

Guidance on COVID-19

Guidance on Managing Infection Related Risks in Dental Services

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Version	Date	Changes from previous version	Drafted by
V1.0	03.04.2020	Initial Guidance	AMRIC Team
V1.1	15.04.2020	<ol style="list-style-type: none"> 1. The introductory material has been updated in view of learning since the last version and has been reorganised to improve sequencing and to clarify a number of points 2. Information on pre-symptomatic and asymptomatic transmission 3. Reference to risk of infection associated with working with dental prostheses 4. Clearer definition of Standard and Transmission Based Precautions 5. Reference to new guidance on use of surgical masks in healthcare settings from the National Public Health Emergency Team 6. Recommendation that staff are asked to confirm absence of fever and respiratory symptoms on arrival at work 7. Recommendation to consider temperature monitoring for patients at reception 8. Removal of a recommendation to minimise AGPs 9. Removal of examples of AGPs 10. Recommendation to use respirator mask and eye protection when performing AGPs 11. Recommendation against use of pre-treatment mouth rinse 12. Brief recommendation on cleaning and PPE required for cleaning 13. Recommendation that room clearance time after AGP is not required unless a patient has known or suspected COVID-19 14. Recommendation on use of Perspex screen at reception 15. Recommendation against use of head covering and overshoes 16. Recommendation on duration of period of infectivity for COVID-19 patients 17. Recommendation on multi-chair dental surgeries 18. Recommendation to identify a lead person for infection prevention and control where possible 19. Recommendation that a process for recording and evaluating any incidents of COVID-19 infection that may occur associated with delivery of dental is developed 	AMRIC Team
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		<ol style="list-style-type: none"> 2. Additional Guiding Principles related to identification of patients that may represent an increased risk for transmission and identification of healthcare workers that represent an increased risk for transmission of COVID-19 3. General Background: Updates to content 4. Key Signs and Symptoms of COVID-19: Updates to content 5. Sources of Infection with COVID-19: Updates to content 6. Before providing or accessing dental services. Additional information on temperature monitoring including reference to recent HIQA review. Acknowledgement that it may not always be possible to avoid bringing non-appointed children. Acknowledgement that it may be necessary to see some patients without an appointment. 7. Routes of Transmission: updates to content and re Updates and resequencing to align with HSE Interim Guidance on IPCE 8. Clear demarcation between consideration of which dental services are provided and the IPC guidance that applies to that service provided. 9. Surgery Preparation: More definitive statement in support of use of transparent screens at reception to align with WHO Guidance of August 3rd. Additional details on cleaning and decontamination. 10. Performing a Dental Procedure: Guidance to minimise the use of cuspidors to align with WHO Guidance of August 3rd. This guidance is available at the following link https://www.who.int/publications/i/item/who-2019-nCoV-oral-health-2020.1 11. Performing a Dental Procedure: Expanded statement on mouth rinsing to acknowledge WHO Guidance of August 3rd 12. Clearer separation of IPC requirements for patients with suspected or confirmed COVID-19 and patients where there is no clinical suspicion 13. Clinical waste: refers to HSE Interim Guidance on IPC 14. Reference to the Scottish Dental Clinical Effectiveness Programme (SDCEP) rapid review on Mitigation of Aerosol Generating Procedures in Dentistry 	

Guidance on Managing Infection Related Risks in Dental Services in the Context of the COVID-19 Emergency

Introduction & Scope

These guidelines are intended to support dental professionals working in dental services other than the hospital setting to deliver services with the lowest possible infection risk. This is based on risk assessment of patients and situations and managing the risk of healthcare associated infection in each situation in the context of the current COVID-19 emergency. The guidelines are intended to support Dentists, Clinical Dental Technicians, Dental Technicians, Hygienists, Therapists and Dental Nurses, Receptionists and Managers). It is relevant to general, specialist and limited practice and to dental hospitals and dental schools. Dentistry and related procedures carried out in general hospitals are outside the scope of this document as the guidance for acute hospital applies. This document replaces a previous version issued on 15 May 2020. The situation continues to change rapidly both with respect to scientific knowledge about the virus and virus transmission and the epidemiological situation therefore regular review of this Guidance Document will be required.

This guidance is relevant at all levels of the Five Level Framework of Public Health Restrictive Measures although the risk of exposure and infection increases in all workplaces with higher levels of community transmission. The extent to which specific oral health services are provided at different levels of COVID-19 transmission in the community is beyond the scope of this guidance. The focus of the guidance is on the delivery of oral health services to low risk people. High risk people (suspected of confirmed COVID-19 and COVID-19 contacts) for whom care may be deferred or provided as outlined in page 17.

Risk Assessment

The Interim Guidance on Infection Prevention and Control for the Health Service Executive recently published emphasises that risk assessment of every situation by the healthcare worker is a foundation for effective IPC. Situational risk assessment underpins the application of this guidance document. <https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/hseinfectionpreventionandcontrolguidanceandframework/>.

General Background on COVID-19

COVID-19 is a novel disease in humans. The virus associated with the disease is SARS-CoV-2. The virus is in many respects similar to other Coronaviruses in particular in relation to its structure and mode of transmission but there is still a great deal of uncertainty in a rapidly changing situation.

It is not possible to differentiate between COVID-19 and other common respiratory infections based on symptoms alone. At the present time COVID-19 should be considered as possible in anyone with acute respiratory infection (sudden onset of at least one of the following cough, fever, shortness of breath) or sudden onset of loss of sense of smell or taste or distorted sense of taste. COVID-19 may also present as deterioration of existing respiratory disease or with very non-specific features such as extreme fatigue or functional decline particularly in frail older people. Dentists and others who provide dental healthcare services to vulnerable groups should be aware of the range of clinical presentations of COVID-19 in those groups. Please see HPSC website for latest case definition.

The laboratory diagnosis of COVID-19 is based mainly on detection of virus RNA in a nasopharyngeal swab but testing of other respiratory samples is important in certain settings. A positive test for SARS-CoV-2 on a nasopharyngeal sample is accepted as establishing the diagnosis. Virus RNA is detectable in most people about the time they become symptomatic and is detectable in some patients 1 to 3 days before onset of symptoms.

There is growing evidence to demonstrate that viral RNA may be detected in some people for long periods (weeks in some cases) after viable virus is no longer detected. Therefore detection of virus RNA does not indicate that a person remains infectious. It is important to note that failure to detect the virus on a sample makes the diagnosis of COVID-19 infection less likely but does not exclude infection.

Incubation Period

People with COVID-19 generally develop signs and symptoms, on an average of 5-6 days after infection (mean incubation period 5-6 days, range 1-14 days).

Key Signs and symptoms of COVID-19

COVID-19 is a contagious viral infection that generally causes respiratory illness in humans.

As above common signs and symptoms include sudden onset of:

- Cough
- Fever
- Shortness of breath
- Loss of sense of smell or taste
- Distortion of sense of taste

Some people with infection have none of these features. Some patients may have other symptoms (muscle aches, extreme fatigue, loss of appetite, decline in function) or may have infection that is minimally symptomatic or asymptomatic. Experience indicates that older people in poor general health are more likely than others to have atypical illness. In some cases the earliest signs of infection in frail older people are a very non-specific decline in their baseline ability to function. This pattern has been very striking in residential care settings.

Laboratory testing is currently performed on people with clinical features that suggest COVID-19 and also in specific circumstances on people where there are no clinical features of COVID-19 including asymptomatic Contacts of COVID-19, asymptomatic healthcare workers in specific circumstances and in a number of other settings in advance of procedures, transfers or admissions.

Clinical Course

Most people with COVID-19 will have mild disease and will recover. A minority will develop more serious illness. Based on current evidence children and younger people are less likely to develop serious illness.

One area of particular concern is high-risk patients. People in the following categories are at higher risk of developing severe disease if they develop infection.

- Older people – the risk goes up progressively in people above the age of 60 and is particularly high in the 70s and 80s.
- Those who are immunocompromised.
- Those with certain underlying medical conditions such as cardiovascular disease, diabetes mellitus, chronic lung disease, chronic kidney disease,
- Those who smoke or are obese

Sources of Infection with COVID-19

COVID-19 infection is acquired as a result of exposure to a person shedding viable virus. It is generally accepted that the highest risk of transmission occurs at about the time an infected person develops symptoms.

Spread from **symptomatic people** is generally considered to be the primary driver of the pandemic.

It is accepted that infection can be transmitted from people with minimal symptoms, from people before they develop symptoms (**pre-symptomatic transmission**) and from people who never develop symptoms (**asymptomatic transmission**) however symptomatic people are generally more infectious. HIQA have provided a useful summary of the evidence related to asymptomatic transmission at

<https://www.hiqa.ie/reports-and-publications/health-technology-assessment/evidence-summary-asymptomatic-transmission>

There are suggestions that children with COVID-19 may be less infectious than adults however there is uncertainty on this issue and the level of infection prevention and control precautions required in the healthcare setting are essentially the same for children and adults in most contexts.

Routes of Transmission

There are 3 routes of transmission of infection of concern as follows:

Droplet Transmission

Direct droplet transmission is accepted as a major route of COVID-19 transmission. Droplet transmission occurs when larger respiratory droplets shed from an infectious person impact on the mouth, nose or eyes of a person in close proximity to a person who is shedding the virus. Liquid particles larger than 5 microns diameter are considered as droplets. They generally do not stay suspended in the air for extended period and are associated with infection over a relatively short range.

Contact Transmission

COVID-19 is transmitted by touching the mouth, nose or eyes with hands contaminated with virus following contact with surfaces contaminated with droplets, oral secretions or nasal secretions from an infectious person. The relative importance of direct droplet transmission and contact transmission is unclear but both are accepted as important.

Airborne Transmission

Airborne transmission of COVID-19 is not accepted as a major driver of the COVID-19 pandemic but it is generally accepted that it can occur in some settings. Airborne Transmission refers to transmission as a result of exposure to small liquid particles from an infectious person that remain suspended in the air for relatively long periods of time, that disperse throughout the room on air currents and are inhaled. Particles less than 5 microns diameter are considered as droplet nuclei or aerosols.

In the context of oral health services aerosol-generating procedures (AGPs) performed on people with infectious COVID-19 is a concern. The Scottish Dental Clinical Effectiveness Programme (SDCEP) has recently published a rapid review on Mitigation of Aerosol Generating Procedures in Dentistry available at <https://www.sdcep.org.uk/published-guidance/covid-19-practice-recovery/rapid-review-of-agps/>

The review categorises aerosol generating procedures as

Group A -use high velocity instruments that emit or require water or irrigants for cooling and will produce aerosols

Group B -use powered low velocity instruments and may produce aerosols

Group C - do not use powered instruments and may produce splatter but are unlikely to produce aerosols.

The paper includes a table that categorises dental procedures according to aerosol generation and it quotes UK Infection Prevention and Control Guidance with respect to use of PPE. This information may be helpful to dental service providers when performing risk assessment.

The document recommends approaches to reducing aerosol and makes recommendations for procedural mitigation (high volume suction and rubber dam) and environmental mitigation (use of fallow time). This review was consulted in developing this guideline. The approach adopted in this guideline is that approaches to reduce aerosol should be adopted routinely if treating people with suspected or confirmed COVID-19 and those who are COVID-19 Contacts and may be appropriate in other settings based on risk assessment.

In addition to exposure related to working directly on the oral cavity of infectious people dental healthcare workers may be exposed to infection risk when working on dental prostheses that have been exposed to oral fluids from infectious people. This work involves both contact with potentially contaminated materials and AGPs.

Managing the Risk of Transmission of COVID-19 in Dental Services

The HSE has recently published “Interim Guidance on Infection Prevention and Control for the Health Service Executive” on the HPSC website. This document outlines broad principles of Infection Prevention and Control applicable to all healthcare contexts. The guidance is available at the following link.

<https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/communityhealthcaresettings/>

Standard Precautions

The foundation of managing the risk of infection of patients and healthcare workers in every healthcare setting including dental care is the application of Standard Precautions to all patients in all settings at all times. For further information on Standard Precautions please see Interim Guidance on Infection Prevention and

Control for the HSE (2020). Note the recommendations of the National Public Health Emergency Team (NPHET) on use of surgical masks in healthcare are reflected in the HSE guidance.

Transmission -based Precautions

Transmission-based Precautions are measures taken in addition to Standard Precautions to manage risk of transmission of infection when caring for people with known or suspected infectious disease for which Standard Precautions alone are not sufficient. Transmission-based Precautions include Contact, Droplet and Airborne Precautions. For details on Transmission-based precautions please see the Interim Guidance on Infection Prevention and Control for the HSE (2020).

Key points in the context of dental practice are the risk associated with provision of dental services in the context of the COVID-19 pandemic. As dental work relates to the oral cavity there is likely to be significant Contact and Droplet exposure if providing any dental care to a person with infectious COVID-19. There is a risk of Airborne exposure if performing an Aerosol Generating Procedure (AGP) on a person with infectious COVID-19. Although most people with infectious COVID-19 can be identified prior to treatment based on assessment for clinical features of COVID-19 and risk factors for COVID-19 this will not reliably identify all infected or infectious people. The probability of caring for an unidentified infectious person is higher in the context of high levels of community transmission of COVID-19 as reflected in the Five Level Framework of Public Health Restrictive Measures. This document is intended to support services to keep the risk of infection as low as possible in dental services at all framework levels.

IPC Precautions Required to Manage the Risk of Associated with Provision of Dental Services

Note that additional detailed IPC guidance is available in Interim Guidance on IPC for the HSE.

The following are guiding principles related to controlling the risk of COVID-19 in all healthcare settings.

- i. Identification of both those patients that may represent an increased risk for transmission of COVID-19 and those patients who may be at greater risk of harm as a consequence of COVID-19 before arrival for treatment
- ii. Identification of those healthcare workers that represent an increased risk for transmission of COVID-19 to patients and excluding them from the workplace
- iii. Identification of those healthcare workers that may be at a greater risk of harm as a consequence of COVID-19 and ensuring that they have appropriate medical advice regarding their work
- iv. Reduce unnecessary footfall through the practice.
- v. Minimise workplace contacts (the degree of interaction between people)
- vi. Maintain physical distance (for example use floor markings).
- vii. Avoid unnecessary physical contact or other exposure in the clinical environment.
- viii. Follow **Standard Precautions with all patients at all times**
- ix. Follow the NPHE recommendation on use of surgical masks by healthcare workers
- x. Follow **Transmission-based Precautions** when required
- xi. Note. Guidance on the safe use of PPE, including donning and doffing PPE including a video is available on www.hpsc.ie.

Responsibility for delivering safe and effective care

All healthcare workers in dental services must act to protect their patients, while also safeguarding their own health, and the health and wellbeing of colleagues.

All healthcare workers in dental services are advised to remain up to date on the COVID-19 public health and occupational health guidance, available from the Health Protection Surveillance Centre.

Before providing or accessing dental services

Staying away from work if unwell

A key element in managing the risk of exposure to risk to healthcare workers and patients from an infected healthcare worker is that staff members do not present for work if they have fever, symptoms of respiratory tract infection or other symptoms of COVID-19. Staff members should be asked to confirm that they are free of fever and symptoms of COVID-19 on arrival at work. Staff members should not present for work if they have been identified as Contacts of COVID-19 and should observe government guidance on travel and restrictions on movement related to travel.

Some healthcare services monitor temperature of all healthcare workers on arrival at work and mid shift. This is recommended by the NPHET for residential care facilities and for homecare services. A recent HIQA evidence review [cite here] indicates that monitoring of temperature in the setting of airport screening has significant limitations in that there are many causes of increased temperature other than COVID-19 (raised temperature is not a specific test for COVID-19) and because many people with COVID-19 do not have a raised temperature (raised temperature is not a sensitive test for COVID-19). If temperature checking is implemented there must be criteria for identifying as significant fever and a clear process for managing staff with a raised temperature.

Going off duty if symptoms develop

Healthcare workers should be aware that they must go off duty promptly if they develop symptoms of COVID-19. Healthcare workers and dental practices should consider a plans for transportation home without using public transport if they become symptomatic at work. They should be asked to confirm that they remain well about mid-shift. Healthcare workers who develop fever or respiratory symptoms should seek medical advice by telephone at the earliest opportunity.

In relation to risk to patients and healthcare workers of infection from patients (for example while waiting for treatment) key elements of managing that risk are addressed as follows.

Limit footfall

Limit footfall through the practice by discouraging unnecessary attendance at the practice by people who can be dealt with by telephone. Limit the number of visits by each individual to the practice by providing any treatment that can be safely given at each attendance. This also limits the number of different interactions on each day. Longer appointments for patients could be considered.

Identify high risk patients

Identify all patients with new onset fever or symptoms of respiratory illness or other symptoms of COVID-19, all COVID-19 Contacts and those with a history of travel before they attend the practice (for example by telephone call or text). Defer the appointment for symptomatic patients, COVID-19 Contacts and people who are restricting their movements for any reason if possible. If appropriate such patients should be directed towards medical care for assessment of the need for testing for COVID-19.

Non-contact based measurement of temperature at reception may be considered as an additional approach to identify people with unidentified COVID-19. As noted above raised temperature is neither sensitive nor specific for COVID-19. Where temperature is measured at reception it is necessary to have a clearly criteria for interpretation and pathways for directing those identified with raised temperature.

Identify patients from counties/regions that may be subject to specific COVID-19 related restrictions from time to time and consider if any additional precautions, including rescheduling of treatment, are required in relation to patients from those counties/regions.

If providing dental services in a Residential Care Facility or to patients from a Residential Care Facility or similar setting establish in advance of attending /before seeing the person if there is evidence of transmission of COVID-19 in the Residential Care Facility.

When are people no longer infectious?

In general patients with COVID-19 are considered non-infectious 10 days after onset of illness if they are well and have had no fever for the last five days. This extends to 14 days for people with more severe disease requiring hospitalisation. Retesting is generally not appropriate in these circumstances however if there is a specific concern about an patient, for example a patient with impaired immune function, it is appropriate to discuss with the patient's medical team.

Signage

Place signage at the entrance to the practice and ensure a further verbal check for fever or symptoms of respiratory illness or other symptoms of COVID-19, COVID-19 Contact status and history or recent travel at reception to identify symptomatic patients and COVID-19 Contacts. This verbal check should apply to the patient and to any accompanying person (parent, guardian, carer) who needs to enter the dental surgery to accompany the patient.

Screening staff from patients

Transparent screens between reception staff and patients/accompanying persons may reduce exposure to respiratory droplets. They should be used when possible. If this is not possible and reception staff are within 2m of patients or accompanying persons staff should use surgical masks.

Dental prostheses and moulds should be safely packaged and appropriately labelled for transport to the laboratory with appropriate cleaning and disinfection before being sent to the laboratory and after laboratory work prior to placing in the patient's mouth.

Infection Prevention and Control Lead Person

Identify a specific person to take a leadership role for infection prevention and control and support them with training and some protected time for this role. It is expected that this person will be a dental professional. They need not have a formal qualification in Infection Prevention and Control but should be very familiar with relevant national guidelines and be able to point colleagues to relevant supporting materials. The amount of protected time will vary with size of practice but should be

sufficient to ensure that they can keep up to date with relevant guidance, deal with questions from colleagues and periodically check on signage and processes for managing risk.

This requirement for a IPC lead is in addition to the Dental Council Code requirement for a Decontamination Lead although it may be appropriate for the same person to fulfil both roles. This IPC lead role is a management function and therefore is distinct from the role of the Workers Representative referred to in the Health and Safety Authority requirements.

General Building Lay Out and Cleaning

Take full account of the use of the building and its environs.

Liaise with other users in the building and its environs to support physical distancing.

Consider floor markings to demonstrate minimum requirement for social distancing

Remove non-essential items from non-treatment areas

Ensure that all furniture, fittings and floor coverings in the reception and waiting area are made of or covered with materials that are easy to clean and decontaminate.

Ensure hand sanitiser is available.

Ensure that an environmental cleaning protocol is available to ensure that appropriate cleaning is performed.

Cleaning of non-treatment areas is normally performed with detergent and water or detergent wipes.

For cleaning the non-treatment environment use of plastic apron and household gloves are an appropriate level of PPE.

All touch surfaces should be cleaned at a minimum of once per day and whenever visibly dirty.

Toilets should be cleaned at least twice per day and whenever visibly dirty.

Operational Processes

Ask patients attending the practice to come alone if possible

Ask parents not to bring non-appointed siblings to the appointment if possible

To limit walk in situations, use signage and answering machine messages to ensure that access is by scheduled appointment, unless the dentist deems that the attendance can be safely managed.

Prior assessment of the patient to check for symptoms is easier and managing footfall through the practice are easier with scheduled appointments

Promote hand hygiene at reception (signage, verbal reminders and provide alcohol hand rub).

Promote respiratory hygiene and cough etiquette (signage, provide tissue and bins).

Reduce use of waiting areas and arrange for patients to attend the surgery directly at the appointed time.

Promote social distancing to the greatest extent possible while waiting treatment.

Consider asking the patient to wait in their own vehicle rather than in a waiting area where this is practical.

To the greatest degree practical the patient should establish phone contact on arrival to help manage attendance and check in.

Ask patients and any accompanying person should perform hand hygiene with hand sanitizer on arrival. If the person is wearing gloves ask them to remove and discard the gloves before performing hand hygiene.

Ensure that scheduling of appointments is managed to reduce patient contacts and allow appropriate time for any cleaning and disinfection required before the next patient.

Minimise non-essential interaction (especially physical contact) between staff members and patients and between staff members.

Monitor supplies of materials required for good infection prevention and control practice including supplies required to support hand hygiene and supplies of PPE.

Processes for instrument cleaning and decontamination must adhere manufacturer's recommendations and all applicable standards.

Treatment Area Environment Cleaning

Remove non-essential items from treatment areas.

Ensure hand sanitiser is available.

As below, if an AGP is required on a patient with suspected or confirmed COVID-19 it should be performed in a room with mechanical ventilation. If for any reason an AGP is performed on a patient with known or suspected COVID-19 in a room that is not mechanically ventilated the room should be vacated for 1 hour after completion of treatment before cleaning commences.

Single treatment room dental surgeries are preferred from first principles however, it is not clear that multiple-chair dental surgeries are associated with increased risk. There should be adequate space between chairs to ensure that there is no physical contact between either patients or staff working at different chair and staff caring for patients in separate chairs should generally work independently of each other accepting that supervisors and trainers will need to move between stations in the conditions of an educational setting. Physical barriers, for example plastic shields may be used in reception areas to reduce the risk of interaction between patients and staff.

Increased ventilation helps to disperse aerosols generated. Increased ventilation may be achieved naturally (for example opening a window where practical) or by appropriately controlled, mechanical ventilation. At all times it is appropriate to maximise ventilation in so far as practical given the facility and climate conditions.

Cleaning of the Treatment Area

Ensure that an environmental cleaning protocol is available to ensure that appropriate cleaning and disinfection is performed. Standard cleaning and disinfection agents used in healthcare settings are appropriate.

Ensure that members of staff are clear on the distinction between routine cleaning required after all patients and any specific additional requirements in the event that a patient with suspected or confirmed infectious disease including COVID-19 is cared for.

In the event that treatment is provided to a patient with suspected infectious disease including COVID-19 more extensive cleaning of all contact surfaces is required and disinfection of those surfaces is also appropriate.

Cleaning of the general clinical environment is normally performed with detergent and water or detergent wipes. Disinfection is not a substitute for cleaning.

When disinfection is required (for example after caring for a person with COVID-19 or other infectious disease) it must follow cleaning or be performed simultaneously with cleaning as a 2 in 1 process. Additional details on cleaning and decontamination are available in the Interim Guidance on Infection Prevention and Control for the HSE 2020.

For cleaning in treatment areas use of plastic apron and household gloves are an appropriate level of PPE.

All touch surfaces should be cleaned at a minimum of once per day and whenever visibly dirty.

Surfaces in the treatment area that are touched by the patient, patient's body fluids, and equipment or by dental staff should be cleaned between patients.

Performing a Dental Procedure

Limit personnel in the treatment room to the minimum required and ensure that the door remains closed throughout to discourage access to the room during treatment. The minimum number of people required may include a parent or carer if the patient needs to be accompanied.

Non-essential personnel should not enter the treatment room during the procedure to address other issues.

The determination of the appropriate PPE in each situation must be guided by an assessment of the risk that the person is infectious

Use of dental cuspidors may be minimised or avoided by use of high volume suction and /or by asking the patient to spit into a disposable cup.

If dental cuspidors are used minimise physical contact between the patient and the cuspidor and ensure that the cuspidors are effectively cleaned and decontaminated between patients.

There is generally no requirement to vacate (fallow time) a room after a AGPs is performed assuming the person treated and any accompanying person has been assessed as low risk for COVID-19. To date there is no evidence that fallow time in this context is associated with reduced risk of infection.

Pre-treatment mouth rinsing is not recommended. There is no clinical evidence to indicate that they are effective in reducing transmission of infection.

The Role of Testing

Testing of patients without fever or respiratory symptoms to assess infection status in advance of essential treatment is generally not appropriate for access oral health care at this time however in keeping with evolving practice in other domains of healthcare it may be appropriate in certain specific contexts for example complex or lengthy treatment in patients or where there is concern that the patient may have been exposed to particular risk of COVID-19 infection for example in a residential care facility.

Patients where there is no suspicion of COVID-19 and who are not Contacts of COVID-19 or in whom there are other specific risk factors for COVID-19

The following applies to patients who have been assessed for clinical features suggestive of COVID-19 and who have no such features and in whom there is at present no evidence that they are currently infectious for COVID-19 patients or COVID-19 Contacts or otherwise at specific risk.

All dental procedures: Standard, Contact and Droplet Precautions

Aerosol Generating Procedures: Standard Contact, Droplet Precautions. Note however that additional precautions including use of a respirator mask instead or a surgical mask may be applied based on individual risk assessment.

The Health and Safety Authority indicate that where a risk assessment indicates that workers need to use a close-fitting respirator mask for their protection that every effort should be made to comply with the requirement for fit testing of the workers, as far as is reasonably practicable. When fit testing of all staff is not immediately possible, then fit testing should be prioritised for those at greatest risk.

The requirement for protection from airborne transmission when performing AGPs on material removed from the mouth of people with suspected or confirmed COVID-19 in a laboratory or equivalent setting may be managed differently. For example it may be possible to manage the risk by decontamination of the item.

Patients with suspected or confirmed COVID-19 or who are Contacts of COVID-19 or in whom there are other specific risk factors for COVID-19

Where possible to defer dental procedures until after the infectious period/period of self-isolation or restricted movement has passed to avoid harm to the patient the risk of exposure of patients and staff in the dental surgery is avoided.

The following applies to patients with suspected COVID-19 until clinical evaluation has excluded or confirmed the diagnosis; it applies to those with confirmed COVID-19 until the infectious period has passed (see above), it applies to Contacts of COVID-19 until the recommended period of self-isolation (14 days) has past.

Additional precaution may also apply to people with who have recently travelled outside of Ireland depending on current Government advice on travel.

If it is essential to perform AGPs on patient with suspected or confirmed COVID-19 or on COVID-19 Contacts

1. Procedural measures to reduce aerosol generation (high volume suction and rubber dam) are appropriate when possible
2. The procedure should be performed in a facility with appropriately controlled mechanical ventilation such as an operating theatre.
3. Those performing the procedure should follow HPSC guidance on PPE use for AGPs

All dental procedures: Standard, Contact and Droplet Precautions

Aerosol Generating Procedures: Standard Contact, Droplet and Airborne Precautions.

Clinical Waste

Principles of management are as per HSE Interim Guidance on Infection Prevention and Control. See also HSE standard operating procedures:

<https://www.hse.ie/eng/about/who/healthwellbeing/our-priority-programmes/hcai/resources/dental>

Continuing Review

As in all healthcare delivery, there are risks of infection associated with delivery dental services in the context of the COVID-19 pandemic. Dental practices should record and evaluate any incidents of COVID-19 infection that may be associated with delivery of dental services and should inform the Department of Public Health.

ENDS