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(SARS-CoV-2 is the virus and COVID-19 is the disease

WHICH MASK AND WHEN, WHY THE EMPHASIS ON EYE PROTECTION FOR COVID-19

Staying within the 6th August Victorian guidelines, never rely on a mask of any type to protect you 100% - it's going to be the efforts and behaviours you apply that drive down your risk, not whether you wore a P2 respirator or a surgical mask.

Is COVID-19 transmitted via the airborne route? Particle specialists say that anything from your mouth is an aerosol!

1. Measles, varicella have an R0 of 15+ - some refer to this as classic airborne transmission. SARS-CoV-2 is more like Influenza and TB with an R0 of 2 - 4 and some refer to this as small particle airborne transmission – helpful?
2. Never consider just one risk reduction strategy because none is 100% - the more available measures you use e.g. being outside, the more you drive down risk i.e. this is not business as usual plus a mask of any type
3. If you think wearing a P2 respirator was more protective than a surgical mask at the clinic but you did not fit check it every time you wore one nor used eye protection, then you are more likely to be increasing your risk.
4. **A P2 must be fit checked every use - worn incorrectly it is dangerous. Note increased settings for use as per new guidelines. It does not appear to be recommended for use in most GP clinics.**
5. **Not wearing eye protection especially when close to pt is against the guidelines – there are receptor sites on the conjunctivae for SARS-CoV-2. Wear eye protection with your mask when in the same room as a patient**
6. Aerosol generating procedures that require a P2 are not routinely used in clinics (use spacer not nebuliser)
7. Masks/respirators and eye protection can be worn for extended times – do not confuse this with reuse.

What would I do?

1. Every day ask of yourself and all colleagues (and your household) the same list of 10+ symptoms and not just a temp check with "are you well"? Note what guidelines say about use of accurate devices.
2. Same when pts book, go through all the symptoms and do telehealth first before asking them to attend.
3. If pt is suspect COVID-19 on telehealth, arrange for swab at drive through/resp clinic, treat/advise/hospital
4. If necessary to see suspect COVID-19 pt, they wait in car, take mask to them – you wear mask, gown, eye protection and gloves. Outside is safer with unlimited air changes. Examine throat outside is safer.
5. If essential, bring masked suspect pt to cons/treatment room without using waiting room, open window and have least time possible within 1.5 metres. Discuss with pt outside as needed after to reduce time inside
6. When pt leaves, change gloves, put fresh ones on and use a detergent/disinfectant wipe over high touch surfaces and leave wet (for any surface that is visible soiled – go over with fresh wipe). Remove gloves, HH
7. To reduce risk, I do not have pts inside waiting, I have windows open as much as possible and I do not use a staff room – all these actions drive down risk and are not to punish staff and patients but to protect them
8. I would treat all pts as possible COVID-19 in Melbourne where there is community transmission

Reference 1 DHHS

Health care workers who use particulate filter respirators (PFRs) such as P2 or N95 respirators, must be trained in their correct use, including how to perform fit-checking and safe removal. Unless PFRs are used correctly, their effectiveness will be compromised and the risk of infection (to the wearer) increased. PFRs with valves should not be used, as there is a risk of exhaled air, from wearers who are infected, containing viral particles.

Reference 2. Ref from my website – pls see

A meta-analysis of subsequent studies that compared N95 respirators to medical masks showed no difference between the 2 types of masks for preventing laboratory-confirmed viral infection, laboratory-confirmed influenza infection, influenza-like illness, or clinical respiratory illness.[24] A case study from China reported that of 41 health care workers (85% wearing a surgical mask and 15% wearing an N95 mask) identified to have had exposure for ≥10 min at a distance of <2 m from patients with SARS-CoV-2 undergoing aerosol-generating procedures, none became positive by nasopharyngeal swab within 14 days of exposure.[25]

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