Academy of PHYSICAL MEDICINE

Safety Policy Post-Lockdown

with Danny Orchard

10th May 2020

TRANSCRIPT

Please note, this is not a verbatim transcript:

- *Some elements (repetition or time-sensitive material for example) may have been removed*
- *In some cases, related material may have been grouped out of chronological sequence.*
- *The text may have been altered slightly for clarity.*
- *Capitalisation and punctuation may be erratic…*
- *There may be errors in transcription. If something appears odd, please refer to the recording itself (and let us know, so that we can correct the text!)*

Steven:

Good afternoon. Once again. Today I'm joined by Danny Orchard from Core Clapton. Danny, welcome.

Danny:

Thanks again.

Steven:

Great to have you with us. We're talking some pretty serious stuff today rather more about policy than actual practice and you've produced this fantastic document and it's 30 pages of very carefully thought out policy work regarding how we make sure we touch all the right bases as we bring our clinics back into operation. Perhaps I should say to people that if they want to download this document, there are two ways to do it. The first is if you use this Bitly link on your website, Bitly/Core Clapton, you will get the opportunity to download this as a Word document and also on the Recordings page for today's CPD, it's already there as a download. Also, I imagine if you get in touch with Danny at Core Clapton, you'll be able to do the same. Anyway. Danny, tell us about the document. What's prompted this for you?

Danny:

Yes first of all I would like to say I'm not an expert in this at all. Like I said, Core Clapton, which is a charity that's trying to promote Osteopathy and make it affordable to people on low incomes and we're slowly trying to do some research looking at outcome measures etc. So from suddenly being a single Osteopath in a small one room clinic many years ago to suddenly running a charity, I've had to obviously do a lot of policies and all the sort of things you need for any sort of organisations bigger than a few people but I wouldn't say I'm an expert. What really prompted this was actually a grant we applied for because as most of you out there are aware we're kind of suffering during the lock down and we've not had any sort of government help at all.

Danny:

So we were applying for some of these big grants and they had a big section that said, 'What is your safeguarding policy for COVID - 19?' which led us to sort of scurry around trying to find what the actual guidelines were. Obviously the GOC and the, iO have been putting out regular guidelines updating as much as they can based on what the Physiotherapists and the NHS are doing and I guess I was looking around at Twitter, we were really kind of keeping an eye on a lot of this stuff and even the Physiotherapists are asking what are Aerosol Generating Procedures (AGP). There's varying clarity because at the end of the day it's a risk assessment. And it's the same with a large building you have to do risk assessment. You can't have everything by the guidelines because it then becomes impossible so you have to make a judgment call really on what's happening at that moment in time. So basically we fought for this grant and then looking at reopening and actually we're having our first patients day, only any key workers and NHS staff for now so it was kind of timely because we put the document together for a grant and it's actually led to us having a nice sort of procedure for opening our clinic.

Steven:

You're very modest Danny; you really undersell the nature of Core Clapton and we've done a broadcast with you before so that we could highlight what you do down there but as you said you are a charity. You're providing an incredible facility down there in London and I know you're short

of cash and of course people who want to can donate to Core Clapton through Just Giving and we'll give them the opportunity to do that later. Obviously funds are tight for everybody but particularly for charitable enterprises like yours. The document, I see it serves a number of purposes obviously from yours primarily, it satisfies the grant givers that you've thought about COVID - 19 so there's always a need to satisfy people in offices that you've ticked the right boxes when it comes to having policies.

Steven:

But actually it's probably it's certainly the most recent, most comprehensive document that I've seen by anybody who has thought through all the things that we should take into account when opening a clinic in currently in quite a high risk Coronavirus situation but even as we get out of this and there will be a continuing risk for a very long time to come as we all know. These sort of things need to be in place. You started off with a section on preparing to re-open and do you want to talk us through what you put into that part of it?

Danny:

I guess I'm just reading the Facebook posts that everyone's doing. Facebook is a lot of people doing a lot of great research around this topic so it's clear that there's a lot of stuff that we didn't, none of us really know how to go about it. What sort of training do we need for our staff? How can we sort of create some sort of self assessment checklist to make sure we're all competent and competent with the things we're going to do? I think as you said, because we are a charity and we have sort of low income people coming amongst others, there's a real risk because as we know, you've got two thirds of the people dying out their minorities, so we have to be extra careful in terms of not being a vector and spreading it.

Danny:

I mean, I'm healthy. I think I had it right at the start and had a fever for a few days. I'm not too worried about catching it myself, although we should be, especially if we have families etc but I definitely didn't want to be a vector to transmission of it. So, you know, we're taking it as seriously as possible but you know, there's some great stuff out there, sort of questioning how much PPE you use. The more PPE you use, the more likely you are to have behaviours that then are non-hygienic so touching your face etc so it's a real risk assessment rather than any strict guidance so preparing to reopen was just about, the staff, the bigger team and what we're going to have to learn.

Steven:

Do you think there's a danger Danny, the people who, let's say, in this case

Steven:

People who know that they have had COVID - 19, they've been tested for it, had it, and they've now been tested and they're clear, do you think there's a danger that they no longer believe that they can be a vector for the disease which I would imagine is definitely not the case.

Danny:

Yeah, I mean, it's a great question and I don't think anyone knows yet. There's some studies looking at the reinfection rate and it can be up to 2% now.

Steven:

Well no, I didn't mean that, I just sense amongst people that think, 'If I've had the disease, I'm safe. I can go out and ignore all the decontamination measures and everything else.' But the fact is, if I touch Coronavirus, I can still pass Coronavirus to you, even if I can't catch the disease again, if that is the case.

Danny:

Yeah, and it's a good question especially when you look at the Aerosol Generation, if it's suspended in the air and depending on the size of the particles etc, can you walk into it, have it on you, walk out and then pass it on? Again I don't necessarily know and that's why they're talking about droplet spread directly onto mucous membranes; that's your eyes and your mouth really that you need to protect. There's very little to say the hands are really important to protect unless you've got cuts or less sweat is going into it. But again, if you don't have gloves on, you know, it potentially leads into bad behaviors so I think you're right in terms of if you've had it, you're going to be more gung ho and then you're more likely to leave the door open to the PPE stuff but I think if you just think that every person could have it that's the key thing really. Every patient is hot as they say and every person is vulnerable and if you just think about that, then you should be safe. You think of the treatment room as a contagious space and then outside the treatment room is a non-contagious space and you're trying to stop the spread of stuff coming out into it but we can go into more detail on that later.

Steven:

Yeah. I also think the business of BAME, Black And Ethnic Minority backgrounds, can be slightly misleading as well because effectively, although there is a greater risk of death and serious illness in those communities, actually we still have to treat every patient as though they might suffer that ultimate fatal consequence, don't we because we don't know of any of our patients who is really at risk from this? We've got guidelines of course.

Danny:

Yeah, absolutely and this is the discussions going on Facebook about risk and whether you die of coronavirus or die with it and

Steven:

Or because of it

Danny:

Months or years later we look retrospectively but I think as we don't know at the moment, we have to be safe for everyone.

Steven:

Yeah, indeed. Now you talked about Aerosol Generating Procedures (AGP) earlier on, which as you say, has caused a bit of confusion. Can you tell us what you now have learned what that actually means particularly in terms of Osteopathic, Chiropractic and Physiotherapeutic procedures?

Danny:

So an AGP, an Aerosol Generating Procedure is basically anything that causes a large volume of air to be produced by the lungs, it's going to be carrying particles on it. Initially the guidelines, sorry, our re-opening document, we based it initially on acute hospital management guidelines in terms of the layout, which is why it's a bit, it's quite in depth and maybe too in depth for some people who aren't running a large clinic but you know, they're talking about physiotherapists who are going to be doing intubation when they're actually going into the throat. They're doing oscillation of the lungs and techniques that are there to induce coughing. So a lot of respiratory Physiotherapy is to do just that. So they're obviously clear Aerosol Generating Procedures. With stuff that Osteopaths do, it's very hard to say.

Danny:

But you know, anything from lifting a heavy patient means that you could start to heavy breathe and that means that deeper air is going to come out potentially causing aerosol. If someone's doing some squats in the room and theoretically they could be producing more aerosols, which then makes it more likely that the room will fill up with contagious material down to to chest compressions on the lung if you're going to do some sort of sternal release or upper rib technique. So it's really hard to know because it's how fast you do them, how much pressure you put in there, and sort of health states of the patient, I guess,how close you are to the mouth. There's so many factors, which is why it needs to be a risk assessment at the moment doing it. But to kind of clearly say this is definitely an AGP versus this is not, I think it's almost impossible, which is why Dawn Carnes is talking about this later on today in the iO lecture but it's complex.

Steven:

Well interestingly, you've mentioned the procedure though, if you're oscillating the lungs, but it is categorically stated by the NHS that doing chest compressions for CPR is not an Aerosol Generating Procedure and that's compressing the chest considerably more than we would ever do in terms of oscillating during treatment as an Osteopath or Chiropractor.

Danny:

Yeah true and I think again with guidelines, especially when the political guidelines, they're looking at what's the greater good or what seems like, my take on that is people probably were standing back and not doing CPR because they're clearly producing aerosols maybe people were dying so they sort of said, listen, for CPR, when it's that important, don't worry too much about it, it's not an AGP. But, I think then that's why it's a little bit dangerous to extrapolate from that to, to an osteopathic technique with it. Especially if there's a way around it. If you could do the same technique, you know, in a different format. Again, I think, the talk last week with Matthew saying you could lie on your front and do a prone technique, you know, that will make a lot of sense to me. So really it's about mitigating that risk but I do think it's dangerous just to extrapolate from other areas that aren't directly related to it .

Steven:

In terms then of protecting oneself in Aerosol Generating Procedures, and I don't want to get into too much detail about PPE because that would be to cover what the IO is covering in its broadcast after this in its webinar, have you got any idea how far, let's say you mentioned the patient doing squats. So if someone's doing squats and is breathing more heavily because they're doing squats, over what distance are you vulnerable to an aerosol generated bug?

Danny:

Yeah, these things we don't really know. There's a paper I shared on Facebook, which had the distance a couple of meters straight away and then within seconds it's filling the room and it can take up three hours to stay in that room before it then settles on all the surfaces. So when you think about cleaning, the floor and horizontal surfaces are going to be collecting, potentially infectious material. So also being realistic, you know you could start to get really, paranoid. You think about every single tiny little spore that might be out there floating around. So that's kind of why we're going to treat the room as a potentially infectious space. We're going to leave it for 30 minutes to settle and then clean it quickly and then that space is now clean and fresh and decontaminated.

Danny:

So we'll be going in fully donned, going into the room with our masks to protect us and then we'll leave the room. We'll have a doffing station just outside of .... We're quite lucky because we have a big centre so we can have a doffing station outside. If you've got very small clinic, you know it's going to be more difficult. So you could do half the doffing inside and leave your mask. But just treat that room as you know the aerosols is going is going to be around there potentially for a while.

Steven:

Any thoughts on the risk from that aerosol. So if we're wearing fluid resistant masks, fluid resistant surgical masks I think is the correct term isn't it, of whichever category you'll tell us about in a minute, that's going to prevent us inhaling something? If our patients are also wearing those masks, does that completely overcome the problem of aerosol generation?

Danny:

Again, it's a risk assessment. If you're going to be doing lots of stuff that's making really heavy breathing and there's a chance that they may have it, which again we're kind of assuming that everyone might have it, then you might want to have an FFP3 mask on to breathe with to make completely sure that you're not going to catch it. You don't have to have a patient in one of those at all. The current guidelines is just to have a mask of any type. It doesn't even have to be a fluid resistant one for the patient. Just something to stop them then coughing on you. But really PPE is about protecting and again, as you say, we want to go into too much today but it's protecting yourself from the stuff. So the fluid resistance is so that you don't absorb it through the material. If it's just stopping it, the spread of it then any, any protective covering should be enough.

Steven:

Yeah. And are you also using visors or eye protection in your clinic? Will you be doing that?

Danny:

We're going to use in glasses because again you're trying to protect the mucous membranes. So we've got these good old fashioned chemistry specs you get partly because some of our staff wear

glasses so they're Over glasses. And I've seen pictures of people in their visors and I think, you know, great, great, they've dived into it and gone full hog but again, it's just direct splashing onto the eyes and I'm not going to be treating someone who's coughing or symptomatic so again, I'm not too cautious about that. As long as if I do get it I'll stop working and we're going to make sure our staff are aware to not come in if they're symptomatic. We'll take temperatures. You can't avoid getting it yourself somewhere on the bus etc so really as long as you're asymptomatic, when you're treating patients, you're putting on all your protective stuff so that you can easily catch it and definitely not transferring it to them then I think we're doing everything we can possibly do.

Steven:

And that is all that can be expected of us and I don't think that we could be held legally liable for anything that happens to a patient if we are doing that given that it's almost impossible to prove where a patient might have contracted the virus. The biggest problem, biggest risk to us in the clinics is that somebody, a patient perhaps who did get COVID - 19 says, 'Well, I don't think they were using the right procedures in that clinic.' and then it becomes irrelevant whether we actually were the vector that caused them to have the disease. It means that we weren't adhering to our responsibility to keep patients from harm.

Danny:

I think as long as you're showing, again, if you do a risk assessment and you've looked at them, maybe share it with colleagues just to make sure that it looks right then as long as you're following that, you said that we looked at the risk, we decided what the potential effect of it may be and we've mitigated for that and then I don't think you can get in trouble with doing that whereas if you put full PPE in and then you're not really exposing it properly or you're just walking out and having your lunch then you probably can be.

Steven:

Well interestingly I looked on the NHS website today sometime, yesterday, I can't remember the time flies at the moment and there's a section on there which talks about correct PPE and disposal of PPE and I couldn't find a single thing which explained how you are supposed to correctly dispose of PPE, whether you have to treat every item of PPE as clinical waste or whether, as I know is policy elsewhere. If you're talking about disposable scrubs or you know, paper covers for plinths, you can double bag them, leave them for 72 hours and then dispose of them as normal waste on the theory that the bug will have died in that time. What is your understanding about disposing of PPE?

Danny:

Yes, no, exactly that really.

Steven:

There were two there, which one Danny, you can't sit on the fence?

Danny:

Oh sorry what were the choices?

Steven:

Do you have to dispose of everything as clinical waste or can you double bag the paper stuff and keep it for 72 hours and dispose of it?

Danny:

Stop there.

Steven:

Did you lose it?

Danny:

Definitely. You can put it aside. I think things should be single use or really sessional use so glasses and stuff, you can clean it after session. Aprons need to be fluid resistant so it isn't going into you, but so they, they like it to be disposable, no reason why you can't have the same, treat your apron as glasses ie something that you clean each time so it's still single use. Sorry I'm doubling up because I have just read the latest guidelines saying it was showing that masks now be sessional use so you can keep masks and goggles on for a session so you know, the morning session then clean them and change them at lunchtime whereas a few days ago everything was single use you'd have to clean up after every patient or change them. But whatever way you're doing it, anything that's been in that room is now clinical waste and therefore has to be either disposed as clinical waste or put into a bag and kept for 72 hours until it's no longer infectious. So I think it's kind of the same thing. It's just one is disposing straightaway clinical waste. The other is waiting until it turns in household waste.

Steven:

Then you're going to have a problem tomorrow if, because when you reopen, you're going to have to shave because the masks and things don't fit over facial hair.

Danny:

Yeah. I'm going to get one of those sort of the beard ones I think as well.

Steven:

Is there one yet?

Danny:

Uh I don't know. Actually. I don't know.

Steven:

I'm really thinking back to my days in the military when we were preparing for nuclear, biological, and chemical warfare. If it ever got to the stage where we needed respirators, everyone had to shave. And I really only applied to the Navy who were allowed to have beards. But there were no masks that could give you a seal of a facial hair.

Danny:

Yeah, I guess thinking about it we're worrying about us being infected hence the fluid protecting stuff so it's probably less relevant as long as you properly wash it and it doesn't go anywhere near the patient so depending how big....

Steven:

If you've got a thick enough beard it will act as a filter won't it....

Danny:

Yeah, I think we've got a big beard there's a danger of it touching someone and maybe that's that

Steven:

Sessional use. And again, I looked into that and of course it means as I interpreted it, if you're wearing one of those surgical masks or one of your staff is, you can't actually take it off. You can't, you're not allowed to put it under your chin to get a breath of clear air in between patients. You're supposed to keep it on the whole time, otherwise it doesn't count as a session.

Danny:

Yeah. And I think the reason they changed from a single use per patient to sessional use was that every time you try and take it off and clean it, you're potentially infecting bits of it is a higher risk so the most safest thing to do is to have the masks and gloves on for your session and not touch it. That's all.

Steven:

Yeah.

Danny:

But obviously if you, if you get things that itch and stuff then you should probably treat it as a single use. Take it off, scrub it, clean it, put it back on again. So I think you just have to be really aware of how much accidental touching you're doing and just try and minimize that.

Steven:

Yeah, I think given that the masks themselves, provided you can get hold of them, are relatively cheap. Lots of people will be changing them in between patients just so they can take them off and get a breath of, as I say, clearer air (..in between..). You produced a very nice little diagram in your patient pathway in this document of exactly how a patient will move through Core Clapton and I suspect that people would be very keen to develop something for their own building, even if it's only a sort of a step by step guide to help patients come in and leave for the patient's benefit. What considerations did you have when you made up that diagram?

Danny:

I think we based it mostly on the two distance social isolation measures so we were trying not to have people going in and out at the same time. Gain, we've got a large building and there's a fire exit at the back as well so it was quite easy for us to have a single stream of coming in one way and going out the back. In essence people are going to .... And we've got a buzzer outside, people are going to ring, we come out and give them a mask and this is just copying what the local GP says he's doing, give them one of the cheaper masks, this is the non-fluid repellent ones. We will have our masks on if that's an admin staff otherwise the Osteopath will have their masks and their gloves on as well and

their goggles, they're fully ready to go and then we go and treat them, 10 minutes for consultation and treat them. What did you just say, you'll have to remind me. Oh sorry I can't hear you Steven for some reason. Is that me? I will do a little song and dance before we get Steven back on line.

Steven:

How are we doing, can you hear me now?

Danny:

Yeah. So excellent. Cool stuff. I think, you know, if you've got a small practice and you can't have them going in another exit then that's fine. And you'll probably be able to look at timings and have patients arriving at different times so that they're not going past each other but having said that we have been super cautious for this grant and also for insurance. But if people have got a mask on, then if you look at the NHS guidelines for all the HE? Guidelines and for a reception worker for example, they should have a mask if you can't keep two meters distance, which is a lot of the time if they do lean near the desks then so if you, based on that you could argue that patient's coming close, going past each other as long as they both put masks on, they're kind of safe. So the one that's leaving has a mask. Someone's popped out to give the new one a mask and they're fine. So again, reading different bits of the sort of legislature you can work your clinic.

Steven:

Where are the patients in your practice getting their masks? Are they being given masks at the door or being told just to bring something of their own to cover their face?

Speaker 2:

So we just bought a load of the cheap ones, the non-fluid repellent ones. So we're going to go and give them, but we also, in our online booking kind of procedure or whether in the admin ..... And we'll be giving, we'll be suggesting that they come in and then the end of the day after they've got their own stuff on. As far as I'm concerned, it's totally fine because they've not touched anything. They're just keeping it on and leave them with it on. So it's just about them emitting fluid, I guess.

Steven:

Finoula sent in a question really about the Aerosol Generating Procedures we discussed a little while ago. She's saying well surely breathing releases a virus anyway, so what's the real difference?

Danny:

So if you're going into a room and they've definitely got it in a COVID Ward in hospital, then it's likely that it's going to be in the air and then you're going to want something as tight as possible. So you want an FFP3 mask. We're treating asymptomatic patients. We don't quite understand the asymptomatic spread properly yet. Don't quite know how big the aerosol particles the virus will hang on to. So again, it's about trying to be safe as possible. If you go as far as thinking well any breathing will do that, which is true, and I get that, you literally as soon as they come out of the room, it's going to still be coming out. It's going to affect your front, your reception area you just literally couldn't open and I think the key thing is it still is 80% of the population are fairly, it's like a flu to

them. I think we have to still be realistic that we're trying to save the vulnerable and It's really important that we don't get a second wave, but 80% of the population are going to get mild flu from it and that is all and the economy thing is another question that we can get onto, but we have to be realistic about this.

Steven:

Vladimir sends in a predictable question. What do you think about the standard AP dog technique for releasing the thoracic? Is that an AGP?

Danny:

I think that's probably one of the potentially most likely ones to do that because your face is quite close to their face and some explanation of that. So I'll probably not be doing those because of our patient base but again, it's a risk assessment as far as I'm concerned. If you've got a very healthy population in a distant part of the country that's not a Hot Spot and you decide to do that, I don't think you could necessarily be taken to Court on that but it all depends who's coming next etc.

Steven:

And again, you talked about the atmosphere in the room being contaminated potentially with Coronavirus after a patient leaves and it's very difficult to recycle the air completely in a room, isn't it? Even we're fortunate at the moment we can open the windows and let some air blow through, but there's no way of anyone telling us how long it takes to completely replace all the air with cleaner. And even so the air outside might have Corona virus in it as well if there were people passing by.

Danny:

Yeah, exactly. I think you have to aerate the rooms as much as possible. I mean the guideline would be based on they had an exact amount of airflow you need to have because it was a hospital. If you've got windows and obviously then either have them open the whole time or just when you take the patient out, open fully and give it a bit of time to air. But and again, it's a risk sort of,(for success make you say no of sleep) but it's, you know, it's going to be around in that room. You're going to wait for it to settle then clean it as much as you can, but I don't think you can avoid being sort of everywhere to a certain degree. So as long as you're not getting droplet infection, which is the main concern, is direct droplet infection into your mucus, then I think we can be less worried about that.

Steven:

And I think we're already, what we're seeing here is, is what you touched on earlier on that people are getting obsessed with trying to achieve zero possibility of transmitting the virus when actually what we've got to do is to apply the best possible practice we can and accept the fact that there will always be some sort of risk in this.

Danny:

Yeah, absolutely. And then, if you start getting really busy and you're seeing patients who are in real need and then you might have to drop your standards slightly, not to anything that would be

dangerous, but that the time between patients may be slightly reduced. So initially you may start with a gap, and then it may drop down to sort of 20 -15 minutes because you need to see patients who need to be helped. And I think it's important to remember that the HE Health Education England have been keen for us to get out there and help people who are going to be suffering and we're going to cause more suffering and more costs to the economy in the future.

Steven:

Yeah, Danny, I've forgotten, It's a while since I've been down to Core Clapton, do you have carpets in there? I asked the question because Hugo was asked whether it's a problem in his own clinic.

Danny:

Yeah, it's a good question. I can't actually answer that. I've seen some posts. We don't have carpets. I can answer that bit but I don't know. I see a few posts saying that carpets aren't quite as bad as people think but hospitals and GP surgeries always have heavily washable sort of vinyl floors. I'm not sure you'd have to look into specifically the effect of whether you can put like antiviral carpet cleaner shake and vac it does that work? You'd have to look it up I am afraid.

Steven:

Again, we need to talk in terms of what is feasible and reasonable, don't we? I mean there are relatively few people with mucus membranes in their feet, so the transmission from the carpet to the foot is not going to be a particular problem. It's the biggest problem as always, is what you touch with your hands before you touch your face I guess. And so again, are you going to kick up Coronavirus by walking across the carpet? I would have thought the chances are very low and I wouldn't have thought that we would be failing to exercise our duty of care simply because we continued to accomplish in the clinic.

Danny:

Logically it seems to me. Yeah, no, I agree. I agree. And I think, you know, again, if you're in a COVID ward in a hospital and everyone there has it and you have the carpet, it's probably picking up spores the whole time or creating aerosols that would be bad but in a clinic where we are treating asymptomatic patients, I'm assuming everyone is doing triage actively contagious then, or symptomatic, sorry, then . Sorry. Then, es, it's mitigating risk.

Steven:

Sarah has asked the question, I wonder, I don't know what your procedures are at Core Clapton for getting patients to come into the clinic, but she's talking about collecting patients from the car park, which II presume one would have to do if they haven't got a mobile phone that you can text and asking whether it is permissible to go out into the car park in your PPE and then come back in. So there's two questions there for you: What's your procedure for actually bringing the patients into the clinic in the first instance? And then what do you think about what she's asking?

Danny:

So we've got a hand sanitizer outside and then a buzzer after that. So they're told to sanitize their hands, then press our buzzer and then someone comes to get them and gives them a mask and then they walk in. We're sanitizing the handles as we go so that each time we can open doors and get to the clinic and we're meeting them with our PPE on so I guess when you're going outside, it just depends how far you go. And it depends how many surfaces you're touching that you can't control. But if you've literally wiped them all between patients and you know, I think you also have to think from a PR sort of perspective. You know, if you're seen to be touching a hundred doors with gloves on and then going into the room and treating them, that might look quite bad so you have to make a call. You want to put the gloves on in the room just in front of the patient after washing your hands. I mean, some people are not going to use gloves and I think, I don't really want to comment on that. We're following PHE guidance for now until it changes because we're going to be treating doctors and we don't want to be looking to challenging anything but there is some good evidence to show that washing your hands thoroughly is as good as gloves, but we're just taking extra precautions I didn't see the need to not do that. You get used to gloves quite quickly.

Steven:

Yeah and I think as you said, the logic here is that there's no reason why you can't go outside in PPE as long as you don't start touching lots of other potentially contaminated surfaces. One thing that does occur to me as well, you've got a sanitizer and you tell patients then to press the bell, I guess all of us have to assume that patients won't follow the instructions as well. So we've got to be careful. But even though we've told them not to do it the other way round, we should still sanitize the bell push.

Danny:

Yeah. And I think you could, you could tell patients to just assume that someone in the day may have had the virus and so when they leave mention they change their clothes and don't expect everything to be a hundred percent.

Steven:

I guess probably the other, the other part of that question is, I mean, people are pressing the buzzer. Do your patients never arrive early? Are you assuming that they will never get there while you're in the middle of treating other people? Because actually you want them to wait outside until it's their turn, don't you?

Danny:

Yeah, exactly. And you know, when we start getting busier and when it feels more acceptable to see people who are not just urgent cases, we'll have to revisit the plan and have 2 meter distance seats. They can still sit there. But it's all about reducing the amount of time someone spends in a potentially contagious space. Having someone in the waiting room increases the likelihood that it could be kind of in the air, they could contract it but it's not throwing them into any sort of the lions pit as it were. So I think you' just have to make your choice on that really, have them wait outside or if you have a space for them to sit in, have the window open and have them sit there.

Steven:

Have you done any research into air purifiers? Somebody here has said that if they haven't got ventilation or good ventilation in their rooms, what can they use? And I can't remember whether you've got direct outside ventilation into your rooms or not.

Danny:

Yeah, we've got windows. We're okay. But again, I haven't really looked into it because of that. I know that if you think a patient's symptomatic, you're supposed to shut them in that room and then turn off the aircon. That's probably more about spreading it to the rest of the system. So I would imagine most hospitals don't have open windows and therefore normal air con is enough. If you look at the original document and I can send a link, it does have a flow rate, which is suggested. So again, you can work with your system and see if it's the adequate flow rate.

Steven:

Interestingly, I've always thought air conditioning was a potentially very serious vector for all diseases. But Alpra has asked about aprons and you talked about these earlier on and I'm presuming that she's referring to the very flimsy plastic aprons. Did you say that they can be used as sessional items as opposed to a one off?

Danny:

So I was sort of referring to the big ones that you can wipe and clean and that's treating it the same as the goggles. If it's touching the patient and II assume that they will be then I would change it after each patient, so you have a good wipe down or dispose or change it. So after each patient gloves and aprons have to be out after every patient, eye mask and goggles can be sessional.

Steven:

Okay. So I've had a few more questions about air conditioning. What about, so are you checking patient's temperature?

Danny:

Yes Sire we've got one forehead one, which we're checking but also for the staff as well, just to sort of that's for Osteopaths. So we've taught our admin staff to do basic triage over the phone and when they come in again just the symptomatic thing, the temperature and cough, et cetera and then the Osteopath is using a thermometer and Oximeter to test the blood flow. Again, that's quite interesting because we're quite keen to start seeing more vulnerable people and people who are maybe POST COVID. It's going to be better for us to do that in a smaller practice. I don't think necessarily need to.

Steven:

I saw there was quite a lot of debate about the validity of those Pulse Oximeters in various forums and in the news recently because actually I think the NHS guidance was that they are great for monitoring the deterioration or the improvement of a patient who's quite a long way down the COVID 19 pathway, but they're not a particularly good screening tool for people who have or haven't got it.

Danny:

I completely agree with that and so we'll be looking at respiratory rates and a few of the factors for testing their respiratory health. But again, that's more when we go towards treating people who have had the virus and have lung issues. Load more training, we are not ready for it yet.

Steven:

Do you know, I wish I'd had time to look this up myself, but Phil's asked as primary care practitioners, are we, Osteopaths, Chiropractors and so on, are we eligible to be tested for COVID - 19?

Danny:

I would assume so. And again, I haven't checked it exactly, but because we've been allowed to stay open the whole time and would be deemed important, I would say yes.

Steven:

I kind of thought my own view on it is though it's kind of pointless because if I test negative for COVID - 19 right now, that's only valid for this very snapshot in time. I'm now going to go and see five patients. At the end of the day. I could now be positive. A much more useful test will be whether I'm immune to COVID -19 perhaps.

Danny:

Yes the antibody testing is still.... There's question marks about how useful it is but I think most testing is more that if you have a slight cough or cold or temperature, you get tested to see if you're contagious and then can go back to work. So it's not testing when you are asymptomatic it's more when you're sick

Steven:

Ray's asked about the different types of masks and he's given us a whole load of abbreviations, KN95, N95, FFP2 to FFP3. Can you give a 10 - 22nd burst on the difference between those types or masks? And again, I don't want to encroach on what the IO is doing.

Danny:

Again, I'm not an expert in this at all, but the N95 and FFP2 are the same as far as I'm aware as a Classic dust mask and they keep about 95% of particles from coming into the mask. And then the FFP 3, which has got a respirator is about 98%. So it's not much better than an FFP2 whereas a surgical class, but I know the stats, but they're, they're much lower and they're just for direct contact with large droplets.

Steven:

Right. Okay. Roddy's asked about guidelines for practitioners who've had a post positive COVID 19 diagnosis. Have you got any, I haven't seen it in your documents here. Have you got anything in there about people who have tested positive?

Danny:

No, not really because they were still saying that for patients that had it suggest them as potentially having it. And this was just cause it hasn't really changed much but they're now sort of being much more relaxed about whether patient may or may not have it as long as they're not symptomatic. So I'd probably say currently the feeling is that as long as they don't have the classic temperature and cough, then they're fine to treat.

Steven:

Right well I'm sure I read, and I, I won't be able to remember the source of this, but I'm thinking it was the NHS, one of the NHS resources that actually if you have tested positive for COVID 19 you have to have two consecutive negative tests before you're clear to go back into our currently normal public environment.

Danny:

Yeah, that's, I'm going to have to do some more looking up on that because I've read the sort of six weeks potentially and different things, so it's not currently clear but I know doctors are going back to work as soon as symptoms - 14 days after.

Steven:

Yeah. And that's probably as good a guideline as any isn't it? If you've been tested, you wait till 14 days after the last symptoms have disappeared and then you're clear but imagine getting negative test is probably quite hard.

Danny:

They quite often say seven days after symptoms have gone which for 14 days for family member because of that, that's sort of that delay in infection.

Steven:

Clare's asked about cleaning masks. According to her research, the best way to clean the mask is to leave it to dry for 72 hours because washing or cleaning with alcohol decreases its effectiveness. Does that ring a bell with you?

Danny:

We were discussing this quite a lot and we decided we would just go with disposing of them because of that. And since you can now use them sessionally, it's only like one mask per day or two masks per day so we're less concerned. I think if you leave them out for 72 hours they're going to be safe and you know bright light and fresh air, ozone kills things. So I think you can probably reuse them after if you've got enough masks and you can sort of bag them and name them, date them if you wanted to save the environment. We're just playing it super safe.

Steven:

One of our viewers has sent in an answer to an earlier question. Joanne says that the General Chiropractic Council has told them that they are not classified as key workers and therefore they're

not entitled to testing. I don't know. I haven't seen anything from the GOC on that. Pip says, what's the status for PPE when a patient brings family with them, for example, to translate?

Danny:

Yeah. I think if it's an essential part of treatment, their translation, you'd bring them in and give them a mask, same as with the patient and kind of continue as normal.

Steven:

It's going to pose a problem for a lot of people, isn't it? Because if you're a clinic, a small clinic, and your rooms are a fairly standard clinic room size, you're now trying to distance yourself from two people instead of one.

Danny:

Yes, but in terms of having people too close together, I treat them as a unit. So you've got two people sitting next to each other. They're just treated as one person. So if you've got family members then to treat them as one person, but if you, if they're in the room, they're going to be, you know, think of them as being contagious. Give them masks, et cetera. But I don't think we can avoid that if they needed treatment. Yeah. I just want to say I'm just a, you know, clinic sort of owner, manager, whatever, and I'm not an expert in the talk. Now, if you get a chance to see Dylan's talk, I'm sure be a really useful one. But we are getting back to the work because we want to see our patients when they need to be seen and we want to help key workers. I think things are being relaxed so then anyways, good luck to everyone who does, but just take the precautions you can for both the profession, in terms of PR, and also the thing that you said was a potential vector so you're not spreading it. But at the same time make patients aware that when they leave they should change their clothes and sort of clean down just in case. And then I think that's the best we can do. If you've got any issues with the document, do please email me and I will answer any questions I can or I'll get the team to. Gabrielle and Senor Benida, Ben and Pietro put a lot of effort into it as well. Free, you can use it. I think you can copy it and make a copy and use the bits to it. There's a self-assessment checklist we did, which we thought we really needed too, to making sure our staff, especially for your insurance, have gone through it and read the right bits and signed it off. So that should be quite useful to use. I think that's been useful and please enjoy the document and check out our charity if you've not heard of us. Bye bye. Take care.