



COVID-19 GUIDANCE FOR HEALTHCARE IN SECURE ENVIRONMENTS

Practical advice for clinicians

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

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

RCGP Secure Environments Group
Healthcare in Secure Environments
COVID-19

COVID-19 GUIDANCE FOR HEALTHCARE IN SECURE ENVIRONMENTS

20 April 2020 – correct at date of publication

With thanks to Dr Éamonn O'Moore and Susanne Howes (PHE), Kate Davies, Denise Farmer and Fiona Grossick (NHS England and NHS Improvement), Rupert Bailie (HMPPS), Dr Linda Harris, CareUK, Dr Alexandra Lewis, Dr Jake Hard, Dr Jonathan Leach and the RCGP COVID-19 team, and to colleagues working across UK secure environments for sharing examples of good practice

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SECTION A: COMMUNICATION AND TRIAGE

A1: COMMUNICATION AND TRIAGE

- Principles of good communication should be followed. Remember to be patient and compassionate at all times, following principles of trauma-informed care and de-escalation where required. Residents are likely to be feeling more anxious and the current situation of lockdown may exacerbate challenging behaviour.
- Use telephone interpreting services (e.g. language line) and provide written information in other languages where required. Use simple picture prompts to assist communication if needed.
- **Efficient triage by appropriately trained healthcare staff is essential.** Where possible, use telephone triage. Some secure environments have in-cell phones. Others are using wing-based telephones at specified times to allow individual patients to contact healthcare. Identifying a room on the wing from which to make calls will facilitate confidentiality. Telephones should be cleaned after use.
- Where telephone use is limited, consider prioritising ‘extremely vulnerable’ and ‘high risk’ medical patients, to minimise their face-to-face contact with other residents or staff.
- All appointments offered should be based on clinical need and **triage for this purpose will need to be carried out by a senior clinician**. Questionnaires may be useful to assist residents to clarify their medical concern.
- Where a **face-to-face** appointment is identified as clinically necessary, a **home visit** should be facilitated if the resident is either being **shielded** or in **protective isolation** due to suspected or confirmed COVID-19.
- If the decision is made to bring a resident to the healthcare department, they should be **screened for COVID-19 symptoms before being transferred from their cell** and should adhere to local ‘social distancing’ measures at all times.

A2: TELEPHONE CONSULTATIONS AND REMOTE WORKING

- Information governance principles should be followed and all consultations should be coded correctly.

- **Telephone consultations:** [RCGP Top Tips for COVID-19 telephone consultations](#) has been adapted for secure environments for use by medical and nursing staff:
 - Use a checklist of questions/template to guide and record your conversation.
 - Remember to keep compassionate. Residents will need to feel listened to in order to accept reassurance.
 - Check whether the resident's [symptoms are consistent with COVID-19](#)
 - Check for COPD, asthma or other possible causes of their symptoms.
 - Check whether the resident has any medical conditions or medications that could place them at increased risk of deterioration
 - When talking, does the patient sound breathless or unable to complete sentences without pausing for breath? Are there any [red flag symptoms](#)?
- **Remote working:** HMPPS have currently agreed to 2 software solutions for video consultations: *Visionable* and *Involve*. Details of these and how providers can draw up business cases can be obtained from local NHS England and NHS Improvement Health and Justice commissioners. Remember to **check compatibility with local hospitals**.
- **Video consultations** offer the potential for cross-site primary care cover, reduction in escorts, visiting consultant cover e.g. psychiatrists providing online consultations.
- The [BMJ Visual summary COVID-19: remote consultations](#) and [Roger Neighbour's Ten Tips for successful video consultations](#) provide useful guidance on remote working for clinicians.
- Remote access to SystemOne also enables healthcare staff working from home to: provide advice to onsite staff; prescribe; review and create registers of e.g. 'high risk', 'extremely vulnerable', end of life patients; stratify local care priorities for 'business as usual'; assist with any applications for Early Release on Medical Grounds and to take part in multi-professional meetings by using e.g. Microsoft Teams, once permission has been granted by the prison governor and security team. Software will need to be purchased to support secure VPN connection.
- **A security pass** must be requested and approved locally (by the prison) before any item (e.g. laptop) that would ordinarily be prohibited in a secure environment may be brought in.

SECTION B: INFECTION PREVENTION AND CONTROL

B1: GENERAL PRINCIPLES

- COVID-19 transmission occurs mainly through **droplet** (coughing, sneezing) and **contact** (contaminated surface) spread. The risk of aerosol spread (contact, droplet or **airborne**) is increased during aerosol generating procedures (AGPs).
- **All secretions (except sweat) and excretions, including diarrhoeal stools from patients with known or suspected COVID-19, should be regarded as potentially infectious.**
- **COVID-19: Infection Prevention and Control (IPC) guidance**, issued jointly by DHSC, Public Health Wales (PHW), Public Health Agency (PHA) Northern Ireland, Health Protection Scotland (HPS) and Public Health England, is updated as new evidence about COVID-19 emerges.
- The UK government has underpinned public health measures in legislation, **[The Health Protection \(Coronavirus\) Regulations 2020](#)**.

- General measures to prevent coronavirus spreading should be followed by all residents and staff.
 - more frequent **hand washing** (20 secs), avoid face touching, 'catch it, bin it, kill it'
 - hand sanitiser gel available e.g. on entry/exit, at keys and radio collection points
- **Social distancing** (remain at least 2 metres apart) should be observed at all times, in all areas, by both residents and staff. In practice, this can be difficult to achieve in secure environments but HMPPS has introduced measures to reduce numbers of residents coming into contact with one another.
- **PHE messages and NHS health advice should be reinforced:**
 - **Verbal and visual reminders:** use e.g. staff prompts, marking tape on the floor where residents queue for food and medicines, posters, **in-cell TV and radio** messages
 - **Leaflets and letters** to residents, using written information in other languages, easy read versions and simple picture prompts where necessary
- Regular cleaning and disinfecting of objects and surfaces, using standard cleaning equipment, should be carried out. Communal areas e.g. showers, phones should be cleaned as frequently as possible, including before and after use.

B2: POPULATION MANAGEMENT MEASURES

- HMPPS, advised by PHE, has issued operational guidance on COVID-19 to ensure key regime priorities are delivered to residents (meals, access to healthcare and medication, safety and welfare services, provision of family contact) under an **Exceptional Regime Management Plan (ERMP)**.
- To reflect UK government requirements for social distancing, shielding and household isolation, prisons have now:
 - stopped association, group activities (work, gymnasium and education), and visits from family and friends.
 - Introduced new cohorting arrangements and movement protocols.
- **Inter-prison transfers (IPTs) were stopped from 01 April 2020**, except in exceptional circumstances agreed by HMPPS Gold Command. Due to operational requirements and the need to make best use of available accommodation, some movements are recommencing in line with internal HMPPS 'Protect and Mitigate' population strategy.
- Close collaboration and partnership working between healthcare and prison staff is required to ensure that residents are safely located in suitable areas of the establishment. On the advice of PHE, three types of cohort units have been introduced into prisons:
 - **Reverse Cohort Unit (RCU)** for temporary separation of a) newly received residents (for at least 14 days) to monitor them for emerging symptoms (to prevent potential infection spread from the community) and also to protect them from infection where there is a confirmed COVID-19 outbreak, b) patients recently returned from hospital (see section D4ii), c) cell-sharing contacts of symptomatic residents (see below)
 - **Protective Isolation Unit (PIU)** for temporary isolation of symptomatic residents (for up to 7 days)
 - **Shielding unit (SU)** for temporary isolation of 'extremely vulnerable' residents who are at risk of severe illness from coronavirus (COVID-19), in line with

national guidance during the pandemic wave and/or during any specific outbreak of COVID-19 in prisons.

- Wherever possible, **single cells or single person use of multiple occupancy cells** is preferred, for each of the 3 cohorts.
- In practice, there may not be 3 specific areas, however, it is important that:
 - RCU residents are separated for at least 14 days and screened, both for signs of infection with COVID-19 and also for medical conditions that necessitate shielding or isolation/stringent social distancing (i.e. 'extremely vulnerable' or 'high risk' categories.)
 - If RCUs receive new residents sequentially over several days, there should be appropriate separation maintained between residents, who should be grouped according to their date of arrival, in order to prevent cross-contamination. Different groups of residents should not mix as they access the restricted regime.
 - 'Extremely vulnerable' residents should be offered the opportunity to 'shield' in a SU to minimise their risk of COVID-19 infection.
- Public Health England has advised that it is not always necessary to move a resident who becomes symptomatic to a different location and it may be preferable to isolate them in their current location and establish effective barrier control around them rather than relocate them and risk introducing infection into another area of the prison. In practice, where there are large numbers of symptomatic residents, prisons and their healthcare teams may find it easier and more effective to cohort patients to specific areas (PIUs) rather than leave them scattered across the prison. Such decisions will require local-level risk assessment and agreement.
- **Three possible options for management when resident in a multiple-occupancy cell becomes symptomatic:**
 - Both residents kept together and isolated (minimum 14 days.)
 - Non-symptomatic resident is removed from the cell and taken to RCU to isolate (minimum 14 days); Symptomatic resident isolated in current cell.
 - Symptomatic resident removed from cell and re-located to PIU (minimum 7 days.) Non-symptomatic cell-mate isolates in original cell (minimum of 14 days.)
- Where possible, prison staff working in RCU, PIU, SU should not be cross-deployed to other areas. Consideration should also be given to arranging healthcare duties to minimise staff footfall between different areas.

B3: PPE

- Significant amendments were published (02 April 2020) to clarify appropriate use of PPE, depending on setting and context. PHE have also developed additional guidance on the use of PPE for custodial and healthcare staff. (see **Appendix H3**).
- **PPE guidance headlines:**
 - **PPE should be worn for ALL patient contact (<2m) – not just suspected COVID-19 patients**
 - **Type of PPE** will be informed by **individual and local organisational risk assessment** (see **Appendix H3**)
 - **Aprons and gloves** should be changed between patients

- **Fluid repellent surgical masks and eye protection** can be used for a **session** of work (in a single area, change if becomes damaged or go on rest break)
- **Hand hygiene** should be practiced and **extended to exposed forearms**, after removing any item of PPE.
- **Staff should take regular breaks, rest periods (and keep well hydrated).**
- It is important to put on and take off PPE correctly. If possible, have a buddy to supervise you and make sure you do this correctly.
- **Order for putting on PPE:** Apron/gown, surgical mask, eye protection (where required) and gloves.
- Order for removing PPE: Gloves, apron/gown, eye protection, surgical mask
- **PPE for Aerosol Generating Procedures (AGPs) and CPR: FFP3 respirator, long sleeved disposable gown, gloves and disposable eye protection.**
- [The Resuscitation Council UK](#) considers that during CPR, there is always the potential for rescuers to be exposed to bodily fluids, and for procedures (e.g. chest compressions, tracheal intubation or ventilation) to generate an infectious aerosol. Early application of a defibrillator, while other healthcare professional colleagues don Level 3 PPE, maximises healthcare professional safety, while also providing the patient the best chance of effective resuscitation.
- **Patient use of PPE:** Residents with **possible or confirmed COVID-19 infection** should wear a fluid-resistant surgical face mask (FRSM) in **clinical and communal areas** and when **being transported**, unless their clinical care would be compromised (e.g. receiving oxygen via face mask)
- **It is important that prison staff are able to access PPE in a timely manner to avoid delay to hospital admission** when residents are sick and suspected of being infected with COVID-19.
- All used PPE must be disposed of as clinical waste, adhering to waste disposal and IPC guidance.
- **Decontamination and other considerations:** Providers may decide to advise all staff (including doctors) to change in to easily washable uniform on site and remove it before going home.

SECTION C: PATIENT CARE – NON-COVID-19

C1: NON-URGENT CLINICAL RESPONSIBILITIES

- Local decisions will need to be made about how clinical provision is organised and prioritised.
- Long term condition registers should be reviewed (or made) in order to stratify patients for clinical review and blood monitoring. Those who have advanced or unstable disease or who have recently been discharged from hospital (due to reduced hospital capacity) should take clinical priority.

C1i: CLINICS, BLOOD TESTS, SCREENING AND OTHER CONSIDERATIONS

- **Clinic appointments** should be **triaged by a senior clinician** and face-to-face contact avoided where possible (See [section A1](#))

- It is important to **remember there is a risk of increased morbidity and mortality from non-COVID-19 conditions.**
- **Referral to secondary care should continue where indicated.** Hospitals may offer telephone consultations and these should be facilitated, with a member of the healthcare team present during the consultation.
- Where examination is important and can be facilitated remotely e.g. skin conditions, a **video** consultation should be arranged, where possible. Alternatively liaise with security staff to facilitate **photography** so that images can be sent to the secondary care team by email.
- **Blood tests** should be done where clinically necessary. Frequency of disease and drug monitoring should be considered in light of previous results; it may be possible to extend the interval between tests if previous results have indicated disease stability. Specialist advice should be sought where there is uncertainty.
- **Screening:** ongoing disease screening should continue while there is capacity to do so because residents may be at higher risk of disease and may not engage with primary care teams in the community.
- **BBV testing, referral and treatment for Hepatitis C** should continue while there is capacity to do so. Planning will be needed to ensure continuity of treatment since only 28-day supplies of medicines may be ordered and home care medicines' delivery services may be restricted.

C1ii: RECEPTION DUTIES, SEGREGATION ROUNDS

- **Reception duties** should continue as usual at all times that new residents are coming into the establishment, to ensure health needs and risks are identified. RCU measures should be clearly explained and residents advised that these are not punitive.
- **Segregation rounds: PSO 1700 amendments (COVID-19)**
 - **Section 2.2** daily visits with social distancing, member of healthcare team (doctor, registered nurse or healthcare officer). If daily visit not possible, prison to record in Silver Defensible Decisions log and consider how to mitigate any risks.
 - **Section 2.3 paragraph 4: doctor or registered nurse** must visit every prisoner in segregation as often as their individual health needs dictate and **at least every three days**. If this is being carried out by a registered nurse they must carry out a clinical risk assessment and consider the prisoner's physical, emotional and mental well-being and whether a doctor visit needs to take place.

C2: LONG-TERM CONDITIONS

- **There is a risk of increased morbidity and mortality from non-COVID-19 conditions** during the pandemic and it is important to identify and prioritise care for patients whose long-term medical conditions are advanced or unstable.
- **Risk stratification:** in addition to **PHE** and **NHS** information, advice on risk stratification for specific medical conditions and medication is available in NHS Specialty guides and from [British Society of Rheumatology](#), [British Association of Dermatologists](#), [British Society of Gastroenterologists](#), [British Thoracic Society](#), NHS Digital (see also C2i, C2ii). Further clarity about specific patients/medicines should be sought from hospital specialists.

- **Patient communication:** letters should be given to residents who are at i) **highest risk** of severe illness and rapid clinical deterioration with COVID-19 infection who require **shielding** ii) **'high risk'** and should be advised to **self-isolate**.
- **Management of long-term conditions:** NICE [COVID-19 rapid guidelines](#) provide information on management of long-term conditions during COVID-19. Further advice should be requested from a patient's specialist if needed. If newly arrived in custody, and not yet referred or seen in a local hospital, advice should still be sought from a local specialist if required.

C2i: 'EXTREMELY VULNERABLE' PATIENTS - SHIELDING

- NHS Digital HJIS searches have identified people in secure environments who should be shielded. Where Read coding is incomplete, it may be necessary to perform other data searches. (see **C2 Risk stratification**)
- A **shielding letter ('highest risk')** should be given to each patient (see template on SystemOne and [Appendix H2i](#)). They should be advised to shield, in order to minimise face-to-face contact with others, during the course of the pandemic wave (at least 12 weeks) and also during any ongoing outbreaks of COVID-19 in the prison in which they are located. This may necessitate ongoing shielding after the pandemic wave in the community has subsided.
- Local arrangements for shielding will vary but all meals, medicines and any necessary healthcare should be brought to the resident's room.
- A resident may decline to shield. If this is the case, it is important to ensure that they fully understand the implications of their decision and ask them to sign a disclaimer form. Their decision should also be recorded in the COVID-19 Defensible Decisions log.

C2ii: 'HIGH RISK' PATIENTS – SELF-ISOLATION

- Identify and send **'high risk' (not shielding) letter** (see [Appendix H2ii](#)) to residents at increased risk of severe illness and rapid clinical deterioration with COVID-19 infection:
 - Aged 70 years or older (regardless of medical conditions)
 - Pregnant – patients identified for early release
 - <70 years with underlying health condition requiring annual influenza vaccination: diabetes/chronic respiratory/heart/kidney/liver-think hepatitis/splenectomy/sickle cell/neurological disease. Learning disability. Immunocompromised (HIV, chemotherapy, long term steroid treatment.). BMI 40 or above
- **Case finding:** Read codes and medicines searches (e.g. aspirin, statin, ACE inhibitor, b-blocker; metformin, sulphonylureas, insulin, GLP-1); historic influenza vaccination; BMI. See also **C2 Risk stratification**)
- Use telephone triage where possible to reduce the need for face-to-face contact
- If face to face assessment is required, consider using a dedicated 'cold area' (a room to be used only for residents without symptoms of COVID-19) or 'home visit' to cell.

C3: FRAILTY AND END OF LIFE CARE

- It is important for all older residents and those who have physical limitations, to be encouraged to maintain their mobility and reduce the risk of falls. Links to exercises for

people with reduced mobility can be found on the [RCGP Spotlight on Healthcare in Secure Environments Toolkit](#).

- Some residents may be suitable for **Early Release on Compassionate (or Medical) Grounds (ERCG/ERMG)**. Further advice on making applications for early release on medical grounds for residents with determinate and indeterminate sentences can be found in the [RCGP Spotlight on Healthcare in Secure Environments Toolkit](#).

C3i: ASSESSING FRAILITY

- An **objective, holistic assessment of frailty** should be carried out for all residents who are identified to be in the **'high risk'** and **'extremely vulnerable'** groups (C2i and C2ii) in order to **plan appropriate individualised pathways of care** for those who are not already on an end of life pathway.
- Residents who require assistance with mobility should have a PEEP (Personal Emergency Evacuation Plan) in place, which will be recorded on NOMIS, however a PEEP should not be used for the purpose of determining clinical frailty.
- The **Clinical Frailty Scale (CFS)**, when used in line with [NICE NG 159 COVID-19 rapid guideline: critical care in adults](#), and taken together with age and co-morbidities, can help to inform clinical discussions around ethical care escalation decisions, including whether or not a patient would benefit from admission to critical care, were they to become ill with COVID-19.

C3ii: TREATMENT ESCALATION PLANS, ADVANCED DIRECTIVES AND DNACPR

- **Treatment Escalation Plans (TEP)** should be discussed early with residents and discussions should involve families, where possible. It may be helpful to involve a **Family Liaison Officer (FLO)**, appointed by the secure establishment, for this purpose.
- **Advanced Decisions to Refuse Treatment (ADRT)** should be identified and discussed with patients. Where a resident has an ADRT in place, it is important to clarify their wishes if they were to become ill with COVID-19. If a patient draws up an ADRT, they may revoke or replace it, providing they retain capacity.
- **DNACPR** is a specific decision relating to CPR in the event of cardiac arrest. It is important to identify residents with pre-existing DNACPR notices and to make ALL staff aware of them. It is also important to identify those for whom CPR would not be considered appropriate, in order to have honest and early discussions with them about what would happen, were they to arrest if infected with COVID-19. Even if a patient does not agree with the DNACPR decision made, they should still be involved in discussions.
- Where **critical care** would be unlikely to benefit a resident, this should be sensitively discussed with them and clear documentation made in SystmOne, once a care pathway has been agreed with them. Although such anticipatory conversations are hard for clinicians, they form an important part of high quality end of life care.

C3iii: END OF LIFE CARE

- End of life care should be underpinned by the 6 ambitions of the [Dying Well in Custody Charter](#).
- Guidance for patients with COVID-19 has been collated by [Northern Care Alliance NHS Group](#) and the [Association for Palliative Medicine of Great Britain and Ireland](#). It provides

suggestions for simple, non-pharmacological and pharmacological measures that can be initiated for patients with palliative needs around COVID-19. See also Sections E6, [H4](#).

- 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: MENTAL HEALTH

With thanks to Dr Alexandra Lewis, Consultant Forensic and Child & Adolescent Psychiatrist

- Adverse psychological and behavioural responses to the COVID-19 pandemic are likely to be highly prevalent throughout the prison population and this may affect the delivery of physical health care interventions as well as the general operation of establishments.
- Individuals with pre-existing mental health disorders are not necessarily more vulnerable to adverse psychological and behavioural responses in pandemics, although some may become more symptomatic (e.g. those with Obsessive Compulsive Disorder (OCD) and anxiety disorders).

C4i: PSYCHOLOGICAL AND BEHAVIOURAL RESPONSES

- **Psychological responses:** most commonly seen in pandemics: '**distress symptoms**'
 - irritability
 - distractibility
 - increased sense of vulnerability
 - sleep difficulties*
 - medically unexplained physical symptoms*
- The last 2* can lead to a surge in healthcare demand creating a significant burden on primary care services. Studies from the SARS pandemic found a ratio of **50-100 individuals seeking care due to concerns about exposure: 1 actual exposure**.
- Having a plan in place to manage such presentations can help to manage the demand
- **Behavioural responses:** to pandemics: '**risky behaviours**'
 - increased use of illegal drugs, tobacco, alcohol
 - interpersonal violence
 - forgetting to take medication/running out of medication
 - unsafe sex
- These behaviours can have implications for healthcare provision as well as for the functioning of the general regime.

C4ii: PSYCHOLOGICAL FIRST AID - responding to psychological and behavioural responses

- **Psychological First Aid (2007)** is an evidence based intervention that seeks to build resilience and can be delivered by specialists or lay people. It is based on 5 principles:
 - 1) Safety** - provide credible information about how to protect self/family, educate about prevalence of misinformation and conspiracy theories, especially on social media (Zika study)
 - 2) Calming** - emphasise importance of sleep, nutrition, exercise, hydration, avoid watching rolling news, be aware of old news being presented as new
 - 3) Increase self and community self-efficacy** – e.g. employing behavioural interventions such as diaphragmatic breathing, progressive muscle relaxation,

visualisation, yoga instead of medication to manage sleep difficulties/anxiety, find opportunities for meaningful activity

4) Connectedness - through messages such as 'we are all in it together', normalise the shared experience, develop new shared routines, facilitate communication with loved ones

5) Hope/Optimism - strong messaging – e.g. 'This will end', 'Most people will do well', draw on strengths gained from surviving previous adversities

C4iii: OTHER SIMPLE MEASURES

- **Health promotion messages** encouraging a **compassionate** approach towards one another, with simple praise and support given by staff for positive and caring behaviours displayed by residents.
- Sharing of anxiety management tips via radio/in-cell TV will benefit both residents with pre-existing mental health problems and those who are feeling more anxious as a result of the current COVID-19 pandemic.
- For all residents, consider advising (either in writing or on radio/in-cell TV)
 - Relaxation and breathing exercises
 - Avoid anxiety-provoking and distressing programmes on TV
 - Restrict watching news to e.g. twice a day to reduce anxiety
 - Reading
 - Colouring, match craft, other creative activities
 - Chess, cards, board games
 - Write letters to loved ones
 - Try to avoid anxiety provoking TV. Limit watching news. **Entertainment:** have you thought about things to do, books to read or TV shows to watch?
 - In-cell exercises to keep fit when regime is limited or self-isolating
- **Links to cell-based workouts, gentler exercises, yoga and relaxation resources** and a therapeutic activity (distraction) pack available on the RCGP Spotlight on Healthcare in Secure Environments Toolkit.
- Explain any necessary changes to arrangements for appointments using posters, letters or through in-cell radio and TV to reduce residents' anxiety.
- If extremely anxious, residents should be offered the opportunity to talk. This may be facilitated by telephone. Access to listeners will not necessarily be possible. Arrangements for access to Samaritans' phone should continue, with careful cleaning between use.
- **Mental health screening and assessment:** reduced staffing may lead to increased waiting times for screening and reduced capacity for face-to-face mental health appointments.
- **Timely and appropriate response to collateral information** and concerns about residents expressed by wing officers and allied professionals will be especially important.
- Support should be provided through **ACCT** where required.
- Consideration should be given to facilitate visiting psychiatrist consultations by telephone or video link.
- The Royal College of Psychiatry has produced COVID-19 guidance for clinicians in community and inpatient settings, including advice about mental health medicines.

C4iv: PUBLIC HEALTH LAWS, MENTAL CAPACITY ACT AND MENTAL HEALTH ACT

- Public Health England has published [COVID-19: infection prevention and control \(IPC\) guidance](#) and the UK government has passed a [Coronavirus \(COVID-19\) action plan](#) together with [Health Protection \(Coronavirus\) Legislations 2020](#).
- The coronavirus legislations exercise powers detailed in the Public Health (Control of Disease) Act 1984 with the purpose of limiting the spread of COVID-19. Regulation 14 refers to the initial detention of persons to enable screening and assessment.
- If a prison resident appears to symptomatic for COVID-19 or there is reason to think that they may be contaminated and may infect or contaminate others, they should be asked to return to their cell or to an identified location in the prison for further assessment.
- It is important to relate to residents, at all times, in a manner that is trauma-informed. If the resident refuses to return to their cell, they can be legally restrained in order to protect the health and safety of others
- If it is thought that presentations are due to an underlying mental disorder, the **Mental Health Act** is the correct legislation to use. If there are doubts about whether an individual has the capacity to make wise or unwise decisions then the **Mental Capacity Act (2005)** is the correct legislation.
- Hospital transfers under the **Mental Health Act (1984) sections 47 or 48** can only be for mental health assessment/treatment and not for physical health needs. The Mental Health Act cannot be used to transfer someone to hospital for treatment for acute medical needs associated with Coronavirus, against their will, even if they appear to be making an unwise decision.

C5: SUBSTANCE MISUSE

- In conjunction with DHSC, and with advice from NHS England and NHS Improvement, PHE has now published [guidance for commissioners and providers of services for people who use drugs or alcohol](#). The guidance is to support the continuity of drug and alcohol treatment services throughout the Coronavirus (COVID-19) pandemic, while protecting staff and service users.
- Very little is known about COVID-19 and the impact on people with substance misuse disorders however it is likely that multiple complex physical, psychological and social factors may contribute to an increased risk of COVID-19 infection and more serious complications. Supply chains for illicit substances are also likely to be impacted by restrictions on borders, travel and social isolation/'lockdown' measures, which will have an impact on people using these illicit substances.
- The risk of harmful substance misuse behaviours is likely to increase during the period of EPRR (see C4i 'risky behaviours') and there will be additional risk due to a reduced operational capacity for searches. It is therefore very important to ensure all residents are aware of dangers of illicit use and sharing of equipment and containers - health messages through in-cell TV, radio, posters – in partnership with substance misuse team
- **Smoking:** Smoking cessation advice and support remains important, including provision of NRT. Vapes should continue to be offered (obtained from prison or canteen) as part of harm reduction and smoke-free estate provision. Further information is needed on

vaping/COVID-19. Where smoking cessation advice cannot be delivered face to face, it may be provided on in cell TV and radio and through written information.

- **Opioids use other CNS depressants:** Residents must be made aware of the dangers of opioid use and other CNS depressants that could impact on breathing, particularly if they are infected with COVID-19.
- Advice should be given about drugs including methamphetamine, cocaine which may cause or exacerbate lung disease.
- **Psychotropic drugs including spice and cannabis** may exacerbate anxiety, paranoia and other mental health disorders, making it harder for residents to cope with the restrictions and loss of control associated with secure environments and with anxieties about COVID-19.
- **Substance misuse prescribing:** see Sections E3, E7 and F.
- Ensure that residents with substance use disorders are not discriminated against if a rise in COVID-19 cases places added burden on secure environments and healthcare provision (both in secure environments and in secondary care).
- **Harm reduction measures** should be advised in patients who have a history of high risk behaviour for infection

C6: ACUTE ILLNESS (non-COVID-19) AND TRAUMA

- **If a patient is unwell but does not have symptoms suggestive of COVID-19** they can be brought to the clinic for further assessment if it is felt that face-to-face examination is required. If possible, consider using a 'cold' clinic room (for use only by 'high risk' and non-COVID-19 patients).
- **If a patient is unwell and also is suspected of COVID-19** they may require a face-to-face assessment. **Remember there is a risk of increased morbidity and mortality from non-COVID-19 conditions during the current pandemic.**
- Assessment should be done wearing recommended PPE. It may be necessary to do a 'home visit' rather than bring the patient to the healthcare department. Some secure environments may have the facilities to set up a specific 'hot' clinic (potentially in a cohorted area) or decide to designate one clinical space for seeing all potential COVID-19 cases who require face-to-face assessment.
- Where acute illness or trauma require hospital assessment, this should be arranged in a timely way to **avoid delay to treatment.**
- **Discussion with the hospital should occur ahead of transfer**, whether or not the resident has COVID-19 symptoms.
- **On return from hospital**, follow PHE guidance on **protective isolation** ([section D4ii](#)).

SECTION D: PATIENT CARE – COVID-19

D1: PRACTICALITIES OF MANAGING RESIDENTS NEWLY SYMPTOMATIC FOR COVID-19

- A resident suspected of having COVID-19 infection who is well enough to remain in the secure environment should be placed in **protective isolation for at least 7 days** (see Section D2v). Keeping a resident's family informed of their protective isolation is important and secure establishments may appoint FLOs to assist with this.

- **Local cohorting** arrangements should be followed. These may change as numbers of symptomatic residents increase (see section B2: Population management measures)
- If transferred to a specific PIU location, the **resident should wear a surgical face mask during transfer.**
- They should be held in a **single cell (or alone in a higher occupancy cell).**
- Careful **multi-professional team discussion** will be required (if necessary, taking advice from local PHE) when deciding the location for residents who become symptomatic:

- with nursing, medical or social care needs
- who are located in SUs

The needs of other co-located vulnerable residents, the risk of infection transmission during transfer and the added workload for staff delivering care across multiple locations will need to be taken into account.

- **Residents who have been sharing a cell** with someone who becomes unwell should be placed in **isolation for 14 days** (incubation period) (see section B2: Population management measures, for possible options for location)
- **Some residents may not report symptoms** because they:
 - have not noticed them
 - are reluctant to report them, due to anxiety, a wish to remain in shared accommodation, thoughts of suicide, deliberate-self harm or even a wish to infect others.
- If a resident is observed by another resident or a member of staff to be unwell but is not reporting symptoms, it is important to ensure that they are tactfully asked and assessed and isolated where appropriate.
- Support should be provided through the ACCT process if the need is identified.

D2: INITIAL ASSESSMENT, INITIAL MANAGEMENT AND MONITORING

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

D2i: INITIAL ASSESSMENT

- Initial assessment should include assessment of breathlessness (see also Section A2: Telephone consultations and online working).
- Use **clinical judgment through careful history taking and questioning.**
- Consider all causes of cough, breathlessness and fever and examine patients where clinically indicated.
- In some circumstances, it may be appropriate to perform a limited examination. BP and auscultation should be used when crucial for decision making. If limited examination has been performed, this should be documented **(O/E LE)**.
- NB if taking drugs affecting the immune system (e.g. oral prednisolone), a resident may have an atypical COVID-19 presentation and may not develop a fever.
- Check **NEWS2 score** (or other EWS) if a resident appears unwell and may require admission to hospital.

D2ii: INITIAL MANAGEMENT: MILD SYMPTOMS (see also NICE (NG163))

- Once in **protective isolation** (see B2 for cohorting options), provide the resident with clear **safety netting advice**. Consider using simple picture prompts and check that they understand it, by asking them to repeat it back. Consider using written information, with translation if required.
- Advise the resident to:
 - **drink regularly** (c. every 20 minutes)
 - **wash their hands regularly**
 - **take paracetamol (or lowest dose ibuprofen for shortest time needed) if required**
- **Paracetamol** should be **available** to be taken **up to 1g qds** (IP or supervised, depending on the risk of the resident.) For symptomatic residents, it should be supplied via healthcare free of charge, using usual protocols. Where ibuprofen is considered appropriate, this should also be supplied by healthcare, using usual protocols.

D2iii: INITIAL MANAGEMENT: UNWELL

- If a resident appears unwell, check NEWS2 (or other EWS). If this indicates the need for **immediate admission to hospital, usual escort procedures and safe transfer advice** should be followed. PPE should be immediately accessible to escort staff to avoid delay to transfer.
- The hospital and ambulance should be told in advance of transferring a patient that they are suspected of having COVID-19.

D2iv: MONITORING

- Residents in protective isolation should have regular opportunities to **discuss any anxieties** (see section C4i – Psychological and behavioural responses). This may not require a member of healthcare staff but it is important that an anxious resident is neither ‘fobbed off’ nor given unscientific/incorrect advice (as far as is currently known).
- **Residents will not require regular observations by healthcare staff unless indicated for other clinical reasons or there are signs to indicate a deterioration in their health.** Where possible, assessment should be done without entering the room.
- It is important to be aware of patients who have underlying co-morbidities and fall into ‘**extremely vulnerable**’ or ‘**high risk**’ **medical categories for COVID-19**, as they are at **higher risk of deteriorating, needing closer monitoring or hospital admission.**

D2v: DISCHARGE FROM ISOLATION

- See also B2: Population management measures
- **Symptomatic residents: After 7 days***, the period of isolation can end, providing the resident has had **no fever for 48h** (without using medicines to reduce fever) and has no new or deteriorating symptoms. A persisting cough alone beyond 7 days is not a reason for ongoing isolation. (*see B2 for exception/PIU option - both symptomatic and non-symptomatic resident to remain together in PIU in cell for 14 days).
- **Contacts of symptomatic residents:** should remain in isolation for **14 days**. If they become symptomatic during the period of isolation, they should remain in isolation for at least 7 days from the start of their symptoms and until they have had **no fever for 48h** (without using medicines to reduce fever) – whichever is the longer.

- A resident should be assessed by a member of healthcare, by asking questions and checking their temperature, before protective isolation measures can be stopped.
- While not discussing the specific health of another resident, staff and residents can be reassured that a persisting cough alone beyond 7 days is not a reason for ongoing isolation of a resident who has been symptomatic for COVID-19.

D2vi: REPORTING

- Confirmed cases of COVID-19 should be notified to local Public Health England (PHE) Health Protection Teams (HPT) by prison or immigration removal centre (IRC) healthcare teams as soon as possible.
- HPTs will contact PHE's National Health and Justice Team and Centre Health and Justice leads in response to cases in prisons and PPDs. The HPT and the National Health and Justice Team will decide whether or not to declare a formal outbreak.
- If an outbreak is declared, the national contingency plan for outbreaks in PPD should be followed. Clinicians should attend outbreak control team meetings (OCTs) where possible, balanced against their other commitments.

D3: MANAGEMENT OF CLINICAL DETERIORATION

- Residents with suspected COVID-19 may be initially well but deteriorate, becoming increasingly breathless. This may not happen for around 7 days, which is important to explain to the resident.
- Remember other causes for clinical deterioration: increasing cough (e.g. COPD exacerbation, asthma), persisting fever (e.g. sepsis of other cause, UTI, cellulitis), increasing breathlessness (pneumonia, pulmonary embolus, tension pneumothorax)
- Symptoms and signs of deterioration/severity:
 - severe shortness of breath at rest or difficulty breathing
 - coughing up blood
 - blue lips or face
 - feeling cold and clammy with pale or mottled skin
 - collapse or fainting (syncope)
 - new confusion
 - becoming difficult to rouse
 - little or no urine output
- Pulse oximetry (Sats <92% (<88% in COPD) on air) indicates serious illness. NEWS2 scoring will be required to decide appropriate monitoring and whether or not admission is required.

D3i: STEP UP PRIMARY CARE: NON-PHARMACOLOGICAL AND PHARMACOLOGICAL CONSIDERATIONS

D3ia: NON-PHARMACOLOGICAL CONSIDERATIONS

- It is important to **discuss risks, benefits and likely outcomes of the treatment options** for patients suspected to have COVID-19 and to put a **Treatment Escalation Plan (TEP)** in place, since clinical deterioration can be rapid.
- For patients with advanced co-morbidities and those who have been assessed to be 'extremely vulnerable' or 'high risk', a **frailty assessment** should be done at the earliest

opportunity, in line with [NICE NG 159 COVID-19 rapid guideline: critical care in adults](#).(see C3i).

- If a resident has an **advance directive, ADRT or DNACPR** in place, this should **inform care planning**. If there is no ADRT or DNACPR in place, this should be sensitively discussed as part of drawing up a TEP, involving family and a FLO, where possible.
- It is recognised that **difficult ethical decisions** may need to be made quickly. It is important that clinicians can have **access to senior level colleagues to help with such decision making**.
- The level of care that can be provided for a resident in the secure setting will depend on what is available at the local level, in terms of capacity and skill mix of workforce (e.g. 24h care provision on site), access to specialist support for clinical teams, and access to medicines and equipment to enable safe effective nursing of patients.
- **Care equivalence with the community should be offered, whether through provision of on-site ‘step up’ primary care, hospital admission or end of life care, taking into account clinical need and individual patient assessment**

D3ib: PHARMACOLOGICAL CONSIDERATIONS

- The level of care offered and choice of medicines (and routes for these) will depend on pre-existing workforce skill mix and capacity as well as availability of equipment and supply of medicines.
- See **Section E5 and E6** (‘step up’ primary care and end of life care prescribing) for details of medicines.

D3ii: HOSPITAL ADMISSION

- Secure environments provide primary healthcare. Where a patient is assessed to require clinical admission this should be facilitated. It may be for:
 - Medicines that cannot safely be provided in the secure environment (local decision see D3i) e.g. oxygen, IV antibiotics, IV fluids or subcutaneous
 - Possible access to critical care
 - Hospital or hospice-based end of life care, if this cannot be provided on site
- **Appropriate PPE should be available for escort staff to facilitate immediate transfer to hospital once the decision for admission has been made (see Appendix H3).**
- In line with current prison guidance on respiratory infections (same principle as for TB), **escorting staff will NOT BE ALLOWED INTO ICUs on bed watch duty**. This is an IPC issue and there is a risk of getting in the way of staff delivering one-to-one specialist care. Hospitals may also request more distant security observations for ward-based bed watches, to comply with their IPC policies during the COVID-19 pandemic.

D4: MANAGEMENT OF RESIDENTS DISCHARGED FROM HOSPITAL

D4i: STEP DOWN PRIMARY CARE: NON-PHARMACOLOGICAL AND PHARMACOLOGICAL CONSIDERATIONS

- The level of care that can be offered by each secure environment will depend on the resources available (see D3i) however it is possible that patients who have been admitted to hospital will be discharged earlier than usual, due to pressure on beds.

- Healthcare teams should work with their local hospital trusts to ensure that a patient's healthcare needs can be met in prison when they are discharged back.
- The availability of 24h nursing care, respiratory physiotherapy, IV or s/c medicines, oxygen and social care provision will all influence the timing of hospital discharge. Local agreement will be required.
- Other prison residents cannot be expected to provide social care.
- If a patient's condition deteriorates following discharge from hospital or the level of care that a secure environment can provide does not meet a resident's clinical needs, further admission should be arranged.

D4ii: INFECTION PREVENTION AND CONTROL (IPC) POST-HOSPITAL DISCHARGE

- Residents discharged from hospital should return to **protective isolation** in the secure environment for **14 days**. PHE have suggested that following:
 - **Return from hospital requiring over-night stay or more**, patients should be returned to protective isolation (NB this could be in an RCU).
 - **Return from prolonged day-case treatment** e.g. chemotherapy, dialysis, radiotherapy, patients should also be considered for protective isolation, although they may already be in the shielding category.
 - **Attendance at A+E**, local risk assessment will be needed to decide if there is a need to put returning patients into protective isolation, taking into account advice from the hospital department of IPC.
 - **Routine OPD visit** (now at minimal level), the need to protective isolate someone should be risk assessed; it is likely to be a lower risk environment than other scenarios.
- **On return to the secure environment following admission with COVID-19 infection:**
 - During transport back to the secure environment, the patient **should wear a surgical face mask for the whole journey and until they enter their cell/room**.
 - Escorting security staff should wear PPE (see [Appendix H3](#)).
 - **Protective isolation** should continue for **14 days** and until the patient has had **no fever for 48h** (without using medicines to reduce fever) – whichever is the longer - unless the hospital has advised of another reason for persistent fever.

D5: END OF LIFE CARE

- Care should be underpinned by the 6 ambitions of the Dying Well in Custody Charter for those residents who are 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.
- Social care needs should be met.
- Symptoms experienced in COVID-19 include: **cough, fever, breathlessness, anxiety, agitation and delirium**. These should be managed in line with **NICE rapid guideline**

[NG163]: managing symptoms (including at the end of life) in the community (April 2020) with anticipatory prescribing. See Section E5 and E6.

D6: RESUSCITATION

- **Identify residents at increased risk of severe illness** and rapid clinical deterioration with COVID-19 infection ('extremely vulnerable' and 'high risk' medical conditions). See C3 and D3 re-DNACPR and treatment escalation discussions.
- Reduce the likelihood of on-site cardiac arrest and unprotected CPR by identifying and tracking patient deterioration with NEWS2 (or other EWS) and facilitating timely hospital transfer.
- If a resident has a cardiac arrest, **PPE MUST be put on prior to initiating resuscitation. Level 3 PPE with an FFP3 respirator is recommended for carrying out CPR** since [The Resuscitation Council UK](#) considers that during CPR, there is always the potential for rescuers to be exposed to bodily fluids, and for procedures (e.g. chest compressions, tracheal intubation or ventilation) to generate an infectious aerosol.
- **Early application of an AED**, while other healthcare professional colleagues don Level 3 PPE, will maximise healthcare professional safety, while also providing the patient the best chance of effective resuscitation.
- Regular training on PPE use will reduce the time taken in the event of a cardiac arrest.
- If a patient has additional oxygen provision, this may be continued 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 is extremely important at every stage of PPE removal.
- A post-resuscitation debrief should be done and follow up support should be offered to staff and other residents, affected by the death.

D7: CARE AFTER DEATH

- The death of a resident from COVID-19, whether this takes place on site or in hospital, is likely to have a significant impact on the whole secure environment community – both residents and staff.
- **PHE Guidance for care of the deceased with suspected or confirmed coronavirus (COVID-19)** should be followed.
- All residents should stay at least 2m from the deceased person and all non-essential staff contact with the deceased person should be avoided, to minimise risk of exposure. The usual processes for dealing with a death in custody should be followed, ensuring that IPC measures are implemented, as set out in the PHE guidance.

D7i: CHANGES TO DEATH CERTIFICATION

- Due to Article 2 (Human Rights Act 1988) and subsequent inquest, prisons are exempt from verification of death by nurses and other healthcare professionals. However,

temporary agreement may be reached with the local Senior Coroner, HMPPS and PPO where assurance is given and robust training and governance is in place.

D7ii: PPO/CORONER'S CASES

- Every death in custody will continue to be investigated by the PPO, however investigations into COVID-19 deaths are currently on hold, while legal clarity is sought about the approach. Evidence (e.g. CCTV) should be preserved and information will be gathered through submission of paperwork and remote interviews.
- **The 48/72 hour immediate review needs to be completed by providers and shared with commissioners within the usual timeframe as it will inform PPO case prioritisation.**
- Clinical reviews will continue to be requested and concerns about capacity/action should be highlighted to the PPO regionally.

D7iii: CARE OF OTHER RESIDENTS

- Pastoral care and vigilance for emerging symptoms of mental health deterioration, in both residents and staff, will be required. Support services should be identified and communicated to those involved in the individual resident's care, in a timely and effective way.

SECTION E: PRESCRIBING

E1: GENERAL CONSIDERATIONS

- NHS England and NHS Improvement: Advice for health and justice healthcare teams on medicines and pharmacy services continuity sets out the changes required to ensure residents receive ongoing medication during the COVID-19 pandemic.
- In principle, safe prescribing and good medicines governance should continue, including medicines reconciliation, appropriate medicines handling (including CDs), In Possession (IP) risk assessment, timely generation of prescriptions and availability of medicines.
- Prescribing should follow NICE COVID-19 guidance, where there are changes to usual clinical treatment.
- Generate up to 4 x 28 day repeat prescriptions.
- **In-possession:** where safe and appropriate:
 - issue regular medicines 28 days IP at a time
 - prioritise IP switching in residents with 'extremely vulnerable' and 'high risk' medical conditions
 - provide symptomatic relief, antibiotics and other necessary medicines IP
- **Supervised consumption (STT)** should continue for medicines at high risk of abuse and diversion and for residents unsuitable for IP medicine (according to IP risk assessment). Continue checking the resident's mouth, wearing appropriate PPE where indicated.
- Arrange with the prison to facilitate social distancing in medicines queues.
- Residents in **protective isolation or shielding** should have **medicine supplied to their door** (both IP and STT).

- **Medicines distribution:** IP medicines can be given out by unregistered staff. STT requires registered healthcare professionals. Support to self-medicate can be provided by officers or social care workers.
- **On transfer** to another establishment: supply **7 days** of medication (currently no IPT).
- **On release** back to the community: Ideally prescribe **28 days medicines for supply or using FP10 (including CDs) and 14 days FP10MDA** to manage reduced access to primary care and substance misuse services post-release.
- It will be important to **clarify availability of supervised consumption service** at selected pharmacies since many community pharmacies are stopping supervised consumption during the current pandemic. If there is **no confirmed supervised consumption service** available at the selected pharmacy, consider **prescribing 'daily collection'** on FP10MDA prescriptions.

E2: LONG-TERM CONDITIONS

- See also **Section C2:**
- Prescribing guidance is available: [NICE rapid coronavirus \(COVID-19\) guidelines](#), [NHS Specialty guides](#), [British Society of Rheumatology](#), [British Association of Dermatologists](#), [British Society of Gastroenterologists](#), [British Thoracic Society](#).
- Use of oral steroids, DMARDs, biologic and other immunosuppressant medications during the pandemic and when a patient is suspected or confirmed to have COVID-19 is covered in [NICE rapid coronavirus \(COVID-19\) guidelines](#).
- Contact local specialists for further advice if needed.
- **ACE inhibitors and ARBs for treatment of high blood pressure:** MHRA have issued a statement, advising of the importance of continuing treatment.
- Consider **Sick Day Rules for ACE inhibitors, ARBs, diuretics, metformin, NSAIDs:** patients with fever or diarrhoea/vomiting are at risk of dehydration and AKI (see p49 linked document).
- **NOAC/DOAC and warfarin switching guidance** has been published by RPS.

E3: SUBSTANCE MISUSE

- PHE is due to publish new substance misuse guidance. In the interim:
- Continue to provide withdrawal observations in the early days in custody.
- **Location of new residents** with substance misuse issues will need to be **agreed locally, and take into account IPC cohorting measures and individual patient risk** (e.g. patient at high risk of alcohol withdrawal may need inpatient unit location but other new residents may have withdrawal observations facilitated in RCU rather than in usual areas allocated for residents with substance misuse issues)
- Stabilise the resident on OST then consider writing 2-3 x28 day scripts.
- **If operational issues prevent the safe supply of methadone, consider using buprenorphine instead of methadone** to reduce time spent on measurement of methadone. Oro-dispersible buprenorphine (e.g. Espranor) is less likely to be diverted and more quickly administered than crushed buprenorphine tablets.
- Injectable buprenorphine (Buvidal) administered on a weekly or monthly basis, has the potential to provide longer protection, reduce frequency of patient-facing interactions therefore reducing staff workload and reducing the risk of COVID-19 transmission

(although the close contact at the time of injection poses a risk of infection). It also has the potential to reduce the risk of people dropping out of treatment and reduce the risk of overdose and drug-related death. Currently, it is not recommended for use in the community or secure environments due to operational, clinical and continuity of care challenges.

- **Prior to release, consider increasing OST dose** to i) reduce the risk of using illicit opioids on top of the OST script and ii) increase engagement with community drug services; patients on low dose OST are likely to find the burden of attending pharmacies and appointments greater than the benefit of buying heroin and will not engage with drug services after release – see SMMGP webinar 12/03/2020 [Drug related deaths in criminal justice settings](#).
- **Naloxone training:** consider providing training **at induction/first appointment** with substance misuse services. Consider sharing naloxone training with all residents **on in-cell TV**.
- Optimise assisted withdrawal for patients with a history of alcohol misuse and continue to locate where withdrawal observations can be done safely.
- Optimise assisted withdrawal for patients who have been misusing benzodiazepines prior to custody.
- Gabapentinoid assisted withdrawal for residents identified as being at increased risk of drug-related death remains an important prescribing safety choice. Follow up medication reviews and support could be provided over the telephone. Where staffing levels or restriction of movement make support of patients going through gabapentinoid assisted withdrawal unfeasible, dose reductions may need to be suspended.
- [Drug-related deaths resource](#): SMMGP webinar (12 March 2020)
- **Release planning and prescribing:** see Sections [E7](#) and [E](#).

E4: MENTAL HEALTH PRESCRIBING

- NICE guidance and principles set out in [Safer Prescribing in Prisons \(2nd edition, Jan 2019\)](#) should be continue to be followed.
- In addition [RCPsych COVID-19: providing medication](#) sets out guidance for managing mental health medicines, including antidepressants, anxiolytics and antipsychotics, depot guidance.
- **Consider delaying planned changes to or withdrawal from medicines** since anxiety, depressive and psychotic symptoms are all likely to worsen during extreme stress and social disruption and patients will be at increased risk of relapse or recurrence of affective and psychotic illness. Capacity to monitor patients will also be reduced.
- **Take advice** from the onsite mental health team and local visiting psychiatrists about patients whose mental health appears to be deteriorating. Consult the prescriber if changes need to be made to specialist-initiated medicines.

E5: PRIMARY CARE PRESCRIBING (STEP UP)

- Prescribing should follow **NICE COVID-19 rapid guideline [NG163]**
- See **section D3i** regarding local variation in provision of enhanced primary care.

E5i: SYMPTOM CONTROL

Cough

- **Non-pharmacological:** avoid lying on back if possible (cough ineffective).
- **Pharmacological:** opioid cough suppressants, if cough causing distress. Avoid if risk sputum retention e.g. bronchiectasis. Short-term only.

COUGH

(only if causing distress; short-term use – risk dependence)

- 1st choice: **codeine phosphate** 15-30mg every 4h PRN (max qds); increase to 30-60mg qds PRN (max 240mg/24h)
- 2nd choice: **morphine sulfate** (oral solution 10mg/5ml) 2.5-5mg every 4h PRN; increase to 5-10mg every 4h PRN
- **If patient already taking regular morphine, increase regular dose by 1/3rd**
- NB constipation risk – consider regular stimulant laxative

Fever

- **Non-pharmacological:** keep the room cool; wear loose clothing; cool face with flannel/cloth; fluids – up to 2 litres/d; **avoid portable fans** (possible risk infection spread)
- **Pharmacological:** If fever AND other symptoms, consider **paracetamol** or **lowest effective dose NSAID** for **shortest period to control symptoms**, taking into account risk/benefit of chosen medicine.

FEVER

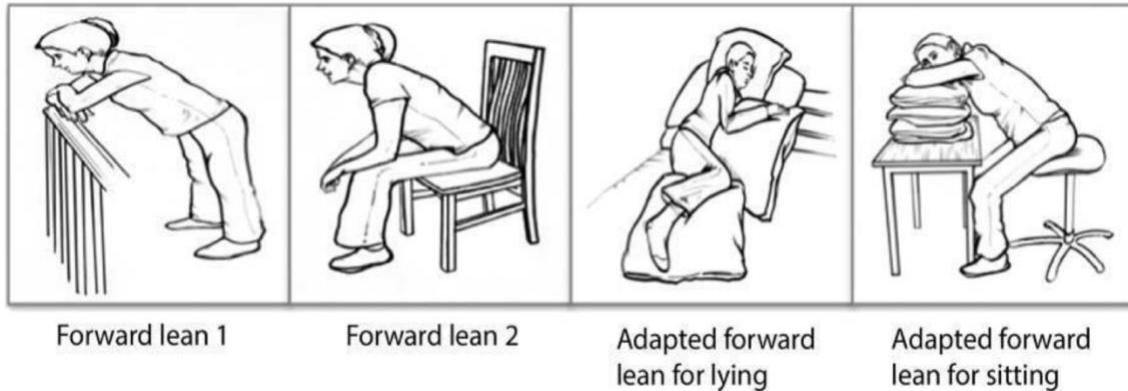
(only if fever AND other symptoms)

- **Paracetamol** 0.5-1g every 4-6h PRN (max 4g/24h) or
- **NSAID** lowest effective dose, shortest period needed to control symptoms

Breathlessness

- **Non-pharmacological:** Calm and reassure the patient by touch, talking and explaining. Encourage breathing techniques - pursed lip (nose in 5 secs, mouth out 5 secs), co-ordinated breathing training. Air across the face may help (open a window if possible; do NOT use a fan (risk infection transmission)).

- Body positioning – see picture published in [Northern Care Alliance NHS Group and the Association for Palliative Medicine of Great Britain and Ireland COVID-19 and Palliative, End of Life and Bereavement Care in Secondary Care](#)



BREATHLESSNESS

(end of life, moderate to severe, if causing distress/agitation: benzodiazepine + opioid)

- **ORAL morphine sulfate** 2.5 - 5mg every 2-4h PRN (if already on opioids 5-10mg or 1/12th of 24h dose every 2-4h PRN) **or morphine sulfate MR** 5mg bd (up to 30mg/d) **or MXL** 30-60mg od.
- **S/C morphine sulfate** 1-2mg every 2-4h PRN (if more than bd and if skills/availability use: **syringe driver morphine sulfate** 10mg/24h, increasing stepwise to 30mg/24h)

ANXIETY add:

- **ORAL lorazepam** 0.5mg **SL** PRN (max 4mg/24h); reduce to 0.25mg (max 2mg/24h if elderly, underlying debility)

AGITATION/DISTRESS add:

- **S/C midazolam** 2.5-5mg (if more than bd and if skills/availability use: **syringe driver midazolam** 10mg/24h, increasing stepwise to 60mg/24h)

CONSIDER:

- Trial **oxygen therapy**, where available/agreed
- **Antiemetic** and **regular stimulant laxative**

Agitation, anxiety and distress

- (see also **Breathlessness**)
- **Non-pharmacological:** being present can help, using touch, talking and explaining. Explore concerns and anxieties. Adjust lighting to ensure adequate.

AGITATION, ANXIETY, RESTLESSNESS

- **ORAL diazepam** 5 - 10mg or **lorazepam** 0.5mg – 1mg **SL** qds PRN (max 4mg/24h); reduce to 0.25mg (max 2mg/24h if elderly, underlying debility)
- **S/C midazolam** 2.5-5mg every 2-4h PRN (if more than bd and if skills/availability use: **syringe driver midazolam** 10mg/24h, increasing stepwise to 60mg/24h; reduce to 5mg/24h if eGFR <30.

E5ii: PNEUMONIA

- Rapid diagnosis of suspected community acquired pneumonia will only require auscultation and BP measurement if they are crucial to decision making e.g. alternative diagnosis or whether to admit (NEWS2). If limited examination is performed, this should be documented (o/e LE). Pulse oximetry can assist in tracking the deteriorating patient.
- Management should follow **NICE COVID-19 rapid guideline [NG165]: managing suspected or confirmed pneumonia in adults in the community (April 2020)**
- **Breathlessness** – see E5i
- Do NOT offer antibiotics if pneumonia likely to be due to COVID-19 virus or symptoms are mild. Provide safety netting advice
- **Prescribe antibiotics if at high risk of complications due to age, frailty, co-morbidities, or severe illness with previous lung infection.**
- Recommended antibiotics are:
 - **1st line** (oral): **doxycycline** 200 mg day 1, then 100 mg od for 5/7 total (not in pregnancy)
 - **Alternative/2nd line:** **amoxicillin** 500 mg 3 times a day for 5 days.
 - for penicillin allergy: NICE guidance (NG138) for Pneumonia (community acquired)
- **IV antibiotic** prescribing decisions will be made locally, depending on agreed enhanced primary care provision.
- **Do NOT offer oral steroids** unless indicated for another condition e.g. asthma

E5iii: OXYGEN

- **Oxygen treatment is a key part of managing more severe symptoms associated with COVID-19.** This aspect of care provision will be subject to local agreement,

depending on staff capacity and skill mix, oxygen cylinder procurement, delivery and return, and collaborative risk assessment with prison/security teams.

- For **end-of-life breathlessness**, if available, consider a **trial of oxygen therapy**. Continue if it alleviates breathlessness.

E5iv: INTRAVENOUS AND SUBCUTANEOUS MEDICINES

- IV/SC provision as part of 'step up' primary care will be agreed locally depending on pre-existing workforce skill mix, capacity, access to 24h pharmacy and availability of equipment.

E6: END OF LIFE CARE

- Follow the ambitions set out in the Dying Well in Custody Charter (section D5), use **NICE COVID-19 rapid guideline [NG163]** and NICE Guidelines (NG31): Care of dying adults in the last days of life. (2015)
- See also Northern Care Alliance NHS Group and the Association for Palliative Medicine of Great Britain and Ireland COVID-19 and Palliative, End of Life and Bereavement Care in Secondary Care
- **See E5i** and **Appendix H4** for flow charts of symptom relief.
- **Anticipatory prescribing** is required but should be in the context of agreed levels of end of life care, depending on skills and capacity of workforce, availability of 24h pharmacy and equipment.
- It should also take account of NHS advice regarding waste and medicines shortages; smaller quantities or different medicines/formulations/routes of administration should be prescribed, when necessary e.g. s/c, rectal or long-acting formulations.

E7: PRESCRIBING FOR RELEASE

- See also section F.
- Patients being release should be prescribed to allow for reduced access to community primary care and substance misuse services:
 - **Ideally 28 day supply of medicines** to take home (or FP10 if unplanned/short notice release where medicines cannot be supplied by in-house pharmacy)
 - **14 day FP10MDA script if on OST (supervised consumption, if confirmed as available, or daily pick up)**

SECTION F: RELEASE PLANNING

- In order to reduce the number of people in prisons across the UK, criteria have been drawn up to identify people suitable for temporary release. Those who, after risk assessment, are considered suitable for safe release will require medicines or prescriptions, as detailed in **section E7**.
- **Follow up with community substance misuse services will need to be arranged**, where possible, for those residents requiring them.
- If residents requiring OST are released on a Friday, in order to avoid missed doses over the weekend, consideration should be given to providing labelled OST medicine for the weekend, if it is not possible to identify a pharmacy accommodating either supervised

consumption or daily pick over the weekend, in the locality that a resident is being released to. The risk of OST overdose in this scenario would need to be carefully weighed up against that of acquiring illicit opiates due to lack of access to OST.

- A **discharge summary** should be sent via **secure email to the registered GP on release**. Patients without a registered GP should be allocated to a registered GP practice in their area of release, where possible.
- Patients who fall into the shielding category should be provided with a **shielding letter on release** (see template on SystemOne).
- **NHS volunteer responder scheme:** vulnerable people can be referred to the NHS volunteer responder scheme <https://volunteering.royalvoluntaryservice.org.uk/nhs-volunteer-responders>

SECTION G: STAFF CONSIDERATIONS

G1: STAFF ILLNESS, VULNERABILITY AND HOUSEHOLD CONTACTS

- If a member of staff becomes unwell on site with a new, continuous cough or a high temperature, they should go home and are advised to follow the stay at home guidance.
- Occupational health should be informed of staff who are self-isolating due to symptoms or household contacts. They will be involved in providing advice about self-isolation and shielding to staff with 'high risk' and 'very high risk' conditions and to their employers.
- Staff who are unable to work onsite are well enough may be able to work remotely by:
 - enabling telephone or video consultations where these have been enabled locally and providing they have a secure VPN connection.
 - attending virtual multidisciplinary team meetings
 - carrying out tasks that can be done remotely, such as entering data
- Staff with 'high risk' conditions and older staff returning from retirement, who do not fall into the shielding category, may be best assigned to work in 'cold' (non-COVID-19) areas with restricted staff and resident access.

G2: STAFF MENTAL HEALTH AND WELL-BEING

With thanks to Dr Alexandra Lewis, Consultant Forensic and Child & Adolescent Psychiatrist

- The mental health of staff may be affected by COVID-19. Advice on mental health is provided by RCPsych.
- Evidence from the SARS, H1N1, Zika and Ebola experience has shown that health care workers are particularly vulnerable to developing mental health symptoms as a result of their work with affected patients, both at the time of the outbreak, and after the event.
- **Vulnerability** is increased by:
 - concerns about own health and safety in workplace e.g. lack of adequate PPE, feeling distressed/panicky wearing PPE
 - being asked to work outside comfort zone
 - unclear/evolving policies
 - illness stigma from family/friends/neighbours
 - restricted time with those usually turned to for support e.g. due to longer/more frequent shifts worked, self-isolation

- It is important to lead with compassion and to avoid a 'get on with it' culture where expressing uncertainty, grief and fear can be hard for staff.
- Without being able to express and to have fear and stress acknowledged, staff may develop risky self-care behaviours such as increased alcohol consumption, forget to use seatbelts, forget to take medication, fail to maintain strict hygiene procedures, experience relationship difficulties and disturbed sleep.
- **Simple interventions for supporting staff well-being:**
 - taking regular breaks
 - maintaining hydration
 - having identified colleague to check in with
 - encouraging and constructive communication (will also make it feel ok to speak up if something doesn't feel right)
 - explicitly recognise jobs well done

G3: EXPOSURE TO RESIDENTS WHO MAY HAVE COVID-19

- Current advice is that if a member of staff has helped someone who was taken unwell with a new, continuous cough or a high temperature, they do not need to go home unless they develop symptoms themselves.
- PPE is currently advised for all patient contact <2m and therefore the risk of unprotected exposure to COVID-19 is reduced.

G4: RETURN TO WORK

- Occupational health should be involved where there is uncertainty around staff return to work, however, in general, symptomatic staff can return to work on day 8 after the onset of symptoms if:
 - Clinical improvement and no fever for 2 days
 - Cough if the only persistent symptom (post-viral cough may persist for several weeks)

H: APPENDICES

H1: FURTHER LINKS (COVID-19) IN SECURE ENVIRONMENTS AND TRAINING

PHE:

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

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

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

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

COVID-19: laboratory investigations and sample requirements for diagnosis

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

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

RCGP:

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

RCN:

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

RCPsych:

Responding to COVID-19

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

Digital – COVID-19 guidance for clinicians

<https://www.rcpsych.ac.uk/about-us/responding-to-covid-19/responding-to-covid-19-guidance-for-clinicians/digital-covid-19-guidance-for-clinicians>

BMJ:

<https://bestpractice.bmj.com/topics/en-gb/3000168;>

<https://www.bmj.com/content/368/bmj.m800>

<https://www.bmj.com/content/bmj/368/bmj.m1211.full.pdf>

<https://www.bmj.com/content/bmj/suppl/2020/03/24/bmj.m1182.DC1/gret055914.fi.pdf>

PPE:

RCGP COVID-19 GP Guide personal protective equipment

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

NICE: RAPID GUIDELINES AND EVIDENCE SUMMARIES

<https://www.nice.org.uk/covid-19>

NICE guideline [NG31]: Care of dying adults in the last days of life (2015)

<https://www.nice.org.uk/guidance/ng31>

NHS SPECIALTY GUIDES

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

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

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

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

CEBM Oxford COVID-19 Evidence Service: Rapid diagnosis strategy of community-acquired pneumonia for clinicians (April 2020)

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

FURTHER LEARNING RESOURCES – STEP UP PRIMARY CARE

Resources for Acute Care Cross Training – University of Bradford

<https://icmanaesthesiacovid-19.org/cross-skill-training-for-pandemic-covid-19>

Topics include: Advanced Respiratory Monitoring and Support in Critical Care, Maintenance of Nutrition and Hydration Status in the Critically Ill, Advanced Cardiovascular Monitoring and Support in Critical Care, General Care of the Unconscious Patient.

E-learning produced by the University of Huddersfield

resources <https://hhs.hud.ac.uk/covid19/>

Topics include: Management of acute respiratory symptoms, Auscultation and respiratory assessment, Critical care skills for non-critical care nurses, End of life care, Transmission and Cross Infection)

Sunderland University: Respiratory Masterclass COVID-19

<https://www.sunderland.ac.uk/study/short-courses-cpd/respiratory-masterclass/>

Aimed at staff with minimal critical care experience who need to have knowledge of nursing those with Covid-19 respiratory symptoms. It will include the anatomy of the respiratory system, respiratory failure, supplementary oxygen therapy options, and an overview of NIV, CPAP and ABG analysis.

H2: PATIENT LETTERS

H2i: Shielded (see SystemOne template)

H2ii: High risk

H2iii: RCU – new arrivals

Name: Healthcare Department
Prison number (or NHS Number): HMP XXXXXXXXXXXX
Residence: Address (line 1)
Address(line 2)
Address (line 3)/Postcode
Date: XX/XX/2020

IMPORTANT: PERSONAL

Dear *(first name, surname)*

IMPORTANT ADVICE TO KEEP YOU SAFE FROM CORONAVIRUS

You may be aware that the NHS has been sending letters to people across the UK who they have identified as being at very high risk of severe illness from coronavirus (COVID-19) because of an underlying health condition. You may also have heard about '**shielding**', a word that is being used to describe ways that people with serious underlying health conditions can protect themselves, by minimising all interactions with others.

You have been identified as someone at risk of severe illness if you catch Coronavirus (also known as COVID-19). This is because you have a health condition that means if you catch the virus, you are more likely to be admitted to hospital than other people.

The safest course of action is for you to follow shielding advice and stay behind your door, to avoid all face-to-face contact for at least twelve weeks, except from healthcare staff who you must see as part of your medical care and prison staff co-ordinating your access to showers, telephone calls and delivering your meals, which you should eat in your room. You should not go out of your room except for showers and telephone calls. You should not take part in association. If you do not wish to leave your room to use the showers, it is very important to keep up good personal hygiene, and you should 'strip wash' regularly.

Shielding is for your personal protection. It is to try to stop you coming into contact with Corona virus infection. It is your choice to decide whether to follow the measures we advise. Should you choose to shield yourself, your medicines will be made 'in possession', so long as your risk assessment shows that this is safe for you. If, at any point, you think you have developed symptoms of coronavirus, such as a new continuous cough and/or high temperature, you should press your cell bell and ask the officers to tell the healthcare team straightaway.

We understand that the information and advice in this letter may make you feel more anxious than usual. We would like to reassure you that, as a healthcare team, we will do all we can to support you through this difficult time and we will be doing welfare checks. We will continue to provide your urgent healthcare needs and will let you know if there are any changes to national guidance.

Yours sincerely

Dr XXXXXXXXXXX and the Healthcare team at HMP XXXXXXXXXXX

H2i

Name:
Prison number (or NHS Number):
Residence:

Healthcare Department
HMP XXXXXXXXXXXX
Address (line 1)
Address(line 2)
Address (line 3)/Postcode
Date: XX/XX/2020

IMPORTANT: PERSONAL

Dear *(first name, surname)*

IMPORTANT ADVICE TO KEEP YOU SAFE FROM CORONAVIRUS

You have been identified as being in the group of people who may be at increased risk from coronavirus, due to your medical condition(s). This is usually people who require a flu vaccination each year.

The advice for people who may be at increased risk from COVID-19 (Coronavirus) is the same as for most other people in the community.

You should only leave your room for very limited purposes:

- for collecting your food and medicines
- showering and telephone calls
- exercise
- any medical need

When you leave your room, you must be careful to maintain 'social distancing', by keeping at least 2 metres apart from all staff and other residents.

Yours sincerely
Dr XXXXXXXXXXX and the Healthcare team at HMP XXXXXXXXXXX

H2ii

Name:
Prison number (or NHS Number):
Residence:

Healthcare Department
HMP XXXXXXXXXXXX
Address (line 1)
Address(line 2)
Address (line 3)/Postcode
Date: XX/XX/2020

IMPORTANT: PERSONAL

Dear *(first name, surname)*

IMPORTANT ADVICE TO KEEP YOU SAFE FROM CORONAVIRUS – NEW RESIDENTS

Welcome to HMP XXXXXXXXXXXX.

For the first 14 days of your stay here with us, you will be located in an area of the prison that is away from other residents. This is in order to help prevent the introduction of the Coronavirus (COVID-19) into the prison from the community.

While in this area, you will have access to health care services.

We are following the advice from Public Health England here in the prison and, as part of this requirement you will need to respect ‘social distancing’, by keeping at least 2 metres apart from all staff and other residents when you are out of your room.

During your first 14 days here at HMP XXXXXXXXXXXX, you will be effectively ‘self-isolating’. You should only leave your room for very limited purposes:

- to collect your food and medicines
- to take a shower and make telephone calls
- to exercise – you must maintain careful social distancing, even during exercise
- any medical need

If you become unwell with symptoms of Coronavirus during your first 14 days in HMP Bedford, a member of the healthcare team will assess you and you will be looked after. You will be asked to stay behind your door and food and medicines will be brought to you. You will still have access to contact your loved ones.

If you become unwell with any other problems, not related to the Coronavirus, you will be assessed by the healthcare team and offered any necessary advice and treatment.

Yours sincerely

Dr XXXXXXXXXXXX and the Healthcare team at HMP XXXXXXXXXXXX

H2iii



Recommended PPE for healthcare and custodial staff in prisons and places of detention (COVID-19)

Context	Disposable Gloves	Disposable Plastic Apron	Disposable Fluid Repellent Coverall/ gown	Fluid Repellent (Type IIR) Surgical Mask	Filtering Face Piece Respirator	Eye/ Face Protection
Performing an aerosol generating procedure on a suspected or confirmed case (including resuscitation)	✓ Single use	✗	✓ Single use	✗	✓ Single use	✓ Single use
Direct health, social & security related tasks with a suspected or confirmed case or persons in shielding (where 2 metre social distancing cannot be achieved) including Escorts and Bedwatches of non COVID cases	✓ Single use	✓ Single use	✗	✓ Single/sessional use	✗	✓ Risk assess sessional use
Cell/room visits to possible or confirmed cases (not within 2 metres)	✓ Single/sessional use	✓ Single/sessional use	✗	✓ Single/sessional use	✗	✓ Single/sessional Use (if risk of spitting.)
Escort and Bedwatch of COVID confirmed/suspected (if within 2 metres or travelling in an ambulance)	✓ Single use	✗	✓ Single/sessional use	✗	✓ Single use	✓ Single use

- Staff should minimise any non-essential contact with suspected or confirmed COVID-19 patients.
- Single use refers to disposal of PPE after each patient/prisoner and or following completion of a procedure or task.
- Single session refers to a period of time when the healthcare/custodial worker staff is undertaking duties in a specific setting/exposure environment. Session ends when the staff member leaves the setting/exposure environment.
- Where indicated prison staff should wear disposable plastic aprons and eye protection if available.
- Reusable eye/face protection must be decontaminated according to manufacturer, supplier or infection control

COVID-19 CUSTODIAL PPE Guidance

PPE for use in prison based on guidance published by Public Health England, for activities requiring close contact with a possible COVID-19 case.

Contact with confirmed or suspected COVID-19 cases and mandatory security tasks

Escort to hospital, bed watch, CPR or self-harm response, cleaning post BBV* incidents involving spray treatments.

Eye protection, if there is a risk of body fluid entering the eye.

Eye protection, eye shield, goggles or visor.

Fluid resistant surgical mask.

FFP3 or FFP2 face mask.

Disposable apron where available.

Long sleeved fluid repellent gown/coverall.

Nitrile gloves

Nitrile gloves.

Wash your hands before and after patient contact and after removing some or all of your PPE

Clean all the equipment that you are using according to local policies

Use the appropriate PPE for the situation you are working in (General / AGPs or High risk areas)

Take off your PPE safely

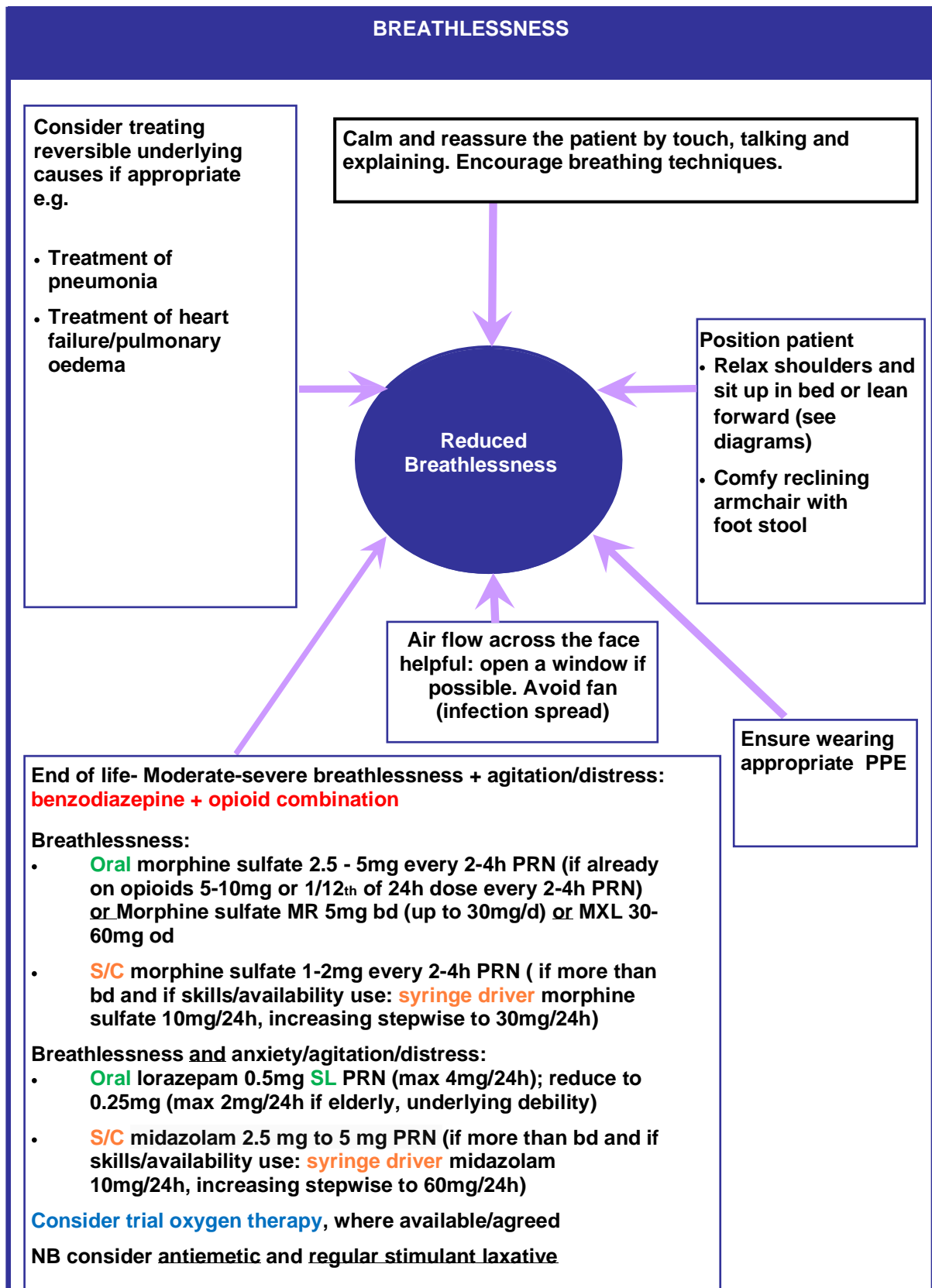
Take breaks and hydrate yourself regularly

For further information and detailed operating procedures please refer to the Safe Operating Procedures as issued from Gold Command.

*BBV – Blood Borne Virus

H3

H4i: Breathlessness (adapted) - with permission from CareUK End of life care for patients in prison: COVID-19



H4ii: Restlessness and agitation (adapted) - with permission, from CareUK End of life care for patients in prison: COVID-19

