Inter Regional Prosthetic Audit Group (IRPAG+) & British Society of Rehabilitation Medicine SIGAM (BSRM) Working Group

Guidance to Support Reimplementation of Prosthetic Services

Aim of document

This guidance document is designed to assist the escalation of services in a safe and consistent manner across prosthetic centres. The guidance is intended to compliment not substitute existing policies and to support staff working within the prosthetic environment. It may also support Prosthetic and Orthotic MDT staff in discussing their specific service needs with their Trust. The interpretation and implementation of the guidance will vary in response to local conditions and constraints.

Method of development

An initial working group of ten participants reviewed and developed six key areas of the prosthetic service. These key areas relate to the patient pathway, service delivery and workshop manufacture. The working group comprised representation from all professional groups within Prosthetic & Orthotic MDTs. Reference was made where appropriate to existing policies for example, Public Health England (PHE) and The International Society of Prosthetics and Orthotics (ISPO) recommendations (Appendix A). A brief survey of prosthetic centres to identify service levels and alterations during the Covid-19 pandemic was conducted (Appendix B). Further development of the document was undertaken in collaboration with the Special Interest Group for Amputee Medicine (SIGAM) which sits within the British Society of Rehabilitation Medicine (BSRM). This collaboration was in response to the lack of national guidelines as services are returning to normal following an unprecedented and extended period of shutdown.

Recommendations

1.0	**New referrals**
1.1	Weekly MDT review and prioritisation of new referrals: • Patients on protected pathways (Sarcoma, Infection, Trauma) • Primaries • Transfer-ins • Pre-amputation assessments and consultations • Second opinions • Prenatal referral following 20 week scan.
1.2	Categorise backlog as *'routine'* and *'priority'*.
1.3	Sub-categorise as *'shielding'* and *'non-shielding'* (subject to regular review).
1.4	'Shielding' patients may still need to be seen as a priority.
1.5	Patients who are self-isolating should not be seen until after 14 days from developing symptoms and should be red-flagged to the team.
1.6	Appropriate clinician to triage new referrals via remote consultation where appropriate.
1.7	Prioritise backlog of new referrals since cessation of services.
1.8	Prioritise backlog in order of referral date overridden where necessary by clinical need.

1.9	Reduce non-urgent clinical/manufacturing activity to decompress backlog of patients waiting to commence rehabilitation or progress treatment.
	Patients at risk (shielding)
1.10	Remote video consultations by appropriate clinician to advise/avoid deterioration. Provide home exercise information and counselling/psychology if required and available. Consider domiciliary visit where appropriate.
1.11	Careful consideration and evaluation of potential risks versus benefits should be undertaken prior to issuing an appointment to these patients or commencing an episode of care.
1.12	Patients who have special needs or managed under the Mental Capacity Act (e.g. service users with impaired cognition) may not be able to fully evaluate the associated risks of attending the centre. The decision to bring them to any appointment should be considered in their best interest, including their guardian or advocate. Remote consultation should be used when appropriate.
2.0	**Managing appointments and rebooking of established patients**
2.1	Application of telephone Covid-19 screening questionnaire by trained reception/ administration staff or a clinician to identify the 'at risk' patients.
2.2	Confirm if patients have their own transport or if hospital transport is required (if available).
2.3	Advise that patients should attend the centre unaccompanied or if necessary, with the assistance of only one carer/guardian who should stay in the car park unless the situation demands.
2.4	Contact all patients 24 hours before their appointment to check if they or people they live/interact with are symptomatic.
2.5	If they/household are symptomatic the appointment should be postponed or revert to remote consultation.
2.6	Advise patients to contact reception on arrival at the centre but prior to entering the building/clinic room/area. Where possible ask patients to wait in their vehicle.
2.7	Patients who attend the clinic with symptoms – provide with a mask, isolate, and postpone.
2.8	Check/record temperature preferably using an infra-red thermometer (or follow local protocol).
2.9	Observe strict adherence to pre-allocated appointment times. Provision may need to be made to accommodate transport patients waiting for appointments/pick up.
2.10	Identify patients who may require additional time for example difficult repair work, unusual socket design, medical or mental health issues.
2.11	Allow time between patients for preparation, hygiene, and cleaning.
2.12	Use specific wheelchairs to bring patients from car park, or for those who are not able to use their prosthesis, do not have any prosthesis or who need to drop their prosthesis for repair work.
2.13	The wheelchair needs to be disinfected properly in-between patients as per local infection prevention guidelines.
2.14	Allocate single toilet for patient use to be disinfected in between patients, ensure hand-washing.
2.15	Patients are advised to bring their own mask to cover the nose and mouth, and not to touch items unnecessarily.
	Backlog appointments
2.16	Categorise backlog as *'routine', 'priority'*, sub-categorise as *'shielding'*, *'non-shielding'* (NHS Digital, 2020).

2.17	Triage appointments (by appropriate clinician) that have been postponed, identify if an appointment is still required, routine or priority.
2.18	Consider the use of remote consultations where possible to reduce unnecessary clinic attendances and to signpost patients.
2.19	GP referrals may be required in the absence of a counsellor or psychologist.
2.20	Introduce a drop off and pick up service for mechanical repairs to reduce unnecessary centre visits and maintain postal deliveries where appropriate.
2.21	Examples of priority appointments (not listed in a particular order): • Keyworkers as per the UK government definition • Medical review of stump ulcer(s) or infections • Paediatric cases • Multiple limb loss patients • Patients with dependents and care responsibilities • Inpatients who require a prosthesis to enable discharge • Socket issues that could cause soft tissue breakdown • Patients at risk of developing contractures/pressure sores • Primary patients within the first year of prosthetic rehabilitation • Patients reporting prosthetic related falls.
2.22	Examples of non-priority appointments: • Second limbs • Sports limbs for children • Upgrades • Commencement of MPK trials (priority status subject to clinical/MDT review and available resource).
3.0	**Rationalisation**
3.1	Prior to service escalation it is recommended that workshop processes are reviewed at least in the short term. This is to reallocate capacity/resource with a view to decompressing the build-up of new referrals and backlog of priority patients.
3.2	Application of single stage processes where possible/review the need for check sockets and complex manufacturing builds etc.
3.3	Postpone non urgent manufacture such as second limbs and upgrades to free up capacity for priority work.
4.0	**Clinic throughput**
4.1	Implementation of rota system/teams/split shifts in clinics and workshops to maintain social distancing and maximise the number of appointments for patients – dependent upon local conditions and constraints.
4.2	Detailed processes need to be developed for managing patient flow throughout the building, including floor marking, signage and adjustment of clinical areas.
4.3	Implementation of 2 metre social distancing measures/marking across the centre. Additional supplies to be ordered to support the new processes e.g. limb bags and clinical waste bags.
4.4	Questionnaire scripts to be developed, this is to help the admin staff/clinicians to check patient symptoms via a phone call the day before their appointment.
4.5	Devices and limbs should be considered contaminated and decontaminated as per the local infection control guidance.
4.6	Clinic areas should have hand cleaning facilities, hand sanitizer and visual poster guidance on good hand washing techniques.

4.7	Antiseptic wipes and appropriate disposal facilities in clinic areas as per local infection control guidance.
4.8	Appropriate plastic/Perspex screening if required in confined areas (e.g. workshop and reception area).
4.9	Patients who attend the clinic with symptoms – provide with a mask, isolate, and postpone.
4.10	Patients should only enter a clinic area when invited accompanied by only one carer/guardian if necessary (e.g. children and patients requiring support due to mental health issues).
4.11	Patients and carer to sanitise hands prior to entering clinic area.
4.12	Minimal use of waiting areas by patients. Patients with own transport should wait in their vehicles.
4.13	Prepare and sanitise clinic areas prior to and following each episode – factor additional time into the appointment slot for preparation and cleaning.
4.14	Clinicians to work with one patient at a time as opposed to multiple contacts.
4.15	Clinicians remain in clinic area with patient – consider allocating a runner to move between areas/pick up equipment as and when required – refer to local Infection Control team for local guidance.
4.16	Many Rehabilitation Medicine doctors and other members of the team cover other areas which could be Covid positive. In these cases, careful planning to ensure no contamination (e.g. attend the prosthetic clinic first, shower and change uniform/clothes before clinic).
4.17	Maintain social distancing in clinic areas – one patient per room unless space is available in larger centres sufficient for the safe treatment of additional patient/s.
4.18	When working at a distance of less than 2 metres use appropriate PPE.
4.19	Patients with MRSA, VRE to be seen at the end of the day or in a room that will not be used until Red clean has been completed.
5.0	**Personal Protective Equipment**
5.1	When treating patients at a distance of less than 2 metres use PPE (disposable gloves, apron, visors/goggles/surgical mask) in accordance with local NHS Trust policy and National Guidelines.
5.2	Do not wear PPE outside the clinic/treatment area - allocate a runner to move between areas/pick up equipment as and when required.
5.3	Dispose of gloves/aprons between jobs. Surgical mask use is episodic/sessional.
5.4	Refer to additional information listed in Appendix A, and local Trust policies.
5.5	Avoid using computers during consultation or use easy to wipe keyboard if necessary.
6.0	**Prosthetic & orthotic workshop**
6.1	Implementation of rota system/teams/split shifts in workshops where necessary/possible in order to maintain social distancing and safe working.
6.2	Plastic/Perspex screens fitted in confined areas.
6.3	Consider use of hospital scrubs if available or wash uniform daily.
6.4	Use of runner in larger centres to move across areas/departments.
6.5	Prosthetic/orthotic devices (including used PPAM-aid and Femurett) should be considered contaminated and treated as such (MHRA, 2015).
6.6	Ensure supply and use of appropriate PPE – dispose of gloves/aprons between jobs. Mask use is episodic/sessional.
6.7	One prosthetic/orthotic device per workspace to avoid cross-contamination.

6.8	Review workshop space, de-clutter, ventilation, installation of wipe down/easy to clean surfaces.
6.9	Apply cleaning rota/protocol of machines and tools.
6.10	Allocation of 'clean' area for devices awaiting collection/delivery.
6.11	Refer to comprehensive ISPO Covid-19 suggestions for P & O clinics (ISPO, 2020).
7.0	**Additional considerations**
7.1	Particular consideration required for vulnerable patients who have been shielding for a considerable time – identify, contact and provide appropriate support.
7.2	Staff not in a 'shielding' category but who feel they may be more vulnerable should be fully supported in the workplace with appropriate input from Occupational Health/HR as per local/company regulation and risk assessment procedures.
7.3	Staff adapting to new ways of working – support and encouragement required particularly with regard to the use of PPE and social distancing.
7.4	Consider staff support such as group reflection or confidential 1 to 1 if this is available. Staff need to be made aware of any support that may be available (see Appendix A).
7.5	Centres will need to decide internally with regard to how to inform patients of these changes, for example by way of an information sheet or letter describing changes to the service.
7.6	Local community Physiotherapy departments are shut/redeployed – barrier to progressing rehabilitation – Centres should alert community settings as services open up.

Appendix A

Further information, useful links

Health & Care Professions Council (HCPC)	https://www.hcpc-uk.org/
Government (Gov.uk)	https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention and-control
	https://www.gov.uk/guidance/working-safely-during-coronavirus-covid-19/offices-and-contact-centres
	https://digital.nhs.uk/coronavirus/shielded-patient-list)
The British Psychological Society	https://www.bps.org.uk/coronavirus-resources/professional

References

ISPO (2020). *Suggestions for Prosthetic Orthotic Clinics that Must Remain Open During the COVID-19 Pandemic (version 2). Working Document.* April 6, 2020. Available at: https://www.ispoint.org/page/COVID-19

MHRA (2015). *Managing Medical Devices Guidance for healthcare and social services organisations.* Available at: https://www.gov.uk/government/publications/managing-medical-devices pp. 43-47

NHS Digital (2020). *Coronavirus (COVID-19): Shielded patients list.* Available at: https://digital.nhs.uk/coronavirus/shielded-patient-list

Appendix B

Survey of Prosthetic Centres

The Inter Regional Prosthetic Audit Group (IRPAG+), undertook a snapshot questionnaire across prosthetic centres to identify service levels and alterations during the Covid-19 pandemic. Consideration was also given to identify any preparations underway to support the reimplementation service escalation at the appropriate time.

Eight centres responded and results disseminated. In summary all centres reported delivering an emergency service to support key workers, deal with breakages/repairs and intervention to prevent injury and deterioration. All centres are providing face-to-face appointments in emergency situations as well as a postal supply service. The majority of centres report undertaking remote video or telephone consultations.

Significant numbers of staff are re-deployed into other roles. Some are working from home and in three centres staff have been furloughed. Four centres introduced a staff rota system.

All centres but one have introduced a local protocol to support the current situation delivering an emergency service. Three centres report preparations are now being considered as to the re-implementation/escalation of services at the appropriate time.

There remains some activity with primary inpatients and protected pathways although this is restricted. There is no routine activity across all eight centres that responded and new referrals remain on hold.

Acknowledgements

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This is a working document and will be subject to review as the situation evolves over the coming months.

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