Seasonal Respiratory Infections and COVID-19: General Dental Services - Operational Guidance

4 June 2020

Updated and Renamed 22 December 2021

(Significant updates highlighted)
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1.0 Introduction and Background

COVID-19 is a highly infectious severe acute respiratory syndrome caused by SARS-CoV-2. Due to the nature of dental treatment dental team members are at particular risk of developing COVID-19. As such health service dentists were informed by the Health and Social Care Board to restrict the provision of aerosol generating procedures (AGPs) on 18 March 2020 and to cease all AGPs on 23 March 2020.

This guidance document was initially developed by the General Dental Services Re-establishment Group and contained operational guidance to assist practices in their preparations for a phased return to practice as outlined in the letters issued on 2 and 18 June 2020 by the Acting Chief Dental Officer available at http://www.hscbusiness.hscni.net/services/3111.htm

This set of guidance focuses on the implementation of social distancing within dental practices, preparation of staff, and the implementation of enhanced cross-infection control procedures. Preliminary guidance in relation to the patient pathway was also included which was supplemented in the updated document issued on 19 June 2020 to include advice to assist dental practitioners as they prioritise their time.

The measures to facilitate social distancing of staff and patients in dental practices will be influenced by the size, layout and location of the practice and as such each practice will need to develop their own policies and procedures following review of this guidance. The guidance was subsequently updated in September and October 2020 to reflect advice in relation to the patient pathway and enhanced Infection Prevention and Control measures in relation to Aerosol Generating Procedures.

This current version of the Operational Guidance contains a substantial update with the introduction of two patient pathways replacing the three COVID risk pathways present in the previous version.

Any queries can be forwarded to gds.correspondence@hscni.net in the first instance.

As the situation is continually progressing, and specific measures may change, it is recommended that the following webpages and practitioners HSCNI email accounts be reviewed regularly:

BSO Dental COVID-19 Webpage: http://www.hscbusiness.hscni.net/services/3111.htm

1.1 Changes in current guidance

COVID-19 Infection Prevention and Control guidance is developed on a UK wide basis by the UK IPC Cell and issued jointly by the Department of Health and Social Care, Public Health Wales, the Public Health Agency, NHS National Services Scotland, the UK Health Security Agency, and NHS England. The IPC Dental Appendix applies to all primary care dental services, including those in the independent and private sector as well as the CDS. This Operational Guidance is based on the recently updated UK COVID-19 IPC guidance document and associated Dental Appendix available at
and

The updated guidance considers COVID-19 alongside other seasonal respiratory viruses and has been agreed by the four UK Chief Dental Officers and it is strongly advised that practitioners review the Dental Appendix. The Operational Guidance summarises the Dental Appendix applying the guidance to a GDS setting with the key themes applicable to all dental settings in NI.

An additional appendix outlining the Hierarchy of Controls has also been included to assist practices in the development of their own risk assessments specific to their practice circumstances with all tiers within the hierarchy required to control and manage risk.

The key messages include:

- The triage of patients, prior to their appointment and re-checked upon arrival, using screening questions. Example screening questions are outlined in section 4.2
- Based on triage, the patient should be assigned to either the respiratory pathway or non-respiratory pathway
- The optional and voluntary use of LFDs prior to treatment on the non-respiratory pathway
- For patients on the non-respiratory pathway standard IPC measures apply
- For patients on the respiratory pathway transmission based IPC measures as well as standard IPC measures apply
- Patients on the respiratory pathway should have treatment postponed if possible with treatment restricted to urgent treatment where treatment cannot be provided remotely or postponed
- If treatment is required for patients on the respiratory pathway then they should be segregated by space or by time from other patients e.g. seen at the end of a treatment session
- Fallow times are only required following an AGP on the respiratory pathway
- The implementation of social distancing of 1 metre on the non-respiratory pathway and 2 metres on the respiratory pathway
- The universal use of face masks by staff
- The universal use of face masks by patients on the respiratory pathway and face coverings by patients on the non-respiratory pathway

The following flowchart summarises the decision making algorithm in dental settings:

![Flowchart](image)

### 2.0 Practice Preparation

The development and implementation of new policies and procedures will help ensure professional and public confidence that dental practices are as safe an environment as before the COVID-19 pandemic. As such practices should consider the following actions to facilitate social distancing within dental practices.
2.1 Access to the Dental Practice

- Access to the practice could be restricted to patients with pre-booked appointments (with consideration given to those who need to book appointments in person)
- Patients on the non-respiratory pathway should be asked to wear a face covering unless they have an exemption or reasonable excuse with signage at the entrance to the practice. Further information is available at: http://www.hscbusiness.hscni.net/pdf/HSS(MD)_58-2020.pdf and https://www.nidirect.gov.uk/articles/coronavirus-covid-19-face-coverings
- Patients on the respiratory pathway should be provided with a face mask (type II or IIR) if tolerated
- Patient information posters are available in sections 4.8 and 10.0 of this guidance and should be displayed at the entrance to the practice
- Resources to support practices as they encourage patients to wear face coverings is available at https://www.publichealth.hscni.net/covid-19-coronavirus/guidance-hsc-staff-healthcare-workers-and-care-providers/guidance-ppe
- Patients could be advised to attend alone and to minimise any personal belongings brought into the practice
- Patients could be advised to attend close to their appointment time
- Paediatric and vulnerable patients could be accompanied by one person with parental or caring responsibility. If additional carers are required this may be agreed prior to the appointment.
  - Chaperones should be screened in the same way as patients
  - Chaperones who would be placed on the respiratory pathway should not enter the practice. An alternative chaperone should be arranged or treatment postponed in these circumstances
  - Chaperones should be asked to wear a face covering
- If car parking facilities are available patients may be advised to wait in their car prior to being invited in for their appointment
- A one-way system within the practice could be considered with separate entrance and exits
- Separate entrances for staff and patients could be considered
- Patients could be met at the door and guided through the practice
  - This guide should wear PPE (fluid resistant mask plus optional face visor following risk assessment)
- Interpreting services to be provided through The Big Word telephone interpretation service. Further information is available at http://www.hscbusiness.hscni.net/services/2730.htm
- Provide hand hygiene facilities for patients as they enter and exit the practice
• Information posters in relation to COVID-19 diagnosis, social distancing, cough etiquette and hand hygiene should be on display outside, or at the entrance to the practice, and in the waiting area (please refer to section 4.8 and 10.0)

2.2 Reception Area

• Re-organise reception area to allow social distancing of staff and patients of 1 metre
• Perspex screens to be considered if necessary
• Receptionist to wear PPE (fluid resistant/type IIR mask plus optional face visor following risk assessment) if necessary
• Minimise the time patients stay in reception
  o Appointments could be made over the phone and not in person if possible (with consideration given to those who need to book appointments in person)
  o Consider contactless payments or payment over the phone
  o Paperwork could be emailed to the practice or to the patient if possible
  o HS45 forms do not need signed until further notice (patient consent should be recorded in the clinical records)
• Communication between the reception and the surgeries could be optimised to control movement of patients and staff within the practice
• Reception area and equipment to be disinfected regularly
• Provide hand hygiene facilities for reception staff
• If paperwork is required consider asking patients to bring their own pen

2.3 Waiting Area

• Waiting areas can be used with appropriate mitigations in place
• Reorganise waiting area with 1m distancing between chairs
• Use floor markings to indicate 1m distancing if necessary
• Remove all unnecessary fixtures e.g. magazines, toys, drinks dispensers
• Frequent cleaning throughout the day
• Ensure that tissues and a foot-pedal operated bin are available
• Consider the use of a separate waiting area for patients on the respiratory pathway with 2m distancing
  o Alternatively patients on the respiratory pathway could be taken straight to the treatment room
  o Or the same waiting area can be used when patients on the non-respiratory pathway are not present with the area cleaned following its use
• Ventilation within waiting areas should be considered in line with The Workplace (Health, Safety and Welfare) Regulations (Northern Ireland) 1993
which requires that every enclosed workplace is ventilated by a sufficient quantity of fresh air with adequate ventilation of 8-10 litres per second per person.

2.4 Toilet Facilities

- Patients to be advised to use the bathroom prior to attending the practice
- Display signage on handwashing techniques (please refer to section 4.7)
- Disable hand dryers and provide disposable towels and a foot-pedal operated bin
- Information posters in relation to cough etiquette and hand hygiene should be on display (please refer to section 4.8)
- Toilet facilities to be frequently cleaned

2.5 Staff Areas

- Social distancing of staff should be maintained
- Staff rooms could be re-organised to allow social distancing
- Face coverings to be worn by staff. Further information is available at https://www.publichealth.hscni.net/publications/staff-guidelines-face-coverings-all-hsc-facilities

2.6 Equipment

It is advised that practices review the Scottish Dental Clinical Effectiveness Programme “Practice Reopening Checklist” prior to an increase in the number of patients attending the practice. The checklist is available at:


3.0 Staff Preparation

3.1 Staff Leadership

Each practice should have nominated a COVID-19 lead as part of their COVID-19 Business Continuity Plan. The COVID-19 lead should:

- Review updated and newly published guidance
- Disseminate information to members of the dental team
- Consider the impact on existing practice policies and procedures
- Develop new practice policies and procedures if necessary
• Review and update the Business Continuity Plan as necessary including plans for patients to access care in the event of the practice having to close
• Consider necessary staff training

3.2 Staff Training

Staff training could be considered in regards to:

  o The COVID-19 case definition
  o The respiratory pathways as outlined in section 4.1
  o COVID-19 guidance (e.g. social distancing of patients and staff)
  o Management of a possible COVID-19 positive patient
  o Practice policies and procedures to facilitate social distancing
  o Enhanced Cross-infection Control measures
  o Environmental cleaning
  o Clinical clothing
  o Use of PPE
  o Hand hygiene
  o Management of medical emergencies
  o Safeguarding
  o Use of rubber dam

3.3 Staff Screening

• Procedures should be developed to ensure staff inform the practice of any COVID-19 symptoms or if a member of their household develops symptoms and to follow self-isolation advice
  o Please refer to section 4.2 for further details
  o Further information in regards to the diagnosis of COVID-19 is available at
    and https://check.covid-19.hscni.net
  o The process for the testing of symptomatic healthcare workers is outlined at
    https://www.publichealth.hscni.net/covid-19-coronavirus/coronavirus-national-testing-programme-essential-or-key-workers
  o The online testing portal is available at
    https://www.gov.uk/get-coronavirus-test
  o Information in relation to the Test Trace and Protect Strategy is available at
• Staff should follow any personal medical advice given to them


• Information in regards to ordering Lateral Flow Device tests for asymptomatic testing of staff is available at [https://hscbusiness.hscni.net/pdf/Lateral_Flow_Testing_for_Primary_Care_Staff_120521.pdf](https://hscbusiness.hscni.net/pdf/Lateral_Flow_Testing_for_Primary_Care_Staff_120521.pdf)

• At the time of issuing approximately 45% of dental practices have ordered LFTs through the NHS Portal. The HSCB, PHA, and DoH strongly recommend regular testing of asymptomatic health care workers as outlined above.

Risk assessments should be completed for vulnerable staff with redeployment to duties without patient contact considered. These may require updating to reflect this new version of the Operational Guidance.


• Risk assessment templates are available at [https://www.publichealth.hscni.net/sites/default/files/2021-04/14_04_21%20COVID19%20Risk_Assessment%20v0.pdf](https://www.publichealth.hscni.net/sites/default/files/2021-04/14_04_21%20COVID19%20Risk_Assessment%20v0.pdf)

• Practices may need to consider local arrangements for the management of patients on the respiratory pathway depending on individual staff risk assessments.

The HSCB, PHA and DoH strongly recommend all health care workers are fully vaccinated against COVID-19 including accessing their booster jabs if appropriate. Further information is available at [https://www.publichealth.hscni.net/covid-19-coronavirus/northern-ireland-covid-19-vaccination-programme](https://www.publichealth.hscni.net/covid-19-coronavirus/northern-ireland-covid-19-vaccination-programme)

3.3.1 COVID positive staff

• Staff with possible COVID symptoms should self-isolate, not attend work, and book a COVID test
• Symptomatic staff who then receive a negative COVID test can return to work when they are well
• Symptomatic staff who receive a positive test should self-isolate for 10 days from the onset of symptoms and not return to work until after the period of self-isolation and the clinical symptoms have improved with no fever for 48 hours
• Asymptomatic staff who receive a positive test should self-isolate for 10 days from the date of the positive test and can return to work after the period of self-isolation
  o Should they then develop symptoms they should self-isolate for 10 days from the onset of symptoms and not return to work until after the period of self-isolation and the clinical symptoms have improved with no fever for 48 hours
• Staff who have tested positive will be contacted by the PHA Contact Tracing Service team following a COVID positive test
• Further advice should be sought from the PHA if two or more cases are identified. The PHA Duty Room can be contacted at 0300 5550119 or via email at PHA.DutyRoom@hscni.net
• If appropriate PPE has been worn, then patients will not be considered as close contacts and will not be required to self-isolate
• Particular care should be taken in staff areas to ensure social distancing is maintained and face coverings are worn as per section 2.5 of this guidance
• Frequent cleaning of non-clinical areas and compliance with section 5 of this guidance minimises the risk to staff and patients and should minimise the need for practices to close following a staff member receiving a COVID positive test
• It is advised that members of the dental team should deactivate Bluetooth or disable the StopCOVID NI app while providing care and treatment. Further information is available at https://www.nidirect.gov.uk/articles/coronavirus-covid-19-stopcovid-ni-proximity-app
• Practice policies in regards to the management of staff absence may require review

3.3.2 Staff identified as close contacts

• Staff who have been identified as close contacts, who have not been vaccinated, should isolate for 10 days from the date of contact and follow advice from the PHA Contact Tracing Service. Further information is

- Staff who have been identified as close contacts, who are fully vaccinated are not required to self-isolate. However further mitigations are required prior to any staff who have been identified as close contacts, who have been fully vaccinated, from returning to work. These mitigations were updated on 21 December 2021 and are outlined in HSS(MD)85/2021 along with a template employer checklist: [https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-hss-md-85-2021f.pdf](https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-hss-md-85-2021f.pdf)

- The majority of fully vaccinated health and social care staff will be able to continue in their usual role

3.4 Uniforms

- Clinical clothing worn during the provision of dental treatment and decontamination should not be worn outside of the practice
- Clinical clothing should be short sleeved
- Clinical clothing should be washed at a minimum of 40°C and at the hottest temperature suitable for the fabric at the earliest opportunity

3.5 Staff Wellbeing

Dentists and their staff have had to make dramatic changes to their professional and personal lives during the COVID-19 pandemic with resulting stress and anxiety. Practices should be mindful of the wellbeing of everyone who works in the practice.

Roz McMullan, Chair of Probing Stress in Dentistry, has shared some advice and resources which is available at: [http://www.hscbusiness.hscni.net/pdf/Ltr%20from%20Roz%20McMullan%20Chair%20Probing%20Stress%20in%20Dentistry%20Group%2006.05.20.pdf](http://www.hscbusiness.hscni.net/pdf/Ltr%20from%20Roz%20McMullan%20Chair%20Probing%20Stress%20in%20Dentistry%20Group%2006.05.20.pdf)

Other resources available to dental practitioners include:

- The Inspire General Dental Services Assistance Programme is available confidentially 24 hours a day at 0800 3895362 with further info available at [http://www.hscbusiness.hscni.net/services/3078.htm](http://www.hscbusiness.hscni.net/services/3078.htm)
- BDA members may contact Health Assured 24 hours a day as part of the BDA Member Assistance Programme at 0800 0305182 with further info available at [https://bda.org/health-assured](https://bda.org/health-assured)
- A summary of Wellness Resources available to the dental team is available at [https://hscbusiness.hscni.net/pdf/Wellness_Resource.pdf](https://hscbusiness.hscni.net/pdf/Wellness_Resource.pdf)
Resources available to all members of the dental team include:


Resources available to the general public include:

- PHA stress control classes available at https://stresscontrol.org/
- Helplines NI: https://helplinesni.com/
- Health Care Apps: https://apps4healthcareni.hscni.net/
- Lifeline Crisis Response: 0808 808 8000
- Samaritans: 116 123

3.6 Staff Vaccination

- The HSCB and DoH would encourage as many healthcare workers as possible to receive their COVID vaccine, COVID booster and flu vaccine. This includes all members of the primary care dental team.
- Further information for healthcare workers is available at https://www.publichealth.hscni.net/covid-19-coronavirus/northern-ireland-covid-19-vaccination-programme
- Practitioners are advised to monitor their HSCNI email accounts in regards to accessing their COVID booster and flu vaccines
- The Operational Guidance must still be followed even following vaccination of staff.

4.0 Patient Pathway

4.1 Respiratory Care Pathways

The UK Government published “Infection prevention and control for seasonal respiratory infections in health care settings (including SAES-CoV-2) for winter 2011 to 2022” on 23 November 2021. The guidance outlines two respiratory care pathways based on the individual patient’s respiratory risk assessment.

and


The respiratory care pathway places patients in either a non-respiratory pathway or a respiratory pathway.

Standard Infection Prevention and Control procedures are sufficient and should be followed for patients in the non-respiratory pathway.

Transmission based and Standard Infection Prevention and Control procedures should be followed for patients in the respiratory pathway.

4.2 Patient Respiratory Screening

Patients who are confirmed or possible COVID-19 positive, or are identified as having a suspected or confirmed respiratory infection should be placed on the respiratory pathway. As such it is suggested that the following questions be asked for all patients and chaperones within 48 hours of their attendance and checked upon arrival. An example template is included in section 10.0.

- Have you had any of the following symptoms in the past 10 days?
  o A new persistent cough (coughing for more than an hour or more than three coughing episodes in a 24 hour period)
  o A high temperature or fever
  o Loss of, or altered, sense of smell or taste
- Have you or any members of your household had a confirmed diagnosis of COVID-19 in the last 10 days?
- Are you or any member of your household waiting for a COVID-19 PCR test result?
- Have you travelled internationally in the last 10 days to a country that is on the government red list?
  o Further info available at
- Have you been identified by the PHA Contact Tracing Service as someone who should currently be self-isolating or quarantining?
- Do you have any new or worsening respiratory symptoms not already mentioned which suggest you may have a respiratory virus?
  o For example a runny nose, sore throat, difficulty breathing, shortness of breath, congestion, sneezing.
Patients who answer “Yes” to any of the above patient screening questions should be placed in the respiratory pathway.

Patients should be advised to follow any personal medical advice they receive. A patient is deemed to be “recovered” following their period of self-isolation as long as it has been ten days since the onset of symptoms and they no longer have a high temperature. The cough and altered sense of smell or taste may persist in some patients despite being “recovered” and COVID-19 free.

Patients who answer “No” to all of the above patient screening questions should be placed on the non-respiratory pathway.


4.3 Pre-appointment COVID Testing

- Lateral Flow Device testing (LFDs) may be used as an additional mitigation for patients on the non-respiratory pathway
- The use of LFDs is optional and voluntary at both a practice level and a patient level
- Treatment cannot be refused to patients who decline pre-appointment testing
- IPC guidance outlined in section 5.0 must still be followed
- Patients may undertake two LFDs in the five day period immediately before their appointment and should only attend the appointment if both tests are negative
- Patients who receive a positive test should self-isolate and book a PCR test. The patient should be placed in the respiratory pathway if necessary.
- Tests can be taken in the patient’s own home and practices are not expected to supply the LFDs
- LFDs are available to members of the public through local community pharmacies or can be ordered online. Further info is available at: https://www.nidirect.gov.uk/articles/coronavirus-covid-19-testing#toc-3

4.4 Patient Medical Screening

- Consideration should be given to updating medical histories prior to the booking of an appointment
- For Clinical Extremely Vulnerable patients, where an appointment is necessary, consideration should be given to scheduling the appointment at the start or end of a session
• Further information in regards to shielding and vulnerable people is available at https://www.nidirect.gov.uk/articles/coronavirus-covid-19-advice-vulnerable-people

4.5 Appointment Planning

• Appointment lengths should be sufficiently long to allow for any necessary fallow time and enhanced cleaning between appointments on the respiratory pathway
• Staggering of appointments could be considered to facilitate social distancing of patients
  o This may include flexible working hours with staggering staff start/end times, break times and lunch times
• As per section 5.4 sufficient time should be allowed on the respiratory pathway for enhanced environmental cleaning including the application, “contact time” and “drying time” of the disinfectant
• A short notice cancellation list could be utilised to minimise any lost activity time
• When carrying out domiciliary visits the guidance outlined in section 5.0 should be followed along with any additional measures required by care homes. PPE should be donned prior to entering the care home or domiciliary setting with gloves, apron and visor doffed upon leaving the treatment room. The mask should not be doffed until leaving the care home. Further advice is available in section 5.0 and at: https://www.health-ni.gov.uk/publications/covid-19-guidance-nursing-and-residential-care-homes-northern-ireland

4.6 Patient Triage and Prioritisation

Please refer to section 6.0 for advice in prioritising patients during this time in which the number of patients who can be seen may be reduced.

4.7 Encountering a COVID positive patient

• Screening questions should be asked within 48 hours of attendance and checked upon arrival
• If you encounter a possible or confirmed COVID positive patient in your practice but prior to any treatment the patient should be asked to leave the practice and to follow self-isolation advice
  o Any non-urgent treatment should be postponed. If urgent treatment is required and cannot be postponed the patient should be placed on the respiratory pathway
• If a patient is receiving treatment and it becomes apparent that they are possible or confirmed COVID positive you should halt treatment at a safe point. The patient should be asked to leave the practice and follow self-isolation advice
  o Any necessary treatment should be postponed or if treatment cannot be halted or postponed the patient should be placed on the respiratory pathway
• If appropriate PPE has been worn then dental care professionals will not be considered as close contacts and will not be required to self-isolate
• If PPE has not been worn or has been significantly breached then dental care professionals should follow the advice in section 3.3.2
  o If level 1 PPE was worn while providing an AGP on a patient who subsequently tests positive for COVID within 48 hours then dental care professionals will be considered as close contacts and should follow the advice in section 3.3.2
• Particular care should be taken to ensure social distancing is maintained between patients and that face coverings are worn as per section 2 of this guidance
• Further information in regards to management of exposed healthcare workers is available at

• Frequent cleaning of non-clinical areas and compliance with section 5 of this guidance minimises the risk to staff and patients and should minimise the need for practices to close following contact with a COVID positive patient
• It is advised that members of the dental team switch off their StopCOVID NI app while in work. Further information is available at

4.8 Patient Communications

• Practices should consider updating practice communications to inform patients of the changes to the delivery of dental services
• Patients should be given relevant instructions prior to attendance
• Information posters are available in relation to COVID-19 diagnosis, social distancing, cough etiquette and hand hygiene should be on display
- PHA posters are available at
  https://www.publichealth.hscni.net/publications?keys=coronavirus&page=0

- Social Distancing posters:
  https://www.publichealth.hscni.net/publications/social-distancing-poster


- Cough Etiquette poster:
  https://www.publichealth.hscni.net/sites/default/files/2020-02/Catch%20it%20bin%20it%20kill%20it%20SQUARE.png

- Hand Hygiene posters:

  https://www.publichealth.hscni.net/publications/coronavirus-wash-your-hands-poster


- NI Executive face covering posters:

- HSCB patient information webpages are available at:
  http://www.hscboard.hscni.net/our-work/integrated-care/dental-services/

  http://www.hscboard.hscni.net/coronavirus/#Dental

- Further posters are included in Section 10.0
5.0 Infection Prevention and Control

5.1 Surgery Preparation

- All unnecessary objects and equipment should be removed from surgeries
- Barriers should be considered where possible
- All necessary equipment and materials should be prepared prior to the appointment
- Doors should be closed during treatment and decontamination
- Windows should be opened
- PPE should be donned prior to the patient entering the surgery
- Ideally only the dental team (dentist and dental nurse) and the patient should be present during treatment with the surgery door closed
  - Exceptions may be required for patients attending with a guardian or carer and should be recorded in the clinical notes
  - Chaperones should not be present during AGP treatment on the respiratory pathway unless absolutely necessary
- Particular attention should be given to hand hygiene throughout
- Open surgeries with multiple dental chairs in a single room should be arranged to ensure social distancing is maintained

5.2 Categorisation of Dental Procedures

Section 6.4 outlines a categorisation of dental procedures based on the characteristics of the instruments used and assumptions regarding aerosol generation. In summary:

- Group A procedures (Aerosol Generating Procedures) use powered, high velocity instruments that emit or require water or irrigants for cooling. These procedures will produce aerosol particles <5um
- Group B procedures use powered low velocity instruments. These procedures may produce aerosol particles <5um, with the amount depending on instrument use
- Group C procedures do not use powered instruments. These procedures may produce splatter but are unlikely to produce aerosol particles <5um

Further information is available in section 3 of the SDCEP rapid review “Mitigations of AGPs in Dentistry.”

5.3 Non-respiratory Pathway

- Standard Infection Prevention and Control Procedures are adequate in the non-respiratory pathway
• Patients and chaperones on the non-respiratory pathway should be asked to wear a face covering unless they have an exemption or reasonable excuse with signage at the entrance to the practice.

5.3.1 Environmental Cleaning

• Decontamination of the dental surgery following treatment should follow existing practice policies and procedures as per PEL 13(13) and PEL 13(13) Addendum 1 and should follow the manufacturer’s guidance. PEL 13-13 and PEL (13-13) Addendum 1 are available at http://www.hscbusiness.hscni.net/services/2706.htm

• A fallow time is not required following an AGP on the non-respiratory pathway
  • Particular care should be given to the cleaning of open surgeries with multiple dental chairs
  • PPE should be worn as per section 5.3.4
  • The use of fumigation and fogging/misting with disinfectant is not currently recommended

5.3.2 Instrument Decontamination

• Decontamination of re-useable dental instruments should follow existing practice policies and procedures as per PEL 13(13) and PEL 13(13) Addendum 1
  • Staff should wear PPE as per section 5.3.4
  • Staff should be aware of social distancing in the local decontamination room
  • Dental water lines should be flushed as per existing practice policies and procedures

5.3.3 Clinical Waste Management

• The management of clinical waste should follow existing practice policies and procedures

5.3.4 Personal Protection Equipment

• The minimally necessary level 1 personal protection equipment on the non-respiratory pathway, and for environmental decontamination, and the decontamination of reusable dental instruments includes:
  o Disposable gloves
  o Disposable plastic apron
- Fluid resistant surgical face mask¹
- Eye/face protection (visors, shields, or glasses/goggles)

- The requirements are the same for non-AGPs and AGPs
- Disposable plastic aprons may not be necessary if the risk of splashing can be mitigated with high-volume suction or rubber dam
- Sessional use of fluid resistant surgical face masks may be appropriate following risk assessment
- Re-useable eye protection should be cleaned and decontaminated as per manufacturer’s instructions

- Staff may choose to wear an FFP3 mask while performing AGPs on the non-respiratory pathway following a personal risk assessment (as per section 3.3)
- Advice in regards to the donning and doffing of level 1 PPE is available at https://www.gov.uk/government/publications/covid-19-personal-protective-equipment-use-for-non-aerosol-generating-procedures
- Receptionists should wear fluid resistant masks if it is not possible to maintain social distancing in the reception area
  - Sessional use may be appropriate following risk assessment

5.4 Respiratory Pathway

- Transmission based Infection Prevention and Control Procedures are required in addition to Standard Infection and Prevention Control Procedures
- Patients on the respiratory pathway should have treatment postponed if possible with treatment restricted to urgent treatment where treatment cannot be provided remotely or postponed
- If treatment is required for patients on the respiratory pathway then they should be segregated by space or by time from other patients e.g. seen at the end of a treatment session
  - Social distancing of 2m is required
  - Patients on the respiratory pathway should not use the same waiting area at the same time as patients on the non-respiratory pathway
  - Ideally a separate waiting area could be used; alternatively patients on the respiratory pathway could be taken straight to the treatment room or the same waiting area can be used when patients on the non-respiratory pathway are not present with the area cleaned following its use

¹ Please note that most standard dental masks are fluid resistant. Practitioners should check their stock to ensure that their masks are “IIR Compliant.”
5.4.1 Environmental Cleaning

- Decontamination of the dental surgery following treatment should follow existing practice policies and procedures as per PEL 13(13) and PEL 13(13) Addendum 1 and should follow the manufacturer’s guidance. PEL 13-13 and PEL (13-13) Addendum 1 are available at http://www.hscbusiness.hscni.net/services/2706.htm
  - For patients on the respiratory pathway this guidance also recommends cleaning all hard surfaces which may have become contaminated and other frequently touched sites/points after every patient. A combined detergent/disinfectant solution at a dilution of 1000 parts per million available chlorine or a general purpose neutral detergent in warm water followed by a disinfectant solution of 1000 parts per million available chlorine should be used
  - If alternative cleaning agents/disinfectants are to be used they should conform to EN standard 14476 for viricidal activity
  - Products must be used according to manufacturer’s instructions and recommended “contact times” and “drying times” must be followed

- A fallow time is required following an AGP on the respiratory pathway
  - The fallow time can commence from the end of the AGP

5.4.2 Instrument Decontamination

- Please refer to section 5.3.2

5.4.3 Clinical Waste Management

- Please refer to section 5.3.3

5.4.4 Personal Protection Equipment

- The minimally necessary level 1 personal protection equipment on the respiratory pathway for non-AGPs, and for environmental decontamination, and the decontamination of reusable dental instruments includes:
  - Disposable gloves
  - Disposable plastic apron
  - Fluid resistant surgical face mask
• Eye/face protection (visors, shields, or glasses/goggles)

• The minimally necessary level 2 personal protection equipment on the respiratory pathway for AGPs includes:
  o Disposable gloves
  o Fluid resistant gown\(^2\)
  o Fit tested FFP3 mask or hood
  o Eye/face protection (visors)

• FFP3 masks or hoods may be used on a sessional basis in certain clinical settings with a session ending when the healthcare worker leaves the care setting/exposure environment. As such sessional use of FFP3 masks and re-useable respirator masks may be appropriate if the healthcare worker does not leave the surgery between patients and the mask is not removed. Particular care should be given to the donning and doffing of PPE in these circumstances

• Disposable gowns and disposable visors are single patient use

• Re-useable gowns, re-useable eye protection and re-useable FFP should be cleaned/disinfected between patients as per manufacturer’s instructions.

• Re-useable FFP3 masks and hoods should be cleaned/disinfected as per manufacturer’s instructions.


• Further information in regards to FFP3 masks and hoods is available at: [https://www.hse.gov.uk/pubns/priced/hsg53.pdf](https://www.hse.gov.uk/pubns/priced/hsg53.pdf)

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\(^2\) Disposable gowns should be used as far as possible. Re-useable gowns may be used if a sustainable supply of disposable gowns is not available. If re-useable gowns are being used this should be recorded in the practices policies and procedures with sufficient information to show that a sustainable supply of disposable gowns are not available. It is acceptable to use up existing stock of reusable gowns and to honour existing lease/rental/service agreements. When decontaminating reusable gowns the use of accredited laundries compliant with the relevant standards (BS EN 14065) and guidance (HTM 01-04) offer the least risk option but it is the responsibility of the dentist to carry out a risk assessment and put sufficient arrangements in place to ensure safety for their staff and patients.
Further advice in regards to the use of valved FFP3 masks when a sterile field is required is available at

Advice in regards to the donning and doffing of level 2 PPE is available at: https://www.gov.uk/government/publications/covid-19-personal-protective-equipment-use-for-aerosol-generating-procedures
  o The gloves, gown and visor should be removed in the surgery and the mask removed outside of the surgery as per the link above

5.4.5 Aerosol Generating Procedures

The following section applies to patients on the respiratory pathway receiving an AGP in GDS practices:

Fallow Times

- After providing an AGP a period of time (a fallow time) should elapse before cleaning and decontamination
- The length of the fallow time is determined by a combination of the length of the AGP, the use of high speed suction, the use of rubber dam and the Air Changes per Hour (ACH) of the surgery
- The fallow time can commence from the end of the AGP though practitioners may decide to commence the fallow time at the end of the appointment to facilitate scheduling
- **AGPs should not be performed in surgeries without any natural or mechanical ventilation in either pathway**
- Further information is available in section 5.1 of the SDCEP rapid review “Mitigations of AGPs in Dentistry” available at:
- The following flow chart, reproduced from the SDCEP rapid review, outlines the process for determining the necessary fallow time:
Mitigating Measures

- High speed suction should be used as far as possible for procedures in which splatter production is likely
- High speed suction is defined as a vacuum system with an air intake of more than 250 litres per minute and with an aspirator tip of at least 8mm
- High speed suction systems should be serviced as per manufacturers guidance to ensure adequate air flow
- Slow speed saliva ejectors should be used as far as possible but will not result in a reduced fallow time
- Use of rubber dam should be considered and will result in a reduced fallow time
- Further information is available in section 4 of the SDCEP rapid review “Mitigations of AGPs in Dentistry.”

Ventilation

- The dispersion of dental aerosols which have not been removed by suction is primarily achieved by dilution in the air. As such ventilation, and the Air Changes per Hour (ACH) within a surgery, is the main mitigating measure associated with AGPs and in determination of the fallow time
• The Workplace (Health, Safety and Welfare) Regulations (Northern Ireland) 1993 require that every enclosed workplace is ventilated by a sufficient quantity of fresh air with adequate ventilation of 8-10 litres per second per person.

• **HTM 03-01** (updated 22 June 2021) states that dental treatment rooms in health care facilities built **since 2021** should have at least 10 ACH with a supply and extract system. HTM 03-01 (2021) is available at: [https://www.england.nhs.uk/publication/specialised-ventilation-for-healthcare-buildings/](https://www.england.nhs.uk/publication/specialised-ventilation-for-healthcare-buildings/)

• **AGPs should not be performed in surgeries without any natural or mechanical ventilation in either pathway**

• Surgeries with mechanical ventilation can calculate the ACH for each surgery using information found in the specification or manual of the ventilation or air flow system present in the surgery³:

  \[
  \text{ACH} = \frac{\text{Air Flow Rate from manufacturer’s specification (m}^3 \text{ per hour)}}{\text{Surgery volume (m}^3)}
  \]

• Natural ventilation, e.g. an open window, cannot be included in the above calculation

• Where the ACH of an existing ventilation system is unknown, or where natural ventilation is used as the sole method of ventilation or to supplement mechanical ventilation, the ACH can be modelled or verified by a competent person for example a company registered with the Heating and Ventilating Contractors Association, a Chartered Engineer who is a member of Chartered Institution of Building Services Engineers or another appropriate professional body

• Ventilation systems should be maintained and serviced as per manufacturers guidance and as outlined in HTM 03-01

• Further information in regards to ventilation is available in section 5 of the SDCEP rapid review “Mitigations of AGPs in Dentistry.”


**Air Cleaners**

• Air cleaners using high efficiency particulate air (HEPA) filtration, germicidal ultraviolet light, alone or in combination, remove or inactivate airborne particles

• Air cleaners with an air flow system may be used to supplement existing natural or mechanical ventilation

• Currently air cleaners should not be used in surgeries without any natural or mechanical ventilation. **AGPs should not be performed in surgeries without any natural or mechanical ventilation**

³ Please refer to Appendix 7.0 for worked examples
• Technical advice should be sought on device suitability and installation to ensure optimal efficiency particularly when using multiple air cleaners in a surgery or if existing mechanical ventilation is in place
• Surgeries with air cleaners can calculate the equivalent ACH for each surgery using information found in the specification or manual of the air cleaner present in the room
• Due to variation in air flow output, the location of the air cleaner in the surgery, the layout of the surgery and the efficiency of the filtration systems, it is recommended that the efficacy of air cleaners is assumed to be 0.5. The eACH can therefore be calculated as:

\[ \text{eACH} = \frac{\text{Air Flow Rate from manufacturer's specification (m}^3\text{ per hour)}}{\text{Surgery volume (m}^3\text{)}} \times \frac{1}{2} \]

• Air cleaners can be used alongside mechanical ventilation to calculate a total ACH:

\[ \text{Total ACH} = \text{ACH} + \text{eACH} \]

• Alternatively the ACH can be modelled or verified by a competent person for example a company registered with the Heating and Ventilating Contractors Association, a Chartered Engineer who is a member of Chartered Institution of Building Services Engineers or another appropriate professional body
• Air cleaners should be maintained and serviced as per manufacturers guidance and as outlined in HTM 03-01
• Further information in regards to air cleaners is available in section 5.2 of the SDCEP rapid review “Mitigations of AGPs in Dentistry.”

Risk Assessment

• Practices should complete a risk assessment specific to each surgery prior to implementing a reduced fallow time
• The risk assessment should record the air flow rate of each item of ventilation (i.e. mechanical ventilation and air cleaners etc), the calculated or verified total ACH and the necessary fallow times
  o Please note that the same ventilation system may result in differing fallow times depending on the size of each surgery

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6.0 Clinical Prioritisation

6.1 Triage Process

During the COVID-19 pandemic practices have developed processes to triage patients who contact their practice with a dental need. As re-establishment of the GDS progresses it is expected that demand for care and treatment will be high.

As such it may be necessary to maintain and modify existing triage processes within practices to ensure that patients are offered appointments based on clinical priority with the most pressing needs prioritised. As more routine care resumes, triage processes may become less important and therefore could be further modified to suit individual practice circumstances. As routine check-ups resume particular care should be given to patient priority groups as outlined in section 6.3.

Triaging should be based on an assessment of each individual patient. The following aspects should be considered as part of the triage process:

- The patient’s respiratory screening (as per section 4.1 and 4.2)
- The urgency of the dental condition (as per section 6.2)
- The ability to provide definitive or remedial treatment (as per section 6.4)
- Priority patient groups (as per section 6.3)
- Shielding or Clinical Extremely Vulnerable patients (as per section 4.3)\(^5\)

Following an assessment of each patient possible triage outcomes include:

- Remote management
- Urgent appointment offered
- Non-urgent appointment offered if capacity available
- Routine appointment offered if capacity available
- Within each category treatment may be postponed due to insufficient capacity or the inability to provide treatment in the current phase.
  - These patients are to be reviewed once capacity is available or if the dental condition becomes urgent

The triage process for each individual patient should be recorded in the clinical notes. The figure below summarises the triage process.

\(^5\) Shielding is currently paused and as such CEV patients should be offered appointments with consideration given to scheduling the appointment at the start or end of a session
As summarised above it is expected that this process will be modified and adapted by each practice taking into consideration the balance between its capacity to provide treatment and the level of unmet treatment needs of their patients. As routine care and routine check-ups resume the reliance on individual triage will reduce.

The section that follows provides a flexible framework and advice that should be considered when determining clinical prioritisation for patients. This is based on the dental condition, priority groups and treatment available in each phase.

6.2 Hierarchy of Dental Conditions

6.2.1 Emergency Dental Conditions

Emergency Dental Conditions include
- Rapidly increasing oro-facial swelling
- Swelling involving the eyelids, neck, or affecting swallowing/breathing or causing trismus
- Trauma involving facial bones
- Uncontrolled post-extraction bleeding inpatient with coagulopathy or on anticoagulant medication.
Patients presenting with emergency dental conditions who cannot be managed in primary care should be referred to secondary care or the Emergency Department. Referrals should be forwarded as normal as per pre-COVID-19.

6.2.2 Urgent Dental Conditions

Care and treatment for urgent dental conditions should be provided by all dental practices. Due to the impact of social distancing and enhanced cross-infection control procedures on appointment planning consideration should be given to ensuring that urgent appointments are available at short notice.

Urgent Dental Conditions include:

- Simple trauma affecting an adult tooth which involves the dentine or pulp or luxation/avulsion of permanent tooth
- Oro-facial swelling not involving the eyelids, neck, or affecting swallowing/breathing or causing trismus
- Post-extraction bleeding not controlled by measures at home
- Severe dental pain that cannot be controlled by self help advice
- Dental and soft tissue infections
- Oro-dental conditions that are likely to exacerbate systemic medical conditions
- Suspected oral cancer
- Orthodontic patients requiring urgent review where it is feared that unwanted tooth movement may be occurring

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6 Further guidance is available at [https://www.bos.org.uk/COVID19-BOS-Advice/Recovery-Phase-Advice](https://www.bos.org.uk/COVID19-BOS-Advice/Recovery-Phase-Advice)
6.2.3 Non-urgent Dental Conditions

The treatment of non-urgent dental conditions is appropriate if sufficient capacity is available and should be priority based.

Non-urgent dental conditions include:

- Mild dental trauma
- Moderate dental pain
- Moderate to severe caries with no pain
- Fractured, loose or debonded restorations with moderate pain
- Acute periodontal conditions
- Moderate to severe, currently unstable periodontitis\(^7\)
- Fractured, loose or debonded crowns, bridges, veneers
- Fitting of previously constructed crowns, bridges, veneers

- Fractured or loose dentures
- Denture additions and relines
- Fitting of previously constructed dentures
- Patients in active orthodontic therapy who have not been reviewed for more than 12 weeks
- Fractured, loose or lost orthodontic appliances
- Preventive treatment
- Soft tissue lesions (not clinically suspicious of cancer)
6.2.4 Routine Dental Conditions

The treatment of routine dental conditions is appropriate if sufficient capacity is available and should be priority based.

Routine dental conditions includes:

- Routine examination/check-up
- Mild dental pain
- Treatment of minimal caries
- Fractured, loose or debonded restorations with mild or no pain
- Periodontal maintenance
- Provision of new crowns, bridges, veneers
- Provision of new dentures
- Provision of orthodontic maintenance
- Provision of new orthodontic treatment
6.3 Patient Priority Groups

Consideration should be given to prioritising the following patient groups particularly as routine treatment and patient check-ups resume:

- Patients with incomplete treatment from prior to COVID-19
- Patients who have contacted the practice during the pandemic and had treatment postponed
- Patients who have been referred to the UDC and require further treatment
  - Consideration should be given to reviewing incomplete treatments and patients who have contacted the practice during the pandemic to prioritise these unmet oral health needs
  - The length of time which has elapsed since the patient contact should be taken into consideration
- Patients requiring dental treatment prior to a medical intervention (e.g. chemotherapy, radiotherapy, surgery etc)
- Patients with systemic medical conditions that may be exacerbated by dental conditions
- Patients from vulnerable groups
- Patients with a high caries rate
- **Paediatric patients**
  - Particular priority should be given to paediatric patients who are 12 months or more overdue for their routine check-up

6.4 Treatment Provision

This section outlines a categorisation of dental procedures based on the characteristics of the instruments used and assumptions regarding aerosol generation. In summary:

- AGPs, or Group A procedures, use powered, high velocity instruments that emit or require water or irritants for cooling. These procedures will produce aerosol particles <5um
- Group B procedures use powered low velocity instruments. These procedures may produce aerosol particles <5um, with the amount depending on instrument use
- Group C procedures do not use powered instruments. These procedures may produce splatter but are unlikely to produce aerosol particles <5um

Further information is available in section 3 of the SDCEP rapid review "Mitigations of AGPs in Dentistry."

Dental AGPs include:
- Ultrasonic scalers (including piezo)
- High speed handpieces (that is >60,000 rpm)
- Piezo surgical handpieces
- Air polishers

The combined 3-in-1 syringe is currently not deemed to be an AGP. The table below outlines common AGPs along with alternative non-AGP procedures that could be considered.

<table>
<thead>
<tr>
<th>AGP</th>
<th>Alternative non-AGP</th>
</tr>
</thead>
</table>
| Use of the high speed hand-piece (air rotor or electric hand-piece at >60,000rpm) | • Use of slow speed hand-piece (air-driven or electric)  
• Use of an electric motor to maintain speed of <60,000 rpm  
• Removal of caries in open cavities using hand excavation or slow hand-piece without water coolant spray, with high speed suction and rubber dam if appropriate  
• Atraumatic restorative techniques  
• Use of fluoride releasing glass ionomer  
• Provision of temporary restorations  
• Preventive treatment in non-cavitated caries  
• Provision of temporary overdentures prior to definitive provision of anterior post-crowns  
• Provision of paediatric stainless steel crowns utilising the Hall technique |
| Use of cavitron, piezosonic and other mechanised scalers             | Hand scaling with suction                                                          |
| Use of piezo surgical hand-piece                                    | Use of slow speed hand-piece, surgical hand-piece, or electric motor at speed < 60,000rpm |
| Air abrasion and air polishing                                      | No alternative                                                                     |
In addition, the use of high and slow speed suction and the use of rubber dam should be considered as far as possible when providing any operative procedure. Impressions should be decontaminated according to manufacturer’s instructions. Adjustment of decontaminated dentures, removable orthodontic appliances, or other removable appliances is acceptable.

Additional information on medical AGPs is available at:


The following steps should be considered to reduce the generation of aerosols:

- Provision of alternative treatments which are not AGPs
- Continued use of good moisture control and cotton wool
- The use of slow and high speed suction
- The use of rubber dam
- During surgical extractions the use of saline dispensed via a syringe or similar along with high speed suction may produce less aerosol than coolant from the hand-piece

6.5 Preventive Measures

Preventive advice is key to the re-establishment of the GDS including advice issued to individual patients and the promotion of good oral hygiene and diet advice for all patients.

Consideration should be given to the issuing of preventive advice to patients particularly those who have had treatment postponed and those in high risk and vulnerable groups. The following approaches should be considered:

- Oral hygiene advice
- Dietary advice
- Fluoride advice (toothpastes and mouthwashes)
- Prescription of high strength fluoride toothpastes (2800 and 5000ppm)
- Use of anti-microbial mouthwashes
- Smoking cessation advice

Practices could consider utilising their social media accounts and websites to share preventive advice and oral health promotion messages.

Further guidance in regards to preventive care includes:


Online resources in relation to oral health promotion include:

https://www.dentalhealth.org/

http://www.dentalbuddy.org/

https://www.bsdh.org/index.php/oral-health-resources

https://teethteam.org.uk/dental-professionals.php

https://www.bspd.co.uk/Resources

https://www.bspd.co.uk/Portals/0/Press%20Releases/BSPD%20Press%20Release%20Dr%20Ranj%20Videos%20Launch.pdf

https://www.stopsmokingni.info/
7.0 Air Changes per Hour Worked Examples

The ACH of a surgery can be calculated as follows using information found in the specification or manual of the ventilation or air flow system present in the room:

\[
ACH = \frac{\text{Air Flow Rate from manufacturer’s specification (m}^3\text{ per hour)}}{\text{Surgery volume (m}^3\text{)}}
\]

When using an air cleaner the equivalent ACH can be calculated as follows with an efficacy of 0.5 assumed:

\[
eACH = \frac{\text{Air Flow Rate from manufacturer's specification (m}^3\text{ per hour)}}{\text{Surgery volume (m}^3\text{)}} \times \frac{1}{2}
\]

Example 1: Mechanical Ventilation System
Air Flow Rate = 200 cubic feet per minute = 340 m\(^3\) per hour  
Surgery Size = 4m \times 3m \times 2.5m = 30m\(^3\)  
ACH = \(\frac{340}{30} = 11\) Air changes per hour

Example 2: Mechanical Ventilation System
Air Flow Rate = 200 cubic feet per minute = 340 m\(^3\) per hour  
Surgery Size = 5m \times 4.5m \times 2.5m = 56.25m\(^3\)  
ACH = \(\frac{340}{56.25} = 6\) Air changes per hour

Example 3: Air Cleaner combined with natural ventilation
Air Flow Rate = 400 m\(^3\) per hour  
Surgery Size = 5m \times 4.5m \times 2.5m = 56.25m\(^3\)  
eACH = \(\frac{400}{56.25} \times 0.5 = 3.5\) Air changes per hour

Example 4: Combined Mechanical Ventilation System and Air Cleaner
Ventilation Air Flow Rate = 340 m\(^3\) per hour  
Surgery Size = 5m \times 4.5m \times 2.5m = 56.25m\(^3\)  
ACH = \(\frac{340}{56.25} = 6\) Air changes per hour  
Air Cleaner Flow Rate = 400 m\(^3\) per hour  
eACH = \(\frac{400}{56.25} \times 0.5 = 3.5\) Air changes per hour  
Total ACH = ACH + eACH  
Total ACH = 6 + 3.5 = 9.5 Air changes per hour

Example 5: Use of two Air Cleaners combined with natural ventilation
Air Flow Rate = 200 m\(^3\) per hour  
Surgery Size = 4m \times 3m \times 2.5m = 30m\(^3\)  
ACH per air cleaner = \(\frac{200}{30} \times 0.5 = 3.3\) air changes per hour  
Total ACH = 3.3 \times 2 = 6.7 air changes per hour
Alternatively the ACH can be modelled or verified by a competent person for example a company registered with the Heating and Ventilating Contractors Association, a Chartered Engineer who is a member of Chartered Institution of Building Services Engineers or another appropriate professional body.

8.0 Hierarchy of Controls

This section is included to support practices to assess, manage and monitor risk in the context of managing infectious agents. The hierarchy of controls can be used to help implement effective controls, reduce the spread of respiratory pathogens and should be applied in order and used to identify the appropriate controls for your practice circumstances.

The key areas and measures are summarised below in order of effectiveness with all tiers within the hierarchy required to control and manage risk. It is strongly recommend that practices review the full guidance at https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/covid-19-guidance-for-maintaining-services-within-health-and-care-settings-infection-prevention-and-control-recommendations#HOC

8.1 Elimination (physically remove the hazard)

The most effective measure in the hierarchy of controls are those that eliminate risk. Key mitigations include:

- Patient screening (section 4.2)
- Postponement of non-urgent treatment on the respiratory pathway (sections 5.4 and 6.0)
- Staff screening (section 3.3)

8.2 Substitution (replace the hazard)

When the source of infection cannot be eliminated substitutions could be implemented to reduce or control the risk. Examples include remote assessment and remote treatment however this may not always be possible (section 5.4 and 6.2.2)

8.3 Engineering controls (control, mitigate or isolate people from the hazard)

Engineering controls are used to reduce or control the risk of exposure at the source. Key mitigations include:

- Maintenance of ventilation systems (section 5.4.5)
- Dilution of air with natural ventilation
- Use of screens that do not impact on air flow within the room
8.4 Administrative controls (change the way people work)

Administrative controls, including updating practice procedures and processes, help to prevent the introduction of infection and to control and limit any potential transmission. Key mitigations include:

- Patient screening prior to attendance (section 4.2)
- Maintaining separation of the respiratory and non-respiratory pathway (section 5.4)
  - Through appointment planning e.g. seen at different times
  - Through patient placement e.g. seen in different places
- Social distancing (section 2.0)
- Staff training on updated policies and procedures (section 3.2)
- Education of and communication with patients (sections 2.1 and 4.9)
- Use of appropriate hand hygiene for staff and patients (section 2.1 and 5.1)
- Safe spaces for staff (section 2.5)
- Regular cleaning of non-clinical areas (section 2.0)
- Adherence to IPC guidance (section 5.0)

8.5 Personal Protective Equipment

PPE is considered the least effective of the hierarchy of controls and should be considered in addition to all previous mitigations. PPE considerations include:

- Use of appropriate PPE when required (section 5.0)
- Adequate supply of PPE
- Fit-testing for staff wearing FFP3 masks (section 5.4.4)
- Universal use of face masks and face coverings (section 2.1 and 5.0)
- Staff training on the donning, doffing and disposal of PPE (section 3.2, 5.3.4 and 5.4.4)
- Visual communication with patients on display communicating the importance of face covering, PPE, hand hygiene and social distancing (section 4.8 and 11.0)
9.0 Acknowledgements

The HSCB would like to thank the GDS Re-Establishment Group for the initial development of this guidance.

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Philip McLorinan  GDP, NIDPC
Michael O’Neill  GDOS, DoH
William Priestley (Chair)  Dental Adviser, HSCB
## 10.0 Amendments

<table>
<thead>
<tr>
<th>Date</th>
<th>Amendment</th>
</tr>
</thead>
<tbody>
<tr>
<td>05/06/2020</td>
<td>Initial publication</td>
</tr>
<tr>
<td>19/06/2020</td>
<td>Addition of section 5.6 and 6.0 and rewording of introduction to reflect this addition.</td>
</tr>
<tr>
<td>22/06/2020</td>
<td>Clarification in relation to the use of re-useable PPE in section 5.6</td>
</tr>
<tr>
<td>09/09/2020</td>
<td>Insertion of risk stratification information from UK COVID IPC guidance in section 4.1 with minor adjustments throughout document to reflect updated guidance. Sections 4.1 to 4.5 renumbered to 4.2 to 4.6 Section 5.6.1 re-worded and appendix 7.0 inserted to provide further clarification in relation to fallow times. Appendix 7.0 and 9.0 renumbered to 8.0 and 9.0 Other updates in relation to CMO letters and NI legislation</td>
</tr>
<tr>
<td>21/10/2020</td>
<td>Substantial update to sections 5.6, 6.4 and 7.0 following publication of SDCEP Rapid Review of AGPs in Dentistry and UK COVID-19 IPC Dental Appendix. Insertion of sections 3.3.1 and 4.6. Section 4.6 renumbered to 4.7</td>
</tr>
<tr>
<td>02/02/2021</td>
<td>Minor amendments</td>
</tr>
<tr>
<td><strong>22/12/2021</strong></td>
<td>Substantial update to all sections of the guidance following publication of revised UK COVID-19 IPC Dental Appendix.</td>
</tr>
</tbody>
</table>

Any queries in relation to this guidance can be forwarded to [gds.correspondence@hscni.net](mailto:gds.correspondence@hscni.net) in the first instance.
Patients MUST wear a face covering when visiting the dentist

Protect staff and protect the public
Patients MUST wear a face covering when visiting the dentist

Protect staff and protect the public
Dentistry during the pandemic

Enhanced PPE
Dentists are still working in full PPE

Reduced numbers
Infection control means fewer patients can be seen

Patient triage
Dentists are treating people with urgent needs first

Patient self-care
Dentists are providing more telephone advice

Patients MUST wear a mask when attending a surgery.
Your safety is our #1 priority.
Example Respiratory Screening Questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do you have any of the following symptoms:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• high temperature or fever?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• new, continuous cough?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• a loss or alteration to taste or smell?</td>
<td></td>
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<tr>
<td>If yes, apply TBP's or if treatment can be deferred, reschedule</td>
<td></td>
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<tr>
<td>providing this is not detrimental to patient care/treatment plan.</td>
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<tr>
<td>2. Have you or any member of your household/family had a</td>
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<tr>
<td>confirmed diagnosis of COVID-19 in the last 10 days?</td>
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<tr>
<td>If yes, apply TBP's or if treatment can be deferred, reschedule</td>
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<td>providing this is not detrimental to patient care/treatment plan.</td>
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<tr>
<td>3. Are you or any member of your household/family waiting</td>
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<td>for a COVID-19/SARS-CoV-2 PCR test result?</td>
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<td>If yes, apply TBP's or if treatment can be deferred, reschedule</td>
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<tr>
<td>providing this is not detrimental to patient care/treatment plan.</td>
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<td>4. Have you travelled internationally in the last 10 days to a</td>
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<td>country that is on the government red list?</td>
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<tr>
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<td>providing this is not detrimental to patient care/treatment plan.</td>
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<td>5. Have you or any member of your household/family been</td>
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<td>advised to isolate by any NHS organisation in the last 10 days?</td>
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<td>If yes, apply TBP's or if treatment can be deferred, reschedule</td>
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