Oral Health Care during Phases 2 and 3 of the COVID-19 Response Plan
Summary of Changes and Frequently Asked Questions

In an effort to consolidate the information provided in the updated 'Oral Health Care during Phases 2 and 3 of the COVID-19 Response Plan' document and provide a central place where the major changes made to the document can be addressed, the College has created this document highlighting the major changes related to dental hygiene practice including an updated FAQ. However, registrants must fully read all documents provided and if following that review you 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.

During the process of revising the previously published 'Transitioning Oral Healthcare to Phase 2 of the COVID-19 Response Plan' document and establishing the updated 'Oral Health Care during Phases 2 and 3 of the COVID-19 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 this guidance. 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 unsupported by evidence, which may inhibit practice altogether. *This revised document will continue to be updated as evidence becomes available or as best practice changes*.

While the guidelines that have been produced for Phases 2 and 3 of the 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.

Each practice, and each professional within that practice, must 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. We encourage you to continue to take a slow, thoughtful, and measured approach, utilizing sound professional judgment.

Summary of Notable Changes

- Page 7/8 – Addition of *Hierarchy for infection prevention and exposure control measures for communicable disease* diagram from the BCCDC.

- Page 8 – Additional symptoms of COVID-19 have been added to the list for pre-screening purposes.

- Page 9 – A clear distinction has been made between "vulnerable patients" who have numerous co-morbidities and may experience a more severe form of COVID-19 if ever

exposed and "high risk patients" who are at a higher risk of having COVID-19 due to potential exposure. Revisions have been made regarding consulting with vulnerable patients to determine when care should be deferred.

- Page 10 – Addition of the concept of 'point of care risk assessment' (PCRA) to align with the term used by the BCCDC.

- Page 10 – A new section has been added related to temperature measurement of all patients.

- Page 11, Appendix E – Information regarding pre-procedural rinses and the reduction of disease transmission has been provided indicating they are not evidence-based at present and have not been shown to have clear clinical benefits.

- Page 12 – The section on screening and education has been reworded to emphasize that everyone in the facility must self-monitor daily for any of these symptoms and must stay home and isolate when identified.

- Page 13 – Additional guidance has been added regarding OHCPs who are deemed essential workers and who return from essential travel outside of Canada. These individuals will need to follow additional protocols to reduce risk to patients, colleagues, and the public.

- Page 14 – OHCPs and staff who are immunocompromised should have collaborative discussions to consider job functions and exposure risks.

- Page 16 – High volume suction use has been aligned with the current IPAC guidelines which indicate this level of evacuation should be used "whenever the creation of droplets, spatter and spray is possible".

- Page 16 – In an effort to minimize the spread of droplets, spatter and spray, use of AGMP instruments should be kept to a minimum.

- Page 17 – New table: **Required personal protective equipment by procedure and COVID-19 status of patient**.

- Page 17 – All facilities must have an exposure management protocol in place. It should be reviewed periodically to ensure it is familiar to all OHCPs and staff.

- Page 19 – Additional information has been added related to HVAC/air flow.

- Page 20 – There is no longer a recommendation to limit the exchange of paper documents as the BCCDC indicates there is no evidence of paper-based COVID-19 transmission.

- Page 23-36 – Appendices A through E have been added since the previous publication

Frequently Asked Questions (FAQ)

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 more specifically, their approaches to the provision of oral healthcare have been vastly different. As such, it would not be appropriate to overlay documents produced in other jurisdictions in the response to Phase 2 and Phase 3 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 should be kept to a minimum and high-volume suction should 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". A particular ASTM level is not specified in the IPAC guidelines because the appropriate level of mask to select needs to be determined based on the nature of the treatment being provided. Registrants may find it helpful to review information from mask manufacturers, as they typically provide further information about the filtration level and treatment indications in the specifications that they publish.

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 should 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 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 should be kept to a minimum.**

9. Are temperature checks required for pre-screening of patients?
    - All patients should have their temperature measured on arrival. OHCPs should use a touch free device if possible or clean and disinfect thermometers between patients and document the patient's temperature in their record. If the temperature is elevated and cannot be explained by another diagnosis, consider delaying the appointment and referring for testing.

10. Patients who are pregnant are considered to be vulnerable for severe expression of COVID-19 should they become infected. 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.

11. When should vulnerable patients (i.e. those with underlying comorbidities) without emergent issues have regular care deferred? If the benefit of providing care to a vulnerable patient is determined to outweigh the risk, when should care be provided?
    - Patients considered to be vulnerable for severe expression of COVID-19 (should they become infected) include those with pre-existing conditions such as serious respiratory disease, serious heart disease, immunocompromised, severe obesity, diabetes, chronic kidney disease or those undergoing dialysis, liver disease and pregnant patients.

      Age is a risk factor that needs to be considered in the context of comorbidities which increase the risk of severe COVID-19 symptoms.

      While deferral of vulnerable patients should always be considered, it must only be done following a virtual or telephone consultation between the patient and the OHCP responsible for the patient's care to discuss the risks/benefits of providing necessary care to prevent possible exacerbation of an oral condition. In some cases, virtual care may be a reasonable option.

      Pre-existing conditions and age should not be an obstacle to receiving care, particularly when there is currently low incidence and prevalence of COVID-19 in BC. However, OHCPs may consider taking additional precautions when scheduling high-risk patients. Effective risk mitigation can include scheduling vulnerable patients as the first appointments of the day to limit the opportunity for contact with other patients, OHCPs and staff.

12. 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.

13. Are N95 or surgical masks able to be cleaned or re-used?
    - It is a foundational concept in IPAC practice that disposable masks should not be re-worn. Accordingly, masks should be changed between each patient or sooner when they become visibly soiled.

      The BCCDC has a resource allocation framework with various stages and if a need arose, additional jurisdictional guidance would be issued under the authority of the PHO.

14. The 'Oral Health Care during Phases 2 and 3' 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.

15. What steps need to be taken to resume providing care to residents of long-term care facilities?
    - On July 6, 2020, the College released a statement which provides information for OHCPs regarding the resumption of oral health care in long term care and assisted living settings.

16. 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.

17. Are there changes to documentation requirements?
    - As per CDHBC Practice Standard #8, documentation must reflect an accurate description of the procedures, interactions and considerations taken during the client care appointment. When these elements align with the standards and guidelines depicted in the CDHBC Infection Prevention and Control document, no additional documentation is required. When additional measures are being taken (e.g. taking client temperature upon arrival, using a pre-operative rinse, or deferring use of ultrasonics), these additional precautions should be documented accordingly.

18. I disagree with the approach my employer is taking with regards to providing care during the COVID-19 pandemic. 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.