REPUBLIC OF KENYA

MINISTRY OF HEALTH

Occupational Therapy Practice Guidelines

In Conjunction with the Kenya Occupational Therapists' Association

Guidelines to be used by Occupational Therapists in rehabilitation of Patients during COVID-19 Pandemic

The Purpose of this guideline is to provide occupational therapists a practical checklist of points to consider in relation to the potential rehabilitation needs of patients requiring occupational therapy services. It can be used to plan and structure appropriate occupational therapy interventions in relation to COVID-19.

Table of Contents

Foreword

Occupational Therapy guidelines have been developed in response to the Coronavirus disease 2019 (COVID-19). COVID-19 is a serious respiratory viral infection caused by a novel corona virus recently named SARS-COV2. Towards December 2019 this virus was identified as a cause of upper and lower respiratory tract infections in Wuhan, a city in the Hubei province of China.

COVID - 19 has affected our daily routine, interrupted our lifestyle, interrupted our office work, interrupted our financial plans and interrupted our future plans. This has led to stress, anxiety, familial discord, sleep cycle disruption, lack of physical activity, overburdened household, routine excessive screen time, pain, and lethargy. Occupational Therapists should take up their role of ensuring that quality of life of the patients is improved regardless of their situation through meaningful use of activities to ensure patients regain balance in their lifestyles, remain physically active and enjoy a sense of independence.

I expect every occupational therapist to adhere to these guidelines to aid them in provision of quality and effective screening, management and provision of occupational therapy services to all persons and more especially to the vulnerable persons with disabilities. As experience and knowledge on COVID-19 is rapidly evolving, these guidelines will be updated periodically.

Dr. Patrick Amoth

Ag. Director General for Health

MINISTRY OF HEALTH

Acknowledgements

This guide has been compiled by representatives from Ministry of Health, Occupational Therapists from diverse sectors and representative of training institutions in collaboration with Kenya Occupational Therapists' Association. The guideline was based on the clinical guidelines developed by the World Federation of Occupational Therapists (WFOT) and other international affiliated Occupational Therapists practices.

The development of the guideline was carried out under the auspices of the Director General for Health, Directorate of the Healthcare Services, in the Division of Health Systems Strengthening. In this regard, we highly acknowledge Dr. Patrick Amoth, Dr Laban Thiga and Dr. Julius Ogato support. We as well recognize other committee members' role in drafting the guideline.

Background

Occupational Therapy Services for Management of COVID-19

Occupational Therapists specifically deal with Remedial, restorative treatments and rehabilitation of persons with Physical, Cognitive, Psychosocial and Developmental Impairments.

As a profession, we recognize the consequences and changes that are occurring in how people access and undertake their occupations as a result of the COVID19 pandemic. (WFOT)
These include, but are not limited to: accessing resources, activities of daily living, communication, mobility, social isolation, displacement, issues with mental health and wellbeing. Occupational therapists understand the vital need to access and use infection control measures combined with the need to sustain good physical, psychological, mental health and stamina in order to stay safe and healthy.
Occupational Therapists are essential service providers, the following areas of intervention should be considered depending upon individual needs and severity of COVID - 19 case.

- Positioning for maximizing respiratory functioning
- Bed Mobility
- Pulmonary rehab
- Early Mobilization
- Communication management to increase social participation
- Cognition training and re-orientation (prevention of delirium)
- Sensory stimulation
- Energy conservation
- Mental wellness (decreasing anxiety and depression symptoms)

*40% of people with severe COVID-19 experience neurological complications including confusion, delirium, higher risk of stroke, and other brain related complications a new study from Wuhan, China published in JAMA Neurology has suggested.

Guidelines for Occupational Therapists

Step 1: Sensitization of Staff and Clients on COVID - 19

- All Occupational Therapists must undergo sensitization and stay updated on the latest information about COVID - 19
- Have appropriate written infection prevention protocols
- Have signage about hand and respiratory hygiene
- Client should be given up to date information on COVID-19
- Always follow the infection control protocol

Step 2: Preparation of Working Spaces

- Routinely clean and disinfect all frequently touched surfaces and equipment with the appropriate cleaning agents
- Ensure social distancing
- Ensure availability of clearly labelled waste bins
- Stay calm and have an objective view
- Ensure availability of running water and soap or an alcohol-based sanitizer

Step 3: Risk Assessment

- Contact intensity: whether low, medium or high depending on the proximity and duration of contact between a client and the therapist during a therapy session.
- Number of contacts per client: (low, medium or high) the number of persons a client interacts with from when he /she arrives at a facility for therapy till the time the client leaves.
- Number of contacts per therapist:(low, medium or high) the number of persons a therapist interacts with at the facility both staff and clients in a day.

- Modification potential of the service area: (low, medium, high) based on the degree of modifiability to reduce risk of contact of persons in a room at a time and allow social distancing.
- Identify the minimum number of people required to safely conduct a session.
- Carefully consider equipment use and discuss with infection control services to ensure it can be properly decontaminated. Avoid moving equipment between infectious and non-infectious areas. Wherever possible, single patient use, disposable equipment is preferred.

Step 4: Personal Protective Equipment Use

Below are the recommended guidelines for PPE use by Occupational Therapists

How to Put On (Don) PPE Gear

More than one donning method may be acceptable. Training and practice using your healthcare facility's procedure is critical. Below is the recommended way of donning.

1. Identify and gather the proper PPE to don. Ensure choice of gown size is correct (based on training).
2. Perform hand hygiene using hand sanitizer.
3. Put on isolation gown. Tie all of the ties on the gown. Assistance may be needed by other healthcare personnel.
4. Put on an approved N95 filtering face piece respirator or higher (use a facemask if a respirator is not available).
    - If the respirator has a nosepiece, it should be fitted to the nose with both hands, not bent or tented.
    - Do not pinch the nosepiece with one hand.
    - Respirator/facemask should be extended under chin.
    - Both your mouth and nose should be protected.
    - Do not wear respirator/facemask under your chin or store in scrubs pocket between patients.
    - Respirator: Respirator straps should be placed on crown of head (top strap) and base of neck (bottom strap).

- Perform a user seal check each time you put on the respirator.
- Facemask: Mask ties should be secured on crown of head (top tie) and base of neck (bottom tie). If mask has loops, hook them appropriately around your ears.

5. Put on face shield or goggles. When wearing an N95 respirator, select the proper eye protection to ensure that the respirator does not interfere with the correct positioning of the eye protection, and the eye protection does not affect the fit or seal of the respirator. Face shields provide full face coverage. Goggles also provide excellent protection for eyes, but fogging is common.
6. Put on gloves. Gloves should cover the cuff (wrist) of gown.

After completion of these procedures the occupational therapist may now enter patient room.

How to Take Off (Doff) PPE Gear

More than one doffing method may be acceptable. Training and practice using your healthcare facility's procedure is critical. Below is the recommended way of doffing.

1. **Remove gloves.** Ensure glove removal does not cause additional contamination of hands. Gloves can be removed using more than one technique (e.g., glove-in-glove or bird beak).
2. **Remove gown**. Untie all ties (or unsnap all buttons). Some gown ties can be broken rather than untied. Do so in gentle manner, avoiding a forceful movement. Reach up to the shoulders and carefully pull gown down and away from the body. Rolling the gown down is an acceptable approach.
3. Dispose in trash receptacle.

- **Note:** The Occupational Therapist may now exit patient room.

4. **Perform hand hygiene.**
5. **Remove face shield or goggles.** Carefully remove face shield or goggles by grabbing the strap and pulling upwards and away from head. Do not touch the front of face shield or goggles.
6. Remove and discard respirator (or facemask if used instead of respirator). Do not touch the front of the respirator or facemask.

- Respirator: Remove the bottom strap by touching only the strap and bring it carefully over the head. Grasp the top strap and bring it carefully over the head, and then pull the respirator away from the face without touching the front of the respirator.

- Facemask: Carefully untie (or unhook from the ears) and pull away from face without touching the front.

7. Perform hand hygiene after removing the respirator/facemask and before putting it on again if your workplace is practicing reuse.

Note: Facilities implementing reuse or extended use of PPE will need to adjust their donning and doffing procedures to accommodate those practices. (**Adapted from CDC guidelines on PPE use, https://www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe**)

Occupational Therapy Key Areas of Interventions during COVID - 19 Pandemic

The suggested assessment and intervention areas provided in this guide are not exhaustive, and not all suggestions will be necessary or appropriate for every individual. The intention is to provide a broad overview of the interventions that occupational therapists should consider at each stage of a person's treatment and recovery journey. This has been structured around the main practice settings where occupational therapists are working with people with COVID-19**:**

1. Critical care settings
2. Inpatient/step-down rehabilitation following discharge from ICU or acute ward
3. Community rehabilitation
4. Outpatient clinics

Service Area	Pre requisites	Specific Intervention Processes
Intensive Care Unit / Critical Care Setting	**OT knowledge and skills** • Ability to assess and manage people who are critically unwell, with very complex needs	**OT interventions** **a) Screening and assessment** • Maintaining an **occupation focus**: Information gathering – from the person, family members, caregivers

	• Ability to risk assess whether therapy input is appropriate, and recognize changes in vital signs that indicate when sessions should be stopped • Experience of working with people on ventilators, with tracheostomies and other medical attachments • Competence in manual handling and positioning • Experience of working with people with complex neurological presentations and in low wakefulness or arousal • Competence around need for splinting.	• Identify occupational baselines, social and mental health history • Cognition – through function, as well as standardized screening and assessment tools • Delirium - Wakefulness and awareness – for those who are slow to wake from sedation or experience prolonged consciousness disorders • Physical abilities – muscle strength, tone, gross and fine motor skills, coordination **b) Goal setting** • This should be completed with the person whenever possible, or family and caregiver • Activity analysis and grading of tasks to support gradual regaining of function for people with limited exercise and activity tolerance • Short-term goals – what does the person want and need to be able to do? • Interventions to reduce likelihood of long-term impairments; skills to support hospital discharge (mobility, seating, self-care) • Long-term goals – skills to support return to desired occupations (self-care, productivity, leisure) **c) Prevention and management of physical disability** • Advice on bed and chair positioning regimes, to maintain range of movement,

		manage muscle tone changes and facilitate occupational engagement • Manual handling and proning assistance • Provision of specialist seating to enable occupational engagement • Consideration of pressure care needs • Upper limb management, addressing loss of range and edema • Upper and lower limb splinting, when of clinical benefit (not routinely) **d) Occupational Engagement** • Advice on management of breathlessness and fatigue. Consider grading and pacing of tasks, and teach energy conservation strategies. • Early and complex rehabilitation to improve static and dynamic sitting balance and tolerance • Early and complex rehabilitation to promote mobility and function • Personal care – daily practice of washing, dressing and grooming tasks • Facilitate autonomy and control through adaptation of suction tubing, bed controls and engagement in routine, timetabling and goal setting • Communication – alongside speech and language therapists, consider

		compensatory, adaptive strategies and use of technology as appropriate • Feeding and drinking – consider compensatory/adaptive equipment as required to improve independence and use of gross upper limb movements. • Provide advice to nursing staff regarding cognitive strategies • Engagement in leisure activities to promote physical, cognitive and psychological recovery as well as provide diversion individually selected based on person's choice and equipment available **e) Psychological Interventions** • Listen to the patient's lived experience, normalizing their experience and supporting a feeling of safety • Enabling connection with family and friends – using digital tools, photographs and letters • Rest and relaxation – provide access to appropriate mindfulness and wellbeing tools, with the support of technology when available • Encourage use of sleep hygiene strategies • Consider use of patient diaries to promote recovery following discharge.

		• Management strategies for anxiety symptoms, including referral to appropriate psychological services. • Consider anxiety component to breathlessness and dysfunctional breathing. • Consideration of low mood and strategies to improve mood, including timetabling and engagement in enjoyable activities. • Referral to appropriate psychological/ psychiatric services **f) Discharge planning and onward referrals** • Onward referrals to inpatient and community services as early as possible to expedite discharge process • Early preparation for community discharge through liaison with family • Risk assessment for step-down to ward, particularly for individuals with delirium, agitation or inability to communicate or call for help • Handover to onward therapy teams regarding current goals and rehabilitation plans, sharing results of assessments and outcome measures as appropriate and permitted • Advice to person and/or their family regarding legal rights in relation to work, sick pay and what to inform their employer

		regarding finances and benefits to manage bills during hospital stay • Information for the person and their family/caregivers about the possible long-term functional impact of critical care treatments
Inpatient or following discharge from ICU to general wards	**a) OT knowledge and skills** For clients from ICU: • Experience of assessing and supporting people with complex needs • Experience of working with people with tracheostomies • Knowledge of impairments following critical care admissions • Knowledge of discharge planning and community referral pathways. • For client from acute care to general wards: • Experience of assessing and supporting people with complex needs	**Occupational Therapy Interventions** **Screening and assessment** • Applying an occupation focus, consider what assessments and interventions have already been completed with the person in the critical care and/or acute setting, refer to previous results as appropriate and only repeat where needed to establish current level of function. **Breathlessness and Fatigue** • Specialist assessment of posture and seating for provision of appropriate seating on the rehabilitation unit and to identify seating requirements for discharge • Physical abilities – strength, tone, gross and fine motor skills, coordination • Equipment and assistance required with activities of daily living • Cognition – through function, as well as standardized screening and assessment tools • Perception and vision • Communication Need for step-down care

	• Knowledge of discharge planning and community referral pathways.	• Mental health – fear, anxiety and mood • Mental capacity Identification of post intensive care syndrome (PICS) and recommendations for management plan • Functional outcome, independence and activity measures **Goal setting** • Discuss and agree with the person, and family and caregivers if appropriate, taking a 'what matters to you' approach • **Short-term goals –** interventions to reduce likelihood of long-term impairments; skills to support hospital discharge (mobility, seating, self-care) • **Long-term goals –** skills to support return to desired meaningful occupations, which may be progressed further in the community (self-care, productivity, leisure) • Apply activity analysis and graded tasks to support regaining function for people with limited exercise and activity tolerance • Assess the risk to support positive risk-taking strategies to help the person regain function and confidence **Occupational Engagement** • **Position Management** advising on range of movement and muscle tone changes through 24-hour positioning regime and interventions, including splinting as

		required for the upper limb, correct positioning of feet and lower limb splints • Intensive rehabilitation to improve functional sitting ability, tolerance, balance and mobility • Advice on management of breathlessness and fatigue, alongside physiotherapists. • Consider grading and pacing of tasks, and teach energy conservation strategies • Functional upper limb rehabilitation and retraining • Training on transfers and mobility • Personal care – toileting and continence management; daily practice of washing, dressing and grooming tasks. • Interventions to aid communication, drinking and feeding, in conjunction with speech and language therapists • Cognitive rehabilitation and delirium management • Engagement in leisure activities to promote physical, cognitive and psychological recovery as well as provide diversion. Individually selected based on person's choice and equipment available. **Psychological interventions** • Listen to the person's lived experience, normalizing their experience and supporting a feeling of safety

		• Enabling connection with family and friends – using digital tools, photographs and letters • Rest and relaxation – provide access to appropriate mindfulness and wellbeing tools, with the support of technology when available • Encourage use of sleep hygiene strategies • Consider use of a diary to promote recovery following discharge • Application of trauma-informed approaches • Management strategies for anxiety symptoms, including referral to appropriate psychological services. • Consider anxiety component to breathlessness and dysfunctional breathing • Consideration of low mood and strategies to improve mood, including timetabling and engagement in enjoyable activities. • Referral to appropriate psychological/ psychiatric services. **Discharge planning and on ward referrals** • Cognitive review and intervention prior to discharge including strategies and education • Consider physical environment of discharge location, and arrange provision of necessary equipment and environmental adaptations

		• Consider social environment of discharge location and support needs of the household, making onward referrals to social care as needed • Ensure discharge arrangements protect other vulnerable members of the household, e.g. if person requires an additional period of self-isolation upon discharge • Provide welfare and return to work advice, including graded adaptation discussions • Make onward referrals for community-based physical and psychological rehabilitation • Education and liaison with family and caregivers regarding discharge and support needs • Complex discharge planning and risk assessment if patient is to be discharged with artificial airway or non-invasive ventilation • Provide information to person, family and caregivers regarding post-COVID-19 fatigue, psychological changes, cognition, and breathlessness.
Community rehabilitation	**a) OT Knowledge and Skills** • Experience of assessing and supporting people with complex needs	**B) Occupational Therapy Interventions** **Screening and Assessment** • Maintaining an occupation focus: In liaison with hospital discharge team, urgent

	• Experience of supporting people receiving oxygen therapy • Experience of supporting people with tracheostomies • Experience of environmental assessment and specification of adaptations • Knowledge of a range of physical and neurological impairments • Knowledge of mental health conditions including anxiety, depression and PTSD • Competence in screening for mental health needs and providing psychosocial interventions to aid wellbeing and acceptance • Triage and risk assessment skills – to identify the right support to address people's needs and establish need for immediate or delayed	environmental assessment to facilitate safety and independence in the home • Information gathering from individual, family and care givers – establish pre-morbid baseline and any reported or perceived changes to functional independence in activities of daily living **Functional assessments to identify:** • cognitive and physical abilities during activities of daily living, mobility and transfers • attention, memory, executive functioning, orientation • posture and positioning, tolerance, muscle strength, upper limb function • Screening for visual difficulties and sensory changes • Screening for anxiety and depression **Capacity and insight assessments** **Goal setting** • Ongoing goal setting and review that follows a model of coaching and active listening: supporting the person to have complex and difficult conversations around what matters to them • Building confidence through positive experiences

	occupational therapy input • Awareness of existing community pathways and availability of specialist local services, e.g. psychological, pulmonary, respiratory	• Supporting the person to establish a healthy occupational balance between self-care, productivity and leisure • Using a graded approach to build resilience and skills to return to roles, routines and occupations. **Occupational Engagement** • Environmental interventions – teach strategies, advise on assistive technology and adapt the home to aid safety and independence • Cognitive rehabilitation – executive functioning, memory, orientation. • Teaching strategies, use of memory aids and communication approaches to enhance independence. • Referring to specialist neurological and memory services as needed • Provision and grading of occupation - focused upper limb exercise program • **Moving and handling interventions** – specification of hoisting equipment and training of caregivers • Mobility interventions and specification of mobility aids. • Onward referrals for wheelchair services, falls prevention and strength and balance programs

		• Identify need for long-term compensatory measures, e.g. home adaptations, re-housing and referral as appropriate • **Vocational rehabilitation** – grading, work hardening, employer liaison • Education and intervention around psychological wellbeing. • Address the barriers to people staying connected with families, friends, work and their community • Encourage engagement in meaningful occupations, physical activity and relaxation to promote wellbeing and reduce symptoms of mental ill health • Onward referral and collaboration where additional specialist input is required, e.g. cardiac, pulmonary, psychological. • Breathlessness and fatigue management – education, intervention and review. • Self-management techniques – pacing, grading, prioritizing, relaxation • Sleep hygiene education • Facilitation of group/individual rehabilitation delivered by other competent professionals, e.g. upskilling and training of therapy assistants, support workers and leisure providers • Provision of 'remote' services where interventions can be provided effectively

		via phone or video call (Discuss with client/caregivers if it can be possible) • Creation of self-management resources suitable for a range of audiences • Education, advice and support for family and caregivers
Outpatient clinics	**Occupational therapy needs** Some areas may consider setting up local post COVID-19 clinics, or follow-up of people recovering from the virus in existing outpatient settings.	• People recovering from hospital admissions due to COVID-19 may have a wide range of short and long-term rehabilitation needs. • The role of occupational therapists in these clinics will overlap with colleagues in community-based services, and collaboration and communication between settings should be encouraged to provide an effective and efficient service to individuals.
Elderly Home Settings	**Occupational Therapists Knowledge and Skills** The OT working in this area should have knowledge in geriatrics and have an understanding of the high risk levels of COVID - 19 on the elderly. The OT must understand other comorbidities that may occur alongside COVID - 19 and the overall implications on the performance of the	**Occupational Therapy Interventions** **Screening and assessment** • Applying an occupation focus, consider what assessments and interventions have already been completed with the person in the critical care and/or acute setting, refer to previous results as appropriate and only repeat where needed to establish current level of function. **Breathlessness and Fatigue** • Specialist assessment of posture and seating for provision of appropriate seating on the

	patient's activities of daily living.	rehabilitation unit and to identify seating requirements for discharge • Physical abilities – strength, tone, gross and fine motor skills, coordination • Equipment and assistance required with activities of daily living • Cognition – through function, as well as standardized screening and assessment tools • Perception and vision • Communication Need for step-down care • Mental health – fear, anxiety and mood • Mental capacity Identification of post intensive care syndrome (PICS) and recommendations for management plan • Functional outcome, independence and activity measures **Goal setting** • Discuss and agree with the person, and family and caregivers if appropriate, taking a 'what matters to you' approach • **Short-term goals –** interventions to reduce likelihood of long-term impairments; skills to support hospital discharge (mobility, seating, self-care) • **Long-term goals –** skills to support return to desired meaningful occupations, which may be progressed further in the community (self-care, productivity, leisure)

		• Apply activity analysis and graded tasks to support regaining function for people with limited exercise and activity tolerance • Assess the risk to support positive risk taking strategies to help the person regain function and confidence **Occupational Engagement** • **Position Management** advising on range of movement and muscle tone changes through 24-hour positioning regime and interventions, including splinting as required for the upper limb, correct positioning of feet and lower limb splints • Intensive rehabilitation to improve functional sitting ability, tolerance, balance and mobility • Advice on management of breathlessness and fatigue, alongside physiotherapists. • Consider grading and pacing of tasks, and teach energy conservation strategies • Functional upper limb rehabilitation and retraining • Training on transfers and mobility • Personal care – toileting and continence management; daily practice of washing, dressing and grooming tasks. • Interventions to aid communication, drinking and feeding, in conjunction with speech and language therapists

		• Cognitive rehabilitation and delirium management • Engagement in leisure activities to promote physical, cognitive and psychological recovery as well as provide diversion. Individually selected based on person's choice and equipment available. **Psychological interventions** • Listen to the person's lived experience, normalizing their experience and supporting a feeling of safety • Enabling connection with family and friends – using digital tools, photographs and letters • Rest and relaxation – provide access to appropriate mindfulness and wellbeing tools, with the support of technology when available • Encourage use of sleep hygiene strategies • Consider use of a diary to promote recovery following discharge • Application of trauma-informed approaches • Management strategies for anxiety symptoms, including referral to appropriate psychological services. • Consider anxiety component to breathlessness and dysfunctional breathing

		• Consideration of low mood and strategies to improve mood, including timetabling and engagement in enjoyable activities. • Referral to appropriate psychological/ psychiatric services. **Discharge planning and on ward referrals** • Cognitive review and intervention prior to discharge including strategies and education • Consider physical environment of discharge location, and arrange provision of necessary equipment and environmental adaptations • Consider social environment of discharge location and support needs of the household, making onward referrals to social care as needed • Ensure discharge arrangements protect other vulnerable members of the household, e.g. if person requires an additional period of self-isolation upon discharge • Provide welfare and return to work advice, including graded adaptation discussions • Make onward referrals for community-based physical and psychological rehabilitation

		• Education and liaison with family and caregivers regarding discharge and support needs • Complex discharge planning and risk assessment if patient is to be discharged with artificial airway or non-invasive ventilation • Provide information to person, family and caregivers regarding post-COVID-19 fatigue, psychological changes, cognition, and breathlessness.

Occupational Therapy Workforce Management during COVID - 19

Various measures have been proposed on work scheduling and planning of workforce to ensure continuity of care in the key service areas mentioned above.

Service Area/ Phase	Workload/ Bed Capacity	Occupational Therapy Staffing	Equipment needs
Critical Care settings	Less than 4 patients with COVID - 19	1 Per Shift	PPE (Equipment will largely depend on the client's needs and facility)
	All patients within the critical care setting available space e.g. 10 ICU Beds	2 OTs per shift	

Inpatient/step-down rehabilitation following discharge from ICU or acute ward	8 patients in a ward/ isolation unit	1 Per shift	PPE (Equipment will largely depend on the client's needs and facility)
Community Rehabilitation	8 patients in a in a given area and depending on the geographical distribution of the area.	1 Per shift	PPE (Equipment will largely depend on the client's needs and facility)
Outpatient Clinics	8 patients in an outpatient clinic	1 Per shift	PPE (Equipment will largely depend on the client's needs and facility)
Elderly Home Settings	8 patients in a home setting	1 Per shift	PPE (Equipment will largely depend on the client's needs and facility)

Guidelines for Resumption of Occupational Therapy Services

Whereas it is presumed that Occupational therapy services in the hospitals are running, those in community centers and schools with occupational therapy clinics are closed down due to COVID - 19. Closure of schools has greatly affected delivery of the so much needed occupational therapy services to the vulnerable persons with disabilities and more especially the children.

The guidelines herein will strictly adhere to both the WHO and Government of Kenya guidelines. These draft guidelines also propose strategies that will ensure continued occupational therapy services in both public and private facilities.

To ensure Occupational Therapy services is in line with existing directives and protocols from the Ministry of Health, the Occupational Therapy Practitioners will stay updated on COVID - 19 information as they go about their duty.

Strategies towards Opening of Occupational Therapy services

1. Establish a reopening committee and create a work plan.

Create a committee to brainstorm your reopening work plan. The committee will meet often to spearhead a coordinated effort for reopening Occupational Therapy services in a way that instills confidence among service users, service providers and employees. The committee will involve stakeholders ranging from service user representatives, service provider representatives, employers or human resource representatives. Furthermore, loop in any stakeholders like the National Council of Persons with Disabilities, ministry of health and ministry of education representatives that will play a key role in your work plan, and designate a point person to answer employee and service users' questions as well as proactively respond to complaints.

Key areas that should be included in every service provider work plan:

- Create a communication plan for informing employees on new clinic protocols (e.g. Schedule spacing, use of personal protective equipment [PPE], and equipment cleaning frequency).
- Create a communication plan for distributing pertinent information to new and existing service users. This includes information about appointments as well as safety procedures and requirements (e.g., medical screens, visitor restrictions, and clinic measures to enforce WHO and MOH guidelines).
- Review existing workplace safety policies and make a plan for updating them with your new procedures.
- Develop a plan to let your referral sources know you're open for business. Be sure to inform them of your hours of operation (especially if they differ from your pre-pandemic hours), the protective measures you've implemented to prevent infection, and any innovative service delivery options you are offering (e.g., outreach or homecare services).
- Consider easily understandable signage for service users who need access to your services so they know when and where they can enter (e.g., whether they can enter through the front door and the hours during which they can enter).
- Assess your cleaning and PPE supplies to make sure you are well equipped to ramp up in-person services.
- Develop checklists to make sure you are considering everything before you move forward.
- Develop a cleaning protocol in accordance with WHO and Government of Kenya guidelines that covers everything from computer hardware to linens and surfaces.

2. Reconfigure your clinic to meet all WHO and Government of Kenya guidelines on COVID - 19.

WHO and Government of Kenya guidelines for healthcare settings recommend certain measures for reducing the spread of infection, including:

- Limiting face-to-face contact where necessary;
- Frequently washing hands;
- Using face coverings (masks);
- Creating at least six feet of space between individuals;

- Installing physical barriers or partitions in waiting room areas;
- Placing curtains or partitions between shared patient areas;
- Routinely cleaning and disinfecting all surfaces and equipment.

Shared Work and Break Areas

- Use these guidelines to develop a strategy for reconfiguring shared work spaces for social distancing.
- Limit the number of employees allowed in any shared areas at the same time. Implement cleaning and infection control protocols (e.g., non-touch trash receptacles and requirements for cleaning common items like refrigerators and microwaves).
- Do not allow employees to share food for the time being.
- In high-traffic work areas, either create individual workstations or implement cleaning protocols to reduce the spread of infection via computer hardware and office equipment.

Entry Spaces and Waiting Areas

- Rethink your clinic's entry space by restricting the area to service users only. Restrict the number of service users allowed in the area and/or requiring service users to wait in their vehicles or in an open space where social distancing is possible.
- Create a barrier or use a visual guide (e.g., a tape line) at the front desk to encourage social distancing.
- When checking service users in, encourage them to use mobile money to process their payment, if possible (rather than having your staff receive hard cash).
- Consider having service users' use a patient portal to complete questionnaires and electronically sign documents. Finally, try to arrange for delivery people to use an alternate entrance so they can avoid entering the waiting area.

Clinic Operations

The entry space isn't the only clinic area prone to crowding. To reduce density throughout your office, consider the following measures:

- Stagger your patient schedules.
- Consider expanding clinic hours or increasing the number days per week your clinic is open to reduce the number of service users in the clinic at any given time while continuing to meet service user needs.
- Offer virtual visits whenever possible or offer a combination of in-person and telehealth visits.
- Remove extraneous furniture and equipment to open up your space.
- Post signs explaining your clinic's social distancing guidelines for employees and service users.
- For your mobile therapists, implement cleaning protocols for equipment that will come back into the clinic after home visits.
- Provide your therapists with PPE, hand sanitizer, and cleaning supplies for the road.
- Consider scheduling telehealth visits in lieu of home visits whenever possible to reduce the spread of infection.

Telehealth Services

Telehealth service provision has proven to work extremely well during the pandemic, rehabilitation service providers have a rare opportunity to start integrating telehealth into their practice models.

Doing so as soon as possible allows your employees and service users to become accustomed to new workflows. It also supports business continuity in the event of any future disasters or emergencies.

Telehealth provides service users with more options for receiving services. Rehabilitation service providers should be creative and think about how they can incorporate virtual care into their intervention plans.

Develop a process for reviewing your schedule and thinking about which service users may benefit from virtual visits. Educate your employees about the appropriate use of telehealth services.

Finally, telehealth service provision is mostly possible in urban settings where network and internet connectivity s high.

3. Reconfigure your employee schedules

As you reconfigure your clinic, also consider reducing the number of employees allowed in the clinic at any given time. To do so:

- Identify those employees (e.g., your front office staff) who can continue to offer services considering their age and health conditions.
- Review your patient schedule and create a rotating dedicated telehealth day where possible for your employees to work at home.
- Allow therapists who are delivering virtual visits to do so at home to avoid overcrowding in the clinic.
- For those clinicians who need to be onsite, stagger their schedules to ensure observance of social distancing guidelines.

4. Prepare for potential employment issues.

The pandemic and subsequent lockdown put a new spin on employment issues. Employers must now consider the following when reopening their clinics:

- How and when to bring back employees on leave;
- The best approach for hiring new employees in the midst of a pandemic;
- Employee testing and monitoring protocols to keep everyone in the clinic safe;
- Employee concerns about returning to the workspace out of fear about becoming infected with the virus.

Bringing Back Employees from leave

If you have any employees on leave, determine who will return to work and how they will return to work (Based on the level of vulnerability to COVID - 19).

Communicate early with employees if you are changing their work hours, and job duties.

Reducing Risk in the Workplace

Healthcare providers are classified as high-risk exposure jobs because of the high potential for COVID-19 exposure. The guidelines recommend the following for employees who fall into the high-risk category:

- Implement policies for reducing exposure, including educating service users on COVID-19 symptoms and instructing them to cancel in-person sessions if they are sick.
- Post signs in your clinic describing COVID-19 symptoms and inviting service users to bring their own mask if they have safety concerns.
- Consider implementing an employee testing and monitoring plan to prevent outbreaks.
- Provide employee training about infection control, COVID-19 symptoms, and your new post-pandemic policies.
- Make sure you have plenty of cleaning and sanitation supplies on hand (and do not require your employees to bring their own).
- Have hand sanitizer, soap, and cleaning supplies readily available to coincide with your new protocols for cleaning treatment areas.
- Remove equipment and supplies that are not easy to disinfect, such as therapy putty, play dough, bean bags, and cloth chairs.
- Provide your employees with PPE masks and gloves.
- Your employees should be equipped with the N95 filtering face piece respirators.
- Make sure you have enough PPE for all employees.
- Implement protocols for how and when to use PPE.
- Implement procedures for PPE disposal and have dedicated biohazards bins for disposal.

Infection Testing and Monitoring

Implement a COVID-19 testing and monitoring plan when your clinic reopens to reduce the risk of infection.

Testing plan should include any combination of the following:

- Daily screening protocols, such as temperature and symptom checks;

- Periodic Virus testing at the Government of Kenya approved laboratories;
- Ramp up your environmental controls and strict policies on prohibiting sick employees and service users from entering your clinic in order to reduce the risk of infection.

5. Implement an exposure plan

An exposure plan is a critical component of your reopening strategy. As a rehabilitation service provider, your plan will cover both employees and service users. Your exposure plan can include the following key points, based on CDC guidance:

- Requiring return-to-work certifications for employees who fail a screening or who have tested positive for the virus. The certification should be from a laboratory approved by the government of Kenya.
- Get a list of the people who reside with the infected employee or service user.
- Employees who were exposed to an infected person to remain home for 14 days' self-quarantine.
- Prohibiting infected service users from returning to the clinic for 14 days.
- Closing off the area where the infected employee or the patient was located for 24 hours and heavily disinfecting the area (require gowns and gloves as part of a decontamination process and refer to the CDC cleaning guidelines for specific decontamination steps).
- Informing employees of the exposure while maintaining the confidentiality of the individual.
- Training employees on the exposure plan.
- All occupational therapists should monitor themselves for signs of illness.
- If you are sick, stay home.
- If you have symptoms, think you were exposed to COVID-19 or have returned from travel outside of Kenya or from a COVID-19 affected area within or outside of your county within the last 14 days, do not go to work, notify your supervisor immediately.
- If you start experiencing symptoms while you are at work, if not already wearing PPE, immediately put on the PPE.

References

1. Canadian Association of Occupational Therapists. https://www.coto.org/docs/default-source/covid-19/covid-19-return-to-work-guidance-for-occupational-therapists.pdf?sfvrsn=cb132626_4 [Accessed 10 June 2020].
2. Centers for Disease Control and prevention. CDC guidelines on PPE use, https://www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe [Accessed 12 June 2020].
3. Grasselli G, Zangrillo A, Zanella A, et al. Baseline characteristics and outcomes of 1591 patients infected with SARS-CoV-2 admitted to ICUs of the Lombardy region, Italy. JAMA 2020; 323:1574–81.
4. Mao L, Jin H, Wang M, et al. Neurologic manifestations of hospitalized patients with coronavirus disease 2019 in Wuhan, China. JAMA Neurol. 2020.
5. Royal College of Occupational Therapists. A quick guide for occupational therapists: Rehabilitation for people recovering from COVID-19. London; 2020.
6. World Federation of Occupational Therapists. https://www.wfot.org Occupational Therapy and COVID-19 pandemic-information & resources [Accessed 12 June 2020].
7. World Health Organization. COVID-19 strategic preparedness and response plan, 2020. Available: https://www.who.int/docs/defaultsource/coronaviruse/covid-19-sprp-unct-guidelines.[Accessed 10 June 2020].
8. World Health Organization. Rehabilitation in health systems: guide for action. Geneva: World Health Organization, 2019.
9. World Health Organization. Rehabilitation, 2030. Available: https://www.who.int/disabilities/care/rehab-2030/en/[Accessed 10 June 2020].

Annex 1

List of Contributors

1. Dr. Laban Thiga - Ag. Director, Directorate of Health Care Services
2. Dr. Julius Ogato - Head, Department of National Health Services Strengthening
3. Mrs. Irene Gichohi - DIP OT, BSc OT, Ag. Chief Occupational Therapist
4. Mr. Nicholas Nyamweya - DIP OT, BSc OT, Occupational Therapist – Chief Occupational Therapist's Office
5. Mr. Evans Obaigwa - DIP OT, HND Sensory Integration Therapy, BSc OT, MSC OT, MSC Gerontology, President - Kenya Occupational Therapists' Association
6. Miss. Eunice Ndirangu – DIP OT, BSc OT, MSc Community Health Development, Senior Lecturer and HOD, Occupational Therapy Department, Kenya Medical Training College, Nairobi
7. Mr. Erastus Shuma – DIP OT, BSc OT, World Federation Of Occupational Therapists Representative, Private Practitioner
8. Mr. Peter Nyaberi – DIP OT, County Occupational Therapist Kisumu County
9. Mr. Lincoln Kabanya – DIP OT, BSc OT, Coordinator of Occupational Therapy services, Nairobi County
10. Mr. Naphtali Yego – DIP OT, BA Counselling Psychology, BSc OT, MSc OT, Chief Occupational Therapist - Moi Teaching and Referral Hospital.