ADA COVID-19 Risk Management Guidance

Last updated 4 August 2020

The following information is provided as an update to the ***ADA Managing COVID-19 Guidelines*** document released in March 2020, to provide updated risk management guidance to dental practitioners. This document should be used in conjunction with the following documents:

- *ADA Dental Service Restrictions in COVID-19*
- *Level 1 Decision Tree*
- *Level 2 Decision Tree*
- *Level 3 Decision Tree (new)*
- *Transmission Based Precautions*
- *Environmental Cleaning and Disinfection Guidance in the context of COVID-19 (new)*

All of these documents and other resources are available on the ADA's COVID-19 microsite.

Risk Assessment

Assessment of risk remains a key responsibility of dental practitioners providing care during ongoing concerns about COVID-19 transmission. Information on case definitions and local considerations that may guide screening questions specific to each State and Territory are available from the Australian Government Department of Health.

In addition, it is imperative that dental practices incorporate risk assessment and mitigation processes for the provision of clinical dentistry, **especially in areas where COVID-19 community transmission exists**, and ensure that all staff have completed infection prevention and control training and are familiar with standard and transmission-based precautions, including the use of personal protective equipment.

The majority of dental services (general and specialist) are provided in an office-based clinical setting in private practices. Public dental services are subject to guidance from State and Territory Health departments.

If a patient or dental team member is diagnosed with COVID-19 after treatment is provided, subsequent management of the dental practice including the need for COVID-19 testing will be under the direction and advice of the state/territory communicable diseases branch, as part of the contact tracing process.

Based on the level of dental service restrictions in place, it may be appropriate to defer certain types of treatment, such as **non-urgent** treatment or **aerosol generating procedures** (AGPs[1]). State and Territory Governments will advise what stage of restrictions is in place. ADA Branches may also advise members about dental service restrictions' recommendations based on local conditions as they emerge. Dental service restriction levels are detailed in the *ADA Service Restrictions in Covid-19* document.

Decision Tree documents have been provided by the ADA to assist practitioners to decide what level of infection control precautions to use, based on whether a patient is considered as low, moderate or high risk or confirmed with COVID-19.

The ADA Transmission-based Precautions document outlines the step-by-step processes involved in providing dental treatment using droplet precautions for patients considered to be suspect or probable for COVID-19. Further information on transmission based precautions is detailed in the Australian Dental Association Guidelines for Infection Control (2015) and the NHMRC Australian Guidelines for the Prevention and Control of Infection in Healthcare (2019).

The Infection Control Expert Group has recommended that healthcare workers who have direct contact with patients in geographic areas with significant community transmission of COVID-19:

- Avoid performing unnecessary AGPs if possible.
- If an AGP is required, contact and airborne precautions with eye protection be used. This includes the use of a particulate filter respirator (P2 or N95) or equivalent instead of a surgical mask.
- Health care workers who use P2 or N95 respirators should be trained in their correct use, including how to perform fit-checking and safe removal.
- Unless P2 or N95 respirators are used correctly, protection against airborne pathogen transmission will be compromised.
- Following an AGP, the room should remain vacant for at least 30 minutes.

As full airborne transmission-based precautions can not be achieved without a negative pressure room, patients confirmed as COVID-19 positive, should NOT be treated in office-based practice,

P2/N95 respirators are required in the context of AGPs in areas with community transmission, in the absence of dental dam, or when patients have clinical risk factors for COVID-19. More information is available here.

[1] *Aerosol Generating Procedures (AGPs) in dentistry include procedures that use any of the following devices: high speed handpieces, low speed/prophy handpieces, surgical handpieces, ultrasonic and sonic devices, air polishing devices, and hard tissue lasers. The triplex when air and water are used together or when used with air on a wet surface is considered an AGP.*

General principles for infection control measures in the context of COVID-19:

Appointment provision

- Develop a system prior to patient attendance (e.g. a phone call, SMS) to pre-screen patients for risk criteria. Where risk criteria are identified, systems should be in place to manage patients appropriately, including appointing an appropriate person (e.g. a senior clinician) to assess whether it is appropriate to provide treatment and if so, what additional patient management and infection control processes may be required.
- Consider alternative/virtual models of care such as the use of telemedicine technology (where appropriate), especially for people who are vulnerable to severe illness such as elderly or immunocompromised people.
- Consider varying/staggering appointment times to allow for infection control measures and physical distancing to be achieved.
- Request that patients attend alone or only bring 1 support person to minimise the number of people in the waiting area.
- Consideration should be given to patients who may be poor historians and may not have the capacity to answer COVID-19 screening or risk assessment questions accurately.

Attending the dental practice

- Use signage at the practice entrance asking patients not to enter if they are unwell or have COVID-19 symptoms, have been tested for COVID-19 and are awaiting test results, have been in contact with anyone diagnosed with COVID-19, or have returned from interstate or travelled to an area identified as high risk for community transmission, in the last 14 days.
- Screen patients for symptoms at entry to the facility and as part of routine clinical assessment. Anyone who is symptomatic should be advised to access testing at an appropriate location. Patients who are referred for testing and/or awaiting test results should have their appointment delayed or conducted via an alternative method (e.g. telemedicine) unless clinical urgency dictates otherwise.

In the waiting room

- Use signage in the waiting area reminding patients of the need for physical distancing and introduce measures to encourage physical distancing to ensure 1.5 metres of space between people where appropriate. This may include giving patients the option to wait in their vehicle if practical. Household members who are normally in close contact should be permitted to sit together.

- Use signage in the waiting area to remind patients to practice hand and respiratory hygiene
- Provide facilities to enable hand and respiratory hygiene such as availability of alcohol based hand rub (ABHR), hand washing facilities and tissues, and ensure all patients undertake ABHR prior to sitting in the waiting area.
- Ensure that all high touch, unnecessary items in communal areas e.g. toys and magazines are removed
- Identify the surfaces that will predictably be touched often by patients, so that these can be subjected to frequent environmental cleaning.

In the dental surgery

- Ensure all patients undertake a pre-procedural mouthrinse for 20 seconds before commencing treatment using either 1% hydrogen peroxide, 0.2% povidone iodine, 0.2% chlorhexidine, or essential oil mouthrinse.

    - If patients are unable to undertake a pre-procedural mouthrinse, consider providing a topical "mouth toilet' with gauze soaked in mouthrinse, focussing on wiping the buccal mucosa and dorsal tongue surface.

    - If emergency treatment is required for a patient who refuses a pre-procedural mouth rinse, other protective measures may be required as an alternative. In this instance, dentists who decide to proceed without using a pre-procedural mouthwash should document their reasons for doing so and only undertake more urgent treatment under rubber dam if possible and using supplementary PPE for all staff members involved[2].

- Consider strategies to mitigate the risk of contact transmission of pathogens by limiting patients putting fingers in their mouth to point out areas of concern, or insertion and removal of prostheses

- Consider strategies to mitigate the risk of transmission of pathogens in droplets and aerosols including:
    - The use of high volume evacuation and dental dam wherever possible
    - Substitution of AGPs for non-aerosol generating procedures e.g. hand scaling instead of using ultrasonic scalers

[2] *Patients may refuse to undertake a pre-procedural mouthrinse, however the widespread international recommendation for a pre-procedural mouth rinse during COVID-19 attests to their use as best practice for dentists in avoiding adverse events such as spread of infection by a patient in a dental practice and provides support for their use. While a dentist may be justified in refusing to treat if a patient refuses the mouth rinse or an appropriate alternative, from a legal standpoint, the patient should be made aware of these contractual conditions of entry PRIOR to attending the appointment or upon entry to the clinic in order to be enforceable. Hence, patients should ideally be informed of COVID-19 conditions of entry either at the time the appointment is made, or by SMS or email prior to the appointment.*

- Adopt measures to reduce the risk of infection transmission after exiting clinical areas e.g. hand hygiene after treatment and before the patient returns to the reception or waiting area.

After treatment

Environmental cleaning is an important part of standard precautions in Dentistry, and cleaning is an essential part of disinfection. Ineffective cleaning results in retention of organic matter on surfaces which can inactivate many disinfectants. Cleaning reduces the soil load, allowing the disinfectant to work.

Coronaviruses can survive on surfaces for many hours but are readily inactivated by cleaning and disinfection.

During an outbreak, the frequency and efficiency of environmental cleaning should be increased to ensure any contaminants are removed, as the risk of contact transmission exists if environmental surfaces are not regularly de-contaminated. Further information on recommended routine cleaning frequencies is available from the NHMRC Australian Guidelines for the Prevention and Control of Infection in Healthcare (2019).

The ADA's Environmental Cleaning and Disinfection Guidance in the context of COVID-19 document outlines the recommended environmental cleaning and disinfection processes based on a risk assessment including individual patient risks as well as community risks of disease transmission.

Routine cleaning should be enhanced, and if transmission-based precautions are required, this includes the need for either a:

- 2-in one clean, with wipes impregnated with both detergent and disinfectant, or
- 2-step clean, which involves a physical clean using detergent solution followed by use of a TGA listed hospital-grade disinfectant.

The TGA list of disinfectants approved for use against COVID-19 is available HERE.