OST maintenance prescribing separate from symptom management, Use separate chart; see additional notes**	**Methadone (PO) or (SC) name one prescriber** **Buprenorphine (SL/PO)** SC) see additional notes See York Pathway. (PO) – usual dose (SC) half oral dose in 0.9% N/Saline (SC). Continue usual maintenance dose. NB SC (weekly/monthly preparation) use restricted in UK prisons.	**Additional notes:** Maintenance OST prescribing should continue at usual dose. Do **not** modify dose if other opioids are introduced for symptom control. Buprenorphine: SC use restricted currently. Oral lyophilisate likely to be easier to use than SL if unable to swallow.

🐟 Recommended as Priority medicines for palliative and end of life care during a pandemic

- Use oral medication where patient can swallow. Use subcutaneous route if unable to swallow.
- **Oxygen** use should be in line with NICE NG163 and NHS Clinical guide for the optimal use of Oxygen therapy during the coronavirus pandemic

Positions for assisting breathlessness (see British Lung Foundation)

Forward lean standing	Forward lean sitting	Forward lean sitting (adapted – pillows on table)	Side lying/forward lean lying (adapt with pillows under patient to achieve more vertical position)

Table 1: Symptom Management in COVID-19 (including EoL) - see also link-enabled version

C7: <u>**RESUSCITATION**</u>

- <u>Resuscitation Council UK guidance</u> on CPR for patients with suspected/confirmed COVID-19 in primary care settings should be followed.
- **Prevent cardiac arrest and resuscitation on site where possible**
  - Identify early patients at risk of severe illness, acute deterioration or cardiac arrest.
  - Take appropriate steps to prevent cardiac arrest.
  - Seek advice early re- admission to hospital for acute/advanced medical care.
  - Facilitate timely hospital transfer
  - If resuscitation would be inappropriate for a patient, discuss DNACPR with the patient and record clearly in SystmOne and communicated to all staff
- If the patient has a cardiac arrest, apply defibrillator, cover the mouth and nose with towel/cloth and start chest compressions while wearing non-AGP PPE.

Resuscitation Council UK

Resuscitation of adult COVID-19 patients: primary care settings infographic

Consider treatment escalation and resuscitation decisions for all inpatients

① **999** Recognise cardiac arrest. Do not put your face near the patient's face to listen/feel for breath. Call 999, state the risk of COVID-19

② Attach defibrillator if available – shock if indicated. Early restoration of circulation may negate the need for chest compressions and ventilations

③ If no PPE is available, the individual must decide the course of action. As a bare minimum, cover the patient's nose and mouth with a cloth if chest compressions are carried out in the home/public space. Ideally don at least non-AGP PPE (eye protection, gloves, disposable plastic apron and fluid resistant face mask) before commencing chest compressions.

Ventilations and further ALS measures should only begin when assistance has arrived wearing AGP PPE (eye protection, disposable gloves, coverall/gown, FFP3 mask). If not wearing AGP PPE, withdraw to a distance of at least 2 metres.

Version 1. Published 11 May 2020.

- Additional oxygen provision can continue during cardiac compressions. If airway support is required, staff should only use equipment for which they have been trained. This may be an oro-pharyngeal airway, bag and mask or, if trained, a supraglottic airway (e.g. i-gel).
- After resuscitation, PPE should be correctly removed and disposed of. Equipment should be disposed of or cleaned, as appropriate. Handwashing at every stage is essential.
- A post-resuscitation debrief should be done and follow up support should be offered to staff and other residents, affected by the death.

C8: DEATH FROM COVID-19

- The death of a resident from COVID-19, whether on site or in hospital, is likely to have a significant impact on the whole secure environment community – both residents and staff. Pastoral care and vigilance for emerging symptoms of mental health deterioration, in both residents and staff, will be required. Support services should be identified and communicated to those involved in the individual resident's care, in a timely and effective way.
- **PHE Guidance for care of the deceased with suspected or confirmed coronavirus (COVID-19)** should be followed.
- All residents should stay at least 2m from the deceased person and all non-essential staff contact with the deceased person should be avoided, to minimise risk of exposure.
  The usual processes for dealing with a death in custody should be followed, ensuring that IPC measures are implemented, as set out in the PHE guidance.
- **Changes to death certification:** Due to Article 2 (Human Rights Act 1988) and subsequent inquest, prisons are exempt from verification of death by nurses and other healthcare professionals. However, temporary agreement may be reached with the local Senior Coroner, HMPPS and PPO where assurance is given and robust training and governance is in place.
- **PPO/Coroner's Cases:** Every death in custody will continue to be investigated by the PPO, including deaths from COVID-19. Evidence (e.g. medical records, decision making logs, CCTV*) should be preserved and information will be gathered through submission of paperwork and remote interviews. *CCTV is the responsibility of HMPPS and not the healthcare provider.
- **The 48/72 hour immediate review needs to be completed by providers and shared with commissioners within the usual timeframe as it will inform PPO case prioritisation. This report must include all information requested on the report template, including ethnicity, testing and symptom status.**
- Clinical reviews will continue to be requested and concerns about capacity/action should be highlighted to the PPO regionally.

C9: MENTAL HEALTH

- The Centre for Mental Health has published a report [Covid-19: Understanding inequalities in mental health during the pandemic](#), which identifies that mental health is at greatest risk from the pandemic in people with existing mental health problems, long-term physical conditions, women and children experiencing violence and abuse, and Black, Asian and minority ethnic communities. The report states that the combination of existing structural inequalities and the unequal impacts of the pandemic mean that people whose mental health was at greatest risk prior to Covid-19 are likely to be disproportionately affected in the longer term.
- It is important to understand that adverse psychological and behavioural responses may occur during pandemics, whether or not a person has pre-existing mental health conditions.
  Psychological responses: **'distress symptoms'**
    o irritability
    o distractibility
    o increased sense of vulnerability
    o sleep difficulties

- o   medically unexplained physical symptoms

Behavioural responses: 'risky behaviours'
- o   increased use of illegal drugs, tobacco, alcohol
- o   interpersonal violence
- o   forgetting to take medication/running out of medication
- o   unsafe sex

- Many of these responses have been reported across the UK during lockdown due to threat of illness and death, separation and loss, concerns about finance or housing. They have also been reported by residents in secure environments.
- Contact with loved ones has been limited to brief daily phone calls, time behind a locked door has often exceeded 23 hours/day, groups for education and recovery have stopped, libraries have been closed and meaningful activities have been severely restricted. In addition, there have been delays to court hearings/trials, restricted sentence options and delays to sentence progression as courses for sentence requirements have been stopped.
- Where available, in-cell phones have allowed more frequent contact and video calls have had a significant positive impact on residents and their families. Outdoor HIIT exercise sessions, in-cell workouts/yoga, craft, printed education, recovery and mental health resources have all provided some purposeful activity. There have also been some local community initiatives to provide books, activity packs or bags of snacks.
- The effect of the lockdown on residents with pre-existing mental health disorders has been variable; some have experienced an exacerbation in symptoms e.g. obsessional, anxiety and PTSD symptoms; others have experienced a reduction in pre-existing anxiety due to being in their cells, away from threats of bullying and violence.
- Reduced access to illicit substances has been protective on mental health.
- During the recovery period, there is likely to be a growing disparity between closed environments and the community. This is likely to have a negative impact on the mood and behaviour of some residents and it will be important to be vigilant for mental health deterioration, ensuring a trauma-informed approach to care.

- **PSYCHOLOGICAL FIRST AID (PFA) - responding to psychological and behavioural responses**
  Psychological First Aid (PFA) is an evidence based intervention that seeks to build resilience and can be delivered by specialists or lay people. Training is available from PHE. It is based on 5 principles:
  1) Safety - provide credible and accurate information about keeping safe from infection
  2) Calming - sleep, nutrition, exercise, hydration, avoid watching rolling news
  3) Increase self and community self-efficacy – behavioural interventions (breathing, progressive muscle relaxation, visualisation, yoga, find opportunities for meaningful activity)
  4) Connectedness – normalise, develop new shared routines, facilitate communication with loved ones
  5) Hope/Optimism - strong messaging e.g. 'This will end', 'Most people will do well', draw on strengths gained from surviving previous adversities

- **OTHER SIMPLE MEASURES**
- Throughout the recovery phase, residents will benefit from: health promotion messages encouraging a compassionate approach towards one another, relaxation and breathing exercises, advice to avoid anxiety-provoking TV (restrict watching news to e.g. twice a day), reading (include pictorial/easy read options), colouring, match craft, other creative activities, chess, cards, board games, writing letters to loved ones.
- **Simple practical advice** is available from Every Mind Matters and RCPsych. This can be delivered either 1:1, in meetings with peer mentors/Health Care Champions or via radio/in-cell TV and will benefit both residents with pre-existing mental health problems and those anxious due to COVID-19.
- **Links to cell-based workouts, gentler exercises, yoga and relaxation resources** and a therapeutic activity (distraction) pack are available on the RCGP Spotlight on Healthcare in Secure Environments Toolkit.

- **MENTAL HEALTH SCREENING AND ASSESSMENT**
- Reduced staffing may lead to increased waiting times for screening and reduced capacity for face-to-face mental health appointments.
- **Paper-based or telephone screening and prioritisation of face-to-face assessments** should continue where access to residents remains restricted, during the recovery phase.
- **It will be important to respond to appropriately and in a timely way to collateral information;** concerns about residents expressed by wing officers and allied professionals will be especially important. Support should be provided through **ACCT** where required.
- **Video consultations** may be used for visiting psychiatrist appointments and Mental Health Act assessments, to facilitate timely transfer to and from mental health inpatient hospitals where onsite staff are limited.
- Hospital transfers under the **Mental Health Act (1984) sections 47 or 48** are for mental health assessment/treatment only - not for physical health needs. The Mental Health Act cannot be used to transfer someone to hospital for treatment for acute medical needs associated with Coronavirus, against their will, even if they appear to be making an unwise decision.
- RCPsych COVID:19: Providing medication and NHS Mental health, learning disabilities and autism: guidance provide useful information for clinicians (with easy-read versions)

C10:   SUBSTANCE MISUSE (see also Section C2i, C2iii and C12)

- In conjunction with DHSC, and with advice from NHS England and NHS Improvement, PHE has published guidance for commissioners and providers of services for people who use drugs or alcohol. The guidance is to support the continuity of drug and alcohol treatment services throughout the Coronavirus (COVID-19) pandemic, while protecting staff and service users.
- It will be important to ensure that residents with substance use disorders are not discriminated against (either in the secure environment or by secondary care services) if a local outbreak occurs during the recovery phase which places strain on health provision.
- Very little is known about COVID-19 and the impact on people with substance misuse disorders however it is likely that multiple complex physical, psychological and social factors may contribute to an increased risk of COVID-19 infection and more serious complications.
- Supply chains for illicit substances have been impacted by restrictions on borders, travel and lockdown measures. This has had an impact on the quality of drugs available e.g. heroin resulting in increased risk of harm and drug-related death. Supply routes are likely to open up in the coming months which may also increase the risk of overdose and drug-related death due to increasing access and purity of available drugs.
- Harmful substance misuse behaviours e.g. hooch production, Spice intoxication have been seen in some residents during lockdown (see C9 'risky behaviours') while other residents have reduced or stopped illicit use, due to reduced supply (interception of 'throw overs', visits stopped).
- **Harm reduction advice** should be provided to all residents so that they are aware of the dangers of illicit use and of sharing equipment and containers. Health messages can be delivered through in-cell TV, radio and posters, in partnership with substance misuse team. Printed in-cell material should be made available where face-to-face 1:1 and group recovery interventions are restricted or suspended.
- **Opioids and other CNS depressants**: Residents must be made aware of the dangers of opioid use and other CNS depressants that could impact on breathing, particularly with COVID-19 infection.
- **Methamphetamine, cocaine** may cause or exacerbate lung disease and residents should be warned that it could put them at increased risk of severe illness with COVID-19 infection.
- **Psychotropic drugs including spice and cannabis** may exacerbate anxiety, paranoia and other mental health disorders, making it harder for residents to cope with the restrictions and loss of control associated with secure environments and with anxieties about COVID-19.
- **Substance misuse prescribing**: (see C2i, C2iii and C12.)

- **Smoking:** [COVID-19: advice for smokers and vapers has been published.](#) Smoking cessation advice and support will remain important throughout the recovery phase. NRT should be provided (healthcare) and vapes should continue to be offered (obtained from prison or canteen) as part of harm reduction and smoke-free estate provision. Further information is needed on vaping/COVID-19. As restrictions are eased, face-to-face opportunities for smoking cessation advice will increase. Where smoking cessation advice cannot be delivered face to face, it may be provided on in cell TV and radio and through written information.
- Drug-related deaths resource: SMMGP webinar (12 March 2020)

C11:   SEGREGATION

- **PSO 1700 amendments (COVID-19)** were made in the early stages of the pandemic to ensure that residents held in segregation were able access healthcare, despite restrictions to face-to-face clinical care and reduced staffing levels. These amendments continue to be effective throughout the pandemic recovery phase.
  - o *Section 2.2 daily visits with social distancing, member of healthcare team (doctor, registered nurse or healthcare officer). If daily visit not possible, prison to record in Silver Defensible Decisions log and consider how to mitigate any risks.*
  - o *Section 2.3 paragraph 4: doctor <u>or</u> registered nurse must visit every prisoner in segregation as often as their individual health needs dictate and at least every three days. If this is being carried out by a registered nurse they must carry out a clinical risk assessment and consider the prisoner's physical, emotional and mental well-being and whether a doctor visit needs to take place.*
- Current PHE guidance on use of PPE should be followed when seeing residents in SSU (see [B4](#)).
- With the rollout of telemedicine in secure settings, in response to the pandemic, NHS approved mobile devices with HMPPS-approved software will provide **mobile access to SystmOne** for clinical encounters in SSU. SystmOne access at the point of care should improve patient safety.

C12:   MANAGING RELEASE FROM SECURE ENVIRONMENTS

C12i: RELEASE PLANNING

- See [NHS Guidance for healthcare teams on the release of adult patients from the secure and detained estate during coronavirus (COVID-19)](#)
- **Joined up working between health and National Probation Service/CRCs is essential for safe release** during COVID-19
- **Discharge Planning Meetings** continue to be key to ensure **continuity of care** on leaving secure settings both during recovery and beyond COVID-19 . They should be held **at least 6/52 pre-release** to identify healthcare referrals and other arrangements that need to be in place for safe release.
- Meetings should be attended by substance misuse, mental health, primary care, OMU and HMPPS teams and the resident. If a resident DNAs the discharge planning meeting, NPS/CRC can support them with GP pre-registration.
- **Discharge of <u>pregnant patients and women on mother and baby units</u>:**
- Through the Gate service (trauma-informed) and housing must be provided
- Review registered community GP details. **If no GP, pre-registration to be completed**
- Refer for [needs assessment re-unborn child/child by social services](#) include details of any children in home where mother will be living
- Allocate link midwife at birthing unit of choice if in 2nd/3rd trimester
- Inform local named safeguarding midwife
- If protection plan in place for unborn child it must inform all release planning/location decisions

- Log protection plan on [Child Protection – Information Sharing (CP-IS)](). Document on S1
- **Pre-registering a Patient**
- At discharge planning meeting (or other appointment): resident to choose GP practice
- Contact chosen GP practice (telephone/email). If resident NFA or surgery declines to register them, contact NHSE/CCG to request allocation to local practice https://www.england.nhs.uk/ccg-details/
- Email chosen GP with:
  - Completed GMS1 form
  - Discharge letter
  - COVID-19 risk/shielding status
  - Details of TTO medication provided to patient at release
- Patients returning to Wales: COVID-19Wales@justice.gov.uk

- **DISCHARGE PLANNING ACTION LIST**
- **6/52 pre-release**
  - Review registered community GP details. **If no GP, pre-registration to be completed**
  - Referrals to community mental health and substance misuse services.
  - **If pregnant**: see **pregnant patients and women on mother and baby units** (above)
  - Home address and mobile phone number on release – share with community teams (consent)
  - Medication review
  - Prepare discharge letter to be emailed to community GP
  - Prepare discharge pack for resident (tailored for local area)
  - COVID-19 risk review. Shielded Patients: GP letter and patient information for release
  - COVID-19 status: Symptoms (past/current); Test (not tested/tested; positive/negative)
- **1/52 - 48h pre-release**
  - Complete **SEAT discharge template**
  - Complete **discharge letter** (if not already done) and email to community GP
  - Arrange **1:1 patient TC/VC** with community services (GP/Substance misuse/CMHT)
  - **If pregnant**: see above. Confirm pre-release TC/VC/visit from link midwife. Confirm social services needs assessment of unborn/child complete.
  - Discuss [NHS volunteer responder scheme]() refer/self-refer (shielded/self-isolating) until 31st July
  - Check resident's contact number/address shared with community teams (with consent).
  - Naloxone training refresher
  - Check contents individualised **discharge pack** (information for resident)
  - Communicate with pharmacy team/prescribe TTOs (see C12ii)
- **On day of release**
  - Check resident for symptoms of COVID-19
  - Copy of community GP discharge letter to patient
  - Copy of shielded letter to patient (if clinically extremely vulnerable) - template on S1
  - [NHS volunteer responder scheme]() Refer/self-refer (if shielded/self-isolating) until 31st July
  - Hand over any outstanding outpatient appointment letters.
  - Check resident has community SMS/CMHT appointment details
  - **If pregnant**
    - Check resident has link midwife and social worker details.
    - Pass patient to Through the Gate team
    - Contact link midwife and social services team
  - Daily OST dose administered before release
  - TTOs/script (and naloxone) to patient
  - Email community GP to confirm release (discharge letter/COVID-19 risk and status/test results/details of medication provided to patient on release)
  - Resident to be given a face mask/face covering (by the prison) to wear on public transport
  - Patients returning to Wales: contact COVID-19Wales@justice.gov.uk

- **IF COVID-19 SYMPTOMS ON DAY OF RELEASE**
    - **Duty GP must**
        - **inform PHE local health protection team (HPT)**
        - **complete notification form** immediately
    - **Clinician must Inform NPS/CRC** (probation provider/community rehabilitation responsible officer) – may need further action transport/licence conditions

- **Discharge Letter Contents** (to community GP)
- Consider holding **pre-release clinic** for preparation of discharge letter. Details to include:
    - New key diagnoses
    - COVID-19 risk category (low/med/high). Confirm if advised to shield
    - COVID-19 status (past/present symptoms; test status – declined/awaited/positive/negative)
    - Any outstanding investigations/referrals/OPA
    - Changes to medication – rationalisation/dose
    - Details of TTOs/FP10/FP10MDA given to patient on release

- **Discharge Pack Contents** (information for resident)
- Consider providing individualised multi-professional discharge pack (health/CRC/OMU/HMPPS)
    - Copy of community GP discharge letter (and shielded patient letter if applicable)
    - Harm reduction advice (see below)
    - Naloxone (to be provided with TTOs/script – see C12ii)
    - Details of NHS help for suicidal thoughts
    - COVID-19 government community guidance: Staying alert and safe (social distancing)
    - Guidance re-face coverings/masks for hospital attendance, total triage GP appointment system
    - Local services details: GP/pharmacies/SMS/CMHT/Samaritans/housing/job/education
    - NHS volunteer responder scheme details (use if shielded/self-isolating) until 31st July

- **Harm reduction advice** (Resident at risk of drug use/sex working following release)
    - Hygiene practices e.g. wash hand/injection site, clean surfaces before/after preparing drugs
    - Avoid sharing alcohol and drug consumption equipment, including drinking vessels, pipes, bongs, vapes, joints, snorting tubes, and injecting equipment
    - Ensure take-home naloxone is available and stored in an accessible location
    - Do not inject alone due to risk of overdose. Inject in the presence of others but not close contact; remain at least 2 metres away.
    - How to access treatment (OST), care and managing withdrawal symptoms if required to self-isolate
    - Sex work: COVID-19 can be transmitted by close contact including kissing, coughing. Avoid close/direct contact with anyone with respiratory symptoms.
- **NHS volunteer responder scheme** provides support for:
    - People who want to continue to stay at home or who need to avoid busier public spaces, such as supermarkets
    - People with caring responsibilities
    - People who are self-isolating because they've been diagnosed with COVID-19 or have symptoms
    - People who've been instructed to self-isolate by the 'Test and Trace' service, because they've been near someone infected.
    - People who are self-isolating ahead of planned hospital care.
    - Frontline health and care workers
- **Patient referral to NHS volunteer responder scheme (until 31/7/2020)**
- People can be referred to the NHS volunteer responder scheme if symptomatic/shielded. Application:
    - **Online: https://www.goodsamapp.org/NHSreferral Phone: 0808 196 3382**
- **Self-referral (until 31/7/2020)   Phone: 0808 196 3646 (8am to 8pm)**
    - Further info: https://volunteering.royalvoluntaryservice.org.uk/nhs-volunteer-responders

C12ii: SAFE PRESCRIBING FOR RELEASE

- **ON TRANSFER** to another establishment: supply **7 days** of medication

- **PRE-RELEASE (see [NHS guidance on medicines continuity](#))**
- Pharmacy teams should be informed of residents due to be released in week ahead
- To manage reduced access to primary care and substance misuse services post-release, prescribe:
  TTO up to 28day supply medicines (including CDs) or FP10 28day script
- **BUT assess patient risk of self-harm or drug-related death**. If risk too great for 28d/14d consider:
- TTO 7day supply medicines and provide post-dated FP10 scripts 3x 7d.
- Arrange for patient/community support worker/NHS volunteer to take all future dated scripts to patient's chosen local pharmacy

- **OST PRE-RELEASE PLANNING:**
- **Consider increasing OST to achieve optimal dose** to:
  - reduce risk illicit opioids on top of OST script
  - increase engagement with community drug services
- patients on low dose OST are likely to find the burden of attending pharmacies and appointments greater than the benefit of buying heroin and will not engage with drug services after release – see SMMGP webinar 12/03/2020 Drug related deaths in criminal justice settings
- **Consider switch to buprenorphine** 7-28d pre-release
- Substance misuse/recovery team should:
  - contact pharmacies in resident's local release area to clarify if OST supervised consumption service available
  - provide naloxone training to resident.
- To manage reduced access to primary care and substance misuse services post-release, prescribe
  - **If OST supervised consumption available: FP10MDA up to 14day bridging script**
  - **If OST supervised consumption <u>unavailable</u>: FP10MDA 14d bridging script <u>daily pick up</u>**
  - **Naloxone kit** (and training)
- **Buvidal prescribing**: It will be important to liaise with community substance misuse teams pre-release to agree ongoing OST treatment plans if injectable buprenorphine (Buvidal) has been prescribed.
- **Friday releases**: To avoid missed doses over weekend, consider providing labelled OST medicine for weekend, if not possible to identify a pharmacy for supervised consumption/daily pick at weekend, where resident is being released to. The risk of OST overdose should be carefully weighed up against risk acquiring illicit opiates due to lack of access to OST.

- **ON RELEASE (see [NHS guidance on medicines continuity](#))** ideally supply:
  - **28 days medicines or FP10 for 28 days** (including CDs)
  - **14 days OST or FP10MDA for 14 days** (daily pick up if no supervised consumption available)
  - **Naloxone kit** (with guidance on use)
  BUT assess patient risk of self-harm or drug-related death (see above)
- [Accessing medicines post-release: information for support workers (probation/Youth Offending Teams)](#)

SECTION D: STAFF CONSIDERATIONS

D1:   STAFF CONSIDERATIONS

- **COVID-19 Risk Management**
- Staff who have been identified as clinically extremely vulnerable have been shielded since March 2020. Shielding arrangements are changing and, from 1st August, shielding is due to be put 'on pause'.
- In June, Public Health England published a report of the disparities in risk and outcomes from COVID-19 which identified additional risk factors. Following up the PHE report, recommendations have been

made to address the [impact of COVID-19 on BAME communities](). An expert working group has also produced a [Risk Reduction Framework for NHS Staff at risk of COVID-19 infection]().

- As a result, COVID-19 risk assessments are being done with all NHS staff. These are intended as a tool for discussion and will allow more individualised risk advice and support to be given.
- Remote working arrangements for shielded staff have varied depending on role and local decisions.
- Secure VPNs and software (e.g. Microsoft Teams) have enabled staff at different sites (including those who are shielded) to continue to meet during lockdown and it is likely that these arrangements will continue through and possibly beyond the COVID-19 recovery phase. NB a **security pass** must be requested and approved locally (by the secure environment) before any item (e.g. laptop) ordinarily prohibited in a secure environment may be brought in.

- **COVID-19 Symptoms, contact tracing and self-isolating**
- If a member of staff develops [COVID-19 symptoms]() onsite (new continuous cough, fever, change in sense of smell) they should:
    - inform their line manager, who will contact occupational health, HPT and prison COVID-19 lead
    - immediately go home and follow the stay at home guidance
    - inform all household contacts/close contacts within previous 48h who should self-isolate for up to 14d (depending on outcome of COVID-19 test)
    - arrange to have a COVID-19 test
    - cooperate with NHS contact tracing requirements
- Reasons for staff to self-isolate:
    - [COVID-19 symptoms]()
    - COVID-19 Test positive (inform line manager. Await further advice from occupational health team/NHS test and trace service)
    - Household contact of someone who has symptoms or has tested positive
    - Someone in support bubble has symptoms or has tested positive
    - Identified as contact from contact tracing at work
- It is important for all staff to wear PPE for all essential tasks <2m and to maintain social distancing in offices/communal areas. Without this, there is a risk of groups of staff being identified as close contacts through contact tracing programme and taken off duty to self-isolate for 14 days (unless index case COVID-19 test result negative, at which point they can return to work)

D2:   STAFF MENTAL HEALTH AND WELL-BEING

- COVID-19 will continue to pose a threat to the mental health of staff working in secure environments throughout the recovery phase. Exposure to risk, challenges and uncertainties regarding PPE, changes to government rules and regime restrictions, and the ongoing threat of illness due to COVID-19 are all likely to contribute fatigue, poor sleep, symptoms of anxiety and depression, and 'risky behaviours'.
- Mental health vulnerability is increased by personal concerns about health, workplace safety, being asked to work outside comfort zone, unclear/evolving policies, illness stigma from family and friends, isolation and loneliness.
- Psychological First Aid (PFA) may benefit staff more than 'debriefing' in the crisis situation (BMJ editorial, [COVID-19: adverse mental health outcomes for healthcare workers]()). A compassionate approach to leadership, provision of formal and informal support systems (supervision, buddying), and opportunities for staff to express their fears and have their stress acknowledged will be protective in the coming months. There will need to be a clear path for referral/access to mental health services for staff, where escalating symptoms and clinical illness is suspected as a result of COVID-19.

D3:   RETURN TO WORK

- Occupational health teams will provide advice on return to work following absence due to COVID-19 contact and illness. They will also be able to provide advice on reasonable adjustments to allow staff who are clinically vulnerable to remain safe during the recovery phase of the pandemic.

E1:   FURTHER LINKS (COVID-19) IN SECURE ENVIRONMENTS   Contents ¬

PHE:

COVID-19: prisons and other prescribed places of detention guidance

https://www.gov.uk/government/publications/covid-19-prisons-and-other-prescribed-places-of-detention-guidance

Guidance on shielding and protecting people defined on medical grounds as extremely vulnerable from COVID-19

https://www.gov.uk/government/publications/guidance-on-shielding-and-protecting-extremely-vulnerable-persons-from-covid-19

COVID-19: laboratory investigations and sample requirements for diagnosis

https://www.gov.uk/government/publications/wuhan-novel-coronavirus-guidance-for-clinical-diagnostic-laboratories/laboratory-investigations-and-sample-requirements-for-diagnosing-and-monitoring-wn-cov-infection

NHS England and NHS Improvement:

Coronavirus guidance for clinicians and NHS managers https://www.england.nhs.uk/coronavirus/

NHS Good Practice Guidance for Digital Primary Care https://www.covid19-gpg.innovationlab.org.uk/topics/remote-working/total-triage-consult

NHS Digital COVID-19 – high risk shielded patient list identification methodology Rule logic https://digital.nhs.uk/coronavirus/shielded-patient-list/methodology/rule-logic

NHS Specialty Guides

https://www.england.nhs.uk/coronavirus/secondary-care/other-resources/specialty-guides/#medicine

NICE:

Rapid guidelines and evidence summaries https://www.nice.org.uk/covid-19

NICE guideline [NG31]: Care of dying adults in the last days of life (2015**)**
https://www.nice.org.uk/guidance/ng31

NICE BNF:

Prescribing in Palliative Care: https://bnf.nice.org.uk/guidance/prescribing-in-palliative-care.html

CEBM:

Oxford COVID-19 Evidence Service: https://www.cebm.net/oxford-covid-19-evidence-service

Rapid diagnosis strategy of community-acquired pneumonia for clinicians (April 2020**)**

https://www.cebm.net/covid-19/rapid-diagnosis-of-community-acquired-pneumonia-for-clinicians/

RCGP:

COVID-19 (Coronavirus) https://www.rcgp.org.uk/covid-19.aspx

RCGP COVID-19 GP Guide personal protective equipment

https://www.rcgp.org.uk/about-us/rcgp-blog/covid-19-gp-guide-personal-protective-equipment.aspx

RCN:

COVID-19 (Coronavirus) https://www.rcn.org.uk/covid-19

RCPsych:

Responding to COVID-19

https://www.rcpsych.ac.uk/about-us/responding-to-covid-19/guidance-for-psychiatrists-and-other-professionals-working-in-mental-health-settings-(covid-19)

Delirium management advice patients with confirmed/suspected COVID-19 in acute trust setting
https://www.rcpsych.ac.uk/docs/default-source/members/faculties/old-age/covid-19-delirium-management-guidance.pdf?sfvrsn=2d5c6e63_2

BMJ:

https://bestpractice.bmj.com/topics/en-gb/3000168 (BMJ Best Practice COVID-19)

https://www.bmj.com/content/bmj/368/bmj.m1211.full.pdf (managing mental health challenges faced by healthcare workers during COVID-19 pandemic)

https://www.bmj.com/content/bmj/suppl/2020/03/24/bmj.m1182.DC1/gret055914.fi.pdf (visual summary: COVID-19: remote consultations)

https://www.bma.org.uk/advice-and-support/covid-19/adapting-to-covid/covid-19-video-consultations-and-homeworking (telemedicine and remote consultations)

https://www.bmj.com/content/369/bmj.m1808 (testing: specificity and sensitivity)

(COVID-19) and Obstructive Sleep Apnoea (OSA) guidance

https://www.brit-thoracic.org.uk/media/455098/osa-alliance-cpap-covid-19-advice-20-3-20-v10.pdf

4AT Rapid Clinical Test for delirium: https://www.the4at.com/

H8H
Hanham Secure Health

COVID-19 Risk Stratification

High Risk List

People with a Solid Organ Transplantation.

Specific Cancer Patients:
- o People who are undergoing active chemotherapy (does not include hormone therapy for breast cancer) or radial radiotherapy for lung cancer
- o People with cancers of blood/bone marrow e.g. leukaemia, lymphoma or myeloma (note this also includes myeloproliferative disorders*) at any stage of treatment
- o People having immunotherapy or other antibody treatments for cancers
- o People having targeted cancer treatments that can affect the immune system e.g. protein kinase inhibitors/PARP inhibitors
- o People who have had bone marrow or stem cell transplants in last 6 months or who are still on immunosuppression drugs

People with Severe COPD:
- o Pts on triple therapy- LABA, LAMA and ICS
- o Pts who have had 2 or more course of ABx/steroids in last 12 months
- o Pts who have required hospitalisation in the last 12 months
- o Pts with MRC breathless > 3

People with Severe Asthma:
- o Pts with 2 or more prescriptions of prednisolone in the last 12 months
- o Pts who have been admitted to hospital in the last 12 months
- o Pts who have ever been admitted to ITU due to asthma

People with Other Severe Respiratory Conditions:
- o Pulmonary Sarcoidosis (moderate risk if no treatment and structurally normal lungs)
- o Pulmonary Hypertension
- o Cystic Fibrosis
- o Bronchiectasis
- o Interstitial Lung Disease

People with Severe Neurological Conditions:
- o Active myositis/polymyositis
- o Muscular dystrophies
- o Motor Neurone Disease
- o Any neurological condition that affects respiratory/bulbar function

People with rare diseases and inborn errors of metabolism that significantly increase the risk of infections:
- o Sickle cell disease (not trait)
- o Severe Combined Immunodeficiency
- o Thalassaemia at risk of iron overload* or those with a splenectomy plus other co-morbidity/age ≥70
- o Those with inherited anaemias e.g. Pyruvate kinase deficiency or congenital dyserythropoietic anaemia, who have had a splenectomy and are at high risk of iron overload.
- o Aplastic Anaemia and Bone Marrow failure patients as per guidance*
- o Diamond-Blackfan anaemia as per guidance*

People on immunosuppression therapies sufficient to significantly increase risk of infection:
- o See guidance from individual specialities overleaf

People who are pregnant with significant congenital heart disease.

Splenectomy Patients:
- o With associated haematological malignancy
- o With associated Thalassemia or inherited anaemias as mentioned above
- o All others are Moderate risk.

People with High Risk Diabetes:
- o Hba1c >75
- o Recent admission in last 12 months with DKA

People with Significant Heart Failure that that have required admission due to this in the last 12 months.

At discretion of GP:
- o Severe Dementia
- o Severe Frailty with multiple long-term medical conditions.

E2: Risk Stratification

*Patients with any type of blood cancer at any stage of treatment have been identified centrally as being high risk. However according to BSH guidance some patients who have myeloproliferative and other disorders or are in remission may in fact not be at high risk. The guidance around this is complex and I would suggest that we keep all of these pts as high risk and shielded for now. If you want to assess on an individual basis the guidance can be found here:

https://b-s-h.org.uk/about-us/news/covid-19-updates

https://haemoglobin.org.uk/covid-19/

***Guidance for Individual Specialities

Gastroenterology

- o IBD and co-morbidity or age ≥ 70 on anti-TNF or biologic or immunosuppressant or prednisolone 5-20mg daily.
- o IBD on ≥ 20mg prednisolone equivalent per day.
- o IBD and recent combination biological/ immunomodulatory/ steroids last 6/52.
- o Moderate to severe disease activity not controlled by biological/ immunomodulator/ steroids.
- o IBD and short gut syndrome requiring nutritional support.
- o IBD and TPN requirement.

    https://www.bsg.org.uk/covid-19-advice/bsg-advice-for-management-of-inflammatory-bowel-diseases-during-the-covid-19-pandemic/

Renal / Nephrology

- o Autoimmune disease on biologics/cytotoxics last 6/12
- o Intravenous immunosuppressant
- o Oral cyclophosphamide
- o ≥ 20mg prednisolone daily equivalent > 4/52 in the last 6/12
- o ≥ 5mg daily prednisolone equivalent plus one other immunosuppressant > 4/52 in last 6/12
- o Nephrotic range proteinuria
- o History of repeated high dose immunosuppressant over a number of years
- o Any immunosuppressant and:
    - o Age ≥ 70
    - o Autoimmune lung or heart disease
    - o Co-morbidities – DM/ respiratory/ HTN/ CVD/ CKD3 or more

    https://renal.org/stratified-risk-prolonged-self-isolation-adults-children-receiving-immunosuppression-disease-native-kidneys/

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Rheumatology

- o ≥ 20mg prednisolone daily equivalent > 4/52
- o Oral cyclophosphamide
- o Intravenous cyclophosphamide in last 6/12
- o Any 2 immunosuppressant therapies (not hydroxychloroquine or sulphasalazine)
- o ≥5mg daily prednisolone equivalent plus one other immunosuppressant > 4/52
- o (not hydroxychloroquine or sulphasalazine)
- o Single agent immunosuppressant (not hydroxychloroquine or sulphasalazine) or ≥5mg prednisolone for >4/52 and other comorbidity or age ≥ 70.

    https://www.rheumatology.org.uk/Portals/0/Documents/Rheumatology_advice_coronavirus_immunosuppressed_patients_220320.pdf?ver=2020-03-22-155745-717

    https://www.rheumatology.org.uk/Portals/0/Documents/COVID19_risk_scoring_guide.pdf?ver=2020-03-23-165634-597

Dermatology

- o Any 2 immunosuppressant therapies (not hydroxychloroquine or sulphasalazine)
- o ≥ 20mg prednisolone daily equivalent > 4/52
- o ≥ 5mg daily prednisolone equivalent plus one other immunosuppressant > 4/52
- o (not hydroxychloroquine or sulphasalazine)
- o Oral cyclophosphamide
- o Intravenous cyclophosphamide in last 6/12
- o Rituximab or Infliximab for skin conditions
- o Single agent immunosuppressant and other comorbidity or age > 70.

    https://www.bad.org.uk/shared/get-file.ashx?itemtype=document&id=6674

Moderate Risk List

- o Patients ≥70 years of Age
- o Patents <70 years of Age who have a condition that entitles them to the annual flu vaccination.
- o Patients who are pregnant

Low Risk List
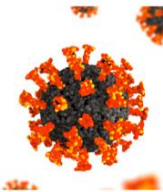
- o Anybody not moderate or high risk