Transitioning Oral Healthcare to Phase 2 of the COVID-19 Response Plan
Frequently Asked Questions

Since releasing a number of documents on Friday, May 15th, 2020 with information related to the resumption of in-person non-essential care, the College has received several questions. In an effort to consolidate the information provided in the series of documents and provide a central place where the more frequently asked questions can be addressed, the College has created this FAQ. However, registrants must fully read all documents provided and if following that review, they have specific questions, this document may offer further clarification. This document is not a substitute for reviewing the fulsome documents provided. Guidance will be updated as further information becomes available.

In establishing the 'Transitioning Oral Health Care to Phase 2 Response Plan', the four oral health colleges considered the many contexts of the provision of oral healthcare, including the various ways dental hygienists practice, and the most current and available evidence to support the guidance. The intention is to outline a transition to practice where oral healthcare providers can assess and reduce the risk of providing care to their patients in ways that uphold safe practice. The aim has been to provide guidance that would allow for professional discretion in applying foundational principles of infection prevention and control without creating artificially high expectations, which are not supported by evidence, and may inhibit practice altogether. The 'Transitioning' document will continue to be updated as evidence becomes available or as best practice changes.

While the guidelines that have been produced for the Phase 2 response plan are based on BCCDC directives, and supported by the most current and available evidence, these guidelines are intended as a *minimum* acceptable level of care. Oral healthcare providers are not limited from implementing additional measures that they feel are prudent and further support their safe practice.

It should be noted that the ability to resume the provision of non-essential care on May 19th, 2020 does not mean that there is an expectation from the College of a 'must' return. Each practice, and each professional within that practice, will have to consider all the information provided as well as their own circumstances to determine when and how care can be provided in a manner that will keep patients, themselves and all those within the practice safe. Some registrants may have decided that a resumption of the provision of in-person non-essential care on May 19th was not prudent or desirable for a multitude of reasons. As Dr. Henry stated, this resumption can be an anxiety-inducing time for many. As such we encourage you to take a slow, thoughtful and measured approach, utilizing sound professional judgement.

Questions:

1. The BCCDC document is targeted to community-based allied health care providers but doesn't specifically list dental professionals. Has the high aerosol-producing nature of dentistry been taken into consideration with the guidelines released? Will the BCCDC release an additional document for oral health providers?
    - The BCCDC document entitled 'COVID-19: Infection Prevention and Control Guidance for Community-Based Allied Health Care Providers in Clinic Settings' was developed with all allied health care providers in mind, including dental hygiene and dentistry. The recommendations in both this document and the COVID-19 infection prevention and control document developed for physicians, nursing professionals and midwives use the same language to describe the use of an N95 respirator and eye protection (i.e. goggles or face shield), gloves and gown for procedures that are aerosol generating for patients with suspected or confirmed COVID-19 or airborne diseases. This document and others will be updated as new information becomes available.

2. Why does the BC document differ from guidelines produced in other provinces?
    - BC has adopted a "Made in BC" approach for the entire pandemic response and this document speaks to creating a principled approach of empowering oral healthcare professionals to discern how and when they will provide oral care within their unique contexts. In addition, each province's reality during the pandemic varies broadly, and their approach to the provision of oral healthcare more specifically has been vastly different. As such, it would not be appropriate to overlay documents produced in other jurisdictions in the response to Phase 2 of the Restart BC plan.

      Furthermore, there continues to be a scarcity in dental-specific evidence related to the provision of care while considering the implications of COVID-19. As information becomes available to all jurisdictions, documents will be updated accordingly.

3. How can AGMPs (aerosol generating medical procedures) be kept to a minimum in an office that is open concept and where other OHCPs are doing AGMPs? Are operatory dividers needed? Do operatories need to be sealed off?
    - Each practice setting is unique, and the physical space should be considered when making risk assessments to determine which patients to treat and when. Considerations should be made with respect to ventilation, proximity of patients, potential for aerosol travel between patients and the risk that is created by providing care. **AGMPs must be kept to a minimum and high-volume suction must be used to reduce aerosols at source.**

4. Why is the use of N95 masks for AGMPs required only with suspected or confirmed-positive patients? What about the asymptomatic period of infection? Given that we are taught to follow universal precautions for all, shouldn't we treat all patients as "suspected positive" or as infectious as per the IPAC (Infection Prevention and Control) guidelines (i.e. use N95 masks for all patients)?
    - The BCCDC document 'COVID-19: Infection Prevention and Control Guidance for Community-Based Allied Health Care Providers in Clinic Settings' has stated that N95 masks are only required for the provision of AGMPs to patients who are suspected (presumed positive) and confirmed positive for COVID-19. The BCCDC is the official authority on setting standards for care during this pandemic and the College has incorporated the current BCCDC position on patient management.

      OHCPs can take further steps to reduce the risk of transmission by carefully pre-screening patients for signs and symptoms of the virus, thereby reducing the potential for infectious patients in the clinical setting. If the perceived risk of transmission is greater than the determined need for oral care, the care should be postponed.

5. What is the minimum PPE required for oral healthcare, including dental hygiene, procedures?
    - The CDHBC IPAC guidelines define minimum PPE as "gloves, protective eyewear, masks and protective clothing" (IPAC guidelines, page 19-20,). If gowns are worn over scrubs, any such long-sleeved clothing is patient-specific and must be changed before each new patient.

6. What level of masks are being recommended if no aerosols are being produced?

- The CDHBC IPAC guidelines provide guidance on mask use for the provision of all oral healthcare, including dental hygiene treatment, EXCEPT when providing AGMPs to a suspected or confirmed COVID-19 positive patient. The IPAC guidelines do not stipulate the "type" or level of mask but surgical masks are deemed "appropriate".

7. What are considered to be AGMPs?
    - Triplex syringes (i.e. use of water, air and/or both), ultrasonic scalers, air polishers, and polishing cups are all examples of instruments that produce AGMPs. The use of these instruments must be kept to a minimum; however, this does not prohibit their use entirely. All oral healthcare providers, including dental hygienists, should use their professional discretion to determine when AGMPs may be appropriate for individual patients. For example, the water jet from a triplex syringe would likely produce significantly less aerosol compared to ultrasonics and therefore may be employed judiciously if the circumstance requires it.
    - **It is not recommended that a dental hygienist provide an AGMP for a presumptive or positive COVID-19 patient.**

8. Can we use saliva ejectors (with backflow valve)?
    - Yes.

9. Is hand scaling a non-AGMP? What is being recommended?
    - Hand scaling is not considered to be of equivalent aerosol-producing capacity as many other procedures. Hand scaling may be provided as an appropriate form of debridement when the risk assessment deems that the benefit of providing oral healthcare outweighs the risk to the patient and the OHCP.

10. Can I use an ultrasonic scaler if I use the proper PPE?
    - Ultrasonics are known to produce significantly greater amounts of aerosols than hand scaling. **The use of ultrasonics must be kept to a minimum.**

11. Why is the 'Transitioning Oral Health Care to Phase 2' document silent on pre-procedural rinses?
    - The literature does not yet provide sufficient evidence to support a guideline for the use of a pre-procedural rinse as an efficacious means of reducing COVID-19 viral load in aerosols. OHCPs may choose to offer such procedures but are encouraged to align their practices with evidence-informed guidelines related to COVID-19.

12. Are temperature checks required for pre-screening of patients?
    - The presence or absence of a fever may or may not indicate an early symptom of COVID-19; however, this is only one of a list of pre-treatment screening questions that should be posed to patients. The absence of a fever may be affirmed by the patient but in the presence of other COVID-19 related symptoms, this patient should be postponed unless care is urgent.

13. Are prescription eyeglasses sufficient for PPE or is more coverage required (i.e. shield, visor, etc.)?
    - Page 16 of the 'Transitioning Oral Health Care to Phase 2' lists examples of eye protection (in addition to masks), which include full face shield, mask with attached visor, non-vented safety glasses or goggles (regular eyeglasses are not sufficient). When using eye protection

for multiple patient encounters, they should be cleaned and disinfected as per the guidance found on the BCCDC site.

14. Can I use a 3D printed face shield?
    - Yes.

15. Patients who are pregnant are considered high risk for severe COVID-19. What are the guidelines for a pregnant OHCP?
    - The pregnant OHCP must consider the risks and self-determine whether returning to the provision of non-essential care is necessary and appropriate for their particular circumstance. Further information to support this determination can be found on the BCCDC website. This and any other health-related concerns should be discussed with the appropriate health professional to guide the OHCP's return to practice.

16. Does a free-standing high-efficiency particulate air (HEPA) filter unit replace the need for HVE during the use of AGMPs, including some dental hygiene treatments?
    - There is no evidence to indicate whether a standalone HEPA filter would be effective at replacing an HVE during the provision of AGMPs, however, the OHCP may wish to consider this as an additional measure to managing airborne contaminants in the operatory.

17. Should healthy individuals with healthy periodontium be deferred for now in order to reduce overall risk to the OHCP?
    - An assessment of each individual patient's risk of receiving care versus the risk of deferring care must be completed in order to determine when patients should be scheduled. If a patient's risk profile for COVID-19 is low, it would stand to reason that care could be safely provided.

18. How long should vulnerable patients (i.e. elderly or with underlying comorbidities) without emergent issues continue to have regular care deferred? What is the full list of conditions that define patients as "vulnerable"?
    - People with chronic diseases are at higher risk of death if they become ill with COVID-19. The BCCDC provides the following list of people who may be at higher risk for acquiring COVID-19 which includes:
        - People with medical conditions such as heart disease; hypertension (high blood pressure); lung disease; diabetes; and cancer.
        - People with weakened immune systems from a medical condition or treatment, such as chemotherapy, older adults, seniors and Elders.

    Deferral of care is indeterminate at the present time and should be re-evaluated based on changes in community transmission rates, assessed risk of the patient and recommendations made by BC's Public Health Officer (PHO).

19. BC's Transitioning OHCPs to Phase 2 document recommends scheduling vulnerable patients at the beginning of the day, however, it also says to defer them whenever possible. When is it recommended to schedule vulnerable patients instead of deferring care?

- Vulnerable patients (as listed above) should have non-essential care deferred whenever possible. It is only in the cases where care is deemed necessary that vulnerable patients be seen and in doing so they should be scheduled at the beginning of the day.
- Patients at higher risk **and** who may be suspected or confirmed COVID-19 positive, yet also require essential care, should be scheduled at the end of the day.

20. Why are gowns recommended for disinfecting an operatory but not for care itself?
    - The use of gowns for disinfecting operatories is meant to be consistent with whatever garment was worn during the procedure completed on the same patient. The CDHBC IPAC guidelines (page 20) stipulate that long sleeved garments are intended to be patient-specific and should be removed prior to the next patient. If choosing to wear a gown for oral health care, including dental hygiene treatment, the same garment should be maintained for operatory disinfection then should be replaced prior to interacting with a new patient.

21. The BCCDC document recommends gowns be worn for in-person care. What are the BC OHCP expectations for wearing gowns? How often should they be changed?
    - The BCCDC document recommends the use of gowns for interactions with patients who have symptoms consistent with COVID-19, who are suspected or confirmed COVID-positive. Gowns should be changed after each individual patient interaction. If OHCPs choose to wear gowns for low-risk patients, a new gown must be worn for each new patient interaction as per the CDHBC IPAC guidelines (page 20).

22. Are home-sewn gowns acceptable? What about lab coats?
    - Gowns and lab coats are long-sleeved over-clothes that may be worn to protect clothing or scrubs from contamination. Long-sleeved garments (i.e. lab coats or gowns) can be fabricated commercially or personally but must be changed after each individual patient interaction (CDHBC IPAC guidelines, page 20).

23. What is the standard for laundering gowns, lab coats, scrubs, etc.? Is regular laundering sufficient or is a hospital grade disinfectant recommended?
    - Laundering of clinic attire does not require hospital-grade detergent. Laundry detergent and hot water wash is adequate for laundering soiled clinic attire; however, care should be taken in doffing clothing and transporting to laundry facilities.

24. Are N95 or surgical masks able to be cleaned or re-used?
    - The BCCDC has not provided specific guidelines on cleaning and re-use of N95 masks, therefore, we cannot offer specific guidance around this at this time. The CDHBC IPAC guidelines direct OHCPs to discard surgical masks when soiled, damaged, damp or wet (i.e. between each patient or more frequently if needed).

25. BC's Transitioning OHCPs to Phase 2 document references draping a patient and using a bib. What does this mean?
    - Drapes and bibs are interchangeable terms (CDHBC IPAC guidelines, page 13) and are recommended for all patient care procedures to protect the patient's clothing and reduce their exposure to splatter and debris.

26. What steps should be taken in considering when to provide care for residents of long-term care facilities?
    - Residents in long-term care facilities have been the most vulnerable segment of our population in the face of the COVID-19 outbreak and the provision of oral care in LTCFs may not be considered feasible until further guidance is offered by the BC PHO.

27. Are there guidelines for oral healthcare providers that work in multiple practices or locum work?
    - There are no restrictions set out by the BCCDC or WorkSafe BC limiting the provision of care among multiple community-based dental offices.

28. Where should PPE be doffed following a patient interaction?
    - Doffing of gloves and gown (if worn) and associated hand hygiene should occur in the operatory. Then, if the patient is not 2 meters away, exit the room and complete the doffing of face PPE (masks, eyewear, face shield if worn) and associated hand hygiene process. Please refer to the BCCDC site on Steps for Donning and Doffing PPE.

29. I disagree with the approach my employer is taking with regards to resuming care. What should I do?
    - We encourage registrants to have a professional and collaborative dialogue with all members of the oral healthcare team in order to arrive at an approach that focuses on the safety of the patient as well as the members of the oral health team. Specific questions or concerns related to employment matters should be directed to the BC Dental Hygienists Association.