The Association of Reproductive and Clinical Scientists (ARCS) and British Fertility Society (BFS) U.K. best practice guidelines for reintroduction of routine fertility treatments during the COVID-19 pandemic.

Prepared by the ARCS/BFS COVID working group* on behalf of the Executive Committees of ARCS and the BFS.

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Introduction and background

Arising in China in late 2019, the novel coronavirus (SARS-CoV-2) has swept the globe. Confirmed cases of COVID-19 have grown rapidly and, at the time of writing, exceed 3 million worldwide. The pandemic has resulted in unprecedented actions across health services worldwide and necessary responses are forcing economies into recession.

In March a letter from the Chief Executive and Chief Operating Officer of the NHS directed all NHS providers to, amongst other measures, prepare to '*postpone all non-urgent elective operations from 15th April at the latest, for a period of at least three months*'. On the 23rd of March 2020, the Prime Minister announced a 'lockdown' in order to limit the spread of the virus. This lockdown included strict social distancing rules and a moratorium on all but essential travel. Subsequently private hospitals cancelled all elective work and the NHS block booked their capacity for urgent NHS work.

Against this backdrop, ARCS and the BFS published initial guidance on the 16th March, which was updated and expanded on the 18th March. This guidance recommended that assisted conception centres cease all elective treatment activity as soon as possible to reduce the potential burden on the NHS from treatment complications, ensure social distancing, reduce risk of viral infection for patients and free up essential resources to aid in the fight against the pandemic. The BFS/ARCS guideline was followed on the 23rd March by the publication of General Direction 14 by the HFEA, which limited treatments to fertility preservation in patients who were, in the written opinion of a registered medical practitioner, likely to become prematurely infertile.

From the outset ARCS and the BFS have been acutely aware of the impact of the closure of the sector on patients, staff and the field of fertility treatment, and have supported the prospect of reopening services as soon as it is considered safe to do so, balancing risks and empowering our members to prepare and respond proportionately and professionally. On 1st May 2020, the BFS and ARCS published a position statement (1) detailing their view that the milestones necessary to allow treatment to resume in the U.K. had largely been met. On the same day the HFEA wrote to all licensed centres in the U.K. advising that,

from the 11th May 2020 they would be able to apply for treatment to restart, subject to their being able to demonstrate that steps necessary to protect staff and patients against infection had been put in place.

In order to provide clear guidance to centres as to what steps should be taken to provide this protection and how they should be implemented, the BFS and ARCS have produced this guideline document.

The BFS and ARCS recommend that this guideline should be used in conjunction with prevailing Government, health service and HFEA advice and regulations, to ensure safe and sustainable service delivery during the ongoing pandemic. The ARCS/BFS COVID working group have identified several areas where good clinical practice, based on five key principles, can help to minimise risk to patients and staff from the reintroduction of services.

1. Five Key Principles

The following principles underpin the approach taken in developing this guidance:

- Resumption of fertility services must take place in a manner that minimises the chances of spread of COVID-19 infection to patients and fertility clinic staff.
- Centres should ensure a fair and transparent approach to any prioritisation policy.
- Resumption of treatment should not result in an undue burden on the NHS.
- Patients considering treatment should be fully informed about the effect of the ongoing pandemic on their treatment and give informed consent to having fertility treatment at this time.
- The fertility sector should adopt sustainable changes in working practices that help to build resilience against any future increases in the spread of COVID-19 in the community.

2. Ensuring patient safety

a. Information and consent

It should be recognised that patients are likely to be anxious about coronavirus infection and its potential effects on pregnancy. Patients should be made aware that the present experience is limited and does not indicate that the severity of infection is any worse in pregnancy. At this stage, there is no evidence of an increased risk of fetal anomalies or adverse pregnancy complications (RCOG) (2). Nonetheless, patients should be carefully counselled, taking into account their individual clinical situation and risk profile, and the likely persistence of the virus in the local community in the medium term. This counselling and the patient's decision whether or not to proceed with fertility treatment should be documented in the medical record.

b. Prioritisation and exclusions

Patient prioritisation may form part of service resumption in the event that clinic resources do not allow all patients to be treated without delay. Fertility preservation for patients facing cancer chemotherapy or other treatment that is likely to affect their fertility should continue to be a priority. In addition, it is reasonable to prioritise patients in whom delay is most likely to significantly affect the outcome of treatment. Patients at special risk include those with a low ovarian reserve, advanced age and those facing extirpative pelvic surgery (for instance due to severe endometriosis or bilateral ovarian cysts). The above list is not exhaustive, and each clinic

should decide on which groups, if any, to prioritise based on the profile of its patient population and how it organises its care.

Particular caution should apply to patients with underlying medical problems whose co-morbidity places them at a higher risk of complications in the event of contracting coronavirus infection. This includes patients with obesity, hypertension, diabetes and those receiving immunosuppressive medication. It may be appropriate for such patients to delay conception until epidemiological evidence shows a sustained reduction in the community spread of the infection.

c. Triaging, screening and testing

At the time of writing there are no widely available, reliable serological tests in the UK and reliance must be placed on symptomatic screening and antigen testing. It is likely that the coming weeks will see rapid progress in both the availability and efficacy of testing for coronavirus, and centres are advised to follow local and national guidelines and consider implementing a testing policy as soon as practicable.

- **Before starting treatment**: A screening questionnaire (see Appendix 1) and antigen test (if available) should be completed. Patients and donors with a diagnosis of COVID-19 infection should not start treatment until they have recovered and are not considered infectious. National guidelines should be followed in this regard. Centres should consider whether they advise patients and potential donors to self-isolate, if possible, from the start of ovarian stimulation treatment until egg collection.

- **During treatment**: A coronavirus screening questionnaire should be administered prior to every clinic visit. Patients and donors with a negative coronavirus antigen test at the start of treatment, and who remain negative on questionnaire screening throughout should be allowed to complete treatment. In centres that institute an antigen testing policy, consideration should be given to performing a further antigen test as close as reasonably possible to any surgical procedure depending upon local guidelines and availability of testing.

- **Action in the event of suspected COVID-19**: If a patient or donor develops symptoms suggestive of coronavirus or screens positive on the questionnaire during treatment, an antigen screen should be arranged and treatment should not proceed unless the patient screens negative as defined by national guidelines. In the event of a patient or donor presenting with suspected or confirmed Covid-19 after the ovulatory trigger, a multi-disciplinary individual risk assessment should take place to balance the risks of refraining from oocyte retrieval against those of proceeding. At present there is little data on the risks of minor surgical procedures in women with a diagnosis of Covid-19. Patients who become symptomatic after oocyte retrieval but prior to embryo transfer should be advised to freeze all their embryos for future use

- **Donors**

  There is currently limited evidence that viral particles may be present in semen, but there is no evidence of infectivity. Centres are advised to keep abreast of developments in this area and risk assess actions appropriately if further evidence emerges.

d. Reducing face-to-face interactions

Centres should consider ways in which the frequency and duration of visits required to undergo fertility treatment may be reduced without compromising safety and quality. Telephone and video consultations should replace face-to-face interactions in most situations, depending on the patient profile and the expectations from the consultation. Patients with a learning disability or complex needs may not be suitable for treatment without a face-to-face consultation. Centres should ensure that any software used meets the requirements of data protection. Clinicians may require training in the performance of 'virtual' consultations, including the need for confidentiality, accurate patient identification and provision of sufficient time for patients to assimilate information and ask questions. Recording of consultations should only be allowed with consent from both sides. Consent for fertility treatment may be taken remotely, provided the clinician is satisfied that the patient thoroughly understands the implications of consenting. Software packages exist to aid this process.

Centres that provide group patient information sessions should explore the use of videos and podcasts that can be accessed from home, avoiding the need for patients to congregate in large numbers.

Online counselling options should be available to patients.

Centres should aim to reduce the number of visits required for monitoring ovarian stimulation, particularly in women with a normal ovarian reserve.

Centres should minimise the number of accompanying persons. Virtual consultations, including those where an interpreter is needed, offer a way of managing care safely without the need for multiple attendees in person.

e. Minimising clinical risk

1. Clinical protocols to minimise the risk of OHSS are a well-established part of modern reproductive medicine practice, based on the value of a GnRH-Antagonist protocol and GnRH-agonist trigger in appropriate cases. Centres should bear in mind the value of these and of careful ovarian stimulation to minimise the risk of hospital admission for patients and to reduce the burden on the NHS. Operative and infective complications following oocyte retrieval are rare, and preventative measures such as prophylactic antibiotics should be considered to reduce risk where appropriate. The use of empirical immunosuppressive treatments should be avoided. There is insufficient evidence of benefit from these treatments, and they may increase the risk of severe infection.

f. Minimising risk in the laboratory

Evidence to date suggests that the respiratory virus responsible for COVID 19 is not present in follicular fluid or seminal plasma, nor associated with gametes or embryos. Standard infection control procedures and good laboratory practice are, therefore, considered appropriate in the IVF laboratory during this time. This includes standard IVF laboratory PPE and the use of biological safety cabinets. When working with follicular aspirates or semen, which may contain blood, class 2 workstations offer the most protection for the operator. Safety glasses may be used with class 1 workstations, for additional protection, but the risk of possible impairment on microscopy

should be considered. Laboratory staff should aim to minimise handling and sharing of pipette handles/teats, pens and keyboards etc. and clean down equipment, such as microscope controls and eyepieces between operators.

Currently available evidence indicates that the cryopreservation of gametes and embryos during the pandemic may be performed using routine practices, although centres are advised to risk assess and consider similar practice and storage to that used for seropositive infectious diseases such as HIV, as a precaution for known COVID -19 positive patients only (e.g. high security straws or vials, vapour phase or separate liquid phase storage).

g. Patient Personal Protective Equipment (PPE)

Centres should consider asking all visitors to the centre to use a face covering, and masks may be provided for those who need them. Provision must be made for safe disposal of PPE used by visitors.

3. Practical preparation for service resumption

a. Clinic Layout

As resumption of fertility services must take place in a manner that minimises the spread of COVID-19 infection to patients and fertility clinic staff, areas of the clinic may require reconfiguration to enable safe physical distancing.

Consideration should be given to the layout of each area including:

- Patient reception
- Patient waiting areas
- Consultation and counselling rooms
- Clinical rooms used for ultrasonography or phlebotomy
- Procedure rooms for oocyte recover or embryo transfer
- Laboratories
- Administration offices
- Communal staff areas (e.g. dining room, staff room)

The following measures, relating to clinic layout, should be considered:

- Physical barriers between staff and patients, and/or appropriate PPE for the activity being undertaken
- Spacing of furniture to ensure physical distancing is maintained between persons not from the same household (e.g. waiting area chairs, workstations in administrative offices)
- Signage and information clearly describing the requirements in place

b. Physical distancing

Social distancing guidelines should be adhered to at all times, in line with Government guidance and revised centre policy. Centres should consider each type of patient and staff interaction and put measures in place to minimise the risk of COVID-19 infection.

Consideration should be given to the following interactions and processes, in terms of physical distancing. (This list is not exhaustive and centres should undertake assessment of all areas within their licensed facility):

- Patient arrival and checking in process at the clinic
- Patient consultation
- Patient consent taking
- Phlebotomy
- Ultrasonography
- Counselling
- Semen production
- Oocyte or Surgical sperm recovery
- Embryo transfer
- Staff meetings
- Confidentiality
- Witnessing
- Staff work discussions
- Staff breaks
- Use of corridors, communal areas, lifts and stairways

The following measures should be considered to ensure physical distancing wherever possible:

- Reconfiguration of areas of the clinic (see section above)
- Implementation of restrictions to the use of communal (social) areas, such as the staff room
- Staff working from home should be encouraged where possible
- Production and delivery of semen samples from home, following guidelines to avoid compromising the sample
- Implementation of virtual meetings wherever possible, minimising face to face appointments. (e.g. consultation, injection teaching and counselling)
- The use of electronic platforms for consent-taking, where available
- Use of approved electronic communications and messaging systems wherever possible
- Implementation of restrictions on partners and companions for appointments, where possible and appropriate
- Limiting staff and patient numbers permitted in each clinic area

c. PPE

Public Health England (PHE) has produced a comprehensive set of documents regarding the prevention and control of COVID-19. https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/covid-19-personal-protective-equipment-ppe

The guidance is designed for UK use of PPE in relation to COVID-19. These are applicable to all health care settings and are updated as necessary.

Centres should refer at all times to this PPE guidance. Other local guidelines may apply for NHS centres but are likely to broadly conform with those from PHE.

Whilst ensuring appropriate PPE use, centres should work to conserve stocks and inappropriate overuse should be avoided as PPE remains a national resource issue.

Practice and procedures in the sector should be covered either under outpatient or secondary care guidance or in guidance on the safe handling of materials in a laboratory setting as detailed in the documents referenced below, however these should not be taken in isolation without reference to the more detailed PHE guidance to ensure the correct measures are being used:

Table 1
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/879107/T1_poster_Recommended_PPE_for_healthcare_workers_by_secondary_care_clinical_context.pdf

Table 2

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/878750/T2_poster_Recommended_PPE_for_primary__outpatient__community_and_social_care_by_setting.pdf

Table 4

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/879111/T4_poster_Recommended_PPE_additional_considerations_of_COVID-19.pdf

and

https://www.gov.uk/government/publications/wuhan-novel-coronavirus-guidance-for-clinical-diagnostic-laboratories/wuhan-novel-coronavirus-handling-and-processing-of-laboratory-specimens

Centres should ensure that they review published national guidelines regularly for updates to ensure that they continue to comply.

Centres should include a description of their zones of work and acknowledgement of the PPE needs in their strategy document. In addition, it is recommended that centres maintain a record confirming that all relevant members of staff have undergone training in the proper donning and doffing of PPE.

Appendix 2 provides a summary of recommendations applicable to the fertility setting. It should be seen as a guide only and not without reference to national guidance which may change over time.

d. Equipment

Centres should ensure that equipment is fit for purpose and has been maintained appropriately during any period of close down. Maintenance and servicing schedules should have been maintained except where allowed through HFEA guidance (3).

All equipment should be validated for use. Up-to-date validation documentation should be maintained.

Where possible centres should consider using equipment that may allow for greater physical distancing, automation or facilitate a more flexible workflow within the department (e.g. use of time lapse devices, computer assisted semen analysis (CASA) and electronic witnessing systems in the laboratory).

Staff should minimise sharing of any equipment where possible and equipment should be cleaned between operators (e.g. microscope eyepieces or keyboards).

e. Consumables

Centres should work to ensure that the supply chain for all consumables is intact. This should include, where necessary, contacting suppliers to ensure availability.

Contingency plans must be in place, for each critical consumable, should supply chain fail. Particular attention should be given to the supply of laboratory media, which may have short shelf life, embryo safe cleaning products, fertility drugs, liquid nitrogen and gas cylinders containing carbon dioxide, nitrogen, and oxygen. Some products may be in particularly high demand as much of the world reinitiates fertility treatments at a similar time and following a likely reduction in manufacturing. Stockpiling is not advised.

4. Operational preparation for service resumption

a. Scheduling of appointments and procedures

In order to minimise the footfall through centres and facilitate physical distancing it is important to keep visits and the time spent in the clinic to a minimum. It is recognised that this will reduce work capacity in many centres and some measures may include an element of compromise. Risk assessment should be undertaken where necessary.

- **Number of visits:** centres should advise that only individuals required for each appointment should attend (this may include those accompanying disabled patients or interpreters when needed). As much activity as possible should be undertaken by phone or video call. Centres must ensure that appropriate confidentiality and clinical record keeping is maintained at all times.

  Consideration may include condensing visits into a single pathway e.g. scan and blood tests can be undertaken without a return to the waiting area and “drop-in” visits discouraged. Treatment protocols should be reviewed to minimise the number of clinic visits required for monitoring and treatment. Persons accompanying patients home after procedures such as oocyte retrieval should remain outside the clinic.

- **Duration of visits:** centres should aim to encourage patients to attend at their given appointment time and should aim to avoid them from being kept waiting. Consideration to the length of appointments to allow for unexpected delays should be given, ensuring they are well spaced and also the addition of a buffer to allow catch-up if needed. Protocols should be reviewed to reduce the length of time spent in the department by individuals e.g. drop off appointments for semen analysis.

b. Working patterns

Working patterns within centres may need to change to accommodate social distancing measures to ensure safety for staff and patients. Staff returning to centres will need to adopt a flexible approach to working. Managers need to find a balance between allowing flexibility and facilitating collaboration for all staff. This may involve risk assessments of the clinic and departments to demonstrate alternative ways of working. This may involve:

- splitting the workforce into teams to work across a longer period of the day and to ensure that staff numbers are restricted in the clinic.
- to work shifts and avoid crossover of staff for long periods of time
- to work virtually where possible to avoid patients coming into the clinic.
- to work from home where possible and to avoid staff numbers in highly populated areas such as administration offices

c. Staff responsibilities

Fertility clinic staff have been identified as key workers and with that has come some social privilege but also a responsibility to the wider community to ensure that they comply with national lockdown guidance at home and whilst travelling to and from work. They must ensure proper reporting of symptoms and contacts as well as submitting to testing as appropriate, to reduce the risk of bringing COVID-19 into the healthcare setting.

Physical distancing within work spaces is equally important where possible to reduce the risk of spread of infection within staff groups as workload increases.

d. Maintaining safe working practices

- Maintain working from home where feasible and effective and when appropriate confidentiality measures can be maintained
- Bring back homeworkers only as needed
- Consider implementing shifts working with two teams (or more if appropriate) and condensed working hours providing a shorter working day with fewer breaks to incorporate fewer in the department for longer with longer down time
- Review clinic zones in conjunction with work scheduling to avoid staff moving between zones more than necessary
- Consider scheduled breaks in the working day and where those may be taken in order to reduce rest area overcrowding
- Consider staff protection (see above) when close working is unavoidable e.g. some laboratory spaces/practices

e. Training

Many centres are involved in training whether through formal training programmes or local skills training and CPD. COVID-19 work patterns should not be a barrier to continuing to support training in all areas of practice. Consideration to work patterns must include the potential for inclusion of relevant trainees. Physical distancing rules apply and measures put in place to reduce risk where that is not feasible. Since changes in practice are likely to exist for some time this is an important training period for both new and existing practitioners and indeed, they may bring useful ideas and insights from experience elsewhere.

f. Reciprocal agreements

Contingencies should be in place to allow for unexpected staff reduction and centres should investigate the feasibility of sharing staff across facilities. This may occur within groups, within or across NHS Trusts or for stand-alone centres by arrangement with their neighbours. It is recommended that the breadth and scope of reciprocal arrangements between centres should be reviewed, to incorporate staffing, consumable provision and general support, where applicable and where possible.

Whilst it is generally considered that the peak of the COVID-19 pandemic has passed in the UK, a caveat to increasing public freedoms is the risk of a "second wave" of infection. Since the incidence of asymptomatic infection and population immunity can only be estimated, the severity of a second wave and the effect on workplaces where staff have previously been relatively protected should be considered. In a staged resumption of treatments, centres need to take into account the potential for a number of staff being sick or isolating at any one time. The workforce may also be depleted by members of staff who remain shielding currently. The volume and complexity of work undertaken should be matched by an appropriate number of staff with the appropriate skill mix.

g. SOP & policy updates

In March, Persons Responsible were required to confirm that they had a COVID 19 strategy in place and that this was formally documented. Centres' strategy documents should now be revised, or new versions created to encompass the points indicated within this guidance, and in order to fulfil the requirements of the HFEA, as specified within the self-assessment questionnaire, demonstrating how treatment can be offered safely.

Centres should develop COVID-19 specific documentation to reflect changes in their practice. It should not be necessary to rewrite the full complement of centres' SOPs. This should include the relevant risk assessments undertaken.

Many lessons will have been learnt during the COVID-19 pandemic and centres may well need, for the foreseeable future or wish permanently to change working practices and SOPs may be updated as per the centre's document control policy in a stage-wise fashion.

BFS and ARCS would be very pleased to hear from centres who wish to share new best practice developed from this time of change.

5. Information, conduct consent and support

a. Patient information

Centres are responsible for ensuring patients are given timely information before considering treatment. Patient information must set patient expectations regarding the adaptations within the centre and in treatment pathways and procedures, and include risks of attending the clinic and proceeding with treatment, during the COVID-19 pandemic.

While data remains limited, there is growing evidence that the coronavirus has low impact on early pregnancy and perinatal risk. The RCOG, which is closely monitoring international evidence as it emerges, has now advised that pregnant women do not appear to be more likely to be seriously unwell than other healthy adults if they develop coronavirus. Moreover, they have stated that there is no evidence to suggest an increased risk of miscarriage, and that it is unlikely that if the mother contracts the virus that it would cause problems with the baby's development, stating that none have been observed thus far (RCOG, Coronavirus (COVID-19) infection and pregnancy – guidance for healthcare professionals: Version 8 – 17/3/20).

Centres should ensure patients have access to information regarding the following:

- Signposting to current Government guidance relating to minimising spread of infection
- The symptoms of Covid-19 and what to do if concerned
- Clinic policy on screening and testing for Covid-19
- The safety measures within the clinic (e.g. physical distancing, using PPE as described and washing and sanitation of hands)
- The triage process in place at the clinic
- Any clinic policy on prioritisation of patients and rationale for this
- Clinic policy regarding attendance of partners or companions for the different types of appointments
- Clinic policy in the event of suspected or confirmed infection, according to stage of treatment.
- The availability of online resources to minimise clinic visits (e.g. on line consent completion, virtual appointments, patient information, counselling etc.)

b. Staff information

Centres should ensure staff are given timely information before resumption of treatment services. Staff information must set expectations regarding the adaptations within the clinic and in treatment pathways and procedures, and include risks of attending the clinic and treating patients, during the COVID-19 pandemic.

c. Staff conduct

Staff have a responsibility to try to minimise the spread of COVID-19 and to follow Government guidance as well as specific safety measures introduced in centres relating to their conduct and interactions with others.

Staff should maintain up to date knowledge of, and adhere to, Government guidelines and clinic policies established to stop the spread of COVID-19.

d. Patient and staff support

- **Patients**

Patient support during the pandemic is critical. Staff should be aware that there may be heightened anxiety around COVID-19. Centres should ensure appropriate self-help and counselling provision in order to cater for this and the potential anxieties created by both the delays already experienced and by undergoing treatment during the pandemic.

Centres should signpost to and assist patient support groups where they exist. These groups should be encouraged to meet through social media and video conferencing.

- **Staff**

The period of time which centres were closed and staff were not participating in their usual daily practice will vary according to setting. Many staff will have been away from the workplace for a period of furlough or redeployment and, depending on their role, the duration away and their level of experience and confidence, may require some reorientation, refresher training, competency assessment and support. This should be judged on a case by case basis.

Prior to their involvement in treatment services, staff are expected to ensure that they are competent and confident enough to be able to operate a safe and effective service. Staff should be encouraged to request support from clinic leaders for themselves or colleagues as required to achieve this.

Staff support policies and procedures should be in place to ensure that:

- The mental well-being of staff is considered and reviewed as necessary
- Staff support and counselling systems are in place should they be needed
- Staff continue to be engaged and encouraged to provide feedback on progress and potential improvements to treatments during the COVID-19 pandemic
- Peer support is available as needed
- Staff safety in the workplace is paramount and centres should ensure that risk assessments are in place where appropriate to minimise the risk of infection.

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Disclaimer

This guidance represents the views of ARCS/BFS, which were reached after careful consideration of the scientific evidence available at the time of preparation. In the absence of scientific evidence on certain aspects, a consensus between the relevant members of the COVID-19 working group and the Executive teams has been obtained. It is produced as an aid to good clinical practice and clinical decision making.
ARCS/BFS are not liable for damages related to the use of the information contained herein. We cannot guarantee correctness, completeness or accuracy of the guidance in every respect.
The advice expressed herein is not binding on professionals working in the field of human reproduction and embryology, however it represents best practice in the view of the BFS and ARCS.
Please be aware that the evidence base for COVID-19 and its impact on infertility patients, pregnancy and related healthcare services is developing rapidly and the latest data or best practice may not yet be incorporated into the current version of this document. ARCS and BFS recommends that any departures from local clinical protocols or guidelines should be fully documented in the patient's case notes at the time the relevant decision is taken.

References:

1) https://www.britishfertilitysociety.org.uk/2020/05/01/position-statement-on-the-resumption-of-fertility-treatment-in-the-uk-during-covid-19-pandemic/

2) https://www.rcog.org.uk/globalassets/documents/guidelines/2020-04-17-coronavirus-covid-19-infection-in-pregnancy.pdf

3) https://www.hfea.gov.uk/treatments/covid-19-and-fertility-treatment/coronavirus-covid-19-guidance-for-patients/frequently-asked-questions-for-patients-on-coronavirus-covid-19/

Appendix 1:

Triaging Questionnaire for Covid-19

Have YOU or YOUR PARTNER or ANY MEMBER OF YOUR HOUSEHOLD been diagnosed with Covid-19?

Have YOU or YOUR PARTNER or ANY MEMBER OF YOUR HOUSEHOLD had any of the following symptoms in the last 2 weeks

1. Fever (feeling hot or a temperature above 37.5 degrees Celsius)
2. Persistent cough
3. Loss of the sense of smell
4. Loss of the sense of taste
5. Sore throat

Have YOU been in contact with anyone in the last 2 weeks who has any of these symptoms or has been diagnosed with Covid-19?

Appendix 2. PPE – recommended for COVID-19 protection.

This Table is adapted from www.gov.uk: *Table 1. Recommended PPE for healthcare workers by secondary care clinical context* and *Table 2. Recommended PPE for primary outpatient community and social care by setting* for the fertility sector. It should be used as a preliminary guide only and with reference back to Public Health England publication COVID-19: infection prevention and control guidance available at https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control

Reference to the website will provide the most up to date guidance which may change as the pandemic changes. Local guidance may also apply.

PPE in the setting of a fertility clinic

Setting	Context – as described www.gov.uk[1]	Areas in the fertility clinic workplace	Gloves - disposable	Plastic apron - disposable	Fluid-resistant coverall or gown - disposable	Fluid resistant surgical mask	FFP respirator	Eye/face protection	
Fertility Centres – see guidance on triage. This should minimise the chance of "confirmed or possible cases" entering the Centre therefore reducing risk.	Social distancing – where 2m distance possible	Waiting areas Clinical consultation				YES[8] Sessional use[2]			
	Working in reception/communal area and unable to maintain 2 metres social distance	Reception/admin staff check in etc Consultation				YES[8] Sessional use[2]			OR ensure appropriate physical screen protection[3]
	Working in an inpatient area with possible or confirmed case(s) (not within 2 metres)	Day case theatre Other clinical zone – not direct patient care: Clinic support Chaperone Showing men to semen production room Assisting direct patient care procedures				YES[8] Sessional use			

	Direct patient care – possible or confirmed case(s) (within 2 metres)	Undertaking clinical examination, venepuncture, ultrasound scanning, IUI, embryo transfer etc.	YES – single use[4]	YES – single use		YES[8] – sessional use		YES[8] – sessional use	
	Operating theatre with possible or confirmed case(s) – no aerosol generating procedures[5]	Undertaking procedures in conscious sedation/local anaesthetic theatre area	YES – single use	YES – single use	Consider – depending on procedure and setting and normal protocol	YES[8] – single or sessional use		YES[8] – sessional use	
		Associated staff – runner etc	YES – single use	YES – single use		YES[8] – sessional use		YES[8] – sessional use	
	Performing a single aerosol generating procedure on a possible or confirmed case in any setting outside a higher risk acute care area[6]	GA or heavy sedation procedures where AGP a risk	YES – single use		YES – single use		YES	YES – single use/ reuse with cleaning	
		Working in diagnostic Andrology laboratory[7]	YES Sessional use			YES Sessional use		YES – sessional use	
		Working in Clinical Embryology laboratory[7]	YES – single use			YES – sessional use		YES – sessional use	

1 https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control

2&4 see descriptors in website above

3 e.g. Perspex screen

5 conscious sedation, low flow oxygen supplementation and use of Entonox are not considered aerosol generating processes. Follicular fluid aspiration is not an aerosol generating process.

6 Procedures including AGPs should only be performed where strictly necessary and should be avoided where there is a risk of COVID-19. Consideration to alternatives (local or regional anaesthesia, conscious sedation, deferment) should be made and if alternatives are not available consideration given to screening patients beforehand. It is not expected that this will form a routine part of most fertility centres work and therefore the complex risk assessments and measures in relation to AGPs are not discussed as they are beyond the scope of this guidance.

7 https://www.gov.uk/government/publications/wuhan-novel-coronavirus-guidance-for-clinical-diagnostic-laboratories/wuhan-novel-coronavirus-handling-and-processing-of-laboratory-specimens - handling bodily fluids to be performed within in a microbiological safety cabinet only. Eye protection for laboratory staff is not considered necessary where workstations provide sufficient protection for the process being undertaken, and should be risk assessed. Risk assessment should include the risk of transmission between operators through sharing of microscope eyepieces. Where eye protection is not worn microscope eyepieces should be cleaned between operators.

8 Table 4 guidance may be apply in these areas. If local guidance does not already exist Centres should undertake their own risk assessment for each area.