Consultation on proposed supplement to the IPC practice standard:

Supplementary risk management principles for oral health during the COVID-19 pandemic

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Dental Council
Te Kaunihera Tiaki Niho

Introduction

Since early 2020, the Dental Council and Ministry of Health (the Ministry) have issued joint COVID-19 guidelines for oral health services at each of the four alert levels.

The government recently announced its plan to move from the alert level system to the COVID-19 protection framework, (also known as the "traffic light system") which primarily manages the movement of people depending on the level of COVID-19 community transmission, pressure on hospitalisation levels, and vaccination status.

This presents an opportunity to consider the infection control measures used currently in oral health practice to reduce the risk of COVID-19 transmission.

The Council notes the following:

- under the new protection framework, health services will continue to be provided at all times – including oral health services
- the Government anticipates that COVID-19 community transmission will increase throughout Aotearoa New Zealand following the move, but with the benefit of a highly vaccinated population
- oral health practitioners have a responsibility to limit the risk of widespread COVID-19 transmission when providing oral health services
- mitigating the risk of COVID-19 transmission when providing oral health services has specific challenges, due to the closeness of oral health care, duration of interaction, and inability for patients to wear a mask during care
- ongoing access to oral health care and clinical educational opportunities for our future workforce are critical, given that COVID-19 cases will remain in the community for some time to come.

Within this context, the Council considers it timely to change its approach.

The Council has critically reflected on control measures currently used to limit COVID-19 transmission in the oral health setting, new information that has become available, and international experiences and learnings to date.

The objectives of the review are to:

- simplify and streamline the guidelines, and leverage off the existing infection prevention and control (IPC) practice standard
- limit the level and frequency of ongoing changes required
- continue to keep the public, practitioners and their staff safe – by following a risk-based, scientific and evidence informed approach.

Proposals

The Council proposes to publish standards specific to COVID-19 as a supplement to the IPC practice standard, titled: *Supplementary risk management principles for oral health during the COVID-19 pandemic (Attachment 1)*.

As previously signalled to practitioners, the Council is exploring potential minimum requirements on ventilation and air purifying. At this point, no mandatory requirements are proposed, but guiding

principles are included for consideration. If Council proposes specific changes to ventilation and air purifying requirements in the future, these will be the subject of a separate consultation.

Given the priority and immediate focus for practitioners to provide care within the COVID-19 environment, other identified changes to the IPC practice standard are on hold, for consultation at a later stage.

Key changes

The new proposed *Supplementary risk management principles for oral health during the COVID-19 pandemic:*

- will replace all current and previous COVID-19 alert level guidelines issued to date
- will be provided as a supplement to the IPC practice standard
- includes:
    - an updated patient screening tool
    - the risk-based precautions to be followed for each patient risk category during the COVID-19 pandemic
    - other steps to mitigate the risk of transmission of COVID-19
- may require updating from time-to-time if significant changes impact the risk management approach to COVID-19 but hopefully less frequently. The Council will not necessarily consult on minor updates required, or changes based on further or new Government requirements.

Patient screening

Screening patients to assess their COVID-19 risk will continue to be a significant factor in mitigating COVID-19 risk in the dental setting.

The risk assessment questions have been simplified, and questions are now limited to a positive or suspected status, self-isolation, symptoms, and vaccination status.

The assessment has three patient risk categories:

- low risk – patients who answer “no” to all screening questions and are vaccinated
- medium risk – patients who answer “no” to all screening questions and are unvaccinated or whose vaccination status is unknown
- high risk – patients who answer “yes” to any screening question, who is confirmed or suspected to have COVID-19.

A patient who presents with a negative PCR test result within 72 hours of appointment **without** any symptoms is considered a low-risk patient.

Please note: testing or vaccination are **not** requirements that patients need to meet to access oral health care.

The Council has an expectation that oral health practitioners will not refuse to treat those who are unvaccinated. Under the Code of Health and Disability Service Consumers’ Rights, patients have the right to freedom from discrimination, to be treated with respect, and the right to services of an appropriate standard.

As with every health care interaction, practitioners need to assess the risk to their own, and to their staff's safety, and implement appropriate evidence-based measures commensurate with the level of that risk.

Vaccination status is one of many risk factors for infection and transmission. This standard provides for the delivery of care to both vaccinated and unvaccinated patients with risk mitigations.

Aerosol generating procedures (AGPs)

Emerging evidence and a more generally held view among scientists indicate that the risk attached to dental APGs has been disproportionately high. In addition, there is increasing recognition that aerosol generating behaviours (AG-Bs), such as coughing and sneezing, pose a risk equal to or greater than certain AGPs, if the patient is infected with COVID-19.

Within this context, it is the Council's view that the patient's COVID-19 risk status is the more important consideration in determining appropriate infection control measures, rather than the type of procedure performed (AGPs vs non-AGPs).

This view is reflected in the draft supplement, with:

- no differentiation in PPE requirements based on the use of AGPs
- stand down times are only required for moderate and high-risk patients, irrespective of the care provided. This means that stand down times are no longer linked to AGPs, but linked to the individual patient risk.

PPE

The PPE changes are informed by a greater understanding of the spread of the COVID-19 virus - such as lower risk of fomite transmission than previously thought, research and papers, international experience, ongoing supply chain demands, and recognition of the ongoing, significant increase in waste being generated.

The proposed PPE requirements are set out in Figure 1 below.

Figure1: PPE requirements

	Low risk of transmission Patient has no clinical or epidemiological risk factors for COVID-19 and is vaccinated OR Patient presents with a negative PCR test result within 72 hours of appointment without any symptoms	Moderate risk of transmission Patient has no known clinical or COVID-19 epidemiological risk factors, but there is no evidence that the patient is fully vaccinated	High risk of transmission Patient is confirmed or suspected to have COVID-19, or to have clinical and/or epidemiological risk
	Standard requirement	Standard requirement	Standard requirement
	Standard requirement [1]	Standard requirement [1]	Long sleeve, fluid resistant gown
	• Safety glasses that have side protection, or • Goggles, or • Full face shield	• Safety glasses that have side protection, or • Goggles, or • Full face shield	• Safety glasses that have side protection, or • Goggles, or • Full face shield
	At minimum, medical/surgical mask Level IIR	P2/N95 [2,3]	P2/N95 (single use) [2]

[1] This means the outer protective clothing you normally wear (gown, scrubs, tunics etc.). It can be short sleeve or long sleeve. When long sleeve, change between patients. When short sleeve, change between patients OR alternatively wear a plastic apron over it and change the apron between patients. Ensure proper cleaning of the forearm up to the elbow when performing hand hygiene when short sleeve is worn.

[2] Fit tested, and fit checked at the time of use. Respiratory protection can also be achieved using: half or full-face reusable respirator with P2 filter, supplied air respirator (SAR), or powered air-purifying respirator (PAPR). If P2/N95 is not available due to supply shortages, you can use KN95 purchased only from reputable medical suppliers – be aware of counterfeit products which will provide insufficient respiratory protection.

[3] Disposable respirators can be used during a session, up to 4 hours – and must be changed when visibly dirty, damaged, or wet.

Key changes to PPE requirements are:

- A change from *impervious* gowns to *fluid resistant* gowns. This means that practitioners may use launderable fluid resistant gowns.
- For low and moderate risk patients, practitioners have the option of wearing a long sleeve or short sleeve gown[4].

  When long sleeve gowns are used, change between patients.

  When short sleeve gowns are used:

  - change between patients OR alternatively wear a plastic apron over the short sleeve gown and change the apron between patients
  - proper cleaning of the forearm up to the elbow is essential to protect yourself and the patient.
- It is no longer a requirement to use a face shield/visor over the protective eyewear (additional eye protection still required over prescription glasses).
- P2/N95 respirators:
  - P2/N95 no longer required for low risk patients. At minimum, a medical/surgical mask Level IIR required.
  - P2/N95 no longer single use for moderate risk patients. Sessional use up to 4 hours allowed. Change earlier when visibly dirty, damaged or wet.
  - In response to frequently asked questions by practitioners, further clarification on alternative respirators is provided in footnote 2 to the Figure 1.

Room requirements

Room requirements mostly remain unchanged in the proposed supplement to the IPC standard, except for the following.

Multi chair clinics

The Council recognises that the room and stand down requirements cannot be met for moderate and high-risk patients for more than one patient at a time. This creates a barrier to accessing care, in particular for patients under 12 years of age who are currently ineligible for vaccination. It is anticipated that vaccination of children between 5-12 years will commence soon in Aotearoa New Zealand.

The Council explored a pragmatic solution to facilitate access to care, whilst proposing attainable protective measures.

To alleviate this, for MODERATE risk patients under 12 years of age for multi chair clinics ONLY the following requirements will apply:

a. A multi chair clinic can be used as long as enough space is maintained in the clinic so that patients and their support person are able to maintain a distance of at least 2 metres from others when entering and exiting the clinic.

b. Support people are low risk.

c. Stand down times do not apply.

[4] This means the outer protective clothing you normally wear - gown, scrubs, tunics etc.

d. Rooms with **up to four chairs**, at minimum:

- investigate options for improving ventilation, and as an additional infection prevention and control measure consider the use of multiple portable HEPA filtration + UV-C units spread throughout the room (with airstream entering filter first). Seek technical advice on the most beneficial use of these units, and any improvements in ventilation that can be made.

e. Rooms with **more than four chairs**, at minimum:

- consult with a ventilation expert to maximise air circulation, direct airflow away from other pods as much as possible, and explore air purification.
- explore whether dividers (up to 2m in height) to create pods of up to four chairs, are suitable and provide additional protection to others, within your specific environment.

Multi chair clinics treating moderate risk patients over the age of 12, must meet the room and stand down requirements as defined in the supplementary COVID-19 standard. The reasons being that the majority of these patients have the ability to be vaccinated, or get a negative PCR test before treatment.

Ventilation and air purifying

The Council engaged Jacksons Engineering to develop draft proposals/positions on potential ventilation and air purifying options for dental practices. The Council also discussed and gauged the views of other scientific/academic experts[5] on the potential transmission risks within dental practices.

At this point, the Council is providing preliminary guidance principles to support those who want to progress improvements in their practice ventilation and air quality.

The Council will continue to work with its subject-matter experts and others to develop a deeper understanding, gather more information, and validate the current working proposals before making a final decision.

The Council is also aware of work by the Ministry and other government agencies on ventilation standards across the health sector and will continue to explore opportunities for collaboration and sharing of insights and information.

The Council is signalling now that it considers there is a need for a minimum ventilation standard for dental practices. As noted above, should Council propose specific measures, these will be the subject of a separate consultation in the future.

Acknowledgement

The Council wants to thank the clinical advisory group for their contribution in developing proposals for its consideration.

Other subject-matter experts who provided the Council with advice:

- Prof Jonathan Reid – University of Bristol UK
- Mr Mark Gormley – University of Bristol UK
- Jacksons Engineering – Lance Jimmieson, Kevin O'Connor
- Jeremy Tuohy – the Ministry science advisor.

[5] Bristol University, UK – leads in AERATOR study, NZ Ministry of Health science advisor

A reference list of resources considered during the recent review process is attached (*Attachment 2*).

Consultation question

Please provide your feedback by responding to the following question.

1. Do you support the proposed *Supplementary risk management principles for oral health during the COVID-19 pandemic*? If you do not support the draft, please share your concerns, reasons for your view, and proposed alternatives if you have any.