Coronavirus RCOphth update – need to know points

19th March 2020

**Please note the coronavirus situation changes rapidly. This is the most up to date advice we have at this time, please check the Gov.UK website: https://www.gov.uk/government/collections/coronavirus-covid-19-list-of-guidance and the RCOphth website for updated information https://www.rcophth.ac.uk/2020/03/covid-19-update-and-resources-for-ophthalmologists/*

Contents

1 Background

How is the virus transmitted?

As a new disease, transmission may not be full understood, but the following is believed to be the case currently. Coronaviruses are mainly transmitted by large respiratory droplets via coughing and sneezing and direct or indirect contact with infected secretions. It is potentially transmissible through contact with or aerosol droplets from tears of infected patients. Isolation, standard cleaning and disinfection combined with suitable personal protective equipment (PPE) directed to the correct patients are very effective in preventing transmission.

There is uncertainty over whether ophthalmologists, with close contact on slit lamps or other close up procedures, are at any increased risk compared with other health care professionals or whether there is any risk from drops/spray generated in intraocular procedures such as phacoemulsification, although the latter seems unlikely given experience with patients carrying hepatitis or HIV. For SARS-CoV, evidence suggests that use of both respirators and surgical face masks offer a similar level of protection, potentially reducing the risk of infection by up to 80%.

What to do

Liaise closely with your clinical lead for ophthalmology and infection control team to find out and follow national and local policy including the exact process for your eye clinic and hospital. The principles of action requested for all healthcare professionals by NHS leaders are as follows:

- Free-up the maximum possible inpatient and critical care capacity.
- Prepare for, and respond to, the anticipated large numbers of COVID-19 patients who will need respiratory support.
- Support staff, and maximise their availability.
- Play our part in the wider population measures newly announced by Government.
- Stress-test operational readiness.
- Remove routine burdens, so as to facilitate the above.

2 Actions you can take to reduce exposure to infected patients

Before arrival in clinic

Work with your clinical lead for ophthalmology and your hospital infection control (IC) team to ensure messages reach patients that, if they are at risk, they should assess their symptoms online through the NHS 111 online symptom checker, before attending their appointments or arriving at the hospital. This may involve website changes, communication in letters and text alerts, recorded messages on the hospital phone line, posters and admin staff at the front of the hospital or in reception, or proactively calling patients with appointments.

Detect at risk patients

Ask patients whether they have symptoms of coronavirus infection, particularly:

- fever
- acute onset persistent/continuous cough

but also

- hoarseness
- shortness of breath

- sore throat
- wheezing
- muscle pains.

You should also establish if the patient has or has had contact with a known or likely coronavirus infected person or it they have travelled to any at risk area. Follow the detailed guidance on case definition and risk and categorise as detailed by Public Health England. Also establish if they have an immediate sight threatening issue but do not let that delay any required isolation or sending the patient home.

Ensure that you have a suitable isolation room agreed with IC, and you know where it is, or use the nearest room and shut the door if necessary. Ensure you have a supply of PPE and understand how to use this including removal after use.

Dealing with each category

No known risk – see as normal, using scrupulous standard infection control as for any patient (eg hand hygiene, clean instruments). There is no known need for using face masks or gloves for every patient but discretion is to be used. Use normal surgical masks for specific situations or patients, especially prolonged slit lamp exposure time or patients with watery discharging eyes. Balance mask use with the possibility of supplies running low if the pandemic is prolonged.

Travel/contact but no symptoms – most hospitals are currently seeing as normal, using standard infection control as for any patient (e.g. hand hygiene, clean instruments).

Patients with clinical symptoms or travel and clinical symptoms with no immediate sight or life-threatening symptoms, should be isolated immediately in the hospital or ideally at home. The patient should follow government advice for isolation, they can use the NHS 111 online symptom checker or, if very unwell, call NHS111 and follow given advice. Advice on eye conditions can be given by leaflets or online for common conditions, and consultation and advice should be provided by telephone or video via the eye clinic where possible.

Patients with clinical symptoms or travel and clinical symptoms who have a probable immediate sight or life-threatening issue should be isolated immediately and follow local policy from your IC team, seeking advice from NHS111, or regional PHE or Health Protection team as required. The patient will need to be seen either by you or in another unit where the ophthalmic assessment and care can be delivered in a suitable isolation setting with specific PPE and infection control processes.

Table: PPE for patients who have or probably have Covid

Table 1: Transmission based precautions (TBPs): Personal protective equipment (PPE) for care of patients with pandemic COVID-19

	Entry to cohort area (only if necessary) no patient contact*	General ward *	High risk unit ICU/ITU/HDU	Aerosol generating procedures (any setting)
Disposable Gloves	No	Yes	Yes	Yes
Disposable Plastic Apron	No	Yes	Yes	No
Disposable Gown	No	No	No	Yes
Fluid-resistant (Type IIR) surgical mask (FRSM)	Yes	Yes	No	No
Filtering face piece (class 3) (FFP3) respirator	No	No	Yes	Yes
Disposable Eye protection	No	Risk assessment	Risk assessment (always if wearing an FFP3)	Yes

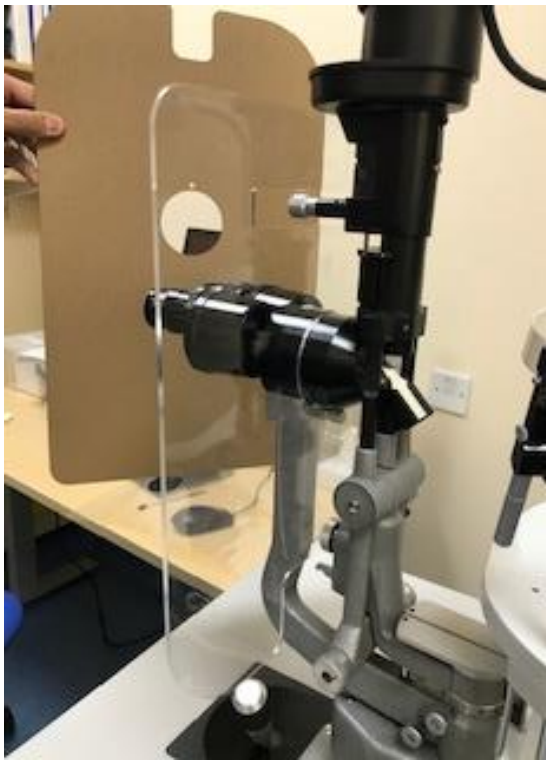
For all patients

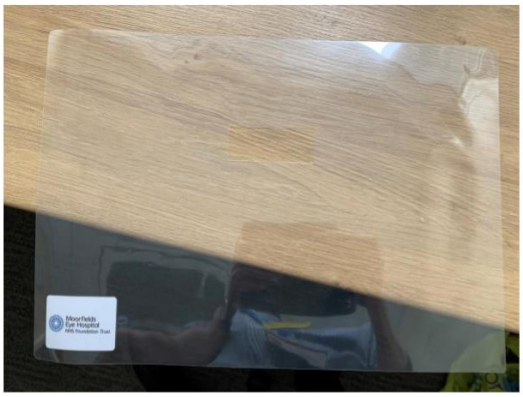
Please be extra scrupulous for all patients using exemplary infection control processes – know and follow your local ophthalmology infection control policy carefully.

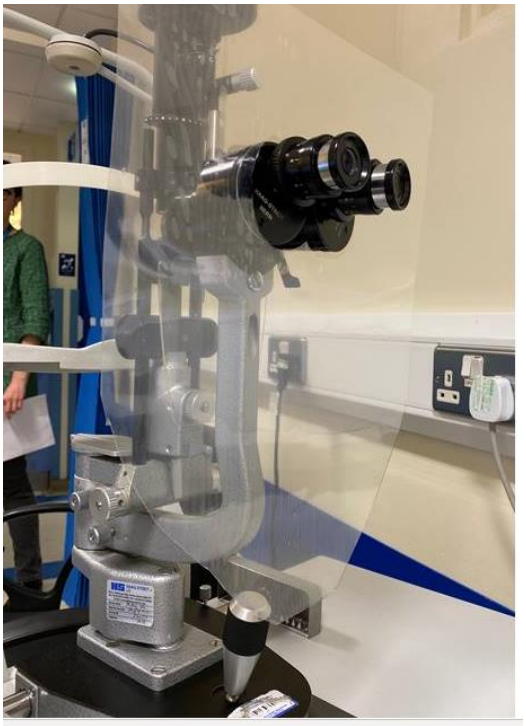
- Use good hand hygiene.
- Use good tissue practice - **CATCH IT, BIN IT and KILL IT** – cough/sneeze into a tissue, throw it away as soon as possible, wash your hands after coughing and sneezing as soon as possible.
- Support patients to use good tissue practice and hand hygiene.
- Ensure areas and equipment are regularly cleaned.
- Clean slit lamp before and after each patient, including the on/off switch and any controls used during the examination.
- Clean consulting room door handle.

Breathguards for slitlamps

Ophthalmology is not currently on the national list for high risk aerosol generating procedures or care BUT staff are concerned that there may be an increased risk because of the prolonged close contact on the slit lamp. Many units are trying to source large transparent plastic commercial slit lamp breathguards e.g. from Zeiss, Haag Streit and Star Optical. Some hospitals have fashioned makeshift breath guards from A4 acetate sheets (previously used on overhead projectors) or A3 or A4 laminator “pockets” from a stationary shop and also can be ordered via NHS Procurement. The latter can be passed through a laminator to fuse the two layers to create a thicker clear sheet. By cutting circles out near the top of the sheet one can place it around the slitlamp eye pieces and secure above or below, trimming the bottom to not get in the way. This makes a large transparent shield similar to but thinner than those commercially available. These homemade sheets will require regular cleaning with alcohol wipes between patients. In addition, some units have informed us they are able to source local businesses, DIY stores or even local school design and technology teams which can manufacture custom made breathguards to local specifications from perspex, which is more robust and can be properly cleaned and disinfected. Creating a cardboard template from them to work from has proved useful in some of these examples and Haag-Streit offers templates for slit lamps BQ 900, BP 900, BI 900 and BM 900 which can be found in the COVID-19 resources section on RCOphth website.







Reducing numbers seen or cutting elective care

The latest advice is that all non-urgent elective operations will be postponed from 15th April at the latest, for a period of at least three months. However you also have full local discretion to wind down elective activity over the next 30 days as you and the hospital see best, so as to free up staff for refresher training, beds for COVID patients, and theatres/recovery facilities for adaptation work. Emergency admissions, cancer treatment and other clinically urgent care should continue unaffected. Please work to reassure patients who actually need to come in for sight saving care that they will be as protected as possible from exposure.

You should urgently discharge all in-patients who are fit to leave. The government is taking action to increase social care support for those remaining in for social reasons. There are few such patients in ophthalmology but there may be some.

Hospitals and eye units need to rapidly draw up plans to reduce or cease some or most elective care including all non-urgent theatre and how to undertake urgent care safely. Make plans to prioritise care which is sight or life threatening and how to deliver care non face to face or defer appointments. Decisions on when to implement steps of your plan will be advised on at national level but with guidance from your local hospital leadership team. The College has adapted an escalation plan from Moorfields Eye Hospital that can be further adapted as required for local use.

For those who must attend, consider how to reduce on site waiting time and try to minimise close packed waiting areas, patient journey time and staff-patient contact time. Consider treatment changes that might reduce the frequency of required attendances for the next few months eg changes in intravitreal treatment regime or longer-acting drug.

Consider whether patients need a consultation at all, or whether other forms of consultation can suffice, such as telephone review or virtual clinics and make arrangements to deliver this. Low risk patients attending for minor eye conditions e.g. conjunctivitis in non-contact lens wearers should be proactively diverted with appropriate advice on self-management, the likelihood of spontaneous resolution and red flag symptoms. Note: currently there is no advice to treat conjunctivitis as a high-risk situation in the absence of other symptoms suggestive of coronavirus. We understand conjunctivitis is usually a later onset symptom and isolated conjunctivitis would be unlikely to be an early presenting feature of coronavirus. However, most conjunctivitis does not need to attend a hospital.

We are expecting national guidance soon which is likely to advise the suspension of diabetic eye screening except in high risk cases, such as pregnancy.

When undertaking surgery try to restrict general anaesthesia to cases where there is no other option but to use a general anaesthetic. If a patient is scheduled for elective non-urgent treatment which can only be done under general anaesthesia, then this treatment should be postponed.

Tips for reducing clinical contact time to reduce exposure

- Keep the examination brief and pertinent to the decision making required for the consultation
- Avoid where possible re-examination of patients who have already been assessed

- Try to establish as much of the medical and ophthalmic history, or investigation results, as possible before calling the patient into the room
- Limit the number of accompanying adults with the patient
- Consider whether a special test (visual field, OCT, ultrasound) is absolutely critical to your decision making
- Where possible avoid lengthy procedures at the slit lamp
- Use other investigations if they can provide the required clinical information and reduce the time of close contact e.g. at slit lamp or gonioscopy e.g. van herick, ret cam, optos, OCT, anterior segment cameras, ultrasound
- When testing visual acuity, start from the lowest achievable line to speed things up
- Where appropriate use an indirect ophthalmoscopy in preference to slit lamp examination
- Keep more than one meter away from patients except where clinical examination requires it.

For PRP and other prolonged slit lamp interventions

- Symptomatic patients should be deferred and seen in 2 weeks if symptom free.
- Those who should be self-isolating should be deferred. These patients will normally be out of self-isolation within 2 weeks. In theory, this could allow irreversible progression but is unlikely. For context, the National Diabetic Eye Screening Service (DESP) guidance expects laser treatments to start within 2 weeks of screening.
- Consider undertaking retinal laser procedures which cannot reasonably be deferred using an indirect ophthalmoscope delivery system rather than a slit lamp delivery system.
- Standard surgical mask for patient and doctor.

For immunosuppressed and vulnerable patients

Immunosuppressed patients needing to attend uveitis or inflammatory disease clinics are at high risk medically and review by telephone or video triage should be used in place of face-to-face attendance where clinically appropriate. Where this triage identifies vision loss or other very high risk situations, they should be invited to attend face to face with efforts to isolate them from other patients via a dedicated clinic area or time period. Try to arrange local blood test taking and remote monitoring for therapy, and make arrangements to continue supply of their medicines by registered post or local pharmacy. PHE guidance and advice on immunosuppressed patients is expected soon.

It is also important to formulate an action plan now to protect other vulnerable patients (pregnant, old and frail, serious systemic co-morbidities) in terms of deferring treatment or seeing away from other patients in crowded areas.

Staff

Make contingency plans with 1st, 2nd, 3rd tier teams to cover as staff go off, including for on call. Think how non clinical staff can be trained and used to support outpatient clinical care.

Consider segregating staff into teams with those dealing with covid + patients and those dealing with covid -ve patient, separated to segregate risks.

Colleagues who are at an increased risk (including pregnant women and those with underlying health conditions) should speak with their line manager in order to make adjustments to their working conditions, but with the aim of being able to continue to work such as working remotely or moving to a lower risk area.

Colleagues at risk of severe illness from Covid-19 (including people who have received an organ transplant and are taking immunosuppression medication and people with cancer undergoing chemotherapy or radiotherapy) should work remotely.
For more information, please visit the PHE website.

Over the next few weeks registered nurses and allied health professionals currently in non-patient facing roles may be asked to support direct clinical practice in the NHS, following appropriate local induction and support. The four UK chief medical officers have written to all UK doctors stressing that it will be appropriate and necessary for clinicians to work beyond their usual disciplinary boundaries and specialisms under these difficult circumstances, and they will support people who do so. Equivalent considerations apply for nurses, allied health professionals and other registered health professionals.

Refresher training for all clinical and patient-facing staff is planned to be provided within the next fortnight. A cross-specialty clinical group supported by the Royal Colleges is producing guidance to ensure learning from experience here and abroad is rapidly shared across the UK including: a short education package for the entire NHS workforce; a service guide, including for anaesthetics and critical care; COVID-19 clinical management guides in collaboration with NICE.

As extra coronavirus testing capability comes online, Public Health England is trying to establish as a matter of urgency NHS targeted staff testing for symptomatic staff who would otherwise need to self-isolate for 7 days. For those staff affected by PHE's 14 day household isolation policy, staff may be offered by their hospital - on an entirely voluntary basis - the alternative option of staying in NHS-reimbursed hotel accommodation.