IPC UPDATE - A GUIDE FOR PRIVATE DENTAL PRACTICES

11TH JANUARY 2022

BRITISH ASSOCIATION OF PRIVATE DENTISTRY

THIS DOCUMENT IS PRODUCED TO ASSIST PRACTICES AS THEY TRANSITION FROM THE PREVIOUS COVID PROTOCOLS TO THE UPDATED IPC GUIDELINES. TO AVOID CONFUSION, IT IS INTENTIONALLY A 'CUT AND PASTE' STYLE, WITH ADDITIONAL COMMENTS WHERE NECESSARY. YOU SHOULD STILL READ THE IPC GUIDELINE AND THE DENTAL APPENDIX IN FULL.

INTRODUCTION

Private dentists and their teams have shown remarkable resilience and functioned under difficult circumstances during the Covid-19 pandemic. Without any special support for the sector from the government, most private practices nevertheless invested heavily to enable the safe reopening and ongoing safe delivery of the full range of dental services from June 2020. Private practices often found themselves the only available dental service for patients while other practices were either shut or providing a very limited service. In some areas the limited access situation is ongoing.

As the Nation seeks to transition to normal life while dealing with the challenges of Covid, the profession has also been waiting for the evolution of guidelines that will enable the continued safe transition of UK dentistry to some sort of sustainable normality.

This document has been produced using the information largely as presented in the latest release of the IPC guidelines and Dental Appendix on 24 November 2021. It is intended to assist members of The British Association of Private Dentistry (The BAPD), in drawing up their own practice protocols and adopting an approach that complements the updated UK IPC guidance for dental settings. It is hoped this will support the ongoing safe delivery of private dental care. It uses the COVID-19: infection prevention and control dental appendix guidelines and where necessary to ensure a consistent approach across the profession, references or uses parts of the SOP released by the OCDO.

This document should be used in conjunction with the IPC and the Dental Appendix. Any actions or protocols employed should take into consideration the unique circumstances of each individual situation and the clinical judgement of the dental team.

Implied guidance in this document is not intended in any way to supersede any legislation or regulation from relevant authorities.

Employers should comply with all applicable legislation, regulations (including the Health and Safety at Work Act) and employment law.

Those in England providing any NHS dental care should familiarise themselves with the full updated SOP document published by the OCDO.

Those providing any NHS dentistry in NI, Scotland and Wales should also look to the updated NHS SOP's as they become available in each Nation.

BACKGROUND

On the 24th of November 2021, The UK Health Security Agency (UKHSA), NHS England, Public Health Wales and Public Health Agency (Northern Ireland) published the revised COVID-19: infection prevention and control (IPC) guidelines, now encompassing ALL winter respiratory viruses and titled Infection prevention and control for seasonal respiratory infections in health and care settings (including SARS-CoV-2) for winter 2021 to 2022.

This document:

- Is applicable to all UK settings where healthcare is delivered
- Takes into consideration the impact of all seasonal respiratory infections
- Outlines the IPC principles and expected safe systems of work
- Forms the basis for the revised Dental Appendix

The revised Dental Appendix is applicable to England, and provides the detail applicable to all those providing dental care in England, irrespective of setting.

(Links to updated guidelines for the other nations will be added as they become available)

The whole Dental Team, including Dental practice owners, Associates, DCPs, Dental Practice Managers, Receptionists and anyone else associated in any way with the management and delivery of dental care should refer to both documents and any other guidance subsequently released by regulatory authorities.

THE UK IPC - WHAT'S CHANGED?

In addition to SARS-CoV-2 (including variants of concern) this guidance now considers other seasonal respiratory infections, including influenza and RSV. Decision makers are advised to use local and national prevalence and incidence data during the winter months to guide local service delivery.

There is an emphasis on risk assessment, especially the requirement for rigorous screening of patients prior to attendance.

The main changes from the previous version of this guidance include:

- removal of the 3 distinct COVID-19 care pathways (high, medium and low)
- adoption of the hierarchy of controls
- use of a screening tool to place patients on either a non-respiratory or a respiratory pathway
- for the non-respiratory pathway, guidance that physical distancing should be at least 1 metre in all areas where possible, for example when not providing direct clinical care. This should be increased to 2 metres whenever feasible

What has not changed:

- organisations and employers have a responsibility to assess, manage and monitor risk, based on the measures prioritised in the hierarchy of controls
- all patients should be screened for COVID-19
- universal masking/face coverings to remain as an IPC measure for staff and patients within dental settings across the winter period
- patients with suspected or confirmed respiratory infection should have non-urgent treatment deferred if it is considered clinically appropriate
- patients with symptoms of respiratory infection, or who have a confirmed respiratory infection, and whose treatment cannot be deferred, should be segregated or isolated, for example separated by space or time, from other patients
- continuation of 2 metres physical distancing for patients with suspected or confirmed respiratory infection

UNDERSTANDING AND USING A HIERARCHY OF CONTROLS

A key aspect of adopting the new IPC guidelines is an understanding of a hierarchy of controls. When the 'hierarchy of controls' is applied in order, the dental team will be able to identify the appropriate controls to reduce risk to service users and the dental team. The safe systems of work outlined in the hierarchy of controls, include:

Elimination - using triaging or screening to ensure potentially infectious patients or team members, **where possible**, do not attend the practice until they are well. Sometimes it may not be possible to defer a patient's treatment

↓

Substitution - this is not always possible in a dental practice but sometimes, for example, a video consultation might be appropriate, especially where the patient and the clinical problem is known to the clinician

↓

Engineering - ventilation, barriers, screens

↓

Administrative controls - see here for examples, but these often involve changing the way the team would usually work, so as to minimise risk

↓

PPE - after applying or considering all the above, and an unacceptable risk of transmission remains, it may be necessary, for example, to consider the extended use of RPE for patient care in specific situations.

Applied sequentially, elimination, substitution, engineering, administrative controls and personal protective equipment (PPE), are an integral part of IPC measures. Organisations and dental practice owners have a responsibility to ensure risk assessments are undertaken in the context of managing infectious agents. Key areas and measures for assessment are outlined in the main IPC guidance.

CONSIDERATIONS FOR THE PLANNING AND DELIVERY OF DENTAL SERVICES

1. Patient Screening

- All patients should be screened in advance of their appointment.
- Patients should also be screened on arrival at the practice.
- Accompanying persons such as carers or parents should be identified and screened in the same way as patients
- Use the UK IPC sample screening tool for COVID-19 for health and care settings (winter 2021 to 2022) and regularly check the .uk.gov site for any updates

2. Placement of patient on Respiratory or Non-Respiratory pathway

On completion of the screening and risk assessment the practice should determine whether the patient is to be placed on the **respiratory pathway** or the **non-respiratory pathway** and whether face to face dental care is to proceed.

Diagram summarising the two pathways for patients attending dental settings

3. Delivery of care

A. Non-Respiratory pathway

For patients on the non-respiratory pathway:

- Dental care may proceed using standard infection control precautions for both AGP and non-AGP treatments (The list of AGP's is currently under review.)
- **No Fallow time** requirement post AGP

B. Respiratory pathway

For patients on the respiratory pathway:

- Triage by a dental professional to determine whether care can be deferred until respiratory symptoms resolve or any COVID-19 isolation period has been completed.
- Where face to face care is necessary patients should be separated in time or space from other patients.
- Transmission-based precautions (TBPs) apply in addition to SICPs.
- Fallow time is required post AGP

A SPECIAL NOTE ON VULNERABLE PATIENTS

Patients who are identified as vulnerable or extremely vulnerable may be seen for dental care in the same way as other patients. It is now accepted that for most of these patients the risk of COVID-19 infection (and therefore having a serious outcome) will be considerably reduced because of the vaccine programme, however the dental team should remain vigilant for further guidance that may pertain to emerging variants.

Patient preference: The dental team should be aware that someone with a health condition may want to take additional precautions that they feel are right for them. These could include:

- Preferring to continue social distancing
- Preferring to avoid crowded waiting rooms

The latest government guidance is here

DOMICILIARY DENTAL SERVICES

The IPC guidance applies to all settings. Patients should be screened in advance *and* upon the arrival of the dental team

Those patients with suspected or confirmed Covid-19 should be treated using the respiratory pathway:

- Routine care visits should be deferred.
- If care cannot be deferred TBPs must be used.
- Patients who require urgent care involving an AGP, should receive that care in an appropriate clinical dental setting

DENTAL TEAM TESTING BEFORE DOMICILIARY AND CARE HOMES VISITS

Care Homes:

- All visiting professionals who are not regularly tested through another route such as NHS staff, should be tested on the day of their visit, similar to visitors. For further guidance on testing for visiting professionals, see here.

Domiciliary visits:

- Pre-visit COVID-19 risk assessment and testing of the dental team.
- As well as undertaking their own risk assessment, dental teams should be part of a risk assessment by the home-care team.

VENTILATION REQUIREMENTS

- All enclosed workplaces must be ventilated by natural or artificial means as set out in the Workplace (Health, Safety and Welfare) Regulation.
- Clearance of infectious particles after an aerosol generating procedure (AGP) is dependent on the ventilation and air change within the room.
- Current healthcare guidance for new buildings and major refurbishments specifies that a treatment room should have at least 10 air changes per hour (ACH).
- Specialist advice should be sought on how best to achieve the recommended air changes.

Q. Can an Air Cleaner or Air Purifier suffice?

The SAGE EMG position on air cleaners is:

"Air cleaning devices are not a substitute for ventilation, and should never be used as a reason to reduce ventilation; all occupied spaces must have some background ventilation to be suitable for human habitation and to comply with building and workplace regulations"

However, they also acknowledge that air cleaners "may be suitable for spaces where there is insufficient ventilation and the ventilation can't be improved. There is currently very little evidence that air cleaners are an effective control to prevent COVID-19, however the principles of air cleaning suggests that they may be useful in some cases". Further information on ventilation for dentistry is available here.

For the avoidance of doubt: we understand that there MUST be a source of fresh air to the treatment room.

It is recognised that transitional arrangements may need to be in place to support dental practices where air changes are unknown or below this recommended level.

OCCUPATIONAL HEALTH FOR THE DENTAL TEAM

Vaccination:

England: The Department of Health and Social Care (DHSC) has formally announced that individuals undertaking Care Quality Commission (CQC) regulated activities in England must be fully vaccinated against COVID-19 to protect patients no later than 1st April 2022, regardless of their employer, including secondary and primary care. This applies to the whole of the dental sector in England (both NHS and private care) and is expected to pass into legislation in January.

In practical terms, this means that unvaccinated individuals will need to have had their first dose by 3rd February 2022, in order to have received their second dose by the 1st April 2022 deadline.

Scotland Details will follow as we receive them

Northern Ireland Details will follow as we receive them

Wales Details will follow as we receive them

Respiratory infection of a dental team member:

- **Symptoms + Negative PCR test:** consider the risk to service users (particularly those who are immunosuppressed or at high risk of complications from respiratory infections) before returning to work.
- **Once medically fit to return to work:** If a team member is in any doubt about risk they may pose to service users or colleagues, this should be discussed with their line manager in the first instance.
- **Staff who are fully vaccinated against COVID-19 and are a close contact of a case of COVID-19, not in their own household:** may be allowed to return to work without the need to self-isolate. Please keep an eye on specific guidelines as they could change.

- **Requirements for PCR and lateral flow device (LFD) antigen testing:** There are country-specific variations on the requirements for PCR and lateral flow device (LFD) antigen testing and these policies are under continual review and subject to change. Refer to country specific policy for:
- **England** – COVID-19 management of exposed healthcare workers and patients in hospitals and accompanying letter issued by NHS England
- **Scotland** – Coronavirus (COVID-19) – exemption of fully vaccinated social care staff from isolation: information for providers
- **Wales** – COVID-19 contacts: guidance for health and social care staff
- **Northern Ireland** – management of self-isolation of close contacts of COVID-19 cases who are fully vaccinated - additional safeguards for health and social care staff

Staff asymptomatic testing (PCR or LFD) for SARS-CoV-2

Must be implemented in accordance with current national and local policy.

- **England** – Asymptomatic staff testing for COVID-19 for primary care staff
- **Scotland** – COVID-19 healthcare worker testing
- **Wales** – COVID-19 testing health and social care staff
- **Northern Ireland** – COVID-19 health and social care workers

Risk Assessment for 'at risk' team members

A risk assessment is required for health and care staff who may be at high risk of complications from respiratory infections such as influenza and severe illness from COVID-19, for example, pregnancy, medical, genetic or any other predisposition Guidance on carrying out risk assessments is available here.

Safe Systems at Work and Correct use of PPE

As part of an employer's duty of care, they have a role to play in ensuring that staff understand and are adequately trained in safe systems of working, including donning and doffing of PPE. A fit testing programme must be in place for those who may need to wear respiratory protection.

Other

The main IPC guidance provides further information about hand hygiene, respiratory and cough etiquette, safe management of the care environment.

1.PATIENT SCREENING

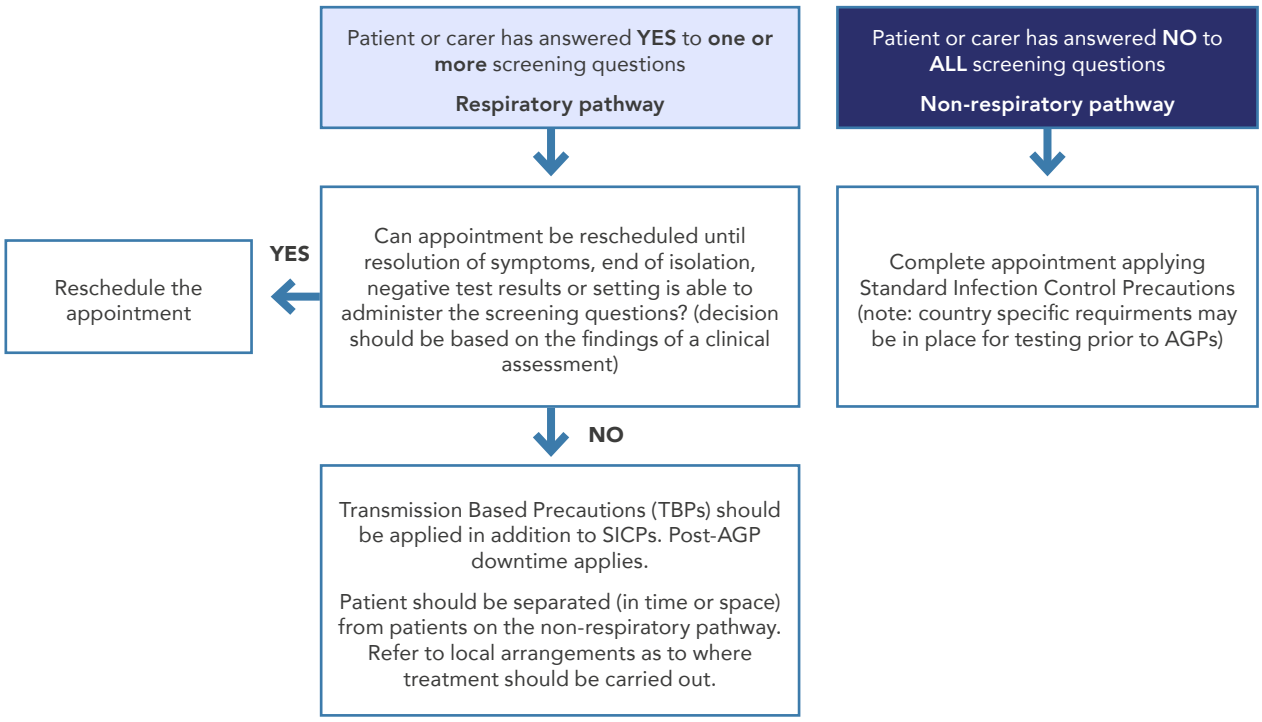
In the guidance, screening is used to identify patients, who may have COVID-19 but who do not display any symptoms, before and at entry to the dental practice.

- Country-specific requirements for screening may vary and should be followed.
- Screening of patients in advance of them attending will:
    - minimise the risk to staff and other patients and
    - minimise the inconvenience to the patient
- Screening for early recognition of COVID-19 should be undertaken for all patients.
- Wherever possible Screening should be done prior to attendance at the dental setting to ensure rapid implementation of recommended control measures.
- Patients should be encouraged to inform the dental setting as soon as any symptoms occur and not to wait until the day of the appointment.
- Signage should be displayed prior to and on entry to the dental setting instructing patients with respiratory symptoms or suspected or confirmed respiratory infection to inform reception staff immediately on their arrival.
- Screening should be undertaken by staff who are trained and competent. See Appendix 1 for an example of COVID-19 screening questions.
- Screening for COVID-19 should also be applied to individuals accompanying the patient.
- Anyone accompanying the patient should be advised not to attend if they have symptoms of respiratory infection.
- Accompanying persons who are symptomatic should not be permitted to enter the dental setting. Exceptions should only be made for specific circumstances and following a risk assessment.

Use of rapid COVID-19 testing

- is not a requirement of the respiratory or non-respiratory pathway. Dental settings may choose to use LFD testing to provide pre-appointment testing as part of their risk mitigation, providing it is agreed by the country that they are working in that this is an appropriate use for these tests.
- As testing arrangements are a devolved responsibility, settings should ensure that any testing is carried out in line with country specific requirements.
- Lack of a negative test must not be used to refuse patient care.

Based on the screening, patients attending for an appointment will be assigned into either Non-Respiratory or Respiratory pathways for their treatment.



USE OF MASKS IN THE DENTAL PRACTICE

Patients and visitors

Universal masking to prevent the transmission of SARS-CoV-2 and other respiratory infectious agents in dental settings should continue to be applied for all patients and visitors.

- **Non-Respiratory Pathway**: For patients on the non-respiratory pathway, face coverings are acceptable.
- **Respiratory Pathway**: Patients with confirmed or suspected respiratory infection should be provided with a surgical facemask (Type II or Type IIR). The patient requirement to wear a surgical facemask must never compromise their clinical care.

The Dental Team

Surgical facemasks should continue to be worn during the winter period 2021 to 2022 by staff in all areas within dental settings, except in staff areas when eating and drinking.

Organisations in Scotland should refer to Coronavirus (COVID-19): Guidance on the extended use of facemasks and face coverings in hospitals, primary care and wider community care settings.

Surgical masks (Type IIR)

Surgical masks can be either Type II or Type IIR. When worn as PPE to protect against splash or spray, a fluid-resistant surgical mask (FRSM) (Type IIR) should be worn.

Surgical masks must:

- be well fitted covering both nose and mouth
- not be allowed to dangle around the neck after or between each use
- not be touched once put on
- be changed when they become moist or damaged
- be disposed of as single use
- be worn once and then discarded as healthcare (clinical) waste. Hand hygiene must always be performed after disposal

PHYSICAL DISTANCING

Physical distancing is the recommended distance that should be maintained between staff, patients and visitors unless mitigations are in place such as the use of PPE.

- A physical distance of at least 1 metre between and among patients, staff, and all other persons in healthcare settings is advised by the WHO. This distance should be increased wherever feasible
- Physical distancing should remain at 2 metres where infectious respiratory patients are cared for.
- Patients who have been screened to the non-respiratory pathway are able to sit in waiting rooms together provided a physical distance of at least 1 metre can be maintained.

2. NON-RESPIRATORY VS RESPIRATORY PATHWAY

A. Non-Respiratory pathway

- Dental care may proceed using standard infection control precautions (SICPs) for both AGP and non-AGP treatments (The list of AGP's is currently under review.)
- No Fallow time requirement post AGP

IMPORTANT NOTE: The application of SICPs during care delivery is determined by

- an assessment of risk to and from individuals
- the task,
- the level of interaction and/or
- the anticipated level of exposure to blood and/or other body fluids.

TBPs, as outlined in the guidance, are not routinely required. However, the application of IPC measures must be assessed, and risks mitigated as outlined under the hierarchy of controls.

B. Respiratory pathway

- Triage by a dental professional to determine whether care can be deferred until respiratory symptoms resolve or any COVID-19 isolation period has been completed.
- Where face to face care is necessary patients should be separated in time or space from other patients.
- Transmission-based precautions (TBPs) apply in addition to SICPs.
- Fallow time is required post AGP.

3. DELIVERY OF CARE

A. Treating Patients in the Non-Respiratory Pathway

When the screening process and risk assessment has identified the patient as suitable for treatment in the Non-Respiratory pathway:

- Standard infection control precautions (SICPs) are to be employed.
- SICPs are to be used by all staff, in all care settings, at all times, for all patients.
- National (country specific) policy for SICPs should be followed. These are available for Wales, Northern Ireland, and Scotland. NHS England is developing a national IPC Manual for England as set out in the UK 5-year Tackling Antimicrobial Resistance National Action Plan (2019 to 2024).
- Ventilation guidelines must be followed.

PPE (Personal protective equipment) and processes to be used as part of SICPs when treating patients on the non-Respiratory pathway in the Dental Setting. This includes AGP and non-AGP procedures

- Hand hygiene
- FRSM Type IIR
- Single use disposable gloves*
- Single use disposable plastic apron**
- Eye protection***

* Vinyl gloves are not recommended for direct patient care; they may be used for equipment and environmental cleaning.

** Required when carrying out close contact patient care and AGPs. A single use fluid repellent gown should be used if an apron will not provide adequate protection against splashing or spraying.

*** Goggles or visor. Regular corrective spectacles are not considered as eye protection.

B.TREATING PATIENTS IN THE RESPIRATORY PATHWAY

(KNOWN OR SUSPECTED INFECTION)

When the screening process and risk assessment has identified the patient for treatment in the Respiratory pathway, TBP's are applied in addition to SICPs.

- **Patients attending the practice:** should be segregated from other patients as promptly as possible. If a separate room is not available, the patient should be asked to return home or return to their car and asked to phone the dental setting so arrangements for their care can be discussed.
- **Consider deferral of treatment:** A Clinical Assessment should take place to determine whether it is appropriate to defer treatment. This assessment can be undertaken remotely if appropriate. Treatment should not be deferred without this Clinical Assessment
- **Antibiotic Stewardship:** If treatment is deferred antibiotic stewardship is advocated to ensure antibiotics are only prescribed when appropriate. UK guidelines on antimicrobial stewardship can be found at dental AMR toolkit.
- **Transferral of care to an Urgent Care Centre:** Depending on local arrangements, patient care could be transferred to a designated site, for example an urgent care centre.
- **Face to Face attendance:** patients should be separated in time or space from other patients.
- **Arrival:** patients are advised to arrive on time (not early) and wait in their car or outdoors if possible, until contacted to advise to enter the building for their appointment
- **Patients should wear surgical facemasks** whilst in the dental setting
- **Separate waiting and Reception areas** should be used
- **Timing of appointments:** these individuals should be seen at the end of the day or session to reduce any post AGP downtime (where an AGP is performed) impacting on the remaining patient consultation list.
- **Physical distancing of at least 2 metres is required** for patients on the respiratory pathway.
- **Treatment areas:** Where space allows, a dedicated consultation or treatment room should be identified for placement of individuals with respiratory symptoms.
- **Multiple chairs in the same room**: in settings where multiple chairs are in

use in the same room, there should be physical spacing of at least 2 metres and airborne precautions should be applied. Where possible patients with a known or suspected respiratory infection should be managed in a closed surgery with adequate ventilation.

- **Accompanying persons** should not be present during AGPs unless they are considered essential following a risk assessment, for example a carer, parent or guardian
- **Ventilation:** each clinical area must have adequate ventilation
- **Transmission-based precautions (TBPs)** apply in addition to SICPs.
- **Fallow time is required post AGP**
- National (country specific) policy should be followed.

PPE (Personal protective equipment) and Processes to be used when treating patients on the Respiratory pathway in the Dental Setting:

NON-AGP

- Hand hygiene
- FRSM Type IIR
- Single use disposable gloves*
- Single use disposable plastic apron**
- Eye protection***

AGP

- Hand hygiene
- FFP3 or Respirator/hood
- Single use disposable gloves*
- Single use disposable plastic apron**
- Eye protection***

* Vinyl gloves are not recommended for direct patient care; they may be used for equipment and environmental cleaning.

** Required when carrying out close contact patient care and AGPs. A single use fluid repellent gown should be used if an apron will not provide adequate protection against splashing or spraying.

*** Goggles or visor. Regular corrective spectacles are not considered as eye protection.

RESPIRATORY PROTECTIVE EQUIPMENT (RPE)

1. Respirators can be single use or single session use (disposable or reusable).

2. **England:** Reusable respirators can be used if they comply with HSE recommendations and should be decontaminated and maintained according to the manufacturer's instructions.

3. **Check Country specific guidelines:** In some countries of the UK reusable respirators are not recommended. Dental settings should check the relevant country-specific advice on the use of reusable respirators.

4. All tight fitting RPE, for example FFP3 (filtering facepiece or hood) respirators must:

    - be fluid-resistant
    - be fit tested on all healthcare staff who may be required to wear a respirator to ensure an adequate seal and fit according to the manufacturer's guidance. Where fit testing fails, suitable alternative equipment must be provided
    - be fit checked (according to the manufacturer's guidance) every time a respirator is donned to ensure an adequate seal has been achieved
    - be compatible with other facial protection used, for example protective eyewear, so that this does not interfere with the seal of the respiratory protection
    - be disposed of and replaced if breathing becomes difficult, the respirator is damaged or distorted, the respirator becomes obviously contaminated by respiratory secretions or other body fluids, or if a proper face fit cannot be maintained
    - not be allowed to dangle around the neck of the wearer or hang from one ear after or between each use
    - not be touched once put on

Remove RPE and eye protection in a safe area (for example outside the clinical area). If RPE is removed in a clinical area following an AGP, appropriate post AGP downtime must have elapsed before the RPE is removed. All other PPE should be removed in the patient care area. Perform hand hygiene after removing and disposing of RPE.

Further information regarding fitting and fit checking of respirators can be found on the Health and Safety Executive website.

Respirators with exhalation valves are not fluid-resistant unless they are also 'shrouded'. Valved non-shrouded respirators should be worn with a full-face shield (a Type IIR mask is not acceptable) if blood or body fluid splashing is anticipated.

Respirators and powered hoods with exhalation valves should not be worn by a healthcare worker when sterility directly over the surgical field is required, for example in theatres or surgical settings or when undertaking a sterile procedure as the exhaled breath is unfiltered.

Dental care such as surgical extractions and implant placement are not considered sterile procedures in this context. It is unlikely that this will apply to situations where an FFP3 is worn while carrying out surgical procedures in primary care settings as they are not usually considered sterile procedures. See CAS alert for more information.

Further information on RPE can be found in section 6.5.6 of the main IPC guidance.

GENERAL PPE GUIDANCE

ALL PPE must be:

- compliant with the relevant BS/EN standards (technical standards as adopted in the UK post-EU exit)
- located close to the point of use
- stored to prevent contamination in a clean/dry area until required for use (expiry dates must be adhered to)
- single use only, unless specified by the manufacturer
- disposed of after use into the correct waste stream for example healthcare waste

Hand hygiene should be performed after removal of PPE. See guidance on donning (putting on) and doffing (removing) PPE.

Any reusable PPE must have a decontamination process in place that follows the manufacturer's instructions, and responsibility assigned.

Disposable gloves should:

- be worn when exposure to blood and other body fluids, non-intact skin or mucous membranes is anticipated or likely
- be changed immediately after each patient and after completing a procedure or task even on the same patient
- be put on immediately before performing an invasive procedure and removed on completion
- not be decontaminated with alcohol-based hand rub (ABHR) or soap between use
- be changed when they become moist or damaged

Inappropriate use of gloves, that is not changing them as recommended above, risks the gloves contributing to the transfer of organisms and cross-infection.

Gloves are not required when undertaking administrative tasks for example using the telephone, using a computer or tablet, writing in the patient notes.

Gloves are not an alternative to hand hygiene.

Disposable plastic aprons (or gowns if an apron does not provide sufficient protection) should be worn to protect staff uniform or clothes from contamination when providing direct patient care (if there is a risk of extensive splashing or spraying) and during environmental and equipment decontamination.

Aprons should be:

- worn to protect uniform or clothes when contamination is anticipated or likely
- changed between patients or after completing a procedure or task
- fluid-resistant gowns should be worn when a disposable plastic apron provides inadequate cover of staff uniform or clothes for the procedure or task being performed and when there is a risk of extensive splashing of blood or other body fluids
- disposable aprons and gowns should be changed between patients and immediately after completion of a task
- disposed of and replaced if damaged

Aprons are not required when undertaking administrative tasks, (for example using the telephone, using a computer or tablet).

- Eye or face protection (including full-face visors) should:
- be worn if blood and/or body fluid contamination to the eyes or face is anticipated or likely and always during aerosol generating procedures
- not be impeded by accessories such as piercings or false eyelashes
- not be touched when being worn
- if reusable, must have a decontamination schedule in place in line with the manufacturers' instructions

Regular corrective spectacles are not considered as eye protection.

PPE AND SUSTAINABILITY

Disposable plastic aprons:

We are concerned about the recommendation to use disposable plastic aprons.

1. Scientific evidence: There is only very weak evidence to support the use of plastic aprons.

2. Efficiency: Their non-absorbent nature means that should significant droplet contamination occur, this will be distributed from the apron to both the operator and the immediate surroundings during doffing.

3. Environmental consideration: There is a significant environmental impact from the manufacture and disposal of plastic products.

Our objection to plastic aprons for the above reasons is not intended to override the formal guidance of the IPC but rather to encourage consideration of alternatives that are effective and environmentally friendly.

AEROSOL GENERATING PROCEDURE (AGP)

An AGP is a medical procedure that can result in the release of airborne particles (aerosols) from the respiratory tract. When treating someone who is suspected or known to be suffering from an infectious agent transmitted by the airborne or droplet route an AGP can transmit the infectious agent.

Currently Dental procedures that use high velocity air and water streams are considered AGPs and these include:

- ultrasonic scaler (including piezo)
- high speed air rotor (or electric rotor that is greater than 60,000 rpm)
- piezo surgical handpiece
- air polishers

3-in-1 syringe: Research has demonstrated that use of the 3-in-1 syringe with either air-only or water-only resulted in lower levels of contamination, with water-only causing the least contamination. There is currently no consensus to include the use of a 3-in-1 as an AGP. **Non-surgical dental extractions**: are not considered AGPs.

Practical considerations:

- AGPs should only be carried out when essential
- Only staff who are required to undertake the procedure should be present
- TBPs are required when undertaking AGPs for patients on the Respiratory Pathway.

POST AGP DOWNTIME (FALLOW TIME)

Post-AGP downtime/Fallow time IS NOT required for AGPs on the Non-Respiratory pathway (patients or individuals with no known, suspected or possible respiratory infection).

Post-AGP downtime/Fallow time IS required for AGPs on the Respiratory Pathway. (patients or individuals with known, suspected or possible respiratory infection).

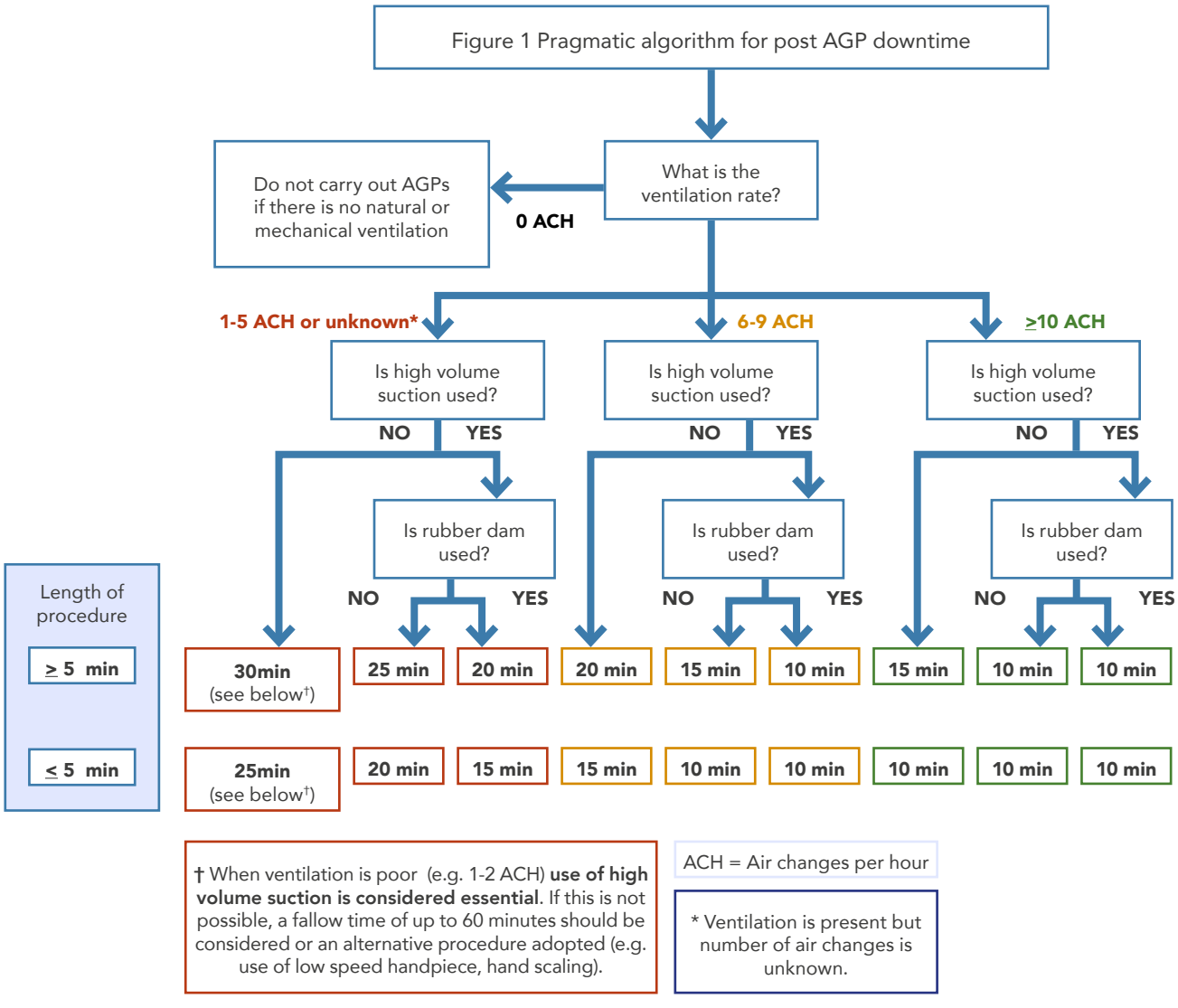
The Scottish Dental Clinical Effectiveness Programme, (SDCEP) has proposed a pragmatic algorithm (Figure 2 below) with mitigation factors for post AGP downtime. The SDCEP rapid review of AGPs is available here.

The working group advises that:

- **No natural (window) or mechanical ventilation:** No AGPs in that room
- **ACH unknown:** a baseline post AGP downtime of 30 minutes is recommended without mitigation such as high-volume suction/rubber dam. This can be reduced with mitigation factors such as high-volume suction/rubber dam
- **1 to 5 ACH:** a baseline post AGP downtime of 30 minutes is recommended without mitigation such as high-volume suction/rubber dam. This can be reduced with mitigation factors such as high-volume suction/rubber dam
- **6 to 9 ACH:** a baseline post AGP downtime of 20 minutes is recommended
- **10 or more ACH without mitigation:** a baseline post AGP downtime of 15 minutes is recommended
- **10 or more ACH with mitigation such as high-volume suction/rubber dam:** a baseline post AGP downtime of 10 minutes is recommended
- **Same household:** provided that mitigating measures such as screening, high volume suction/rubber dam and cleaning/disinfection of the environment are employed between patients, post-AGP down time is not considered necessary for successive appointments between members of the same household

- **Patients on the respiratory pathway** should be separated by space or time from other patients for example with end of session appointments
- **Maintenance of equipment**: All equipment, including ventilation, suction and air cleaners, should be maintained according to manufacturer's instructions and be operating effectively
- **A minimum post AGP downtime of 10 minutes** is required to allow larger droplets to settle before environmental cleaning
- **Post AGP downtime commences** at the end of aerosol production (i.e. as soon as the use of the piece of equipment generating the aerosol has ceased)

Figure 2: Algorithm for post AGP downtime



SAFE MANAGEMENT OF THE CARE ENVIRONMENT AND EQUIPMENT

Frequently touched sites and points in reception, waiting rooms and surgeries, for example dental chairs, should be cleaned between patients and:

- equipment used for cleaning, for example cloths, should preferably be disposable;
- reusable items such as mops/buckets should be stored clean and dry between use
- medical devices and equipment should be managed as per manufacturer's instructions
- Decontamination of equipment and the environment following dental treatment should follow country specific guidance for England, Scotland, Wales or Northern Ireland

Reusable Large Dental Equipment (for example dental chairs, cabinetry, dental lights, x-ray equipment) should be decontaminated following manufacturer's instructions:

- between patients
- after blood and body fluid contamination

Reusable Small dental equipment (for example handpieces, scalers, hand instruments) should be decontaminated in accordance with manufacturer's advice and in line with decontamination guidance.

Cleaning or disinfectant solutions and products:

- Only products that have proven efficacy against bacteria and viruses, including RSV, influenza and SARS-CoV-2 should be used
- Manufacturer's recommended 'contact time' must be followed for all cleaning or disinfectant solutions and products.

Areas where there may be higher environmental contamination: An increased frequency of decontamination and cleaning should be incorporated into the cleaning of, for example:

- toilets
- frequently touched surfaces such as door and toilet handles
- staff room equipment, for example kettles, microwaves, fridge handles

ADDITIONAL ADVICE FOR ENVIRONMENTAL MITIGATION MEASURES

Air cleaning devices

Recirculating air cleaning devices based on HEPA filter systems or UV-C are likely to be effective, but each device needs to be validated by the manufacturer and maintained.

There are currently no general recommendations for devices that remove viable microbes from air, either by filtration or microbicidal action. This is because there is variability in the rate they pass air through the device, the removal or inactivation will vary according to filtration or microbicidal efficacy, and over time filters will become progressively blocked. Microbicidal treatment such as UV can become obscured by a build-up of dust and the spectrum of UV emission, critical for microbicidal efficacy, can change over time.

Addition of recirculating air cleaning devices could enhance the effective air change rate. Devices should be correctly sized and the impacts on the room air flow considered. The effectiveness of air cleaning devices will depend on the flow rate of the device, the efficiency of air cleaning and the size of the room.

Fans

- should not be used on the respiratory pathway
- should be cleaned regularly to remove visible soiling
- should be directed to move air towards windows and mechanical extract points
- should not be directed towards doors, driving air into other rooms

Planned preventative maintenance, and cleaning of fans and their blades should continue.

Air conditioning units

Fixed and portable air conditioning units which do not recirculate to other rooms, can be used. Where there is poor air circulation within a room, it may be beneficial to mix air to dilute aerosols. These types of air conditioning will cool staff wearing water repellent PPE.

Portable air conditioning

- Should not be directed towards doors as this will drive air into other rooms,
- Pipework or cables should not impede fire doors.
- Care should be taken when emptying the reservoir of portable air conditioning due to the risk of legionella or other microorganisms being present in the condensate water. See separate HTM 04-01 guidance for England, Wales, Northern Ireland and Scotland on this.
- Daily emptying of the reservoir should be recorded.
- Planned maintenance should be carried out on the device following manufacturer's guidance and should be recorded.
- Do not use portable air conditioning that incorporates humidifiers.

Fumigation and fogging

The use of fumigation and fogging devices with disinfection chemicals are not advised for routine cleaning and or disinfection against COVID-19 and should only be considered in healthcare settings when multi-drug resistant organisms cannot be eradicated. Any use must always be under specialist IPC advice.

EMERGING VIRAL VARIANTS AND MUTATIONS

Omicron

The Omicron SARS-COV-2 variant, also known by the PANGO lineage identifier B.1.1.529, was made a variant of concern by the WHO on 26.11.2021 and has led to a rapid international response with specific changes to public mask/face covering guidelines and new PCR test requirements for International travellers arriving in England.

More and more cases are now being identified within the UK, and there is evidence of enhanced transmissibility. There is still no consensus on whether Omicron has altered morbidity or whether it has significant immune escape compared to the Delta variant. Reports from South Africa, and the rest of the world, suggest generally mild symptoms.

How does this affect the IPC Guidelines and the Dental Appendix?

The flexibility built into the updated guidelines allows practices to modify their operating procedure by undertaking a risk assessment and then adopting an approach in line with the hierarchy of controls. An important part of risk assessment includes Monitoring and Surveillance. In real terms, for a dental practice this means keeping an eye on local infection rates and on the emergence of new variants. This should happen on an ongoing basis and special notice paid to notifications from the authorities about variants of concern such as Omicron.

There is therefore no need to delay adopting the guidelines or wait for a further update, or revert to previous versions of guidelines. In simple practical terms, if a practice feels the risk is high, they should use the Respiratory Pathway and TBPs.

IPC UPDATE - A GUIDE FOR PRIVATE DENTAL PRACTICES

11TH JANUARY 2022

BRITISH ASSOCIATION OF PRIVATE DENTISTRY