# CONTINUED PREPARATION AND ADAPTATION OF WORKPLACE AND PRACTICE DURING COVID-19

Joint Council for Cosmetic Practitioners
Assuring Public Safety

*Supported by*

sk:n

# Contents

# 1.0 Introduction

## 1.1 Introduction

This revised guidance document builds on and updates the outcome of a co-ordinated effort undertaken earlier this year by the Joint Council of Cosmetic Practitioners (JCCP), with support from sk:n, to ensure, as far as is reasonably possible, best practice is adopted when working in pandemic conditions under Government approval. As always, safety of the patient, members of the public and the practitioner is central to our every consideration. There should be no compromises in safety for financial gain. This document does not make a suggestion of when face to face practice is appropriate, this must be in line with government advice. The document presents JCCP guidelines for consideration for use by cosmetic practitioners (and their staff), for which the core principles have been agreed by independent and expert opinion in the Cosmetic Practice Standards Authority (CPSA).

This guidance should be used by competent cosmetic practitioners to ensure that they comply with patient safety and public protection standards required by Government agencies and by UK statutory professional and voluntary registers.

The following issues are important in placing an understanding of this guidance document in context.

- The Coronavirus pandemic is an evolving and dynamic crisis. Therefore, this guidance will be updated accordingly, but should not supersede contemporaneous government or healthcare regulatory body advice.
- There is no policy or process identified which can consistently eliminate the risk of contracting or transmitting this virus.
- This guidance must be considered in addition to statutory obligations for Health and Safety in the workplace and your professional regulator.
- We advise practitioners, as ever, to avoid working in isolation, to seek supervision where appropriate and to keep up to date with ongoing developments, through their professional associations and networks.
- Please refer to our most current statements during Government or Local Authority imposed working or business restrictions for further context when reaching decisions in implementing this guidance. A most recent copy can be found here

The guidance included in this document relies upon the expertise provided by stakeholders in the non-surgical cosmetic industry, bringing together the work of Government and international reputable authorities. We are grateful for the shared experiences from the international community, some of whom are at different stages of their epidemic.

All branches of healthcare and public life will undoubtedly change as a result of the pandemic. As a sector we will need to develop and process a 'new normal' in order to better safeguard ourselves and our patients. This 'new normal' will not be apparent immediately. Accordingly, we will be expected to be versatile and innovative: without ever veering from best practice principles and patient safety imperatives.

The term 'patient' is used synonymously with the term 'client' throughout this guidance document to refer to members of the public who present for cosmetic treatment.

## 1.2 Document Purpose

We recognise the uncertainty that currently exists at this challenging time and reach out to you to encourage you to work as safely and responsibly as possible. We wish you to aim to return to work safely and to support you in minimising the risk of harm to both yourselves, your patients and to members of the public.

In the absence of definitive government and professional advice, these guidelines are designed to provide you with a range of basic principles to achieve a standard of safety within the limits of our shared current understanding. It is important to understand that this document is a guidance document, rather than presenting a 'standard' against which to benchmark and 'reset' your practice. As such we encourage practitioners and staff to continue to explore and to adopt government advice on how to practise lawfully, safely and responsibly. Therefore the guidelines presented within this document should not be regarded in isolation or as an alternative to other definitive advice offered by employers or by Government agencies to inform local decision making.

We cannot support a resumption of practice during a government-imposed lockdown period or advise on specific dates for reopening while a lockdown is in place and definitive end dates have not been provided. Government advice (and that provided by Professional Statutory Regulators) on resumption of practice should form *part* of the decision to reopen, alongside advice from your Insurer and evidence of your ability to implement an informed risk-assessed policy, and other material factors that may impinge on your capacity to perform safely and responsibly.

The JCCP and the CPSA will continue to work with UK Government agencies and with the scientific community to review, consider and disseminate advice to the aesthetic practitioner community in order to provide further appropriate and proportionate guidance on how to practise lawfully and safely during this dynamically changing time.

## 1.3 Return dates

Previously, the Department of Health and Social Care has further advised that it cannot provide comments on individual cases of whether or not a business is permitted to open. 'It is for each business to assess whether they are a business exempt from closing having considered the Regulations'. Additional information to assist interpretation of the Regulations by businesses can be found in the guidance. At this time, where businesses do remain open they are strongly advised to do so only where staff and customers can adhere to Guidelines on 'Working Safely During Corona Virus (Covid-19)'.

The JCCP understands that the obligation to cease practice in the UK under coronavirus legislation where the treatment is provided by registered healthcare clinicians for a medical or medically-related purpose is still an area of debate for some individuals working within aesthetic practice. So far, we have seen Government imposed lockdowns demand closures on many services deemed non-essential and close-contact ranging from personal care to sporting instruction and wherever these may arise again, for practitioners wishing to use this guidance with a view to resuming practice before the Government advises, you should be prepared to defend and confirm *both* the medical nature of the treatment *and* the need or urgency attached to it. Again our most recent statement regarding this should assist you come to determine whether you should continue to proceed with a treatment or to postponing the treatment [https://www.jccp.org.uk/NewsEvent/updated-jccp-statement-on-the-uk-governments-stages-of-lifting-lock-down-restrictions).

# 2.0 Standard precautions

## 2.1 COVID-19 transmission

The transmission of COVID-19 is thought to occur mainly through respiratory droplets generated by coughing and sneezing, and through contact with contaminated surfaces. The predominant modes of transmission are assumed to be droplet and contact. This is consistent with a recent review of modes of transmission of COVID-19 by the World Health Organization (WHO). It is important to note that this strain of coronavirus is highly contagious.

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/881489/COVID-19_Infection_prevention_and_control_guidance_complete.pdf

## 2.2 Hand hygiene

Hand hygiene is essential to reduce the transmission of infection. All staff and patients must decontaminate their hands by washing with antimicrobial soap and water for at least 20 seconds, taking care to systematically clean thoroughly especially under the finger nails and palmar creases as well as ensuring washing of the forearms.

Hand hygiene must be performed immediately before every episode of direct patient care and after any activity or contact that potentially results in hands becoming contaminated, including the removal of personal protective equipment (PPE), equipment decontamination and waste handling.

When managing the same patient between activities the practitioner can use an alcohol-based hand rub

Refer to 5 moments for hand hygiene.

https://www.who.int/infection-prevention/campaigns/clean-hands/5moments/en/

Before any clinical interaction practitioners should be 'bare below the elbows', All hand and wrist jewellery should be removed, barring a single band plain ring which should be navigated during hand hygiene moments.

Fingernails should be clean, short and free of artificial nails or adhesive nail products.

Breaks in skin should be covered with a transparent occlusive dressing.

## 2.3 Respiratory secretions and cough hygiene – 'Catch it, bin it, kill it'

Patients and staff should be encouraged to minimise potential COVID-19 transmission through good respiratory hygiene measures which are:

- Disposable, single-use tissues should be used to cover the nose and mouth when sneezing, coughing or wiping and blowing the nose – used tissues should be disposed of promptly in the nearest waste bin.
- Tissues, waste bins (lined and foot operated) and hand hygiene facilities should be available for patients and staff
- Hands should be cleaned (using soap and water if possible) after coughing, sneezing, using tissues or after any contact with respiratory secretions and contaminated objects.
- Encourage patients to keep hands away from the eyes, mouth and nose.

The best method to minimise transmission is to, where possible, avoid contact. Patients should be questioned prior to face to face contact as detailed below. However, should a patient attend clinic and

display symptoms they should be candidly questioned and in cases of a new cough, fever, myalgia or recent infection must be asked to reschedule and promptly requested to leave the site.

Should you be in a situation where you believe that a suspected COVID-19 +ve patient has been in the clinical area you must:

- Immediately stop all activity.
- Ensure no other patients are admitted to the waiting room.
- Doors should be kept closed with windows open to improve airflow and ventilation.
- Use disposable cloths/papers/mop attachments and either a combined detergent disinfectant solution at a dilution of 1000 parts per mission (ppm) available chlorine (av.cl) or a neutral purpose detergent followed by disinfection (1000ppm av.cl)
- Dispose of all cleaning cloths/wipes as well as all waste associated with suspected positive patient into a waste bag. If clinical waste is collected at your facility ensure it is disposed of in the clinical waste; if this is not possible seal the bag tightly in another bag and store for 72 hours and dispose of in the standard waste, ensuring adequate PPE and hygiene before and after contact.

### 2.4 Clothing

We advise the use of a simple uniform which is put on at your practice and removed at the end of the day. On removal it should be placed in a laundry bag alone and washed at 60°C. This should not be worn to and from work and should be washed on a daily basis.

## 3.0 Triage

### 3.1 Triage

The following questions should be asked and documented before booking any patient for a face to face appointment.

- Are you currently suspected of having COVID-19
- Have you been in contact with or are living with someone suspected or confirmed of having Covid-19?
- Do you have a fever, or have you had a high temperature in the last 14 days (a fever is a temperature greater than 37.8°c?
- Have you had a loss of or change in your normal sense of smell?
- Have you had a cough or any other respiratory signs in the last 14 days?
- Do you suffer from any of the following? Diabetes, cardiovascular disease, including hypertension, chronic lung disease, immunodeficiency, cancer under active treatment?
- Are you pregnant?
- Are you over 70 years of age?

https://www.nhs.uk/conditions/coronavirus-covid-19/people-at-higher-risk-from-coronavirus/whos-at-higher-risk-from-coronavirus/

In the event that the patient successfully triages, they must be given the following instructions either via phone or email.

- Attend your appointment unaccompanied.
- Upon arrival, you must wash your hands.
- Please limit the wearing of jewellery. Wedding rings may be worn provided hands are kept clear from the face. Minimal make-up should be worn.

- Please limit the personal possessions you bring with you. The clinic may reserve the right to prevent personal items entering the treatment rooms.
- When the treatment is complete, you must wash your hands once more.
- Follow the markings in the waiting area and clinic to ensure 2 metres distancing at all times, except when undergoing treatment.

### 3.2 Bookings and payment

We urge clinics to accept payment by card only, or contactless payment for example by phone, reducing contact wherever possible and cleaning card machines after use where necessary. If for any reason payment by cash is unavoidable, additional precautions, including hand washing, must be taken.

Appointments must be by prior arrangement only. Signage should be placed on the front door to inform patients that the clinic runs on an appointment only system with a controlled entry policy.

Patients may be provided with surgical face masks and overshoes to don upon entry and after washing hands.

### 3.3 Temperature screening

Temperature screening is not believed to be an effective method of limiting transmission due to possible lack of symptoms, incubation period and possible use of anti-pyretics.

https://www.who.int/news-room/articles-detail/updated-who-recommendations-for-international-traffic-in-relation-to-covid-19-outbreak#:~:text=Temperature%20screening%20alone%2C%20at,tracing%20of%20incoming%20travellers.

The triage process referred to above is likely to preclude patients attending with an elevated temperature (pyrexia). However, risk assessment in the light of further medical history taking or the detection of overt symptoms may indicate the need to confirm the patient's temperature; in this situation the appointment should be cancelled or rescheduled.

However, some organisations may wish to implement temperature screening as a matter of routine and practitioners should be compliant with such a policy.

## 4.0 Reception Areas

A demarcation line 2 metres should be placed in front of the reception desk to show the limit of incursion that a patient may advance to. Inside of this reception area should become known as "clean".

To maximise social distancing, staff should limit the number of patients in the reception area at any time. Provision must be made to ensure 2metre distancing at all times.

Patients should attend treatments alone.

The time spent in the clinic should be minimised as much as possible. Minimal waiting area chairs should be provided. Employing video consultation to avoid multiple attendances and using a text or call system to allow patients to wait off site are encouraged. If there is a queue patients should be sent away and recalled. Booking times should be planned to avoid queuing.

Windows should be opened wherever possible.

Hand sanitiser must be made available in the waiting area, but not on the reception counter, as this will encourage breaking the 2 metre distancing rule.

The treatment staff should not be permitted to pass through to the “clean” area. Reception staff should only pass into the “clean” area once they have cleaned their hands.

There should be no point of sale items, displays, magazines or brochures available in the waiting area. Coronavirus has been shown to be active on paper and cardboard for 24 hours. Brochures should be made available only in the “clean” area and these will be passed to the patient on a needs basis to take home.

Reception areas should be maintained as paper free wherever possible.

Surfaces should be decontaminated after each patient passes through the waiting area.

## 5.0 Staff

**Staff are classified into two types for the purposes of this guidance document:**

Employees who work mainly in the reception area and not involved with direct patient care and secondly, employees that are in direct contact with patients.

Staff should take regular breaks and rest periods.

### 5.1 People that are not involved in direct patient care.

Regular cleaning of keyboards, phones and other frequently used items using cleaning solutions designated in section 8.4 will be required. A sufficient supply of cleaning products should be made available.

As teamwork and environmental awareness is highly important, the receptionist should be designated as the principal ‘rule enforcer’ of the new safety ‘regime’.

As each patient leaves the clinic, reception staff must leave the reception area, and clean the seating area with an appropriate product (section 8.4) and then return immediately to the reception area, and clean their hands.

**Hand washing definition:** hand hygiene measures should be undertaken with soap and water. This is the most important measure to reduce the risks of transmission and must be carried out frequently (before putting on gloves, after removing gloves, and after each contact with the patient whether or not gloves have been used). Normal liquid soap will be used for hygienic washing for over 20 seconds each time. Hands must be dried with disposable towels. Another option is to use hand sanitiser, but it is not as a substitute for frequent hand washing. Practitioners should avoid touching their faces.

If reception staff are at risk of not maintaining 2 metre distancing, they should wear a surgical mask and consider eye protection at all times.

### 5.2 Staff working directly with patients

The wearing of jewellery, nail polish and other non-essential accessories should be minimized.

Uniforms must not be worn on the journey in to or from work.

On a daily basis, employees should carry their uniform and shoes in a disposable bag. Allowing for the two-metre distancing rule, uniform should be changed into on site in a designated changing room. Handbags and personal possessions such as phone/iPad etc. should be safely stored in a locker or other safe place.

Procedure-appropriate PPE should be donned prior to the treatment. Staff should avoid returning to the changing place, except to change out of your uniform at the end of the day.

At the end of the shift, staff should wash their hands thoroughly and place their uniform and shoes into a designated storage bag. Uniforms should be washed on a daily basis separately from other household linen at a temperature exceeding 60°C.

## 6.0 Personal Protective Equipment

Certain procedures convey a higher risk of transmission. For example, aerosol generating procedures (AGPs) present risk of aerosolised transmission. This guidance therefore seeks to set out clear and actionable recommendations on the use of PPE, as part of safe systems of working. Incidence of COVID-19 varies across the UK and risk is not uniform.

### 6.1 Training

Staff should be trained on 'donning and doffing' PPE. Videos are available to demonstrate how to 'don and doff' PPE for AGPs and how to 'don and doff' PPE for non-AGPs.
https://www.gov.uk/government/publications/covid-19-personal-protective-equipment-use-for-aerosol-generating-procedures

https://www.gov.uk/government/publications/covid-19-personal-protective-equipment-use-for-non-aerosol-generating-procedures

Staff should know what items and type of PPE they should wear for each setting, procedure and context. As such all staff should have access to the safest, recommended form of PPE that protects them for the appropriate setting, procedure and context.

Gloves and aprons are subject to single use, with disposal after each patient.

Fluid repellent surgical masks and eye protection can be used for sessional use that do not involve aerosol generating procedures, at the discretion of the practitioner. Practitioners should note that any soiling or risk of exposure will change this.

Gowns or coveralls should be worn for any higher risk treatment. FFP3 masks should be worn form AGPs on a single use basis.

Hand hygiene should be practised and extended to exposed forearms, after removing all PPE items.

### 6.2 Plume generating procedures: laser and ablative plasma.

It is well known that plume from these procedures can contain toxic substances, including viruses. We therefore recommend that all procedures which create a plume should be undertaken in line with recommendations for aerosol generating procedures, including relevant use of PPE.

Practitioners are recommended to undertake patient/treatment specific risk assessment which takes into account such factors as:

- The extent of plume
- The use of mechanical ventilation for extraction.
- Treatment length
- Any additional risk factor identified

Practitioners should consider extended time periods for room ventilation prior to use by another patient.

https://www.bmla.co.uk/clinical-guidance-for-laser-procedures-during-the-covid-19-pandemic/

https://www.schuco.co.uk/surgical-smoke-plume/

Practitioners are encouraged to follow-up more detailed guidance which will be forthcoming from laser specific organisations such as BMLA. Further, they should consider the option of avoiding all higher risk, plume generating procedures until such guidance becomes available.

Practitioners are further reminded of their obligations towards their organisational policies in the first instance. Where there may be a variance between these guidelines and those of the employing organisation, the practitioner should discuss such matters with their organisation and ensure that they comply fully with their employer's legal and contractual responsibilities.

June update:

For laser related treatments the BMLA has updated its guidance:
https://www.bmla.co.uk/category/standards-and-guidance/

## 6.3 Procurement, supply and risk assessment

EN 149 is the European standard required to ensure respirator face masks meet conformity requirements. Due to supply problems of PPE, it is possible that practitioners are unable to obtain the required type of mask, or that the relevant mask is not specified with the required conformity. The government has made urgent arrangements to obtain PPE which maintains conformity but obviates the need for EN assessment and CE labelling.

(https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/879498/Guidance-for-businesses-ppe-regulations-version-2.pdf)

Therefore, when purchasing or using face masks, the following should be taken into consideration.

- *It is imperative that PPE, including face masks, is purchased from a reputable supplier. It is the responsibility of the distributor to ascertain that appropriate conformity is in place.*
- 'FFP' is a European statement of efficiency according to the EN149 standard. In obtaining facemasks, practitioners may be presented with a range of different international 'standards' and it will be necessary that they become familiar with these. As a working guide, 'FFP2' (95% efficiency at filtering to 0.3 microns) is approximately equivalent to the Chinese 'KN95' and the American 'N95' standards.

https://www.hse.gov.uk/news/assets/docs/face-mask-equivalence-aprons-gown-eye-protection.pdf

We recommend that practitioners perform a visual inspection of face masks/visors prior to use, to include:

- General integrity –
    - Straps– ensure they are present and intact
    - Face seal– visual check to ensure the seal is undamaged
    - Nose clip (if applicable) – must be present and intact
- Filtering material – ensure there are no visible defects
- Finish of parts – inspect to ensure there are no sharp or jagged edges
- Valve (if applicable) – present and intact

(https://www.hse.gov.uk/research/rrpdf/rr1087.pdf)

## 6.4 Treatment specific Risk assessment and access to appropriate Personal Protective Equipment.

This guidance document recommends the use of FFP 2 non-valve respirators for general use by practitioners within their practice, since these masks provide protection to the wearer *and* limit the spread of droplet infection, protecting the patient. Please see Appendix 1 for various mask types and uses.

All patients should be viewed as being 'potentially' Covid-19 positive. Of equal importance is the need to regard perioral treatments, lip fillers and intraoral treatments such as dental blocks as high risk and requiring the use of face shields, fluid repellent coveralls and 'FFP 3' face masks. We do not recommend that practitioners should routinely perform these elective procedures. Rather, we recommend that practitioners should undertake a risk assessment before proceeding to undertake any aesthetic procedure which considers factors such as relative need, urgency of treatment response, application of clinical judgement with regard to medical need against 'weighed' risk.

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/881489/COVID-19_Infection_prevention_and_control_guidance_complete.pdf

It must be remembered that face mask use is only one pillar supporting the defence against Covid 19, and that gowns and gloves, eye protection, distancing and modified behavioural responses are equally important.

Disposable coveralls may be used in place of gowns.

https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/04/C0284-ppe-gowns-letter-qa-sa.pdf

## 6.5 Fit testing.

The stated clearance of respirator masks (and thus their safety) only applies where there is an effective seal around the face. In the absence of formal policies and procedures for 'fit testing' arrangements, the wearer must apply additional caution in ensuring an adequate seal is in place. For those who wear glasses, they should not steam up when wearing a mask. Facial hair may compromise the seal. Please see page 62 of the following guidance document:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/881489/COVID-19_Infection_prevention_and_control_guidance_complete.pdf

Under Health & Safety (COSHH) regulations, fit testing is a legal requirement for employers where the treatment necessitates the use of a FFP mask, including for use during the Covid-19 pandemic.

The resources below provide valuable guidance and JCCP recommend that employers review their requirements for 'qualitative' fit testing through a competent person.

https://www.hse.gov.uk/respiratory-protective-equipment/fit-testing-basics.htm
Guidance on RPE fit testing. HSE.
RPE at work. HSE
https://www.rcn.org.uk/magazines/bulletin/2020/june/fit-test-vs-fit-check-covid-19

## 6.6 Sessional use of PPE

Aprons and gloves are subject to single use as per Standard Infection Control Precautions (SICPs), with disposal and hand hygiene after each patient contact. Respirators, fluid-resistant (Type IIR) surgical masks (FRSM), eye protection and disposable fluid repellent coveralls or long-sleeved disposable fluid repellent gowns can be subject to single sessional use in circumstances outlined in section 6.1.

A single session refers to a period of time where a practitioner is undertaking duties in a specific clinical care setting or exposure environment. Once the PPE has been removed it should be disposed of safely. The duration of a single session will vary depending on the clinical activity being undertaken.

PPE should not be subject to continued use if damaged, soiled, compromised, and uncomfortable and a session should be ended. While the duration of a session is not specified here, the duration of use of PPE items should not exceed manufacturer instructions. Appropriateness of single versus sessional use is dependent on the nature of the task or activity being undertaken and the local context.

**Eye protection/face Visor disinfection**

Eye protection and lenses or face visor, where reusable, must be disinfected between patients; to do this use solutions in section 8.4 or consider proprietary brands: Use 2 Clinell® wipes or first with detergent and warm water and then solution of Sodium chlorine 1000ppm i.e. Actichlor® or Presept®.

## 6.7 Donning and Doffing

Please refer to the Public Health Guidance - Guide to 'donning and doffing' standard Personal Protective Equipment (PPE). All staff should complete the 'donning and doffing' training before commencing work in the clinic.

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/877658/Quick_guide_to_donning_doffing_standard_PPE_health_and_social_care_poster__.pdf

## 6.8 Disposal of PPE

All used PPE should be deposited in an appropriate waste bin with a hard cover and pedal opening. All waste should be collected and disposed of in marked clinical waste bins. Should this not be available, waste must be stored for 72 hours in two sealed waste disposal bags prior to disposal.

# 7.0 Cleaning and Waste Management

Staff should receive training and information on the proper cleaning methods required.

A thorough cleaning and disinfection of surfaces and areas of contact with the patient should be carried out after every procedure.

Staff should inform the patient of the disinfection of the treatment room between patients and to explain the cleaning procedure to the patient for their own piece of mind.

## 7.1 Equipment

Equipment should be single-use items if possible.

Reusable, non-invasive equipment must be decontaminated:

• between each patient and after patient use

• after blood and body fluid contamination

• at regular intervals as part of equipment cleaning

## 7.2 Cleaning in common zones:

At the end of the working day, all common areas should be subjected to a thorough cleaning and disinfection regime. This should be carried out with either:

A combined detergent disinfectant solution at a dilution of 1000 parts per million (ppm) available chlorine (av.cl.)
Or
A neutral purpose detergent followed by disinfection (1000ppm av.cl.)

All door and window knobs, possible handrails, tables, armrests for chairs and armchairs, switches, telephones, should be cleaned and disinfected, Follow manufacturer's instructions for dilution, application and contact times for all detergents and disinfectants.

For items that cannot withstand chlorine-releasing agents, consult the manufacturer's instructions for a suitable alternative to use following, or combined with, detergent cleaning.

## 7.3 Cleaning in treatment rooms:

All surfaces including work surfaces and treatment couch must be wiped down with a cleaning solution (section 5.4) at the end of every treatment.

Cleaning at the end of sessions should be carried out as per 7.2

## 7.4 Room ventilation

Clearance of infectious particles is dependent on the mechanical/natural ventilation within the room. A single air change is estimated to remove 63% of airborne contaminants; after 5 air changes, less than 1% of airborne contamination is thought to remain.

More detailed information can be found at section 4.14, page 24, of the following guidance link.

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/881489/COVID-19_Infection_prevention_and_control_guidance_complete.pdf

We understand that most clinics and practitioners will not have access to determining the air change rate within their clinical environment. However, practitioners should understand the principle that it is reasonable to recommend an extended period at the end of each treatment session to allow for room ventilation and air exchange. Doors should be kept shut at this time, but windows should be opened to aid the exchange rate.

Staff should avoid the use of fans that re-circulate the air.

## 7.5 Cleaning solutions

The SARS-Cov-2 virus is contained within a lipid envelope and therefore is susceptible to inactivation with detergents.

Evidence recommends the use of alcohol solutions at 70% or sodium hypochlorite solutions at 0.1%. Sodium hypochlorite 0.1% may be obtained by diluting household bleach, which is typically at concentrations of 5%. Therefore, a solution of 1:50 will provide 0.1%. However, you should confirm the initial concentration of the product as it may vary across brands.

Chlorhexidine has been found to be less effective in inactivating the virus.

https://www.ncbi.nlm.nih.gov/pubmed/32035997

https://www.aop.org.uk/coronavirus-updates/coronavirus-how-to-disinfect-optical-equipment-and-premises

If alternative products are used, it is recommended that practitioners should refer to manufacturer advice on the suitability for use of the product as a lipid enveloped virucide, to the EN 14476 standard.

## 8.0 Audit

A cleaning timetable with named responsible staff member should be maintained for each clinic area.

A self-assessment audit should be completed on a monthly basis to ensure the clinic is adhering to the stated policy, to confirm that the policy is effective and responsive to changing demands and new advice provided by government agencies. Practitioners should engage in a process of continuous quality improvement to enhance public protection and patient safety standards.

## 9.0 Other Considerations

### 9.1 Consent

In addition to treatment specific consent, the practitioner must ensure that the patient has a complete and informed understanding of the potential impact that Covid 19 might have upon the treatment. This will allow the practitioner and patient to reach a mutual agreement in 'weighing up' risks and benefits in order to achieve and inform valid consent.

It is important that the patient understands the rationale for the various measures that need to be taken, both by practitioner and patient, to minimise risk. This relates to both peri and post-procedural care and will further enable the patient/patient to take a broader and more informed approach to future decision making in relation to their health and wellbeing.

There is increasing evidence that dermal fillers given in the presence of a recent viral infection (or where a virus is caught after treatment) can increase the risk of delayed hypersensitivity reactions. This should be reflected in medical history taking and must form part of the patients understanding and consent. Furthermore, the practitioner must make allowance for this possibility in terms of post-procedural care, particularly in the event of future lockdowns.

https://www.dovepress.com/delayed-hypersensitivity-reaction-to-hyaluronic-acid-dermal-filler-fol-peer-reviewed-fulltext-article-CCID

It is particularly important that members of the public understand that these measures cannot completely remove all risk in relation to Covid-19. As such members of the public must be provided with sufficient time to consider this fact prior to consenting and receiving treatment.

## 9.2 Education

These requirements imposed on the patient will undoubtedly be unfamiliar to them and there is the possibility, in some instances, of challenge or lack of concordance. We recommend therefore that every effort is made to achieve informed understanding in advance of clinic attendance. Useful measures may include:

- Providing detailed guidance on websites and directing patients to this
- Providing individual instructions with each appointment made e.g. through email.

Patient guidance should consider 'what to expect' when viewed from the patient's perspective. It should be written in layman's terms and supported with rationale to aid understanding and acceptance. Only through education and understanding can compliance be fully achieved, thereby reducing treatment risk in the first instance and optimising wellbeing in the longer term.

## 9.3 Skin preparation

No changes are required in the use of preparatory skin cleaning, assuming this is usually performed with solutions containing ethyl alcohol, or a hypochlorite solution such as Clinisept®. There is evidence that clorhexidine is less effective in the removal of SARS-Cov-2.

https://www.ncbi.nlm.nih.gov/pubmed/32035997

## 9.4 Testing & vaccinations

We cannot currently make definitive recommendations for routine antigen/antibody testing for CoV-SARS-2. We do advise however that wherever practicable and possible, practitioners should avail themselves of 'testing' opportunities to provide both themselves and members of the public with the assurance required to proceed safely with the administration of treatment. As government guidance and testing availability develops, we will review this policy for future versions of this guidance.

The purpose of testing is to confirm that the practitioner does not have the CovSARS2 virus and thereby limits the risk of transmitting Covid-19. In view of this the following factors should be considered:

- The test is a snapshot in time and in any event is not 100% accurate. You should consider taking the test at regular intervals.
- Antibody (blood) tests confirm a past infection. Given uncertainty regarding immunity, the test may not indicate the absence of the CovSARS2 virus and therefore the risk of transmitting it.
- You should review government advice on testing and confirm any test has government approval, including a CE mark.

We also wish to draw your attention to the potential risks that have been identified for patients who wish to receive dermal fillers and who have had, or intend to have, Coronavirus vaccination. Appendix 2 provides a detailed peer reviewed analysis and guidance to enable practitioners to manage this situation. The JCCP recommend that patient assessment should include relevant vaccination history and that the patient must consent to treatment in light of a full understanding of these facts. We further ask that practitioners take an active and professional approach to advising patients with regard to vaccinations during the pandemic, and not permit cosmetic interests to supersede patient best interests, safety and public health.

## 9.5 Time management

It is recommended that practitioners increase appointment length and reduce patient contact time. This will allow additional time for room cleansing and ventilation after each treatment episode, limit unnecessary exposure time and reduce the risk of human error in a stressful environment. Where lengthy treatments are proposed, a risk assessment should be performed.

Clinic owners should consider adjusting their opening times to allow for changes in demand and increased time needed to implement these polices. Staff may be required to be more flexible in their working times to meet these demands.

## 9.6 Risk assessment

We highlight the necessity of ***risk assessment*** throughout this guidance. In general terms, all practitioners should consider ***the need to perform a risk assessment as it relates to products, to premises and to self-management***.

The following further considerations relate to risk assessment of premises:

For commercial premises that operate with a shared reception area, this should form an additional part of the risk assessment which must be conducted in co-operation with other premises users or responsible persons.

There is no risk assessment that can demonstrate fully the safety of mobile practice which involves treating patients in their own homes. The JCCP can therefore not support mobile practice. Where a practitioner works from several different premises, a risk assessment must be performed for each. However, a risk assessment could not conclude the safety of arrangements where there are multiple practice venues in different geographical locations and again the JCCP would not support this practice. We would also remind practitioners that where they provide clinical supervision (including prescribing services) for practitioners in wider geographical locations, that they have a duty of care in attending to these patients and therefore this practice cannot be supported by the JCCP.

## 9.7 Patient confidentiality and GDPR

With Covid-19 restrictions in place, JCCP are aware of the increased need for the use of technology, including social media, for remote discussions with or about patients. The JCCP reminds practitioners of their professional obligation towards patient confidentiality and the legal requirements of GDPR. Online group discussions, particularly on social media, including 'closed' groups are likely to breach these requirements. Practitioners are therefore advised to consider carefully how they maintain confidentiality when using online technology.

## 9.8 'Test and Trace'.

Practitioners will be aware of their requirements for record keeping. In addition, the Government requests that customer information is kept for a period of 21 days, should it be required for the purposes of 'Test and Trace'. JCCP would advise that practitioners maintain records in such a way that this information is readily available if requested.

Further, whilst it is not currently a legal obligation to provide the requested information for NHS 'Test and Trace' services, JCCP would ask its members to comply fully with any such request should, it be made.

Practitioners, whether employers, employees or self-employed, should also be familiar with the wider workplace guidance of the NHS 'Test and Trace' scheme.

## 9.9 Additional resources

**ISCAS**

For useful patient FAQ's.

https://www.cedr.com/app/uploads/2020/05/COVID19-ISCAS-FAQs-Reopening-26May20.pdf

**HIS**

The following guide provides useful important information for clinics in Scotland and additional links useful nationally.

COVID-19 - Guidance for reopening independent healthcare services in Scotland

For helpful further reading, it may also be useful to review the decision-making process used by the CQC to determine if a procedure should be registered as medical for treatment of disease, disorder or injury in terms of

- The defined primary medical benefit
- The person performing the treatment
- The skills required to perform the treatment that are peculiar *only* to that person's professional qualification.

The principle in the example below can apply to other non-laser interventions. Please see:

**'Service specific guidance. Lasers and IPL' at**

https://www.cqc.org.uk/guidance-providers/registration/treatment-disease-disorder-or-injury

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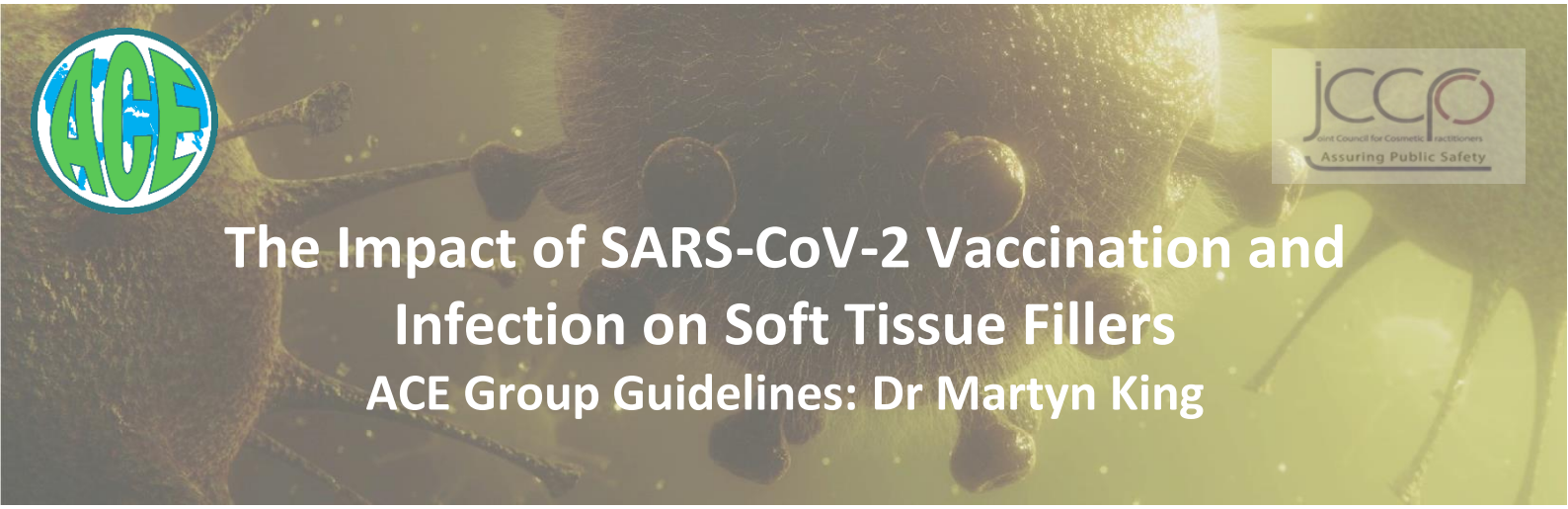
## Appendix 1. Mask types and uses.

**Different types of Mask**

Classification and protection type.

| Equipment | Type | | Protection for wearer | Protection against transmission to limit spread | Properties |
|---|---|---|---|---|---|
| Disposable self-filtering masks | FFP 1 without exhalation valve |  | ✗ | ✓ | • Protective with minimal filtration.<br>• No protection against infctious organisms.<br>• Limits the spread of infection |
| To Standard EN 149 | FFP 2 without exhalation valve |  | ✓ | ✓ | • Protects against *and* limits spread of infection. |
|  Reusable ones have an 'R' | FFP 3 with exhalation valve |  | ✓ | ✗ | • All FFP3 face masks have an exhalation valve.<br>• Protects wearer but does not limit spread. |
|  Non-reusable masks show 'NR' and may be used for a single shift. | FFP 2 with exhalation valve |  | ✓ | ✗ | • Protects against but does not limit the spread of infection |
| Surgical and homemade face-masks. | Disposable surgical masks |  | ✗ | ✓ | • Not protective equipment.<br>• Does not protect against but may help limit spread of infections. |
| | Disposable hygienic masks |  | ✗ | ? | • Not protective equipment.<br>• Does not protect against but may help limit spread of infections.<br>• Efficiency not tested |
| Industrial masks | Buconasal half mask with filter. |  | ✓ | ✗ | • All masks have exhalation valves.<br>• Protects against but does not limit the spread of infection<br>• Reusable |

Appendix 2. ACE Guidelines on SARS-CoV-2 Vaccination and Soft Tissue Fillers.



# The Impact of SARS-CoV-2 Vaccination and Infection on Soft Tissue Fillers

## ACE Group Guidelines: Dr Martyn King

## Introduction

Despite the current low number of reported cases, reactions caused by mRNA vaccinations to SARS-CoV-2 in patients with pre-existing filler is a cause of concern to all aesthetic practitioners. It is well established in the literature, that Delayed Onset Nodules (DONs) or Delayed Onset Reactions (DORs) can occur weeks, months or even years after receiving a soft tissue filler treatment when the immune system is challenged. Potential triggers include viral illnesses[1], bacterial infections (most commonly sinus, ear, or dental infections), dental procedures[2], excessive UV exposure, subsequent minimally invasive aesthetic treatments, and vaccinations[3]. mRNA vaccinations are known to be highly immunogenic[4] by increasing protein translation and modulating innate and adaptive immunogenicity, so it is no surprise that they are also capable of activating an immune response in foreign body implants. However, a study of 106 participants from 18 different countries concluded that COVID-19 vaccines did not appear to confer a greater risk of a soft tissue reaction than other identified triggers[5].

Similarly, acute infection with COVID-19 can also profoundly stimulate the immune system and create a DON or a DOR in a patient who has previously undergone a filler treatment. Current case studies suggest that these reactions are more protracted and can be more difficult to resolve.

Regarding soft tissue swelling following COVID19 vaccination, this is not unique to these vaccines and similar reactions can occur to many different vaccinations[6]. However, the cohort of patients that regularly receive vaccinations, such as the annual influenza vaccine, are generally different to the cohort of patients that undergo soft tissue filler procedures and as the COVID-19 vaccination is currently targeting the entire adult population, the incidence of soft tissue filler reactions is likely to rise.

## Mechanism

It is known that the spike protein of SARS-CoV2 enters cells by binding and blockade of the angiotensin 2 receptors (ACE2) thus creating a pro-inflammatory response and a proliferation of T cells. A study by Li et al (2020)[7] demonstrated that the skin has moderately high levels of ACE2 proteins in the basal layer of the epidermis and also lining the vasculature which may provide the mechanism to why soft tissue fillers may react in an adverse manner. It is also known that delayed hypersensitivity reactions tend to be T cell mediated rather than due to a B cell antibody response[1].

## Incidence

There are currently few published cases that demonstrate a DON or a DOR following either the COVID-19 vaccination or infection. Although due to lockdown restrictions and the current global vaccination programme, these numbers are expected to rise once the number of procedures performed escalate to prepandemic levels. It is essential that all practitioners are mindful of this risk, consent their patients appropriately, risk assess their patients, carefully time their treatments around their expected vaccination date and are knowledgeable on how and when to intervene if a complication does occur.

## Signs and Symptoms

An international consensus group described delayed inflammatory reactions manifesting as discolouration (mostly erythema), painful nodules, induration, tissue hardening and solid oedema[8]. Munavalli et al (2021)[9] who reported on 4 specific cases relevant to this topic included symptoms of significant swelling, burning sensation of the lips, erythema, and tenderness. The oedema appeared to coincide with areas of previous filler injections in all cases.

## Areas of caution

Although the data is currently extremely limited, the provisional evidence would suggest that the tear trough, malar and perioral regions are most susceptible to DORs[9] following COVID-19 infection or vaccination, but this may just represent the greater frequency that these areas are treated. However, patients that have had lip filler or tear trough treatments in the last 6-12 months should be considered at a higher risk.

## Minimising the risk

Before performing any soft tissue filler treatment, the practitioner must take a full medical history, including previous and recent COVID-19 infection and vaccination schedule. Soft tissue filler augmentation is an elective procedure performed by aesthetic practitioners and, as such, should not interfere with patients who are scheduled to undergo SARS-CoV-2 vaccination[3].

The data from the Moderna vaccine trial highlighted two cases of facial swelling and one case of angioderma in patients who had previously had soft tissue fillers in these areas. One had treatment within 2 weeks, one within 6 months and one unreported. Given the study population of 15,184 patients and the incidence of facial filler treatments, it is likely that a significant number of these patients would have had treatment within the last 12 months. For this reason, the ACE Group considers the reaction within 2 weeks of receiving treatment to be significant. Although current evidence is limited, the ACE Group recommend that soft tissue filler augmentation should not be performed on any patient who is due to receive a mRNA vaccination within 2 weeks following treatment. At the time of writing, there are no documented cases of DONs or DORs with the non-replicating adenovirus vaccination that is used for the Oxford/AstraZeneca COVID-19 vaccination but would also advice caution and allow a timescale of 2 weeks prior to vaccination for performing soft tissue augmentation.

From studies on other vaccinations, it is known that the immune response from administration to developing an antibody response that the first 3 weeks are pivotal, and this is when the immune system is most stimulated. Data from Israel in a population of 500,000 has provided further evidence. Following the Pfizer vaccine, immunity within the first 2 weeks of administration remained almost at zero but then rose to about 90% at 3 weeks and then did not rise any further[10]. For this reason, the ACE Group recommends that soft tissue filler treatments are not performed within 3 weeks of receiving a vaccine. This guidance would apply to all current COVID-19 vaccinations.

Although all the current SARS-CoV-2 vaccinations do not use live virus for their immunogenicity, any patient who is immunocompromised by virtue of a medical condition, medication or undergoing oncological treatment should be considered a high-risk. Individual risk assessment based on their medical history should occur, in consultation with their specialist, where appropriate.

Previous soft tissue filler treatments are not a contra-indication to vaccination and these patients should be encouraged to be vaccinated but advised to contact their healthcare practitioner if they do develop some facial swelling following the vaccine[11].

## Consent

Although the incidence is very low, it is important that patients are fully aware of any risks related to COVID-19 infection or vaccination and soft tissue fillers. The ACE Group emphasises that this should be included on consent forms:

> Although there is limited evidence and only a very small number of cases, there is a risk of inflammatory reactions and soft tissue swelling in patients who have previously had soft tissue fillers, or plan to have treatment, after receiving COVID-19 vaccination.
>
> Do not undergo soft tissue filler procedures within 2 weeks of your planned vaccination date or within 3 weeks having received it.
>
> Do not attend for treatment if you have symptoms consistent with COVID-19 or are suffering from ongoing symptoms from previous infection.
>
> If you develop any reactions following your treatment, it is imperative you contact your healthcare practitioner at the earliest opportunity.
>
> If you develop any reactions following your treatment, you may require medication to manage the complication. This may include oral steroid medication which may lower your immunity to COVID-19 if you have recently been vaccinated.

## Treatment of DONs and DORs caused by COVID-19 vaccination

The current evidence would suggest that acute DORs in patients with soft tissue fillers presents as mild to moderate oedema, which is sometimes associated with erythema and tenderness, although cases of angioedema have also been reported. These reactions are often spontaneous and self-limiting[3] and are likely to be due to the heightened immune response following the vaccination but quickly subside without treatment. However, if the response is greater than expected or lasts more than a few days, the evidence suggests that a short course of corticosteroids[3] is likely to manage the complication quickly. The ACE Group recommends a dose of 40mg oral Prednisolone for a duration of 5 days. As an alternative, Dexamethasone 5mg orally for 3 days can be used. Dexamethasone has a longer half-life of 36-72 hours (compared to prednisolone which has a half-life of 18-36 hours).

There are concerns between the medical society and patients that the administration of oral corticosteroids may affect mounting an effective immune response to SARS-CoV-2. The prescribing practitioner must consider the seriousness of the DOR and the individual's medical history before issuing any medication. Immune response is based on many criteria including age, health, lifestyle factors, medical history, and concomitant medication.

Doses of Prednisolone above 20mg per day (or 2mg/kg) for 2 or more weeks or more are sufficiently immunosuppressive to warrant concerns about live vaccinations[12], however steroid therapies that are

short term (less than 2 weeks), alternative day, physiological replacement or topical/aerosol are not contraindications. Although, the response to vaccines may be suboptimal.

If the DON or DOR that occurs because of COVID-19 vaccination does not respond as expected, practitioners should follow the guidelines for COVID-19 infection.

## Treatment of DONs and DORs caused by COVID-19 infection

It would initially be prudent to treat the acute inflammatory response the same as treating the reaction to a SARS-CoV-2 vaccination as this may resolve the situation in a swift and uncomplicated manner. However, from the limited evidence available, patients who contract COVID-19 and develop a DON or DOR tend to have a more recalcitrant problem needing multiple interventions.

If there is minimal response to an initial course of oral corticosteroids, or the problem escalates, the ACE Group recommends a prescription of a tetracycline (such as Doxycycline 100mg BD or Minocycline 100mg BD)[13]. These agents not only have antibiotic properties but also anti-inflammatory and antihumoral activity. If the patient is allergic to tetracyclines or there are other contraindications, a macrolide (such as Clarithromycin 500mg BD) should be considered. Response to treatment should be assessed and dual therapy considered.

Depending on response, hyaluronidase should be considered for hyaluronic acid dermal fillers whilst remaining on antibiotic cover. The dosage used will depend on the extent and size of nodules and the filler product used, but will usually be between 500 to 1000 units, injected directly into the nodules to infiltrate and disperse them and at multiple depths and angles of injection. Follow up and assessment must be undertaken, and hyaluronidase may be repeated up to three times at suitable intervals.

For cases failing to respond or for nonhyaluronic acid fillers, there is evidence for the injection of intralesional steroids (such as triamcinolone acetonide or methylprednisolone acetate) and anti-mitotic agents (such as 5-fluorouracil)[13]. These drugs should be used at a suitable concentration and volume and gradually increased according to response. The ACE Group recommends that only practitioners familiar with these agents and competent at managing complications should consider these treatments and less experienced practitioners should refer.

## Angiotensin Converting Enzyme Inhibitors (ACE Inhibitors)

Due to the mechanism of action of the SARSCoV-2 virus penetrating cell membranes by accessing the ACE2 receptor mechanism, research has been conducted into the use of ACE inhibitors and ARB (Angiotensin II Receptor Blockers) in the treatment of COVID19 and its complications. The single case report in the aesthetics journals, whereby a single case responded quickly (likely spontaneous resolution based on the timescale), the ACE Group cannot recommend this as a potential treatment at this time.

## Anti-Histamines

The mechanism of immune response following a DON or a DOR is likely to be a Type IV delayed hypersensitivity reaction, mediated by a T lymphocyte response. However, even though Type IV immunogenic reactions are unresponsive to anti-histamines[14], there have been reported cases of improvement following the administration of anti-histamines[6]. Due to the low risk of adverse events related to the prescribing of anti-histamines and the small, but possible, risk of advantageous outcomes, the ACE Group suggests consideration of the use of an oral anti-histamine in the case of a recalcitrant DON or DOR following COVID-19 infection or vaccination.

## Other Aesthetic Procedures

There is currently no evidence that COVID-19 vaccination or infection has a detrimental effect on other aesthetic procedures, including botulinum toxin. However, as patients may become unwell and experience flu-like symptoms following vaccination, the ACE Group recommends avoiding treatments for 1 week post vaccine.

## Reporting

There is a distinct lack of reporting of complications in aesthetic practice. The ACE Group advocates that all practitioners should report complications to the manufacturers and the MHRA. The ACE Group also provides a reporting mechanism to facilitate this process via the website and App. Due to the lack of evidence concerning COVID-19 vaccine and infection, it is even more important that reporting occurs. The MHRA have created a dedicated Coronavirus Yellow Card reporting site which should be used:

https://coronavirus-yellowcard.mhra.gov.uk/

### Key Points:

1. Acute soft tissue reactions following mRNA vaccination, including oedema, erythema, and tenderness, appear to be very low in number, relatively mild and self-limiting. Adopting a watchful waiting approach may be the sensible option, especially as treating with oral corticosteroids may impair the immune response to the vaccine.

2. More severe, acute reactions, such as angioedema, should be managed according to the severity although a short course of moderate to high dose corticosteroids, with or without antihistamines, is likely to bring a speedy resolution to the problem.

3. Considering this evidence, patients need to understand the potential risks of soft tissue filler treatments around vaccinations and infections and this should be part of the screening and consent process.

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