

[This document is based on the latest available best practice and scientific evidence about this emerging disease and may change as new information becomes available](#)

~~Transitioning Oral Healthcare~~ ~~to Phase~~ Health Care During Phases 2 and 3 of the COVID-19 Response Plan

~~May 15~~ August 18, 2020

This document is for oral health care providers: certified dental assistants, dental hygienists, dental technicians, dental therapists, denturists, and dentists.

Registrants are expected to read this guidance and follow the expectations within it as they resume the provision of dental care. It is a comprehensive document that covers topics such as ongoing pandemic best practices, personal protective equipment, and infection prevention and control principles and strategies. It applies to [what the BC government is referring to as phase 2 and 3](#) of the [B.C. government's response plan to the COVID-19 pandemic](#).



College of Dental Hygienists
of British Columbia



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1. Introduction

a. Purpose of the document

To consolidate existing [regulatory](#) standards, guidance and expectations ~~and interim~~with recommendations and considerations from government and other authoritative agencies for the treatment of patients during the COVID-19 pandemic. This document is to be considered in [conjunction with oral health care regulatory standards and guidelines for infection prevention and control \(IPAC\)](#) and in tandem with publications from the following agencies:

- [BC Centre for Disease Control \(BCCDC\)](#)
 - [COVID-19: Infection Prevention and Control Guidance for Community--Based Allied Health Care Providers in Clinic Settings \(PDF\)](#)[†]
 - [Infection Prevention and Control Guidance for Surgery in Non-hospital Medical Surgical Facilities](#)
 - [Infection Prevention and Control Protocol for Pediatric Surgical Procedures](#)
 - [Infection Prevention and Control Protocol for Surgical Procedures in Adults](#)
- [Office of the Provincial Health Officer](#)
- [WorkSafeBC](#)

This document is for oral health care providers (OHCPs): certified dental assistants, dental hygienists, dental technicians, dental therapists, denturists and dentists.

OHCPs employed by hospitals, health authorities, and long-term care facilities should refer to guidance provided by their employers and the Provincial Health Officer (PHO). The direction in this document pertains to the delivery of care outside of these settings. These include, but are not limited to, private practice ~~clinics~~facilities, private mobile or community-based practices, and school-based practices.

b. Objective of the document

To prevent and control the transmission of [Severe Acute Respiratory Syndrome Coronavirus 2 \(SARS-CoV2CoV-2\)](#) during emergent, essential and non-essential care of patients by OHCPs.

c. Revisions

[The document is based on the latest available best practices and scientific evidence about this emerging disease and may change as new information becomes available.](#)

- [This document was first published on May 15, 2020 and was titled “Transitioning Oral Healthcare to Phase 2 of the COVID-19 Response Plan”. Immediately following the first publication of this document on the afternoon of May 15, 2020, the BCCDC published *Infection Prevention and Control guidance for surgery in non-hospital medical surgical facilities*, resulting in subsequent edits related to the section called “exposure prevention”.](#)

- [This is the second published version of the document \(August 18, 2020\) and it replaces the May 15, 2020 document. It has been revised to reflect the BCCDC's May 21, 2020 publication of "IPAC guidance for surgery in non-hospital medical surgical facilities". Amendments have been made throughout the document to provide clarity and align with that subsequently published authoritative guidance.](#)
- [Appendices A through E are a new addition since the May 15 publication. Note that Appendix B, Pathway for management of oral health care during the Phases 2 and 3 response plan for COVID-19, was originally published on the CDSBC website on April 30, 2020 and has been updated and included in this version of the document \(August 18, 2020\).](#)

c.d. Disease description

The causative agent of COVID-19 is Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2). The incubation period, the time between exposure and potentially becoming infected, is on average 5-6 days, but can be up to 14 days with or without symptoms. ~~During the asymptomatic period (pre-symptomatic period) some infected persons may be contagious. Transmission from a pre-symptomatic person can occur before the onset of symptoms.~~ [COVID-19 is understood to be highly infective and easily transmissible, primarily as a result of close contact with infected persons through respiratory droplets. This evidence comes from data found in published epidemiological and virologic studies. See Appendix D for a primer on infectious disease and infection prevention.](#)

a. Transmission

~~Transmission of COVID-19 is primarily from symptomatic people to others who are in close contact through respiratory droplets, by direct contact with infected persons or by indirect exposure through contact with contaminated objects and surfaces. COVID-19 is understood to be highly infective and easily transmissible. This evidence comes from data found in published epidemiological and virologic studies.~~

d.e. Disclaimer

Information in the document is based on the current evidence provided in the bibliographies of the authoritative agencies' publications and may be subject to change as continuing research becomes available.

2. Guiding Principles and Assumptions

The following guiding principles and assumptions have been identified as foundational for reintroducing non-essential oral health care services in the context of COVID-19.

- All OHCPs will follow the guidance, expectations, and direction provided by the PHO.
- Some services can be safely and effectively provided virtually. Other services require in-person visits including direct patient care. Oral health college standards and guidelines apply, regardless of whether services are provided virtually or in-person.

- Wherever possible, physical distancing will be maintained during the delivery of care.
- In-person services must only proceed when the anticipated benefits of such services outweigh the risks to the patient, the health professional and the greater community. ~~It is always safer for the patient and the provider to stay home if at all possible.~~
- The OHCP is accountable and is the person best positioned to determine the need for, urgency and appropriateness of in-person care.
- Appropriate personal protective equipment (PPE) must be used for the safe delivery of in-person care. However, all OHCPs must also act to conserve PPE through its judicious use.
- OHCPs must consider if they are the most appropriate health professional to address the patient's needs, referring patients to other members of the health care team when in the patient's interest.
- ~~• OHCPs must not recommend unproven therapies for treating COVID-19.~~
- OHCPs must not prescribe or offer any COVID-19 treatments or therapies that are not within their scope of practice.
- ~~• OHCPs are accountable to provide clear, honest, transparent communication regarding their policies and procedures related to COVID-19.~~
- OHCPs must not recommend unproven therapies for treating COVID-19.

3. Prioritization of Patient Care Services

~~It is anticipated that when services resume OHCPs may face difficult decisions regarding which patients to see and the prioritization of care.~~ The OHCP is accountable for prioritizing access to in-person services based on clinical judgment and with consideration given to the patient perspective and the referral source. When determining priority for in-person care, OHCPs should reflect upon the ~~following~~:

- acuity of the patient's condition,
- functional impairment or impact of the condition on health-related quality of life,
- impact of not receiving services,
- appropriateness of service provision via virtual care,
- necessity of services which can only be provided in-person, and
- duration of patient waits times for care.

4. Ongoing Pandemic Best Practices

Public health officials have indicated that COVID-19 is expected to continue to circulate in the general population for an extended period of time. As such, ongoing measures to control the spread of the disease are anticipated, including requirements to practice physical distancing of at least 2 metres (6 feet) and increased screening for signs, symptoms and risk factors for COVID-19.

Oral health care **Professionals**~~providers~~:

- Must adhere to all ~~BC Centre for Disease Control~~[BCCDC \(BCCDC\)](#) and [BC Provincial Infection Control Network](#) (PICNet) guidance regarding infection prevention and control measures applicable to the practice environment, including PPE use and environmental cleaning best practices.
- Must adhere to all BCCDC and WorkSafeBC guidance regarding occupational health and safety exposure control plans to ensure a safe work environment for staff. This includes robust policies, procedures and organizational cultures that ensure that no employees associated with the practice attend work when they have symptoms of illness.
- Must *not* provide in-person care and should not be in attendance at clinics or other practice settings where other staff and patients are present if they are exhibiting signs of COVID-19 or respiratory illness, including cough, runny nose or fever.
- **Must** follow BCCDC and WorkSafeBC guidelines for self-isolation when an employee is sick with any respiratory illness, support access to primary care provider assessment and testing, and provide sick-leave support where possible until advised by their health care provider that it is safe to return to work.
- **Must** implement COVID-19 screening practices for patients:
 - Screen for probability and symptoms of COVID-19 prior to attendance at the practice environment. If screening reveals the patient is suspected or confirmed positive for COVID-19 or has symptoms of COVID-19, defer patient (where reasonable) until signs and symptoms have resolved.
 - Patients should also be encouraged to make use of COVID-19 resources by calling 811 or visiting [healthlinkbc.ca](#).
 - ~~Screen for risk factors and symptoms of COVID-19 prior to attendance at the practice environment. If patient screening reveals risk factors for COVID-19 or symptoms of COVID-19, defer patient (where reasonable) until signs and symptoms have resolved~~

OHCPs are not expected to provide treatment for patients who are confirmed COVID-19 positive, have signs or symptoms of COVID-19, or have had possible exposure and are awaiting test results unless dental treatment is emergent and, in their professional opinion, it is safe to do so for both patients and staff.necessary precautions can be taken.

A list of key resources is provided in Appendix C.

5. Personal Protective Equipment

Regarding use of [personal protective equipment \(PPE\)](#), OHCPs should follow the directives and recommendations provided by BCCDC, PICNet, and WorkSafeBC. This includes directives that are role-based (e.g. administrative vs. direct patient contact) or specific to the practice context (e.g. mobile practice in long term care settings vs. community-based facilities).

- [Personal Protective Equipment \(BCCDC Website\)](#)
- [COVID-19: Emergency Prioritization in a Pandemic Personal Protective Equipment \(PPE\) Allocation Framework](#)

6. Infection Prevention and Control Principles and Strategies

The risk of transmission of an infection as a result of an oral health procedure represents an important patient safety consideration.

In the context of [COVID-19 low incidence and prevalence of COVID-19 in British Columbia](#), a comprehensive approach includes maintaining routine practices, physical adaptations within the facility, hand hygiene and risk assessment with focus on aerosol and droplet management and [appropriate](#) contact precautions.

Infection prevention and control (IPAC) principles

[IPAC principles](#) include:

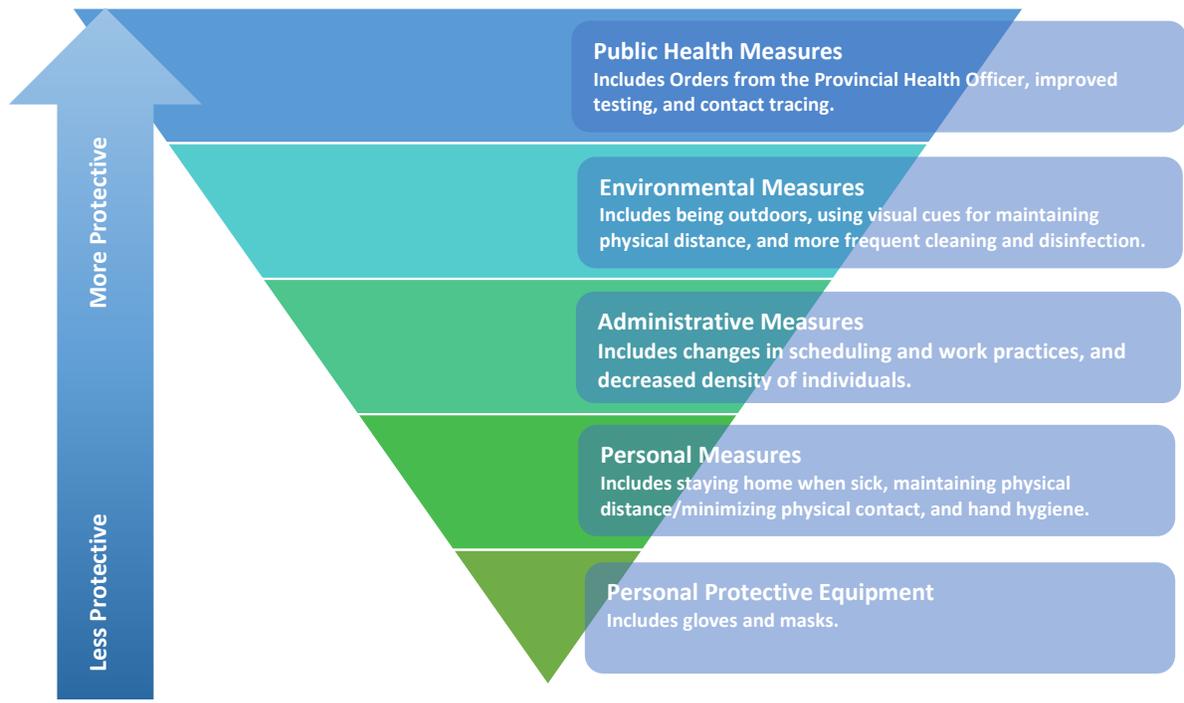
- patient assessment;
- implementation of routine procedures;
- use of barrier techniques to protect patients, OHCPs and staff;
- application of the principles of cleaning, disinfection, sterilization and storage of dental instruments;
- environmental surface protection/cleaning;
- care of overall office setting; and
- safe handling and disposal of waste.

An IPAC strategy to reduce the possibility of disease transmission includes:

- setting specific policies and procedures to identify, communicate and implement effective standards and guidelines;
- written office policies and programs for effective occupational health and safety;
- educating OHCPs, staff and patients about their roles in infection prevention; and
- ongoing review and evaluation of IPAC policies and procedures.

[A hierarchy of exposure control measures \(see Figure 1\) demonstrates those which can be taken to reduce the risk of transmission of COVID-19. Measures at the top are more effective and protective than those at the bottom. By implementing a combination of measures at each level, the risk of transmission of COVID-19 is reduced.](#)

FIGURE 1: Hierarchy for infection prevention and exposure control measures for communicable disease



From www.bccdc.ca/Health-Professionals-Site/Documents/IPC_Guidance_Surgeries_Non-Hospital_Sites.pdf

7. Standards and Guidance for the Provision of Oral Healthcare Health Care During Phase Phases 2 of the COVID-19 Response Plan and 3

a. Patient management and safety

i. Pre-screening protocols

Pre-screening protocols and triage, either by virtual/remote technology or by telephone, must be provided for all patients. This includes asking patients:

- If they have symptoms of COVID-19
 - dry cough
 - sore throat or painful swallowing
 - shortness of breath
 - fever

- runny nose, sneezing, post-nasal drip (~~coryza~~), loss of smell (anosmia) with or without fever
 - [loss of appetite](#)
 - [chills](#)
 - [muscle aches](#)
 - [headache](#)
 - [fatigue](#)
- If they have had close contact or have been in isolation with a suspected case in the last 14 days
 - If they have travelled [internationally outside Canada](#) in the last 14 days

When the patient arrives for their appointment, their pre-screening responses must be confirmed and recorded in their record.

[COVID-19 positive patients](#)

If the patient has ~~symptoms of~~ [screened positive for suspected or confirmed COVID-19 and may be infective](#), OHCPs are encouraged to defer in-person assessment and treatment or alternatively provide care by virtual means. ~~That is,~~ unless [the oral health emergency deferring treatment](#) is a greater risk [to the patient](#) than COVID-19. Where medical management of COVID-19 may be affected by deferring emergent dental treatment, there should be consultation with the primary care provider.

If the patient is COVID-positive, [but requires immediate care](#), treatment should be provided in a hospital or tertiary care facility ~~–~~ [whenever possible](#). Treatment can be provided in a dental practice if the [facility needed expertise](#) and PPE requirements can be met.

[High-risk Vulnerable patients](#)

Patients considered [high risk 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 ~~conditions~~ [disease](#), immunocompromised ~~conditions~~, severe obesity, diabetes, chronic kidney disease or those undergoing dialysis, ~~and~~ liver disease; ~~and~~ [and](#) pregnant patients; ~~and~~.

[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 who are 70 years 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 over. These age should not be an obstacle to receiving care, particularly when there is currently low incidence and prevalence of COVID-19 in B.C. However, additional precautions may be considered when scheduling high-risk patients should be deferred whenever possible. 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.](#)

Staff requirements:

Staff must maintain awareness of data on the local and regional spread of COVID-19.

Staff conducting telephone screening are provided with appropriate guidance on how to screen for signs and symptoms of COVID-19, when to advise patients to self-isolate at home, how to counsel them on signs and symptoms of more severe or critical illness that should prompt them to seek emergent care, and on the indications and locations for testing.

On-site administrative staff who are screening patients ~~must~~[should either](#) be behind a transparent barrier that prevents droplet transmission and allows for communication between staff and patients, or ~~if this is not in place they must~~[wear PPE \(i.e., gloves, gown, mask and eye protection\).](#) ~~if more than 2-metres distance is not possible.~~

ii. Routine practices

Routine IPAC practices (standard precautions) protect patients, OHCPs and staff. OHCPs must maintain routine practices, including risk assessment, hand hygiene, use of PPE and safe handling and disposal of waste.

Point-of-care risk assessment

Risk assessment must be done before each in-person interaction to determine the interventions required to prevent disease transmission.

Prior to any contact with the patient, the OHCP and staff must assess the infectious risk posed to themselves, other OHCPs, staff and patients. The risk will vary with the context of the patient and the type of procedure being contemplated. It is based on the OHCP's professional judgment and must take into consideration the physical environment, including any possible facility limitations, and the resources available, including PPE, in order to safely treat patients.

[Repeat the screening protocol in-person on arrival the day of the appointment, confirming the patient's telephone pre-screening responses and record them in the patient record.](#)

Temperature measurement

[All patients should have their temperature measured on arrival as follows:](#)

- [use a touch free device if possible or clean and disinfect thermometers between patients](#)
- [document their temperature in the patient record](#)
- [if the temperature is elevated and cannot be explained by another diagnosis, consider delaying the appointment and referring for testing](#)

Hand hygiene

Hand hygiene is the single most important measure for preventing disease transmission -

- ~~Hand hygiene must be performed:~~

- ~~when in the patient care environment before and after direct contact with a patient or others.~~

- ~~before procedures~~
 - ~~after risk of body fluid exposure~~
 - ~~before donning gloves and immediately after removing gloves~~
 - ~~before and after mask use~~
 - ~~after contact with environmental surfaces~~
 - ~~after contact with dental laboratory materials or equipment and when hands are visibly soiled.~~

- ~~Patients must perform hand hygiene with soap and water or with an alcohol-based hand rub (ABHR) after removing a mask or other PPE, coughing or sneezing, using a tissue or which when hands are visibly soiled.~~

- ~~Sinks with soap and water should be available to patients and staff. Non-touch waste receptacles for disposal of paper towels are preferred.~~

~~ABHR must contain at least 70% alcohol and be available at multiple locations, including reception, waiting room, operatories and washrooms.~~

Non-touch waste receptacles for disposal of paper towels are preferred. Staff should assist patients with hand hygiene as needed. Hand hygiene must be performed by patients:

- on entering the facility,
- on entering the operatory,
- on leaving the operatory,
- after using the washroom,
- after using a tissue for their face,
- after coughing or sneezing,
- when removing PPE, and
- when hands are visibly soiled.

Personal PPE for patients

Patients presenting without symptoms do not require a mask as long as physical distancing can be maintained.

Routine protective measures including bibs, ~~drapes~~ and eye protection ~~must~~should be provided for patients ~~during treatment.~~

Pre-procedure rinses

Currently there is no evidence that oral pre-procedure rinses reduce risk of transmission of droplet or aerosol spread of disease and, therefore, clinical benefits are unknown. See Appendix E for more information.

Respiratory etiquette

Patients should:

- Cough/sneeze into their elbow sleeve or use a disposable tissue.
- Immediately dispose of used tissues into an appropriate waste bin and perform hand hygiene.
- Refrain from touching their eyes, nose or mouth with unwashed hands.

Post-operative instructions (when applicable)

- Instructions/teaching should be done pre-operatively using telephone/virtual technology where possible.
- When a patient advocate is required to be present for the post-operative instruction, screen for symptoms of COVID-19 on the phone in advance. If symptomatic, ask caregiver/advocate to stay home.
- Staff member to assist caregiver/advocate with hand hygiene as needed.

iii. Additional precautions for COVID-positive patients

Enhanced practices ~~must~~^{must} be considered for patients with a positive social or medical history of COVID-19, this includes:

- Using tele-dentistry or providing other forms of remote oral health care where possible.
- Providing patients with PPE, including a mask upon entry to the facility. Patients presenting in-person with symptoms of COVID-19 should be advised to wear their own mask or be given a surgical/procedure mask if medically tolerated.
- Offering hand hygiene ~~on entering the facility, when leaving the operatory and~~ prior to exiting the facility, in addition to normal hand-washing requirements above.
- Maintaining a 2-metre separation from other patients and staff not directly involved in their care.
- Isolating symptomatic patients as soon as possible. Place patients with suspected or confirmed COVID-19 in private rooms with door closed and offering use of a private bathroom (where possible).
- Scheduling and managing ~~high-risk~~COVID-19 positive patients ~~so as to~~ limit the opportunity for contact with other patients, OHCPs and staff (e.g. at the end of the clinic day or session).
- Considering referral to providers and settings where additional precautions are in place.

For patient advocates with COVID-19

Patient advocates who have signs or symptoms or potential exposures to COVID-19 ~~(including via the patient they accompany)~~ should be instructed to return to pick up the patient or, if required to remain in the facility, perform hand hygiene and put on a medical mask ~~and asked to wait outside or return to pick up the patient after their appointment.~~

b. Oral health care provider and staff safety

i. Screening and education

Screening

~~OHCPs and staff must be screened for symptoms of COVID-19. Respiratory symptoms, including cough, runny nose and/or~~ All facility staff including regulated and non-regulated staff members must monitor themselves daily for symptoms consistent with the common cold, influenza or COVID-19 prior to entering the facility. OHCPs and staff who have symptoms of COVID-19 or have travelled outside Canada in the last 14 days, or were identified as a close contact of a confirmed case must stay home and self-isolate. Travel exemptions for essential service workers are addressed in the next section.

~~fever,~~ should be maintained in a daily log. OHCPs or staff with respiratory symptoms, gastrointestinal symptoms or any other illness must stay home.

Staff who are ill, or with an unprotected exposure to someone with confirmed COVID-19, (as defined by occupational health or their local public health department,) or those otherwise determined to require self-isolation according to public health directives, must follow the policies of jurisdictional public health authorities to determine restrictions and when they can return to work.

Prior to working every shift, staff must report to facility management if they have had potential unprotected exposure to a case of COVID-19 to determine whether restrictions are necessary ~~(which may depend on local jurisdictional guidance),~~ as well as consulting their own ~~healthcare~~health care provider for any needed follow-up.

~~Outpatient and community-based care settings~~ Facilities must ensure that there are processes in place to conduct active screening of staff, external service providers, and patients (and their essential companions/advocates) for signs and symptoms of COVID-19.

If a staff member develops signs or symptoms of COVID-19 at work they should immediately perform hand hygiene, ensure that they do not remove their mask, inform facility management, avoid further patient contact and leave as soon as it is safe to do so.

~~Staff with any signs or symptoms consistent with COVID-19, including mild or atypical symptoms,~~

Return to work for essential workers who have travelled outside Canada

The advice in this section is based on the Ministry of Health's March 16, 2020 document "COVID-19 and Determination of Return to Work of Essential Service Workers Who Have Traveled Out of Canada"

Essential service workers ~~should be tested for COVID-19 and excluded~~ not travel outside Canada unless travel is part of the essential service they provide.

Principles to determine whether an essential worker should return to work earlier than 14 days after returning from work, **essential travel** outside of Canada include:

- Preventing new introductions of SARS-CoV-2 into BC is of paramount importance to limiting the spread of the virus.
- As a baseline, all travelers from outside of Canada are considered potential carriers of the virus and advised to ~~must~~ self-isolate at home or a similar place in which to stay.
- To preserve essential services, it is key to consider the risk that a returning worker could pose by endangering the health of multiple other essential service staff, which could jeopardize the ability to provide the essential service.
- Leaders of essential service should follow the recommended 14-day self-isolation after travel guidance as far as practical and establish thresholds where the delivery of essential service can no longer be delivered and then, and only then, make decisions to waive individual workers from the self-isolation protocol based on an overall risk assessment of:
 - where the person travelled,
 - duration and type of activity,
 - current symptoms of individual or household (if symptomatic, should be assessed by a health care worker before returning to work),
 - essential service type and overall risk of reduced or minimal staffing, and
 - work environment of the individual (e.g. whether working independently or in group setting).

Oral health care providers determined as essential to the delivery of patient care after returning from travel may return to work but must take the following additional precautions to reduce the risk to their patients, colleagues, and the public should they become symptomatic:

- self-monitor daily for signs and symptoms of illness;
- wear a surgical mask at all times and in all areas of the workplace;
- follow infection prevention and control protocols including diligent hand hygiene and the use of personal protective equipment when delivering patient care;
- reduce close contact with other health care workers and avoid shared spaces where possible;
- avoid close contact with others when travelling to and from work and between shifts;
- self-isolate at home on days when not required at their workplace; and
- avoid any unnecessary public establishments.

Additional precautions may vary by facility, healthcare setting, or workplace based on the patient population being cared for and risk assessments made by regional or local public health guidance with regard to testing and further management officials, infection prevention and control experts.

OHCPs ~~and~~ staff health and work restrictions

~~Immunosuppressed staff~~ Staff/OHCPs who are immunosuppressed and/or staff with who have other morbidity/comorbidities may be at risk. A collaborative discussion is appropriate with consideration of job functions and exposure risks.

Education and safety

OHCPs and staff must have basic knowledge of the disease, the infectivity and mode of transmission. Provide staff with information and training on: Knowledge of effective hand hygiene, ~~Respiratory etiquette~~, physical distancing and safe donning and doffing of PPE will increase compliance.

- IPAC:
- ~~Provide staff with information and training on:~~ the risk of exposure to COVID-19 and the signs and symptoms of the disease;
- methods for maintaining physical distance, such as not greeting others by hugging or shaking hands;
- changes made to work policies, practices and procedures due to the COVID-19 pandemic;
- when to use PPE and what PPE is necessary in each situation;
- donning, using and doffing PPE;
- ongoing training in the use of an N95 respirator, where ~~applicable~~³applicable;
- how to report an exposure of COVID-19; and
- safe handling and effective application of cleaning products.

- ~~keep training records for staff, including records for safe work procedures, donning and doffing of PPE and N95 respirator fit testing (where applicable)~~

Staff training should be tracked, recorded and kept up to date.

ii. Exposure prevention

*May 15, 2020 5:00 pm: Note that immediately following the first publication of this document on the afternoon of May 15, 2020, the BCCDC published this document resulting in subsequent edits throughout section 7.b.ii (as highlighted below)*⁴

The majority of exposures are preventable by following routine procedures. Where there is low incidence and prevalence of COVID-19, additional PPE over and above that required for normal precautions is not required.

Hand hygiene

Hand hygiene is the single most important measure for preventing disease transmission and must be performed by all OHCPs and facility staff:

- when in the patient care environment,
- before and after contact with a patient,
- before procedures,
- before donning gloves and immediately after removing gloves,
- before and after mask use,
- after risk of body fluid exposure,
- after contact with environmental surfaces,
- after contact with dental laboratory materials or equipment, and
- when hands are visibly soiled.

Aerosol-generating medical procedures (AGMPs)

An aerosol-generating medical procedure (AGMP) is any procedure conducted on a patient that can induce production of aerosols and droplets of various sizes, ~~including droplet nuclei.~~

PPE for OHCPs and staff

Every effort ~~is~~ must be made to make PPE available and accessible at the point ~~of care with patient.~~

OHCPs must receive training in and demonstrate an understanding of:

- when to use PPE,
- what PPE is necessary, and
- how to properly don, use, and doff PPE in a manner to prevent self-contamination.

Safe donning and doffing practices must be followed. PPE should be removed in the following order: gloves, ~~gown~~ protective clothing, protective eyewear (if separate from mask), mask and perform hand hygiene immediately afterwards. ~~Hand hygiene should occur according to best practices for putting on and removing PPE.~~

~~Change into a separate set of street clothes and footwear before leaving work. Work clothing (e.g. scrubs) There should be placed in a bag and laundered after every shift. Shower immediately upon returning home after every shift.~~

PPE storage

PPE is stored to avoid pilfering, while not inhibiting staff from accessing PPE. There is regular assessment to determine stock of necessary PPE (e.g. gloves, gowns, protective clothing, masks, and eye protection) and necessary supplies including ABHR.

Ensure appropriate number and placement of ABHR dispensers, at entry to the outpatient and community-based care setting facility, in hallways at entry to each exam room, communal areas and at point-of-care for each patient.

Ensure respiratory hygiene products (e.g., masks, tissues, ABHR, no-touch waste receptacles) are available and easily accessible to staff and patients.

Managing droplets, spatter and spray

Appropriate efforts should be made to minimize the spread of droplets, spatter and spray created during dental procedures. Accordingly:

- high-volume suction must be used to reduce aerosols at source, should be used whenever the creation of droplets, spatter and spray is possible;
- A whenever feasible a rubber dam should be used whenever possible, with;
- the use of a rubber dam and high-volume suction in procedures where the creation of droplets, spatter and spray may occur together also minimizes the ingestion and inhalation of contaminated materials and debris;
- unnecessary equipment and items must should be removed from the operatory;
- countertops and touched surfaces should be clear to enable covering with barriers and/or thorough cleaning and disinfection, decreasing opportunities for transmission; and
- use of all rotary hand pieces and other commonly used armamentarium including ultrasonic and sonic scalers, triplex syringes, air abrasion and air-polishing instruments which generate droplets, spatter, spray and other aerosols, should be kept to a minimum.

Precautions for patients with suspected or confirmed COVID-19 or airborne diseases

If treatment cannot be deferred:

- Use of an N95 respirator and eye protection (i.e., goggles or face shield), or goggles, gloves and gown for procedures that are aerosol-generating for patients with suspected or confirmed COVID-19 or airborne diseases, and gowns for AGMPs is required.
- Consider Consideration should be given to limiting the number of staff providing their direct care.
- AGMPs should be kept to a minimum and procedures completed in one appointment whenever possible to reduce risk of transmission.

- Consideration of extraoral forms of radiographic imaging, such as a panoramic radiograph and extraoral bitewing radiographs may be appropriate.
- If AGMPs are performed:
 - ~~There is~~ Appropriate training and N95 respirator fit ~~testing~~ for all staff who may be required to participate in or who may be exposed to these procedures is required.
 - ~~Staff IPAC training, education and testing are in place, tracked, recorded and kept up-to-date~~
 - ~~Consideration of extraoral forms of imaging, such as a panoramic radiograph and extraoral bitewing radiographs may be appropriate to reduce risk.~~
 - In exceptional circumstances, when a patient advocate needs to be present while the patient undergoes the AGMP, PPE for the advocate include N95 respirator or equivalent, gloves, gown, eye protection (goggles or face shield) when the 2 m distance cannot be maintained. If 2 m of distance is possible, a surgical mask with a face shield, gloves, gown and eye protection is sufficient.

TABLE 1: Personal protective equipment by procedure and COVID-19 status of patient

<u>-</u>	<u>PPE for Non-AGMP</u>	<u>PPE for AGMP</u>
<u>Positive or suspected COVID-19 status</u>	<u>Droplet and contact precautions</u> <ul style="list-style-type: none"> • <u>Mask**</u> • <u>Face shield or goggles</u> • <u>Gloves</u> • <u>Gown***</u> 	<u>AGMP precautions</u> <ul style="list-style-type: none"> • <u>N95 respirator</u> • <u>Face shield or goggles</u> • <u>Gloves</u> • <u>Gown***</u>
<u>Negative COVID-19 status</u>	<u>Routine precautions</u> <ul style="list-style-type: none"> • <u>Mask**</u> • <u>Eye protection*</u> • <u>Gloves</u> 	<u>Routine precautions</u> <ul style="list-style-type: none"> • <u>Mask**</u> • <u>Eye protection*</u> • <u>Gloves</u>

** Eye protection can be a full face shield, goggles or safety glasses.*

*** Mask is procedure dependent, level 3 surgical mask for surgical procedures.*

**** Gown may be disposable or reusable*

Handling biological specimens

Clinical specimens should be collected and transported in accordance with organizational policies and procedures. All specimens collected for laboratory investigations should be regarded as potentially infectious and placed in biohazard bags.

~~Clinical specimens should be collected and transported in accordance with organizational policies and procedures.~~ For additional information on biosafety procedures when handling samples from patients under investigation for COVID-19, refer to the [PHAC's biosafety advisory](#). ~~PHAC's biosafety advisory.~~

Exposure management

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.

Exposure management protocols ~~are necessary~~ must be initiated in a prompt and organized fashion once confirmation of contact with an infected individual is confirmed. This may include 14-day isolation and contact tracing through BCCDC.

iii. **Mental health**

Protecting OHCPs and staff mental health

~~Workers in the workplace may also be affected by the anxiety and uncertainty created by the COVID-19 outbreak. It's important to remember that mental health is just as important as physical health, and to take measures to support mental well-being.~~

Once asymptomatic or recovering, self-isolation is required for a minimum of 10 days after symptom onset. There is no limitation on working remotely.

c. **Facility management (office cleaning, housekeeping and waste management)**

General considerations

- Facilities and laboratories should minimize access points.
- ~~• Increased frequency of environmental cleaning and disinfection practices, including cleaning high touch surfaces in patient exam rooms and any central areas is important for controlling the spread of microorganisms. Environmental disinfectants used should be classed as hospital-grade, registered in Canada with a Drug Identification Number (DIN), and labelled as effective for both enveloped and non-enveloped viruses.~~
- Regular cleaning and disinfection are important practices. Clean and disinfect facility spaces in accordance with BCCDC's guidance. (See Appendix C "Key Resources" for more links to guidance on cleaning and disinfection)
- Floors and walls should be kept visibly clean and free of spills, dust and debris.
- Proper hand hygiene and use of PPE must be maintained during cleaning, house-keeping and waste management ~~to effectively block~~

~~transmission.~~ Staff training must be provided to ensure safe handling and effective application of cleaning products.

- ~~• Environmental cleaning and disinfection practices are monitored for compliance.~~

Clinical area

- All contact surfaces must be cleaned between patients and at the end of day.
- ~~Unnecessary~~ Clean and disinfect any surface that is visibly dirty.
- ~~Operatories are cleaned and disinfected after each patient and emptied of all but essential equipment and items must.~~
- ~~Environmental disinfectants should~~ be removed from the operatory ~~hospital grade and registered in Canada with a Drug Identification Number (DIN) and labelled as effective for both enveloped and non-enveloped viruses.~~
- Biomedical and general office waste must be handled and disposed of in a way that protects against transmission of potential infections. Waste from treatment of COVID-19 patients must be treated as biological waste.
- ~~All PPE must be discarded as clinical waste.~~
- Appropriate PPE should be worn for ~~facility cleaning~~ ~~operatories.~~ At minimum wear a gown ~~including~~, gloves, surgical mask and protective eyewear. ~~If wearing a long-sleeved impervious gown, a fresh gown~~ This is needed for cleaning. ~~the same PPE worn by staff before the pandemic.~~
- ~~Wipe down hard surfaces using a two-step process: first with detergent and water, then hospital-grade disinfectant with activity against respiratory virus, including COVID-19.~~
- ~~Where feasible, OHCPs should avoid sharing equipment, treatment rooms, or~~ Clean and disinfect shared equipment in between patients.
- ~~Facility cleaning products.~~ Treatment rooms and disinfection practices should be allocated to a single OHCP per shift ~~monitored for compliance.~~

Reception/waiting area

- ~~There must be~~ Post clear signage at entrance door, waiting room, reception, ~~operatories and washrooms~~ regarding physical distancing, hand hygiene and respiratory etiquette.
- Decrease cloth and fabric surfaces, and ~~remove~~ consider removing fabric covered chairs.
- Remove all unnecessary items from the waiting room, such as magazines and toys, and keep surfaces clear and clean.
- Ensure shared equipment and facilities, such as telephones, computers, washrooms and laundry rooms receive increased cleaning and disinfection.
- Separate waiting room chairs by at least 2 metres.
- Clean surfaces and high-touch surfaces (door handles, chair arms, reception counter, etc.) regularly ~~with a detergent with water or ready detergent wipes.~~
- Areas of known contamination should be cleaned and disinfected.

- [Consider installing partitions such as Plexiglass at the reception counter and other customer service areas.](#)
- [Consider placing lines on the floor to mark a 2-metre distance from the reception desk.](#)

[A Facility Pandemic COVID-19 Preparedness Checklist can be found in Appendix A to assist with planning.](#)

d. Equipment and area specific guidelines

Dental laboratory asepsis

[Effective communication and coordination between the dental facility and commercial dental laboratory is essential. Impressions, prostheses or appliances must be cleaned and disinfected before transport to the lab. Finished devices, prostheses and appliances delivered to the patient must be free of contamination.](#)

Waterlines

~~Back flow prevention valves are required and~~ Flushing of water lines for 20-30 seconds before use in ~~procedure~~[procedures](#) and between patients. ~~is required.~~

• ~~Aerosol generating instruments~~

~~Use of all rotary handpieces which generate aerosols, regardless of whether the motor is electric or air driven (with or without water) and other aerosol generating instruments commonly used in oral health care including ultrasonic and sonic scalers, triplex syringe, air abrasion and air polishing must be kept to a minimum.~~

Handpiece

Consider the use of an anti-retraction dental handpiece or electric handpiece to reduce the risk of cross infection.

Disposable equipment and supplies

Single-use disposable equipment and supplies should be used whenever possible and discarded into a no-touch waste receptacle after each use. All reusable equipment should, whenever possible, be dedicated for use by one patient. If this is not feasible, equipment should be cleaned first and then disinfected or otherwise reprocessed according to manufacturer's instructions and facility protocols.

~~Dental laboratory asepsis. Effective communication and coordination between the dental facility and commercial dental laboratory is essential. Impressions, prostheses or appliances must be cleaned and disinfected before transport to the lab. Finished devices, prostheses and appliances delivered to the patient must be free of contamination.~~

HVAC / air flow –

[Increase air circulation \(exchanges\) and ventilation in patient areas if possible.](#)

Consideration ~~of~~[should also be given to](#) an engineering assessment to evaluate adequacy of existing filtration and ventilation with emphasis on establishing base fresh air exchanges per hour. Consideration could also be given to the strategic use of high

efficiency air exchange units as well as increasing fresh air flow by opening windows, where possible. [Refer to CSA Standards \(Z8000, Z317.13-17\) and CSA HVAC Standard \(Z317.2-19\) for information on infection control during construction, renovation and maintenance of oral health care facilities and for recommendations for heating, ventilating and air conditioning systems.](#)

8. Recommendations and Considerations for Oral Health Care During Phases 2 of the COVID-19 Response Plan and 3

a. Patient management and safety

Administrative recommendations:

- ~~• Consider placing lines on the floor to mark a two-metre distance from the reception desk~~
- [Provide](#) clear messaging regarding office policies and protocols on website, emails and answering machine.
- ~~• During transactions, if possible, limit the exchange of paper documents, including receipts~~
- Where possible, payments should be accepted through contactless or electronic methods.
- Patients' preferred pharmacy details should be kept in their records.
- Establish and maintain a contact register for all people entering the practice including date and time of entry and exit, and the person's [phone and email contact](#) details, to facilitate contact tracing by BCCDC if necessary.

Scheduling appointments and communicating with patients

- In order to accommodate physical distancing, ~~consideration should be given to consider~~ staggering appointment times.
- When speaking with patients during scheduling and appointment reminders, ask patients to:
 - Reschedule if they become sick, are placed on self-isolation or have travelled out of the country within the last 14 days.
 - Attend appointments alone where possible and ~~not to bring~~ [avoid bringing](#) friends or children.
- Consider emailing patients any forms that need to be filled out so patients can complete them prior to arriving at the facility.
- [Ask patients to arrive at the specified time and not earlier and to leave their text/cell number for updates on changes to the arrival time.](#)

- [Patients arriving by car should wait in their car until called to come in for their appointment.](#)
- [Patients travelling on public transportation should wear a mask.](#)
- [Patients not travelling by car should be asked to wait outside the facility if 2-metres distance cannot be maintained from other patients in the waiting room.](#)
- Oral ~~healthcare~~[health care](#) facilities with websites should consider posting information on modifications made to the facility and appointment procedures.
- Patients and their advocates who do not have signs or symptoms or potential exposures to COVID-19 do not require [masking](#)[a mask](#); however, they should be instructed to perform hand hygiene and maintain a minimum 2-metre distance from others at entrances and in any designated waiting areas
- Be generous with appointment times to allow careful, unrushed attention to IPAC procedures.

b. Oral health care provider and staff management and safety

Modify staff areas and work flow

- Hold staff meetings virtually through use of teleconference or online meeting technology.
- Where in-person meetings are required, ensure staff members are positioned at least ~~two meters~~[2-metres](#) apart [or wear masks](#).
- If work in the facility is required, consider staggering start times or developing alternating schedules to reduce the number of people in the workplace at a given time.
- Arrange staffrooms and break rooms to adhere to physical distancing guidelines [or wear masks](#).
- Consider staggered break times to reduce employee gathering numbers.
- Minimize shared use of workstations and equipment where possible.
- ~~Consider implementing the requirement for staff to have dedicated work clothes and shoes. Provide a place for staff to safely store their street clothes while working.~~
- Staff should maintain a minimum 2-metre distance between each other throughout their shifts, especially during any breaks or meal periods when they are not masked.

PPE recommendations

Given community spread of COVID-19 within Canada and evidence that transmission may occur from those who have few or no symptoms, [masking](#)[wearing masks](#) for the full duration of shifts for staff working in direct patient care areas is recommended. The rationale for full-shift masking of ~~outpatient and community-based~~[oral health](#) care staff is to reduce the risk of transmitting COVID-19 infection from staff to patients or other facility staff, at a time when no signs or symptoms of illness are recognized, but the virus can be transmitted. Use of eye protection (e.g., a face shield) for duration of shifts should be

strongly considered in order to protect staff when there is COVID-19 infection occurring in the community.

When masks and face shields are applied for the full duration of shifts, ~~staff must:~~

~~:~~

- perform hand hygiene before they put on their mask and face shield when they enter the ~~outpatient or community-based care setting facility~~, before and after removal, and prior to putting on a new mask or face shield;
- wear a mask securely over their mouth and nose and adjust the nose piece to fit snugly;
- do NOT touch the front of mask or face shield while wearing or removing it (and immediately perform hand hygiene if this occurs);
- do NOT dangle the mask under their chin, around their neck, off the ear, under the nose or place on top of head;
- remove their mask and face shield just prior to breaks or when leaving the facility, while in an area where no patients or other staff are present, and discard them in the nearest no-touch waste receptacle, or otherwise store in accordance with facility policy (see statement below on re-use of masks). Reusable shields should be processed as per facility protocols; and
- perform hand hygiene during and after PPE removal and between patient encounters.
- 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. However, in the context of the COVID-19 pandemic and PPE shortages, ~~outpatient and community-based care settings facilities~~ should follow authoritative jurisdictional guidance with regards to mask use, reuse, and reprocessing.

~~If re-use of masks is recommended, staff must remove their mask by Refer to the ear loops or elastics taking care not to touch front of mask, and carefully store the mask in a clean dry area and in accordance with facility and jurisdictional public health BCCDC's guidance, taking care to avoid contamination of the inner surface of the mask, and perform hand hygiene before and after mask removal and before putting it on again.~~

- ~~Masks should be disposed of and replaced when they become damaged, wet, damp, or soiled (from the wearer's breathing or external splash), or when they come in direct contact with a patient.~~
- ~~Staff should be informed of how to access additional masks as needed.~~
- ~~Examples of eye protection (in addition to mask) include full face shield, mask with attached visor, non-vented safety glasses or goggles (regular eyeglasses are not sufficient)~~

~~Full face shields should be removed (to be processed or disposed of as per facility IPAC guidance). If masks with attached visors are used these should be removed and discarded in the nearest no-touch waste receptacle, and a new mask and eye protection put on. Reusable safety glasses or goggles must be reprocessed per facility IPAC guidance.~~

~~Masks do not necessarily need to be replaced after seeing a patient on droplet and contact precautions if a full face shield is worn over this.~~

~~The area where PPE is put on should be separated from the area where it is removed and discarded allocation during shortages here.~~

External service providers and deliveries

External service providers (including delivery personnel, lab personnel, and contractors) should be screened for signs and symptoms of COVID-19 at every visit. If signs or symptoms are present, or if they are ~~on~~in self-isolation or quarantine ~~as~~per relevant public health directives, they should not enter the ~~community-based care setting, facility~~ and should be advised to follow up with local public health or their ~~healthcare~~health care provider.

External service providers should:

- make adjustments to reduce contact where feasible, e.g., leaving deliveries at the door;
- when entering, perform hand hygiene and put on a mask if a 2-metre distance from staff and patients cannot be ~~ensured~~maintained;
- be instructed by staff on the importance of hand hygiene with ABHR and when and how to perform hand hygiene, e.g., when entering and exiting the setting, and after touching any surfaces in the ~~community-based care environment~~facility; and
- ~~Masks, tissues, ABHR and a no-touch waste receptacle are available for staff, patient, essential companion, and external service provider to use at screening at each entrance~~
- ~~All staff and external service providers are~~be logged at entry to the facility;
- ~~Essential deliveries that are unable to be left outside occur through a single access point~~

~~OCHP and staff health~~

- ~~OCHPs should consider introducing measures to monitor their health and the health of their staff.~~
- ~~Limit the number of potential close contacts between clinical staff.~~
- ~~Continue to limit social interaction outside of work as much as possible.~~

~~Educate staff members regarding the risks associated with the provision~~

9. Appendices

- [Appendix A: Facility Pandemic COVID-19 Preparedness Checklist](#)
- [Appendix B: Pathway for Management of Oral Health Care During Phases 2 and 3 of B.C.'s Response Plan for COVID-19](#)
- [Appendix C: Key resources](#)
- [Appendix D: Infectious Disease and Infection Prevention](#)
- [Appendix E: Oral Pre-procedure Rinses](#)

Appendix A: Facility Pandemic COVID-19 Preparedness Checklist

Facility Pandemic COVID-19 Preparedness Checklist

IPAC Measures

- Acquaint yourself with current clinical information about the recognition, treatment and prevention of transmission of COVID-19.
- Educate all staff about COVID-19.
- Make plans to ensure your family will be looked after in a pandemic so that you can continue to work beyond your normal schedule if required.
- Develop a contingency plan for staff illnesses and shortages.
- Assign a staff member to coordinate pandemic planning and monitor public health advisories.
- Maintain copies of pandemic educational materials and self-care guides for patients (provided by public health).
- COVID-19 posters and signage should be placed at entrance doors, reception area and exam rooms (and preferably in all of these places).
- Post signage and create voicemail message advising patients to check in by phone before presenting for in-person appointments.
- Post hand hygiene and cough etiquette signs in the waiting area.
- Ensure alcohol-based hand sanitizer (with at least 70% alcohol) is available at multiple locations: office entrance, reception counter, waiting room, and by every exam room for use before entering and upon exit.
- When available, provide staff with small bottles of alcohol-based hand sanitizer (with at least 70% alcohol).
- Consider installing Plexiglass partitions at reception counter and other areas
- Limit use of shared items by patients (e.g. pens, clipboards, phones).
- Rearrange waiting room to ensure 2m distance between people.
- Remove difficult to clean items (e.g. toys) from the waiting area. There is no evidence that the COVID-19 virus is transmitted via paper or other paper-based products. As such, there is no need to limit the distribution of paper resources such as leaflets, to patients because of COVID-19.
- Replace cloth-covered furnishings with easy-to-clean furniture.
- Provide disposable tissues and non-touch waste bins in waiting area and exam rooms.

- Provide plain soap and paper towels in patient washrooms and at staff sinks with clear instructions on hand hygiene.
- Display PPE donning and doffing instructions in locations available to all oral health care providers and staff.
- Empty exam rooms of all but bare minimum of equipment (e.g. exam table, chair, BP cuff, lights).
- Provide paper sheeting for exam tables and change between patients.
- Increase air circulation in all areas of the facility wherever possible.
- Keep frequently used doors open to avoid recurrent door handle contamination.

Patient and Staff Management

- Provide patients with symptoms suggestive of COVID-19 a procedure/surgical mask, if available and medically tolerated, and advise individual of how and where to get tested. (delay procedure until test results are known)
- Avoid multiple patients in the facility at the same time (e.g. patients to wait outside or in car until called in one at a time). Minimize number of patients in waiting or operatories.
- Avoid non-essential accompanying visitors, where possible.
- Advise patients and accompanying essential visitors to practice diligent hand hygiene and cough etiquette.
- Minimize the number of tasks that have to be done in the operatory, e.g. record completion.
- Perform hand hygiene before and after each patient contact.
- Wear recommended PPE for any direct contact or when within 2 metres of patients who are suspected or confirmed COVID-19.
- Properly doff and dispose of PPE when leaving patient care area (e.g. at end of shift or during a break) or when PPE is visibly soiled or damaged.
- Monitor staff illness and ensure staff with COVID-19 infection remain off work, or in extreme circumstances implement a “fit-for-work” policy.

Cleaning Guidance

- Inform all staff regarding current cleaning and disinfection guidelines, including approved cleaning products.
- Clean and disinfect shared reusable equipment (e.g. blood pressure cuffs, etc.) in between patients and at the end of each shift.

- Clean and disinfect operatories at least twice a day and a terminal clean at the end of the day.
- Clean and disinfect frequently touched surfaces at least twice a day (e.g. workstations, cell phones, doorknobs, etc.).
- Maintain a minimum 2-week supply of plain soap, paper towels, hand sanitizer, cleaning supplies, and surgical masks, if possible.

Note: This checklist is adapted from Daly, P. (2007). Pandemic influenza and physician offices

Appendix B: Pathway for Management of Oral Health Care During Phases 2 and 3 of B.C.'s Response Plan for COVID-19

The pathway below is an updated version based on the previously published (April 30, 2020) Pathway for Patient Care during the COVID-19 Pandemic to reflect the context of the pandemic in phase 2 and 3 of the BC government's response plan for COVID-19 (low incidence and prevalence with controlled community transmission).

Pathway for management of oral health care during COVID-19 and the measures being taken to mitigate the risk. B.C.'s phase 2 and 3 response plan for COVID-19

- ~~All OHCPs and staff should perform hand hygiene before and after all patient contact, and contact with potentially infectious material, and before putting on and after removing PPE, including gloves. Hand hygiene after removing PPE is particularly important to remove any pathogens that might have been transferred to bare hands during the removal process.~~
- ~~OHCPs and staff should perform hand hygiene by using ABHR with at least 70% alcohol or washing hands with soap and water for at least 20 seconds. If hands are visibly soiled, use soap and water before returning to ABHR.~~

~~Hand hygiene supplies should be readily~~

Virtual/Remote Management of Patient Care

Step 1

All patients must be triaged by virtual/remote technology (i.e. telephone or video) in keeping with Routine Practices within IPAC guidelines as follows:

- A. Establish and post your contact information and hours of service (e.g. voicemail messaging, external signage, website)
- B. Pre-screen patient for positive medical or social history of COVID-19 or any other infectious disease
- C. Pre-screen to determine if patient is higher risk for severe COVID-19
- D. If negative for COVID-19 and negative for higher risk factors for severe COVID-19, schedule required care and proceed to **Step 5**.
- E. If negative for COVID-19 but positive for higher risk factors for severe COVID-19, schedule virtual patient/OHCP appointment to determine if identified risk factors require enhanced scheduling protocols (e.g. first appointment of the day) then proceed to **Step 5**.
- F. If positive for COVID-19 (or any other infectious disease), schedule virtual patient/OHCP triage appointment to include:
 - Identification of chief complaint;
 - Review of medical, dental and social history; and

- Determination of virtual diagnosis (within scope of OHCP).

Proceed to **Step 2**

Step 2

Determine if management of presenting oral condition, disease, disorder of COVID-19 positive patient is required

IF NO

If treatment can be deferred, determine timing of any necessary follow up and consider referral to appropriate hospital or tertiary facility for management of COVID-19 if required

IF YES

Proceed to **Step 3**



Step 3

Determine whether virtual/remote management of COVID-19 positive patient is appropriate

IF NO

If in-person assessment or care is required, continue to **Step 4**



IF YES

If it is determined virtual management is appropriate, care can be provided with virtual/remote technology (e.g. consultation, advice, recommendations, assessment, referral, pharmacological intervention)

Follow up as determined – care to be re-evaluated upon recovery from COVID-19 – referral to tertiary or hospital facility if management of COVID-19 is required

Step 4

Assessment of capacity to comply with Additional Precautions listed in IPAC guidelines including appropriate PPE inventory to provide clinical assessment of COVID-19 positive patient

Necessary PPE should include:

- Surgical masks
- Gloves
- Protective eyewear (face shield, goggles or safety glasses) for OHCPs and clinical staff

IF NO

Refer to appropriate tertiary or hospital facility for treatment of emergent oral health concern

IF YES

Proceed to **Step 5**



In-office Management of Patient Care

Step 5

Provision of clinical assessment and determination of diagnosis

Re-screen for any changes to patient's medical and social history with respect to COVID-19 (or any other infectious disease) status:

- If patient remains negative for suspected or confirmed COVID-19, continue to **Step 7** for provision of appropriate care following clinical assessment and determination of a diagnosis
- If patient remains or is determined to be suspected or confirmed COVID-19 positive after in-office re-screening, initiate enhanced entry-to-facility protocols including supervised hand hygiene, donning of mask and immediate isolation in a designated operatory

Following clinical assessment of emergent concern and determination of a diagnosis, decide if clinical intervention required.

IF NO
Return to **Step 2**



IF YES
And the oral health emergency is a greater risk to the patient than COVID-19 proceed to **Step 6**



Step 6

Determination of aerosol-generating procedure for a COVID-19 positive patient

Does the clinical intervention require an aerosol-generating procedure?

IF NO
Proceed to **Step 7**



IF YES
Proceed to **Step 6a.**



Step 6a. Assessment of PPE inventory for OHCPs and clinical staff to provide aerosol-generating procedure for suspected or confirmed COVID-19 positive patient:

- 1) Fit-tested N95 respirator
- 2) Gloves
- 3) Eye protection (goggles or face-shield)
- 4) Protective clothing

IF NO
(PPE requirements in **Step 6a** not met)
Refer to appropriate tertiary or hospital facility for treatment of emergent oral health concern

IF YES
(PPE requirements in **Step 6a** met)
Proceed to **Step 7**



Step 7

Provision of determined care

Regarding oral health care for a suspected or confirmed COVID-19 patient, the treatment must be provided as efficiently and minimally invasively as possible and arrangements made for a prompt egress of the patient from the facility.

Appendix C: Key Resources

- ~~Information is available to all staff in every care location.~~
- ~~Hand hygiene should be performed after going to the bathroom, before preparing and eating food, and after coughing and sneezing.~~

9. Schedule of Changes

~~Superscript endnotes throughout the document indicate changes that were made following the first publication of this document.~~

- ~~1. *Link to new BCCDC document added*~~
- ~~2. *May 15, 2020 5:10 pm: “should” changed to “must”*~~
- ~~3. *“Where applicable” added to replace “in addition to droplet and contact precautions if AGMPs are performed”*~~

~~May 15, 2020 5:10 pm: Note that immediately on the following the first publication of this document on the afternoon of May 15, 2020, the BCCDC published this document resulting in subsequent edits throughout section 7.b.ii (Exposure Prevention) **topics relating to COVID-19:**~~

- ~~• Symptoms of COVID-19: www.bccdc.ca/health-info/diseases-conditions/covid-19/about-covid-19/symptoms~~
- ~~• BC COVID-19 Self-Assessment Tool can help determine the need for further assessment: <https://bc.thrive.health/>~~
- ~~• Non-medical information about COVID-19 is available 7:30am-8:00pm, 7 days a week at the following toll-free number: 1-888-COVID19 (1-888-268-4319).~~
- ~~• HealthLinkBC and 8-1-1 for health advice on COVID-19 (translation services are available): www.healthlinkbc.ca/health-feature/coronavirus-covid-19~~

Other Resources

- ~~• Ministry of Health, British Columbia’s Response to COVID-19: www2.gov.bc.ca/gov/content/safety/emergency-preparedness-response-recovery/covid-19-provincial-support~~
- ~~• BCCDC website for Health Care Providers, COVID-19 Care: www.bccdc.ca/health-professionals/clinical-resources/covid-19-care~~
- ~~• BCCDC website for Health Care Providers, Personal Protective Equipment: www.bccdc.ca/health-professionals/clinical-resources/covid-19-care/infection-control/personal-protective-equipment~~
- ~~• Office of the Provincial Health Officer, Pandemic Preparedness: www2.gov.bc.ca/gov/content/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/current-health-topics/pandemic-influenza~~
- ~~• Office of the Provincial Health Officer, Orders, Notices & Guidance: www2.gov.bc.ca/gov/content/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/current-health-topics/covid-19-novel-coronavirus~~
- ~~• Government of Canada Coronavirus disease (COVID-19) website: www.canada.ca/en/public-health/services/diseases/coronavirus-disease-covid-19.html~~

- [World Health Organization: www.who.int/health-topics/coronavirus#tab=tab_1](http://www.who.int/health-topics/coronavirus#tab=tab_1)
- [Provincial COVID-19 Task Force, COVID-19: Emergency Prioritization in a Pandemic Personal Protective Equipment \(PPE\) Allocation Framework, March 25, 2020: www.bccdc.ca/health-professionals/clinical-resources/covid-19-care/infection-control/personal-protective-equipment](http://www.bccdc.ca/health-professionals/clinical-resources/covid-19-care/infection-control/personal-protective-equipment)

Infection Prevention and Control Resources

- [PHAC Routine Practices and Additional Precautions for Preventing the Transmission of Infection in Healthcare Settings](#)
- [BCCDC poster for Environmental Cleaning and Disinfectants for Clinic Settings.](#)
- [PIDAC's Best Practices for Cleaning, Disinfection and Sterilization of Medical Equipment/Devices in All Healthcare Settings](#)
- [BC Ministry of Health Best Practice Guidelines For Cleaning, Disinfection and Sterilization of Critical and Semi-Critical Medical Devices In BC Health Authorities](#)
- [BCCDC Respiratory Protections for Health Care Workers Caring for Potential or Confirmed COVID-19 Patients](#)
- [BCCDC website for Healthcare Providers on Personal Protective Equipment](#)

For Patient Management

- [BCCDC Interim Guidance: Public Health Management of cases and contacts associated with novel coronavirus \(COVID-19\) in the community.](#)
- [BCCDC Guidance for Outpatient Management of Suspected or Confirmed Cases](#)

Support for Health Care Providers

- [BCCDC Health Care Provider Support](#)
 - [Psychological Support - Supporting the psychosocial well-being of health care providers during COVID 19](#)
 - [Physician Health Program \(PHP\) - offers confidential advocacy, support, and referral assistance for individual physicians and physicians-in-training. PHP also provides wellness initiatives to promote the ongoing health of our physician community.](#)
- [BCCDC Testing and Management for Healthcare Workers – includes risk assessment for health care workers exposed to COVID-19 and information on return to work after exposure or illness.](#)
- [Information for Patients: BCCDC Patient Handouts.](#)

Appendix D: Infectious Disease and Infection Prevention

This is a primer on infectious disease and infection prevention. Infection requires source, susceptible host and portal of entry specific to the infection. Transmission requires sufficient quantity (dose of exposure: number of organisms, time of exposure), susceptible host and portal of entry.

How does infection occur

To transmit an organism or infection, three elements must be present:

- Source (patient, health care worker, visitor)
- Susceptible person (not immune, pathway for entry of pathogen to new host; risk may be increased with comorbidities such as diabetes, immune suppression, medical care, e.g. medications, medical procedures)
- Transmission (organism/disease specific, specific pathogens have specific transmission)

Exposure may be insufficient to cause replication in the host and not lead to transmission or be sufficient for replication (transmission) in the new host; and may or may not lead to symptoms, which may/may not lead to diagnosis. Exposure and transmission is disease specific and may occur by:

1. Contact

- touch (orofecal e.g.: MRSA, VRE, HPV, Ebola (with bleeding, emesis)
- blood and body fluid, including sexually transmitted disease (e.g. HIV, Herpes viruses, HBV, HPV); percutaneous exposure

2. Droplets

- droplets, spatter and spray (follow “ballistic trajectory” 2 metres; (e.g. pertussis, meningitis, corona virus, influenza virus, varicella zoster (chickenpox), smallpox
- inhalation or direct contact with mucosal surfaces

3. Aerosols (airborne)

- inhalation e.g. tuberculosis, measles, mumps, Ebola, aspergillus species

Principles of Infection Control: specific to route of transmission risk

<u>Standard Precautions</u>	<ul style="list-style-type: none">• <u>Health history: symptoms/signs of disease and exposure risk</u>• <u>Patient scheduling; patient placement</u>• <u>Immunizations</u>• <u>Hand hygiene</u>• <u>Respiratory hygiene/etiquette</u>• <u>Clean/disinfect equipment/environment</u>
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	<ul style="list-style-type: none"> • Safe injection practices • Surgical masks/droplet-aerosol management
<p>Transmission-Based Precautions</p>	<ul style="list-style-type: none"> • Blood/body fluid precautions <ul style="list-style-type: none"> ○ Hand hygiene ○ PPE: Gloves ○ Safe injection practices; surgical controls • Contact precautions <ul style="list-style-type: none"> ○ Hand hygiene ○ PPE: Gloves, protective clothing (before entry and before exit treatment room) • Droplet Precautions <ul style="list-style-type: none"> ○ Mask source patient ○ Patient placement ○ PPE: mask, eye protection ○ Reduce droplets at source: avoid procedures generating droplets (if possible); high volume suction, rubber dam (where possible) • Airborne <ul style="list-style-type: none"> ○ Mask (Level 3 or greater), eye protection ○ Reduce droplets at source: avoid procedures generating droplets (if possible); high volume suction, rubber dam (where possible) ○ Limit staff entry

Appendix E: Oral Pre-procedure Rinses

There is no evidence that pre-procedure rinses reduce risk of transmission of droplet or aerosol spread of disease. This is a developing area of research.

Reduction in microbial burden at source

There is no evidence oral rinses reduce the transmission of infectious disease. Limited *in vivo* data is available. Potential agents currently being assessed as oral rinses include:

- 0.2% povidone iodine
- 1-1.5% Hydrogen peroxide
- Essential oils
- Cetylpyridium chloride
- Chlorhexidine

Before using oral rinses, consideration should be given to the risk-benefit because of the limited evidence to date. Risks may include hypersensitivity and toxicity, and potential lack of patient compliance due to taste and appearance.

Studies

60 pts, mild-mod gingivitis, systemically healthy; comparison of rinse with chlorhexidine (chx), essential oil product (Listerine) and water

- aerosol sample with scaling; with/without high volume suction
- bacterial evaluation (identification & colony counts)
- Results: Pre-procedure rinse (Chx > essential oil/phenol/alcohol (Listerine) > water) along with high volume suction reduced bacterial aerosols

Sawhney A, Venugopal S, Babu GR, et al. Aerosols how dangerous they are in clinical practice. *J Clin Diagn Res.* 2015;9(4):ZC52-ZC57. doi:10.7860/JCDR/2015/12038.5835

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4437160/>

Antiviral effect of essential oil rinse:

- Essential oil rinse (Listerine) & Chx rinse, in-vitro cytopathic effect (CPE) upon HIV1/2 (enveloped DNA virus)
- Similar antiviral effect of rinse seen\

Baqui AA, Kelley JI, Jabra-Rizk MA, Depaola LG, Falkler WA, Meiller TF. In vitro effect of oral antiseptics on human immunodeficiency virus-1 and herpes simplex virus type 1. *J Clin Periodontol.* 2001;28(7):610-616. doi:10.1034/j.1600-051x.2001.028007610.x

<https://pubmed.ncbi.nlm.nih.gov/11422581/>

Essential oil rinse (Listerine): viral recovery after 30 seconds rinsing

- Viruses assessed: Enveloped DNA (HSV1/2); nonenveloped DNA: (adenovirus 5); enveloped RNA (influenza A); non-enveloped RNA (rotavirus)

- Results: ↓ HSV1/2 >95%; influenza A: 100%
Antiviral effect seen at viral envelope

Dennison DK, Meredith GM, Shillitoe EJ, Caffesse RG. The antiviral spectrum of Listerine antiseptic. *Oral Surg Oral Med Oral Pathol Oral Radiol Endod.* 1995;79(4):442-448. doi:10.1016/s1079-2104(05)80124-6

<https://pubmed.ncbi.nlm.nih.gov/7614202/>

Essential oils: peppermint, concentrations 0.2%-1.0% used in cosmetic formulations

Nair B. Final report on the safety assessment of Mentha Piperita (Peppermint) Oil, Mentha Piperita (Peppermint) Leaf Extract, Mentha Piperita (Peppermint) Leaf, and Mentha Piperita (Peppermint) Leaf Water. *Int J Toxicol.* 2001;20 Suppl 3:61-73.

<https://pubmed.ncbi.nlm.nih.gov/11766133/>

Povidone iodine:

- *In vitro*: Povidone iodine(0.23%)
- bactericidal: *Klebsiella pneumoniae* & *Streptococcus pneumoniae* virucidal on SARS-CoV, MERS-CoV, influenza A (H1N1) and rotavirus after 15 second rinse

Eggers M, Koburger-Janssen T, Eickmann M, Zorn J. In Vitro Bactericidal and Virucidal Efficacy of Povidone-Iodine Gargle/Mouthwash Against Respiratory and Oral Tract Pathogens. *Infect Dis Ther.* 2018;7(2):249-259. doi:10.1007/s40121-018-0200-7

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5986684/>

Summary

Antiseptic mouthwash may decrease COVID-19, by reducing oral viral load, reducing transmission in droplets or in aerosols. Preclinical and clinical research needed.

Herrera D, Serrano J, Roldán S, Sanz M. Is the oral cavity relevant in SARS-CoV-2 pandemic?. *Clin Oral Investig.* 2020;24(8):2925-2930. doi:10.1007/s00784-020-03413-2

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7309196/>