OCDO

OFFICE OF CHIEF
DENTAL OFFICER
ENGLAND

NHS

Standard operating procedure

Transition to recovery

A phased transition for dental practices towards the resumption of the full range of dental provision

Published 4 June 2020: Version 1

Contents

Introduction

The COVID-19 measures adopted in March 2020 with respect to dental services set out to manage public health risk against the population's oral health needs. Reducing or suspending care is challenging for any clinician since our first instinct is to offer care. The profession's patience and understanding of the requirement and rationale for the temporary suspension is appreciated, as is the commitment to support the alternative and interim care provisions. Dental teams have ensured that patients were able to access urgent telephone advice, and urgent dental care centres. In addition, dentists, dental care professionals and administrative staff also volunteered to work in other front line COVID-19 services ranging from intensive care to NHS 111. I am incredibly grateful to all those who have risen to the various challenges and for the profession's understanding of the current risks and complexity.

However, the balance of risk is shifting, the complexity and quantity of dental need is increasing, and we now need to safely and effectively resume dental services. The letter, *Resumption of Dental Services in England*, dated 28 May 2020 asked that all dental practices commence opening from Monday 8 June for face to face care, where practices assess that they have the necessary personal protective equipment (PPE) and infection prevention and control (IPC).

During the initial resumption of dental services, the baseline expectation is for practice based urgent dental care (UDC) provision, with flexibility for practices to do what is best for their patients. Detail is covered in the revised standard operating procedures for urgent dental care (UDC SOP), which should be read in conjunction with this SOP.

The subsequent pace of progression towards the resumption of the full range of routine dental care, including aerosol generating procedures (AGP), will need to be risk-managed by the individual practice and will be subject to following the necessary IPC and PPE requirements.

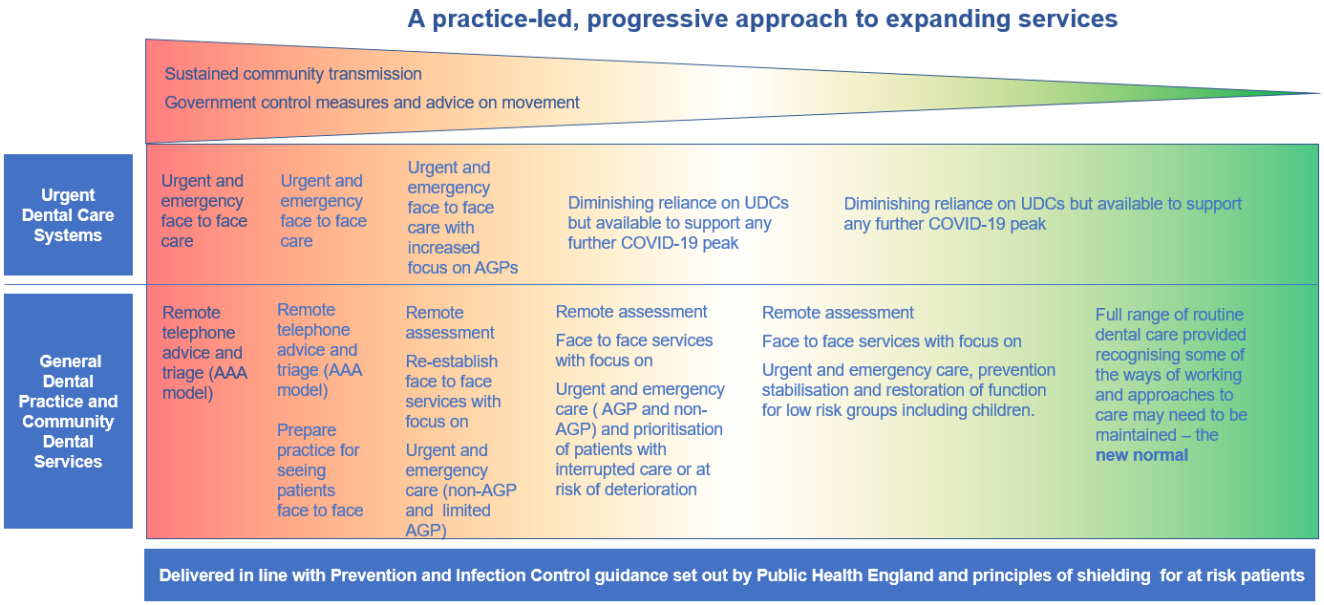
Central to the phased transition of dental services and the resumption of all service provision is the acknowledged clinical judgement of practitioners and their ability to risk manage the delivery of dental care. This document is designed to provide supporting guidance for the initial transition from recommencing face to face care towards the full resumption of dental care services; a practice-led, progressive approach.

In re-commencing service provision, we have a collective responsibility to:

- Monitor safety and assure the protection of the public, our patients and our dental workforce

- Remain agile in our response to a re-imposition of public health measures, be it a local or national requirement to mitigate risk of COVID-19 transmission

.



We all recognise the necessity for enhanced safety standards, including PPE and IPC. This will impact on tempo of clinical care, practice capacity and prioritisation of patients. The standards for IPC and PPE have been produced by Public Health England and must be adhered to. These standards are included in this SOP (Appendix 1). They are the national benchmark and minimum expectation for safe practice and the standard expected by the regulators.

In electing to undertake face-to-face dental care, minimising AGPs and the decision to defer functional and reconstructive work will need to be central to treatment planning. In supporting practitioners to adopt the clinically sound option to stabilise ahead of restoration, the principles are summarised and supported by the Note for Avoidance of Doubt: Provision of Phased Treatments

The limitations in AGPs present an opportunity to re-think our approach to care pathways. The patient-focused, team-delivered minimum intervention oral healthcare philosophy helps in taking on the current challenges in delivering dental care. The philosophy with its four interlinking domains of identifying the problem, prevention & control, minimally invasive treatments and suitable recall strategies dependent upon longitudinal disease susceptibility, underpins all disciplines of dentistry.

Whilst dental teams may use a variety of acceptable techniques to risk manage care, the guidelines for remote consultations, non-AGP periodontal treatment, restorative and paediatric dental care contained in this SOP provide an aide memoire to best practice, minimising AGPs and delivering quality health outcomes.

We will need to support our patients in understanding the rationale behind the dental care management options. With patients and carers fully engaged in the shared decision-making, the opportunity to actively apply minimally invasive oral care brings us a step closer to breaking the “repeat intervention cycle”.

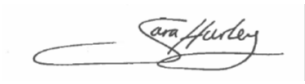
The SOP is designed to support the practice through transition and the shift towards a preventative and minimally invasive clinical approach that meets the current clinical

challenges. The SOP will also assist the Dental Team in fulfilling its responsibility with respect to the GDC Standards for the Dental Team[1] and in particular:

Standard 7.1: You must provide good quality care based on current evidence and authoritative guidance

> 7.1.1 You must find out about current evidence and best practice which affect your work, premises, equipment and business and follow them.
>
> 7.1.2 If you deviate from established practice and guidance, you should record the reasons why and be able to justify your decision.

As a framework and evidenced-based approach the intention is to support the provision of high-quality care in a safe clinical environment, in partnership with our patients. The pace of transition, as with the prevention and intervention decisions managed every day, in every dental surgery, will be set by the clinical leadership in each practice.

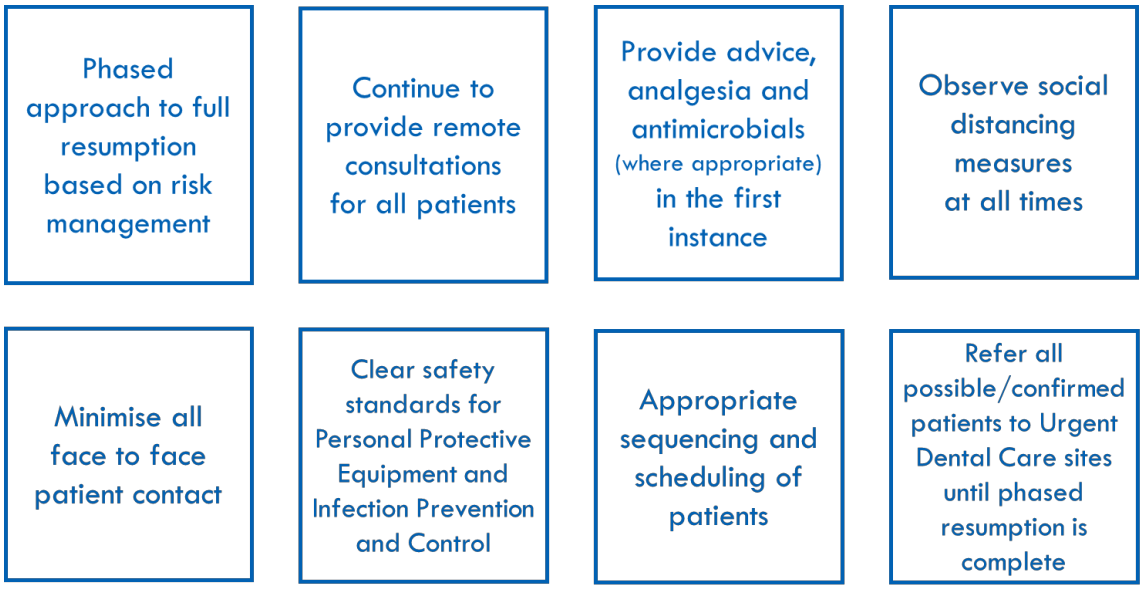


Sara Hurley
Chief Dental Officer England

[1] https://www.gdc-uk.org/docs/default-source/standards-for-the-dental-team/standards-printer-friendly-colour.pdf?sfvrsn=98cffb88_2

Section 1: Key Principles

Our shared goal is to resume the safe and effective provision of the full range of care in all practices. Our enduring priorities are the protection of patients, the dental team and the wider community. It remains a significant responsibility of the whole dental team to ensure that the risk of transmission of COVID-19 between patients, staff, staff and patients, is minimised. The decisions on pace and patient priorities, as ever, sit with the individual practitioner, who is best placed to judge their patient population needs and timing of next steps for their practice.



Ahead of resuming face to face care, all dental practice should continue to provide remote consultations with triage and advice as necessary options. This will enable practices to identify possible/confirmed COVID-19 cases (and household contacts), patients that are shielding, and patients at increased risk, in order to ensure safe care in an appropriate setting.

- Patients that are not suspected or confirmed COVID-19 or their household contacts may be offered face-to-face appointments with the primary care dental practice.
- Primary dental care providers may carry out both non-AGP and AGP care, subject to availability of the appropriate PPE and in line with infection prevention and control guidance.
- Suspected and confirmed COVID-19 patients requiring urgent face-to-face care are to be referred to Urgent Dental Care hubs.
- Patients including COVID-19 and their household contacts, patients that are shielding and at increased risk need to be identified through an initial remote stage of the dental care pathway followed by a face to face stage at Fig 1.

When scheduling an appointment for face-to-face care:

- Care should be delivered in a dental service/care setting which is appropriate and suitably equipped for the patient's care requirements (e.g. appropriate PPE available for AGPs)

- Dental services should take into consideration social distancing and physical and temporal separation requirements which may impact appointment planning and/or referrals

- Robust infection prevention and control procedures in line with government advice must be adhered to

- PPE protocols in line with government advice must be adhered to:

    - For non-AGP care: standard infection control precautions PPE,
        - eye protection, disposable fluid-resistant (Type IIR) surgical masks, disposable apron and gloves should be worn.

    - For all AGPs: to prevent aerosol transmission,
        - disposable, fluid-repellent gown or approved equivalent, gloves, eye/face protection and an FFP3 respirator* should be worn by those undertaking or assisting in the procedure.

  *Please note Section 13 of Appendix 1 includes information on FFP2 and N95 respirators which may be used for AGPs. FFP3/FFP2/N95 applies where FFP3s are referred to throughout this text.

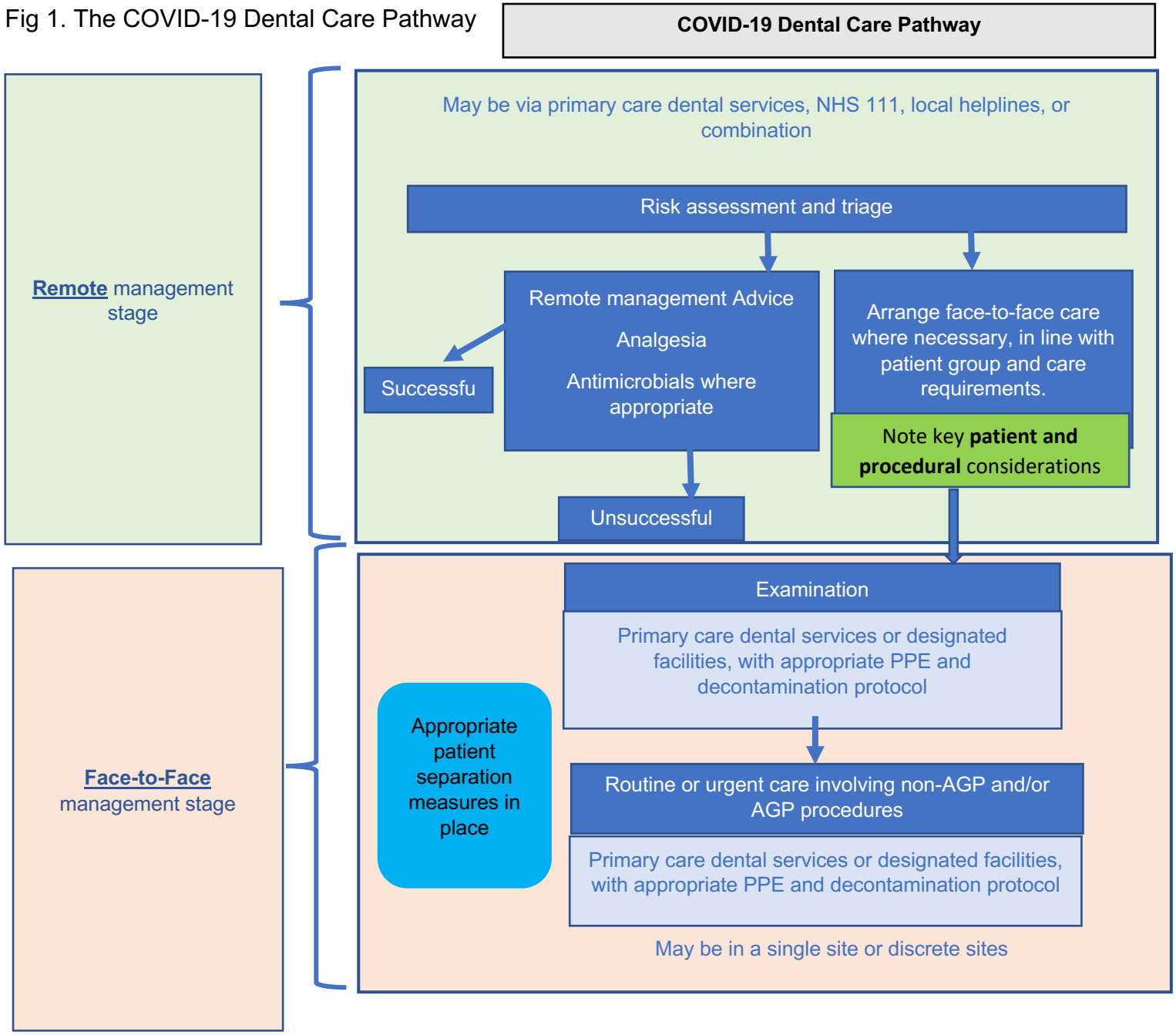
- If treatment is planned:
    - Care planning should focus on achieving stabilisation
    - Keep intervention to a minimum, to reduce exposure risk
    - AGP should be avoided where possible and only undertaken if the dental service has the appropriate PPE
    - Treatment should be completed in the minimum number of visits possible
    - When an AGP has been undertaken, it is recommended that the room is left vacant for one hour for a neutral pressure room[2]. before cleaning is carried out.

Further IPC and PPE detail is contained in Appendix 1 – Guidance for infection prevention and control in dental care settings.

Appendix 1 provides the standard by which regulators will assess practice compliance in the delivery of safe care.

[2] Most dental surgeries are neutral pressure rooms. For further see Section 16 of Appendix 1.

Fig 1. The COVID-19 Dental Care Pathway



Pathway principles

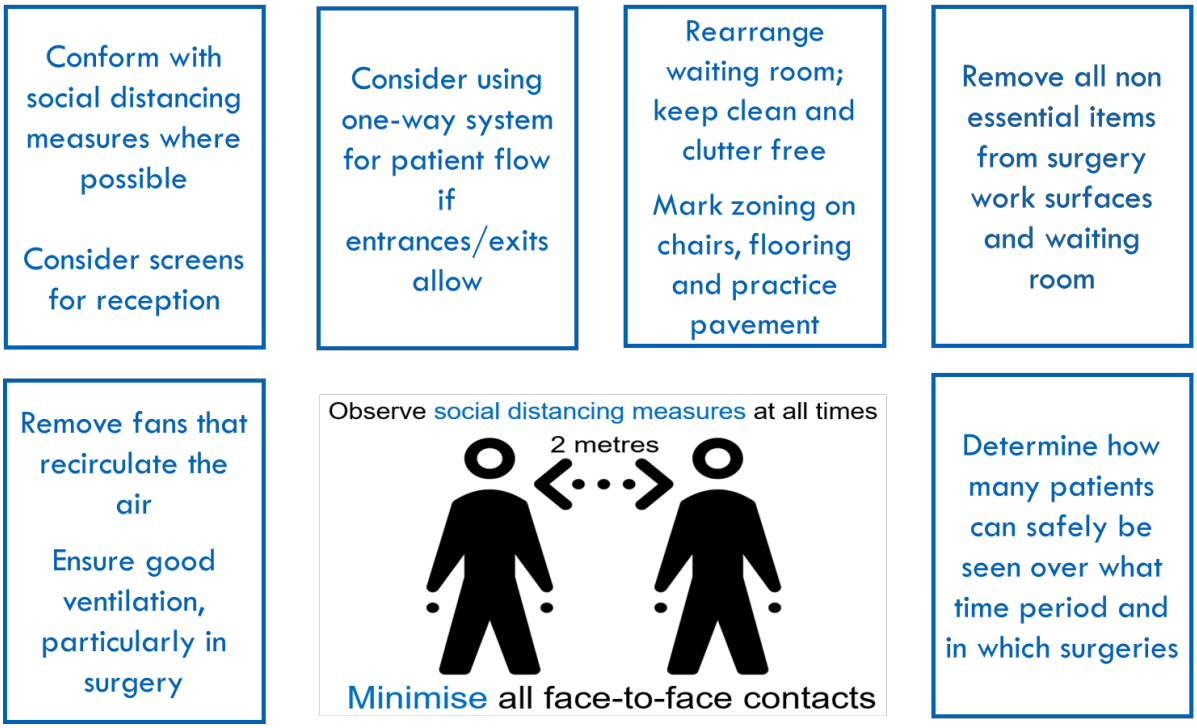
- Remote risk assessment and triage first
- Identify patients with possible/confirmed COVID-19 and their household contacts, patients that are shielding and patients at increased risk
- For possible/confirmed COVID-19 cases and household contacts:
  - Routine care - defer until isolation period complete
  - Urgent care – remote management if possible, face-to-face care only at designated UDC provider site
- Patients that are shielding and patients at increased risk treated in line with local protocols
  - Patients that are shielding – face-to-face care only when absolutely necessary; and via domiciliary visits as far as possible (otherwise at appropriate site)
- Clinical judgement to determine balance between remote and face-to-face care.
- If face-to-face care required, decide if referral needed.
- Avoid AGPs if possible in treatment.
- Where AGPs are necessary, use appropriate PPE and infection control protocols.

To aid practices in assessing the practice environment and designing risk management procedures a sample check list of practical considerations is included at Appendix 2. Together with a "walk-through" of the potential patient journeys through the practice, the check list will help inform and identify the practical modifications to current facilities and working practices.

A similar "walk through" and risk assessment of staff rooms and communal areas should also be undertaken to support social distancing for team members when not undertaking patient facing practice duties.

Patient flow and practice layout should be considered, in order to comply with social distancing measures throughout the practice. For example:

- Measures to separate and minimise the number of patients in practice at any one time
- Establishing single entry and exit points for patients, with alcohol hand gel available for patient use
- Reception interactions:
    - measures to minimise reception use e.g. digital appointment booking (online, email), receipts
    - consider fitting physical barrier at reception e.g. perspex shield
    - set up contactless / card payment where possible
- Allow for 2m distancing, ideally marked on floors
- Remove unnecessary items (e.g. magazines, toys, tv remote) from the waiting area



As a result of these changes, practices will look and feel different to your patients, with new ways of attending and new ways of operating e.g. new measures to support infection prevention and control, social distancing, and screening and triage. It is worth considering how the key changes in your practice may be communicated with patients. For example:

- Information posters throughout practice
- Drafting a "Welcome back" communication (letter/email/text) to patients

Section 2: Supporting the Dental Team

Risk Assessment

Employers will need to consider detailed risk management approaches to safeguarding the health of their staff and minimise the risk of infection. It is therefore essential that all dental practices undertake risk assessments for all their staff (clinical, administrative and domestic staff), recording the discussion with team members and the agreed actions. Further information is available in the Health and Safety Executive's working-safely-guide. Further guidance is also available through the Faculty of Occupational Medicine Risk Reduction Framework.

In risk assessing staff identify possible / confirmed COVID-19 cases, household contacts, staff who are shielding, and those at increased risk. Extremely vulnerable people should not be at work and a risk assessment is required for dental staff at high risk of complications from COVID-19, including Black and Minority Ethnic (BME) and pregnant staff. Further information on risk assessment is available:

- NHS Employers: risk assessments for staff – here
- Risk reduction framework for NHS staff at risk of COVID-19 infection - here

Staff with symptoms of COVID-19, or living in a household where someone has symptoms should not come to work. They must self-isolate and order a test immediately at GOV.UK website or call 119 if they have no internet access. If the test is negative, they no longer need to self-isolate. If, however, the test is positive, they must complete the remainder of their 7-day self-isolation and the NHS test and trace service will send them instructions of how to share details of people with whom they have had close or recent contact. Further information on the NHS test and trace service is found here.

Resilience: supporting the workforce

Our workforce and their resilience remain at the heart of best practice and high-quality patient care. As our primary care and community care dental practices commence the journey back to full operating capability our teams must feel confident that their safety and well-being remains a high priority. To ensure that staff are working safely the pace of the clinical day should be reviewed in order to accommodate regular breaks and rest periods. To maintain social distancing measures in staff areas/facilities consider measures such as staggering breaks and limited use of changing areas/rooms to single occupancy at any one time.

There may also be concerns around an increased chance of infection in the workplace, managing challenging domestic situations as well as other concerns. It is important to understand concerns and provide information about the measures taken and the support available to staff.

The following **mental health and wellbeing resources** are available to staff:

- NHS Employers have resources to support staff wellbeing during the COVID-19 pandemic here
- The World Health Organization has published WHO Mental Health Considerations During COVID-19
- MIND UK and Every Mind Matters have published specific resources in the context of COVID-19
- NHS Practitioner Health has developed frontline wellbeing support during COVID-19
- BDA members can find further information about access to counselling and emotional support here
- Domestic abuse helpline here

Consider the impact that the current unprecedented circumstances could have on the wellbeing of everyone who works in the practice and ensure appropriate support is in place

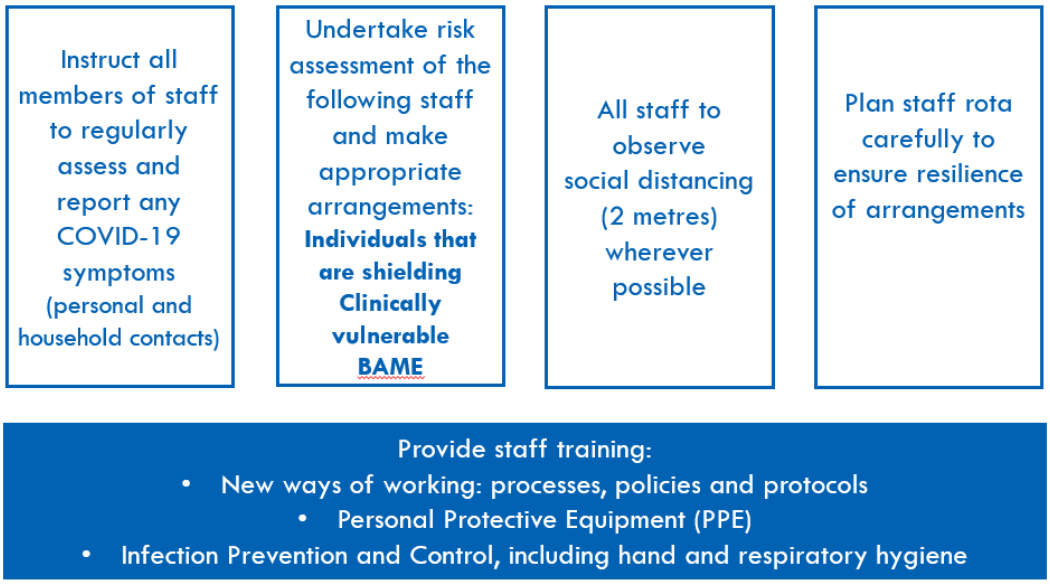
#LookingAfterYouToo

- Provides individual coaching support for primary care staff and can be accessed by video link or telephone with highly trained, experienced coaches
- This support is available to all dental staff and provides opportunities to process experiences, develop coping skills, deal with difficult conversations and develop strategies for self-management in difficult circumstances

Practice Team Responsibilities

Practices should appoint a COVID-19 lead (and deputies if necessary) to ensure:

- Practice is updated with the latest information relating to COVID-19 in dentistry in England
- Practice has a single point of communication with the Regional NHSE/I (keeping updated and disseminating updates), Local Dental Network and Local Dental Committee
- Practice activities are co-ordinated to include training, preparation for 'new ways of working' and implementation of this guidance and any subsequent revisions to guidance
- The development and implementation of practice policies and procedures
- Queries are directed to local infection control teams and dental practice advisors (DPAs)
- Monitoring of stock levels and ensure PPE is available for the practice, arrange for PPE fit testing as necessary, with local/regional points of contact



Training and development

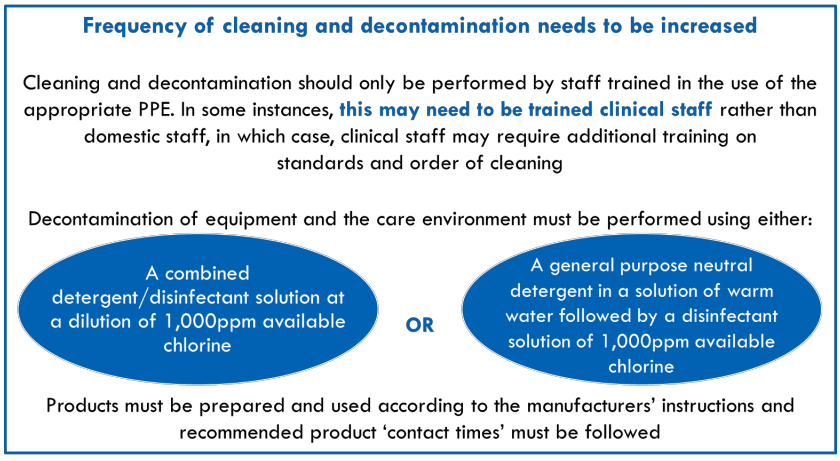
In our transition back to full operating capability, COVID-19 demands a change in pace, preparation, protection and proximity. This means doing things differently along the whole care pathway from the patient's first interaction with the practice through attendance, waiting, treatment and discharge phases. Implementation of these adaptations will require innovation, training and rehearsal to ensure clarity on roles and responsibilities for each member of staff.

It is essential that all practice staff are aware of the symptoms of COVID-19 infection (see here). They should also know what to do if they or someone they live with develops COVID-19 symptoms.

All staff must be up to date with COVID-19: infection prevention and control guidance and should:

- Know what PPE they should wear for each setting and context (see Appendix 1)
- Have access to the PPE that protects them for the appropriate setting and context
- Be confident and competent in donning and doffing of PPE

Cleaning staff should also be trained in IPC measures and decontamination.



Health Education England e-Learning for Healthcare has created an e-learning programme in response to the COVID-19 pandemic that is accessible for the entire UK health and care workforce here.

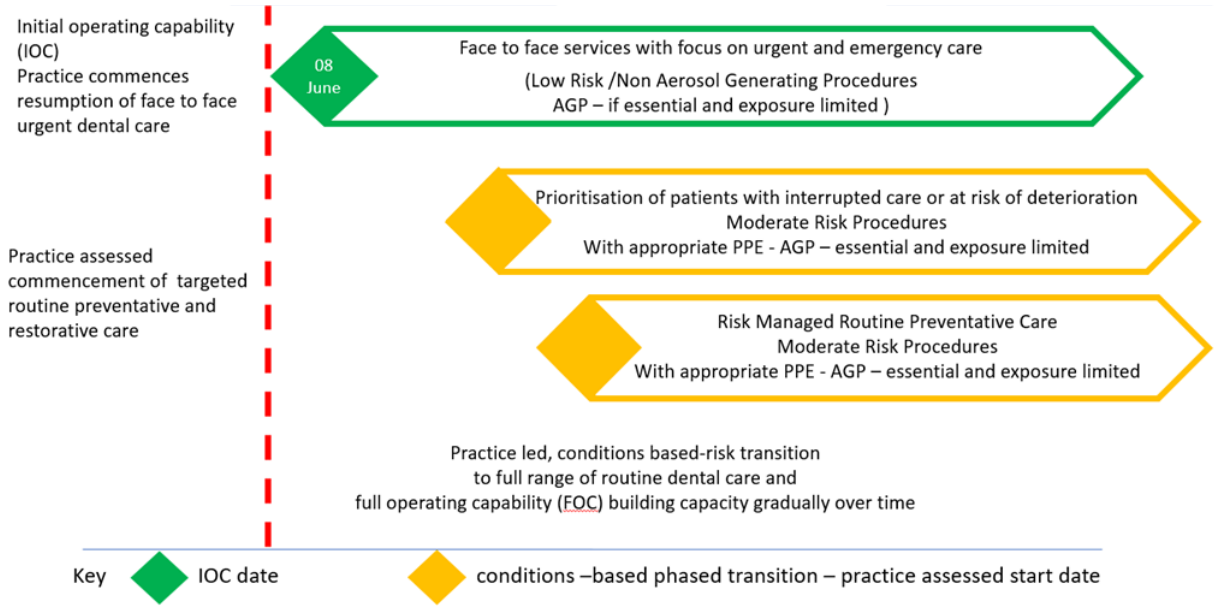
Additional training for staff may be necessary and should be provided prior to recommencing any dental provision. Please consider the below:

- Rubber dam placement
- Four handed technique;
- Decontamination and Infection Prevention & Control courses on e-Learning for Health website
- Updated resuscitation guidelines
- Scenario-based team training in the practice
- Remote consultation/triaging
- Patient prioritisation and determinants
- Training in new IT software tools e.g. online medical history software
- Scenario-based team training of new policies & procedure

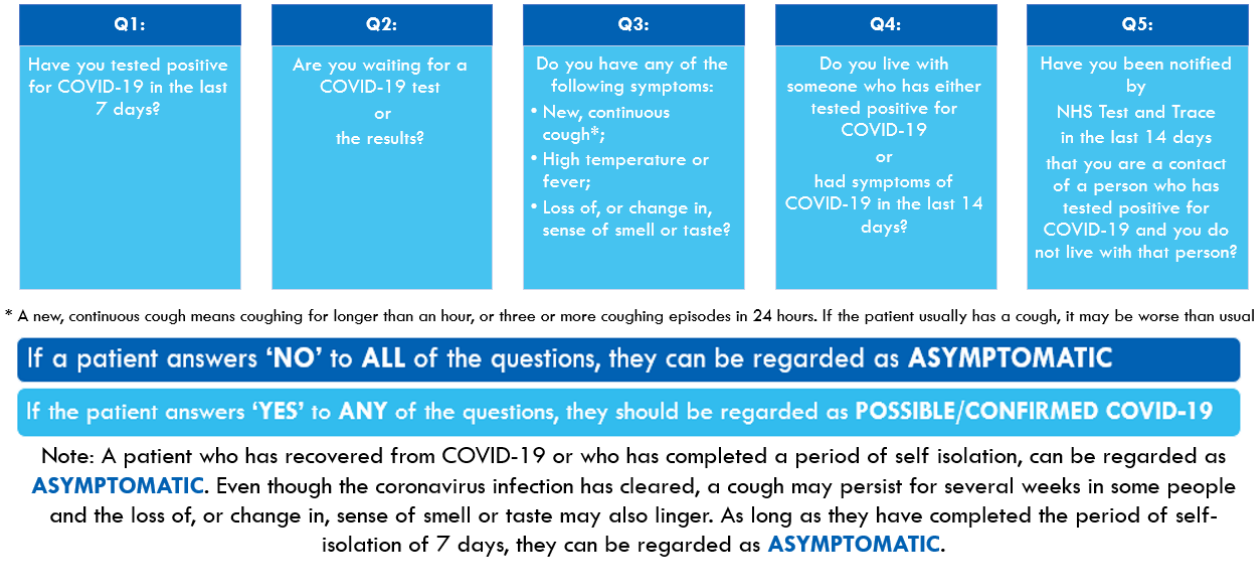
Section 3: Initial Operating Capacity Care Planning

The transition to providing a full range of dental care will take time. A practice-led, progressive approach to expanding services is recommended with the pace of transition subject to a variety of factors, including social distancing, workforce, infrastructure, and availability of PPE. In resuming the provision of face to face care, practices will need to assess capability and capacity, working with their staff to optimise time and resources as well as manage patient expectation. Whilst supporting their current patient base, where capacity allows, new patients should also be seen, particularly those with dental emergencies.

Fig 2. **An example** of a practice-led transition.



Throughout transition from initial operating capability to full operating capability, remote consultations remain the first point of contact. Remote consultations should include the dental triage and COVID-19 risk assessment (See Figure 1 and below).



Note: A patient who has recovered from COVID-19 or who has completed a period of self isolation, can be regarded as **ASYMPTOMATIC**. Even though the coronavirus infection has cleared, a cough may persist for several weeks in some people and the loss of, or change in, sense of smell or taste may also linger. As long as they have completed the period of self-isolation of 7 days, they can be regarded as **ASYMPTOMATIC**.

Primary care dental practices are not expected to provide face-to-face care for patients who have COVID-19 symptoms, who have swab-tested positive for COVID-19, or who have close contact with a COVID-19 case i.e. living in the same household and should therefore be self-isolating or has been notified as a close contact by NHS Test and trace. Where the practice is unable to or cannot accept a patient based on their patient group and/or care needs, that patient should be referred to the appropriate part of the local UDC system. Consideration should be given to liaising (with patient's consent) with the patient's general medical practitioner.

Remote Consultation

As a means of reducing footfall and non-essential face-to-face contact within the dental environment, remote contact should be made with all patients prior to appointments at the dental practice. Guidance is given in Appendix 3.

There are a number of remote video conferencing applications that are currently being used within the NHS. Whilst these may not yet have been disseminated within the primary dental care sector, there are many alternatives that would suffice during this transition period. NHS Digital has guidance on approved video consultation systems that could be utilised, and alternatives for those settings who are in need of a video consulting system as a short-term measure where approved NHS systems may not be easily accessible.

Where video may not be possible as a first line measure, use of the telephone may be adequate. Where a point of contact takes place via video, they should provide equivalent (or better) facilities than those obtainable by a standard telephone call.

For all remote points of contact, General Data Protection Regulations (GDPR) must be followed as per current guidelines during the pandemic.

The General Dental Council (GDC) has set out principles and guidance for remote consultations and prescribing. The Faculty of General Dental Practice (UK) has also provided updated information and guidance on remote prescribing and advice during the COVID-19 pandemic.

Urgent Care

In providing urgent dental care, primary care dental teams should refer to the standard operating procedure for urgent dental care which sets out details around the UDC system approach, the UDC patient pathway, and operating models applicable to primary care dental providers.

Primary care providers of urgent dental care:

- Where there is a need for AGPs, this may be carried out with the appropriate PPE and IPC measures in place and under rubber dam isolation, where appropriate, within the practice.

- Where this is not possible and for all other urgent care requiring AGPs this should take place at specific UDC provider sites designated by local commissioning teams as part of the locally organised system approach

Urgent dental care centres (UDCCs) will be available to see patients:

- On referral for urgent or emergency treatments involving AGPs
- With or suspected to have COVID-19 who require emergency or urgent dental care

Routine dental care

As services resume and practice capacity increases there will be a demand for a broader range of clinical activities. Remote consultations should remain the first point of patient contact and should include the dental triage and COVID-19 risk assessment.

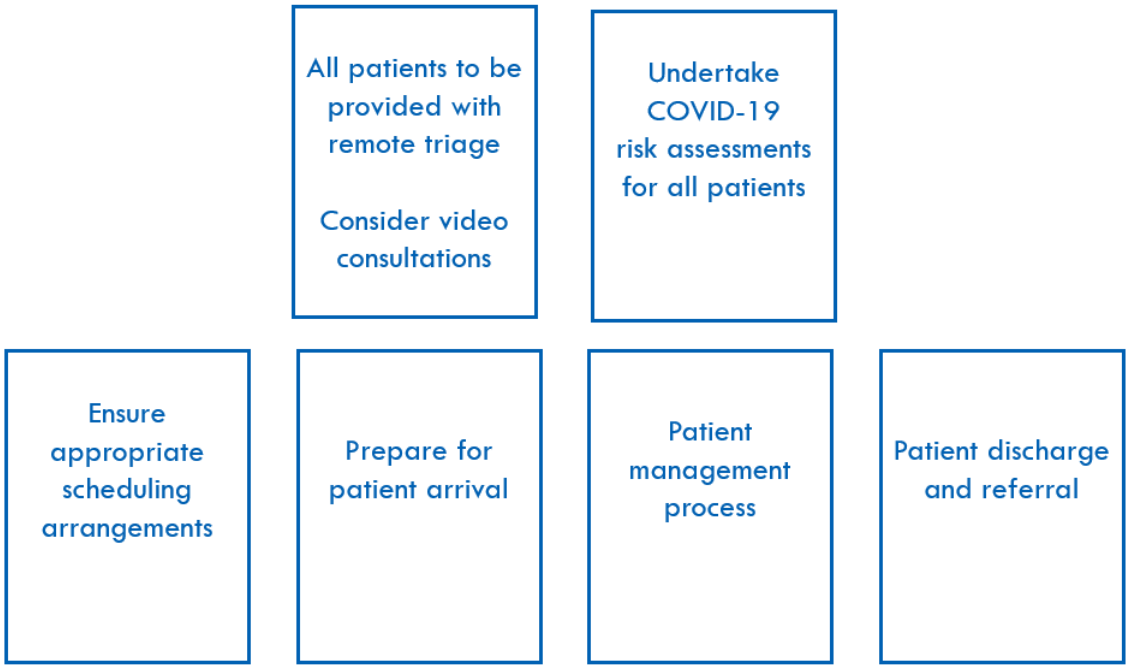
In identifying and prioritising patients, consider methods for logging practitioner/practice time and resources expended on patient record triage together with the outcome of any “remote” patient consultation and pre-appointment screening.

Within the available capacity, recommencing deferred courses of treatment, recall and re-assessments will need to prioritise groups with the greatest need. Practices should consider prioritising patients:

- Who have contacted the COVID-19 UDC system and already been triaged for urgent dental care and/or require follow up care

- With incomplete care plans
- With frequent recall according to NICE recall guidelines e.g. children, high oral disease risk, those patients whose oral health impacts on systemic health and those who have been through stabilisation and need review

- With routine dental care needs, not applicable to any of the above cohorts



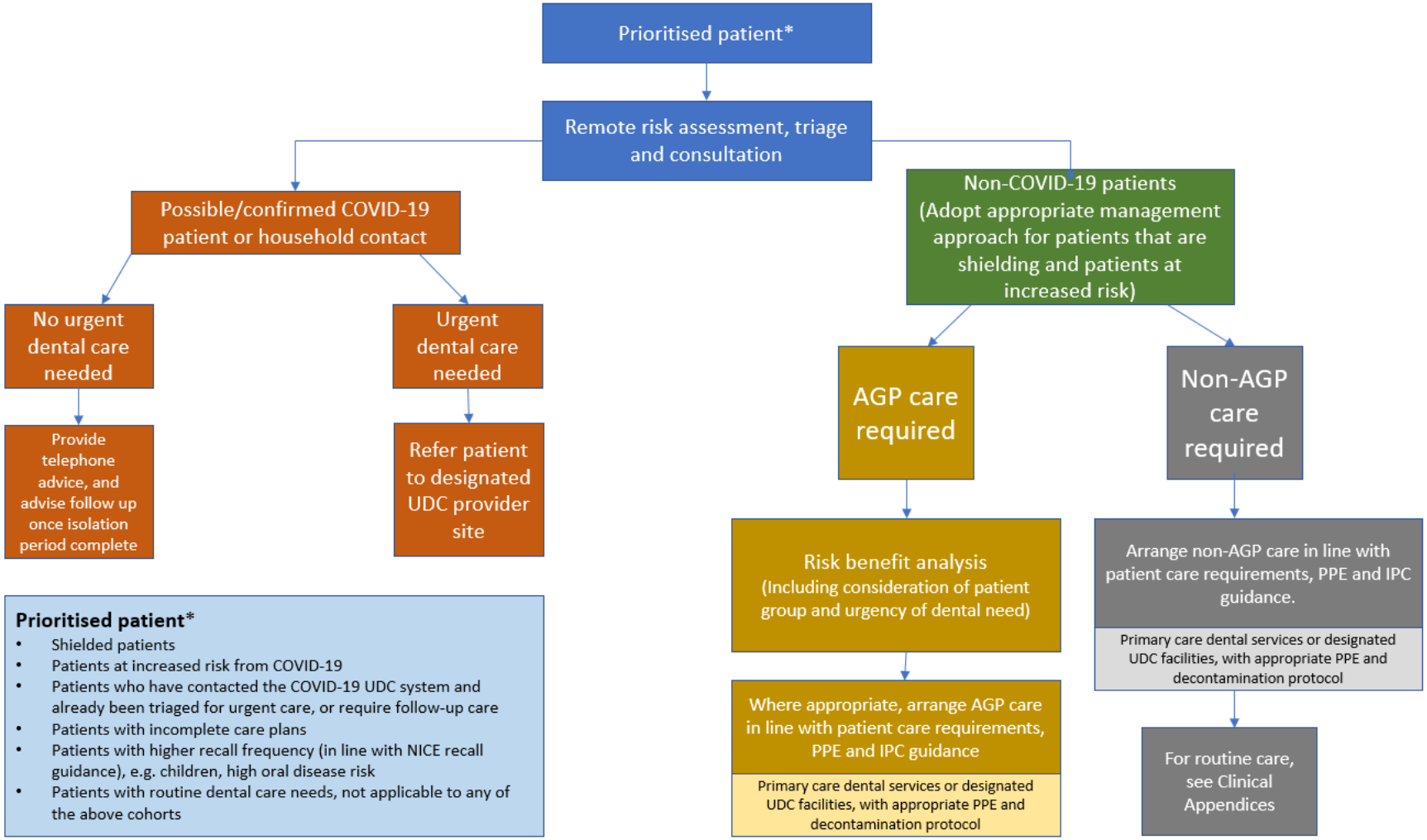
In sequencing and scheduling of patients the aim will continue to be the need to minimise the risk of transmission of COVID-19 between staff, patients, patients and staff.

Significant efforts should be made to ensure that patients that are shielding[3] are separated from other patient groups. They could be seen in any of the following ways:

- in the morning only (allowing maximum time for air clearance/ventilation overnight)
- in a surgery which minimises the number of people passing
- provided with a domiciliary visit by a dedicated dental team

[3] Patients that are shielding should have a named lead care co-ordinator in primary or secondary care, to support care planning. Where necessary dental teams should contact the patient's care co-ordinator, GP or medical specialist to plan care for this group. The latest government guidance on shielding is here: https://www.gov.uk/government/publications/guidance-on-shielding-and-protecting-extremely-vulnerable-persons-from-covid-19/guidance-on-shielding-and-protecting-extremely-vulnerable-persons-from-covid-19#staying-at-home-and-shielding

Fig 2. A summary flowchart for the patient pathway is outlined below:



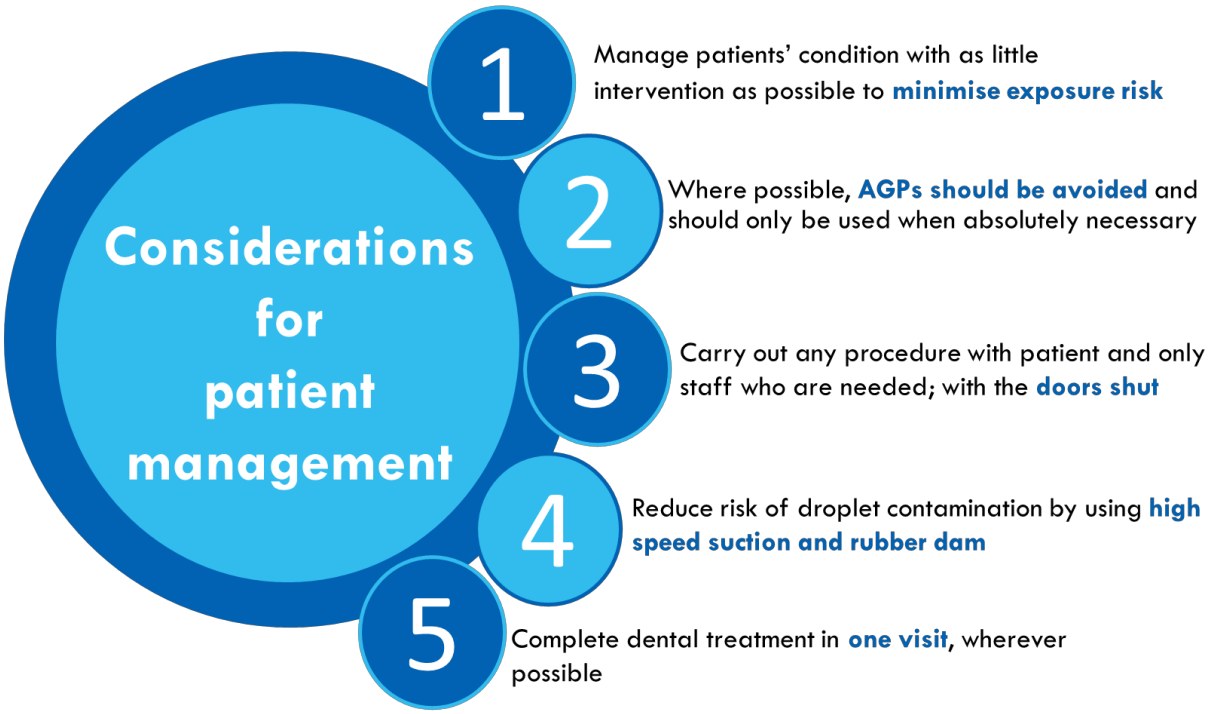
Face to Face Care

Prioritisation of patients to be seen face-to-face will depend upon the clinical judgement and expertise of the practitioner once information has been gathered from the remote point of contact.

Following an oral health care assessment, care planning should focus on achieving stabilisation, with care limited, where judged suitable, to non-AGPs. Deferring functional and reconstructive care remains a viable treatment option under current circumstances. Clinical guidance is contained in Appendices 4-7. Practitioners should exercise their clinical judgement to manage the associated risks with the unique clinical proximity and AGPs involved in dental care.

The focus on stabilisation should be delivered in line with the principles outlined in the Avoidance of Doubt: Provision of Phased Treatments and complemented with a strong focus on prevention of disease progression, including periodontal management, oral health prevention including fluoride applications (i.e. Delivering Better Oral Health).

In appreciating that the clinical treatment options and approaches to care may be unfamiliar to some patients, fully informed consent will be important, as will any decision by the professional not to offer a particular treatment because of a wider risk assessment. Recording valid consent and detailing any risk assessment supporting a treatment plan remains a high priority.



Non-AGPs are listed below:

Urgent dental care, including examination, taking radiographs, using hand instruments, extractions and suction, are not classed as AGPs so universal precautions that prevent droplet contamination should be used.

- Remote consultations
- Oral health assessment
- Preventative and self-care measures delivered in line with Delivering Better Oral Health, non-AGP aspects
- Hand instrumentation/scaling (Appendix 4 – non-AGP periodontal treatment)
- Simple dental extractions
- Caries excavation with hand instruments (Appendix 5 –AMIRD)
- Caries removal with slow speed and high-volume suction (Appendix 5 - AMIRD)
- Placement of restorative material (Appendix 5 - AMIRD)
- Orthodontic treatment
- Removable denture stages (if patient has normal gag reflex)
- Paediatric oral health including stainless steel crowns (Hall crown) and diamine fluoride applications (Appendix 6)

AGPs can increase the risk of transmission of infection to healthcare workers and therefore **should be avoided where possible**

Dental AGPs have been described as:

Using high-speed drills to open an access cavity or surgical high-speed drills to undertake surgical extraction of a tooth/root will necessitate use of additional PPE as for AGPs.

- Use of high-speed handpieces for routine restorative procedures and high-speed surgical handpieces
- Use of ultrasonic or other mechanised scalers
- High pressure 3:1 air syringe

When an **AGP** has been used, it is recommended that the **room is left vacant with the door closed** for 20 minutes in a negative pressure isolation room or **one hour for a neutral pressure room before performing a terminal clean.** Windows to the outside in neutral pressure rooms can be opened

Respirators for AGP (further detail on PPE is contained in Appendix 1)

- FFP3 (filtering 98% of airborne particles) respirators are advised for all AGPs to prevent inhalation of aerosols.

- The HSE has stated that FFP2 and N95 respirators (filtering at least 94% and 95% of airborne particles respectively) offer protection against COVID-19 and so may be used if FFP3 respirators are not available.

    - These respirators offer protection against AGPs, are recommended by the World Health Organization and are used routinely in other countries by dentists for AGPs.

- Operators who are unable to wear respirators e.g. due to facial hair, religious head coverings should wear alternatives such as hoods

All respirators need to be fit tested and checked.

Appendix 1 Guidance for infection prevention and control in dental care settings – authored by PHE

1. Background

COVID-19 disease is caused by SARS-CoV-2 which is from the family of coronaviruses. Where SARS-CoV-2 is circulating in the community at high rates, dental staff may be subject to repeated risk of contact and droplet transmission during their daily work. It is important that the infection prevention and control (IPC) measures contained within this guidance are followed to reduce that risk.

The guidance on PPE in this Appendix is for **all** Dental Care Professionals who have direct patient care regardless of their role.

PPE for dental practices has been allocated to dental wholesalers for practices to purchase. The dental wholesalers that have this stock are Henry Schein, DD Group, Wright Health Group and Try Care Ltd. PPE for dental practices will include equipment necessary for aerosol generating procedures including coveralls and FFP2 respirator masks as recommended by the World Health Organisation as well as the Health Safety Executive and UK Government PPE guidance.

2. Evidence base for PPE guidance

This Appendix is a summary of relevant parts of the UK Government's COVID-19: infection prevention and control guidance[4]. The UK Government guidance on IPC for health professionals was developed by health protection and infection prevention and control experts in collaboration with clinicians.

Expert reviews and advice from the Department of Health and Social Care's New and Emerging Respiratory Virus Threats Advisory Group (NERVTAG)[5] inform the guidance. The guidance is updated regularly, in line with emerging evidence.

The advice is based on the reasonable assumption that the transmission characteristics of COVID-19 are like those of the 2003 SARS-CoV outbreak. T

As SARS CoV-2 is a novel virus, evidence is still emerging so further updates to this Appendix may be made as new evidence emerges

[4] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/881489/COVID-19_Infection_prevention_and_control_guidance_complete.pdf

[5] https://www.gov.uk/government/groups/new-and-emerging-respiratory-virus-threats-advisory-group

3. Patient assessment and considerations

Significant efforts should be made to ensure that patients that are shielding are treated separately to other patients, and while there is sustained community transmission urgent care only should be offered.

Patients without symptoms should be treated separately in space or time to those who have COVID-19, or are suspected cases, or are in household isolation with someone with symptoms.

Confirmed or suspected cases of COVID19 should be discouraged from attending but where they cannot be treated by remote means and have urgent care needs, there should be separation in space and/or time between suspected and confirmed individuals with COVID-19.

Consider allocating a designated surgery and use of separate entrances and waiting areas for suspected/confirmed cases where possible. If this is not possible suspected or confirmed cases of COVID-19 should be placed at the end of the list where feasible.

The public is advised to consider wearing face coverings in enclosed public spaces including dental practices. In common waiting areas, symptomatic patients may be given a surgical face mask to minimise the dispersal of respiratory secretions and reduce environmental contamination.

Patients/carers should decontaminate their hands with alcohol-based hand rub when entering and leaving care services

4. Practice settings

Waiting rooms and reception areas should allow for 2 metre separation physical distancing between patients.

The care environment should be kept clean and clutter free with all non-essential items including toys, books and magazines removed from reception and waiting areas.

Any procedures should be carried out with a single patient (and carer if necessary, e.g. with child) and only those staff who are needed to undertake the procedure present in the room with the door(s) shut.

5. Standard infection control precautions

All dental practices should follow standard infection control precautions (SICPs) necessary to reduce the risk of transmission of infectious agents from both recognised and unrecognised sources.

Guidance from HTM01-05 and NICE on infection prevention and control and decontamination should be used by all staff, in all settings, always, for all patients.

6. Transmission-based precautions

In addition to SICPs, transmission-based precautions (TBPs) are applied when SICPs alone are insufficient to prevent cross-transmission of an infectious agent. TBPs are additional infection control precautions required when caring for a patient with a known or suspected infectious agent and are classified based on routes of transmission:

- Contact precautions: used to prevent and control infection transmission via direct contact or indirectly from the immediate care environment. This is the most common route of infection transmission.

- Droplet precautions: used to prevent and control infection transmission over short distances via droplets (>5μm) from the patient to a mucosal surface or the conjunctivae of a dental team member. A distance of approximately 1 metre around the infected individual is the area of risk for droplet transmission which is why dental teams routinely wear fluid resistant surgical masks (FRSM) and eye protection for treating patients. However, a distance of 2 metres has been defined as the area of risk. Thus, distancing of 2 metres should be facilitated wherever this is possible. This includes all staff adhering to social distancing wherever possible, particularly if not wearing a facemask or visor and when in non-clinical areas such as communal areas and during work breaks.

- Airborne precautions: used to prevent and control infection transmission via aerosols (≤5μm) from the respiratory tract of the patient directly onto a mucosal surface or conjunctivae of one of the dental team without necessarily having close contact. If an aerosol generating procedure (AGP) is being undertaken then airborne precautions are required in addition to contact and droplet precautions.

  The transmission of COVID-19 is thought to occur mainly through respiratory droplets generated by coughing and sneezing, and through contact with

contaminated surfaces. Interrupting transmission in the dental surgery needs to be by undertaking contact, droplet and aerosol precautions.

7. Aerosol-generating procedures (AGPs)

Aerosol generating procedures (AGPs) are defined as any medical and patient care procedure that results in the production of airborne particles (aerosols).

AGPs can produce airborne particles less than 5 micrometres in size which can remain suspended in the air, travel over a distance and can cause infection if inhaled. Therefore, AGPs create the potential for airborne transmission of infections that may otherwise only be transmissible by the droplet route.

AGPs include medical procedures such as intubation, extubation, and tracheostomy procedures.

High-speed devices such as those used for surgical and dental procedures have consistently been shown to generate aerosols which create widespread environmental contamination and therefore a risk of transmission of infection to healthcare workers so AGPs should be avoided where possible.

Instruments powered by air compressor have a high risk of creating aerosols.

Dental AGPs have been described as:

- Use of high-speed handpieces for routine restorative procedures and high speed surgical handpieces
- Use of ultrasonic or other mechanised scalers
- High pressure 3:1 air syringe

NB. Prudent use of PPE is vital at times of sustained community transmission for the sake of the whole health and social care economy. Enhanced PPE to use a 3:1 syringe for examination alone should not be deployed. Use of standard infection control measures can be employed by using the irrigation function followed by low pressure air flow from the 3:1 air syringe and all performed with directed high-volume suction.

Chest compressions and defibrillation (as part of resuscitation) are not considered AGPs so dental staff can commence chest compressions and defibrillation without the need for AGP PPE while awaiting the arrival of other clinicians to undertake airway manoeuvres. [6]

[6] https://www.gov.uk/government/publications/novel-coronavirus-2019-ncov-interim-guidance-for-first-responders/interim-guidance-for-first-responders-and-others-in-close-contact-with-symptomatic-people-with-potential-2019-ncov

Inhalation sedation is not considered an AGP and may be a suitable alternative to general anaesthesia for children needing dental care

More information on AGPs can be found at :
https://hpspubsrepo.blob.core.windows.net/hps-website/nss/2893/documents/1_tbp-lr-agp-v1.pdf

8. Hand and respiratory hygiene

Washing hands thoroughly with soap and water for at least 20 seconds, is essential to reduce the transmission of infection[7]. All dental staff and patient/carers should wash their hands or decontaminate their hands with alcohol-based hand rub[8] (70% ethyl alcohol) when entering and leaving dental care services. See Figures 1a and 1b below.

For staff, hand washing must be performed immediately before every episode of direct patient care and after any activity or contact that potentially results in hands becoming contaminated, including donning (putting on) and doffing (removing) PPE, equipment decontamination, and waste handling. If arms are bare below the elbows, and it is known or possible that forearms have been exposed to respiratory secretions (for example cough droplets) or other body fluids, hand washing should be extended to include both forearms. Wash the forearms first and then wash the hands.

Respiratory and cough hygiene should be observed by staff and patients/carers. Disposable tissues should be available and used to cover the nose and mouth when sneezing, coughing or wiping and blowing the nose – 'Catch it, bin it, kill it'.

9. Staff health

Members of staff who are clinically extremely vulnerable[9] to coronavirus (with specific serious health conditions) should not be returning to work at this time. They should keep themselves safe by staying at home and avoiding all contact with others, except for essential medical treatment or support.

[7] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/886217/Best_practice_hand_wash.pdf
[8] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/886216/Best_practice_hand_rub.pdf
[9] https://www.gov.uk/government/publications/guidance-on-shielding-and-protecting-extremely-vulnerable-persons-from-covid-19/guidance-on-shielding-and-protecting-extremely-vulnerable-persons-from-covid-19

Those aged 70 and over, those with specific chronic pre-existing conditions, those who are seriously overweight, and pregnant women, are clinically vulnerable, meaning they are at higher risk of severe illness from coronavirus. As restrictions ease, this group should continue to take particular care to minimise contact with others outside their household.

Vulnerable members of staff should undertake a risk assessment with their line manager and may need support from Occupational Health. Some members of staff may need to be redeployed to non-clinical activities.

The Faculty of Occupational Medicine has produced a Risk Reduction Framework for NHS Staff which takes into consideration age, ethnicity, pregnancy, sex and underlying medical conditions:

https://www.fom.ac.uk/wp-content/uploads/Risk-Reduction-Framework-for-NHS-staff-at-risk-of-COVID-19-infection-12-05-20.pdf

Members of staff who are pregnant and worried about coronavirus, can get advice from the Royal College of Obstetricians and Gynaecologists at:

https://www.rcog.org.uk/en/guidelines-research-services/guidelines/coronavirus-pregnancy/covid-19-virus-infection-and-pregnancy/

Dental staff with symptoms or who have tested positive for COVID-19 should self-isolate for at least 7 days from onset of symptoms. After 7 days, or longer, if dental staff still have symptoms other than cough or loss of sense of smell/taste, they must continue to self-isolate until they feel better. Staff living in a household where someone has symptoms should stay at home for 14 days from the onset of household contact's symptoms. However, if the member of staff becomes symptomatic during the 14 days isolation, they should isolate for 7 days from the date of symptom onset. [10]

All members of staff who are self-isolating are eligible for coronavirus testing and should be offered the opportunity if they wish to be tested. Use the self-referral portal to book a test. Staff may require evidence that they are no longer infectious prior to working with extremely vulnerable people, subject to local policy. Currently it is not known how long any immunity to COVID-19 might last. If staff become unwell again, they should self-isolate and may need to be retested. Please note that this Guidance for Healthcare workers is subject to change and live links to the document should be kept. Members of staff can also be signposted to the NHS Website: What your coronavirus test result means.

[10] https://www.gov.uk/government/publications/covid-19-stay-at-home-guidance/stay-at-home-guidance-for-households-with-possible-coronavirus-covid-19-infection

Dental care professionals should be trained in all aspects of IPC and fully familiar with HTM01 05 for decontamination.

It is recognised that all staff may have increased anxiety and stress due to operating during the COVID-19 pandemic, and as a result of general measures such as social distancing and isolation from family and friends. There are resources in the main body of the SOP signposting where help can be found. Dental care professionals have a responsibility to take care of their own health and wellbeing, their colleagues and their patients.

10. Other staff considerations

All dental care professionals should have access to and know what PPE they should wear for each setting and context. Training should include donning and doffing PPE for AGPs and non-AGPs. See Figure 2 below. See footnotes for links to resources such as videos and posters. [11],[12]

Cleaning staff should also be trained in IPC measures and decontamination and understand the requirements in HTM01 05.

It is best practice to change into and out of uniforms at work and not wear them when travelling; this is based on public perception rather than evidence of an infection risk.

Uniforms and workwear should be transported home in a disposable plastic bag. The plastic bag should be disposed of into the household waste. Uniforms and workwear should be laundered: separately from other household linen, in a load not more than half the machine capacity and at the maximum temperature the fabric can tolerate, then ironed or tumbled-dried.

Personal items, e.g. mobile phones, should not be taken into the clinical area.

To ensure that staff are working safely they should social distance when not in PPE and take regular breaks and rest periods.

11. Personal protective equipment

Table 4[13] of the Infection Prevention and Control guidance for all health professionals includes advice for dental teams during sustained community

[11] https://www.gov.uk/government/publications/covid-19-personal-protective-equipment-use-for-non-aerosol-generating-procedures
[12] https://www.gov.uk/government/publications/covid-19-personal-protective-equipment-use-for-aerosol-generating-procedures
[13] https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control

transmission. Where there is sustained community transmission of COVID-19 there is an assumption that all patients present a risk of transmission of the virus.

Dentalcare professionals should choose the appropriate PPE depending on whether the treatment includes aerosol generating procedures (AGPs) or not. This is because during AGPs there is an increased risk of aerosol spread of infectious agents irrespective of the mode of transmission (contact, droplet, or airborne), and airborne precautions must be implemented when performing aerosol generating procedure (AGPs).

- Non-AGP treatment of all patients requires standard infection control procedures. This will ensure there is no contact or droplet transmission of COVID-19. Eye protection, disposable fluid-resistant (Type IIR) surgical masks, disposable apron and gloves should be worn.

- For all AGPs, to prevent aerosol transmission, disposable, fluid-repellent gown, gloves, eye/face protection and an FFP3 respirator should be worn by those undertaking or assisting in the procedure.

NB. FFP3 respirators offer a slightly higher level of protection than FFP2/N95 respirators. Please note Section 13 of this Appendix which includes information on FFP2 and N95 respirators which may be used for AGPs. FFP3/FFP2/N95 applies where FFP3s are referred to throughout this text.

HTM01-05 guidance, states that appropriate PPE should be worn during decontamination procedures. PPE includes disposable clinical gloves, household gloves, plastic disposable aprons, face masks, eye protection and adequate footwear.

Operators may be concerned at the ‘splatter’ that is created by dental procedures, however, this is droplet contamination which standard infection control precautions will protect against.

For provision of domiciliary (non-AGP) care in a household setting, disposable plastic aprons, fluid repellent surgical masks, eye protection and disposable gloves should be worn.

The application of the guidance is summarised in Table 1 of this document.

Table 1: Personal protective equipment (PPE) for COVID-19 dental care settings

	Waiting room/reception	Dental surgery	Dental surgery
	No clinical treatment	Non AGP treatment	Treatments Involving AGPs
Good hand hygiene	Yes	Yes	Yes
Disposable gloves	No	Yes	Yes
Disposable plastic apron	No	Yes	No
Disposable gown*	No	No	Yes*
Fluid-resistant (type IIR) surgical mask (FRSM)	Yes	Yes	No
Filtering face piece (FFP3) respirator**	No	No	Yes
Eye protection***	No	Yes	Yes

* Fluid-repellent gowns must be worn during aerosol generating procedures (AGPs). If non-fluid-resistant gowns are used, a disposable plastic apron should be worn underneath.

**If wearing an FFP3 mask that is not fluid-resistant, a full-face visor must be worn. Operators who are unable to wear a FFP3 mask due to facial hair, religious head coverings or other reasons should wear alternatives such as a positive pressure 'hood'.

***Eye protection ideally should be disposable. Re-usable eye and face protection (such as polycarbonate safety glasses/goggles) is acceptable if decontaminated between single or single sessional use, according to the manufacturer's instructions or local infection control policy. Regular prescription glasses are not considered adequate eye protection

12. Risk mitigation

Appropriate use of PPE, effective donning and doffing, following IPC and decontamination guidance (including social distancing, hand and respiratory hygiene) are the
main mitigating factors to reduce the transmission of COVID19

Risk reduction of aerosol contamination can be achieved by using high-speed suction and use of a rubber dam.

Particular care should be taken to avoid surgical extractions at this time. Where it is necessary to remove bone, slow handpieces should be used with irrigation to reduce the risk.

In times of sustained community transmission hand instruments, e.g. scaling instruments, should be used where possible rather than ultrasonic scalers

Physical measures such as plexiscreens, distancing markers, demarked zones can help segregation and isolation

13. Filtering face piece respirators (FFP3/FFP2/N95)

All respirators should:

- be well fitted, covering both nose and mouth
- be specifically fit-tested and fit-checked for the specific make and model of the respirator on all staff undertaking AGPs to ensure an adequate seal/fit according to the manufacturers' guidance
- be fit-checked (according to the manufacturers' guidance) by staff every time a respirator is donned to ensure an adequate seal has been achieved
- not be allowed to dangle around the neck of the wearer after or between each use
- not be touched once donned
- be compatible with other facial protection used such as protective eyewear so that this does not interfere with the seal of the respiratory protection
- be disposed of and replaced if breathing becomes difficult, the respirator is damaged or distorted, the respirator becomes obviously contaminated by respiratory secretions or other body fluids, or if a proper face fit cannot be maintained
- be removed outside the dental surgery where AGPs have been generated in line with the doffing protocol
- be worn with a full-face visor if a non-fluid resistant respirator is used. (Note that valved respirators are not fully fluid-resistant unless they are also 'shrouded')
- cleaned according to manufacturer's instructions if re-usable

FFP3 (filtering 98% of airborne particles) respirators are advised for all AGPs to prevent inhalation of aerosols. This is because FFP3 respirators offer a slightly higher level of protection than FFP2 respirators and advice aims to offer the greatest protection. However, the HSE has stated that FFP2 and N95 respirators (filtering at least 94% and 95% of airborne particles respectively) offer protection against COVID-19 and so may be used if FFP3 respirators are not available. These respirators offer protection against AGPs, are recommended by the World Health Organization and are used routinely in other countries by dentists for AGPs. All respirators need to be fit tested and checked.

Other respirators can be utilised by individuals if they comply with HSE recommendations. Reusable respirators should be cleaned according to the manufacturer's instructions.

It is important to ensure that facial hair does not cross the respirator sealing surface and if the respirator has an exhalation valve, hair within the sealed mask area should not impinge upon or contact the valve.

Operators who are unable to wear respirators due to facial hair or religious head coverings or other reasons should wear alternatives such as positive pressure hoods. These deliver clean air through a High Efficiency Particulate Air filter using a fan mounted on the wearer's belt. Hoods have integral visors.

14. Sessional use of PPE

Gloves and aprons are single use with disposal after each patient.

All PPE worn for patients that are shielding must be single use.

Disposable gowns are recommended as they are easily disposed of at the surgery and require no additional processes. However, where there is a shortage of disposable gowns, reusable gowns may be used. After use, gowns should be transported in a disposable plastic bag. The bag should be disposed of into the household waste. Reusable gowns should be laundered: separately from other household linen; in a load not more than half the machine capacity; and at the maximum temperature the fabric can tolerate, then ironed or tumbled-dried[14] [15].

Fluid resistant (type IIR) surgical mask and eye protection can be used for a session of work rather than a single patient or resident contact.

FFP3/FFP2/N95 respirators have a large capacity for the filtration and retention of airborne contaminants. Sessional use can be used in dental practice. A full-face visor changed between patients will protect the respirator from droplet/splatter contamination.

Although good practice, there is no evidence to show that discarding disposable respirators, facemasks or eye protection in-between each patient reduces the risk of infection transmission to the health worker or the patient.

The rationale for recommending sessional use in certain circumstances is to reduce risk of inadvertent indirect transmission, as well as to facilitate delivery of efficient clinical care.

15. Decontamination

Decontamination of equipment and the environment following dental treatment should follow HTM01 05. Decontamination of equipment and the care environment must be performed using either:

- a combined detergent/disinfectant solution at a dilution of 1,000 parts per million available chlorine (ppm available chlorine (av.cl.)); or
- a general-purpose neutral detergent in a solution of warm water followed by a disinfectant solution of 1,000ppm av.cl

[14] https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/managing-shortages-in-personal-protective-equipment-ppe
[15] https://www.gov.uk/government/publications/decontamination-of-linen-for-health-and-social-care

If alternative cleaning agents/disinfectants are to be used, they should only on the advice of the IPC team and conform to EN standard 14476 for viricidal activity.

Products must be prepared and used according to the manufacturers' instructions and recommended product 'contact times' must be followed.

Dedicated or disposable equipment must be used for environmental decontamination and disposed of as infectious clinical waste. Disposable products are preferred at this time, but where it is safe to do so, items may be reused e.g. dedicated mops should be colour coded according to HTM01 05 for each area according to the guidelines.

Specific information and resources to help prevent Legionella infections in water systems following a sustained dental practice closure can be found here:

https://www.gov.uk/government/collections/oral-health#healthcare-public-health

Dentures or any laboratory work should be disinfected before transport to the laboratory and should be disinfected before being returned to the patient.

16. Environmental decontamination after AGPs

The rate of clearance of aerosols in an enclosed space is dependent on the extent of any mechanical or natural ventilation and the size of the droplets created – the greater the number of air changes per hour (ventilation rate), the sooner any aerosol will be cleared.

When an AGP has been undertaken, it is recommended that the room is left vacant for one hour for a neutral pressure room before cleaning is carried out.

Most dental surgeries are neutral pressure rooms.

Windows in neutral pressure rooms should be opened, or extractor fans that vent to the exterior should be used as air passing externally will be highly diluted and is not considered to be a risk.

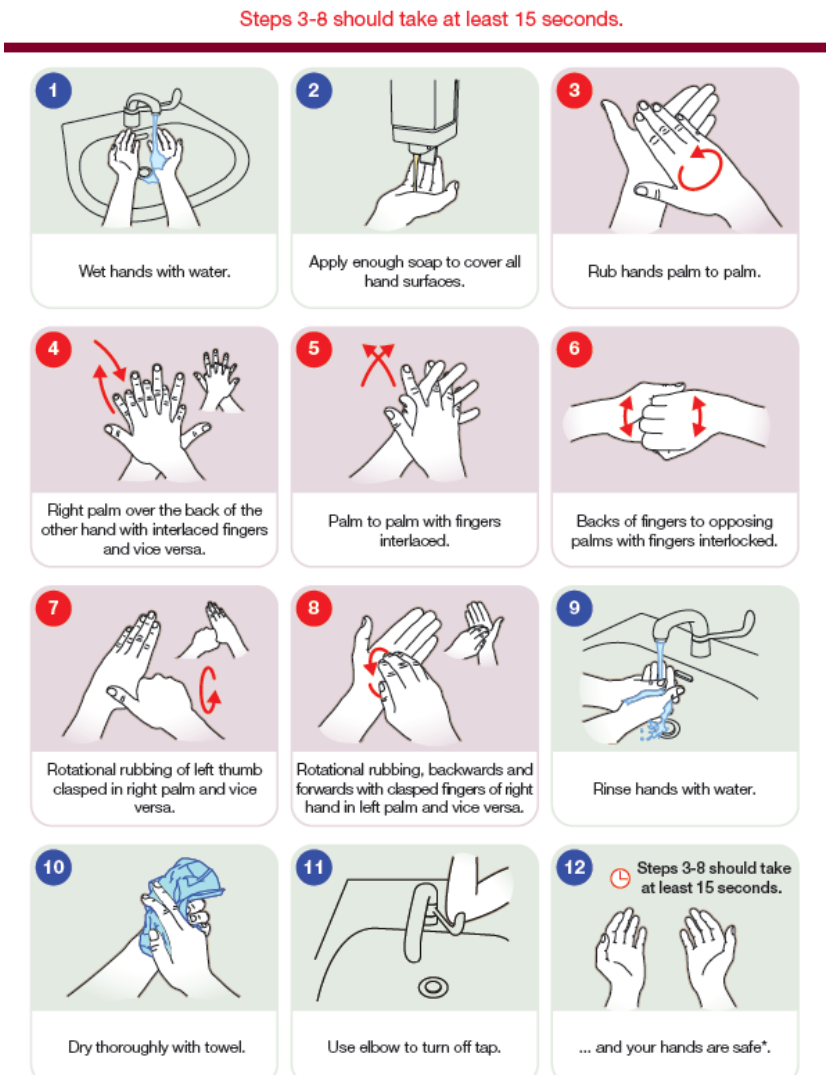
There is currently insufficient evidence to indicate transmission of viable virus through air vent and air conditioning systems.

It is difficult to make general recommendations for devices that remove viable microbes from air, either by filtration or microbicidal action. This is because: there is variability in the rate they pass air through the device, the removal or inactivation will vary according to filtration or microbicidal efficacy, and over time filters will become progressively blocked. Microbicidal treatment such as UV can get obscured by a build-up of dust and the spectrum of UV emission, critical for microbicidal efficacy, can change over time.

FIGURE 1: Hand hygiene

Best Practice: How to hand wash

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/886217/Best_practice_hand_wash.pdf



Best practice: How to hand rub

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/886216/Best_practice_hand_rub.pdf

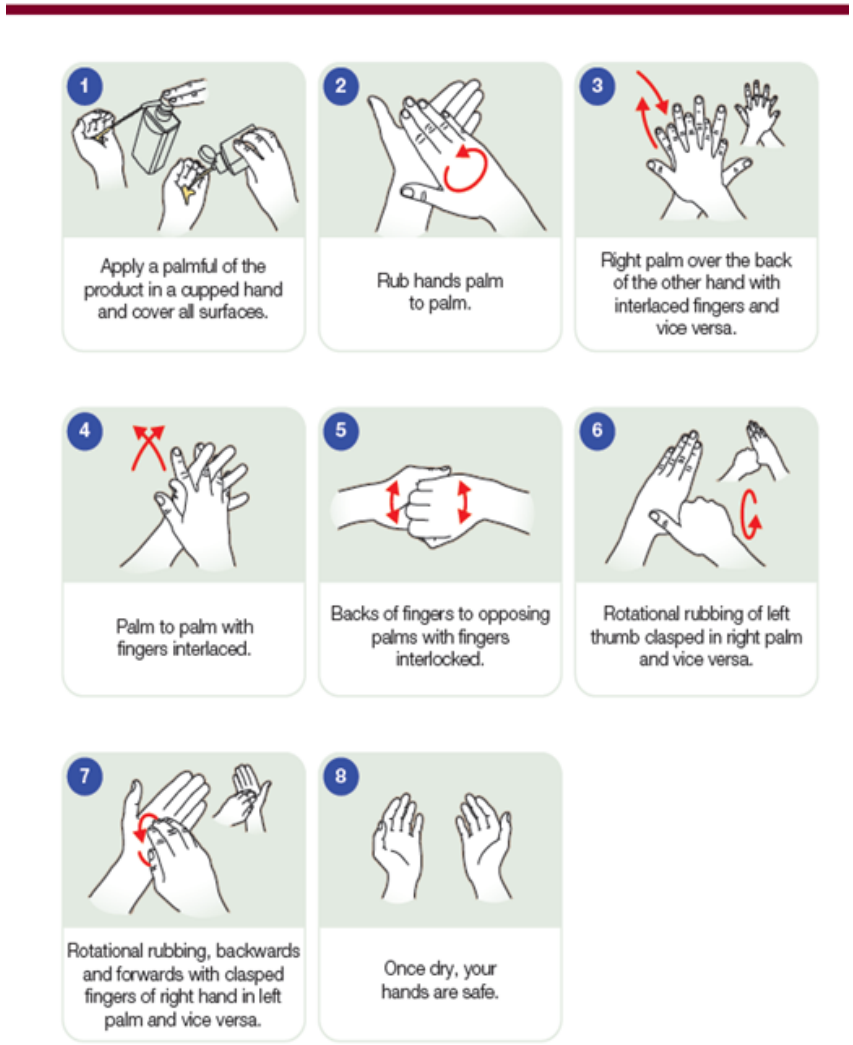


FIGURE 2: Best practice – donning and doffing PPE

Guidance on putting on (donning) PPE for aerosol generating procedures (AGPs), and a video showing how to safely don (put on) PPE specific to COVID-19 for AGPs and which should be used in conjunction with the quick guide to donning PPE and local policies - can be viewed here.

https://www.gov.uk/government/publications/covid-19-personal-protective-equipment-use-for-aerosol-generating-procedures

Donning

COVID-19

Public Health England

Quick guide – gown version

Putting on (donning) personal protective equipment (PPE) for aerosol generating procedures (AGPs)

This is undertaken outside the patient's room.

Pre-donning instructions

- ensure healthcare worker hydrated
- tie hair back
- remove jewellery
- check PPE in the correct size is available

Perform hand hygiene before putting on PPE

1 **Put on the long-sleeved fluid repellent disposable gown**

2 **Respirator**
Perform a fit check.

3 **Eye protection**

4 **Gloves**

Public Health England

Putting on (donning) personal protective equipment (PPE) including coveralls for aerosol generating procedures (AGPs)

Use safe work practices to protect yourself and limit the spread of infection

- keep hands away from face and PPE being worn
- change gloves when torn or heavily contaminated
- limit surfaces touched in the patient environment
- regularly perform hand hygiene
- always clean hands after removing gloves

Pre-donning instructions

- ensure healthcare worker hydrated
- tie hair back
- remove jewellery
- check PPE in the correct size is available

Putting on personal protective equipment (PPE). The order for putting on is coverall, respirator, eye protection and gloves. This is undertaken outside the patient's room.

1 **Don the coveralls**

- Step into coveralls
- Pull up over waist
- Insert arms into sleeves, if thumb hoops available then hoop these over your thumbs, ensure sleeves cover end of gloves so no skin is visible
- Pull up over the shoulders
- Fasten zip all the way to the top

Do not apply the hood of the coverall as there is no requirement for airborne transmission.

Steps 2 to 4 overleaf >

Doffing

COVID-19

Public Health England

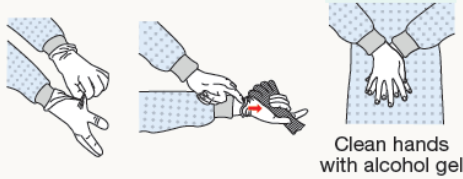
Quick guide – gown version

Removal of (doffing) personal protective equipment (PPE) for aerosol generating procedures (AGPs)

PPE should be removed in an order that minimises the potential for cross contamination.

The order of removal of PPE is as follows:

1 **Gloves –** the outsides of the gloves are contaminated



Clean hands with alcohol gel

2 **Gown –** the front of the gown and sleeves will be contaminated

3 **Eye protection -** the outside will be contaminated

4 **Respirator** Clean hands with alcohol hand rub. Do not touch the front of the respirator as it will be contaminated

5 Wash hands with soap and water

Public Health England

Removal of (doffing) personal protective equipment (PPE) including coveralls for aerosol generating procedures (AGPs)

PPE should be removed in an order that minimises the potential for cross contamination. PPE is to be removed carefully in a systematic way before leaving the patient's room i.e. gloves, then gown/coverall and then eye protection.

The FFP2/3 respirator must always be removed outside the patient's room. Where possible in a dedicated isolation room with ante room or at least 2m away from the patient area.

This is to reduce the risk of the healthcare worker removing PPE and inadvertently contaminating themselves or the patient while doffing.

The FFP2/3 respirator should be removed in the anteroom/lobby. In the absence of an anteroom/lobby, remove FFP2/3 respirator in a safe area (e.g., outside the isolation room). All PPE must be disposed of as infectious clinical waste.

1 Firstly, grasp the outside of the outside of the glove with the opposite gloved hand; peel off

Hold the removed glove in gloved hand

Then, slide the fingers of the ungloved hand under the remaining glove at the wrist

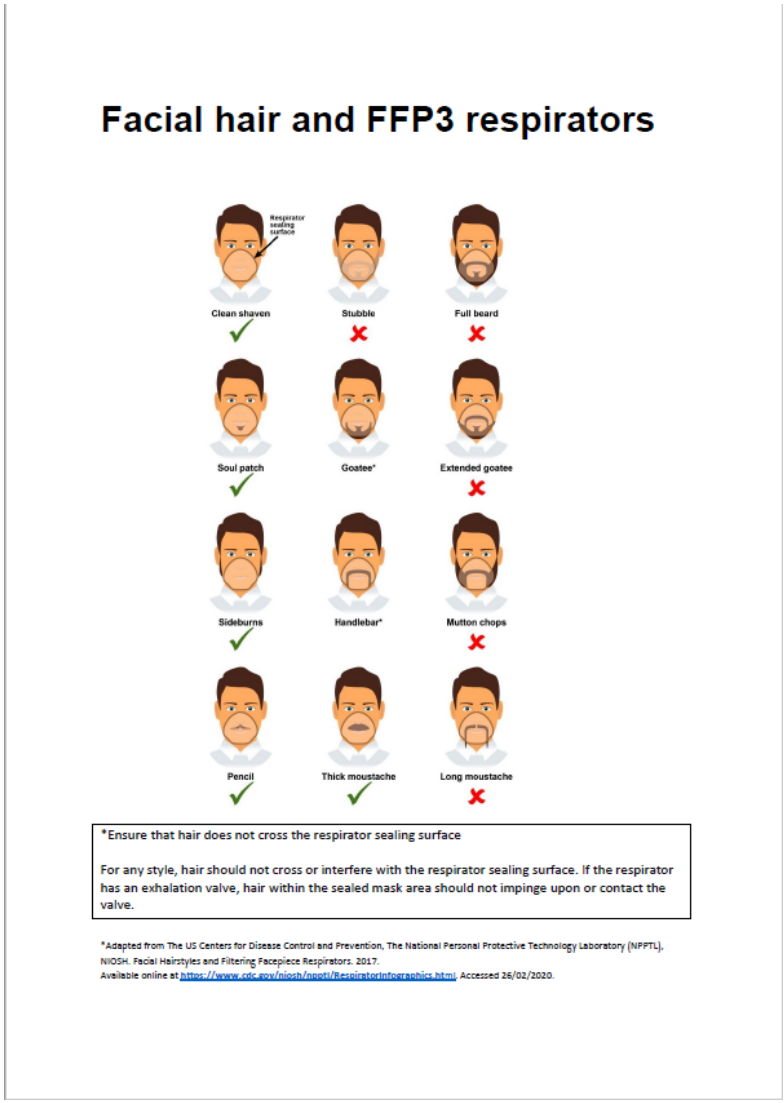
Peel the remaining glove off over the first glove and discard

Clean hands with alcohol hand gel or rub

Steps 2 to 6 overleaf >

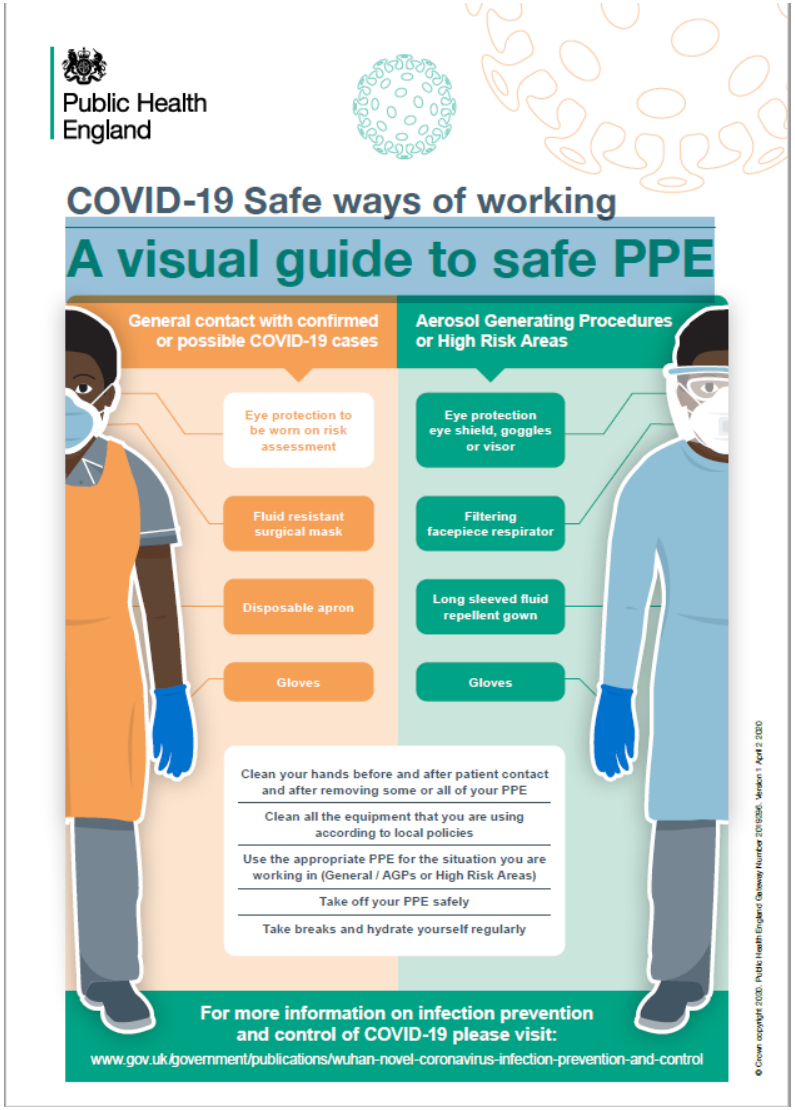
Facial hair and FFP3 respirators. View at:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/877532/Facial_hair_and_FFP3_respirators_220320.pdf



A visual guide to safe PPE. View at:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/878056/PHE_COVID-19_visual_guide_poster_PPE.pdf



Appendix 2: Practice Checklist

	Practice layout	TICK
	Assess and design patient flow allowing for social distancing and minimising patient-to-patient contact	
	Design appointment scheduling to minimise number of patients within the practice at any one time	
	Utilise floor markings – indicating flow and social distancing requirements	
	Considered process for remote payment and appointment scheduling	
	Facility to accept card/contactless payment	
	Placement of COVID-19 and hand/cough etiquette signage	
	Place physical barrier at reception	
	Remove unnecessary items from waiting and reception areas	
	Plan ventilation of all areas	
	Hand sanitising stations at point of entry and exit	
	Staff considerations	
	Ensure social distancing within staff areas/facilities	
	Process for laundering staff uniforms	
	Risk assess staff for return to work	
	Consider staff scheduling (rota)	
	Process for reviewing staff health and well-being	
	Check local health board occupational health contacts and COVID-19 policy highlighting new procedures and protocols	
	Devise a protocol for all staff to follow if they, or someone they live with, develops COVID-19 symptoms, including whether they should apply for a COVID-19 test	

Putting tools in place to facilitate effective staff communications whilst working in “clinical, where individual staff members always work with the same colleagues to limit contact between the teams and, if required, contact track and trace	
Making staff aware of available resources e.g. mental health, resilience, self-care	
Check if there is information relevant to this phase or return available from your indemnity provider	
Review and update continuity plan with required amendments	
Supplies	
Paper towels for hand drying (preferred)	
Personal Protective Equipment supplies sourced	
Medical emergency drugs checked and in date	
Hand hygiene products: sanitisers, soap, paper towels	
Stabilisation materials e.g. restorative materials	
Rubber dam kit and supplies	
Restore contracted services e.g. laboratory staff and clinical waste services	
Single use stationary or means to disinfect	
Check dental materials for expiry date and order as required	
Reprocess instruments prior to returning them to use	
Equipment	
Organise engineer visits for maintenance and testing as required	
Check all equipment is functioning and fit for purpose, including washer disinfector, steriliser, ultrasonic bath, reverse osmosis machine	
Reconnect compressor as per manufacturer’s instructions. Turn on mains electricity, close drains, turn compressor on. Perform any housekeeping and maintenance testing	
Carry out safety and quality assurance checks in radiographic equipment	

	Test the Automated External Defibrillator (AED)	
	Ensure rechargeable items are fully charged and operational	
	If the practice has a drinking water dispenser for staff use, recommission as per manufacturer's instructions	
	Check for and install computer software updates	
	Check operation of chair and light functions. Open air and water lines to unit	
	Flush dental unit water lines with biocidal as per manufacturer's instructions	
	Clean and lubricate couplings and air motors then reconnect, as per manufacturer's instructions	
	Test hand pieces for functionality	
	Test suction system. Run cleaning solution through hoses. Check that the cup fill, bowl flush and spittoon have water flowing	
	Appropriate Portable Appliance Testing is carried out	
	Personal Protective Equipment & Infection Prevention & Control	
	Staff are aware and familiar with PPE recommendations	
	Designate area identified for donning and doffing of PPE	
	Staff are aware and familiar with IPC guidance	
	Process in place for cleaning and disinfecting regularly touched items e.g. reception desks, card machines, door handles, chair arms	
	Rota for cleaning and disinfection of toilet after each use	
	Training	
	Staff know how to don and doff PPE	
	Infection prevention and control	
	Decontamination processes	
	IT training, e.g. tele-dentistry software and use of any triage custom screens or templates	

	Administrative asks including any changes to payment methods and appointment protocols	
	Performed scenario-based training on patient flow and new COVID-19 alterations	
	Basic Life Support and CPR update	
	Rubber dam/Four handed technique training (if required)	
	Considered any further individual/team training requirements	
	Screening	
	Develop a process for screening of both staff and patients	
	Means for recording and logging screening results (staff and patients)	
	Patient communication	
	Develop a process for communicating COVID-19 related changes to patients	
	Update website and answer machine messaging if required	
	Devise a method for tracking patient progression with treatment, so that you can monitor those awaiting AGPs	
	Place a sign(s) on door/window stating that patients suspected or confirmed COVID-19 should not enter the practice and indicating that the practice is only open for patients with a pre-arranged appointment. Include details of how to contact the practice	
	Care plan organisations	
	Prioritise patients into recommended cohorts OR Review the list of patients that contacted the practice during closure and begin to book appointments, prioritising these on the basis of clinical need and available treatments	
	Check NHS e-mail accounts daily for updates from UK government, health board or other organisations. Ensure any updates are communicated to patients and staff as appropriate	
	Practice procedures	
	Patient movement/journey through practice	
	Patient appointment booking	

Remote patient triage prior to attendance	
Medical history completion	
COVID-19 assessment	
PPE	
Treatment protocols	
Cleaning procedures: • Environmental cleaning • Standard infection control precautions • Transmission based precautions	
Treatment payment options	
Use of toilet facilities	
Staff working patterns	
Team communication	
Team reporting of COVID-19 status	
Dealing with known or suspected COVID-19 symptoms in practice	
Laundry	
CPR	
External	
Inform external providers, e.g. insurance company, indemnity provider, waste contractors, IT provider, pharmacy, suppliers, maintenance contractors, dental laboratories, utilities and telecoms of practice reopening date	

Appendix 3: Arranging a remote point of contact

Explain to the patient that due to:

- Government guidelines on social distancing
- By way of trying to reduce the spread of infection

Patients will be remotely contacted by the practice to enable future dental care to be planned appropriately.

Inform the patient that a remote point of contact will be made by a member of staff at the practice (either via telephone or video) and that notes will be made on the patients clinical record (call will not be recorded).

Note that consent has been gained for this remote contact to take place.

- Arrange a convenient date and time for the remote point of contact.
- Explain there will be a time-frame within which the practice will attempt to make contact.
- Follow practice protocol for patients that require an interpreter. If unable to communicate remotely due to language barrier, consider face to face appointment.

- Advise best to complete this point of contact when the patient is free to talk, and confidentiality can be maintained.

- Remote point of contact should be prioritised for patients that are shielding and patients at increased risk from COVID-19.

- Ensure all correct contact numbers are noted and agree on the best number to contact the patient on.

- Practices should establish and develop a protocol for any planned remote points of contact that are missed (e.g. a failure to accept the call may be treated as a missed appointment and that there is no guarantee of a second call).

Flowchart for arranging a remote point of contact

Review patients cancelled during COVID-19 pandemic

Prioritise patients based on date from when they were cancelled.

Further prioritise patients that are shielding and patients at increased risk from COVID-19

Identify patients for a remote point of contact with an identifier

(to note: not face-to-face)

Be aware of and have government guidelines to hand regarding social distancing and call patient

Explain to patient:

- Due to social distancing, using remote point of contact to touch base, and establish need for face-to-face appointment
- Inform how this will take place (phone or video)
- Note consent gained for this point of contact
- Arrange date and estimated time frame patient will be contacted (check correct contact details)
- To allow for a confidential space in which you should be able to talk
- Inform of practice policy for missed calls

Note: if patient is shielding or at increased risk from COVID-19, need for an interpreter, any current dental problems (action as appropriate)

3.1 Completing a remote point of contact

a. Before contacting patients	✓
• Prepare to contact patient via telephone or video • If remote point of contact away from clinical setting ensure: - You have access to the patient record - Appropriate environment where confidentiality can be maintained	
• Ensure you are familiar with and have the most up to date Government COVID-19 guidance to hand	
• Check patient's medical and dental history • Note if patient is shielding (may need to be checked with patient or their GP/medical specialist) or at increased risk of COVID-19 • Note any oral health related risk factors • Check factors that may influence point of contact e.g. language barrier/disabilities (these should have been noted at the time of booking) • Ensure no sensitive information is on display before calling the patient **Prior to starting the consultation, it is important to let the patient know that:** - The call will not be recorded - Reasons for remote point of contact Ensure that this conversation has been documented	
b. Establishing a technical connection	
• Ensure high quality call where the connection will not be lost due to poor connectivity • Check you are both able to hear and speak to one another clearly • Record the patient's phone number to ensure you are able to call back if the connection is lost	
c. Beginning the remote point of contact	
• Confirm the identity of the patient (name/ date of birth) • Try to speak with the patient directly - For children or those lacking capacity, when speaking on patients behalf record name and relationship to patient	
• If the patient does not pick up the call, follow practice protocol for re-booking	

• Explain the purpose of your call (check how the patient is and establish the need for face-to-face appointment)	
• If urgent dental care is needed, follow local protocol to refer to appropriate service (UDC/A&E)	
d. Taking a history	
• Establish the impact of COVID-19 on the patient and their family - make a note of any potential implications from a social, medical and (where appropriate) financial perspective	
• Identify patients who may require additional separation measures and possible referral to an appropriate care setting: ○ Patients with possible/confirmed COVID-19 and their household contacts ○ Patients that are shielding ○ Patients at an increased risk of COVID-19	
• Take a history: - making note of any dental problems that have arisen during lockdown) - change in self-care during lockdown	
• If there were any items being kept under review, discuss these to check the current status	
e. Remote oral assessment	
It is not expected that a definitive diagnosis will be reached from a remote point of contact*	
• Ask the patient to describe their general health and the health of their mouth. If any specific problems are reported, ask for details	
• If video consultation, make a note of the patient's demeanour and note any obvious extra-oral facial swellings or asymmetry	
• If further assessment is needed (e.g. visual, special tests, radiography) consider arranging a face-to-face appointment	
• If unable to gain enough information remotely, make a note and decide if the patient needs to be seen imminently given the current scope of practice which dental services are currently able to provide	

f. Red flags	
▪ Red flags may be raised where there are any signs, symptoms or factors that indicate a patient needs an urgent face-to-face assessment	
Red flags may include, <u>but not be restricted to</u> any patients with: ○ Suspicious oral lesions that merit further investigations ○ Severe infection or spreading infection ○ Safeguarding concerns Relevant practice protocol for each of these red flags should be followed.	
g. Outcomes	
Once a provisional/differential diagnosis has been made, or if further face-to-face assessment is required, this will result in any of the following outcomes: **i. Any appropriate patient advice and information** **<u>NOTE:</u>** - What advice has been given? - Why was this given? - Any resources that have been recommended **ii. Arrange face-to-face appointment for routine dental care** See re-starting dental services. **iii. Arrange face-to-face urgent dental care, e.g. general practice, designated UDC provider, secondary care (please see UDC SOP for further guidance)** Follow local protocol for referral to UDC provider.	
h. Clinical records	
• Clinical record should be kept as usual noting that a remote point of contact due to the COVID-19 was made	

Appendix 4: Clinical guideline 3 - Management of periodontal treatment (non-AGP)

This Appendix has been developed by the British Society of Periodontology and Implant Dentistry (BSP) in collaboration with the OCDO team. It focusses on the management of plaque induced periodontal conditions, principally gingivitis and all grades of periodontitis Stages I, II, III, IV (mild, moderate, severe, very severe).

> *It specifically provides guidance on the provision of periodontal care for patients who are: 1) not known to be COVID-19 +VE or 2) not known to be exhibiting any symptoms of COVID-19.*
>
> *For COVID-19 +VE patients, those exhibiting symptoms, or residing with people who are self-isolating due to suspected COVID-19, treatment should be delayed where possible for 14 days, or to a point where they are clinically fully recovered and have had no fever for the last five days. Otherwise, this group should be referred to an Urgent Dental Care Centre (UDC) for management.*

This SOP embraces the European S3-level treatment *guidelines* published in May 2020. BSP currently endorse these guidelines and are in the process of adapting them to the UK and Irish context, through a formal process, and anticipate publishing an updated version in July 2020.

Table 1: demonstrates the stepwise sequence for treatment of periodontitis and gingivitis.

Steps 1, 2 and 4 are sufficient to stabilise periodontal health in the majority of sites and in the majority of patients, and the evidence-based guidelines demonstrate that there is no difference in outcome from employing non-AGP instruments (hand scaling and root surface therapy using hand curettes) as opposed to AGP instruments such as sonic/ultrasonic scaling devices.

Until more robust research evidence emerges on the safety and most appropriate protocols, periodontal care can continue without AGP, and should be regarded as an essential health procedure. For surgical aspects of Step 3, care requires specialist level 2/3 enhanced skills.

Step 3 procedures involving non-AGPs (re-instrumentation of non-responding sites by hand) may also be performed with the appropriate level of PPE *recommended*.

The S3-treatment guidelines do not support superiority for ultrasonic / sonic instruments over hand instruments, and strongly recommend either may be used for sub-gingival treatment, either alone or in combination.

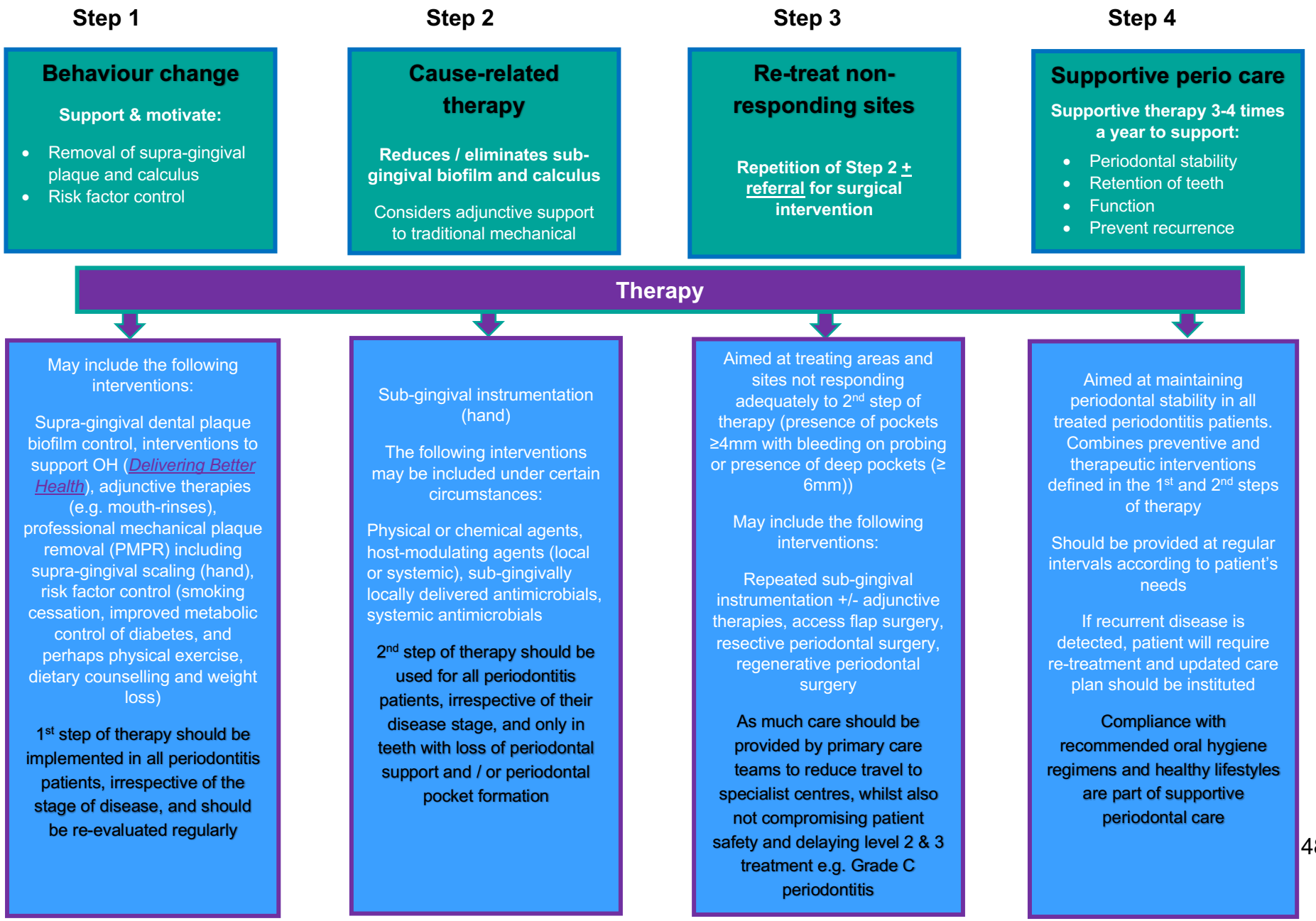
New World Workshop Classification (WWC)

We are aware that a number of dental teams within NHS commissioned services are concerned about the perceived complexity of the WWC, due to the manner in which it has been taught in some areas. We would reassure those teams that the BSP implementation plan is extremely simple and being adopted by other countries for this reason. However, we recognise the need for time to adapt to such changes and the desire of some teams to continue to use the extant classification system.

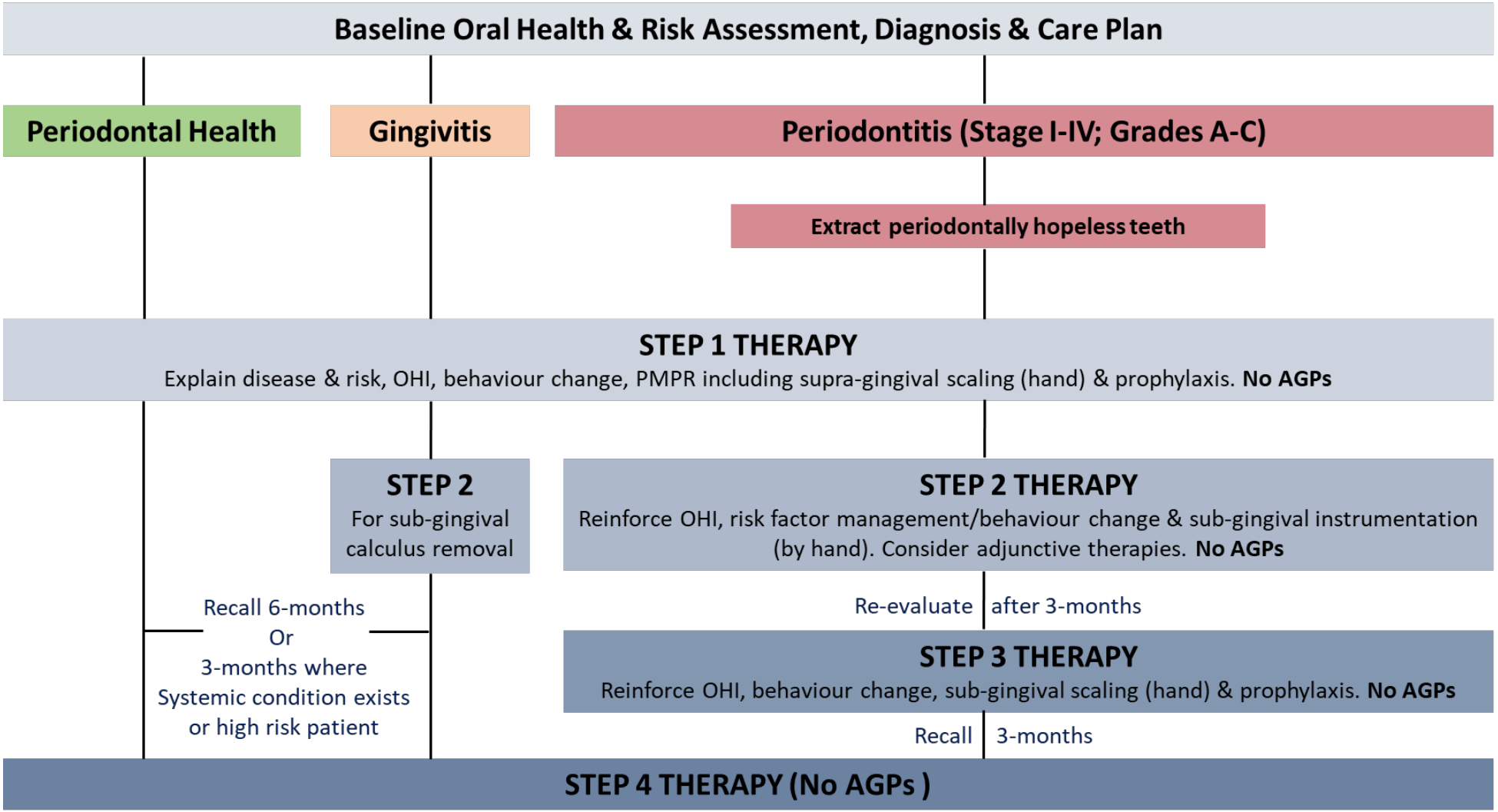
Therefore, we would like to reassure front line clinical teams that in the interim, NHS England's commissioned services can continue to use the existing (extant) classification system, whilst acquainting themselves with the principles of the BSP WWC implementation, if they find this easier to deliver.

Effective care can be delivered using either system in the presence of appropriate examination, risk assessment and treatment planning (and hence a failure to immediately transition should not be considered poor practice). The existing BPE system and associated BSP WWC will form the basis for future care pathway and commissioning development.

Table 1: Flow Chart



Flow Chart of Steps of Minimally-Invasive Periodontal Treatment (without AGP)



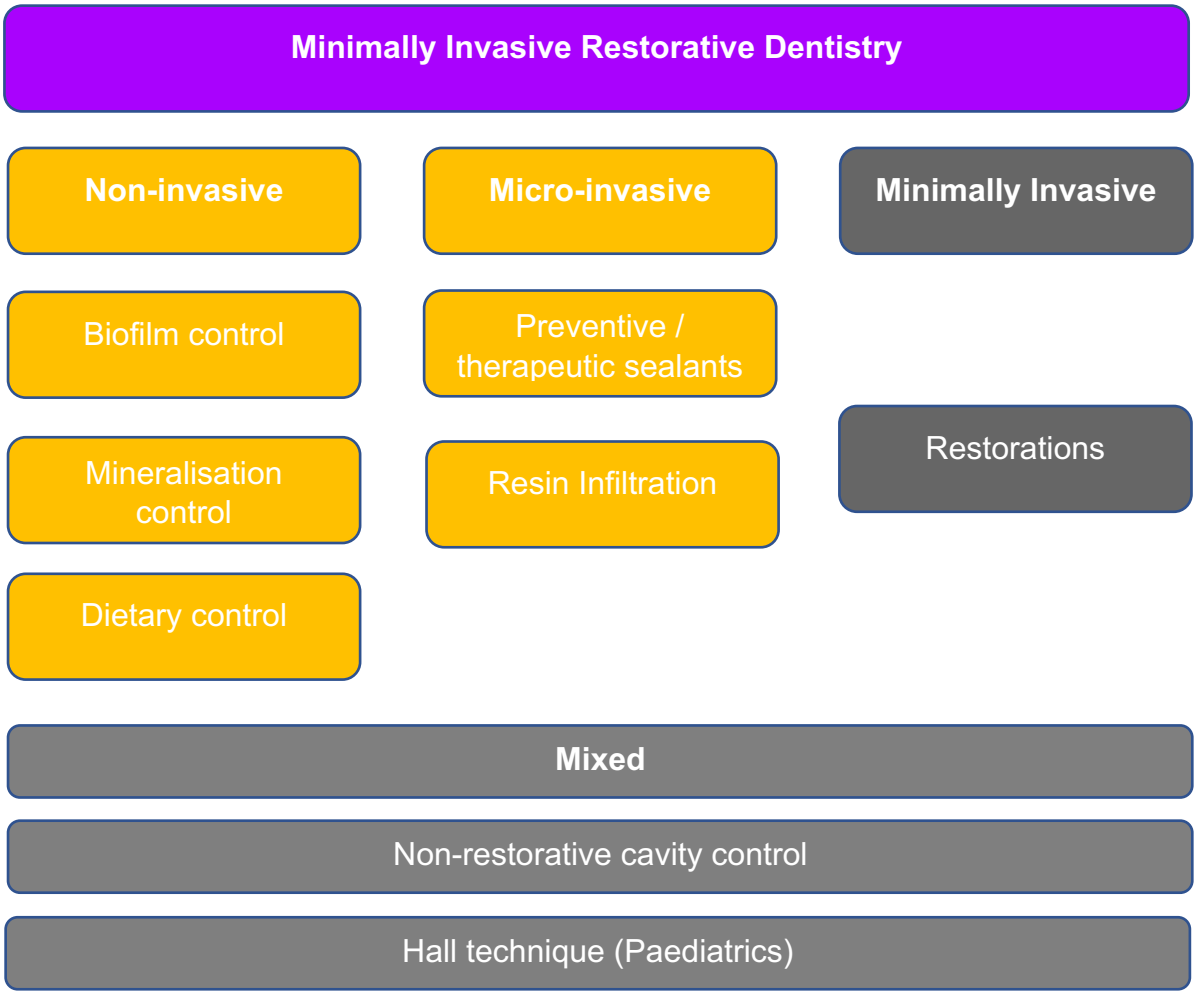
Appendix 5: Clinical guideline - Advanced Minimally Invasive Restorative Dentistry (AMIRD): caries management

We recognise dental teams may use a variety of acceptable techniques, and a shift towards a preventative and minimally invasive clinical philosophy is a journey to best practice that should be supported by appropriate support and training.

This Appendix outlines three distinct areas of advanced minimally invasive restorative dentistry (AMIRD) in managing dental caries, prevention and self-care:

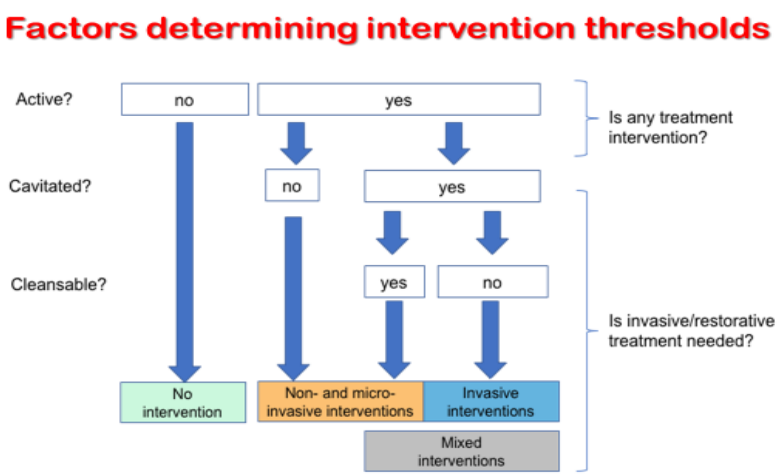
- non-invasive prevention: inactive carious lesions, focusing on susceptibility assessment, non-AGP preventative measures;
- micro-invasive management: for early, non-cavitated, active carious lesions, non-AGP, preventive / therapeutic sealants and resin infiltration;
- minimally invasive restorations: Risk-managed AGP, MI restorative management of patients with active cavitated, deep carious lesions;

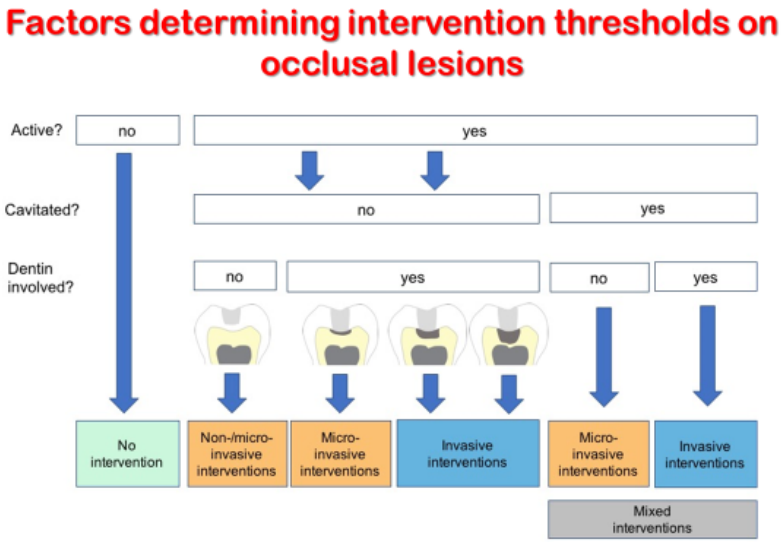
Flowchart 1. When to intervene in the caries process? An expert Delphi consensus statement.[16]



[16] Clinical Oral Investigations 2019; https://doi.org/10.1007/s00784-019-03058-w

5.1 Factors determining caries intervention





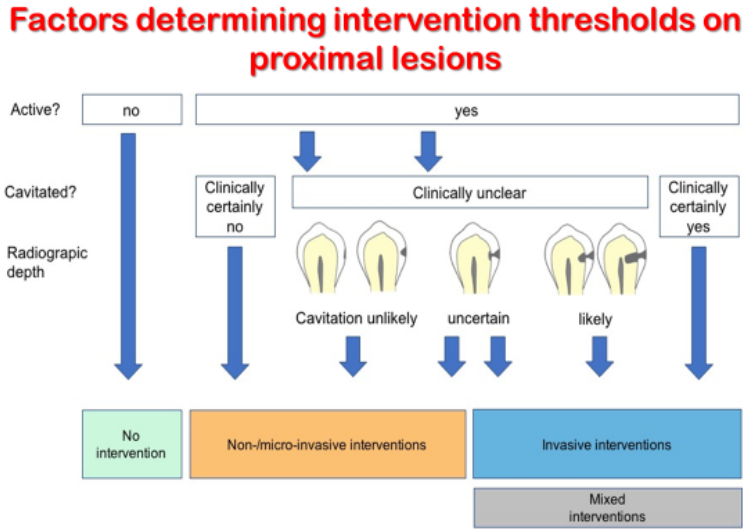


Figure 1. Factors determining when to intervene in the caries process. Is the lesion active, cavitated, cleansable?

Figure 2. The factors specific for occlusal lesions.

Figure 3. The factors specific for proximal lesions.

AMIRD - Non-invasive prevention

Table 2. Non-invasive prevention principles and techniques.

Non-invasive, non-AGP procedures	
Biofilm control	• Oral hygiene - Delivering better oral health • Relevant oral hygiene procedures • Toothpastes with fluoride • Mouthwashes • Rotating/oscillating brushes and flossing
	• Instructed by all clinical oral healthcare team members
Mineralisation control (based on caries susceptibility assessment and at-risk tooth surfaces)	• Application of fluoride varnishes • CPP-ACP (casein phodphopeptide-amorphous calcium phosphate, products containing Recaldent) containing pastes • β-TCP (beta-tricalcium phosphate) containing agents and other remineralisation agents • CHX (chlorhexidine) / Silver Diamine Fluoride in adults (no / limited evidence) • Silver Diamine Fluoride in paediatric patients (UK licence for treating dentine sensitivity)
	Delivery by dentists and dental hygienists & therapists
Dietary control	• Advice on dietary control
	• Delivery/instruction by all clinical oral healthcare team members

Table 3. Micro-invasive dentistry; principles and techniques for early carious lesions.

<table>
<tr><th colspan="2">Micro-invasive, non-AGPs</th></tr>
<tr>
<td>Sealants:

Caries sealing is a procedure that may be used where active early carious lesions are detected in:

1) Accessible non-cavitated surfaces (including occlusal surfaces), confirmed through clinical ± radiographic examination</td>
<td>

Preventative & therapeutic* fissure sealant using proprietary sealants:

Flowable resin composite
Glass-hybrid, GIC (glass-ionomer cement) / RM-GIC (resin modified glass-ionomer cement) (where moisture control is not optimal)

<u>Resin composite:</u>

Adhesion: Composite: 37% orthophosphoric acid-etch enamel fissures (20 secs), wash and dry (10 secs) using separate low pressure water / air streams or wet / dry cotton wool pledgets

Restoration: flowed into fissure pattern, light cure (470nm for 20 secs); check occlusion pre-isolation and after its removal

<u>GIC / RM-GIC:</u>

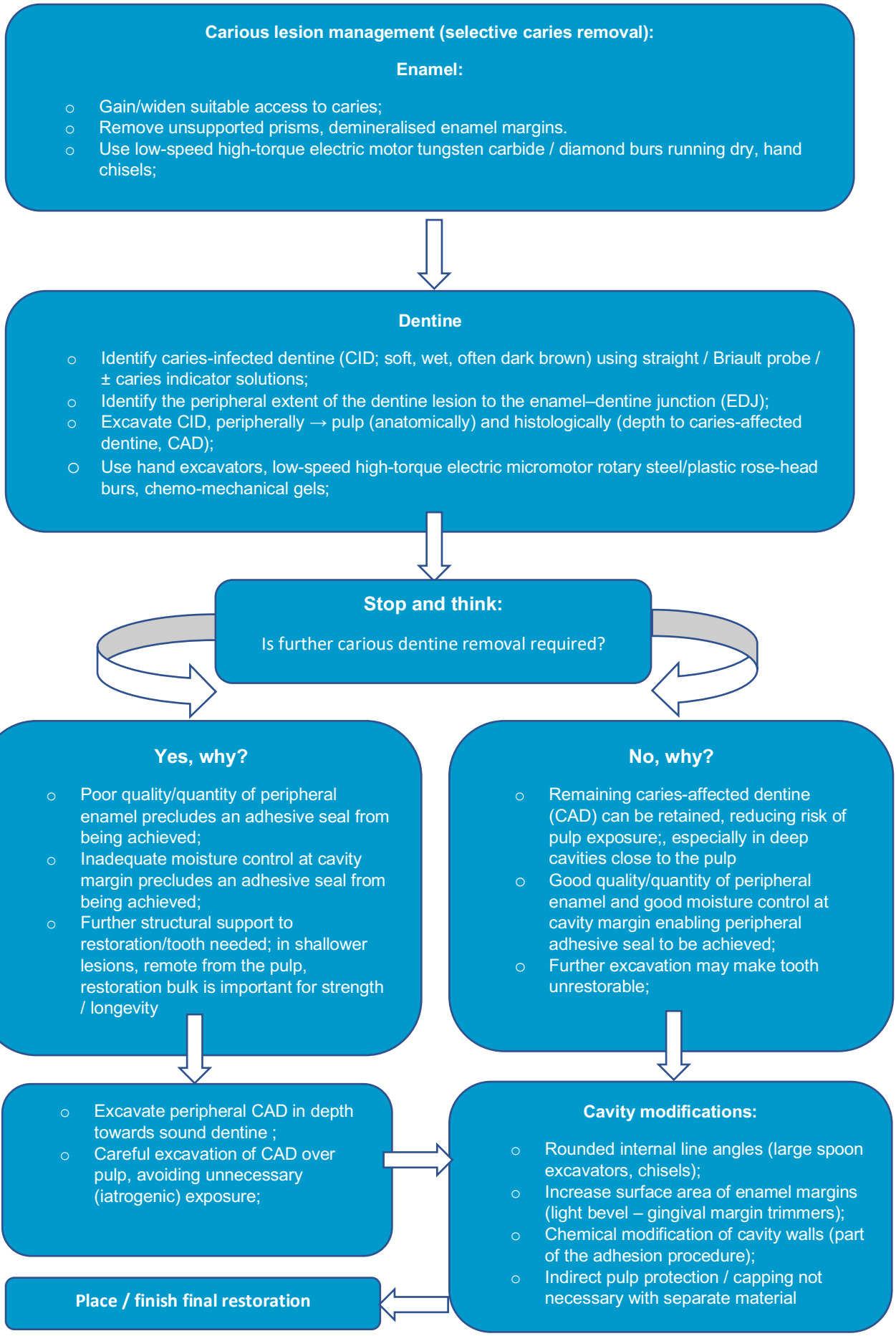
Adhesion: 10% polyacrylic acid conditioning of enamel fissures (15 secs), use separate low pressure water / air streams to wash and dry tooth surfaces or wet / dry cotton wool pledgets / paper points (10 secs)

Restoration: application into fissure pattern, auto-cure / light cured (470nm for 20 secs); check occlusion pre-isolation and after its removal.

*in therapeutic fissure sealing, micro-cavitated fissures may require widening</td>
</tr>
</table>

	Delivery by dentists and dental hygienists & therapists
Resin infiltration For accessible smooth surface, early non-cavitated enamel lesions	Same as for sealants Follow standard published protocols but limit/no use of 3-1 air-water syringes
	Delivery by dentists and dental hygienists & therapists

AMIRD - Minimally invasive restorations, risk-mitigated AGP principles



Appendix 6: Management of caries for the paediatric patient

Management of dental caries, prevention and self-care 0-16 year olds.

Prevention and self-care

Every child and young person should continue to receive tailored oral health advice in line with Delivering Better Oral Health. Clinicians should document the exact advice given in order to fulfil contractual obligations. For example, “Advised to stop bottle use and introduce an open top or free-flow cup, to move from brushing once daily to twice daily, emphasised the importance of brushing last thing at night.” It will not suffice to write “prevention given”. Oral health advice can be given as part of a remote consultation.

Patients should be encouraged to perform optimal self-care in order to minimise the development of new disease. Use of digital health tech can be used to deliver and reinforce key prevention messages. The following videos deliver key information in line with Delivering Better Oral Health and can be freely distributed and placed on practice websites or social media pages if used in their entirety:

0-3 video https://youtu.be/owbp5F0K45c
3-6 video https://www.youtube.com/watch?v=lQE4xxk1r5g
7+ video https://www.youtube.com/watch?v=GHS27DHyIi0

Clinicians may also wish to signpost to oral health apps listed in the NHS Apps Library such as Brush DJ [www.brushdj.com]. Health technology has been shown to motivate positive behaviour change.

Primary Dentition

Management of caries in the primary dentition should favour minimally invasive oral healthcare including consideration of the use of less invasive measures such as silver diamine fluoride (SDF) and Hall crowns, and where appropriate considering extractions over traditional conservative approaches.

The success of placing a preformed metal crown via the Hall Technique requires careful and appropriate case selection, excellent patient management and long-term monitoring. For guidance on the indications, effectiveness, and step-by-step guide on how to place a Hall Crown, refer to the Hall Technique - A minimal intervention, child centred approach to managing the carious primary molar.

Permanent Dentition

Management of caries in the permanent dentition may favour temporisation and stabilisation for a six-month period to minimise an AGP. Clinicians should refer to the recently published Scottish Dental Clinical Effectiveness Programme (SDCEP) guidelines on management of caries in children.

Appendix 7: Management of (non-AGP) Endodontics

This document details proposed workflows for the management of endodontic problems in the phased return to dental treatment provision. Triaging of patients to assess individual risk of COVID-19 transmission is essential prior to appropriate scheduling of any endodontic care.

The aim of these proposals is to relieve symptoms, minimise (where possible) the number of visits to complete treatment, whilst at the same providing the favourable outcomes that are associated with contemporary endodontic therapy and reduce unnecessary loss of teeth.

The document uses diagnostic terminology currently adopted in most dental schools in the UK and described in the AAE Consensus Conference Recommended Diagnostic Terminology in 2009[1]. As an aid for those unfamiliar with this terminology, Table 1 offers a description of symptoms associated with the common diagnostic terms.

Table 1

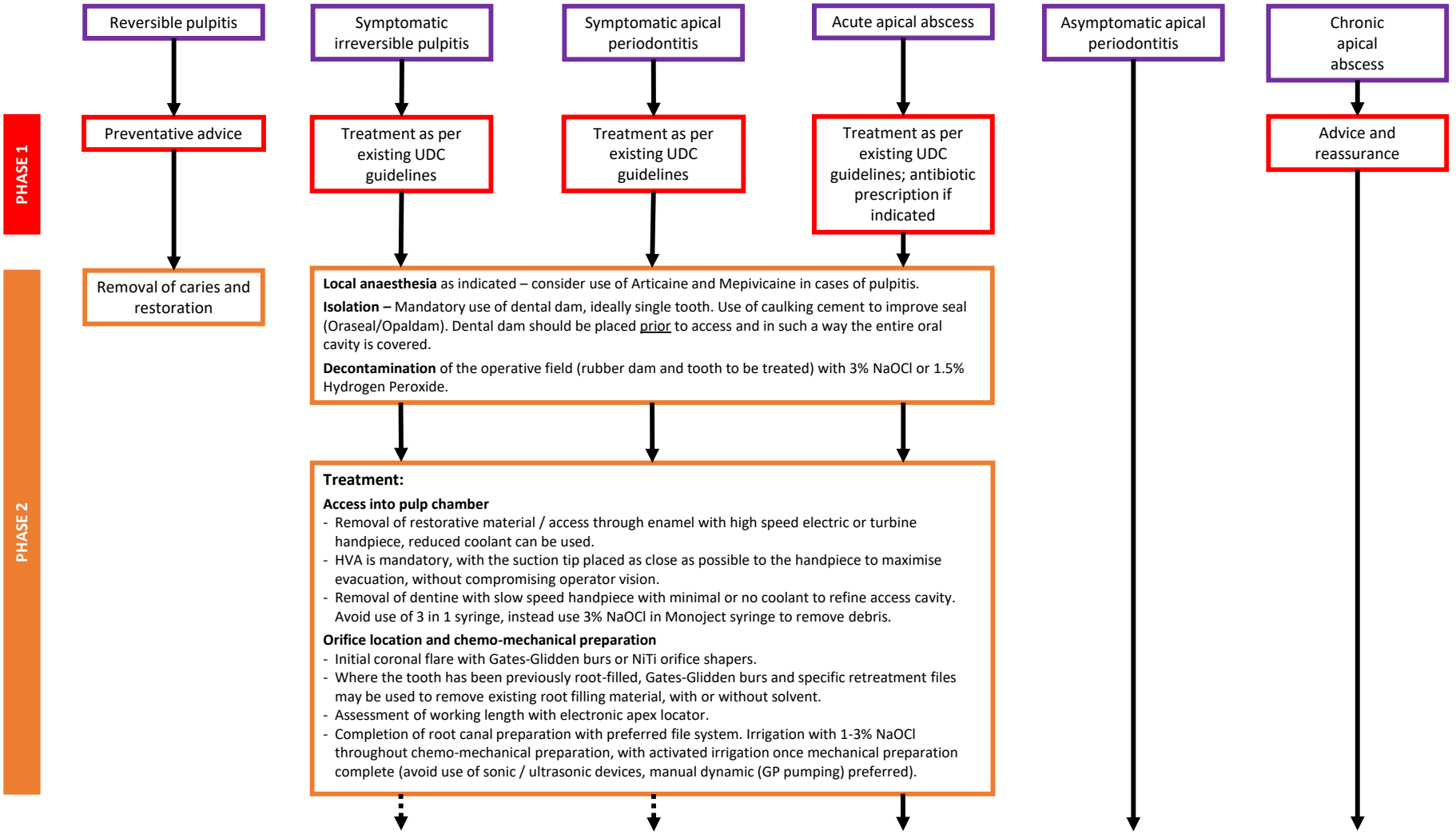
Symptoms	Pulpal/Apical Diagnoses	Treatment
Short duration sharp pain Not spontaneous in onset Cold stimulus worse than hot	Reversible Pulpitis	Caries management, restoration with vital pulp therapy if required
Pain on thermal stimulus Spontaneous pain Lingering pain Referral of pain Postural affects Analgesics ineffective	Irreversible Pulpitis	Root canal treatment
Unresponsive to sensibility testing Tenderness to palpation/ percussion Possible periapical changes on radiograph	Symptomatic Apical Periodontitis	Root canal treatment
Spontaneous pain Extreme tenderness Swelling Possible fever, malaise and lymphadenopathy	Acute Apical Abscess	Incision and drainage, consider antibiotic therapy if indicated Two stage root canal treatment advised
Unresponsive to sensibility testing No symptoms Periapical radiolucency on radiograph	Chronic Apical Abscess	Root canal treatment

Unresponsive to sensibility testing Sinus tract +/- pus discharge Minimal or no pain Periapical radiolucency on radiograph	Asymptomatic Apical Periodontitis	Root canal treatment

*If tooth has been **Previously Treated** or has had **Previously Initiated Treatment** decision should be based upon apical diagnosis.

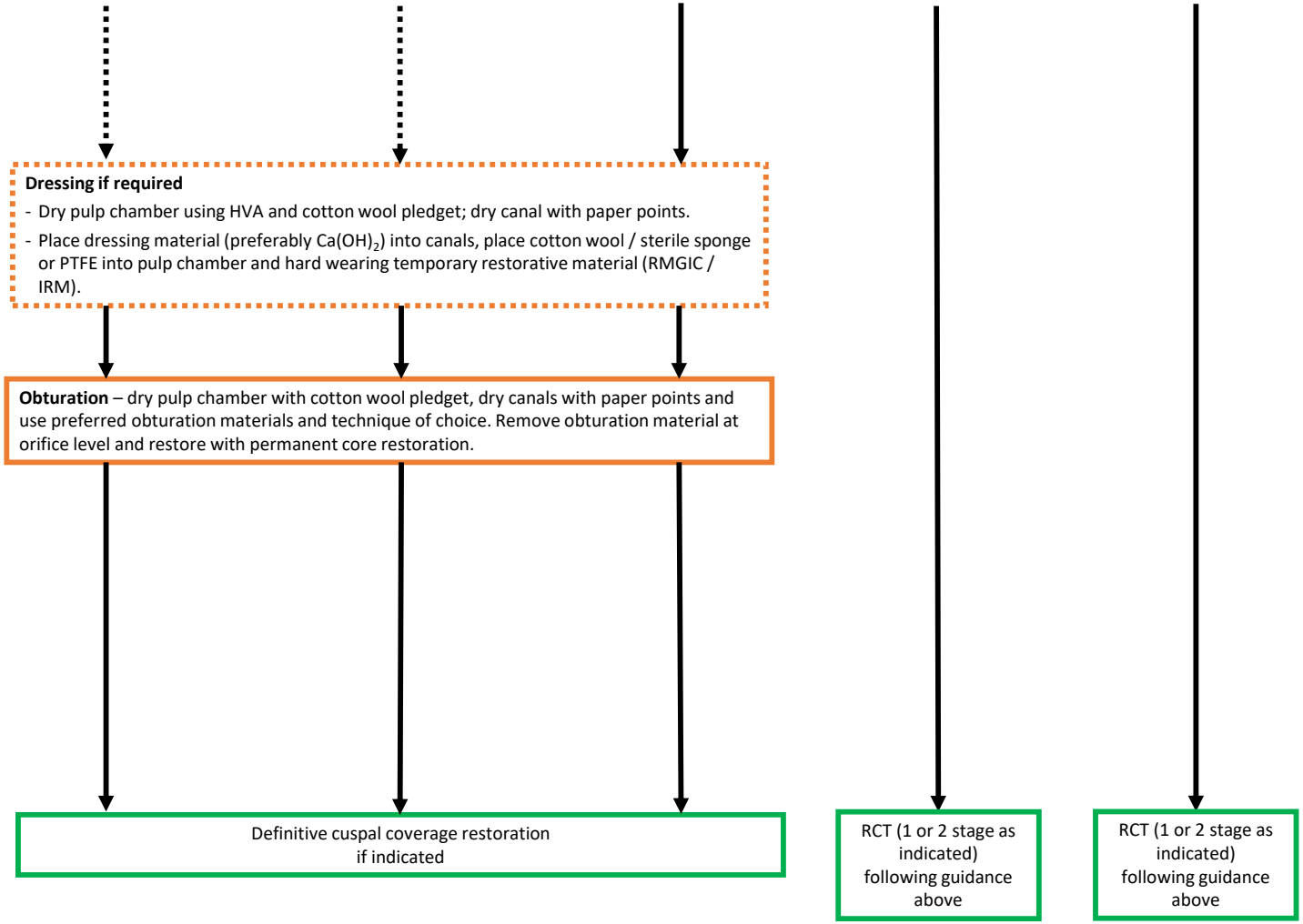
Table 2 shows a flowchart of proposed actions for all common endodontic diagnoses (dento-alveolar trauma is not included in this table), along with the suggested treatment protocols for management, based on the existing ESE quality guidelines for endodontic treatment[2].

Table 2:


Reversible pulpitis
Symptomatic irreversible pulpitis
Symptomatic apical periodontitis
Acute apical abscess
Asymptomatic apical periodontitis
Chronic apical abscess
PHASE 1
Preventative advice
Treatment as per existing UDC guidelines
Treatment as per existing UDC guidelines
Treatment as per existing UDC guidelines; antibiotic prescription if indicated
Advice and reassurance
PHASE 2
Removal of caries and restoration
Local anaesthesia as indicated – consider use of Articaine and Mepivicaine in cases of pulpitis.
Isolation – Mandatory use of dental dam, ideally single tooth. Use of caulking cement to improve seal (Oraseal/Opaldam). Dental dam should be placed prior to access and in such a way the entire oral cavity is covered.
Decontamination of the operative field (rubber dam and tooth to be treated) with 3% NaOCl or 1.5% Hydrogen Peroxide.
Treatment:
Access into pulp chamber
- Removal of restorative material / access through enamel with high speed electric or turbine handpiece, reduced coolant can be used.
- HVA is mandatory, with the suction tip placed as close as possible to the handpiece to maximise evacuation, without compromising operator vision.
- Removal of dentine with slow speed handpiece with minimal or no coolant to refine access cavity. Avoid use of 3 in 1 syringe, instead use 3% NaOCl in Monoject syringe to remove debris.
Orifice location and chemo-mechanical preparation
- Initial coronal flare with Gates-Glidden burs or NiTi orifice shapers.
- Where the tooth has been previously root-filled, Gates-Glidden burs and specific retreatment files may be used to remove existing root filling material, with or without solvent.
- Assessment of working length with electronic apex locator.
- Completion of root canal preparation with preferred file system. Irrigation with 1-3% NaOCl throughout chemo-mechanical preparation, with activated irrigation once mechanical preparation complete (avoid use of sonic / ultrasonic devices, manual dynamic (GP pumping) preferred).

PHASE 2

PHASE 3



References

1. AAE Consensus Conference Recommended Diagnostic Terminology. Journal of Endodontics, 35, 1634, 2009.
2. Quality guidelines for endodontic treatment: consensus report of the European Society of Endodontology. International Endodontic Journal, 39, 921–930, 2006.
3. British Endodontic Society. 2020 https://britishendodonticsociety.org.uk/wp-content/uploads/2020/03/BES-AAA-Document-31st-March-v1.1.pdf