This edition aims to provide condensed practical advice for clinicians working in secure environments for reference during the period of recovery from the COVID-19 pandemic. It also considers leadership and system-level renewal, building healthy secure communities of staff and residents. 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.

Dr Caroline IJ Watson
RCGP Secure Environments Group
Healthcare in Secure Environments COVID-19
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Introduction

In March/April 2020, regime restrictions and compartmentalisation strategies were introduced across UK secure environments in order to protect populations from predicted ‘explosive outbreaks’ of COVID-19. Modelling in April 2020 predicted over 77000 cases and more than 2000 deaths in prisons in England and Wales alone. During Wave 1 (March to June 2020) there were 1945 possible cases, 467 confirmed cases, 41 people hospitalised and 25 deaths in England. Wave 2 was more severe and protracted, lasting more than 6 months, with just over 90 concurrent outbreaks in prisons across England and Wales at one point. Almost 500 people were hospitalised and there were over 140 deaths in prisons in England. New and updated data on the epidemiology of COVID-19 in prison settings since the Variant of Concern (VOC) B117 has shown that in Wave 2, the prison population had a standardised mortality rate (SMR) of 4.54 compared to the wider population. (SAGE EMG Transmission Group, 2021).

Variants of concern (VOCs) pose a real risk of higher rates of virus transmission, clinical impact, and vaccine escape, and they have the potential for amplification in secure settings. In areas with community transmission, since staff have been identified as the main conduits of infection, it will be important to consider offering surge testing for prison populations to run concurrently with community programmes, in order to reduce the risk of outbreaks and subsequent virus transmission back into the community. Vaccination continues to offer the most significant opportunity to break the cycle of COVID-19 infection in the wider community and protect populations in secure environments. It has been rolled out across UK prisons, prioritised by age and risk due to clinical vulnerability.

The year ahead will require agile strategic decision-making at every level within the health and justice system in order to balance the risk of further COVID-19 outbreaks with the importance of opening up regimes to reconnect individuals, facilitate mental health recovery, build emotional and physical health and wellbeing and strengthen resilience.

What’s new?

This guidance has been updated with the aim of serving as a practical reference point for clinicians, recognising that teams are now familiar with many of the changes introduced to help keep patients and staff safe during the COVID-19 pandemic. There is an extended section to assist with setting up remote consultations, updates on testing and population management, and new sections, which include outbreak management, COVID-19 monitoring and complications, vaccination and resilience for recovery. It is 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.
A1: COMMUNICATION

- Good communication remains fundamental to safe, effective, trauma-informed care. Principles include:
  - Active listening
  - Clear questions (good history - new symptoms, trends, deterioration; functional assessment).
  - Explanation, shared decision making and care planning – offer choice and encourage self-care
  - Safety netting advice - build health literacy with every patient contact

- Common barriers and practical solutions to effective communication in secure environments:

<table>
<thead>
<tr>
<th>Barrier</th>
<th>Solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Language</td>
<td>Telephone interpreting services (e.g. thebigword, language line)</td>
</tr>
<tr>
<td></td>
<td>Written information in other languages</td>
</tr>
<tr>
<td></td>
<td>Pictorial resources</td>
</tr>
<tr>
<td>Learning disability/difficulty</td>
<td>Easy read resources</td>
</tr>
<tr>
<td>Low literacy</td>
<td>Pictorial resources</td>
</tr>
</tbody>
</table>

- Specific communication skills are required for remote (telephone and video) consultations and triaging
- For further information on remote consultations, see A3.

A2: TRIAGE

- Secure environments triage systems should involve experienced senior clinicians to ensure safe care prioritisation and best use of appointments. Pressure should not be placed, by prison staff or residents, on the administrative team to make health-based decisions about appointments.
- Telephone triage is advised where possible. There should be no recording of calls.
- Equality of access is important; triage methods and tools should be tailored to meet patient need

<table>
<thead>
<tr>
<th>Triage type</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Face-to-face</td>
<td>Effective 2-way communication</td>
<td>Infection risk</td>
</tr>
<tr>
<td></td>
<td>Useful if individual need e.g. language, dementia</td>
<td>Prison staff required to facilitate access to care</td>
</tr>
<tr>
<td>Paper-based</td>
<td>Low infection risk</td>
<td>One-way communication</td>
</tr>
<tr>
<td></td>
<td>Useful if restricted patient access e.g. outbreak</td>
<td>Need easy-read/pictorial/translated options (A1),</td>
</tr>
<tr>
<td>Telephone</td>
<td>Efficient, 2-way communication</td>
<td>In-cell phone required</td>
</tr>
<tr>
<td></td>
<td>Low infection risk</td>
<td>Unsuitable for e.g. language, hearing loss</td>
</tr>
<tr>
<td></td>
<td>Useful tool post-COVID19</td>
<td>No options for texting</td>
</tr>
<tr>
<td>Video</td>
<td>Patient access if GP/ANP off-site or lockdown</td>
<td>Secure technology, licence purchases, training</td>
</tr>
<tr>
<td></td>
<td>2ndry care triage may avoid A&amp;E, reduce referrals, reduce escorts</td>
<td>HCP must accompany patient</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hospital arrangement required (2ndry care)</td>
</tr>
</tbody>
</table>

A3: REMOTE CONSULTATIONS

A3i: PRINCIPLES AND SCOPE

- Telephone and video consultations have the potential to improve patient access, reduce secondary care referrals and hospital escorts, and improve links with community services. They must be confidential and should not be recorded.
- Principles of safe video consulting in general practice during COVID-19 have been jointly published by RCGP/NHS. Specific secure environments operational guidance is available on Future NHS Collaboration Platform. Healthcare providers must be familiar and comply with IT security requirements.
- Patients must consent to remote consultations.
- If at any point before or during a remote consultation either the patient or the clinician feels that a face to face consultation would be more appropriate, this should be arranged in a timely way.
<table>
<thead>
<tr>
<th>Scope</th>
<th>Locations</th>
<th>Type</th>
<th>Remote Staff</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care</td>
<td>Prison &gt; prison</td>
<td>T/V</td>
<td>GP/ANP</td>
<td>Cross-site cover/patient access</td>
</tr>
<tr>
<td></td>
<td>Prison &gt; community</td>
<td></td>
<td>GP/ANP</td>
<td>Economies of scale</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secondary care</td>
<td>Prison &gt; community</td>
<td>T/V</td>
<td>Visiting psychiatrist (offsite)</td>
<td>Pt access/remote prescribing with off-site clinician</td>
</tr>
<tr>
<td></td>
<td>Prison &gt; hospital</td>
<td></td>
<td>Hospital based clinician (senior grade)</td>
<td>Reduce escorts if specialty suitable</td>
</tr>
<tr>
<td>Pre-release community liaison</td>
<td>Prison &gt; community</td>
<td>V (T)</td>
<td>Community practitioner (GP/ANP/Key worker)</td>
<td>Improve engagement post-release</td>
</tr>
</tbody>
</table>

T – telephone, V – video, ANP- advanced nurse practitioner, NMP – non-medical prescriber

**A3ii: STARTING OUT WITH TELEMEDICINE**

- All prisons planning to use telemedicine require:
  - Visionable licenses
  - NHS secure tablet(s) with Visionable and SystmOne software (no other software allowed)
  - Yubikeys

- Specific permissions are required for bringing IT equipment in and out of prisons.
- Static NHS PCs with HSCN can also be used for Visionable calls. PCs require: Visionable software, webcam secured to PC, audio device (or good quality PC speakers).
- Each prison Visionable user requires a Visionable license and each NHS secure tablet user requires an Okta account and Yubikey to log in. (see below)
- If changes are required to software licence holders, Yubikey users or hardware, NHSEI HJ commissioners should be contacted.
- A local telemedicine champion (e.g. healthcare manager) should be identified in order to:
  - Facilitate Yubikey personalisation for staff (to enable login to NHS secure mobile device)
  - Facilitate Visionable training (admin, managers, HCPs) – see below
  - Ensure all staff are familiar with local telemedicine SOP, including IT security requirements
  - Set up and keep log of:
    - remote consultations - see Future NHS Collaboration Platform
    - mobile device use and storage – see below
  - Coordinate remote consultations through SPOC e.g. admin email

- NHS secure tablet(s) and Yubikeys must be locked away when not in use. Use and storage (daily and weekly) must be logged and breaches reported to head of healthcare and to local commissioners via incident reporting (e.g. Datix).

### Examples of logs for storage and use of mobile devices

#### Mobile device use log

<table>
<thead>
<tr>
<th>Purpose of tablet use (VC, medication, SSU round)</th>
<th>Date/time tablet removed from storage</th>
<th>Tablet removed from storage by: (print name and sign)</th>
<th>Name of HCP using tablet</th>
<th>Date/time tablet returned to storage</th>
<th>Tablet returned to storage by: (print name and sign)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telemedicine appointment</td>
<td>31/03/2020 1pm</td>
<td>Sam Smith xxxx</td>
<td>John Jones</td>
<td>31/03/2020 2pm</td>
<td>Sam Smith xxxx</td>
</tr>
</tbody>
</table>

#### Mobile device daily storage log

<table>
<thead>
<tr>
<th>Number of mobile devices expected in storage</th>
<th>Number of mobile devices witnessed in storage</th>
<th>Name of staff completing daily mobile device storage log (print name and sign)</th>
<th>Date and time log completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>3</td>
<td>Sam Smith xxxx</td>
<td>31/03/2020 5pm</td>
</tr>
<tr>
<td>Mobile device weekly storage log</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>---------------------------------</td>
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<td></td>
<td></td>
</tr>
<tr>
<td><strong>Period covered by weekly log (w/c)</strong></td>
<td><strong>Daily log</strong></td>
<td><strong>Completed (Y/N)</strong></td>
<td><strong>Name of staff completing weekly mobile device storage log (print name and sign)</strong></td>
</tr>
<tr>
<td>w/c 25/03/2020</td>
<td>Mon</td>
<td>Y</td>
<td>Sam Smith xxxx</td>
</tr>
<tr>
<td></td>
<td>Tues</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Weds</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Thurs</td>
<td>Y</td>
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<tr>
<td></td>
<td>Fri</td>
<td>Y</td>
<td></td>
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<tr>
<td></td>
<td>Sat</td>
<td>Y</td>
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<tr>
<td></td>
<td>Sun</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>w/c</td>
<td>Mon</td>
<td></td>
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<td>Tues</td>
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<td>Fri</td>
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<td>Sat</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>Sun</td>
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</tr>
</tbody>
</table>

- **Yubikey**
  - Small key-shaped hard token used to log in securely to NHS tablet.
  - Allows access to SystmOne on tablet (for e.g. SSU rounds, wing-based work, medication delivery).
  - Yubikey set up (personalisation):
    - Find email (nhsmail account) from noreply@okta.com, headed ‘Welcome to HSCN for HMPPS!’. Click **Activate Okta Account** link in email.
    - Create password and click **Create my account**. Insert Yubikey and click **Configure factor**.
    - Click on empty field in ‘Setup YubiKey’ screen then hold thumb for 5-10 seconds on the gold button on top of Yubikey.

- **Visionable**
  - Software required for all VCs involving patients. Also suitable for meetings.
  - Can be downloaded onto static NHS PCs (with HSCN) or NHS secure tablets.
  - All prison-based HCPs using Visionable (to make or chaperone video calls) must have a Visionable license.
• **Set up:**
  - find email (nhsmail account) from Visionable, headed ‘Sign Up for Visionable’. Click sign-up link
  - Complete name, email and create password. Activate account by clicking link sent to NHS email

• **Sign in:**

  ![Visionable app setup](image)

  - **Open the Visionable app**
    Hit the Visionable icon on your desktop to open the app.
  - **Enter your details**
    Type your email address and password.
  - **Sign in to Visionable**
    Tick ‘Keep me signed in’ box and Visionable will automatically log you in in the future.
    - **Signing in for the first time?**
      When you first sign in to Visionable, please make sure the server address is changed to `https://visionable.com`. This will auto populate the next time you use Visionable.

• **Who needs what?**

  - **Prison HCP:**
    - to make/chaperone VC on static PC in prison or from home: **Visionable license only**
    - to log in to secure tablet to access SystmOne: **Yubikey only**
    - to make/chaperone VCs from secure tablet: **Visionable license AND Yubikey**
  - **Hospital/community teams (infrequent use):** to join VCs: **approved email address. No Visionable license**
  - **Hospital/community teams (regular use):** to make/join VC: **approved email AND Visionable license**

• **Visionable training** – see user guide [https://visionable.com/video-tutorials/hmpps/](https://visionable.com/video-tutorials/hmpps/) or email training@visionable.com to book training sessions for healthcare team

• **Basics from Visionable user guide:**

  ![How to schedule meetings](image)

  - **Invite someone from your contacts in the “Invite Contacts” drop down box**
  - **Or type in the email address of an external contact. Once you have done this press “Enter” and the email address will appear in a blue box.**
  - **Please note external invitees’ email addresses must contain an ‘allowed email domain’.”**

  ![Visionable meeting scheduler](image)

  - **Schedule & book meetings**
    - Subject
    - Start date & time:
    - Invite Contacts
    - **External invitees**
      - Email addresses
      - Invite
      - Schedule & book
A3iii: REMOTE CONSULTATION CLINICS

- Set aside remote clinic consulting room for TCs and VCs where possible.
- Ensure hands-free option on telephone to allow patient and chaperone to hear remote caller in TCs.
- Static PC: Set up webcam and 2nd monitor (if possible). Check audio quality of speakers. Use external audio equipment if needed. Ensure Visionable software downloaded onto PC.
- Set up TC/VC clinic appointment ledger on SystmOne. Ensure admin team trained to manage appointments using Visionable; contact details (phone number, email) must be available for each remote consultation to manage e.g. unplanned delay, lost connection.
- To facilitate hospital/community-based clinician access to prison SystmOne patient records, data sharing agreement will need to be agreed with NHSE commissioner.
- If language interpretation/other communication needs: language line/aids must be available. If communication needs cannot be met with TC/VC, face-to-face consultation should be arranged.
- Allocate chaperone from healthcare team to clinic list. NB Only use prison chaperone in emergency.
- Patient consent for VC
  - Consent is essential for every VC. Check with patient before adding to ledger.
  - Ensure patient arrives 10 minutes early and recheck consent immediately prior to VC
  - 1st VC requires signed written consent form (see Appendix and NHS Futures platform)
  - Subsequent VCs require consent to be recorded in S1 notes.
- Clinician onsite in clinic room/patient on wing:
  - Clinician uses static PC + webcam in clinic room; Visionable VC on main monitor; SystmOne records open on 2nd monitor.
  - Patient + chaperone use secure tablet on wing; Visionable VC. SystmOne must NOT be open. Patient must NOT be left alone with secure tablet at any point.
Chaperone must dial in on behalf of patient and remain in the room throughout VC.

**Patient and chaperone in clinic room/clinician remote (hospital/community clinic/at home):**
- TCs: need hands-free option on phone - allows patient and chaperone to hear remote caller.
- VCs: use either static PC or secure tablet. Visionable VC. SystmOne must NOT be open when patient present. Immediately after patient has left, record on SystmOne that VC has taken place.
- Chaperone must dial in on behalf of patient and remain in the room throughout TC/VC.
- Remote clinician: uses Visionable; complies with confidentiality and IG requirements; records contemporaneous notes.

**Responsibilities of remote clinician** (see also A3iv)
- Write accurate detailed clinical record of consultation.
- Make prescribing recommendations/provide remote prescription in line with NHS remote prescribing guidance (see section E).
- Arrange any further investigations and follow up. This may include F2F consultation if either clinician or patient feels that this is necessary at any point during the remote consultation.
- Communicate details of consultation to prison healthcare team and 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.

**Responsibilities of chaperone**
- Obtain patient consent for VC/TC.
- Remain with patient at all times during consultation.
- Arrange for language interpreter/communication aids if required to facilitate consultation.
- Dial in and handle NHS mobile device/static PC/telephone during consultation.
- Stop VC/TC at any time if patient or clinician wishes to end call.
- Avoid opening SystmOne while patient in room. Document brief outline of remote consultation on SystmOne after patient left.
- Communicate to admin team after appointment if further consultation required (VC, TC, F2F).
- Return mobile device to locked cabinet at end of consultation/clinic and complete log.

A3iv: GUIDANCE FOR CLINICIANS WORKING FROM HOME

- All remote clinicians should be familiar with provider organisation’s information governance policy and prescribing policies, including remote prescribing, CD prescribing, electronic prescribing (when available).
- Home background should be neutral with no personal/identifiable information on display, no views through windows, no pictures, no certificates, no personal/luxury items or pets. Clear desk essential.
- Consultations must not be interrupted or overheard. In order to maintain confidentiality, room should be sound proofed or headphones worn.
- VCs should be conducted on secure IT equipment connected to NHS HSCN or using provider organisation VPN.
- All unnecessary computer windows should be closed before starting VC to minimise risk of inappropriate screen sharing.
- SystmOne must be accessible during consultations to make contemporaneous records. Second screen will facilitate simultaneous view of SystmOne and patient.
- If at any point during VC it becomes clear that F2F appointment needed, make timely F2F appointment.
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 nuances 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

**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?

### 4 Cs

<table>
<thead>
<tr>
<th>Communications Check</th>
<th>Confirm Identity</th>
<th>Confirm Participants</th>
<th>Consent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hello, can you hear me?</strong></td>
<td><strong>Ask patient’s name / DOB / Service number</strong></td>
<td><strong>Check who else is there &amp; make introductions</strong> (even if off screen)</td>
<td><strong>Consent for video consulting</strong></td>
</tr>
<tr>
<td><strong>Optimise technology set up</strong></td>
<td><strong>Confirm back up telephone number</strong></td>
<td><strong>Confirm patient location</strong></td>
<td><strong>Confirm confidentiality in place &amp; no party is recording</strong></td>
</tr>
</tbody>
</table>

### 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?

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

**LIFESTYLE ADVICE**
- Revealing common pitfalls
- Clues may be overlooked
- Be aware of what you see

### Shared Part

Agree the Plan

**THINK ALOUD**
- Clearly & using patient’s own language
  - Chunk & Check
  - Watch for NVC cues from patient
  - Check understanding

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

**BEWARE**
- Realistic options
- Genuine choice
- Time for questions
- Further information

**OFFER**
- Tell patient what you’re not sure about, and let them help you.

**IN DIFFICULTIES**
- 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?

Thanks to Dr Roger Neighbour for the consultation model on which this is based and Prof Trish Greenhalgh for her work on remote consultations. Feedback is gratefully received at katherine.king415@mod.gov.uk
B1: COVID-19 TRANSMISSION

- **Respiratory** (droplet and aerosol) – main route. Risk highest if people <2 metres apart.
- **Contact** (contaminated surface). COVID-19 detected in respiratory secretions, blood, urine, faeces.
- **Airborne** – risk with aerosol generating procedures (AGPs) or poorly ventilated indoor spaces, especially if people together for extended time period.

B2: GENERAL PRINCIPLES OF INFECTION PREVENTION AND CONTROL

- **COVID-19: Guidance for maintaining services within health and care settings:** IPC recommendations should be followed. IPC measures/PPE remains unchanged but there is now an organisational responsibility to assess risk and apply a hierarchy of controls to reduce risk; include evaluation of ventilation in the area, operational capacity, infection prevalence/new VOCs in community.
- **All staff and residents** should observe:
  - **Hands:** more frequent hand washing (20 secs) or use of hand rub gel
  - **Face:** cover mouth/nose if sneeze/cough – use disposable tissue, place in disposable rubbish bag, then wash hands. If no tissue, cough/sneeze into elbow (not hand).
  - **Space:** follow social distancing guidance - remain 2 metres apart wherever possible.
  - **Ventilate:** maximise fresh air exchange indoors wherever possible
- **PPE and face coverings:** see B4
- **Decontamination:** healthcare providers may advise all HCPs to change into easily washable uniform on site and remove it before going home.
- **Cleaning and disinfection:** objects/surfaces touched regularly, communal areas e.g. showers, phones. Standard cleaning equipment (see HMPPS protocols). Clean frequently, including before and after use.
- **Health Education on IPC:** use verbal/visual reminders: floor marking tape, posters, in-cell TV/radio, written and pictorial patient information for secure settings, information in other languages

B3: POPULATION MANAGEMENT

B3i: NATIONAL FRAMEWORK FOR PRISON REGIMES AND SERVICES

- In response to the COVID-19 pandemic, prisons introduced an **Exceptional Regime Management Plan (ERMP).** IPC measures, social distancing and compartmentalisation were introduced, regimes and inter-prison transfers (IPTs) were restricted and social visits were stopped in order to protect residents from COVID-19 outbreaks.
- In June 2020, a **5-stage conditional national recovery framework** for prisons and services was published and a **5-stage conditional Exceptional Delivery Model (EDM)** developed, with details for lifting regime restrictions and reintroducing services (including healthcare). EDMs were designed to be aligned with the government recovery road map; clear requirements were set out for transitioning between EDM stages.
- Since June 2020, prisons in England and Wales have transitioned between EDM stages in both directions in response to local virus-associated factors e.g. virus transmission levels, impact on staffing.
- IPTs have been facilitated based on a RAG rating system, related to local community virus transmission and COVID-19 infection levels within an individual prison.
- Following stage 4 lockdown during Wave 2 of the pandemic, transitions between EDM stages have begun again. Further local lockdowns may be needed in the coming months, in response to localised surges of COVID-19 variants. Short-term lockdowns may also be used to facilitate mass testing.
B3ii: COHORTING AND COMPARTMENTALISATION

- Cohorting and compartmentalisation is a process of isolating specific groups of residents from the main population to limit the risk of COVID-19 spread and protect clinically vulnerable residents.
- 3 groups (cohorts) can be isolated either in distinct areas (units) or located throughout the prison with effective infection control barriers and separate regimes in place.
  - Reverse cohorting: separation of new arrivals to reduce risk of virus seeding into the prison.
  - Protective isolation: separation of symptomatic/COVID-19 positive/contacts for ≥10 days
  - Shielding: opt-in separation of clinically extremely vulnerable/vulnerable residents most at risk of severe illness with COVID-19.
- Close partnership working is required between healthcare and prison teams in order to identify and appropriately locate residents. All staff must be clear which residents are isolating to avoid breach of barriers. Cross-deployment of staff between cohorts should be minimised.
- Household: small group of residents who share a cell/dormitory and cannot maintain social distancing.
- Regime group: several households grouped together for exercise and activities (showers, phone calls). Regime group members must socially distance from each other.

B3iia: REVERSE COHORTING (RCU)

- Temporary separation of residents from main population if:
  - Newly arrived from community
  - IPT (depending on RAG rating of sending prison and resident's COVID-19 test status – see B5).
  - More than single day out of establishment at hospital* or court**
- IPT from Green site: Isolation not required if i) pre-transfer LFD negative AND ii) no symptoms or COVID-19 contact. Complete d0/5 or d1/6 swabs at receiving prison. (HMPPS).
- Duration: 14 days or ≥7 days AND 2 negative COVID-19 PCR tests
- Locate in single cell or in household if single cell unavailable (only share with person who arrived with at Reception)
- Households within RCU regime groups must not mix and must observe strict IPC measures (social distancing, hand hygiene, face coverings).
- Residents who consent to COVID-19 testing on entry should not mix with residents who refuse testing.
- *Hospital RC not required if:
  - back from hospital within 24h
  - regular hospital appointments for severe medical condition and already shielding in single cell
- **Court RC – for duration of trial AND 14 days (or ≥7 days AND 2 negative COVID-19 PCR tests) after
- A resident must be assessed by healthcare (check symptoms, temperature) before RC can end.

B3iib: PROTECTIVE ISOLATION (PIU)

- Temporary separation of residents from main population if:
  - Symptomatic for COVID-19
  - COVID-19 positive (symptomatic or asymptomatic)
  - Household contact of resident who is symptomatic or tests COVID-19 positive
- Duration: ≥10 days and 48h without fever.
- Locate in single cell/alone in multiple occupancy cell (unless 2 people test positive at same time who have been sharing cell).
- PIU residents must receive regular welfare checks (by prison) and monitoring (by healthcare) if clinically indicated or if concern flagged up at prison welfare check. Keep non-essential staff contact to minimum while supporting welfare of the patient.
- NB if symptomatic, resident must isolate for ≥10 days even if COVID-19 test negative.
- If resident tests positive for influenza, they must remain separate from other residents (including COVID-19 positive residents)
- Prison staff must have (and document) discussion to inform asymptomatic household contact that:
They must isolate ≥ 10 days
- At increased risk of COVID-19 by remaining in cell with symptomatic/COVID-19 positive resident
- May locate in a separate cell from COVID-19 symptomatic/positive resident.
- If they decline to move cells, a disclaimer form should be signed to accept the risk

- Regime group members from other households do NOT need to isolate unless identified as close contacts by Contact Tracing.
- ALL symptomatic residents must be offered COVID-19 PCR test - see B5. NB tests are voluntary.
- A resident must be assessed by healthcare (check symptoms, temperature) before PI can end.

B3iic: SHEILDING (SU)

- Opt-in separation from main population, offered to residents at risk of severe illness with COVID-19:
  - Clinically Extremely Vulnerable
  - Clinically vulnerable patients identified through QCOVID population based risk model
  - Patients identified by a doctor to be clinically vulnerable
- Locate in single cell/alone in multiple occupancy cell
- Option to shield remains in prisons although stopped in community. Residents should be supported by healthcare staff in their decision making. Those who choose not to shield should sign a disclaimer and be encouraged to follow all other IPC guidance.
- If eligible residents change their mind at any point, and choose to start, stop or restart shielding, they should be supported in their choices.
- NB HMPPS shielding policy and processes are revised as community risk and restrictions change.

B4: PPE AND FACE COVERINGS

- PPE: COVID-19: Infection Prevention and Control (IPC) guidance and current activity/context-specific guidance for prisons and community offender populations should be followed by all staff (see p15). PPE should be disposed of in clinical waste followed by careful hand hygiene.
- PHE guidance for donning and doffing PPE: available for non-AGP and AGP
- Face coverings: national and local guidance should be followed. Residents must wear face coverings:
  - In reception/reception holding room
  - While under reverse cohort conditions/on RCU
  - When attending clinical area e.g. healthcare appointment, medication administration queue (unless in regime group). NB face coverings should be removed for supervised medication administration to allow mouth check. Staff should be vigilant - there is increased risk of diversion with face coverings being used to secrete medicines.
  - On release if using public transport or to approved premises
- Local guidance for face coverings indoors will depend on space, ventilation, activity (e.g. 1:1), outbreak.
- 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). DSH risk can be reduced by safe storage of unused PPE, correct disposal and individual risk of DSH.

PPE Guidance (Staff) – see p15
**Recommended PPE for staff in prisons and community offender accommodation (COVID-19)**

- Table 1 covers all routine prison and community offender accommodation staff tasks. Table 2 covers additional requirements in high risk areas. Table 3 covers officers working in health treatment areas. Staff must at all times seek to minimise any non-essential and avoidable contact with any staff member or prisoner.
- Routine prison and probation tasks, for example searching, where these contacts cannot be avoided have been risk assessed and Standard Operating Procedures written for them.
- For unplanned interventions, for example, assaults, fights, self-harm where the 2 metre social distancing cannot be achieved, grab bags of PPE should be immediately accessible.

**Table 1 – Routine prison and probation accommodation staff tasks – Non-outbreak sites**

<table>
<thead>
<tr>
<th>Context</th>
<th>Disposable gloves</th>
<th>Disposable plastic apron</th>
<th>Disposable fluid repellent coverall or gown</th>
<th>Fluid repellent (type IIR) surgical mask</th>
<th>Filtering face piece respirator</th>
<th>Eye or face protection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Essential, unavoidable and sustained custodial tasks where 2 metre social distancing cannot practically be achieved.</td>
<td>✓ Single use*</td>
<td>✓ Single use*</td>
<td>X</td>
<td>✓ Single / sessional use**</td>
<td>X</td>
<td>✓ Risk assess sessional use**</td>
</tr>
<tr>
<td>Entry to cell or room of possible or confirmed case: use single-use PPE. Risk assess eye protection.</td>
<td>✓ Single use*</td>
<td>✓ Single use*</td>
<td>X</td>
<td>✓ Single / sessional use**</td>
<td>X</td>
<td>✓ Single / sessional Use**</td>
</tr>
<tr>
<td>Drop-offs made with no entry into the cell or room (leaning in only). Risk assess eye protection. Order of drop-offs: first contacts of COVID-19 cases: second possible COVID-19 cases awaiting test results; third COVID-19 positive persons.</td>
<td>✓ Sessional Use**</td>
<td>✓ Sessional Use**</td>
<td>X</td>
<td>✓ Single / sessional use**</td>
<td>X</td>
<td>✓ Single / sessional Use**</td>
</tr>
</tbody>
</table>

**Table 2 – ADDITIONAL requirements in high risk areas (as recommended by local risk assessment or local face mask strategy - Table 1 still applies)**

<table>
<thead>
<tr>
<th>Context</th>
<th>Disposable gloves</th>
<th>Disposable plastic apron</th>
<th>Disposable fluid repellent coverall or gown</th>
<th>Fluid repellent (type IIR) surgical mask</th>
<th>Filtering face piece respirator</th>
<th>Eye or face protection</th>
</tr>
</thead>
<tbody>
<tr>
<td>In addition to table 1 staff identified as per local face mask strategy or local risk assessment as requiring additional protection</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>✓ Sessional use**</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

**Table 3 – Officers on ambulance escort, hospital bedwatch or dental treatment escort**

- There are strict requirements that the escort officers will be given detailed instructions on the security risk and most appropriate level of restraint prior to escort. Escorting officers should not undertake an escort until Security have informed them of minimum restraint requirements for the prisoner described here.
- Escorting officers must carry a copy of the standard letter for clinicians which explains the PPE requirements.

<table>
<thead>
<tr>
<th>Context</th>
<th>Disposable gloves</th>
<th>Disposable plastic apron</th>
<th>Disposable fluid repellent coverall or gown</th>
<th>Fluid repellent (type IIR) surgical mask</th>
<th>Filtering face piece respirator</th>
<th>Eye or face protection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within 2 metres of defined aerosol-generating procedure while the clinician is undertaking the procedure and within the area where the procedure is performed</td>
<td>✓ Single use*</td>
<td>X</td>
<td>✓ Single use*</td>
<td>X</td>
<td>✓ Single use* or battery-powered respirator</td>
<td>✓ Single use*</td>
</tr>
<tr>
<td>Within 2 metres of patient who has undergone an AGP but is no longer in the AGP treatment area</td>
<td>✓ Single use*</td>
<td>✓ Single use*</td>
<td>X</td>
<td>✓ Single use*</td>
<td>X</td>
<td>✓ Single use*</td>
</tr>
</tbody>
</table>

* Single use refers to disposal of PPE after each prisoner and or following completion of a procedure or task.
** Sessional use refers to a period of time when the custody or probation worker is undertaking duties in a specific setting or exposure environment. The session ends when the staff member leaves the setting or exposure environment.

B5: TESTING AND CONTACT TRACING

B5i: TESTING

- COVID-19 testing programmes have been extended in the community and in prisons. Two main types of test are used – Polymerase Chain Reaction (PCR) laboratory tests and rapid antigen lateral flow device (LFD) point of care tests. Other types (e.g. LAMP testing) are being piloted.

B5ia: PCR tests: Used for SYMPTOMATIC and other clinical testing by healthcare teams (see below)
- Advantage: gold standard COVID-19 test; high specificity/sensitivity
- Disadvantages: laboratory required; delay to result
- Use in secure settings:
  - Symptomatic COVID-19
  - Asymptomatic testing newly arrived residents on d0/5 or d1/6
  - Confirmation previous test result (positive LFD, void PCR)
  - Close contact of COVID-19 positive case
  - Pre-hospital
  - During an outbreak (PHE guidance: mass testing day0/1, day 5-7 and 28 day recovery testing)
  - Staff surveillance testing (weekly, led by HMPPS)

B5ib: Lateral flow tests (LFDs) Used for ASYMPTOMATIC surveillance by prison staff/support workers
- Advantages: POC test (home, site) result 30 minutes > early isolation; high specificity
- Disadvantage: lower sensitivity
- Use in secure settings:
  - Surveillance programmes including: at points of prison entry, transfer, pre-court and release to reduce risk of virus transmission into and out of the establishment.
  - During an outbreak at some sites (led by PHE OCT)
  - Staff surveillance testing (twice weekly, led by HMPPS)

<table>
<thead>
<tr>
<th>Asymptomatic Testing Regime</th>
<th>Frequency/Timing</th>
<th>Test Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reception and Transfer</td>
<td>Day 0/1 and Day 5/6</td>
<td>PCR/LFD</td>
</tr>
<tr>
<td>Pre-hospital</td>
<td>Directed by hospital (usual 72h pre-admission)</td>
<td>PCR</td>
</tr>
<tr>
<td>Pre-release</td>
<td>48 hrs prior to release AND</td>
<td>LFD</td>
</tr>
<tr>
<td></td>
<td>On morning of release</td>
<td></td>
</tr>
<tr>
<td>Pre-transfer</td>
<td>On morning of transfer</td>
<td>LFD</td>
</tr>
<tr>
<td>Pre-court</td>
<td>As close as possible to attendance at court (&lt;24h)</td>
<td>LFD</td>
</tr>
<tr>
<td></td>
<td>Regular attendees: test alternate days</td>
<td></td>
</tr>
<tr>
<td>Routine ROTL</td>
<td>Regular ROTL: twice weekly</td>
<td>LFD</td>
</tr>
<tr>
<td></td>
<td>One-off ROTL: on morning of ROTL</td>
<td></td>
</tr>
<tr>
<td>Pre-IRC-transfer</td>
<td>Test once 48 hours before transfer AND</td>
<td>LFD</td>
</tr>
<tr>
<td></td>
<td>24 hours before transfer</td>
<td></td>
</tr>
<tr>
<td>During outbreak</td>
<td>mass test day0/1, day 5-7, 28 day recovery testing</td>
<td>PCR/LFD</td>
</tr>
<tr>
<td>Staff testing programme</td>
<td>Weekly</td>
<td>PCR</td>
</tr>
<tr>
<td></td>
<td>Twice weekly</td>
<td>LFD</td>
</tr>
</tbody>
</table>
- Arrangements for taking swabs and reporting results vary depending on: site, test type, indication.
- Healthcare teams are responsible for:
  - Symptomatic testing
  - Asymptomatic testing with clinical context e.g. pre-hospital admission (directed by hospital).
  - Asymptomatic reception testing (d0/5 or d1/6) unless local prison agreement in place
  - Testing in response to outbreaks, subject to resources and local agreement.
- Testing is voluntary; consent is required: explain procedure (include uncomfortable, gagging, tears), how/when results received, implications of testing/not being tested (e.g. longer in RCU).
- **COVID-19 primary testing form (E28)** should be completed for clinically indicated COVID-19 test but not for prison surveillance programmes.
- **GUIDANCE ON PCR TESTING AND LFD TESTING** is available in pictorial, easy read, large print and multiple languages to support staff performing and supervising tests and residents who self-test.

Images from DHSC/NHS  *Your step-by-step guide for COVID-19 self-testing*

**B5ic: ACTION AFTER TESTING**

- **Test results should be interpreted** in light of:
  - **Pre-test probability**: likelihood of person being tested having COVID-19. Depends on local circulating community infection levels, contact with person with COVID-19, COVID-19 symptoms
  - **Specificity**: PCR/LFD both highly specific (very low false positive rates).
  - **Sensitivity**: PCR > LFD. LFD higher false negative rates; PCR detects lower viral loads in patients.
- Results of all tests (negative and positive) arranged through healthcare teams should be documented in patient health records.
### Symptomatic Action

**PCR**
Immediate isolation. Isolate and separate household contacts. Welfare checks

**Negative**
Continue isolation 10 days. Contacts stop isolating (unless advised by PHE HPT)

**Positive**
Isolate 10 days. Separate from household. Contact trace. No re-test for 90 days

**Asymptomatic**

**Action**

**PCR (LFD)**
Immediate isolation until result available

<table>
<thead>
<tr>
<th>Negative</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>d0/5 or d1/6</td>
<td>Isolate for at least 7 days with 2 negative PCR results (see RCU B3iiia)</td>
</tr>
<tr>
<td>Court return (&gt; 1 day)</td>
<td></td>
</tr>
<tr>
<td>Hospital discharge (&gt;24h)</td>
<td></td>
</tr>
<tr>
<td>Transfer* (amber/red)</td>
<td></td>
</tr>
</tbody>
</table>

**Transfer* (green)**
No isolation required if negative test immediately pre-/post-transfer

**Outbreak**
Isolate as guided by PHE/OCT

**Pre-hospital admission**
Isolate until hospital admission

<table>
<thead>
<tr>
<th>Positive PCR</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Isolate 10 days. Separate from household. Contact trace. No re-test for 90 days</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Positive LFD</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perform PCR. Isolate 10 days. Separate from household. Contact trace.</td>
<td></td>
</tr>
</tbody>
</table>

- **Transfers***:
  - Transfer isolation decisions are dependent on the RAG rating of the sending prison. The rating is decided by HMPPS, depending on national Heat Map data (virus levels and trends in prison and local community, vaccination, other factors).
  - At present, if pre-transfer LFD result is negative, a person transferring from a green site will be required to take d0/5 or d1/6 swabs but will not be required to isolate while awaiting results of these swabs. If a resident declines to take a swab they will need to isolate in RCU conditions for 14 days.

**B5ii: CONTACT TRACING**

- Rapid contact tracing, contact isolation and IPC adherence are essential for prevention, containment and elimination of COVID-19 outbreaks in closed settings.

- **Contact**: exposed to ‘case’ **48h pre- to 7 days post-symptom onset/test positive** without PPE:
  - < 1m ≥1 minute (face-face/skin-skin)
  - 1-2m >15 minutes (exercise/association without social distancing, sharing cell/office/car)
  - Household contact (live in same cell/home)

- **Regime groups** who are not part of the household of a case are **not automatic contacts**; but only when social distance breach or PPE breach (as above)

**B5ii: MANAGING CONTACTS**

- Isolate suspected/confirmed cases; offer separate accommodation to asymptomatic household contacts
- Notify PHE HPT all suspected/confirmed cases
- PHE/Prison/Healthcare collaborate to **identify, isolate and test contacts**
- Case tests positive: All contacts isolate for 10 days from case’s symptom onset/date case’s test done
- Case tests negative: Contacts stop isolating unless i) sharing cell with case ii) test positive iii) symptoms iv) advised to remain isolating by PHE HPT/OCT
- All contacts who become symptomatic become suspected cases: Isolate further 10 days; contact trace
- All contacts who test positive become cases: Isolate further 10 days; contact trace

**B6: OUTBREAK MANAGEMENT**

- **Outbreak**: when ≥2 residents or staff in a prison or place of detention (PPD) develop COVID-19 symptoms or test positive and it is likely that the cases are linked in time (within 14 days) and place.
B6i: IMMEDIATE MANAGEMENT

- Effective communication between prison, healthcare, local hospital microbiology and public health partners is essential during an outbreak.
- Cases (suspected/confirmed) should be isolated (B3iib) and contact tracing initiated.
- If an outbreak is not declared, HPT will continue to support PPD lead and healthcare team with IPC measures and assess developing situation.
- If an outbreak is declared, it should be reported to HMPPS/Home Office and managed through the outbreak control team (OCT), led by public health specialists in line with the national contingency plan for outbreaks in PPDs.
- The role of the ICT/OCT is to ensure that the outbreak/incident is appropriately investigated and managed, and to advise the Governor or appropriate Senior Manager of the PPD on measures required to control it, which may impact on operational, logistic and security challenges for the setting.
- PHE’s National Health and Justice Team will provide advice and support to responding ICT/OCTs, conduct surveillance at a national level, share intelligence with key partners, and develop national guidance for use in preventing and managing outbreaks.

B6ii: OUTBREAK POPULATION MANAGEMENT

- **Compartmentalisation:** There is a need to maximise operational capacity to facilitate movement through the courts and secure estate, however it remains important to be able to protect clinically vulnerable residents from COVID-19 infection and to prevent virus seeding into and between PPDs or back out into the community from PPDs.
- It is therefore important to:
  - Continue to separate newly received residents by reverse cohorting while awaiting assurance from swab results
  - Retain the option to shield for clinically extremely vulnerable and vulnerable residents
  - Retain the ability to isolate residents with suspected/confirmed COVID-19

- **Isolation:** at all times (and especially during an outbreak) rapid isolation should be facilitated for:
  - Suspected/confirmed cases
  - Asymptomatic household members
  - Contacts identified by contact tracing

- Asymptomatic household members and other contacts should be separated from symptomatic suspected/confirmed cases. Where available space does not allow single accommodation, confirmed cases may be cohorted together.
- Separately isolate patients who may have other causes for their symptoms e.g. influenza.
- OCT will advise on lockdown of landings/wings where cases appear to be linked. This is difficult for residents and there should be regular welfare checks and communication e.g. via WayOut TV, letters from governor and healthcare.
- People who require isolation will need in-cell meals and medication; medication should be either provided in-possession or supervised at the cell door (officer support and SystmOne access required).
- **Mass testing:** In addition to testing suspected cases and contacts, public health OCT advice is:
  - Perform mass testing (PCR +/- LFD) of residents in areas (e.g. wing, accommodation block) which appear to be a focus for infection on day 0/1
  - Repeat tests in those areas on day 5-7. Isolate all confirmed cases for 10 days from date of positive test. Further tests may be required if there are continuing signs of transmission.
  - Perform recovery testing 28 days after onset of last confirmed/suspected case to confirm outbreak over

- Once available, mass testing should be facilitated by mobilised mass testing teams in order to retain healthcare team capacity to monitor COVID-19 cases and continue with usual healthcare duties.
- **COVID-19 case isolation and monitoring** (C5, E6)

B6iii: ESCORTS DURING OUTBREAKS

Contents →
• **Court escorts**: Court attendance is a judicial decision. ‘Fit to travel’ is a healthcare decision. HMPPS PECS are responsible for IPC measures/risk mitigation during transit/while in court. See table below.

• During an outbreak, video-link court attendance is preferable, with IPC measures in video-link facilities.

• COVID-19 case/contact in-person court attendance creates public health risk. In exceptional circumstances, if a resident must appear at court when healthcare has assessed they are not fit for travel, the court should liaise with their PECS SCDM. PECS will assess risks and mitigation requirements, seek court approval/acceptance and discuss agreed mitigations with prison.

<table>
<thead>
<tr>
<th>Outbreak Site</th>
<th>Healthcare</th>
<th>Prison</th>
<th>Court</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confirmed C-19</td>
<td>Isolate in cell. Not fit for travel.</td>
<td>LFD Contact court</td>
<td>Liaise with judge to consider options</td>
</tr>
<tr>
<td>Close contact C-19</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suspected C-19 Shielding</td>
<td>Assess &gt; fit for travel</td>
<td>LFD Contact court</td>
<td>Liaise with judge re-video link. If in-person attendance required, PECS IPC measures</td>
</tr>
<tr>
<td>No C-19 contact; no symptoms</td>
<td>Assess &gt; not fit for travel</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

• **Hospital escorts**: Essential escorts only; inform hospital of outbreak/patient’s COVID-19 status and clinical condition. It may be possible to defer some appointments until 10 day infectious window ended; If emergency transfer is clinically indicated, the escort must be facilitated with appropriate IPC measures.

**B6v**: **RECEPTIONS, TRANSFERS AND RELEASES DURING OUTBREAKS**

• **Receptions**: OCT may recommend restricting new receptions. If receptions continue, co-ordinated PECS transfers will assist with concurrent arrival numbers. All i) clinically extremely vulnerable ii) symptomatic new arrivals should be identified in reception and isolated in single cells.

• **Transfers**: OCT may recommend restricting transfers. If transfer essential, notify receiving PPD, LFD, IPC measures. Transfer of symptomatic/confirmed COVID-19 positive should be avoided as priority.

• **Releases**: If case/close contact due to be released before completing 10 day protective isolation, HPT must be informed and resident should be advised of isolation requirements. Probation and approved premises must be informed that resident is being released from outbreak site. They should also be advised if resident to be released is symptomatic, confirmed COVID-19 positive or a close contact. If no fixed abode, local authority must be informed. LFD testing 48h pre-release and on morning of release.

**B7**: **COVID-19 VACCINATION**

• **Vaccination programme**: led by Joint Committee on Vaccination and Immunisation (JCVI), prioritised by age and clinical risk, delivered in UK prisons in parallel with community since January 2021.

• **Astra-Zeneca (AZ)** vaccine has been the vaccine of choice for prisons for over 40s and clinically vulnerable under 65s (Pfizer cold-chain requirements now eased but supply size too large to manage.)

• **UK-based study**: over 150,000 adults >70 years has found 60% (after 28-34 days) - 73% (after 35 days) protection from symptomatic COVID-19 disease after one dose AZ vaccine with 80% reduction in risk of hospital admission. Data continues to be evaluated in light of new variants of concern (VOC).

• Standard Operating Procedures have been developed for each prison, using PGD or national protocol models of delivery, based on NHS vaccination SOP for community settings. Additional practical details about COVID-19 vaccination are available from Specialist Pharmacy Service (SPS).

• **Patient information** about COVID-19 vaccination and what to expect after it is available in easy-read and different languages. There are also Patient Information Leaflets available about the AZ and Moderna vaccines and about the rare clotting risk associated with AZ (1st dose only)

• **COVID-19 vaccination template** should be used on EHR so that vaccine coding is correct and data for administration of 1st dose, 2nd dose and refusal can be entered onto NIMS.
• Where a patient declines to have the vaccine, enter refusal code (Y29ec; 1st dose: Y29ed; 2nd dose: Y29ee) and reason given.

• Due to concerns about extremely rare (10.5 per million) thrombocytopenia associated with thromboembolic events (cerebral venous sinus thrombosis, portal vein thrombosis, PE, DVT) following 1st dose AZ (no events reported after 2nd dose), JCVI has advised non-AZ vaccinations should be given to healthy under 40s, unless other vaccinations are unavailable and other COVID-19 risk factors (male, BMI>30, ethnic background, social deprivation).

• Moderna vaccines have now been introduced to prisons for people under 40. They are being delivered using PGD or national protocol.

• Prisons will need to book clinics that avoid errors related to mixing up AZ and Moderna vaccines e.g. separate lists, separate clinicians, separate clinical areas.

• Vaccine dosing schedule: 2 doses 11-12 weeks apart; currently reduced to 8/52 between doses for >50s and clinically vulnerable due to COVID-19 Variant concerns; ideally same brand vaccine both doses but if Pfizer 1st dose in community, 2nd dose due and no release planned, safer to vaccinate with different brand than leave without 2nd dose.

• Vaccine hesitancy: the decision to delay or refuse vaccination; problematic some prisons, not others.

• Causes/Drivers of COVID-19 vaccine hesitancy:
  o health inequalities, socioeconomic deprivation, systemic racism
  o social disadvantage – lower levels education, poor access to accurate information
  o misinformation, conspiracy theories
  o lack of targeted campaigns/tailored public health messages
  o barriers to access, marginalisation
  o severe side-effects of first dose deter from accepting second dose

• Uptake variability: (UK, March 2021): lower vaccination rates (among eligible) related to: Ethnicity: Black African (58.5%), Black Caribbean (68.7%), Bangladeshi (72.7%), Pakistani (74%), White British (91.3%); Deprivation: (most deprived 87%, least deprived 92.1%); Religion: Muslim (72.3%), Buddhist (78.1%), Sikh (87%), Hindu (87.1%), Christian (91.1%); Women; Younger age

• COVID-19 vaccine hesitancy reasons:
  o Unknown long term effects, concern about side effects, side effects other vaccines
  o Low confidence in vaccine safety (worse since AZ thrombosis ‘scare’), efficacy
  o Perceived lower risk COVID-19 (younger age)
  o Recent COVID-19 infection
  o Lack of trust in vaccine production/speed/pharmaceutical industry, government
  o Concerns vaccine incompatible with religious beliefs
  o Experience of racism
  o Poor experience of healthcare
  o Lack of communication from trusted provider or community leader
  o Conspiracy theories e.g. COVID-19 not real, vaccine modifies DNA
  o Concerns re-risk to fertility, pregnancy, breast feeding

• Strategies to reduce hesitancy:
  o Tailored communication - prison context from trusted sources (e.g. healthcare providers, chaplaincy, peer support workers), accessible (languages, easy-read, different formats e.g. WayOut TV, radio, posters, blogs), address individual concerns (factual/emotional)
  o Flexible delivery models: local action plan development
  o Community engagement: HCPs run discussions with peer support workers, chaplaincy; celebrate vaccinated peers; community immunity benefit; use community rooms (gym, multi-faith room) rather than clinical areas; peer supporters present during vaccination sessions
  o Training/education of HCPs: e-learning modules through provider, communication skills

• Addressing vaccine hesitancy drivers in prisons: HMPPS resources/tailored advice, NHS resource to support hesitancy, NHSEI/Strategy Unit, NHS Midlands/Lancashire CSU case studies - HJ case study

• For Health and Justice versions of PHE vaccine resources contact sarah.vallis1@nhs.net.
C1: RECEPTION AND SECONDARY SCREENING

- Systematic, comprehensive first night screening, record keeping and coding is essential for all patients.
- Each new arrival must have a health assessment in reception to identify:
  - immediate medical needs e.g. essential medication, traumatic injuries, drug/alcohol withdrawal
  - risks to safety
  - long-term conditions requiring co-ordinated care planning and management; long COVID19
  - symptoms of COVID-19/other infectious disease
- It is essential to have:
  - clear documentation and coding (assessment and action plan on EHR)
  - effective communication (f2f, task, phone, email) within healthcare team, with external agencies/community care providers (e.g. pharmacy, GP practice, CMHT, substance misuse services, hospitals), and with prison staff
  - systematic pathways for referral from reception
to ensure:
  - safe first night prescribing
  - suitable location for observation (e.g. withdrawal, ACCT) and isolation (RCU/PIU)
  - care continuity and coordination (in-house referrals e.g. mental health, substance misuse; long-term conditions; outstanding hospital investigations/treatment)
- Court/hospital returns: should ALL be seen in Reception, to identify and manage new or emerging issues e.g. distress due to sentencing, new diagnosis or treatments commenced, new symptoms e.g. COVID-19, and to isolate if required (B3ii).
- COVID-19 testing and isolation: (B5i, B3ii)
- COVID-19 risk stratification: review for all new arrivals (C1ii)
- COVID-19 vaccination status: confirm on entry and book vaccination/add to waiting list.
- Substance misuse: screening, initial assessment and urine drug screen should be done in Reception at all levels of lockdown and recovery. If community supervised OST consumption cannot be confirmed, an opiate induction regime should be initiated and dose escalation managed cautiously, in response to withdrawal observations, in order to avoid overdose.
- Mental health: screening for mental health disorders and suicide risk is essential in Reception. It will be particularly important in the coming months due to the negative impact of COVID-19 on mental health from factors including social isolation, unemployment, increasing debt and poverty, domestic violence, acute illness, deteriorating long-term conditions, bereavement.
- All clinical staff performing first night/second stage screening should be clinically competent to do so and all non-clinical staff should have training in basic mental health and well-being awareness.
- Outstanding hospital appointments: Identify on entry to prison any outstanding hospital referrals, investigations and treatment. A clear pathway with robust administration processes and clinical input must be in place to ensure:
  - Appointments rearranged/new local referrals made in timely way if required.
  - Hospital advised of prison security requirements (e.g. no appointment details to patient’s home address, no mobile text alerts).
  - Prison aware of escort requirements/potential bed watch.
  - Clinician aware of urgent/routine waiting times, in light of impact of COVID-19 on services.
  - Systematic records of all referrals and clear plans to follow up if appointments not received as expected or clinical deterioration while patient waiting to be seen.
  - Patients given safety netting advice to contact healthcare if their symptoms deteriorate or new symptoms develop while waiting to be seen at hospital.
**Patient information:** arrangements for swabs, cohorting, IPC should be clearly explained to new residents. Use communication aids (e.g. telephone interpreting services (e.g. language line), written information in other languages, easy read, pictorial information).

**Secondary screening** - further opportunity to:
- Identify unrecognised physical/mental health issues, disabilities, risk self-harm
- Confirm access to medication, medical equipment (e.g. hearing aid), mobility aids
- Refer in-house (e.g. GP, dentist), check arrangements for outstanding hospital appointments
- Offer screening (sexual health, BBV, national screening programme as eligible)
- Check vaccination status and offer Hepatitis B, COVID-19, other vaccinations as required
- Offer harm reduction, health-promotion advice e.g. smoking cessation, healthy eating, exercise

C1ii: **COVID-19 RISK STRATIFICATION**

- Risk of severe illness with COVID-19 and vaccination status should be reviewed and recorded on all patients on prison entry. COVID-19 risk should also be reassessed when new medical problems arise.

- Read codes/SNOMED-CT codes:
  - CEV (high risk): Y228a / 1300561000000107
  - CV (moderate risk): Y228b / 1300571000000100
  - Low risk: Y228c / 1300591000000101

- Evidence-based tools (e.g. QCovid, Covid-age) have now been developed to calculate a more nuanced risk assessment for serious illness with COVID-19, based on epidemiological data for a range of factors associated with hospitalisation and death from COVID-19, including age, sex, ethnicity, BMI, social deprivation, clinical conditions and treatments.

- QCovid has been used by NHS Digital to develop the COVID-19 Population Risk Assessment. This has identified a broader group of clinically extremely vulnerable (CEV) patients. Where a patient has not been identified as CEV but there is clinical concern, QCovid can be used to quantify their risk.

- Where Read/SNOMED-CT coding is incomplete, SCR(A) is unavailable or a patient has not been registered with a GP in the community, clinical vulnerability can be determined from:
  - First night screening (BMI, ethnicity, medical conditions, medication) SEAT template
  - Medicines reconciliation
  - Problem list/summary

- Comprehensive screening and record keeping with systematic coding is therefore essential.

- CEV patients should be offered shielding in single accommodation and all patients eligible for COVID-19 vaccination should be encouraged to take up the offer, if they have not already done so.

- If a patient has not previously been identified as CEV but medical opinion is that they are clinically vulnerable, they should be offered the opportunity to shield while in prison.

C1iii: **MANAGING RELEASE DURING COVID-19**

- **6/52 pre-release:** Discharge planning meeting to identify needs and make arrangements for safe release e.g. community referrals, GP pre-registration, details of local contacts for housing, finance, employment agencies. NHS RECONNECT services will enhance the continuity and safety of release.

- **48 hours pre-release:** prison to arrange LFD test

- **On day of release:** prison to arrange LFD test and provide face mask. Healthcare to check for symptoms of COVID-19, provide discharge letter, community appointment details, TTOs (C2iii).

- **COVID-19 symptoms or positive COVID-19 test on day of release:** Prison and healthcare must work together to inform HPT, NPS/CRC (probation provider/community rehabilitation responsible officer)
C2: SAFE PRESCRIBING AND MEDICINES MANAGEMENT

C2i: GENERAL PRINCIPLES

- Prescribing and medicines management in secure environments should adhere to GMC good practice and follow RCGP Safer Prescribing in Prisons (2nd edition, Jan 2019) and NICE COVID-19 guidance.
- Prescribing and handling of CDs must meet legal regulations (Misuse of Drugs Act 1971, Misuse of Drugs Regulations 2001). Breaches must be reported (local incident reporting system).
- CD scripts must be printed, hand-signed at time of prescribing, and CDs reconciled with CD register.
- Continuity of medicines is essential to patient safety. Changes may be required in outbreak, on release.
- In-possession risk assessments: should be completed in reception and at other points e.g. post-ACCT closure to inform safe prescribing. Multi-disciplinary team discussion may be required to inform IP risk review post-ACCT closure, particularly if history of repeated self-harm.
- In-possession consumption (IP): lockers for safe IP medicine storage. If safe/appropriate prescribe:
  - regular scripts 28 days IP (up to 4 x 28 day repeat prescriptions)
  - acute scripts e.g. symptomatic relief, antibiotics, analgesia IP
- Supervised consumption (STT): administered by HCP with PPE; mouth checks. Prescribe STT if:
  - medicines at high risk of abuse and diversion
  - IP risk scores that indicate patient is unsafe to have medicines IP
- Door-to-door STT (including OST) required for isolating residents ie shielding, PIU, other residents during outbreak (isolation guided by PHE).
- Medicines queues should follow current safe IPC guidance (social distancing, face coverings)

C2ii: REMOTE PRESCRIBING

- Remote non-CD scripts - 2 options:
  - Prescribe, print and sign script remotely > scan signed script onto HJIS and/or email to HJ site
  - Prescribe remotely on HJIS > print script at HJ site > onsite prescriber to sign within 24h
- Remote CD scripts:
  - Prescribe, print and hand-sign script remotely > scan signed script onto HJIS > send hard copy (recorded delivery) or hand deliver script to dispensing pharmacy to prepare labelled supply and reconcile medicines with CD register.
  - Use stock supply for immediate administration from scanned signed script.
- Remote hospital prescribing: usual prescribing/medicines access arrangements continue.
- Hospital-only prescribing (e.g. Hepatitis C/HIV)
  TC/VC > hospital remote script > hospital labelled supply > hospital arranges delivery to prison
- Shared care prescribing (see also RMOC shared care guidance)
  TC/VC > hospital provides adequate information to enable prison GP to prescribe > hospital shares clear written arrangements for review and monitoring with prison GP.

C2iii: MEDICINES ACCESS ON TRANSFER AND RELEASE

- Transfer: supply 7 days medication on transfer to another secure site
- Release: start planning medicines continuity once release date known
  - Arrange GP2GP transfer; if no community GP, pre-register with community GP
  - Liaise with support worker (probation/Youth Offending Team) to assist with medicines access if release to Approved Premises planned.
  - Assess individual risk of self-harm or drug-related death*.
  - Low risk: Prescribe/supply TTO 28d medicines or FP10 28d (including CDs)
  - Mod risk: Prescribe/supply TTO 7d medicines + post-dated FP10 scripts 3x7d or FP10 4x7d
- Release on OST: Preparation is essential for safe release. Consider:
  - Increase OST dose pre-release to reduce risk illicit use on top of script/failure to engage
Switch methadone to buprenorphine 7-28d pre-release
- If patient on daily oral buprenorphine and long-acting injectable buprenorphine provided by local community SM service, consider option of converting to weekly doses injectable buprenorphine

- Provide naloxone training and naloxone kit (with guidance on use)
- Liaise prison substance misuse/recovery team with community (SM) team:
  - Arrange VC(TC) patient>community or arrange link worker visit pre-release where possible
  - Arrange post-release appointment
- Contact community pharmacy in local release area to set up supervised consumption service.
- Liaise with probation/third sector/other services to set up access to housing/employment/benefits

**Unexpected release from court/Friday release:**
- Provide FP10 28d* (see above). Contact community primary care team. Email discharge summary
- If on OST: Urgent liaison prison/community SM team to set up same day community appointment
- If community SM prescriber unavailable, prison to contact community pharmacy in area of release and provide OST FP10/FP10MDA bridging script (supervised consumption or daily pick up if no supervision)
- Further advice: see DHSC/PHE COVID-19 guidance for drugs and alcohol services

C2iv: MENTAL HEALTH MEDICINES

- Consider carefully before initiating tapering and withdrawal from antidepressant, anxiolytic or antipsychotic medicines during the COVID-19 recovery phase; there has been widespread deterioration in mental health and wellbeing among the general population which is likely to be mirrored or amplified in secure and detained settings, precipitated by months of isolation, illness, lack of exercise, separation from families, very limited opportunities for meaningful activity and reduced access to secondary care services. Some patients may also be more at risk of relapse or recurrence of mental health disorders as restrictions lift and interactions increase, facilitating access to illicit drugs, and increasing the risk of debt, threats of bullying and violence.
- 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.

C2v: SUBSTANCE MISUSE MEDICINES

- Guidance for commissioners and providers of services for people who use drugs or alcohol has been produced to support the continuity of drug and alcohol treatment services throughout the Coronavirus (COVID-19) pandemic, while protecting staff and service users.
- Safe prescribing and handling of OST medicines remains essential, including provision of door-to-door medicines for individuals who are isolating.
- RMOC long-acting injection guidance (April 2021) and guidance for OST on release – see C2iii

C2vi: OTHER SPECIFIC MEDICINES

- VITAMIN D - see NICE COVID-19 rapid guideline NG187 (2020), NICE PH56 and NHS COVID update
  - Vitamin D 10 micrograms (400 units) daily is recommended all year round for bone/muscle health in:
    - populations with little/no sunshine exposure (indoors most of the day, wear clothes that cover up most of their skin when outdoors)
    - adults/young people/children (>4y) with dark skin (African, African-Caribbean, south Asian family origin) who may not make enough vitamin D
  - Provision of Vitamin D supplements will be through prison canteen supplies.
  - Vitamin D will be prescribed only where a proven deficiency requires higher replacement doses.
C3: LONG-TERM CONDITIONS, ADVANCED DISEASE, FRAILTY AND END OF LIFE CARE

C3i: LONG-TERM CONDITIONS - see also NICE COVID-19 rapid guidelines

- CEBM has identified that:
  - LTCs are at risk of neglect during a national disaster
  - Stroke, myocardial infarction, diabetes complications (possibly hypertension) increase in incidence after disasters
  - People who are older and living with deprivation are more at risk
  - Lack of access to routine health care is a leading cause of mortality after disasters
  - Stress, poor diet, limited exercise, weight gain may contribute to exacerbations of LTCs

- LTC management should be prioritised during COVID-19 recovery. This will involve:
  - Updating LTC registers and audits
  - Screening for undiagnosed and ongoing LTCs in Reception and secondary screening.
  - Arranging LTC reviews for patients to:
    - Identify deterioration and optimise care
    - Update individualised care plans, including exacerbation management plans/safety netting
    - Review medications, rescue packs, arrange monitoring investigations e.g. bloods, urine
    - Check patient has named lead professional and details of when/how to contact
    - Discuss healthy eating, managing stress, lifestyle modifications e.g. stop smoking
    - Discuss activities/exercise to increase cardiovascular health and reduce frailty
    - Refer to in-house rehabilitation programmes (pulmonary, cardiac, DESMOND) if indicated.

- Promoting health and wellbeing with messages on National Prison Radio and WayOut TV
- Considering new ways of working e.g. peer support networks for LTCs, group-based health promotion

C3ii: ADVANCED DISEASE AND FRAILTY

see also Toolkit for general practice in supporting older people living with frailty

- COVID-19 clinical risk (CEV/CV) should continue to be assessed and coded in Reception/secondary screening (C2ii) in order to easily identify patients requiring:
  - Shielding in single accommodation (e.g. during a future outbreak)
  - Prioritisation for COVID-19 (and seasonal) vaccination (if unvaccinated)

- There should be clear referral pathways from Reception/secondary screening to facilitate
  - LTC review and individualised care planning
- Patients with advanced disease/complex comorbidities should be referred for a:
  - Frailty assessment
  - Social care assessment
  - Medication review (e.g. STOPP START medication review tool)
  - Falls assessment

- Consider using the Clinical Frailty Scale combined with age and co-morbidities to help to inform clinical discussion around ethical care escalation decisions, including ICU admission.

- Identify whether or not the patient has already made a DNACPR decision and whether they have made Advanced Decisions to Refuse Treatment (ADRT). Document all discussions, any Treatment Escalation Plans (TEPs) and where possible, involve families through a Family Liaison Officer (FLO) appointed by the secure setting. While a person retains capacity they may change their decisions.

- The CFS should not be used in younger people, people with stable long-term disabilities (for e.g. cerebral palsy), learning disabilities or autism.
C3iii: 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.
- See NICE NG191 and Table 1 for guidance on symptom control.
- 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.

C4: MANAGING (NON-COVID-19) ACUTE ILLNESS AND INJURY

- Acute illness and injury: assess and manage in a timely way at all times.

During outbreak:
- Minimise all but essential f2f contact and escorts. Follow IPC/PPE guidance (B4)
- If acute illness/trauma requires urgent hospital assessment:
  o Arrange timely transfer. Follow IPC/PPE guidance
  o Advise hospital of outbreak status and patient COVID-19 status
  o On return from hospital, locate following cohorting guidance B3iii

C5: MANAGING COVID-19

- COVID-19 cases identified by symptomatic testing, asymptomatic surveillance programmes and OCT/PHE-directed mass testing at outbreak sites (B5).
- Identify, isolate, (B3iib) test and trace (B5) all suspected cases/contacts. Follow IPC guidance

C5i: ASSESSMENT AND MONITORING – see Clinical Pathway (E6), Safety netting (E4), Diary (E5)
C5ii: SYMPTOM MANAGEMENT – see NICE NG191 Managing COVID-19 and Table 1
C5iii: HOSPITAL ADMISSION AND DISCHARGE – see COVID-19 Clinical Pathway (E6)

- Secure environments provide primary healthcare. Deterioration with COVID-19 may be rapid and it is important to identify patients who require transfer to hospital (see COVID-19 Clinical Pathway E6)
- If admission is required: contact hospital, advise that patient has suspected/confirmed COVID-19, arrange urgent transfer.
- On discharge from hospital: review all patients in reception to:
  o Arrange co-ordinated follow up/monitoring of any COVID-19 complications
  o Provide safety netting advice in case of further acute deterioration/need for readmission
  o Offer advice re-fluctuating nature of COVID-19 recovery
  o Offer further assessment if symptoms related to COVID-19 persist ≥4/52 or emerge.
  o Advise services available if referral for assessment of long-term effects of COVID-19 needed
- Isolate following >24h in hospital: 14 days or ≥7 days with 2 negative PCR results (B3iii)
- Further deterioration post-discharge: Emergency nurse assess; discuss with/arrange urgent review by GP/ANP. Arrange readmission if clinical need.

C5iv: COMPLICATIONS OF COVID-19 – see NICE NG191

- COVID-19 can affect multiple organs due to inflammation, direct viral effect, volume depletion, haemodynamic instability, coagulopathy and other processes seen in critical illness. Onset of complications is variable and not always associated with severe or critical disease.
• Rapid identification of deterioration and acute complications of COVID-19 is important to ensure optimal management and reduce the risk of long-term complications, disability and death.
• Patients who have been severely ill in hospital with COVID-19 may require ongoing management of COVID-19 complications in the secure setting.

C5iva: ACUTE COMPLICATIONS COVID-19

Relative frequency of COVID-19 complications:
- High: Acute kidney injury, acute myocardial injury, VTE, post-ICU syndrome
- Medium: Acute liver injury, neurological, post-COVID-19 syndrome, cardiac arrest
- Low: septic shock, acute respiratory failure, DIC, cytokine release syndrome, pregnancy complications (associated with underlying medical problems and risk factors), immune thrombocytopenia, aspergillosis, pancreatic injury, subacute thyroiditis.

Acute Kidney Injury
- Incidence (pooled): c.10%. Associated with increased mortality. Causes: hypovolaemia, haemodynamic instability, tubular and glomerular injury, thrombotic, rhabdomyolysis
- Prevention: maintain normal fluid volume.
- Presentation: ↓urine output (<0.5ml/kg/h for 6h adults, 8h CYP); rising NEWS2 score; haematuria + proteinuria; ↑creatinine (26µmol in 48h or ≥50% in 7d), abnormal electrolytes (e.g. Na+/K+).
- Management: If oliguria/↑NEWS2 score/urine dipstick blood/protein → 999 hospital transfer
  - Post-AKI: review co-morbidities/medication; monitor u+e, ACR; ACR 3/12. 2 year follow up if CKD

Acute myocardial injury
- Cause: myocardial inflammation → myocarditis, heart failure, arrhythmias, ACS, sudden death
- Presentation: Chest pain/+palpitations; ECG changes (ischaemic,SV/Varrhythmia); ↑troponin (↑hs-cTnI/↑hs-cTnT); ↑NT-proBNP (>400ng/l)
- Management: ECG, BP/P. If suspect acute cardiac injury → 999 hospital transfer

Venous Thromboembolism (VTE)
- Incidence (pooled): 14.7% VTE/11.2% DVT/7.8% PE hospitalised patients. Higher risk: older, ↑D-dimer.
- Cause: coagulopathy (prothrombotic) due to inflammation, critical illness, VTE – past/risk factors
- Presentation: DVT/PE – usual features
- Management: see NICE VTE NG158. Calculate 2-level DVT Wells score/2-level PE Wells Score.
- If suspect P.E. → 999 hospital transfer. (Use PERC to rule out P.E). If suspect DVT → d/w hospital (Proximal leg vein USS <4h or D-Dimer + interim anticoagulation + Proximal leg vein USS <24h).
- Anticoagulants: DOACs - apixaban/riparoxaban; LMWH 5/7 – see guidance; Warfarin - mechanical heart valve/other CI.

Co-infection:
- Incidence: bacterial co-infection <8% COVID-19 patients (0.1% hospitalised). Viral/fungal < bacterial. Higher risk if longer in hospital/immunocompromised. Causal organisms – vary season/local incidence
- Management: suspect bacterial infection → treat in line with local antibiotic guidance (community-acquired pneumonia e.g. amoxicillin, doxycycline). NB fbc, CXR/CT chest, sputum – confirmation (↑CRP does not confirm bacterial infection in patient with COVID-19; low CRP - less likely)

C5ivb: LONG-TERM EFFECTS OF COVID-19 (‘Long COVID’) – see NICE NG188

- Persisting or emerging COVID-19 symptoms/signs may be seen in patients following COVID-19 infection, regardless of the severity of the acute illness. Symptom nature/severity may fluctuate.
- Ongoing symptomatic COVID-19: COVID-19 signs and symptoms, 4-12 weeks after infection.
- Post-COVID-19 syndrome: signs/symptoms develop during/after COVID-19 infection; last >12/52; not explained by alternative diagnosis
• Large numbers of COVID-19 outbreaks occurred in prisons across the UK during the 2nd wave. Although the majority of cases were mild or asymptomatic, it is likely that persisting or emerging COVID-19 symptoms/signs will be seen in secure settings in the coming months.

• Patients hospitalised/severely ill with COVID-19 may be discharged with complications (e.g. CKD, post-intensive care syndrome – psychiatric, cognitive (30-80%), physical disability e.g. weakness (30-50%)). They will require ongoing support and monitoring tailored to complications.

• Older patients may present with worsening frailty or dementia, loss of interest in eating/drinking. New cognitive symptoms should be assessed with a validated tool.

• Common symptoms (NB variable)
  - Respiratory: breathlessness, cough
  - Cardiovascular: chest tightness, chest pain, palpitations
  - Generalised: fatigue, fever, pain
  - Neurological: cognitive ('brain fog', concentration/memory), headache, insomnia, dizziness, peripheral neuropathy, delirium (older)
  - Gastrointestinal: abdominal pain, nausea, diarrhoea, loss of appetite
  - Musculoskeletal: joint and muscle pain
  - Psychiatric/psychological: depression, anxiety symptoms
  - ENT: tinnitus, earache, sore throat, dizziness, loss of taste/smell
  - Dermatological: skin rashes

• All patients who have had COVID-19 infection (suspected or confirmed, symptomatic/asymptomatic) should be advised to request review if:
  - ongoing symptoms (4/52 or more after diagnosis)
  - worsening/new symptoms develop (anytime)

• It will be important to keep a record of patients who have had COVID-19 (suspected/confirmed) and to ensure that they are aware of available support (including community assessment services).

• Assessment
  - Document:
    - h/o suspected/confirmed acute COVID-19
    - type/severity past/current symptoms
    - timing/duration since onset acute COVID-19
    - co-morbidities
    - impact on ADL
    - worry/distress related to current symptoms

• Investigations/referral:
  - Urgent transfer → hospital if: signs acute/severe complication e.g. O2 desaturation on exercise, cardiac chest pain, signs P.E/severe lung disease
  - Tailor investigations to symptoms - consider:
    - Blood tests: consider fbc, u+e, LFT, CRP, ferritin, BNP, TFT
    - Exercise tolerance test (tailored to safely assess ability) e.g. 1-minute sit→stand (record breathlessness, pulse, O2 sats)
    - Lying/standing BP/pulse e.g. 3-minute active stand test (if postural symptoms e.g. palpitations/dizzy on standing)
    - CXR (ongoing respiratory symptoms 12/52)
  - Refer to mental health team (MHT) if complex/severe psychiatric symptoms and not already under MHT
  - If alternative diagnosis suspected, manage in line with national and local guidance.
  - Consider referral to integrated multidisciplinary assessment service (≥4/52 after onset COVID-19)

• Self-management/supported self-management
  - Develop personalised rehabilitation plan with patient – MDT approach
    - realistic goal setting – record and monitor goals, changes in symptoms
    - advice/education - managing symptoms breathlessness/fatigue/'brain fog'

C5v: END OF LIFE (COVID-19) – NICE NG191 Managing COVID-19, Table 1, C4iii Contents
**Table 1: Symptom Management in COVID-19 (including EoL)**

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Non-pharmacological</th>
<th>1st Line Drug</th>
<th>2nd Line Drug</th>
<th>Dose/Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fever</td>
<td>Keep cool environment.</td>
<td>Paracetamol (PO)</td>
<td>Paracetamol (PO)</td>
<td>500 mg every 4-6h, max 4g/24h</td>
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<tr>
<td>Cough</td>
<td>Offer pharmacological treatment only if other symptoms also present.</td>
<td>Morphine</td>
<td>Ibuprofen (PO)</td>
<td>40mg, p.o. every 6-8h, max 4g/24h</td>
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<td></td>
<td>Avoid portable fans (risk of infection spread).</td>
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<td></td>
<td>Avoid lying on back if possible (cough ineffective).</td>
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<td>Use saline nebulisation and consider codeine or morphine.</td>
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<td>Contraindicated in patients with significant respiratory impairment.</td>
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<td></td>
<td>For severe or persistent cough, consider ruxolitinib 5mg BID (only if patient already taking regular morphine, increase regular dose by 1/3rd.</td>
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<td>NB constipation risk: consider regular stimulant laxative.</td>
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<td>Use of NIV may be necessary.</td>
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</tbody>
</table>

| Symptom Management in COVID-19 (including EoL) – see also link-enabled version | Prescribing in Palliative Care and local guidance. | Prescribing in Palliative Care and local guidance. | Prescribing in Palliative Care and local guidance. |

**Indications**

- Severe or persistent cough
- Severe or persistent irritation cough
- Severe or persistent irritation cough

**Dose**

- Paracetamol (PO): 500 mg every 4-6h, max 4g/24h
- Morphine (PO): 15-30mg every 4-6h, max 120mg/24h
- Ibuprofen (PO): 40mg, p.o. every 6-8h, max 4g/24h

**Side Effects**

- Paracetamol: Nausea, constipation, dizziness, liver toxicity
- Morphine: Constipation, nausea, pruritus, respiratory depression
- Ibuprofen: Dizziness, gastrointestinal bleeding, renal function impairment

**Nursing Considerations**

- Monitor for signs of respiratory distress and adjust medication accordingly.
- Monitor for signs of constipation and provide appropriate laxatives.
- Monitor for signs of acute kidney injury and maintain adequate hydration.

**References**

- National Institute for Health and Care Excellence (NICE)
- Scottish Intercollegiate Guidelines Network (SIGN)
- Royal College of Physicians (RCP)

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

<table>
<thead>
<tr>
<th>Symptom Management</th>
<th>Management Formulary for prisons End of Life:</th>
<th>Pain</th>
<th>Identify and treat reversible causes</th>
<th>Consider type of pain</th>
<th>Explore anxieties/other psychological issues</th>
<th>Start analgesia early, to prevent pain developing</th>
<th>Prescribe regular (not PRN) use in EoL cancer pain</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Follow WHO 3 step pain ladder for cancer pain. Step 1 Non-opioid (paracetamol, NSAID) Step 2 Opioid - weak (codeine, tramadol) Step 3 Opioid – strong (morphine) Adjunct analgesia (antidepressant, antiepileptic) can be prescribed at any time</td>
<td>Step 3 Morphine (PO) Morphine sulfate (10mg/5ml)</td>
<td>See BNF morphine, BNF Prescribing in Palliative Care and local formulary. Initial dose: 5-10mg every 4h. Titrate to achieve adequate pain relief</td>
<td>Step 3 Morphine (SC) Morphine sulfate (10mg/ml)</td>
<td>See BNF morphine, BNF Prescribing in Palliative Care and local formulary. Initial dose: 5-10mg every 4h. Titrate to achieve adequate pain relief</td>
<td>Step 3 Oxycodeone (PO) (IR) or (MR) ONLY if e-GFR &lt; 30 ml/min</td>
<td>Dose equivalence see BNF Prescribing in Palliative Care and local guidance</td>
</tr>
<tr>
<td>Colic</td>
<td>Hyoscine butylbromide (SC) (20mg/ml)</td>
<td>Glycopyrronium (SC) 200mcg every 4hr up to every 1hr. 0.6-1.2mg/24h</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Noisy breathing/Respiratory Secretions</td>
<td>Hyoscine butylbromide (SC) (20mg/ml)</td>
<td>Glycopyrronium (SC) 200mcg every 4hr up to every 1hr. 0.6-1.2mg/24h</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Opiate Substitute Treatment</td>
<td>Methadone (PO) or (SC) (SC) name one prescriber</td>
<td>See York pathway. (PO) – usual dose (SC) half oral dose in 0.9% N/Saline</td>
<td>Continue usual maintenance dose NB SC (weekly/monthly preparation) use restricted in UK prisons.</td>
<td></td>
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</tr>
<tr>
<td>Keep OST maintenance prescribing separate from symptom management. Use separate chart; see additional notes</td>
<td></td>
<td></td>
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<tr>
<td>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.</td>
<td></td>
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</tbody>
</table>

**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) |
Resuscitation Council UK has published [2021 Resuscitation guidelines](#) and [COVID-19 resources](#).

**Resuscitation Council UK guidance** 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 of adult COVID-19 patients: primary care settings infographic**

**Consider treatment escalation and resuscitation decisions for all inpatients**

1. **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.

• 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.

C7: DEATH FROM COVID-19

• PHE Guidance for care of the deceased with suspected or confirmed coronavirus (COVID-19) should be followed. IPC measures include: avoid non-essential staff contact; other residents ≥2m from body.
• Every death in custody will continue to be investigated by the PPO, including deaths from COVID-19.
• 48/72 hour immediate review must be completed by providers and shared with commissioners.
• The death of a patient or member of staff from COVID-19 is likely to have a significant impact on the whole secure/detained community (residents and staff). It will be important to raise awareness of symptoms of mental health deterioration and encourage vigilance in residents and staff.
• There should be signposting to pastoral care/support available for residents and staff support services

C8: MENTAL HEALTH

• Mental health and wellbeing has been adversely impacted in people in prison, with and without pre-existing mental health disorders, by 15 months of isolation, restricted regimes, separation from family and loved ones, limited opportunities for meaningful activity or exercise, and the threat of COVID-19.
• Initially, lockdown led to worsening of e.g. obsessional, anxiety, PTSD symptoms in some people but reduction in pre-existing anxiety in others, due to the removal of threats of bullying and violence. Early protective effects of isolation have stopped and regimes opening are likely to trigger increased anxiety.
• The Centre for Mental Health report Covid-19: Understanding inequalities in mental health during the pandemic states that existing structural inequalities combined with unequal impacts of COVID-19 are likely to lead to people whose mental health was at greatest risk before Covid-19 being affected disproportionately longer term.
• Adverse psychological and behavioural responses occur during pandemics in people with or without pre-existing mental health conditions.
  o Psychological responses - *distress symptoms*: irritability, distractibility, insomnia; medically unexplained symptoms
  o Behavioural responses - *risky behaviours*: increased use illicit drugs, tobacco, alcohol, violence, unsafe sex, poor adherence to prescribed medicines
• Consider training non-clinical staff and peer mentors in the principles and delivery of PFA to assist with psychological support and develop individual and community resilience (D2).

C8i: PSYCHOLOGICAL FIRST AID (PFA)

• Evidence based intervention to build resilience; delivered by professional or lay people; 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) Self and community efficacy – behavioural interventions e.g. breathing techniques, progressive muscle relaxation, visualisation, yoga, meaningful activity
  4) Connection – normalise, develop shared routines, facilitate communication with loved ones
  5) Hope - strong messaging e.g. 'This will end', 'Most people will do well', draw on strengths gained from surviving previous adversities

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C8ii: OTHER SIMPLE MEASURES

- Health and wellbeing messages via radio/in-cell TV to encourage:
  - compassion and generosity towards others
  - relaxation, breathing exercises, mindfulness, yoga
  - reading (include pictorial/easy read options), cards, board games, writing letters to loved ones
  - creative activities colouring, match craft
  - healthy eating, staying hydrated, taking up opportunities to exercise (outdoor, gym, in-cell)
- Simple practical advice on how to look after mental health, improve sleep from Every Mind Matters and RCPsych. Share 1:1, in staff-led or peer-led groups, via radio/in-cell TV.
- Resources: cell-based workouts, gentler exercises, yoga, relaxation and distraction pack; available on RCGP Spotlight on Healthcare in Secure Environments Toolkit.

C9: SUBSTANCE MISUSE

- Guidance for commissioners and providers of services for people who use drugs or alcohol has been produced to support the continuity of drug and alcohol treatment services throughout the Coronavirus (COVID-19) pandemic, while protecting staff and service users.
- 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: Patients 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 to manage the ongoing trauma due to COVID-19.
- 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.

SECTION D: RECOVERY, RENEWAL AND RESILIENCE

D1: RECOVERY AND RENEWAL

- COVID-19 has had a significant impact on individuals, communities, organisations and systems. It has posed a global threat that has exposed and widened inequalities and identified vulnerabilities. It has also provided learning opportunities and expedited change through bringing issues into focus.
- The population in secure and detained settings comprises: individuals disproportionately affected by adverse childhood experiences, health and social complexity and vulnerability, from communities unequally affected by structural socioeconomic disadvantage.
- During COVID-19, necessary IPC measures and digital inequalities in PPD organisations have resulted in ≥23 hours/day isolation, loss of community connections, restrictions on meaningful rehabilitation and employment, and lack of exercise, all of which have threatened to widen the gap and exacerbate the risk to mental and physical health in people in contact with the criminal justice system.
- Recovery from COVID-19 will require effective empowering compassionate leadership at all levels to:
  - Take forward learning and good practice e.g. ↑IP prescribing; ↑liaison between court, prison, healthcare, 3rd sector, community to improve care continuity on PPD entry/release
D2: **BUILDING AND STRENGTHENING RESILIENCE**

- **Resilience** is ‘related to processes and skills that result in good individual and community health outcomes in spite of negative events, serious threats and hazards.’ *(Strengthening Resilience, WHO Regional Office for Europe, 2017)*.
- Resilience operates at 3 levels - individual, community and system - and requires the capacity to:
  - **Adapt** to threat/adverse circumstances
  - **Absorb** - cope and recover from adversity using available skills, assets and resources
  - **Anticipate** – predict and take proactive action to minimise vulnerability
  - **Transform** structures/operations to tackle change/uncertainty and develop new systems suited to new conditions
- Building and strengthening resilience will be key to recovery from the pandemic for:
  - individuals living and working in secure and detained settings
  - healthcare teams and non-clinical teams
  - whole prison/detained communities
  - health and criminal justice systems
- It will require healthy environments, shaped by a compassionate, trauma-informed culture.

**Individual resilience:**
- A trauma-informed approach will help individual patients and staff to address any maladaptive ways of coping and to develop and strengthen resilience skills in domains of:
  - **Vision**: future goal-setting, identify positive purpose, engage in inspiring activities
  - **Reasoning**: problem solve, anticipate, develop resourcefulness – flexible range of solutions
  - **Adaptability**: attitude of realistic optimism, flexible expectations and acceptance of change
  - **Responses**: emotional agility - manage strong feelings, impulses, negative thoughts
  - **Health**: ability to look after physical health (sleep, exercise, diet and hydration); health literacy (ability to access and use health information); self-manage medical conditions; seek support to address e.g. smoking/alcohol/substance misuse; improve physical environment.
  - **Relationships**: develop/maintain strong connections with peers, family, friends, team; build therapeutic connections e.g. substance misuse group work; faith-based; develop generosity

**Community resilience:**
- Creating environments and cultures that facilitate recovery and protect and promote health and well-being will be central to the recovery of communities living and working in secure and detained settings.
- Consider equipping both non-clinical (e.g. prison, chaplaincy) staff and peer support workers with training in Psychological First Aid (**PFA**); increasing opportunities for residents to strengthen healthy connections with their families, faith groups and with each other through group work and peer support.
- In the months ahead, it will be important to be aware of the impact of culture, teamwork and line manager relationships on wellbeing at work. There are **NHS resources** available to support recovery and build team resilience. It will be important to look out for colleagues who display signs of worsening mental health or burnout and prompt them to access available support within the organisation and through their GP.

**System resilience:**
- It will be important to develop health and justice system-level resilience with the agility to reopen courts and relax regimes while remaining able to respond to COVID-19 variant outbreak threat. This will involve ongoing digital development, developing and embedding new ways of working e.g. remote consultations, multimorbidity models of care, and building strong links with community organisations within Integrated Care Systems (ICSs).
E1: FURTHER LINKS (COVID-19) IN SECURE ENVIRONMENTS

PHE:
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

COVID-19: laboratory investigations and sample requirements for diagnosis

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


NHS Digital COVID-19 Population risk assessment


NICE:
NICE COVID-19 guidance and advice
https://www.nice.org.uk/guidance/conditions-and-diseases/respiratory-conditions/covid19

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:

RCGP:

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

RCPsych:
COVID-19: Guidance for clinicians
E2: Patient Information

What can I do to help keep myself safe from coronavirus while I'm in prison?
A patient guide

Some of the answers to these questions were originally written for Inside Time, the national newspaper for prisoners and detainees.

Keeping safe in prison

Q: Is it safe to go out on the exercise yard?
A: As far as everyone in the community, if you go out for exercise, you need to be careful to keep 'social distancing' rules, staying at least 2 metres away from anyone else. This is particularly important for people at higher risk of severe illness with coronavirus due to underlying medical conditions.

Q: Is it safe for an officer to come into my room?
A: It is important for everyone in secure environments – both residents and staff – to follow the public health guidance on social distancing, self-isolation and shielding. Sometimes it will be necessary for officers as part of their duties to come into a cell. Depending on whether you have symptoms or are shielding and depending on the task they have to do, personal protective equipment (PPE) may be worn. Sometimes staff may wear a surgical mask, gloves and an apron. All other times, depending on the situation, they may wear goggles or a visor, a gown and a different type of mask.

Q: Can I catch the virus from food or from things bought from the canteen?
A: COVID-19 transmission occurs mainly through droplet (coughing, sneezing) and contact (contaminated surface) spread. The risk of the virus being spread through the air is increased during certain medical and dental procedures. That is why dental services have been very restricted and why special PPE is needed. For example, someone has a cardiac arrest and they need assistance to help get their heart pumping effectively. COVID-19 virus has also been found in stools and other body fluids, including urine and tears. This means regular handwashing (for at least 20 seconds), avoiding touching your face, and cleaning of any surfaces that are touched is very important.
E3: VIDEO CONSULTATIONS FOR PRISON HEALTHCARE APPOINTMENTS AND HOSPITAL APPOINTMENTS

PATIENT INFORMATION LEAFLET AND CONSENT SHEET

Over the past year, hospitals have been offering appointments by telephone as well as face to face. In GP practices in the community, many appointments have taken place over the phone or using video calls.

In HMP XXXX we can now offer you the choice of having some appointments by video as well as by telephone or face to face. While we know that not every problem can be sorted using a video consultation, we know that most issues can. We also know that it may be possible for you to be seen sooner using video than if your appointment needed to be arranged face-to-face.

You may be offered a video consultation with:
- a member of the prison healthcare team, such as the GP
- a visiting specialist, for example psychiatrist
- a doctor or specialist nurse based in hospital
- a member of a community team you will be seeing after you leave prison, such community mental health team or community substance misuse service

What you should know about Video Consultations in HMP xxxx

- As with all information sent across the internet, the security of video consultations is not 100% guaranteed. It is YOUR CHOICE to be seen using a video call. You do NOT have to agree to it and even if you do agree before the day, you can change your mind at any point.

- If your appointment is with a hospital specialist, as long as face to face appointments are being offered to patients, you can ask to change your video consultation to a face to face appointment at any time, and we will arrange this as soon as it becomes possible.

- During a video appointment, if you or the clinician feels that a face to face appointment is needed, this can easily be arranged as soon as it is clinically necessary.

- Your video appointment may be held in the prison health centre, using a computer with video software and a webcam, or you may have a secure laptop brought to you on the wing. We will confirm this on the day.

- You will ALWAYS have a member of the healthcare team in the room with you during your appointment. They will sign in to the video call on your behalf.

- If for any reason there is a problem with linking up with the clinician on video at the time of your appointment, they will contact the prison healthcare team, who will let you know.

- The clinician seeing you will always be in a private space during the appointment to make sure your appointment is private and confidential.

- No-one will record any part of the video consultation. Video from the appointment will not be stored anywhere.
• The plans for your care that are agreed at your video appointment will be written down in your prison healthcare record, in the same way as for face to face or telephone consultations. If you are seen by a hospital specialist, they will write the details of your care in a letter and send it to the prison as usual.

• You will be asked to give your consent before every video consultation. The first time you are seen you will be asked to sign a consent form. At each appointment after that, you will be asked if you agree to a video call and a note of your spoken consent will be made in your patient record.

• You can ask to stop or leave your video consultation at any point by simply telling the clinician and chaperone during the appointment.

• If you would like to book a video consultation or have any questions about video consultations, please contact [NAME] who will be pleased to help.

I _____________________________ (patient name) confirm that (please tick box as appropriate):

| 1. | I have read and understood the information about Video Consultations that take place at HMP xxxx | ☐ |
| 2. | I have been given the opportunity to ask questions about video appointments for my health while I am in prison | ☐ |
| 3. | It agree that it is my choice to take part in a video appointment for my health | ☐ |
| 4. | I understand that even if I am offered a video consultation, I can choose to have a face-to-face appointment instead | ☐ |
| 5. | I understand I can choose not to have a video consultation at any time without giving reasons and that it will not be held against me for doing so | ☐ |
| 6. | The procedures regarding confidentiality have been clearly explained (e.g. sending information over the internet) to me | ☐ |
| 7. | I understand that if:  
  • I have seen clinician who works at the prison, they will access my prison patient health record to write the details of my consultation in my record.  
  • If I have seen a hospital specialist, they will either access my prison health record or send a letter with details of what was discussed at my appointment, which will be scanned into my prison health record when received. | ☐ |
| 8. | The prison healthcare staff member that has discussed video consultations with me has agreed to sign and date this informed consent form and I have agreed as well. | ☐ |

Patient:

________________________________________  ______________________________________  ________________________
Name of Patient       Signature       Date

Prison healthcare staff member:

________________________________________  ______________________________________  ________________________
Name of staff member   Signature       Date
Keeping You Safe When You Have COVID-19

Safety netting guidance for officers and residents

Most people with Covid-19 only feel unwell for up to a few weeks and some people don’t feel unwell at all. A few people are at risk of becoming more unwell and need extra monitoring and sometimes people need hospital care.

While you are isolating in your cell with Covid-19, it is important that you know when to ask for help. This guide will tell you what symptoms to look out for and what to do if you think you need help.

How to look after yourself in your cell

While you are isolating, an officer will check up on you (through the door). Tell them if you are feeling unwell or feeling worse because they can ask one of the healthcare team to come and see you.

If you have a high temperature:
- get lots of rest
- drink plenty of fluids (water is best) so your urine (pee) is light yellow and clear
- take paracetamol or ibuprofen* if you feel uncomfortable (*unless you can’t normally take this)

If you have a cough:
- try not to lie on your back - lie on your side or sit up

After 10 days you will be able to stop isolating. If you still feel unwell after 4 weeks, put in an application so the healthcare team can follow you up until you fully recover.

When to ask for help

Call the officer on your cell bell. Tell them you need to see the emergency nurse if:
- You slowly start to feel more breathless when you stand up or walk to the toilet or to the door
- You feel unwell with muscle aches, tiredness or shivers
- You feel that something is wrong (feel very weak, very tired, don’t feel hungry, passing much less urine (pee) or your urine is very strong - dark yellow/orange)

When to ask for URGENT help – you may need to go to hospital

Call the officer on your cell bell. Tell them you need to see the emergency nurse if:
- You can’t finish a short sentence when you are sitting or lying still because you are too breathless
- Your breathing gets suddenly worse or your lips/face seem blue
- You cough up blood
- You feel cold and sweaty with pale or blotchy skin or you get a rash that doesn’t fade when you press on it
- You collapse or faint, feel restless or very drowsy
- You stop passing urine (pee) or pass much less than usual

This guidance is available in other languages
Please tell a member of staff if you don’t understand how to use this diary, if you don’t feel well or if you are worried.

Record your oxygen and pulse 3 times a day. Look after the saturation probe and give it back at the end of the monitoring period.

**Ask to speak to healthcare if your oxygen level drops by more than 3% or any oxygen reading is less than 93%**

Follow the *Keeping You Safe When You Have COVID-19* guidance and show your readings to the healthcare team when they ask you.

### Days since 1st symptoms or positive test

<table>
<thead>
<tr>
<th>Days since</th>
<th>Date</th>
<th>Pulse</th>
<th>Oxygen level %</th>
<th>Feeling better/same/worse</th>
<th>Breathing better/same/worse</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>14 Dec</td>
<td>68</td>
<td>97</td>
<td>worse</td>
<td>same</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>76</td>
<td>98</td>
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<td>same</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td>91</td>
<td>98</td>
<td>better</td>
<td>same</td>
</tr>
</tbody>
</table>

#### Baseline

- **1** am, pm, eve
- **2** am, pm, eve
- **3** am, pm
- **4** am, pm, eve
- **5** am, pm
- **6** am, pm, eve
- **7** am, pm, eve
- **8** am, pm
- **9** am, pm
- **10** am, pm, eve
- **11** am, pm
- **12** am, pm, eve
- **13** am, pm, eve
- **14** am, pm, eve
**COVID-19 CASE CLINICAL PATHWAY IN SECURE AND DETAINED SETTINGS**

**Patient reports COVID-19 symptoms: Path S**
- New continuous cough, fever, loss taste/smell

**Initial assessment (qualified HCP):**
- Clinical judgement + NEWS 2 score
- Review patient's COVID-19 risk: Age/COVID/CSC/COVID/catorial opinion based on multiple risk factors
- Document NEWS2/COVID-19 risk
- GP/ANP review observations
- Check DNACPR status/PEoLC register

**Severe/deteriorating**
- **Care (See also Table 1)**
  - D/w GP/ANP. Inform Oscar 1
  - Call 999. Inform operator and hospital suspected COVID-19 case
  - Arrange urgent transfer → hospital

**Moderate**
- **Clinical assessment**
  - Atypical CP+/- New SOB
  - Full sentences Lethargy
  - O2 93-94% * RR21-24 P91-130 (*or3-4% below usual)
  - NEWS2 =3-4

**Care (See also Table 1)**
- As for Mild + D/w GP/ANP
- Consider/treat other causes
  - Asthma/COPD: salbutamol +/- Oral prednisolone
  - DVT/FE: **Wells Score PERC**
  - Pneumonia (bacterial): antibiotic

**Hospital transfer**
- Inform Oscar 1. Call 999. Inform operator and hospital suspected COVID-19

**Treat on site**
- Plan review/escalation
- Safety netting
- Reassess NEWS2. D/w GP/ANP → Red/Amber/Green path

**COVID-19 risk: high**
- ≥65y or <65y CEV
- Or clinical opinion
  - → Oximetry

**Safety netting guidance**
- Inform welfare: e.g. d5/d10

**If clinical deterioration**
- NEWS2. D/w GP/ANP
  - → Red/Amber path

**Patient asymptomatic: Path A**
- Surveillance testing programme/Outbreak mass testing

**Isolate:** Follow PPD cohorting guidance + local plan

- **COVID-19 PCR test**
  - PCR C19 negative
  - Contact trace

- **COVID-19 LFD test**
  - LFD C19 positive
  - LFD C19 negative

**Mild**
- **Clinical assessment**
  - Fever/Cough
  - No SOB. Full sentences
  - ≤92 95% * RR20 P ≤90 (*or1-2% below usual)
  - NEWS2<0-2

**Care (See also Table 1)**
- Fluids, rest
- paracetamol/buprofen
- Agree/document TEP
- Safety netting
- Monitoring:
  - See COVID-19 risk

**No symptoms**
- Care:
  - Discuss results
- Safety netting

Symptoms develop → Path S

**Severe/deteriorating**
- **Care (See also Table 1)**
  - D/w GP/ANP. Inform Oscar 1
  - Call 999. Inform operator and hospital suspected COVID-19 case
  - Arrange urgent transfer → hospital

**Moderate**
- **Clinical assessment**
  - Atypical CP+/- New SOB
  - Full sentences Lethargy
  - O2 93-94% * RR21-24 P91-130 (*or3-4% below usual)
  - NEWS2 =3-4

**Care (See also Table 1)**
- As for Mild + D/w GP/ANP
- Consider/treat other causes
  - Asthma/COPD: salbutamol +/- Oral prednisolone
  - DVT/FE: **Wells Score PERC**
  - Pneumonia (bacterial): antibiotic

**Hospital transfer**
- Inform Oscar 1. Call 999. Inform operator and hospital suspected COVID-19

**Treat on site**
- Plan review/escalation
- Safety netting
- Reassess NEWS2. D/w GP/ANP → Red/Amber/Green path

**COVID-19 risk: high**
- ≥65y or <65y CEV
- Or clinical opinion
  - → Oximetry

**Safety netting guidance**
- Welfare checks
  - Healthcare e.g. d5/d10

**If well, end isolation**
- after 14/7

**If well, end isolation after 10/7**
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