<u>COVID-19 Secure Guidelines For Rehabilitation Service Providers In India</u> About these

Guidelines:

The guidelines are developed based on the recommendation from the World Health Organization and Departments of Health and Social Care from India, the United Kingdom (UK) and the United States (US) by the Indian Occupational Therapists Think Tank (IOTT).

These guidelines were developed to empower rehabilitation professionals providing services for Persons with Disabilities (PwD) in India during the COVID-19 pandemic. It is intended for use by the rehabilitation professionals working both in private and public sectors in India. While the recommendations provided in these guidelines are drawn based on the current evidence available about COVID-19, it is still considered as a general recommendation only. The rehabilitation professionals are advised to adhere to all applicable safety and workplace legislations, recommendations made by both the central and state governments of India, and the rules and regulations of the local organizations/departments. While these guidelines seek to ensure a consistent approach throughout India, users are encouraged to appropriately adapt the recommendations of the guidelines to suit their context taking into account their operational and organizational feasibility for implementation.

Version - 1.0 June 2020

Guideline Contributors:
1. Dr Sureshkumar Kamalakannan BOT, MPH, PhD
2. Dr Karthik Mani BOT, MSc, OTD, OTR/L
3. Mr Manigandan Chockalingam BOT, MSc
4. Ms.Ashwini Rao BOT, PG Dip, OTR

5. Ms Poornima Kamath BOTh, MS, OTR/L
6. Ms Shobana Devi Moorthy BOT, MSc
7. Mr Murali Krishnan BOT, MOTh, Fellow-NDD
8. Ms Sarika S Anish BOT, PG Dip (OT)
9. Mr Jothikumar Ramakrishnan BOT, PG Cert in W/c Mobility
10. Ms Geetha BOT, MSc, DNHE

How to Cite:

Kamalakannan, S., Mani, K., Chockalingam, M., et al. (2020). ***COVID-19 secure guidelines for rehabilitation service providers in India.*** **Retrieved from** https://indianotsthinktank.blogspot.com/2020/06/covid-19-guidelines-for-rehabilitation.html**.**

S.No Contents Pg.No

Snapshot of these Guidelines

- These guidelines are developed based on the evidence from authentic sources from national and international health and social care departments in various countries and multilateral organizations like the World Health Organization and the United Nations.
- Given that the evidence was obtained from authentic sources, it was not critiqued by the contributors as a part of the usual process of guidelines development. However, this section will be added to the future updated versions.
- COVID-19 refers to a new disease that affects humans and animals. In the term COVID-19, CO stands for Corona, VI stands for Virus, D stands for Disease and 19 stands for the year 2019 in which it was discovered.
- The terms SARS-CoV-2 stands for Severe acute respiratory syndrome coronavirus 2, shortened to SARS-CoV-2, is the virus that causes COVID-19 disease. As the name indicates, this virus is genetically related to the SARS-associated coronavirus (SARS-CoV).
- These guidelines may assist rehabilitation service providers build their skills as a rehabilitation service provider with public health knowledge about the pandemic – Understand the vital facts about SARS–CoV–2
- Your rehabilitation centre must be prepared before you restart service to be safe and efficient.
- These guidelines help rehabilitation service providers to understand the characteristics of the transmission of SARS-CoV-2 infection which is very vital to building specific strategies for organizing the environment and providing safe and effective rehabilitation services.
- Reducing the risk of transmission is the ultimate strategy to run a rehabilitation service safely and effectively. The starting point is travel from the provider's residence and follows through ensuring precautions, managing caregivers, moving,

handling, therapeutic service provision, decontaminating environment, managing waste, linen and decontaminating therapeutic equipment.

- In the absence of an understanding towards the Personal Protective Equipment (PPE) such as face masks, gloves, coverall, gown, visor, goggles, it is not possible to prevent and control the transmission of infections among those who come to obtain your services. Hence precise understanding about the specific kind of PPE for specific purposes and the safe ways of provision of rehabilitation and care is imperative.
- Pictorial illustrations would speak better than words and therefore the best practice in the use of PPE and hand hygiene are provided to you in pictures.

Vital Facts about SARS –CoV-2

On December 31, 2019, China reported a novel type of coronavirus, which was later named as Severe Acute Respiratory Syndrome Corona Virus 2 (SARS-CoV-2) resulting in pneumonia of unknown cause, which was then called as COVID-19.[1] After the COVID-19 outbreak was announced as a pandemic by WHO on the 11th March 2020, it had negatively impacted on both lives and livelihoods of hundreds of thousands of people worldwide.[2] As of 18th June 2020, COVID-19 has claimed 445,535 lives, affecting the lives of 8,242,999 people directly and the lives of people in 213 countries indirectly.[3]In India, the disease had claimed 12,573 lives and has affected 380,532 people directly as this document is written.[3-4]

- The predominant modes of transmission for this highly infectious virus are considered to be respiratory droplets (generated by coughing, sneezing, and close-proximity speaking) and through contact with virus-contaminated surfaces.[5]
- Experts predict that the COVID-19 will cohabit with humans for the foreseeable future.[6] ● Although the most common symptoms are fever, dry cough and muscle ache for COVID-19, recent studies suggest that people with COVID-19 can be asymptomatic too. In more severe conditions, this can lead to pneumonia and multi-organ damage.[7] ● People are at higher risk for more severe disease when they are elderly, immunocompromised, with pre-existing respiratory problems, or with comorbidities such as diabetes, hypertension, stroke and other chronic conditions.[8]
- As individuals, people can save the lives of others by merely acting responsibly. India being a highly populous country, with crowded and less advanced transportation systems and substantial non-communicable disease burden – there is a need to be self aware of the consequences to one's own behaviours, actions and practices. These individual behaviours are even more critical for health workers due to the nature of their work involving vulnerable people.[9]

Transmission Characteristics of SARS –CoV-2 Infection

- **Transmission Routes:**

  The transmission of COVID-19 is thought to occur mainly through respiratory droplets generated by coughing and sneezing, and through contact with contaminated surfaces and affected people. The predominant modes of transmission are assumed to be droplet and contact.[10]

- **Incubation and Infection Period:**

  The incubation period is from one to 14 days (median five days). The median time from symptom onset to clinical recovery for mild cases is approximately two weeks and three to six weeks for severe or critical cases. From international data, the balance of evidence is that most people will have sufficiently reduced infectivity seven days after the onset of symptoms[11]

- **Survival in the Environment:**

  SARS CoV-2 can survive and remain viable for up to 5 days on objects, at environmental temperatures of 22 to 25°C and relative humidity of 40 to 50% (which is typical of air conditioned indoor environments). While the survival of the virus on environmental surfaces is dependent on the surface type, current evidence suggests that this virus may remain viable on plastics for up to 72 hours, on stainless steel for up to 48 hours and on copper up to 8 hours. Thus, the frequency of environmental decontamination protocol must consider viral viability based on the surfaces.[12]

Organizational Preparedness

Limiting the transmission of COVID-19 in rehabilitation settings require a wide range of infection control and preventive measures which might have a hierarchy of controls.[13-14] Some of the vital strategies to consider while preparing to keep rehabilitation centres open are as follows

Preparedness before re-opening:

1. Establish a re-opening committee comprising of the clinic owner/s, staff, referral sources, external consultants, patient representatives, and relevant others.
2. Assess current rehabilitation service provision environment (e.g. ensuring 2 metres distance) and the capability to implement infection prevention and control measures (e.g. hand washing station, masks, soap, sanitizers) to restart services.
3. Stock up essential materials related to infection prevention and control (PPE, sanitizers, water supply, etc.)
4. Brainstorm the re-opening process by considering WHO, Ministry of Health and Family Welfare (MOHFW), and state health ministry's guidelines/standards.
5. Develop a cleansing protocol, hand washing protocol, PPE usage and disposal protocol, staggered appointment scheduling protocol, telehealth protocol, visitor protocol, and other necessary protocols
6. Develop a communication plan to inform staff and visitors about standard infection control precautions (SICPs) and transmission-based precautions (TBPs) and infection prevention and control.
7. Develop a communication plan to inform patients about the modified scheduling process and availability of telehealth sessions
8. Develop a communication plan to inform your referral sources that your clinic resumed its operation while highlighting the safety protocols in place, telehealth service delivery option, and change (if any) in the hours of operation

Re-opening of therapeutic services:

9. Add signage inside the clinic premises, so that proximity between individuals is avoided. For example, no handshakes, use of masks/face coverings within the premises, cough etiquettes

(using hands to cover the mouth, use of handkerchief) while coughing), all must enter through one door and exit via the other, in-out sign-on therapy room/restroom doors, etc.

10.Refill adequate cleaning supplies and personal protective equipment (gloves, masks, hand soap, hand sanitizer cleaning wipes, etc.)

11.Place curtains or dividers as needed in the treatment area to ensure separation. Ensure thorough cleaning of these materials periodically.

12.Minimize shared usage of items, materials, writing utensils, computer/laptop, etc. 13.Use tape markings on floor as needed to emphasize social distancing

14.Test and record the temperature of staff as well as the patients and carers daily. Ask staff with high temperature not to report to work. Ask staff to sign a disclosure statement confirming that they did not have any COVID-19 symptoms and they are not in contact with a person with COVID-19 in the past 28 days. Ask for a return to work authorization letter signed by a physician for staff who were sick recently.

15.Replace sofas/benches with individual chairs in the waiting area placed 6 feet apart. Ask visitors with three or four-wheelers to wait in their vehicles.

16.Install plexiglass dividers if the setting has a billing counter

17.Minimize furniture and equipment as much as possible

18.Rotate staff on a shift basis (one or two therapists can work from 9 am-12 pm, other one or two can work between 1 pm to 4 pm.)

19.Limit the number of staff in the staff room at any given point in time.

20.Make arrangements for storage facilities for patients and their carers' belongings to minimize object contamination in the therapy area.

After re-opening practice:

21. Educate patients on COVID-19 and infection control by posting informative flyers/posters

22. Advise patients not to visit if any of their family members have fever, cough, chills, sore

throat, and/or shortness of breath.

23. Encourage patients and the rehabilitation professionals to travel from and to the therapy centre straight rather than traveling to other places before and after visiting the rehabilitation centre.

24. Having a computerized data capture form like the one in Aarogya Setu App for the travel and contact history of the patients and the caregivers will help track and trace possible COVID-19 cases. Ensure patients, caregivers and staff have them registered with the Indian government mandated mobile App Aarogya Setu.

25. Sanitize kits used in the therapy centre and the home visit kits, if any, after each visit. 26. Prepare and obtain a signature from the staff member on Memorandum of Understanding (MOU) if there is any change in work hours, compensation, benefits, &/or job duties post re-opening. Similarly, from the patients and/or caregivers on their contact history and their residence's classified zone.

Reducing the Risk of Transmission in Therapeutic/Rehabilitation settings

A. Travel to Therapeutic Setting:

- Avoid travelling by public transport and shared taxi/autos as these might make you breach infection prevention and control in terms of social distancing. [15]
- Try and travel in your own vehicle (car/bike/cycle) or walk as far as possible. [15] ● Avoid travelling with co-staff/workers. If this is inevitable ensure you clean the contact surfaces with sanitizers/gels. [15]

B. Infection Prevention and Control Precautions:

SICPs and TBPs must be used when managing patients with suspected or confirmed COVID 19.[16]

SICPs are the basic infection prevention and control measures necessary to reduce the risk of transmission of infectious agents from both recognized and unrecognized sources. Sources include blood and other body fluids, secretions and excretions (excluding sweat), non-intact skin or mucous membranes, and any equipment or items in the care environment. SICPs should be used by all staff, in all care settings, at all times, for all patients.[16]

TBPs are applied when SICPs alone are insufficient to prevent cross transmission of an infectious agent. TBPs are additional infection control precautions required when caring for a patient with a known or suspected infectious agent. TBPs are categorized by the route of transmission of the infectious agent:[16]

Contact precautions:

Used to prevent and control infection transmission via direct contact or indirectly from the immediate care environment (including care equipment). This is the most common route of infection transmission.[16]

Droplet precautions:

Used to prevent and control infection transmission over short distances via droplets (>5μm) from the respiratory tract of one individual directly onto a mucosal surface or conjunctivae of another individual. Droplets penetrate the respiratory system to above the alveolar level. A precautionary approach is recommended and 2 metres (approximately 6 feet) has been defined as the area of risk. Thus, distancing of 2 metres should be facilitated wherever this is possible. This includes all staff adhering to social distancing (2 metres) wherever possible, particularly if not wearing a facemask or visor. [16]

Airborne precautions:

Used to prevent and control infection transmission without necessarily having close contact via aerosols (=5μm) from the respiratory tract of one individual directly onto a mucosal surface or conjunctivae of another individual. Aerosols penetrate the respiratory system to the alveolar level. Interrupting transmission of COVID-19 requires both droplet and contact precautions; if an aerosol generating procedure (AGP) is being undertaken then airborne precautions are required in addition to contact precautions.[16]

C. Standard Precautions:

Hand hygiene: Hand hygiene is essential to reduce the transmission of infection in health and other care settings. All staff, patients and caregivers should decontaminate their hands with alcohol-based hand rub (ABHR) when entering and leaving areas where patient care is being delivered. Hand hygiene must be performed immediately before every episode of direct patient care and after any activity/task or contact that potentially results in hands becoming contaminated, including the removal of the PPE, equipment decontamination and waste handling.[16]

Before performing hand hygiene:

- expose forearms (bare below the elbows)
- remove all hand and wrist jewellery (a single, plain metal finger ring is permitted but should be removed [or moved up] during hand hygiene)

- ensure fingernails are clean, short and that artificial nails or nail products are not worn
- cover all cuts or abrasions with a waterproof dressing

If wearing an apron rather than a gown (bare below the elbows), and it is known or possible that forearms have been exposed to respiratory secretions (for example cough droplets) or other body fluids, hand washing should be extended to include both forearms. Wash hands for at least 20 seconds with the forearms first and then the hands. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination. In case where there is no paper dispenser, avoid having a common cloth towel to dry hands. Information can also be provided for patients and caregivers to make their own arrangements (like having a towel or handkerchief etc.) while attending therapy sessions.[16]

Respiratory and cough hygiene – 'Catch it, bin it, kill it'[17-18]:

Patients, staff and visitors should be encouraged to minimize potential

COVID-19 transmission through good respiratory hygiene measures which are:

- disposable, single-use tissues should be used to cover the nose and mouth when sneezing, coughing or wiping and blowing the nose
- used tissues should be disposed of promptly in the nearest waste bin ● waste bins (lined and foot operated) and hand hygiene facilities, should be available for patients, caregivers and staff
- hands should be cleaned (using soap and water if possible, otherwise using ABHR) after coughing, sneezing, using tissues or after any contact with respiratory secretions and contaminated objects
- encourage patients to keep hands away from the eyes, mouth and nose ● some patients (such as the elderly and children) may need assistance with containment of respiratory secretions; those who are immobile will need a container (for example a plastic bag) readily at hand for immediate disposal of tissues. This applies especially in a home visit situation

or patient approaching rehabilitation centre in wheelchair.

Patient use of face masks:

In therapy/rehabilitation providing areas, common waiting areas, where tolerable and appropriate, symptomatic as well as asymptomatic patients and caregivers may wear a surgical face mask. The aim of this is to minimize the dispersal of respiratory secretions and reduce

environmental contamination. A surgical face mask should not be worn by patients if there is potential for their therapy and care to be compromised (such as when receiving oxygen therapy). Though it is difficult for children with disabilities and special needs to wear a mask – it is important to adhere to the principles of infection prevention and control.[19]

D. Managing Caregivers:

Caregivers to all areas of the rehabilitation and care facility should be restricted to essential persons only, such as parents of paediatric patients. Local risk assessment and practical management should be considered, ensuring this is a pragmatic and proportionate response, including the consideration of whether there is a requirement for caregivers to wear the PPE. All caregivers entering a segregated/group area must be instructed on hand hygiene. They must not visit any other rehabilitation or care area. Decisions to suspend or restrict caregivers will depend on local circumstances and risk assessment. Limiting entry points to a facility will help manage local restrictions. Caregivers with COVID-19 symptoms must not enter the rehabilitation facility. [20]

E. Moving and Handling of Patients:

If moving and handling is necessary, consider offering the patient a surgical face mask to be worn during those procedures, to minimise the dispersal of respiratory droplets when this can be tolerated and providing this does not compromise rehabilitation and care. Re-usable moving and handling equipment like wheelchair, push chairs and hoists must, as a minimum, be decontaminated in accordance with the manufacturer's instructions.[20]

F. Provision of Therapeutic Services

Rehabilitation service providers must first understand that you just cannot restart service as might have done before. Strict precautionary measures and safe ways of practice has to be thoughtfully brainstormed. Feasible options for provision of safe and effective therapeutic services must be planned based on the previous patient load and characteristics. If it is not feasible to provide safe therapeutic services, an alternate strategy like tele-rehabilitation, telephonic consultation, home program workbook, and therapeutic video could be considered.[20]

Administrative services within the therapy service provision area like appointments, staff rotation, documentation and payments can be organized online. The Information Technology (IT) equipment can be one's own or carefully used by either one person, or more than one person with strict decontamination strategies.[20]

As a first step, ensure that the patients and carers are coming from the green zones, which are considered COVID infection free zones.[21] If not, a decision to proceed further must be taken with caution.

While providing therapy, it is very essential to maintain 2 metre physical distancing, if this is not possible, use of appropriate PPE must be followed. Shorter the distance without PPE, higher the risk of infection and transmission. Remember that if the therapist and the patient wear appropriate PPE, the rate of transmission is much lower compared to either one of them wearing PPE.

In case of children, who cannot or resist wearing PPE (e.g. masks), caregivers can be used strategically to provide therapy services. This will be useful both for providing therapy and teaching caregivers the ways to provide services at home or under therapist's supervision. In this scenario, make sure the caregiver signs a document consenting that they will not use the training on their own without appropriate qualification and/or certification.

When a therapeutic equipment is used for the rehabilitation session, make sure those set of equipment used for one patient is not shared with another and that equipment is strictly decontaminated as per guidelines provided. Extra care must be taken especially when using therapeutic equipment with children. The transmission and spread of infection are very quick in an indoor therapy environment compared to well-ventilated environment or outdoor therapy.

Ensure the rooms of your rehabilitation centre, especially toilets and wash areas do not have common usable products like soap, towel, mug, glasses etc. Staff, patients and caregivers must be advised to make their own arrangements while accessing these areas. For toilets, alternate strategies can be thought about.

Infection prevention and control, decontamination, physical distancing, use of appropriate PPE and alternate strategies are the key terms that one must remember while restarting services.

G. Environmental Decontamination:

There is evidence for other coronaviruses of the potential for widespread contamination of patient rooms or environments, so effective cleaning and decontamination is vital. Rooms/areas where the PPE is removed must be decontaminated, ideally timed to coincide with periods immediately after the PPE removal by groups of staff (at least twice daily). [22-24]

Opportunities for cleaning of frequently touched surfaces multiple times (more than twice a day wherever possible) should be taken, including for example:

- surfaces such as therapy equipment, door/toilet handles and locker tops, call bells, tables and rails must be cleaned at least twice daily, and when known to be contaminated with secretions, excretions or body fluids;
- touch points in public areas such as lifts and corridors; and
- electronic equipment, including mobile phones, desk phones and other communication devices, tablets, desktops, and keyboards (particularly where these are used by many people), should be decontaminated at least twice daily with 70% ethyl alcohol or product as specified by the manufacturer.

NB. Gloves should be removed, and hands decontaminated before touching equipment.

Therapy rooms:

Cleaning and decontamination should only be performed by staff trained in the use of the appropriate PPE; in some instances, this may need to be trained clinical staff rather than domestic staff, in which case, clinical staff may require additional training on standards and order of cleaning. After cleaning with neutral detergent, a chlorine-based disinfectant should be used, in the form of a solution at a minimum strength of 1,000 ppm available chlorine. [22-24]

To ensure appropriate use of the PPE and that an adequate level of cleaning is undertaken, it is strongly recommended that cleaning of therapy areas is undertaken separately to the cleaning of other common cohort areas in the facility. Dedicated or disposable equipment (such as mop

heads, cloths) must be used for environmental decontamination. Reusable equipment (such as mop handles, buckets) must be decontaminated after each use with a chlorine-based disinfectant. Communal cleaning trollies should not enter therapy rooms. Unused equipment can be stored separately. [22-24]

H. Waste:

Large volumes of waste may be generated by frequent use of the PPE; advice from the local waste management authorities such as corporation/municipality should be sought prospectively on how to manage the waste. Dispose of all waste as infectious clinical waste. [22-24]

I. Linen:

No special procedures are required; linen is categorized as 'used' or 'infectious'. Disposable gloves and an apron should be worn when handling infectious linen. [22-24]

J. Managing Equipment and Care Environment:

Decontamination of equipment and the care environment must be performed

using either:

- a combined detergent/disinfectant solution at a dilution of 1,000 parts per million available chlorine (ppm available chlorine (av.cl.)); or
- a general-purpose neutral detergent in a solution of warm water followed by a disinfectant solution of 1,000ppm av.cl

Only cleaning (detergent) and disinfectant products supplied by employers are to be used. Products must be prepared and used according to the manufacturers' instructions and recommended product 'contact times' must be followed. [22-24]

Equipment:

Consider all equipment used for therapy as reusable (communal items). Patient care equipment should be single-use items if possible. Reusable (communal) non-invasive equipment should as far as possible be allocated to the individual patient or cohort of patients.

Reusable (communal) non-invasive equipment must be decontaminated: ● after and in between treatment episodes of each patients

- after blood and body fluid contamination
- at regular intervals as part of equipment cleaning

An increased frequency of decontamination should be considered for reusable non-invasive care equipment when used in isolation/cohort areas. There is no need to use disposable plates or cutlery. Crockery and cutlery can be washed by hand or in a dishwasher using household detergent and hand-hot water after use. [22-24]

Care environment:

The care environment should be kept clean and clutter free. All non-essential items should be removed from reception and waiting areas, consulting and therapy rooms and lounges. When made available, these items should not be shared at the same time. All toys must be cleanable

and should be cleaned regularly (preferably at the same time as the environment). [22-24]

Personal Protective Equipment (PPE) for SARS CoV-2

A. Scope and Purpose:

It is recognized that in contexts where SARS-CoV-2 is circulating in the community at high rates, health and social care workers may be subject to repeated risk of contact and droplet transmission during their daily work. It is also understood that in routine work there may be challenges in establishing whether patients and individuals meet the case definition for COVID 19 prior to a face-to-face rehabilitation/therapeutic assessment or care episodes.[24-25]

Certain work environments and procedures convey higher risk of transmission and aerosol generating procedures (AGPs) present risk of aerosolized transmission. This guidance therefore seeks to set out clear and actionable recommendations on the use of the PPE, as part of safe systems of working, for rehabilitation professionals providing services for persons with disabilities relative to their day-to-day work. Incidence of COVID-19 varies across the districts

and states risk is not uniform. Hence the elements of the guidance are intended for interpretation and application dependant on local assessment of risk in your work area.[24-25]

B. Safe Ways of Providing Therapy:

- Having one patient for a session with one therapist in one room with appropriate precautionary measures would be ideal to prevent transmission of infection.
- Staff/Co-workers should be trained on donning and doffing the PPE. Staff/Co-workers should know what PPE they should wear for each setting and context.
- Staff/Co-workers should have access to the PPE that protects them for the appropriate setting and context.
- Gloves and aprons are subject to single use as per SICPs with disposal after each patient or resident contact.
- Fluid repellent surgical mask and eye protection can be used for a session of work rather than a single patient or resident contact.
- Gowns or coveralls can be worn for a session of work in higher risk areas. Hand hygiene should be practiced and extended to exposed forearms, after removing any element of the PPE.

- Staff/Co-workers should adhere to physical distancing (2 metres) wherever possible, particularly if not wearing the PPE and in non-clinical areas, such as during work breaks and when in communal areas.
- Staff/Co-workers should take regular breaks and rest periods. Consider staggering staff breaks to limit the density of therapists and co-workers.
- Receiving cash payments can be avoided and payments can be collected through swipe machines or through online payment methods.

C. Summary of Recommended PPE for Rehabilitation Service Providers[24-26]

Setting Context	Disposable Gloves	Disposable Plastic Apron	Disposable Fluid repellent Gown	Surgical Mask	Fluid Resistant Surgical Mask	Filtering face piece respirator	Eye/Face Protection
Any setting	Performing an aerosol generating procedure on a possible case	Single Use	Single Use	Single Use	Single Use		
Non Emergency OP/IP							
Home care/visits							
Direct patient care on a possible case within 2 meters							
Direct patient care but unable to maintain 2 meters distance							
Direct patient care – Any member							
Direct patient care – Vulnerable							
Where any member of the household is a possible case							
Single Use	Single Use	✖	Single Use	Single Use			
Sessional use							
Single Use	Single Use	Single Use	Single Use	✖			
Single Use	Single Use	✖	Single Use				
Single Use	Single Use	Single Use	Single Use	Single Use			
Rehabilitation OP/IP							
Facility with possible or confirmed case(s)							
– and direct patent care (within 2 metres)							
Single Use	Single Use	✖	Sessional use	Single Use			

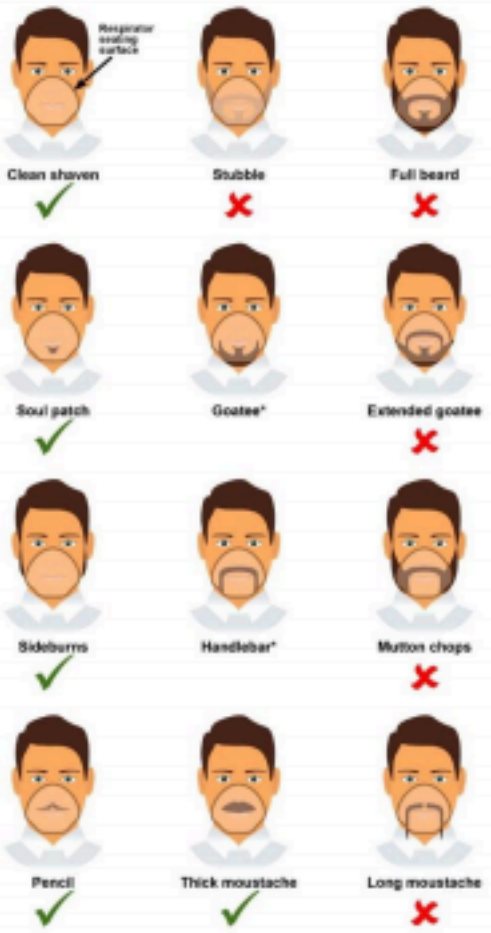
• Single use refers to disposal of the PPE or decontamination of reusable items e.g. eye protection or respirator, af ter each patient and/or following completion of a procedure, task, or session; dispose or decontaminate reusable items after each patient contact

• A single session refers to a period of time where a health care worker is under taking duties in a specific setting/exposure environment e.g. on a ward round; providing ongoing care for inpatients. A session ends when the health care worker leaves the care setting/exposure environment. PPE should be disposed of after each session or earlier if damaged, soiled, or uncomfortable

• Non clinical staff should maintain 2m social distancing, through marking out a controlled distance

D. Best Practice in Use of the PPE and Hand Hygiene[24-27]

Facial hair and FFP3 respirators



*Ensure that hair does not cross the respirator sealing surface

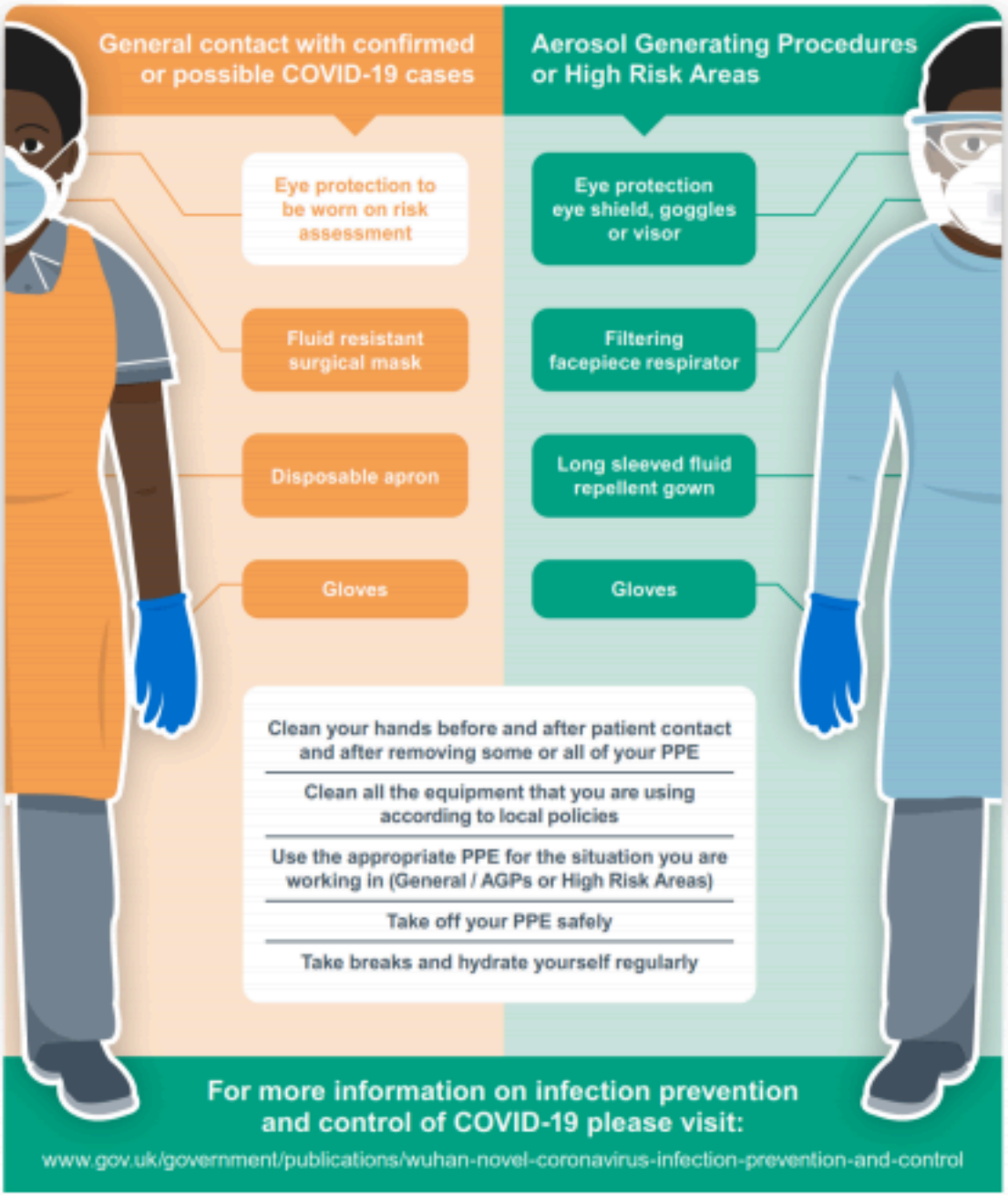
For any style, hair should not cross or interfere with the respirator sealing surface. If the respirator has an exhalation valve, hair within the sealed mask area should not impinge upon or contact the valve.

*Adapted from The US Centers for Disease Control and Prevention, The National Personal Protective Technology Laboratory (NPPTL), NIOSH. Facial Hairstyles and Filtering Facepiece Respirators. 2017.
Available online at https://www.cdc.gov/niosh/npptl/RespiratorInfographics.html. Accessed 26/02/2020.

Public Health England

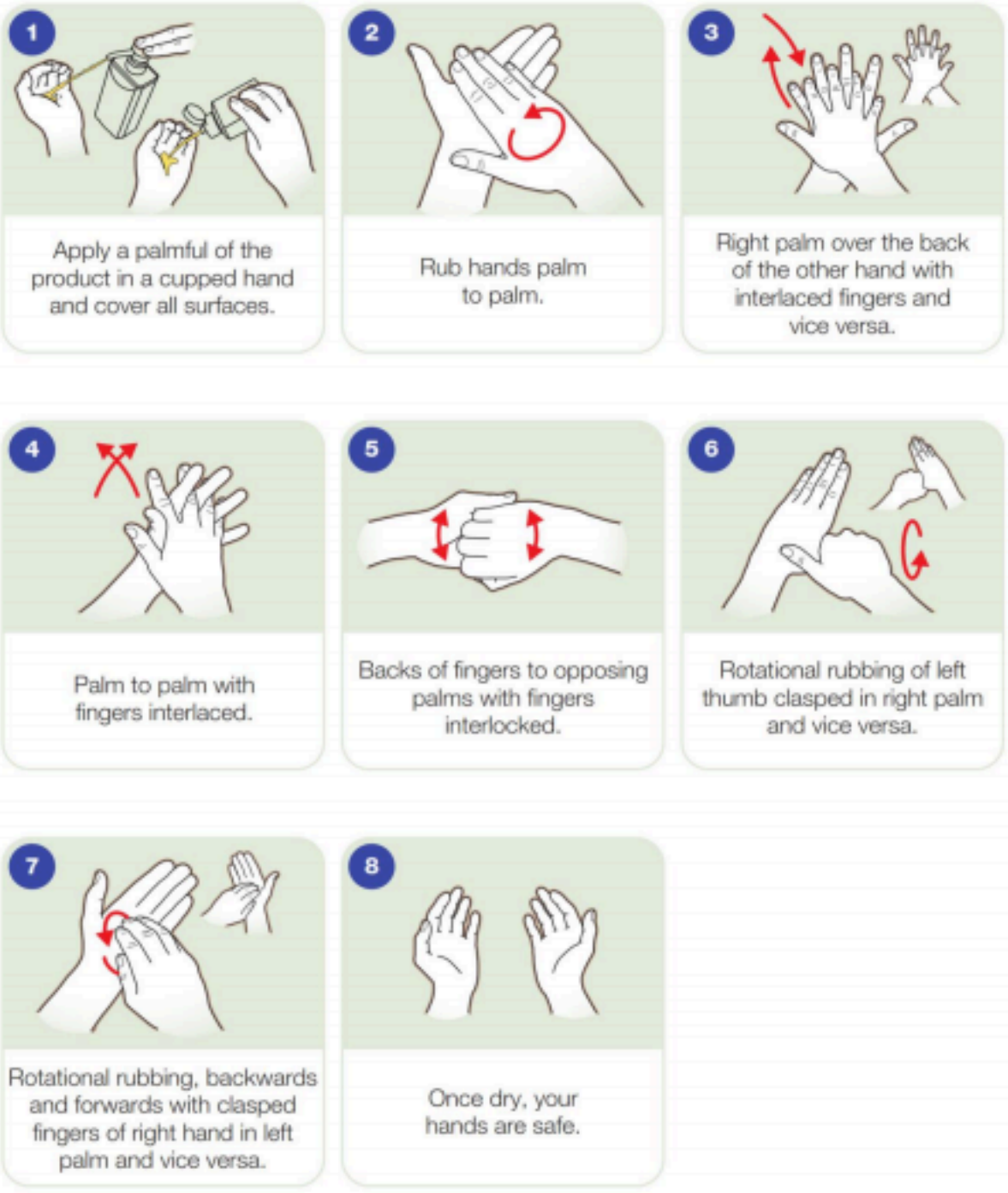
COVID-19 Safe ways of working

A visual guide to safe PPE



Public Health England

Best Practice: How to handrub step by step images



Adapted from the World Health Organization/Health Protection Scotland

Public Health England

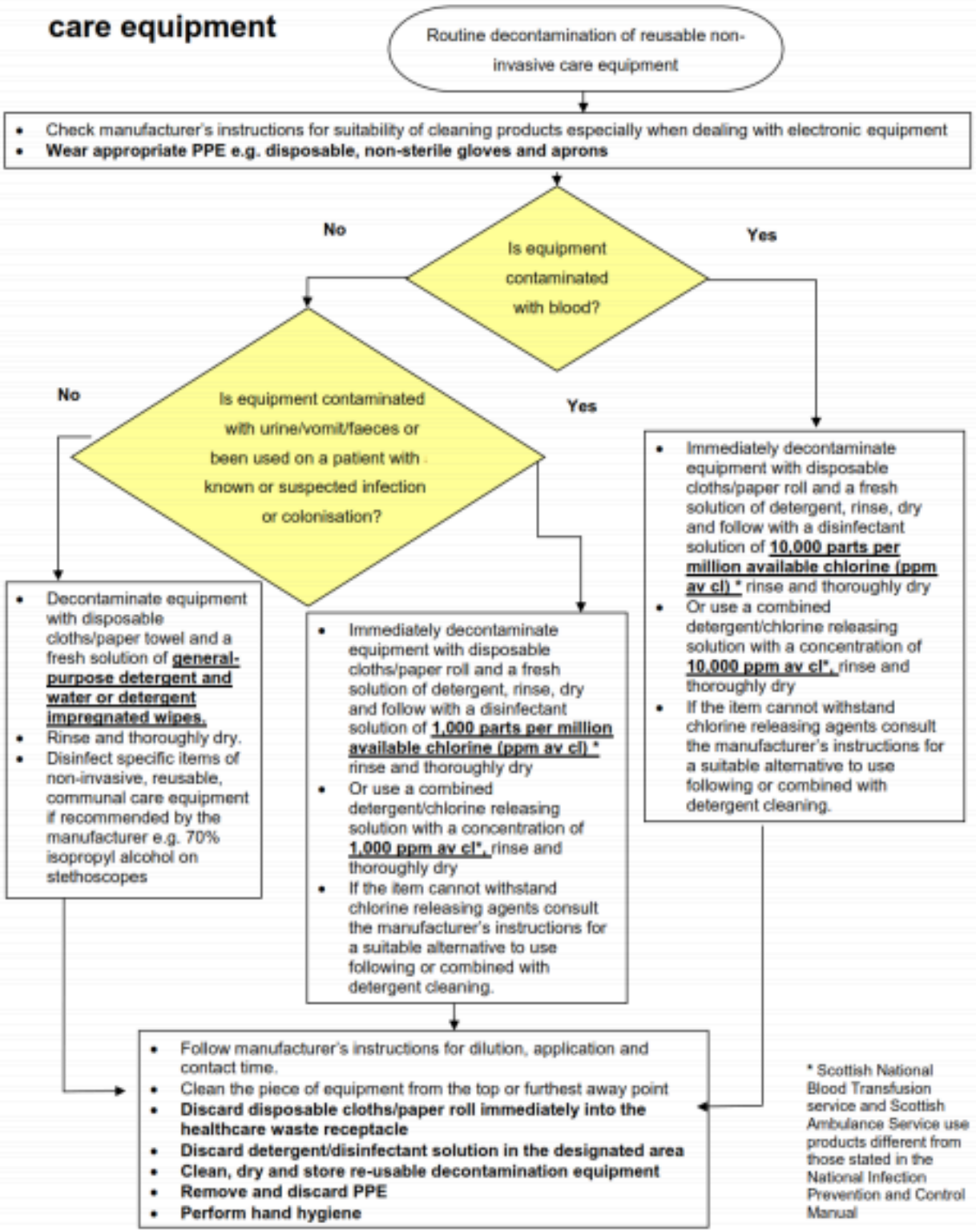
Best Practice: How to hand wash step by step images

Steps 3-8 should take at least 15 seconds.

Adapted from the World Health Organization/Health Protection Scotland

*Any skin complaints should be referred to local occupational health or GP.

Routine decontamination of reusable non-invasive patient care equipment



Prepared and published for the cause of public interest
© Indian Occupational Therapists Think Tank, 2020

References:

1. Zheng J. SARS-CoV-2: An Emerging Coronavirus that Causes a Global Threat. *Int J Biol Sci*. 2020;16(10):1678-1685. Published 2020 Mar 15. doi:10.7150/ijbs.45053.

2. WHO. Novel Coronavirus (2019-nCoV) situation report-1. https://www.who.int/docs/default source/coronaviruse/situation-reports/20200121-sitrep-1-2019-ncov.pdf?sfvrsn=20a99c10_4 (Accessed on 16 June 2020) 2020.

3. Dong E, Du H, Gardner L. An interactive web-based dashboard to track COVID-19 in real time. *Lancet Infect Dis*. 2020;20(5):533-534. doi:10.1016/S1473-3099(20)30120-1

4. Sahu KK, Mishra AK, Lal A, Sahu SA. India Fights Back: COVID-19 Pandemic. *Heart Lung*. 2020; 30 (20):148-5. doi:10.1016/j.hrtlng.2020.04.014

5. Chen N, Zhou M, Dong X, Qu J, Gong F, Han Y. et al. Epidemiological and clinical characteristics of 99 cases of 2019 novel coronavirus pneumonia in Wuhan, China: a descriptive study. Lancet. 2020; 395:507–13.

6. Chakraborty I, Maity P. COVID-19 outbreak: Migration, effects on society, global environment and prevention. *Science of The Total Environment*. 2020; 728 (1):13888.

7. Bai, Yan et al. "Presumed Asymptomatic Carrier Transmission of COVID-19." *JAMA*, vol. 323,14 1406–1407. 21 Feb. 2020, doi:10.1001/jama.2020.2565

8. Godri Pollitt, K. J., Peccia, J., Ko, A. I., Kaminski, N., Dela Cruz, C. S., Nebert, D. W., Reichardt, J., Thompson, D. C., & Vasiliou, V. (2020). COVID-19 vulnerability: the potential impact of genetic susceptibility and airborne transmission. *Human genomics*, *14*(1), 17. https://doi.org/10.1186/s40246-020-00267-3

9. Bavel, J.J.V., Baicker, K., Boggio, P.S. *et al.* Using social and behavioural science to support COVID-19 pandemic response. *Nat Hum Behav,* 4**,** 460–471 (2020). https://doi.org/10.1038/s41562- 020-0884-z

10. Jayaweera, M., Perera, H., Gunawardana, B., & Manatunge, J. (2020). Transmission of COVID-19 virus by droplets and aerosols: A critical review on the unresolved dichotomy. *Environmental Research*, *188*, 109819. https://doi.org/10.1016/j.envres.2020.109819

11. Lauer, S. A., Grantz, K. H., Bi, Q., Jones, F. K., Zheng, Q., Meredith, H. R., Azman, A. S., Reich, N. G., & Lessler, J. (2020). The Incubation Period of Coronavirus Disease 2019 (COVID 19) From Publicly Reported Confirmed Cases: Estimation and Application. *Annals of internal medicine*, *172*(9), 577–582. https://doi.org/10.7326/M20-0504

12. Xu, H., Yan, C., Fu, Q., Xiao, K., Yu, Y., Han, D., Wang, W., & Cheng, J. (2020). Possible environmental effects on the spread of COVID-19 in China. *The Science of The Total Environment*, *731*, 139211. https://doi.org/10.1016/j.scitotenv.2020.139211

13. Adams JG, Walls RM. Supporting the Health Care Workforce During the COVID-19 Global Epidemic. *JAMA.* 2020;323(15):1439–1440. doi:10.1001/jama.2020.3972

14. Health and Care Professionals Council. COVID19 hub. [Internet]. United Kingdom. HCPC.org.uk. (Accessed on 16th May 2020) Available from: https://www.hcpc-uk.org/covid-19/

15. Department of Health UK. Coronavirus (COVID-19): safer travel guidance for passengers. [Internet]. 2020 [cited 2020 June 9] .Available from: https://www.gov.uk/guidance/coronavirus covid-19-safer-travel-guidance-for-passengers

16. Department of health Victoria State. Infection control: standard and transmission-based precautions. [Internet]. 2020 [cited 2020 June 11] Available from: https://www2.health.vic.gov.au/public-health/infectious-diseases/infection-control guidelines/standard-additional-precautions

17. NHS. England. UK. Catch it Bin it Kill it. [Internet]. 2020 [cited 2020 June 11]. Available from: https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2017/09/catch-bin-kill.pdf

18. Centre for Disease control and prevention. USA. Water, sanitation and environmentally related hygiene-Coughing and Sneezing. [internet]. 2020 [cited 2020 June 11] Available from: https://www.cdc.gov/healthywater/hygiene/etiquette/coughing_sneezing.html

19. Cheng KK, Lam TH, Leung CC. Wearing face masks in the community during the COVID-19 pandemic: altruism and solidarity. *Lancet*. 2020. http://doi.org/10.1016/S0140-6736(20)30918-1

20. British Geriatric society. Good practice guide. COVID-19: Managing the COVID-19 pandemic in care homes for older people. [internet]. 2020 [cited 2020 June 02] Available from: https://www.bgs.org.uk/resources/covid-19-managing-the-covid-19-pandemic-in-care-homes

21. Ministry of Home Affairs. Government of India. Guidelines for phased reopening (Unlock 1). [Internet]. 2020 [cited 2020 June 4]. Available from: https://static.mygov.in/rest/s3fs public/mygov_159098900251307401.pdf

22. Hellewell J, Abbott S, Gimma A, et al. Feasibility of controlling COVID-19 outbreaks by isolation of cases and contacts [published correction appears in Lancet Glob Health. 2020 Mar 5]. *Lancet Glob Health*. 2020;8(4):e488-e496. doi:10.1016/S2214-109X(20)30074-7

23. Fraser C, Riley S, Anderson RM, Ferguson NM. Factors that make an infectious disease outbreak controllable. *Proc Natl Acad Sci U S A*. 2004;101(16):6146-6151.

doi:10.1073/pnas.0307506101

24. HM Government UK. OUR PLAN TO REBUILD: The UK Government's COVID-19 recovery strategy. [Internet]. 2020 [cited 2020 June 4]. Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data / file/884760/Our_plan_to_rebuild_The_UK_Government_s_COVID-19_recovery_strategy.pdf

25. Chu DK, Akl EA, Duda S, et al. Physical distancing, face masks, and eye protection to prevent persontoperson transmission of SARSCoV2 and COVID19: a systematic review and metaanalysis. Lancet 2020; published online June 1. https://doi.org/10.1016/S01406736(20)311429.

26. Public Health England. Recommended PPE for primary, outpatient, community and social care by setting, NHS and independent sector. [Internet]. 2020 [cited 2020 June 18]. Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data / file/878750/T2_poster_Recommended_PPE_for_primary__outpatient__community_and_social_care_by_setting.pdf

27. Public Health England.COVID-19 Infection prevention and control guidance. [Internet]. 2020 [cited 2020 June 18]. Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data / file/893320/COVID-19_Infection_prevention_and_control_guidance_complete.pdf

Prepared and published for the cause of public interest