

# Guidelines for oral health services at COVID-19 Alert Level 3

20 September 2021

## Context

The purpose of this document is to describe the conditions within which oral health services can be provided during the New Zealand government COVID-19 Alert Level 3 to protect the safety of your patients, the community, yourself and staff.

The Alert Level system can be activated at a localised or regional level, or nationally. Follow the COVID-19 guideline relevant to the government's alert level applicable to the location in which you practise, and associated travel rules.

The COVID-19 alert settings, related risk assessments (such as the Ministry of Health's Higher Index of Suspicion), and infection prevention and control advice may change based on experiences, learnings and new evidence that becomes available. The Council will continue to work closely with the Ministry of Health, review and update the guidelines to reflect any changes, and inform practitioners of changes made.

### While we are in COVID-19 Alert Level 3

At COVID-19 alert level 3 with community transmission, the government stipulations are that people stay home and do not move about where possible. **Under level 3 you can provide oral health care for your patients that ensures a balance between patients' access to care and protecting public safety by limiting the opportunities for COVID-19 community spread. Please triage the patient by phone first.**

Patients are in either a low-medium or high risk category for care, depending on their responses to the risk assessment questions detailed on page 4.

For the moment, PPE requirements for fully vaccinated oral health practitioners and staff, and the risk assessment and patient management of fully vaccinated patients remain the same as those for unvaccinated people, until a larger proportion of the community has been fully vaccinated.

#### General comments on PPE

- The Guidelines for oral health services at COVID-19 Alert Level 3 should be read in conjunction with the existing [Infection prevention and control practice standard \(IPC\)](#). There have been no changes to the Council's 2016 IPC practice standard. This guideline sets out additional IPC measures that apply during COVID-19 Alert Level 3.
- All team members within the treatment room/area during treatment, must wear the appropriate PPE.
- All used PPE must be discarded as clinical waste (defined as controlled waste in the Council's infection prevention and control practice standard).
- Where a N95 or P2 particulate respirator is used, clinical staff and oral health practitioners must have received training in fit checking and undergo fit testing before use.
- A fit check should be done by the wearer every time. Fit testing must also be undertaken annually and when a different brand is introduced, and when there are significant changes to the wearer's facial features such as significant weight changes or dental work.
- Independent fit testers are available via: <https://nzohs.org.nz/commit2fit/>.
- Ministry of Health guidance on how to perform a fit check is included as Appendix 3. Further guidance on fit testing of N95 masks can be found [here](#).

## Assessing and managing patients

Provide oral health care for your patients that ensures a balance between patients' access to care and protecting public safety by limiting opportunities for COVID-19 community spread.

**Triage all patients by phone first.** If in your professional judgement you need to see the patient to effectively manage their dental condition, then determine the patient's risk category by asking the risk assessment questions (detailed on page 4), over the telephone.

You can see the patient if you can meet the room and PPE requirements. If you are unable to meet these requirements, and the patient requires care, then refer the patient to where they can receive this.

Schedule and manage the patient in a way that limits face-to-face interaction with others.

If over-the-counter or prescription medication is required, please note:

- Prescriptions can be sent to the pharmacy for collection without the patient presenting at the dental surgery.
- Where prescriptions are issued to suspected or COVID-positive patients, please ask the patient not to attend the pharmacy themselves to pick it up – they should send a family member or arrange delivery by the pharmacy (delivery may incur a cost).
- Follow the [rules for electronic prescriptions](#) to support virtual care in the community, published 2020.

## Risk assessment questions

Do you have a confirmed diagnosis of COVID-19?  
 Are you a probable COVID-19 case?  
 Are you required to self-isolate and/or waiting for COVID-19 test results?

YES to ANY

High risk patient

No to ALL

- Do you have new or worsening respiratory symptoms including one of the following: new or worsening cough, sneezing and runny nose, sore throat, fever, temporary loss of smell or altered sense of taste, shortness of breath?
- Do you have any of the less common symptoms, such as: diarrhoea, headache, muscle aches, nausea, vomiting, malaise, chest pain, abdominal pain, joint pain or confusion/irritability - where there is no other likely diagnosis?

No to ALL

Low – Medium risk patient

YES to ANY

In the 14 days before the start of your symptoms have you:

- had close contact\* with someone who is a probable or confirmed COVID-19 case?
- been in attendance at a current location of interest?
- travelled internationally (excluding travel by air from a country/area with which New Zealand has quarantine-free travel (QFT))?
- had direct contact with someone who has travelled overseas (excluding travel by air from a QFT country/area). This includes border staff, quarantine and isolation facility staff, and international aircraft and shipping vessel crew, except those who have travelled exclusively between New Zealand and QFT destinations?
- exited an MIQ facility (excluding recovered COVID-19 cases)?
- worked on an international aircraft or shipping vessel (excluding aircraft from a QFT country/area)?
- cleaned at an international airport or maritime port in areas/conveniences visited by international arrivals (excluding areas/conveniences for travellers by air from a QFT country/area)?
- worked in cold storage areas of facilities that receive imported chilled and frozen goods directly from an international or maritime port?
- travelled from an area with an evolving community outbreak (including in New Zealand and any other country/area with which New Zealand has QFT)?\*\*

Yes to ANY

High risk patient

No to ALL

Low – Medium risk patient

\* A close contact is defined in Appendix 2 of the guidelines

\*\* travel from an area with Alert level 3 or 4 restrictions

## Treatment requirements

### 1. Low-Medium risk patient

Apply standard precautions as per the [Infection Prevention and Control Practice Standard](#).

Treatment can be provided in a dental practice or wherever the patient is normally treated if the room and PPE requirements can be met.

#### **For non-aerosol generating procedures:**

Room requirements: Single room.

Minimum PPE required:

- Surgical mask (Level 2 at minimum, ideally Type IIR)<sup>1</sup>
- Eye protection (Any of the following: (1) safety glasses that have side vents; or (2) goggles; or (3) prescription glasses covered with full face shield/visor. Prescription glasses alone are not considered as eye protection)
- Gloves
- Outer protective clothing as per the IPC practice standard (for example a gown, or tunic over street clothing or uniform)<sup>2</sup>.

#### **For aerosol generating procedures:**

Room requirements: single room, door closed.

Follow the stand down time described on page 8 after completing the aerosol generating procedures, before cleaning.

Minimum PPE required:

- N95 or P2 particulate respirator (single use)<sup>3</sup>
- Eye protection (Full face shield/visor over any of the following (1) safety glasses that have side vents, or (2) goggles, or (3) prescription glasses).
- Gloves
- Long sleeve impervious gowns.<sup>4</sup>

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<sup>1</sup> Type IIR surgical masks has a liquid-repellent layer offering additional protection against particulate matter and infectious splashes, and prevents strike through of fluids greater than 120mmgh. Type IIR meets the EN14683 standards.

<sup>2</sup> Outer protective clothing is to be made from material that does not permit blood or other potentially infectious material to reach clothes or skin underneath. Change outer protective clothing: as soon as possible when visibly soiled or wet, and at least daily. If wearing long sleeved outer protective clothing, change at least between patients

<sup>3</sup> Respiratory protection can also be achieved using: full face reusable respirator, supplied air respirator (SAR), or powered air-purifying respirator (PAPR). Users should be trained how to don, use, doff and decontaminate these appropriately to prevent agent transfer

<sup>4</sup> Change at least between patients

When providing care for a low-medium risk patient (as defined on pages 4) that **will generate an aerosol**:

- Close the door wherever possible.
- Use measures aimed at reducing the extent and contamination of aerosol and splatter **wherever possible**.

For example, high volume evacuation systems (HVE), and use of dental dam\*.

The cumulative impact of using all these measures significantly decreases the amount of aerosol and the level of infectious agents contained within it. Ideally practitioners should use all three measures wherever possible.

This may mean involving a dental assistant when possible, to handle the HVE when aerosol is generated.

All rotary handpieces generate aerosols, regardless of whether the motor is electric or air-driven (with or without water). Other aerosol generating instruments commonly used in oral health care include ultrasonic and sonic scalers, triplex syringe, air-abrasion and air-

\*also commonly referred to as rubber dam

## 2. High risk patient

### For non-aerosol generating procedures:

Treatment can be provided in a dental practice or wherever the patient is normally treated if the room and PPE requirements can be met.

Room requirements: single room, door closed.

Minimum PPE required:

- N95 or P2 particulate respirator (single use) <sup>3,6</sup>
- Eye protection (Full face shield/visor **over any of the following** (1) safety glasses that have side vents, or (2) goggles, or (3) prescription glasses)
- Gloves
- Long sleeve impervious gowns<sup>4</sup>

### For aerosol generating procedures:

Room requirements: The patient should be treated in an Airborne Infection Isolation Room (AIIR).<sup>5</sup>

If an AIIR is not available, treat the patient in a single room with a door which should remain closed. This room should not be positively pressured to the outside corridor. A portable HEPA filtration unit, if available, may be used in this setting and it would provide an additional measure of infection prevention during the assessment and treatment of the patient.

Follow the stand down time described on page 8 after completing the aerosol generating procedures, before cleaning.

Minimum PPE required:

- N95 or P2 particulate respirator (single use) <sup>3,6</sup>
- Eye protection (Full face shield/visor over any of the following (1) safety glasses that have side vents, or (2) goggles, or (3) prescription glasses).
- Gloves
- Long sleeve impervious gown<sup>4</sup>.

Details on the patient and treatment risk profiles and the associated precautions are detailed in table form as Appendix 1.

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<sup>3</sup> Respiratory protection can also be achieved using: full face reusable respirator, supplied air respirator (SAR), or powered air-purifying respirator (PAPR). Users should be trained how to don, use, doff and decontaminate these appropriately to prevent agent transfer

<sup>4</sup> Change at least between patients

<sup>5</sup> An AIIR is a single-occupancy patient-care room, formerly, a negative pressure isolation room.  
<https://www.cdc.gov/infectioncontrol/guidelines/isolation/glossary.html>

<sup>6</sup> Aerosol generating procedures should be avoided where possible. If such a procedure is absolutely essential, appropriate PPE is required. This requirement is due to the prolonged nature of such procedures and the close proximity of the operator. These are distinctive features of the aerosol generating procedures used in clinical dentistry

## Post aerosol generating procedures stand down time before cleaning – for all risk groups

Aerosol Generating Procedures (AGPs) can promote the generation of small particles (<5 µm). These fine particles remain suspended in the air for longer periods than larger particles and can be inhaled resulting in a risk of airborne transmission.

A stand down period after AGPs, before cleaning, is therefore required as specified below.<sup>7</sup>

Air changes per hour (ACH)	1-5 or unknown	6-9		≥ 10
Stand down period after AGPs ( <b>room remains closed with no staff in room</b> ) before cleaning	<ul style="list-style-type: none"> <li>Standard: 30 minutes*</li> <li>High volume evacuation (HVE) used: 25 minutes</li> <li>HVE &amp; dental dam used: 20 minutes</li> </ul> <p>*When ventilation is poor (e.g. 1-2 ACH) or ACH is unknown, use of high volume suction is considered essential. If this is not possible, a stand down period of up to 60 minutes should be considered, or an alternative procedure adopted.</p>	<ul style="list-style-type: none"> <li>Standard: 20 minutes</li> <li>HVE used: 15 minutes</li> <li>HVE &amp; dental dam used: 10 minutes</li> </ul>	<ul style="list-style-type: none"> <li></li> </ul>	<ul style="list-style-type: none"> <li>Standard: 15 minutes</li> <li>HVE and/or dental dam used: 10 minutes</li> </ul>

<sup>7</sup> Adapted from NHS COVID-19 Infection prevention and control dental appendix. Available on: <https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/covid-19-infection-prevention-and-control-dental-appendix#post-agp-downtime>



## Steps to limit transmission for all patients

### Waiting areas

- Avoid the use of waiting room and reception area where possible. Encourage direct patient entry into the treatment room.
- Remove all unnecessary items from the waiting room, such as magazines and toys, and keep surfaces clear and clean.
- Clean surfaces and high-touch surfaces (door handles, chair arms, reception counter etc.) regularly with a detergent with water or ready detergent wipes.
- Areas of known contamination should be cleaned and disinfected as described in the Dental Council's Transmission Based Precautions – Cleaning section contained in the [Infection Prevention and Control Practice Standard](#).

### Contact tracing

- Establish and maintain a contact register for all people entering the practice including date and time of entry and exit, and the person's phone and email details, to enable contact tracing.
- Practices must prominently display the New Zealand COVID Tracer QR code at the entrance of the facility, and people must scan in or register their contact details.

### Patient scheduling and management

- Assess patients for any COVID-19 symptoms before scheduling and confirm the risk assessment is unchanged when they arrive for their appointment; similarly, for a support person that may be attending.
- Ask patients to arrive as close as possible to their appointment time.
- Patients must wear a face covering/mask on entering the practice (provided it can be tolerated) and only remove it once they are in the treatment room. The face covering/mask should be put back on and worn until they exit the dental practice/facility.
- If the patient is not wearing a face covering/mask on arrival, immediately offer them a mask before they enter the practice.
- Limit points of entry to the facility.
- Post visual alerts (e.g., signs, posters) at the entrance and in strategic places (e.g. waiting areas, elevators) to provide patients and healthcare practitioners with instructions (in appropriate languages) about hand hygiene, respiratory hygiene, and cough etiquette.

Instructions should include how to cough into the crook of your elbow or to use tissues to cover nose and mouth when coughing or sneezing, to dispose of tissues and contaminated items in lined, no-touch waste receptacles, and how and when to perform hand hygiene.

- Provide supplies for respiratory hygiene and cough etiquette, including alcohol-based hand rub (ABHR) containing at least 60% alcohol, tissues, and lined, no-touch receptacles for disposal, at healthcare facility entrances, waiting rooms, and patient check-ins.

- Request patients to wash their hands (where facilities allow) or 'hand sanitise' on arrival and departure from the clinic.
- All staff members must wear a surgical mask when in the practice and not engaged in clinical activity (additional PPE requirements apply when providing patient care).
- Practise 2 metre physical distancing wherever possible and practical (between staff; between staff and patients; and patients and patients).

### **During the visit**

- Limit the number of support people in the treatment area to one. Offer the support person a surgical mask instead of their own mask/face covering.
- When generating aerosol support people should be out of the room, when possible.
- If this is not possible, explain the risk of remaining in the room during the treatment to the support person. If they stay and the support person is in the same "bubble" as the patient, the support person does not require PPE additional to a surgical mask (e.g. parent and child). If the support person is not in the same "bubble" as the patient provide them with the same PPE as the clinical staff in the room.
- If when providing care the planned treatment changes so that different room and PPE requirements are needed, stop treatment until the necessary PPE and room requirements are in place.
- If the patient wants to keep their extracted tooth, clean and disinfect the tooth.

### **Hand hygiene**

- All clinical team members should perform hand hygiene before and after all patient contact, and contact with potentially infectious material, and before putting on and after removing PPE, including gloves. Hand hygiene after removing PPE is particularly important to remove any pathogens that might have been transferred to bare hands during the removal process.
- Clinical team members should perform hand hygiene by using ABHR containing a minimum of 60% alcohol or washing hands with soap and water for at least 20 seconds. If hands are visibly soiled, use soap and water before returning to ABHR.
- Hand hygiene supplies should be readily available to all personnel in every care location.
- Hand hygiene should be performed after going to the bathroom, before preparing and eating food, and after coughing and sneezing.

### **Personal protective equipment**

- Select appropriate PPE in accordance with the PPE requirements specified in this document, at minimum.
- Do not wear your outer protective wear, like scrubs/gown/tunic outside of the practice setting.
- Oral healthcare practitioners must have received training on and demonstrate an understanding of:
  - when to use PPE

- what PPE is necessary
- how to properly don, use, and doff PPE in a manner to prevent self-contamination
- how to properly dispose of or disinfect and maintain PPE.

This is of particular importance for staff members not usually wearing PPE, or introducing new types of PPE into the practice, such as an N95 mask or PAPR.

- Any reusable PPE must be properly cleaned, decontaminated, and maintained after and between uses.
- Oral health practitioners using N95 or P2 particulate respirators or equivalent, must have received pre-requisite fit testing and fit checking prior to use.

### **Team management**

- If team members are unwell, they should stay home.
- Consider introducing or continue measures to monitor your own health and that of your team.
- Consider organising team members so that they work within a team 'bubble' when delivering clinical care, to limit the number of potential close contacts between clinical team members and to make tracing of team members to patients simpler.
- Limit your social interaction outside of work as much as possible; and suggest clinical team members (including those with decontamination duties) do the same.
- Ensure your team members understand the risks associated with dental practice during COVID-19 Alert Levels, and the measures you are taking to mitigate these risks.

### **Cleaning and decontamination for low-medium risk patients**

- Appropriate PPE should be worn for cleaning and disinfecting the room. At minimum wear outer protective clothing as per the IPC practice standard, gloves, surgical mask and protective eyewear.
- Clean work and equipment surfaces in the same way as usual; in accordance with the requirements of the Council's Infection prevention and control practice standard.
- Remove and discard PPE as clinical waste (taken off in the following order: gloves, hand hygiene, gown or plastic apron – if used, hand hygiene, protective eyewear (if separate from mask), hand hygiene, mask, hand hygiene).<sup>8</sup>
- Clean and disinfect re-usable PPE as per the manufacturer's instructions.

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<sup>8</sup> <https://www.health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-novel-coronavirus-information-specific-audiences/general-cleaning-information-following-suspected-probable-or-confirmed-case-covid-19>

## Dental appliances

- A clinical dental technician or dental technician will clean and disinfect a patient's dental appliance before making a repair or modification to it, and after completing the work.
- When cleaning and disinfecting a patient's dental appliance, and repairing or modifying the appliance, the following minimum PPE is required:
  - Surgical mask (Level 2 or above)
  - Eye protection (full face shield/visor with glasses, or goggles)
  - Gloves<sup>9</sup>
  - Outer protective clothing as per the IPC practice standard.
- If the patient enters the laboratory, the room and PPE requirements described in the *Patient and treatment risk profile* tables must be met.

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<sup>9</sup> Gloves should at minimum be worn during cleaning and disinfecting the dental appliance before and after repair/modification to it

## Additional steps to limit transmission for high risk patients

**For high risk patients**, additional steps should be taken to limit the risk of transmission.

To minimise risk practitioners must:

- encourage patient respiratory hygiene by providing a facemask, tissues, and ability to wash their hands or use hand sanitiser containing at least 60% alcohol
- isolate symptomatic patients as soon as possible. Place patients with suspected or confirmed COVID-19 in private rooms with door closed and private bathroom (where possible)
- protect healthcare personnel
- emphasise hand hygiene
- limit the number of staff providing their care.

### During treatment

- For high risk patients when possible, no support people should be in the treatment room. If necessary, limit to one support person and provide them with the same PPE as the clinical staff in the room.
- **Limit aerosol-generating procedures where possible.** All rotary handpieces generate aerosols, regardless of whether the motor is electric or air-driven (with or without water). Other aerosol generating instruments commonly used in oral health care include ultrasonic and sonic scalers, triplex syringe, air-abrasion and air-polishing etc. Follow the PPE and room requirements for aerosol generating procedures.
- When aerosol-generating procedures are required:
  - wear at minimum an N95 or P2 particulate respirator\*, a long-sleeved impervious gown, and eye protection as specified.
  - use measures aimed at reducing the extent of aerosol and splatter as appropriate, for example, high volume evacuation systems and use of dental dam\*\*.
  - Preferably use a slow speed handpiece\*\*\*, and where possible, turn the chip air off, to minimise the aerosol generated during the procedure.
  - Observe the relevant stand down time before cleaning specified on page 8.

\* Respiratory protection can also be achieved using: full face reusable respirator, supplied air respirator (SAR), or powered air-purifying respirator (PAPR). Users should be trained how to don, use, doff and decontaminate these appropriately to prevent agent transfer.

\*\* Also commonly referred to as rubber dam.

\*\*\* A slow speed handpiece that operates at  $\leq 40,000$  rpm is preferable.

### Cleaning and decontamination

- Appropriate PPE should be worn for cleaning down the room. PPE should take into consideration manufacturer's recommendations for product use. At minimum wear outer protective clothing as per the IPC practice standard, gloves, surgical mask and protective eyewear.
- Wipe down hard surfaces using a two-step process: with detergent and water, then hospital grade disinfectant<sup>10</sup> with activity against respiratory virus, including COVID-19.
- After treating a high risk patient when aerosol generating procedures have occurred, follow the stand down period as defined on page 11, before cleaning.

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<sup>10</sup> Based on current available literature - inactivation of COVID-19 on surfaces within 1 minute by using 62-71% ethanol, 0.5% hydrogen peroxide or 0.1% sodium hypochlorite

- Remove any linen that has been used into linen bags for hot washing.
- Remove and discard PPE as clinical waste (taken off in the following order: gloves, hand hygiene, gown or plastic apron if used, hand hygiene, protective eyewear (if separate from mask), hand hygiene, mask, hand hygiene).<sup>11</sup>
- Perform hand hygiene thoroughly to elbows.
- Clean and disinfect re-usable PPE as per the manufacturer's instructions.

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<sup>11</sup> <https://www.health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-novel-coronavirus-information-specific-audiences/general-cleaning-information-following-suspected-probable-or-confirmed-case-covid-19>

Risk assessment	Low-Medium risk patient		High risk patient	
	Non-aerosol generating procedures:	Aerosol generating procedures:	Non-aerosol generating procedures:	Aerosol generating procedures:
PPE	<ul style="list-style-type: none"> <li>Surgical mask (Level 2 at minimum, ideally Type IIR)<sup>1</sup></li> <li>Eye protection<sup>2</sup></li> <li>Gloves</li> <li>Outer protective clothing as per the IPC practice standard<sup>3</sup></li> </ul>	<ul style="list-style-type: none"> <li>N95 or FFP2 mask (single use)<sup>4</sup></li> <li>Eye protection<sup>5</sup></li> <li>Gloves</li> <li>Long sleeved impervious gowns<sup>6</sup></li> </ul>	<ul style="list-style-type: none"> <li>N95 or FFP2 mask (single use)<sup>4,7</sup></li> <li>Eye protection<sup>5</sup></li> <li>Gloves</li> <li>Long sleeved impervious gowns<sup>6</sup></li> </ul>	<ul style="list-style-type: none"> <li>N95 or FFP2 mask (single use)<sup>4,7</sup></li> <li>Eye protection<sup>5</sup></li> <li>Gloves</li> <li>Long sleeved impervious gowns<sup>6</sup></li> </ul>

<sup>1</sup> Type IIR surgical masks has a liquid-repellent layer offering additional protection against particulate matter and infectious splashes, and prevents strike through of fluids greater than 120mmgh. Type IIR meets the EN14683 standards

<sup>2</sup> Safety glasses that have side vents; or goggles; or prescription glasses covered with a full face shield/visor

<sup>3</sup> Outer protective clothing is to be made from material that does not permit blood or other potentially infectious material to reach clothes or skin underneath. Change outer protective clothing: as soon as possible when visibly soiled or wet, and at least daily. If wearing long sleeved outer protective clothing, change at least between patients.

<sup>4</sup> Respiratory protection can also be achieved using: full face reusable respirator, supplied air respirator (SAR), powered air-purifying respirator (PAPR), or FFP3 respirators. Users should be trained how to don, use, doff and decontaminate these appropriately to prevent agent transfer

<sup>5</sup> Full face shield/visor **over any of the following** <sup>(1)</sup> safety glasses, or <sup>(2)</sup> goggles, or <sup>(3)</sup> prescription glasses

<sup>6</sup> Change at least between patients

<sup>7</sup> Aerosol generating procedures should be avoided where possible. If such a procedure is absolutely essential, appropriate PPE is required. This requirement is due to the prolonged nature of such procedures and the close proximity of the operator. These are distinctive features of the aerosol generating procedures used in clinical dentistry

Room requirements	<ul style="list-style-type: none"> <li>• Single room</li> </ul>	<ul style="list-style-type: none"> <li>• Single room</li> <li>• Door closed</li> </ul>	<ul style="list-style-type: none"> <li>• Single room</li> <li>• Door closed</li> </ul>	<p>The patient should be treated in an Airborne Infection Isolation Room (AIIR).<sup>8</sup></p> <p>If an AIIR is not available, treat the patient in a single room with a door which should remain closed. This room should not be positively pressured to the outside corridor.</p> <p>A portable HEPA filtration unit, if available, may be used in this setting and it would provide an additional measure of infection prevention during the assessment and treatment of the patient.</p> <p>Follow the stand down time described on page 8 after completing the aerosol generating procedures, before cleaning.</p>
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<sup>8</sup> An AIIR is a single-occupancy patient-care room, formerly, a negative pressure isolation room. <https://www.cdc.gov/infectioncontrol/guidelines/isolation/glossary.html>



### Close contact definition

Assessment of 'close contact' involves a public health risk assessment that considers multiple factors\*, usually by a public health unit team led by a medical officer of health.

A person may be considered a close contact if they have exposure to the same air as a confirmed (or probable) case during the case's infectious period that is assessed as significant, without appropriate personal protective equipment (PPE). Exposure to the same air may include those in a setting immediately after the case, as well as while the case was present. Face-to-face exposure in an enclosed environment that is more than fleeting, and face-to-face contact outdoors within 2 metres for more than 15 minutes, will usually be considered close contact.

In addition, any person with the following exposure will usually be considered a close contact:

- direct contact with the bodily fluids or the laboratory specimens of a case
- living in the same household or household-like setting (e.g., shared section of in a hostel) with a case
- having been seated on an aircraft within 2 metres of a case (for economy class this would mean 2 seats in any direction including seats across the aisle, other classes would require further assessment)
- aircraft crew exposed to a case (a risk assessment conducted by the public health unit in collaboration with the airline is required to identify which crew should be managed as close contacts).

\*Factors that contribute to the public health risk assessment of the level of exposure include (but are not limited to) those related to:

- setting: duration, proximity, ventilation (e.g., indoor/outdoor, ventilation system, airflow), crowding/ability to physical distance, length of time, type of activity (e.g. eating/drinking, singing, shouting, talking, exercising)
- case: infectiousness, level of symptoms, face coverings, hand hygiene, age (e.g., child vs adult)
- contact: mitigating features (all wearing face coverings correctly, using hand sanitizer, vaccination status)

### Criteria to be considered recovered from COVID-19

A person with mild to moderate disease is considered recovered from COVID-19 infection when they meet all of the following criteria:

- It has been at least 14 days since the onset of the COVID-19 symptoms
- They have been symptom-free for at least 72 hours
- They have been cleared by the health professional responsible for their monitoring<sup>1</sup>.

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<sup>1</sup> <https://www.health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-current-situation/covid-19-current-cases>

Normal risk classification applies (low, high) when considering care for these patients.

Different criteria are used to decide when a person who has been hospitalised with COVID – 19 can be considered recovered.

### Ministry of Health guidance on how to perform a fit check (also called user-seal check)

1. Place the P2/N95 particulate respirator on your face.
  2. Place the headband or ties over your head and at the base of your neck.
  3. Compress the particulate respirator to ensure a seal across your face, cheeks and the bridge of your nose.
  4. Check the positive pressure seal of the respirator by gently exhaling. If air escapes, the respirator needs to be adjusted.
  5. Check the negative pressure seal of the respirator by gently inhaling. If the respirator is not drawn in towards your face, or air leaks around the face seal, readjust the respirator and repeat process, or check for defects in the respirator.
  6. Always refer to the manufacturer's instructions for fit checking of individual brands and types of P2/N95 respirators.
  7. If you are unable to achieve a good facial seal do not proceed with the activity. Possible reasons include:
    - the respirator has not been put on properly e.g. headbands are incorrectly positioned, hair or earrings are caught in the seal
    - the respirator is the incorrect size or type for your face
    - facial hair\* (including a 1–2-day beard growth can interfere with an adequate seal)
- If you cannot achieve a good facial seal after working through the possible reasons listed, speak to your team leader. An alternative style or size of respirator may need to be sourced.
8. To prevent failure of the respirator, once you have the respirator in the correct place and have achieved a good seal, do not touch the front of the mask or re-adjust it.

Further information on the different masks and how to use safely see: [role of masks and respirators in health and disability care settings](#).

## Changes between 20 September 2021 and 27 August 2021 versions

20 September 2021 version	
p2	Context extended to allow for provision of all oral health care under alert level 3
p3	Updates to assessing and managing patients' section to reflect extended provision of oral health care
p4	Updated patient risk assessment questions to link higher index of suspicion criteria to COVID-19 symptoms, and alignment of wording to MOH criteria  Updated COVID-19 respiratory and less common symptoms  Decrease of risk categories from three to two patient risk categories – being low-medium and high risk categories
p5	Surgical mask requirements for low-medium risk patients undergoing non-aerosol procedures change to Level 2 at minimum, <b>ideally type IIR</b>  Type IIR surgical masks has a liquid-repellent layer offering additional protection against particulate matter and infectious splashes, and prevents strike through of fluids greater than 120mmgh. Type IIR meets the EN14683 standards.
p10	All staff members must wear a surgical mask when in the practice and not engaged in clinical activity (additional PPE requirements apply when providing patient care).
pp11&13	Removal of gown requirement for cleaning and decontamination – outer protective wear still required as per the IPC practice standard
p17	Definition of close contact and criteria for recovery updated