423 – Clinic Support Discussion

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Steven (00:04):

Well, hello and welcome to today's clinic support discussion. Today, we've got a couple of main issues and as always, I have Claire here to help me out. Claire, what are we going to talk about?

Claire (00:49):

Well, there's one that you wanted to talk about which was, I dunno, something to do with insurance. Nothing important. And then we said we were going to talk about hygiene.

Steven (01:00):

Yeah, we did. Should we do the insurance one first because I think it should be fairly simple. What I would say is that if you've got concerns yourself about the nature of your insurance, what you need, the cover you want and so on, then let us know - this is an issue which can be very confusing and I've spent lots of time looking at insurance and I still don't fully understand the sort of things that we have to do. But what was raised by somebody, I think it was on a Facebook group, was the length of cover that we should have Claire in order to make sure that any claims raised by a patient after we have retired are still met by our policies.

Claire (01:51):

Exactly. So one of the questions was what happens after I've retired? Initially I was thinking of this from a practitioner point of view, but I actually think it's quite helpful to think of it from a patient point of view. If I as the osteopath have done something that's caused damage to a patient and I then retire, the patient has then I can't think of a decent example, say they've broken their leg falling off my couch, but they decide to put the claim in three years later, but I've already retired. They are struggling with a broken leg that hasn't healed for three years. They can't work, they're in pain. Their family life has gone to pieces. So from their point of view, they need to be able to claim from my point of view as a practitioner, I just think, well, I've stopped treating so it doesn't affect me anymore. But I think if we look at it from the patient's point of view, we can see it in a different light.

Steven(03:02):

Well, I've taken this one up specifically with the company that we recommend (BGI) and the standard period of time within which a medical claim can be made is assumed to be three years. I think that's across the board, but it certainly applies to us. And if an adult hasn't made a claim within three years, they're going to struggle to justify why it's taken so long. There are some exceptions, but again, I suspect they wouldn't relate to the sort of therapy that we osteopaths and chiropractors administer and the standard runoff cover for the policies offered by those people who are insuring us osteo passing chiropractors is three years for that reason. So does that help with your three year leg break issue?

Claire (03:55):

Yeah, and it was a bad example. I should have thought that through better. Obviously having a broken leg for three years is unusual - as I know.

Steven (04:06):

But also I should say if the claim is made during that three years, it doesn't have to be resolved. I would suspect if you had a problem that was that protracted, you wouldn't wait until the problem was resolved to raise it with the osteopath concerned or the practitioner concerned. And once the claim has been made, then it's covered.

Claire (04:29):

That's true. But there is still a limit on the amount of time for the claim to be processed. And the other thing that was being discussed at the time was actually quite similar. And that's what happens if you die. Now, of course our flippant response, your flippant response would be, it doesn't matter, you'll be dead. But if you see it from the patient's point of view, if you drop dead tomorrow and you've done something that has injured a patient, they should still have some kind of way of claiming,

Steven (05:06):

Well, as I said, it seems to be a legal assumption that three years is the standard period within which you can make a claim about something that's gone wrong in treatment. And again, like I said, that doesn't mean that that's the claim resolved in three years. It means you just have to have brought it to the attention of the insurers within that period. And I've had someone called mischief maker say, I thought that's why we continued to pay runoff insurance for seven years. The point here is mischief maker that we don't continue to pay for our insurance policies. Once you retire, you can stop your insurance cover, but you continue to have that runoff cover for three years afterwards. The seven years that you're mentioning there I think is what relates to our keeping of records after a patient comes to see us. I think that three years is pretty reasonable to be honest, Claire, I mean surely I can't think of many instances where you wouldn't have recognised a problem within that time, particularly when you're dealing with osteos or chiropractors.

Claire (06:10):

Interesting though, we have to keep patients notes until they're 25 if we treat them as children. So if I treat a baby and cause problems, where do we stand with that?

Steven (06:26):

Right. And that is the really difficult one because if you look at the regulations laid down in the osteopaths and the chiropractors acts of 1993 or whenever they were, it says you must have appropriate insurance in place to cover claims that might arise. I can't remember the exact terminology, but you get the gist of that. And obviously a child might not claim until after they reach 18. So technically if you treat a child today and retire tomorrow, it's possible that that child might not be in a position to recognise or have capacity to claim until they're much, much older. And so technically your insurance should still cover that event even long after the three years has expired. And I might not be explaining that terribly clearly. And this is where the difficulty arises and where BGI are going into consult with the underwriters over how they overcome the problem because the three year thing is still in place.

There are two types of policy:

One is called ***claims made***, one is called ***claims occurring***, and pretty much all of the medical malpractice policies are claims made policies, which means that the claim has to, the incident has to occur or be reported during the time the policy is active and that will include their runoff cover. So that means that if the claim occurred years and years ago and your policy is no longer active, then you aren't covered for it. Whereas if it's a claims occurring policy, then as long as the policy was active when the incident occurred, you're still covered for it. And I still get confused by these terms even though I have read through them a dozen times this morning to try and get it clear in my mind and I've got them written down on a piece of paper here in front of me. But this is what Nick, our contact at BGI is going in to try and sort out.

(08:34):

We all know that the risk is extremely low. We know that there's very, very little chance of a claim occurring after three years, but legally we're supposed to be covered and what we don't want to do is be paying for insurance for years and years and years after we've retired. Those claims occurring policies are generally more expensive than claims made for the obvious reason, but they do depend on you having had insurance in place at the time of the incident. And again, that serves to further muddy the waters, I know, but it is something that we will have to get back to you with clarification on once we've got it because that thing about children is the thing that bothers me.

Claire (09:13):

I wonder what GPs have in place because the risk to them is significantly higher than the risk with us.

Steven (09:21):

We also know their premiums are much, much higher as well. So I think where we could ask GPs or we could ask any other medical practitioners about the runoff, but I suspect that the best people to ask are the insurance brokers themselves.

(09:41):

Chris says that from the McTimoney Chiropractic Association, she was told that they should keep notes for eight years because they can sue for seven. Keeping notes is different to insurance cover. They can certainly request access to those notes for seven. But again, Chris, I will get back to you on this, but as I understand it, the standard limit for making a claim is three years after the incident occurred. So yeah, I will check on that for you.

Right, so that's our wonderful little insurance problem. I thought that was going to be a really simple one for us to resolve when it came in sometime back there and turns out it's not and the insurance brokers themselves don't have an answer for it either. And I'm pretty confident that BGI do a claims made policy, which is the one which wouldn't cover you for those children and so on, but they say that everybody else operates on that basis as well, which helps to keep the premiums down, but they're looking at something which will provide some cover for those rare occurrences.

Right. Would you like to move on or have you got more to add?

Claire (10:49):

No, I think that's it. I think that's all I've got on insurance.

Steven (10:52):

It doesn't mean that you and the audience there need to stop sending in your comments. If you've got things that you know better than we do about insurance, then please share them. One of the things that as I've said we will try to do is to keep everybody updated with what they need to have and what is offered by the various brokers. So let's move on then Claire. This one should be a bit more long-winded.

Claire (11:14):

Possibly as dry though. So hygiene, one of the things that I've been pondering on is what people are doing as regards to hygiene post-covid. And I feel very lucky that during the lockdowns and during us treating, not treating, arguing about treating and not treating, we knew somebody who was very knowledgeable about government policy and she kept up to date with all of the covid policies, health and safety policies and would just update us and let us know what changes had happened. And so we were able to help everybody be very clear about their policies. Now, I suspect that most people in their clinics currently for a health and safety policy have a covid one. And as we said in the last clinic discussion, the same as with the GDPR documents.

It's sensible just to glance over them every year and make sure that they're still valid. Because if something happens, and this is what you say your policy is, but this is not what you are doing, we don't know what the repercussions might be. So I just thought it was worth us going through and also finding out what everybody else is doing.

Steven (12:40):

Yeah, absolutely. Sharing what different clinics are doing. In preparation for this, I looked up the NHS current hygiene regulations, which of course this is God knows how many pages of type script on a webpage and I've identified that we fall into category FR4, risk category four, which applies, I think this is the relevant one, it applies to physiotherapy outpatient clinics, but they don't mention chiropractors or osteopaths obviously. And even that one had 72 rows in it. And Justin can probably put the thing up on the screen here. So you can see that it deals with all this sort of stuff. Patient's toys if they're owned by the premises, walls accessible up to two metres, internal glazing, hand dispensers and things like that. But it does cover patient treatment tables as well.

(13:40):

I wasn't expecting that you'd be able to read all those words. It's just an example of how they've laid it out. So I'll read the bit about patient trolleys and treatment couches, and this surprises me, it says patient trolleys and treatment couches should be visibly clean with no blood and bodily substances, dust, debris, adhesive tape stains or spillages. That's pretty easy to achieve in our clinics. And then it says check clean weekly. That seems, I would've expected them to say they get wiped down between patients, and I have seen that on different guidelines, but it seemed a little bit vague to me. So those were the NHS guidelines and these are updated this year from the 2021 guidelines, which would've dealt with covid, but they still relate an awful lot to aerosol transmission of viruses and so on.

Claire (14:39):

I love the fact that they say to check they're clean weekly, not to clean weekly.

Steven (14:44):

Well, it's really weird. I mean ceilings and walls full clean every two years.

Claire (14:50):

Don't you clean your ceiling every week, Steven?

Steven (14:53):

I try very hard to do it on a daily basis, Claire. I really do. Toilets, bidets, urinals - full clean daily including touchpoints, flush handles, and descale as per the product instructions.

Claire (15:06):

I'd love to know if any or chiropractors have got a bidet, in their patient toilet.

Steven (15:13):

Well as always, they do relate to the NHS facilities and of course we have to put this into context, don't we? Because even in an NHS outpatient clinic, they're probably getting a huge number of people with a vastly different spectrum of diseases and problems coming through the clinic and they've probably got to be a lot more careful, right?

Pip, who sent in some questions before Pip says, I still ask people to wash their hands when they arrive and we use soap, not hand gel, the gel won't get dirt off soap will. I'm curious if people still do this.

And that is interesting because it is still amongst some of the guidelines that we should do that, but I suspect an awful lot of us have now reverted to our approach to hygiene that we had before covid, and that is we wash our own hands, but we let patients pretty much do as they will, don't we, Claire?

Claire (16:13):

I think one of the reasons for having this conversation is we genuinely don't know what other people are doing. I say that for the whole of the community. We all have our own approach and we might have discussed it with our best mate, but we probably haven't had a group discussion like this since Covid. So I think a lot of people don't know quite what they're supposed to be doing.

Steven (16:38):

My view on this as is pretty much always the case is that we should apply some bloody common sense, but of course that's very easy for me to say and less easy to put into practice when everyone's trying to work out what would be acceptable to the general councils. The first thing to keep in mind is that the chances of anyone complaining that your clinic is unhygienic is very, very low. And unless you've got bodily fluids and substances and so on all over your treatment table, the chances of people contracting something untoward from your clinic are pretty bloody low. And the same measures that we took before covid would be appropriate if a practitioner's got a cold or the flu or something, they should probably elect not to come into work. You'd probably want to say to patients if you've got serious bugs, don't come into the clinic and if they have, well maybe ventilate the rooms after the patient's been in there. So that's all very easy for me to say, but it would be really simple to have this

in a checklist, wouldn't it? I think I'm talking myself into producing some sort of checklist here, aren't I?

Claire (17:49):

Seem to create more work for yourself, don't you, in these shows?

Steven (17:51):

Well, that's the point of this organisation is that we try to do the work for everyone else and that's why I don't have time to practise much in clinic.

Chris, same Chris says, no wonder that there are so many hospital incurred infections. Well, that might be the case. Admittedly, hospitals do a lot more intrusive work than we do. She's talking about not cleaning their couches down, I think.

Chris is back in again - The McTimoney Trust Community Clinic in Birmingham has a shower and a blow dryer in it so that towels are not needed. A shower. I probably need some explanation as to why a clinic needs a shower, but there must be a reason for that. Very dirty patients, perhaps.

(18:40):

One of the questions that came in in addition to wiping down treatment tables and washing hands and so on, was about whether people put the loo seat down when they flush it, which at first I thought, oh, come on, don't be ridiculous. That's really not an important issue. So I thought, well, I better look this up and this is not me in any way dismissing the person who sent that comment in because I actually found that there had been a study done, I think it was in a UK hospital as far as I'm aware it's the only study done into the ups or downs of loo seats. And they did it I think with four different toilets, two that were fitted with lids and two that weren't. And they inserted faecal matter, which had been seeded to an appropriate level with C difficile and they flushed the ones with lids, with the lids down and they flushed the ones without lids as they were.

(19:43):

And then they measured the contamination on the various surfaces around the loos and they found that the level of contamination before the flush and after the flush was higher with the no lids than it was with the lids down. The viral particles were the most widespread, the bacterial ones being heavier. They didn't escape very far anyway. And so I thought, oh, well maybe there is something in this, but then I suppose it depends first of all, that people using the loo are carrying some sort of virus. Second that people are traipsing through the loo on a fairly frequent basis while these things are still airborne or that they're touching contaminated surfaces and then their faces before they wash their hands. And then I got to wondering, sorry, this is just the way I explored this particular trial. What they did was they put faecal matter that was contaminated into the loos and flush them, but that didn't take

into account the fact that a patient coming into the toilet who has C difficile or some other bug is going to be breathing in and out all over the place, which is probably a bigger contaminant than flushing the loo.

(20:50):

So there was no comparison with that, I thought. Anyway, that was my thoughts on that. I leave it to you whether you put the loo lid down when you flush or not.

Claire (20:59):

Can I add something to that? What happens if the loo seat is down? It's been flushed with C difficile in there. You then have to touch the loo seat with your hand to get it up.

Steven (21:10):

Yes, you're right.

Claire (21:14):

Normally you would, Steven, you don't just do another wee on top of the loo seat. Contamination from touching the loo seat, possibly bearing in mind that there's not generally a high turnover of people using a loo in a clinic, It's possibly higher because you've touched the loo seat.

Steven (21:33):

Yeah, well it was the Loo lid, not the seat that was the issue. But I wonder if it's actually something which is possibly of academic interest, but we shouldn't be wasting too much time on in our clinic hygiene policies. There's no way we can be in the loo to make sure that patients put the lid down when they flush anyway, is there,

Claire (21:55):

But you know that every single person watching this, next time they go to the loo, they're going to be standing there going, do I leave it up? Do I put it down?

Steven (22:04):

Should I open it with my foot? I got a load of people coming in here.

Going back to insurance. Amy says, do BGI do insurance for people who are voluntarily deregistered. Amy, BGI are incredibly flexible as insurance brokers. They are in my opinion, far better value than anyone else, but I am not a financial advisor. I have to say that because otherwise someone will accuse me of giving inappropriate advice. BGI will insure you for whatever it is you do, regardless of whether you are registered with somebody or not registered with somebody. So if you said that you were a musculoskeletal therapist and no longer an osteopath or a chiropractor,

they'd insure you on that basis. I suspect that their fees, their premiums would vary slightly because clearly it's much easier to complain about someone who is registered and that's often a route into a more expensive civil action.

But I can't answer for the actual premiums. But yes, they will cover you no matter whether you're registered or not.

Karen says, I offer hand sanitizer to patients when they arrive, then I still wipe down all surfaces that they may have touched between appointments and Karen, I think that's probably one of the key bits here, isn't it? It's the touch points, it's the door handles and the couch covers and the chair arms, things like that, things where there is likely to be some contamination, which can be easily passed on to someone else, and I'm not sure, I forget whether it was Pip earlier on who were saying that they don't use hand sanitizer, they use soap and water because it doesn't get the dirt off. Of course it's not the dirt we're worried about, it's the viruses. So it's whatever kills the virus. And I know soapy water is good at killing quite a lot of viruses, but so is hand sanitizer I believe, and it's also easier for patients to use because you don't need a towel afterwards.

Claire (23:55):

I'm going to jump in there and say that we were always advised for covid to use soapy water rather than hand sanitizer because it was more effective.

Steven (24:06):

Yes, and I'm sure there were good reasons for that. I guess it's a question now of it's much easier to say to a patient, do you mind sanitising your hands and than to say, do you mind going out to the bathroom where you can wash and dry your hands? And again, that whole drying business is a bit of a hygiene nightmare, isn't it? In some cases. So it's a question of what's likely to be more effective in terms of practicality rather than clinical results perhaps. But yeah, we were advised that you're quite right.

Jen says, where can we access some of these wonderful resources or checklists that you kindly do please, Jen, I've already talked myself into doing a checklist and once it's available, it will be on the business resources, I think it's called, page on our website along with all the other stuff, the other policies that we put there.

I'm going to have to research this one because I can tell you what Steven Bruce thinks about these things, which may not be what the government or our regulators say.

And on the subject of our regulators, Claire, of course I did look up what the chiropractic council and the osteopathic council say about this, and they are typically somewhat opaque. The GOSC has got guidelines which were updated last month, but most of it says this is what the osteopathic practice standards tell you. So generic stuff about being hygienic and clean in your clinic and then refers to some other

national hygiene guidelines, which of course are largely not relevant to us, but gets them off the hook given us the relevant stuff. When I looked at the GCC site, what I found was a whole lot of stuff about covid, so really harking back to a situation we had several years ago, which doesn't pertain now and I couldn't find, there might be some stuff, but I couldn't find stuff which is currently relevant in terms of sanitization in our clinics.

(26:07):

So Jen, I will get onto it for you and I will try and clear it with both those governing/regulating bodies, but I can't guarantee that they'll answer me too quickly.

Jason says, I was at a and e the other week with someone. The clinical staff had masks on as chin guards or under the nose or not on the face properly or on the face properly but kept touching them. Never noticed the NHS being that good on hygiene.

Yeah, and it's rather like that thing between soap and water or hand gel, isn't it? You can put the rules in place, but it's a question of how they're implemented and whether people comply with them and we all know how much fun it was wearing face all day and every day. Very few people did it properly. I did notice though in the guidelines that we are still if requested by a patient expected to wear a face mask. We don't have to do it otherwise, but if a patient wants us to, then we should comply with that. So bear that in mind.

RB says, hi, is there anything about clinic flooring requirements please? A physio friend was telling me the other day that they're required to have hard moppable flooring, but the osteo clinics I've been in have hard-wearing commercial carpet type flooring.

Interesting you should say that RB, because in the NH S'S own guidelines, which we had up on the screen a little while ago and which I can share with you if you really, really want me to, when they talk about floors, they distinguish between hard flooring and carpets and it says regarding carpets a full clean daily, which I presume means Hoover, and carpet shampooing should be conducted at a frequency to maintain the standard. So again, that's going to be a local policy issue, but the basic thing there is that carpets are perfectly acceptable and I just think you have to take normal sensible common sense precautions to make sure that your carpets are clean and I guess we could spend some time exploring, Claire, how are you going to get a virus from the carpet?

Do you have your patient's nose down on the carpet pile when they come to see you or are they just walking across it in their outdoor shoes?

Claire (28:13):

This came up during covid actually. There was a lot of discussion about whether the floors and carpets should be sanitised between patients and I think it was Mrs. Trellis who commented on somebody's post on Facebook and said, I don't generally have

my patients licking my floors, so I think I'm fairly safe. What the rest of you are doing, I really can't comment on,

Steven (28:37):

We can always rely on Mrs. Trellis for a few good comments. Going back to RB, though, you've said what your physio friend has told you, always bear in mind that there will be people who implement rules which they don't really have to. They will go beyond what's required of them. They'll make assumptions about these things, but it is definitely acceptable in the NHS's own guidelines that you can have carpets on the floors. How you clean them of course is going to be a policy issue.

Alex says, between each appointment I have a UV light on for 15 minutes with a fan to bathe the room for airborne diseases. Also, every evening at midnight, the entire clinic has fluorescent UV lights that bathe the entire clinic for two hours with UV light together with a HEPA filter and inbuilt UV light to filter the air in all the rooms. This is in addition to cleaning the surfaces and we've been relatively bug free. Bloody hell, Alex.

(29:35):

I'd be interested to know how much it costs to set all that up. It sounds brilliant and it would certainly satisfy anyone who did complain about your hygiene procedures. You could hardly argue you weren't taking it seriously, which is where we're going to fall down is if something goes wrong and someone complains. If we've been seen not to be trying our best, then we're going to fall foul of one of the standards in the chiropractic code of the osteopathic practise standards. Alex, you're definitely not going to do that, but you aren't the only clinic that's been bug free even though other clinics aren't doing that full UV light sanitation process. So yeah, I suspect it's going to be a difficult sell to get everyone to do that.

Mike says we need the Japanese Bidet toilet. The loo lid lifts up as you approach it. Okay. Mike's probably a salesman for Japanese Bidet toilets I think here, but we'll see.

Claire (30:30):

They also have the plastic that goes around the seat that moves around in between users. You've seen not seen one of these before?

Steven (30:40):

No, I haven't. I'm glad it doesn't move around during users. That would be very disconcerting.

Simon says if you use needles, I thought you couldn't have any form of carpet. Yeah, I used to think that but it's not true. Is it Claire?

Claire (30:55):

No, it all depends on your county council and it really varies from place to place. So we have not been required to have a sink in our treatment rooms until this year and we've been functioning for 20 years and that's been all okayed by the county council. We've had some rooms with carpet, some rooms without carpet and they've always been absolutely fine about it. So I think it just depends on who you have coming out and what their rules are locally.

Steven (31:29):

Yes, and I think you can probably argue a case for carpets, can't you? I mean it's obviously easier to lose a needle in the carpet if it's deep pile, but the sort of carpets that we put in clinics are generally not massive deep shag pile carpets, so not that big a risk. I understand why they say that. Again, I think they're going beyond what's necessary to protect us and our patients.

Gary says, I was told that being overly clean can lead to an overactive immune system and autoimmune conditions says Gary, who hasn't washed for four months. (sorry, Gary!). Yeah, I'm not sure how we apply that principle in the cleanliness of our clinic rooms actually Gary, but I take what you say there. I mean my policy with my children was always to get them out in amongst all the bugs and the dirt and everything else to build up their immune systems as I think a lot of people would do. Claire, you're pulling a Face.

Claire (32:26):

No, I was actually going to try and look this up and then got into my head that we must find an immunologist to come on the show, an evening show and talk about this because everyone has different views. So many of us have talked for years about the fact that you need to be exposed to bugs to build up immunity and resistance and what have you. So it'd be interesting now post covid to see what immunologists really think about that theory I think.

Steven (32:59):

Yeah, and I guess what we're all looking for here is a baseline below which we shouldn't slip in terms of realistic cleaning sanitization procedures for our clinics, isn't it? There's no harm in going full-blown UV lighting and HEPA air sanitizers and stuff like that. Nothing wrong with that at all. Fantastic. I wish we could do it.

There's nothing wrong with having hard flooring in all of your rooms and that creates an image in a clinic, which is maybe a personal choice. I don't know, maybe others would prefer to have the carpet image. Maybe that makes them look a little bit more private medical provision rather than NHS medical provision and I don't have simple answers.

I will try to get a baseline, as I say, for the checks that I want to do.

Kim says, this is so entertaining Steven. Just use common sense. Well yeah, and common sense is great and I think we should do that. And we all know that the chance of a problem happening, I say it again and again and again, The chance of a problem arising is so small, but when it does, we don't want to be held culpable because we fail to adhere to some guideline that we're also supposed to know, which is buried deep on page 362 in subparagraph C within some NHS guidelines somewhere.

Claire (34:20):

Just to pick you up on that subparagraph C, one of the problems that you have is that you are married to somebody who follows the rules and will look for rules to follow. So I'm sure that what goes on in other practitioners heads actually is verbalised between the two of us and you say it's common sense to do this and I say, well, the rules say this because I found a rule. So just because we're coming up with ideas for today and Steven will say one thing and I'll say another, both of us appreciate that actually all of the stuff that's going round in your heads about whether we should do this or shouldn't do this is enhanced or emphasised between the two of us.

Steven (35:08):

And you're absolutely right Claire, and I'm with you. If there is a rule, if it's the law, you have to do it. Where I think common sense is applicable is when the rule is not specific. It's not clear when we're given guidelines and going back to what the osteopathic council says, it will say follow osteo practice standard a six or something. Well that's really general and they give some breakdowns of what it might mean, but it gives you flexibility within there and I think we all have to say we can take reasonable precautions in our clinic. For example, I have seen nothing that says we should do as Alex does very commendably and put UV lights on all the time. There's nothing to say we have to do that, but my word, quite apart from anything else, what a great selling point that you can say to your potential customers and your customers, I am doing everything I can possibly think of to keep you safe from bugs and viruses. I think that's wonderful.

Annie here says she's still wearing an FFP two mask when she's leaning over patients, especially when treating their cranium. She also uses a HEPA air filter on all day during treatments and provides surgical masks if patients would like, if they come in with a cold, they'll often happily wear a mask and there's no reason not to do that. And many patients I'm sure will appreciate that you do.

Claire (36:31):

Even before Covid, if I had a cold, I used to wear a mask. I just think it's polite to other people and I think it's absolutely fine if a patient comes in with a streaming cold to ask them to wear one. And I say that knowing that we still don't know whether

wearing a mask works or not, but if it makes them feel better, if it makes you feel that you might be a little bit more protected, I don't think there's a problem with it.

Steven (36:56):

Yeah, I mean I agree. I actually think we do know substantial evidence on how the masks affect the transmission of bugs and we know that they're better at protecting the wearer than they are the people who aren't wearing the masks. But there's no doubt that they can't make the transmission of viruses worse. So psychologically it's working, it has to have some effect. That's probably, that's a very unscientific thing to say, but they cannot possibly make things worse, so it's a good thing to do.

I was going to mention Peter regarding acupuncture and he saying, he's reiterating what you said, Claire, that the local council requires you to have an acupuncture licence if you use that sort of technique in the clinic, and it also covers any form of skin piercing. If you read the guidance, it says you need a hard continuous floor that comes 150 millimetres up the wall with all your joints welded.

(37:52):

Then you read it further and there's an appendix at the end that says this doesn't apply to acupuncture. What can I say? Only what Claire's already said, which is the person will come out and inspect your premises and they will accept it if you have a carpet they have done with our clinic for however many years it is, we've been checked, excuse me,

Chris says, you can't please all of the people all the time. I had a patient complain that I wasn't following protocols sufficiently during Covid because I automatically offered her my own pen to sign her record card. What she thought when I put my hands on her. She didn't say.

(38:30):

Very good point, very good point. But there always will be people who are looking for something to complain about. We know that, don't we?

Lawrence says, to singularly follow the rules reminds me of the orthopaedic knee surgeon and his opinion on protocols as opposed to guidelines. I can't remember that one. Lawrence, do you remember that? Claire?

Alex goes back to talk about his UV fluorescents. The UV fluorescents were put in by the clinic manager. He's a former anaesthetist and his wife a GP and they're quite switched on. I think he means the GP and the former anaesthetist, not the UV light. And he says he used the government loan during Covid to pay for all this. Not much change out of the 10 K, but that's paid dividends as we have lots of referrals from local GP networks who deem us safe. Brilliant. What a great use of the 10 K.

Actually Claire will I'm sure be anxious to beaver away onto this one. There might even be grants available to do that still. There obviously won't be bounce back loans

or other covid grants, but for something which is deemed to be important for public health, there might well be grants available.

Claire (39:46):

And on that topic, just to let you know, our own county council haven't had a grant available for capital investment in a business for about three or four months. So I'm anticipating that another one will come up in the next month or so. I dunno how every council works, but it's definitely worth checking in the next few weeks or months. See where there's a growth hub grant available.

Steven (40:15):

Yeah, we will keep as best an eye we can on those growth hubs, but they are very much regional things, so we can't speak for all the different areas. But Growth Hub is the thing to Google. If you are looking for something like that.

And I say Google, other search engines are available, but it does remind me that we've had a number of people who've had problems on our own website recently. So I'm just prompted to say for God's sake, don't use Safari because Safari is the one which just doesn't seem to follow normal protocols. Google and Firefox and Chrome or whatever the other ones are, they follow normal protocols and our website works with them. But Safari, keep off it if you can.

(40:57):

Louise says, I have a very rural practice and we ask every patient to remove their shoes in the reception area so that mud, et cetera isn't dragged into the clinic rooms and make the carpets dirty. I think that's a very sensible practice. Or you could offer them over shoes or something like that.

But I still think we need to distinguish between mud and viruses and bacteria because dirt is dirt, but it isn't necessarily something that's going to make us unhealthy. It's just a visible indication of things being put on your carpets.

But equally, if I had rural people with muddy wellies coming into my clinic, I'd be asking 'em to take 'em off as well or bring their own Hoover afterwards. I Claire, what else would you like to say about hygiene while we're here?

Claire (41:38):

Yeah, couch covers.

My questions are have people moved to soft couch covers? Again, have people stuck with clinic armour style couch covers, and are you sanitising between each patient? I'd be fascinated, I should have asked Justin to put a poll up during this show. But yeah, I think it would be interesting to have some sort of idea what people are doing. Maybe we'll put one up on Facebook.

Steven (42:06):

I think we found, didn't we, I don't know about the Beloosh covers, but the Clinic armour covers, they were a little bit colder than using couch roll over a towelling cover, but they were pretty good, weren't they? And therefore we decided not to go back to those towelling covers that were all the rage before Covid.

Claire (42:27):

No, exactly.

Steven (42:27):

I think we got rid of those completely, haven't we?

Claire (42:30):

Yeah, all of those. I thought the clinic armour fabric felt nice. It didn't feel plasticy. I know that majestic towels are also doing them, but I haven't touched those. I don't know. I mean by that I mean have haven't physically put my hands on them to see what they feel like. Yeah,

Maybe now it's good time to tell everybody that we're going to stop doing clinic armour.

Steven (42:57):

Well, I was just about to say, I think Clinic Armour shot themselves in the foot by making such good covers because we sold a lot of them, at a very low markup I might add because we were deliberately trying to get these things out to help people out. We sold a lot of them, but the orders have now dropped off and because it's such a palaver to get them in from Australia and deal with the import taxes and all that sort of stuff, we've now stopped doing it, but that's because the couch covers last so long and they're so reliable and so good. I just don't think people are renewing them.

Claire (43:31):

You say that we've stopped doing it, Steven. We've got one final order going in next week if anybody does want stuff.

Steven (43:38):

Yeah. Okay.

Louise says, we still have our couch covers removed and cleaned down with, what's it called, Clinell between each patient. Remove the couch covers! Gosh, okay. We never bothered to do that During Covid. We used soapy water as was recommended

on the couch covers and wiped the couch covers. It dried quite quickly and it was perfectly adequate for sanitization.

Claire (44:05):

I wonder if she means towelling ones,

Using a different one for each patient.

Steven (44:10):

Right. Okay. What's Clinell?

Claire (44:15):

I've only ever seen clinell wipes. They were the disinfectant wipes that were really popular when covid hit us. I think they were selling £45 for a packet of 20 at one point.

Steven (44:32):

Pips just said they still use the clinic armour and they love it, but they have a heated blanket underneath and she says, our patients blooming love it, smiley face! We were going to do that. There's a reason why we didn't do it, Claire isn't there? What was it? We weren't sure whether they were safe underneath the covers.

Claire (44:50):

It's me. I'm a bit of a brutal practitioner and I was really worried that I would damage the wires of the electric blanket

Claire (45:02):

We've had two practitioners who use heated blankets underneath the clinic armour covers, but they're not osteopaths. So yeah. Was it Pip who said that?

Steven (45:14):

Yeah, Pip.

Claire (45:15):

I'd be fascinated Pip to know whether you feel it's safe with HVTs and what have you. Maybe you're just gentler than me.

Steven (45:22):

Well, that doesn't cut it down much to think she's gentler than you, Claire.

Chris says, my patients all bring their own towels in. It's a nice easy solution, isn't it?

But there's another one here from Phyllis who says they don't use towelling covers, but they use different microfiber covers for each patient. Now we got a load of those microfiber towels in, didn't we? At one point? The great advantage being that they wash and dry very quickly and easily. So, they're still disinfecting between each patient, but they each got a different microfiber cover as well in Phyllis's clinic,

Claire (46:09):

I've actually started examining patients with them undressed, and then once I'm happy with what I've seen, I get 'em to get their clothes back on and usually treat with clothes on. And I know that goes against what a lot of people believe we should be doing with osteopathy, but I feel As A patient, I feel happier being dressed, so I allow my patients that comfort.

Steven (46:31):

Yes, and that was the real point of the towels, wasn't it? Because we used to use the towels to cover the patient rather than cover the table. We had couch roll on the table and I'm sure that people have opinions about couch roll and the way it sticks to the patients when you try and get 'em off.

I've got three or four questions I'm going to try and run through before we end here.

Morgan says, yes, I've moved back to normal couch covers by which I presume Morgan means towelling ones. I still sanitise my face hole and the couch cover and pillow covers are changed daily, which is what we used to do, partly because I prefer black covers and I couldn't get a wipeable couch cover in black that didn't cost the earth.

Karen says yes, sanitising between each patient, still using single use couch covers with paper roll on top, not used towel covers since pre covid.

And Carol says she's had two clinic armour covers in use since early Covid. Definitely worth the money. Yeah. Yeah. I don't think there's any doubt that clinic armour 's covers are worth the money.

Interesting single use couch covers with paper roll on top. I wonder what Karen means by single use couch covers. What do you infer by that, Claire?

Claire (47:45):

I would thought it's similar to scrubs material, slightly papery. Maybe I'm wrong, but that's what I would,

Steven (47:53):

I'm just wondering why you'd put paper roll on top of those because if you've got a disposable cover, why put more paper on top. But if Karen's got the time, we've got two minutes left, she can get back to us.

I think we'd better wind it up there. Claire, there's been 440 people watching us, so lots of information shared and lots of interest in hygiene and whether the loo seat goes up or down and possibly in insurance. I suspect that we haven't answered all your questions with today's show, but I hope at least we've alerted you to some of the important issues, particularly that thing with insurance and so on. I will get back to you once I know the result of B G's consultation regarding insurance runoff cover, and we'll try and get out some clear guidance on clinic hygiene measures for you as well.

(48:38):

That's going to take me a week or so because I'm going to have to do some research and some digging.