BCLA Supplementary Guidance

Proximity Risk Management for Practitioners and Patients

BCLA return to contact lens practice guidance and gloves

The BCLA published its umbrella **guidance on returning to contact lens practice in Covid-19 in May 2020**. We continue to review the published scientific evidence and consult with academics and topic experts to ensure that our published guidance remains accurate and contemporary. Those guidelines are now available in multiple languages to support our worldwide membership.

Different countries find themselves at different stages of managing the pandemic and potentially operating with some restrictions regarding what services and procedures they are, and are not, permitted to deliver in practice. An area of increasing profile is that of proximity. Guidance may be issued by local government and/or regulatory bodies and should be adhered to in addition to any considerations discussed in this document.

Proximity Management

Covid-19 is a virus with rapidly evolving impact, and we now have some improved levels of understanding – for example, how it is transmitted, duration of survival on surfaces, treatment of those exposed and steps that can be taken to reduce risk of contracting the disease. At the time of writing this guidance, we fully recognise that there is still much more to learn and understand about this invisible foe. It is also challenging us in practice to consider how we operate and our standards of practice. We need to design protocols that we need today, and not just think about how we use those we had and adapt them. Proximity management is one of these considerations.

Proximity is defined as 'state of being near in space or time'[1]. In terms of optometric practice, we need to refine this definition further to respect both space (distance) and time. How far away are we from the patient and for how long?

It appears three broad distance brackets shape consideration of proximity: less than or equal to 1m, between 1m and 2m, and greater than 2m. With variations on the latter correlating to the social distances recommended in various countries.

The Center for Disease Control has highlighted the link between distance and time referring to close contact as being less than 6 feet (approximately 2m) for equal to or more than 15 minutes[2]. In relation to the exposure risk that distance and time may present - 1m proximity for six seconds carries the same exposure risk as 2m proximity for 60 seconds[3].

We should also consider environment - the space and ventilation available. The German government, as an example, originally calculated and proposed that any one person needs 20m^2 of indoor retail space (although this has now been reduced to 10m^2) to avoid catching Covid-19, and many sources have highlighted the importance of ventilating spaces through open windows and doors[4]. There has been much speculation regarding the use of air conditioning units and the recirculation of air which appears now to have been settled with this being considered very low risk[5]. Consulting rooms are commonly 9m^2 and rarely have windows that can be easily opened. It should also be recognised that the aerosol gas procedure (AGP) risk for optometric tasks has now been categorised as very low[6].

Compounding these contributors to potential risk is the frequency with which we expose ourselves to risk. Our diaries/appointment books shape the rhythm of our clinics. The number of patients to be seen equaling frequency. Many eye care practitioners (ECPs) have commented that throughout, and when emerged from, lockdown that the capacity in the diaries has reduced

1. https://dictionary.cambridge.org/dictionary/english/proximity (searched on 7 July 2020)
2. Public Health Guidance for Community Related Exposure (Center for Disease Control (CDC), 4th June 2020
3. Derek K Chu, Elie A Akl, Stephanie Duda, Karla Solo, Sally Yaacoub, Holger J Schünemann, on behalf of the Covid-19 Systematic Urgent Review Group Effort (SURGE) study authors* Physical distancing, face masks, and eye protection to prevent person-to-person transmission of SARS-CoV-2 and Covid-19: a systematic review and meta-analysis www.thelan¬cet.com Published online June 1, 2020 https://doi. org/10.1016/S0140-6736(20)31142-9
4. https://www.cdc.gov/coronavirus/2019-ncov/downloads/workplace-school-and-home-guidance.pdf
5. Air conditioning and ventilation during the coronavirus outbreak, Health And Safety Executive (https://www.hse.gov.uk/coronavirus/equipment-and-machinery/air-conditioning-and-ventilation.htm)
6. https://hpspubsrepo.blob.core.windows.net/hps-website/nss/3055/documents/1_agp-sbar.pdf

through extended appointed slots – not necessarily to be in the company of the patient but due to the requirement to clean the environment. A responsibility that is imperative members and all ECPs complete to manage the risk of exposure to any pathogen. Key to this is good hand hygiene practices (see **BCLA Use of Glove in Practice Covid-19 Guidance**) and general practice hygiene protocols.

Recommendation

It is important that we first recognise the need to keep practicing in order that we can continue to provide the same high levels of patient care for which we are famed. ECPs around the globe have practiced throughout their lockdowns and upon emergence finding ways to mitigate the challenges of risk. Contact lens patients present no greater risk than those attending for eye examinations and are no less deserving of our professional support.

We can think of proximity in terms of risk, and it could be expressed in this form
Risk = [distance + time + environment] x frequency

It is therefore appropriate to think about managing each of the component parts with the overarching recognition that ECPs practice using the appropriate personal protective equipment (PPE) as specified by and in accordance with your local government and/or regulatory body. This should be further complemented by the use of slit lamp breath shields in the consulting room and masks/face coverings worn by both ECP and patient[7, 8].

Distance - Think about the tests, tasks and procedures carried out as part of your examinations. Which are the essential ones, and when might those that are nice to know become essential? Consider if elements of the appointment need to be completed within the consulting room. For example, history and symptoms can be conducted via a tele-optometry approach ahead of the appointment. During the appointment what order do you complete your tests – should you revise the structure and flow such that tests of similar working distances are completed together? What technology can you make better use of, or start using, that would allow you to increase your typical working distance? Examples of this might be digital slit lamps and automatic phoropter heads.

Time – Similar to distance considerations what can be done differently to reduce time with the patient? This may be through the use of newer technologies or by revising the approach. It would also be sensible to group and complete tasks of shorter working distances together completing in quick succession (updating records after completion, rather than in between each test). Dictation software or simple voice notes/memos can help to achieve this.

Environment - Think about the tasks completed in the consulting room (smaller space) that can be done outside of it (perhaps even outside the practice) where there could be more space and better ventilation. The new environment should also be considered in terms of impact on other colleagues and patients, along with potential compromise on data protection. With many practices now operating a 'locked door' policy and controlling the number of patients in the practice at any one time it may be possible to consider leaving the consulting room door open during examinations. It should be habit to now leave the consulting room door open when not in use to assist ventilation. This additionally allows the care and attention given to cleaning surfaces and equipment to be seen and fully appreciated by patients.

Frequency – With the inclusion of cleaning time between appointments, the capacity of clinics is reduced, and thus frequency. This need not make the time of the ECP any less productive. In fact, by adopting some of the considerations above you may find your total time with patients has increased.

There are many different ways to manage proximity risk, too numerous to list and will be varied based upon local government and regulatory body guidance. In our guidance on fitting and aftercare of contact lenses patients we will address in more detail some of how this can be achieved based on the experiences and practices of different members.

As ECPs and contact lens practitioners, we have a duty of care to our patients to meet their needs. So that we can continue to practice and deliver the care that is expected. Thus, we have a responsibility to adapt the ways in which we work providing the best level care and protection for our colleagues, our patients and ourselves.

Information correct at time of publishing: 30 September 2020.

7. Coronavirus disease (COVID-19) advice for the public: When and how to use masks. World Health Organisation (19th June 2020)
8. Infection Control Measures During Simulated Slit-Lamp Examination. Felfeli et al. American Academy of Ophthalmology, 3rd June 2020