This document is based on the latest available best practice and scientific evidence about this emerging disease and may change as new information becomes available

Transitioning Oral Healthcare to Phase 2 of the COVID-19 Response Plan

May 15, 2020

This document is for Oral Health Care Providers: certified dental assistants, dental hygienists, dental technicians, dental therapists, denturists and dentists.

Registrants are expected to read this guidance and follow the expectations within it as they resume the provision of dental care. It is a comprehensive document that covers topics such as ongoing pandemic best practices, personal protective equipment, and infection prevention and control principles and strategies. It applies to what the BC government is referring to as phase 2 of the pandemic.

College of Dental Hygienists of British Columbia

CDT bc

COLLEGE OF DENTURISTS of British Columbia

CDSBC College of Dental Surgeons of British Columbia

Table of Contents

1. Introduction

a. Purpose of the document

To consolidate existing standards, guidance and expectations and interim recommendations and considerations from government and other authoritative agencies for the treatment of patients during the COVID-19 pandemic. This document is to be considered in tandem with publications from the following agencies:

- BC Centre for Disease Control
  - COVID-19: Infection Prevention and Control Guidance for Community-Based Allied Health Care Providers in Clinic Settings (PDF)[1]
- Office of the Provincial Health Officer
- WorkSafeBC

This document is for Oral Health Care Providers (OHCPs): certified dental assistants, dental hygienists, dental technicians, dental therapists, denturists and dentists.

OHCPs employed by hospitals, health authorities, and long-term care facilities should refer to guidance provided by their employers and the Provincial Health Officer (PHO). The direction in this document pertains to the delivery of care outside of these settings. These include, but are not limited to, private practice clinics, private mobile or community-based practices, and school-based practices.

b. Objective of the document

To prevent and control the transmission of SARS-CoV2 during emergent, essential and non-essential care of patients by OHCPs.

c. Disease description

The causative agent of COVID-19 is severe acute respiratory syndrome coronavirus 2 (SARS –CoV-2). The incubation period, the time between exposure and potentially becoming infected, is on average 5-6 days, but can be up to 14 days with or without symptoms. During the asymptomatic period (pre-symptomatic period) some infected persons may be contagious. Transmission from a pre-symptomatic person can occur before the onset of symptoms.

d. Transmission

Transmission of COVID-19 is primarily from symptomatic people to others who are in close contact through respiratory droplets, by direct contact with infected persons or by indirect exposure through contact with contaminated objects and surfaces. COVID-19 is understood to be highly infective and easily transmissible. This evidence comes from data found in published epidemiological and virologic studies.

e. Disclaimer

Information in the document is based on the current evidence provided in the bibliographies of the authoritative agencies' publications and may be subject to change as continuing research becomes available.

2. Guiding Principles and Assumptions

The following guiding principles and assumptions have been identified as foundational for reintroducing non-essential oral health care services in the context of COVID-19.

- All OHCPs will follow the guidance, expectations, and direction provided by the Provincial Health Officer (PHO).
- Some services can be safely and effectively provided virtually. Other services require in-person visits including direct patient care. Oral health college standards and guidelines apply, regardless of whether services are provided virtually or in-person.
- Wherever possible, physical distancing will be maintained during the delivery of care.
- In-person services must only proceed when the anticipated benefits of such services outweigh the risks to the patient, the health professional and the greater community. It is always safer for the patient and the provider to stay home if at all possible.
- The OHCP is accountable and is the person best positioned to determine the need for, urgency and appropriateness of in-person care.
- Appropriate personal protective equipment (PPE) must be used for the safe delivery of in-person care. However, all OHCPs must also act to conserve PPE through its judicious use.
- OHCPs must consider if they are the most appropriate health professional to address the patient's needs, referring patients to other members of the health care team when in the patient's interest.
- OHCPs must not recommend unproven therapies for treating COVID-19.
- OHCPs must not prescribe or offer any COVID-19 treatments or therapies that are not within their scope of practice.
- OHCPs are accountable to provide clear, honest, transparent communication regarding their policies and procedures related to COVID-19.

3. Prioritization of Patient Care Services

It is anticipated that when services resume OHCPs may face difficult decisions regarding which patients to see and the prioritization of care. The OHCP is accountable for prioritizing access to in-person services based on clinical judgment and with consideration given to the patient perspective and the referral source. When determining priority for in-person care, OHCPs should reflect upon the following:

- Acuity of the patient's condition.
- Functional impairment or impact of the condition on health-related quality of life.
- The impact of not receiving services.
- Appropriateness of service provision via virtual care.
- Necessity of services which can *only* be provided in-person.
- Duration of patient wait times for care.

4. Ongoing Pandemic Best Practices

Public Health Officials have indicated that COVID-19 is expected to continue to circulate in the general population for an extended period of time. As such, ongoing measures to control the spread of the disease are anticipated, including requirements to practice physical distancing of at least 2 metres (6 feet) and increased screening for signs, symptoms and risk factors for COVID-19.

Oral Health Care Professionals:

- Must adhere to all BC Centre for Disease Control (BCCDC) and BC Provincial Infection Control Network (PICNet) guidance regarding infection prevention and control measures applicable to the practice environment, including PPE use and environmental cleaning best practices.
- Must adhere to all BCCDC and WorkSafeBC guidance regarding occupational health and safety exposure control plans to ensure a safe work environment for staff. This includes robust policies, procedures and organizational cultures that ensure that no employees associated with the practice attend work when they have symptoms of illness.
- Must **not** provide in-person care and should not be in attendance at clinics or other practice settings where other staff and patients are present if they are exhibiting signs of COVID-19 or respiratory illness, including cough, runny nose or fever.
- Follow BCCDC and WorkSafeBC guidelines for self-isolation when an employee is sick with any respiratory illness, support access to primary care provider assessment and testing, and provide sick-leave support where possible until advised by their health care provider that it is safe to return to work.
- Implement COVID-19 screening practices for patients:
    - Patients should also be encouraged to make use of COVID-19 resources by calling 811 or visiting healthlinkbc.ca.
    - Screen for risk factors and symptoms of COVID-19 prior to attendance at the practice environment. If patient screening reveals risk factors for COVID-19 or symptoms of COVID-19, defer patient (where reasonable) until signs and symptoms have resolved

OHCPs are not expected to provide treatment unless, in their professional opinion, it is safe to do so for both patients and staff.

5. Personal Protective Equipment

Regarding use of personal protective equipment (PPE), OHCPs should follow the directives and recommendations provided by BCCDC, PICNet, and WorkSafeBC. This includes directives that are role-based (e.g. administrative vs. direct patient contact) or specific to the practice context (e.g. mobile practice in long term care settings vs. community-based facilities).

6. Infection Prevention and Control Principles and Strategies

The risk of transmission of an infection as a result of an oral health procedure represents an important patient safety consideration.

In the context of COVID-19, a comprehensive approach includes maintaining routine practices, physical adaptations within the facility, hand hygiene and risk assessment with focus on aerosol and droplet management and contact precautions.

Infection Prevention and Control (IPAC) principles include:

- patient assessment;
- implementation of routine procedures;
- use of barrier techniques to protect patients, OHCPs and staff;
- application of the principles of cleaning, disinfection, sterilization and storage of dental instruments;
- environmental surface protection/cleaning;
- care of overall office setting; and
- safe handling and disposal of waste.

An IPAC strategy to reduce the possibility of disease transmission includes:

- setting specific policies and procedures to identify, communicate and implement effective standards and guidelines;
- written office policies and programs for effective occupational health and safety;
- educating OHCPs, staff and patients about their roles in infection prevention; and
- ongoing review and evaluation of IPAC policies and procedures.

7. Standards and Guidance for the Provision of Oral Healthcare During Phase 2 of the COVID-19 Response Plan

a. Patient management and safety

i. Pre-screening protocols

Pre-screening protocols and triage, either by virtual/remote technology or by telephone, must be provided for all patients. This includes asking patients:

- if they have symptoms of COVID-19
  - cough
  - sore throat
  - shortness of breath
  - runny nose, sneezing, post-nasal drip (coryza), loss of smell (anosmia) with or without fever
- if they have had close contact or have been in isolation with a suspected case in the last 14 days
- if they have travelled internationally in the last 14 days

When the patient arrives for their appointment, their pre-screening responses must be confirmed and recorded in their record.

If the patient has symptoms of COVID-19 and may be infective, OHCPs are encouraged to defer in-person assessment and treatment or alternatively provide care by virtual means. That is unless the oral health emergency is a greater risk than COVID-19. Where medical management of COVID-19 may be affected by deferring emergent dental treatment, there should be consultation with the primary care provider.

If the patient is COVID-positive, treatment should be provided in a hospital or tertiary care facility. Treatment can be provided in a dental practice if the facility and PPE requirements can be met.

High-risk patients

Patients considered high risk for severe COVID-19 include those with pre-existing conditions such as serious respiratory disease, serious heart conditions, immunocompromised conditions, severe obesity, diabetes, chronic kidney disease or those undergoing dialysis, and liver disease; pregnant patients; and patients who are 70 years and over. These patients should be deferred whenever possible.

Staff requirements:

- Staff must maintain awareness of data on the local and regional spread of COVID-19.
- Staff conducting telephone screening are provided with appropriate guidance on how to screen for signs and symptoms of COVID-19, when to advise patients to self-isolate at home, how to counsel them on signs and symptoms of more severe or critical illness that should prompt them to seek emergent care, and on the indications and locations for testing.
- On-site administrative staff who are screening patients must be behind a transparent barrier that prevents droplet transmission and allows for communication between staff and patients, or if this is not in place they must wear PPE (i.e., gloves, gown, mask and eye protection).

ii. Routine practices

Routine IPAC Practices (Standard Precautions) protect patients, OHCPs and staff. OHCPs must maintain routine practices, including risk assessment, hand hygiene, use of PPE and safe handling and disposal of waste.

Risk assessment

Risk assessment must be done before each in-person interaction to determine the interventions required to prevent disease transmission. Prior to any contact with the patient, the OHCP and staff must assess the infectious risk posed to themselves, other OHCPs, staff and patients. The risk will vary with the context of the patient and the type of procedure being contemplated. It is based on the OHCP's professional judgment and must take into consideration the physical environment, including any possible facility limitations, and the resources available, including PPE, in order to safely treat patients.

Hand hygiene

Hand hygiene is the single most important measure for preventing disease transmission.

- Hand hygiene must be performed:
    - when in the patient care environment
    - before and after direct contact with a patient
    - before procedures
    - after risk of body fluid exposure
    - before donning gloves and immediately after removing gloves
    - before and after mask use
    - after contact with environmental surfaces
    - after contact with dental laboratory materials or equipment and when hands are visibly soiled.

- Patients must perform hand hygiene with soap and water or with an alcohol-based hand rub (ABHR) after removing a mask or other PPE, coughing or sneezing, using a tissue or when hands are visibly soiled.
- Sinks with soap and water should be available to patients and staff. Non-touch waste receptacles for disposal of paper towels are preferred.
- ABHR must contain at least 70% alcohol and be available at multiple locations, including reception, waiting room, operatories and washrooms.

Personal PPE for patients

Routine protective measures including bibs, drapes and eye protection must be provided for patients.

iii. Additional precautions for COVID-positive patients

Enhanced practices must[2] be considered for patients with a positive social or medical history of COVID-19, this includes:

- Using tele-dentistry or providing other forms of remote oral health care where possible
- Providing patients with PPE, including a mask upon entry to the facility
- Offering hand hygiene on entering the facility, when leaving the operatory and prior to exiting the facility
- Maintaining a 2-metre separation from other patients and staff not directly involved in their care
- Isolating symptomatic patients as soon as possible. Place patients with suspected or confirmed COVID-19 in private rooms with door closed and private bathroom (where possible)
- Scheduling and managing high-risk patients so as to limit the opportunity for contact with other patients, OHCPs and staff (e.g. at the end of the day or session)

For patient advocates with COVID-19

Patient advocates who have signs or symptoms or potential exposures to COVID-19 (including via the patient they accompany) should be instructed to perform hand hygiene and put on a medical mask and asked to wait outside or return to pick up the patient after their appointment.

b. Oral Health Care Provider and staff safety

i. Screening and education

Screening

OHCPs and staff must be screened for symptoms of COVID-19. Respiratory symptoms, including cough, runny nose and/or fever, should be maintained in a daily log. OHCPs or staff with respiratory symptoms, gastrointestinal symptoms or any other illness must stay home.

- Staff ill, or with an unprotected exposure to someone with confirmed COVID-19, as defined by occupational health or their local public health department, or those otherwise determined to require self-isolation according to public health directives, must follow the policies of jurisdictional public health authorities to determine restrictions and when they can return to work.
- Prior to working every shift, staff must report to facility management if they have had potential unprotected exposure to a case of COVID-19 to determine whether restrictions are necessary (which may depend on local jurisdictional guidance), as well as consulting their own healthcare provider for any needed follow-up.
- Outpatient and community-based care settings must ensure that there are processes in place to conduct active screening of staff, external service providers, and patients (and their essential companions) for signs and symptoms of COVID-19.
- If a staff member develops signs or symptoms of COVID-19 at work they should immediately perform hand hygiene, ensure that they do not remove their mask, inform facility management, avoid further patient contact and leave as soon as it is safe to do so
- Staff with any signs or symptoms consistent with COVID-19, including mild or atypical symptoms, should be tested for COVID-19 and excluded from work, and advised to follow local public health guidance with regard to testing and further management.

OHCPs and staff health and work restrictions

Immunosuppressed staff and/or staff with other morbidities may be at risk. A collaborative discussion is appropriate with consideration of job functions and exposure risks.

Education and safety

OHCPs and staff must have basic knowledge of the disease, the infectivity and mode of transmission. Knowledge of effective hand hygiene, respiratory

etiquette, physical distancing and safe donning and doffing of PPE will increase compliance.

Provide staff with information and training on:

- the risk of exposure to COVID-19 and the signs and symptoms of the disease
- methods for maintaining physical distance, such as not greeting others by hugging or shaking hands
- changes made to work policies, practices and procedures due to the COVID-19 pandemic
- donning, using and doffing PPE
- ongoing training in the use of an N95 respirator, where applicable[3]
- how to report an exposure of COVID-19
- safe handling and effective application of cleaning products
- keep training records for staff, including records for safe work procedures, donning and doffing of PPE and N95 respirator fit testing (where applicable)

ii. Exposure prevention

May 15, 2020 5:00 pm: Note that immediately following the first publication of this document on the afternoon of May 15, 2020, the BCCDC published this document resulting in subsequent edits throughout section 7.b.ii (as highlighted below)[4]

The majority of exposures are preventable by following routine procedures. Where there is low incidence and prevalence of COVID-19, additional PPE over and above that required for normal precautions is not required.

Aerosol-generating medical procedures (AGMPs)

An AGMP is any procedure conducted on a patient that can induce production of aerosols of various sizes, including droplet nuclei.

PPE for OHCPs and staff

Every effort is made to make PPE available and accessible at the point-of-care with patient.

OHCPs must receive training in and demonstrate an understanding of:

- when to use PPE
- what PPE is necessary
- how to properly don, use, and doff PPE in a manner to prevent self-contamination

Safe donning and doffing practices must be followed. PPE should be removed in the following order: gloves, gown, protective eyewear (if separate from mask), mask and perform hand hygiene immediately afterwards. Hand hygiene should occur according to best practices for putting on and removing PPE.

Change into a separate set of street clothes and footwear before leaving work. Work clothing (e.g. scrubs) should be placed in a bag and laundered after every shift. Shower immediately upon returning home after every shift.

PPE storage

- PPE is stored to avoid pilfering, while not inhibiting staff from accessing PPE. There is regular assessment to determine stock of necessary PPE (e.g. gloves, gowns, masks, eye protection) and necessary supplies including ABHR.
- Appropriate number and placement of ABHR dispensers, at entry to the outpatient and community-based care setting, in hallways at entry to each exam room, communal areas and at point- of-care for each patient
- Respiratory hygiene products (e.g., masks, tissues, ABHR, no-touch waste receptacles) are available and easily accessible to staff and patients

Managing droplet and splatter

- High-volume suction must be used to reduce aerosols at source.
- A rubber dam should be used whenever possible, with high-volume suction in procedures where the creation of droplets, splatter and spray may occur.
- Unnecessary equipment and items must be removed from the operatory.
- Countertops and touched surfaces should be clear to enable covering with barriers and/or thorough cleaning and disinfection, decreasing opportunities for transmission.

Precautions for patients with suspected or confirmed COVID-19 or airborne diseases

- Use an N95 respirator and eye protection (i.e., goggles or face shield), gloves and gown for procedures that are aerosol generating for patients with suspected or confirmed COVID-19 or airborne diseases.
- Consider limiting the number of staff providing their care.
- AGMPs should be kept to a minimum and procedures completed in one appointment whenever possible to reduce risk of transmission.
- If AGMPs are performed:
    - There is appropriate training and N95 respirator fit-testing for all staff who may be required to participate in or who may be exposed to these procedures
    - Staff IPAC training, education and testing are in place, tracked, recorded and kept up-to-date
- Consideration of extraoral forms of imaging, such as a panoramic radiograph and extraoral bitewing radiographs may be appropriate to reduce risk.

Handling biological specimens

All specimens collected for laboratory investigations should be regarded as potentially infectious and placed in biohazard bags. Clinical specimens should be collected and transported in accordance with organizational policies and procedures. For additional information on biosafety procedures when handling samples from patients under investigation for COVID-19, refer to the PHAC's biosafety advisory.

Exposure management

Exposure management protocols are necessary once confirmation of contact with an infected individual is confirmed. This may include 14- day isolation and contact tracing through BCCDC.

iii. Mental health

Protecting OHCPs and staff mental health

Workers in the workplace may also be affected by the anxiety and uncertainty created by the COVID-19 outbreak. It's important to remember that mental health is just as important as physical health, and to take measures to support mental well-being.

c. Facility management (office cleaning, housekeeping and waste management)

General considerations

- Facilities and laboratories should minimize access points.
- Increased frequency of environmental cleaning and disinfection practices, including cleaning high-touch surfaces in patient exam rooms and any central areas is important for controlling the spread of microorganisms. Environmental disinfectants used should be classed as hospital-grade, registered in Canada with a Drug Identification Number (DIN), and labelled as effective for both enveloped and non-enveloped viruses.
- Floors and walls should be kept visibly clean and free of spills, dust and debris.
- Proper hand hygiene and use of PPE must be maintained during cleaning, house-keeping and waste management to effectively block transmission Staff training must be provided to ensure safe handling and effective application of cleaning products.
- Environmental cleaning and disinfection practices are monitored for compliance.

Clinical area

- All contact surfaces must be cleaned between patients and at the end of day.
- Unnecessary equipment and items must be removed from the operatory.
- Biomedical and general office waste must be handled and disposed of in a way that protects against transmission of potential infections. Waste from treatment of COVID-19 patients must be treated as biological waste.
- All PPE must be discarded as clinical waste.

- Appropriate PPE should be worn for cleaning operatories. At minimum wear a gown, gloves, surgical mask and protective eyewear. If wearing a long-sleeved impervious gown, a fresh gown is needed for cleaning.
- Wipe down hard surfaces using a two-step process: first with detergent and water, then hospital grade disinfectant with activity against respiratory virus, including COVID-19.
- Where feasible, OHCPs should avoid sharing equipment, treatment rooms, or cleaning products. Treatment rooms should be allocated to a single OHCP per shift.

Reception/waiting area

- There must be clear signage at entrance door, waiting room, reception, operatories and washrooms regarding physical distancing, hand hygiene and respiratory etiquette.
- Decrease cloth and fabric surfaces, and remove fabric covered chairs.
- Remove all unnecessary items from the waiting room, such as magazines and toys, and keep surfaces clear and clean.
- Ensure shared equipment and facilities, such as telephones, computers, washrooms and laundry rooms receive increased cleaning and disinfection.
- Separate waiting room chairs by at least 2 metres.
- Clean surfaces and high-touch surfaces (door handles, chair arms, reception counter, etc.) regularly with a detergent with water or ready detergent wipes.
- Areas of known contamination should be cleaned and disinfected.

d. Equipment and area specific guidelines

- **Waterlines**
  Back flow prevention valves are required and flushing of water lines for 20-30 seconds before use in procedure and between patients.

- **Aerosol generating instruments**
  Use of all rotary handpieces which generate aerosols, regardless of whether the motor is electric or air- driven (with or without water) and other aerosol generating instruments commonly used in oral health care including ultrasonic and sonic scalers, triplex syringe, air-abrasion and air-polishing must be kept to a minimum.

- **Handpiece**
  Consider the use of an anti-retraction dental handpiece or electric handpiece to reduce the risk of cross infection.

- **Disposable equipment and supplies**
  Single-use disposable equipment and supplies should be used whenever possible and discarded into a no-touch waste receptacle after each use. All reusable equipment should, whenever possible, be dedicated for use by one patient. If this is not feasible, equipment should be cleaned first and then disinfected or otherwise reprocessed according to manufacturer's instructions and facility protocols.

- **Dental laboratory asepsis**
  Effective communication and coordination between the dental facility and commercial dental laboratory is essential. Impressions, prostheses or appliances must be cleaned and disinfected before transport to the lab. Finished devices, prostheses and appliances delivered to the patient must be free of contamination.

- **HVAC / air flow –** Consideration of an engineering assessment to evaluate adequacy of existing filtration and ventilation with emphasis on establishing base fresh air exchanges per hour. Consideration could also be given to the strategic use of high efficiency air exchange units as well as increasing fresh air flow by opening windows, where possible.

8. Recommendations and Considerations for Oral Healthcare During Phase 2 of the COVID-19 Response Plan

a. Patient management and safety

Administrative recommendations:

- Consider placing lines on the floor to mark a two-metre distance from the reception desk
- Clear messaging regarding office policies and protocols on website, emails and answering machine
- During transactions, if possible, limit the exchange of paper documents, including receipts
- Where possible, payments should be accepted through contactless or electronic methods
- Patients' preferred pharmacy details should be kept in their records
- Establish and maintain a contact register for all people entering the practice including date and time of entry and exit, and the person's phone and email details, to facilitate contact tracing by BCCDC if necessary

Scheduling appointments and communicating with patients

- In order to accommodate physical distancing, consideration should be given to staggering appointment times.
- When speaking with patients during scheduling and appointment reminders, ask patients to:
  - Reschedule if they become sick, are placed on self-isolation or have travelled out of the country within the last 14 days.
  - Attend appointments alone where possible and not to bring friends or children.
- Consider emailing patients any forms that need to be filled out so patients can complete them prior to arriving at the facility.
- Oral healthcare facilities with websites should consider posting information on modifications made to the facility and appointment procedures.

- Patients and their advocates who do not have signs or symptoms or potential exposures to COVID-19 do not require masking; however, they should be instructed to perform hand hygiene and maintain a minimum 2-metre distance from others at entrances and in any designated waiting areas
- Be generous with appointment times to allow careful, unrushed attention to IPAC procedures.

b. OHCP and staff management and safety

Modify staff areas and work flow

- Hold staff meetings virtually through use of teleconference or online meeting technology.
- Where in-person meetings are required, ensure staff members are positioned at least two meters apart.
- If work in the facility is required, consider staggering start times or developing alternating schedules to reduce the number of people in the workplace at a given time.
- Arrange staffrooms and break rooms to adhere to physical distancing guidelines.
- Consider staggered break times to reduce employee gathering numbers.
- Minimize shared use of workstations and equipment where possible.
- Consider implementing the requirement for staff to have dedicated work clothes and shoes. Provide a place for staff to safety store their street clothes while working.
- Staff should maintain a minimum 2-metre distance between each other throughout their shifts, especially during any breaks or meal periods when they are not masked.

PPE recommendations

- Given community spread of COVID-19 within Canada and evidence that transmission may occur from those who have few or no symptoms, masking for the full duration of shifts for staff working in direct patient care areas is recommended. The rationale for full-shift masking of outpatient and community-based care staff is to reduce the risk of transmitting COVID-19 infection from staff to patients or other facility staff, at a time when no signs or symptoms of illness are recognized, but the virus can be transmitted. Use of eye protection (e.g., a face shield) for duration of shifts should be strongly considered in order to protect staff when there is COVID-19 infection occurring in the community.

  When masks and face shields are applied for the full duration of shifts, staff must:

  - Perform hand hygiene before they put on their mask and face shield when they enter the outpatient or community-based care setting, before and after removal, and prior to putting on a new mask or face shield
  - Wear a mask securely over their mouth and nose and adjust the nose piece to fit snugly

- NOT touch the front of mask or face shield while wearing or removing it (and immediately perform hand hygiene if this occurs)
- NOT dangle the mask under their chin, around their neck, off the ear, under the nose or place on top of head
- Remove their mask and face shield just prior to breaks or when leaving the facility, while in an area where no patients or other staff are present, and discard them in the nearest no- touch waste receptacle, or otherwise store in accordance with facility policy (see statement below on re-use of masks). Reusable shields should be processed as per facility protocols
- Perform hand hygiene during and after PPE removal and between patient encounters

- It is a foundational concept in IPAC practice that disposable masks should not be re-worn. However, in the context of the COVID-19 pandemic and PPE shortages, outpatient and community-based care settings should follow jurisdictional guidance with regards to mask use, reuse, and reprocessing.

  If re-use of masks is recommended, staff must remove their mask by the ear loops or elastics taking care not to touch front of mask, and carefully store the mask in a clean dry area and in accordance with facility and jurisdictional public health guidance, taking care to avoid contamination of the inner surface of the mask, and perform hand hygiene before and after mask removal and before putting it on again.
- Masks should be disposed of and replaced when they become damaged, wet, damp, or soiled (from the wearer's breathing or external splash), or when they come in direct contact with a patient.
- Staff should be informed of how to access additional masks as needed.
- Examples of eye protection (in addition to mask) include full face shield, mask with attached visor, non-vented safety glasses or goggles (regular eyeglasses are not sufficient)

  Full face shields should be removed (to be processed or disposed of as per facility IPAC guidance). If masks with attached visors are used these should be removed and discarded in the nearest no-touch waste receptacle, and a new mask and eye protection put on. Reusable safety glasses or goggles must be reprocessed per facility IPAC guidance.

  Masks do not necessarily need to be replaced after seeing a patient on droplet and contact precautions if a full face shield is worn over this.
- The area where PPE is put on should be separated from the area where it is removed and discarded

External service providers and deliveries

External service providers (including delivery personnel, lab personnel, and contractors) should be screened for signs and symptoms of COVID-19 at every visit. If signs or symptoms are present, or if they are on self-isolation or quarantine as per relevant public health directives, they should not enter the community-based care setting, and should be advised to follow up with local public health or their healthcare provider.

External service providers should:

- Make adjustments to reduce contact where feasible, e.g., leaving deliveries at the door
- When entering, perform hand hygiene and put on a mask if a 2-metre distance from staff and patients cannot be ensured
- Be instructed by staff on the importance of hand hygiene with ABHR and when and how to perform hand hygiene, e.g., when entering and exiting the setting, and after touching any surfaces in the community-based care environment
- Masks, tissues, ABHR and a no-touch waste receptacle are available for staff, patient, essential companion, and external service provider to use at screening at each entrance
- All staff and external service providers are logged at entry to the facility
- Essential deliveries that are unable to be left outside occur through a single access point

OCHP and staff health

- OHCPs should consider introducing measures to monitor their health and the health of their staff.
- Limit the number of potential close contacts between clinical staff.
- Continue to limit social interaction outside of work as much as possible.
- Educate staff members regarding the risks associated with the provision of oral health care during COVID-19 and the measures being taken to mitigate the risk.
- All OHCPs and staff should perform hand hygiene before and after all patient contact, and contact with potentially infectious material, and before putting on and after removing PPE, including gloves. Hand hygiene after removing PPE is particularly important to remove any pathogens that might have been transferred to bare hands during the removal process.
- OHCPs and staff should perform hand hygiene by using ABHR with at least 70% alcohol or washing hands with soap and water for at least 20 seconds. If hands are visibly soiled, use soap and water before returning to ABHR.
- Hand hygiene supplies should be readily available to all staff in every care location.
- Hand hygiene should be performed after going to the bathroom, before preparing and eating food, and after coughing and sneezing.

9. Schedule of Changes

Superscript endnotes throughout the document indicate changes that were made following the first publication of this document.

1. *Link to new BCCDC document added*
2. *May 15, 2020 5:10 pm: "should" changed to "must"*
3. *"Where applicable" added to replace "in addition to droplet and contact precautions if AGMPs are performed"*
4. *May 15, 2020 5:10 pm: Note that immediately following the first publication of this document on the afternoon of May 15, 2020, the BCCDC published this document resulting in subsequent edits throughout section 7.b.ii (Exposure Prevention)*