



COLLEGE OF REGISTERED
DENTAL HYGIENISTS
OF ALBERTA

COVID-19 Return to Work Guidelines for Dental Hygienists

All CRDHA registrants are required to abide by these guidelines

Version 3

Reviewed by CRDHA Council June 12, 2020

Effective June 15, 2020

Guidelines are subject to change

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Rationale for these Guidelines

On April 30, 2020, Alberta Health (AH) announced that as part of Alberta’s Relaunch strategy, all regulated health professionals may resume non-essential care **subject to guidelines approved by their respective regulatory colleges**. Dental hygienists in Alberta are expected to follow the most current guidance document provided by the CRDHA. Those who fail to abide by the directive from AH may be considered to be in professional misconduct and could be subject to disciplinary action.

These guidelines provide evidence-based information on how to reduce risk for transmission of the novel coronavirus SARS-CoV-2 in dental hygiene practice. The current level of evidence available at the time of writing (June 12, 2020) suggests that the complete elimination of risk is not possible. By following the risk assessment strategies outlined in these guidelines, dental hygienists can use their professional judgement to make informed decisions about the care they provide based on their own specific practice setting, taking into account factors such as community risk, facility characteristics, client demographics, amongst others. Implementing this process into dental hygiene practice can reduce the impact of biological hazards such as SARS-CoV-2 and allow dental hygienists to protect themselves and their clients from infection.

Please refer to Appendix 1 for a flowchart outlining the decision-making process for providing dental hygiene care during the COVID-19 pandemic using elements from the Return to Work Guidelines. Examples are included to assist dental hygienists in using the tool.

The CRDHA recognizes that the research related to COVID-19 is evolving rapidly, so **recommendations may change as evidence becomes available**. The guidance included in this document does not replace regular standards of practice, professional advice, or the application of clinical judgement to each individual client presentation.

Alberta registered dental hygienists, dentists, registered dental assistants, registered denturists and registered dental technologists are each governed by their own independent Colleges. These governing bodies have produced their own guidelines with respect to their registrants’ return to practice. Dental hygienists are responsible for following these guidelines.

Return to Work

The CRDHA strategy for return to work for dental hygienists involves a phased-in approach to respect the safety and well-being of both clients and dental hygienists. The following chart outlines the phased approach to date:

Date Effective	Version of “COVID-19 Return to Work Guidelines for Dental Hygienists”	Client Restrictions	Guidance for Dental Hygienists
May 4, 2020	1	<ul style="list-style-type: none">Asymptomatic clients only	<ul style="list-style-type: none">Return to emergency and urgent care only following CRDHA guidelinesNo aerosol generating procedures

Date Effective	Version of “COVID-19 Return to Work Guidelines for Dental Hygienists”	Client Restrictions	Guidance for Dental Hygienists
May 19, 2020	2	<ul style="list-style-type: none"> Asymptomatic clients only 	<ul style="list-style-type: none"> Return to non-essential dental hygiene care following CRDHA guidelines No procedures at high risk for aerosol production Risk mitigation for procedures at low risk for aerosol production
June 15, 2020	3	<ul style="list-style-type: none"> Asymptomatic clients only 	<ul style="list-style-type: none"> May incorporate procedures that are at risk for aerosol generation back into their practice if the health benefit of providing the service outweighs the risk of introducing aerosols into the environment

Refer to the [Schedule of Changes](#) for a list of the revisions made to the guideline documents.

Effective June 15, 2020, dental hygienists may incorporate procedures that are at risk for aerosol generation back into their practice if the health benefit of providing the service outweighs the risk of introducing aerosols into the environment. The risk of introducing aerosols into the environment can be mitigated through controls identified in your practice setting’s occupational health and safety hazard assessment.

If you are an employee, **the CRDHA recommends discussing your professional guidelines with your employer(s).** Employers should be aware of the guidelines for dental hygiene practice so that you may work together to create policies and procedures to mitigate the risk of SARS-CoV-2 transmission within your practice setting.

For employment and insurance questions related to returning to work, dental hygienists can refer to guidance from the [Canadian Dental Hygienists Association \(CDHA\)](#) or the Government of Alberta’s [Employment Standards](#). Dental hygienists are reminded that the [CDHA](#) also provides access to social and mental health supports which may be useful during this stressful time.

The CRDHA expects all registrants to use appropriate clinical judgment and follow their Standards of Practice, including Practice Standards and Code of Ethics.

Key Points

- The objective of these guidelines is to continue to minimize the risk and control the transmission of SARS-CoV-2.
- These guidelines only apply for the treatment of **asymptomatic clients** who have been appropriately screened. Defer treatment for symptomatic clients.
- Dental hygienists are at high risk for exposure to SARS-CoV-2 due to the procedures performed within their day-to-day practice.
- Dental hygiene practice settings are required to comply with Occupational Health and Safety legislation, including conducting hazard assessments, implementing appropriate controls and

developing policies and procedures to address risks. Employers and employees have rights and responsibilities under this legislation.

- **If appropriate PPE is unavailable, oral health services must not be performed.**
- These guidelines are created using the most recent evidence and research available at this time. As more data and information becomes available the CRDHA will update the guidelines accordingly.

COVID-19

Created: May 3, 2020

Revised: May 14, 2020

Dental hygienists have a responsibility to remain up to date with developments related to COVID-19.

- [Alberta Health Services \(AHS\) Information for AHS Staff and Health Professionals- Novel Coronavirus \(COVID-19\)](#)
 - [COVID-19 Resources for AHS Staff and Health Professionals](#)
 - [AHS FAQs for Healthcare Workers](#)
- [Health Canada COVID-19- For Healthcare Workers](#)
- [CDHA COVID-19 Related Education](#)

BEFORE CLINICAL CARE STARTS

Evaluate Local Public Health Risk

Created: June 12, 2020

Evaluate your dental hygiene practice with respect to the incidence of disease in your community. If there is an increase in COVID-19 cases in your community, determine if there is a need to modify your practice. These modifications will differ amongst communities and may include the cessation of non-essential care and the return to providing only urgent and emergency care. How dental hygiene care is modified will be dependent on several factors, including level of outbreak changes as declared by public health officials.

Resource:

- [Government of Canada: A framework for risk assessment and mitigation in community settings during the COVID-19 pandemic](#)

Occupational Health and Safety (OHS)

Created: May 3, 2020

Revised: May 14, 2020; June 12, 2020

Health care workplaces must adhere to requirements under the Occupational Health and Safety (OHS) Act where employers ensure, as far as it is reasonably practicable, the health, safety and welfare of their workers, and workers must work in a manner that ensures the health and safety of themselves and others.

- The OHS Code requires employers to assess work site hazards and eliminate or control the existing or potential hazards using engineering controls, administrative controls, and personal protective equipment.
- Employers must continually assess the situation and adjust to meet work site hazards.
- Employers must ensure workers who may be affected by hazards are involved in the hazard assessment and control process and comply with the requirements.
- Specific requirements under the OHS Act and its regulations are available at:
 - [Occupational Health and Safety Act](#) (SA 2017 cO-2.1) – official online version (in effect June 1, 2018)
 - [Occupational Health and Safety Regulation](#) – official online version (in effect June 1, 2018)

Every person employed in Canada has the right to a safe work environment. This includes employers, employees, owners, contractors, sub-contractors, contracting employers, and suppliers. Workers have the right to refuse dangerous work and are protected from reprisal for exercising this right.

For further information, please refer to:

- [Alberta Health Refuse Dangerous Work](#)
- [Alberta Personal Protective Equipment Guideline for Care of Individuals with Suspect or Confirmed COVID-19 in Health Care Settings](#)
- [Canadian Centre for Occupational Health and Safety Three Rights of Workers](#)

Preparing the Office

Created: May 3, 2020

Last revised: May 14, 2020; June 12, 2020

Prepare Equipment

- Perform all function tests required on equipment prior to opening following manufacturer's instructions for use.
- Check all supplies, including medical supplies, for expiry dates.
- Remove and store all unnecessary items from clinical operatories.
 - Practice permits should be onsite and available on request if not posted in clinical area.

If you have any questions about use of equipment during the COVID-19 pandemic, contact the manufacturer directly.

Facilitate Social Distancing

- Increase separation between desks and workstations.
- Eliminate or re-structure non-essential gatherings (e.g. meetings, training classes) of staff and volunteers. Typically, this involves moving in-person meetings to virtual media platforms like teleconference or video conference.
- Limit the number of people in shared spaces (such as lunchrooms) or stagger break periods. Remove chairs to create adequate spacing (6ft/2m). Taping markers at 6ft/2m distances may be helpful to support physical distancing.

See [Considerations for Preparing your Office](#) for suggestions from the CRDHA in preparing your office for return to work.

Waiting Room Management

Created: May 3, 2020

Revised: May 14, 2020

[CMOH Order 07-2020](#) prohibits gatherings of more than 15 people, however this does not prohibit healthcare settings from having more than 15 staff in a workplace.

Scheduling Appointments

- Consider staggering client appointments to minimize client contact in the waiting room or ask clients to wait in their cars and call the practice upon arrival to restrict the number of people present within the facility at any one time.
- Consider longer appointments to allow enough time between treatments to enable additional infection control measures including environmental cleaning.

Waiting Room Layout

- Provide a hand hygiene station upon entry into the clinic, with a notice for people to use it before entry into the rest of the office.
- Ensure there is access to tissues, an alcohol-based hand rub, and a garbage bin for used tissues.
- Placing chairs 6ft/2m apart is recommended.
- Create an office flow to ensure anyone present in office is compliant with 6ft/2m separation.
 - Clients that are from the same household may be seated together
- Use barriers or a partition (e.g. plexiglass) at the reception desk is recommended.

Waiting Room Infection Prevention and Control (IPC)

- Remove toys, reading materials, remote controls or other communal objects.
- Develop and implement procedures for increasing the frequency of cleaning and disinfecting of high traffic areas, common areas, public washrooms, kitchen, staff rooms.
 - Regularly wipe down surfaces with >60% alcohol-based wipes or 0.1% sodium hypochlorite solution, or an appropriate disinfectant against COVID-19 approved by Health Canada (see [Enhanced Environmental Cleaning and Disinfection](#)).
 - Remember to include all touchable surface areas, such as tables, chair arms, doorknobs, light switches, hangers, phone, computers, and anything else with which people come in contact.
 - If surfaces are dirty, they should be cleaned using a detergent or soap and water prior to disinfection.
- In the event a client presents with respiratory symptoms, they should be provided with a mask, asked to wear the mask, return home and be advised to take the Alberta Health Services (AHS) self-assessment online tool.
- Maintain an adequate supply of soap, paper towel, toilet paper, hand sanitizer and other supplies.

The Government of Canada has additional information on [cleaning and disinfection of public spaces](#) during COVID-19.

Staff Training

Created: May 3, 2020

Revised: May 14, 2020; June 12, 2020

Update facility infection prevention and control (IPC) manual and occupational health and safety (OHS) manual, including risk hazard assessments and PPE guidelines related to COVID-19. Review these policies and procedures with staff. Dental hygienists and staff must have basic knowledge of the disease, the infectivity and mode of transmission and should be aware of the steps being taken in their workplace to prevent the risk of transmission of infection and their roles in these measures. Ongoing training may be required as new research around dental hygiene practice during the COVID-19 pandemic becomes available.

Staff training should include:

- The risk of exposure to COVID-19 and the signs and symptoms of the disease;
- Consideration of client flow into and through the practice including methods for maintaining physical distance, such as not greeting others by hugging or shaking hands;
- Timing for operatory usage, cleaning and disinfection and reprocessing;
- PPE requirements, including donning and doffing methods to prevent contamination;
- Masking for staff who are not providing direct client care;
 - Any staff who do not work in client care areas or have direct client contact are required to mask at all times in the workplace if a physical barrier e.g. plexiglass is not in place or if physical distancing (6ft/2m) cannot be maintained;
 - [AHS Continuous Masking](#)
 - [AH Help Prevent the Spread](#)
- Staff that require N95 masks must be fitted and trained in appropriate use;
- How to report an exposure to COVID-19.

Signage

Created: May 3, 2020

Revised: May 14, 2020

Ensure that you post signage in your clinic to ensure everyone adheres to respiratory hygiene and cough etiquette, hand hygiene, and that all clients follow triage procedures throughout the duration of the visit. Post information on the following topics in areas where it is likely to be seen by staff and clients:

- physical distancing;
- hand hygiene (hand washing and hand sanitizer use); and
- help limiting the spread of infection.

At a minimum this includes placing them at entrances, in all public/shared washrooms, and treatment areas. When possible, provide necessary information in languages that are preferred by staff and clients.

The following are examples of signs that you could use:

- [COVID-19 information sheets \(available in multiple languages\)](#)
- [AHS COVID-19 Signage and Posters](#)
- [CDC Cover Your Cough](#)

Staff Screening

Created: May 3, 2020

Revised: May 14, 2020; June 12, 2020

Dental hygienists must be aware of [CMOH Order 05-2020](#) which states that any person who is a confirmed case of COVID-19 or has COVID-like (including but not limited to cough, fever, shortness of breath, runny nose, or sore throat) must be in isolation. This order also requires individuals who have returned from travel outside of Canada to be in isolation for a minimum of 14 days. If an individual becomes sick during the 14-day isolation period, they should remain in isolation for an additional ten days from the start of symptoms, or until the symptoms resolve, whichever is longer.

All staff must self-assess their health daily, prior to presenting to the workplace. They must not have any of the following symptoms and risk factors:

COVID-19 Symptoms: <ul style="list-style-type: none">• Cough• Fever > 38°C• Shortness of breath• Sore throat• Runny nose	COVID-19 Risk Factors: <ul style="list-style-type: none">• Close personal contact with a suspected or lab confirmed COVID-19 person within the last 2 weeks.<ul style="list-style-type: none">○ Close contact includes providing care, living with or otherwise having close prolonged contact (within 2 metres) while the person was ill, or contact with infectious bodily fluids (e.g. from a cough or sneeze) while not wearing recommended personal protective equipment.• Any travel outside of Canada in the previous 2 weeks (all non-essential travel outside Canada should be cancelled, as per the Government of Canada's travel advisory)
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Suggestions for self-assessment tools include:

- [AHS COVID-19 Daily Fit for Work Screening](#)

Should a registrant have any of the symptoms or risk factors listed above, or answer 'YES' to any questions in the screening tool, they are unfit to work and **must not present to the workplace**. Inform your employer and complete the [AHS online self-assessment tool](#) for further direction. The questionnaire intends to identify **new** symptoms or **worsening** of symptoms that are related to allergies, chronic or pre-existing conditions. Those with symptoms **related to pre-existing conditions or allergies** can still go to work.

Daily fitness to work screening question results should be recorded in your own personal logbook. The logbook should be kept by each registrant and be made available to health authorities if requested.

Due to the requirement for staff screening, prepare for the possibility of increases in absenteeism due to illness among staff and their families. Dental hygiene practice owners should implement sick leave policies for staff that are flexible, non-punitive, and consistent with public health guidance, allowing employees to stay home if they have symptoms of respiratory infection. Ask staff to stay home if they are sick and send staff home if they develop symptoms while at work. Employees are not required to have a medical note.

Changes to the Employment Standards Code will allow full and part-time employees to take 14 days of job-protected leave if they are:

- required to isolate
- caring for a child or dependent adult who is required to isolate.

If you or someone on your team tests positive for COVID-19, see section below for “Contact Tracing.”

- [AHS Return to Work Guide](#)

Contact Tracing

Created: May 14, 2020; June 12, 2020

To enable quick contact with employees, dental health care settings should maintain an up-to-date contact list for all staff, including names, addresses and phone numbers.

For the purposes of public health tracing of close contacts, employers need to be able to provide:

- roles and positions of persons working in the workplace;
- who was working onsite at any given time;
- names of clients in the workplace by date and time; and
- names of staff members who worked on any given shift.

If a staff member or client is confirmed to have COVID-19, and it is determined that other people may have been exposed to that person, **AHS will be in contact with the health care setting to provide the necessary public health guidance.** Records/contact lists will be requested for contact tracing and may be sought for up to two days prior to the individual becoming symptomatic. Dental health care settings need to work cooperatively with AHS to ensure those potentially exposed to the individual receive the correct guidance.

Reference:

- [CMOH 16-2020 Appendix A: Workplace Guidance for Community Health Care Settings](#)

Booking Client Appointments

Created: May 3, 2020

Revised: May 14, 2020, June 12, 2020

Before booking a client appointment, client pre-screening should be conducted remotely to determine if the client has any COVID-19-like symptoms and the risk to the client if they were to contract COVID-19.

As part of pre-screening, ask the following questions **before** booking and **upon arrival**:

- Do you have a fever or have felt hot or feverish anytime in the last two weeks?
- Do you have any of these symptoms: dry cough, sore throat, shortness of breath, runny nose, difficulty breathing?
- Have you experienced a recent loss of smell or taste?
- Have you been in contact with any confirmed COVID-19 positive patients, or persons required to self-isolate because of a potential risk of COVID-19?
 - Close contact includes providing care, living with or otherwise having close prolonged contact (within 2 metres) while the person was ill, or contact with infectious bodily fluids (e.g. from a cough or sneeze) while not wearing recommended [personal protective equipment](#).

- Have you returned from travel outside of Canada in the last 14 days?

If the client answers 'YES' to any of these questions, inform them that you cannot provide dental care and they must not present to the clinic. Advise them to complete the [AHS online self-assessment tool](#) and follow the instructions for self isolation.

If dental treatment is urgent, refer to a dentist. If emergency dental care is medically necessary for a client who has, or is suspected of having COVID-19, dental treatment should be provided in a hospital or other facility that can treat the client using the appropriate airborne precautions.

If the client answers 'NO' to all of the questions above, continue pre-screening to **determine if the client is at increased or high risk of severe illness from COVID-19**. In general, risk for hospital admission, more severe disease or death is higher with advanced age, or with one or more medical conditions including cardiovascular disease, hypertension, diabetes, lung disease (including moderate to severe asthma) or those that are immunocompromised or have an active malignancy. Set specific hours for these at-risk clients keeping in mind any aerosol generating procedures that may be occurring in your clinic. This may involve booking these clients early morning appointments when there are no aerosol generating procedures being performed in the clinic. Use professional judgment to determine the safest way to see these patients.

Where clients present in-person without phone screening, staff **must** screen clients upon entry to assess for symptoms. This includes anyone accompanying a client to their appointment (guardian, caregiver).

In response to CMOH 05-2020, dental hygiene treatment for clients with clinical symptoms suggestive of COVID-19 or a positive COVID-19 test result must be deferred until 10 days from the start of symptoms, or until symptoms resolve, whichever takes longer.

Point of Care Risk Assessment

Created: May 3, 2020

Revised: May 14, 2020; May 26, 2020; June 12, 2020

Clients with influenza-like symptoms or known COVID-19 are not to be seen in community clinics. If emergency dental care is medically necessary for a client who has, or is suspected of having COVID-19, dental treatment should be provided in a hospital or other facility that can treat the client using the appropriate airborne precautions. These clients should NOT be treated in a regular dental operator.

When a client arrives at the clinic for their appointment, offer a mask for continuous mask wearing. **Screen** for fever (using an appropriate thermometer) and symptoms of COVID-19 before they enter the dental setting.

- [IPC Recommendations for Selection of Thermometers \(COVID-19\) for Staff & Visitor](#)

If a client arrives at your clinic and is suspected or confirmed to have COVID-19, take the following actions:

- Defer non-urgent dental treatment & assess for dental emergency referral.
- Give the client a mask to cover his or her nose and mouth.
- If not acutely sick, send the client home and instruct the client to take the [AHS online self-assessment](#).
- If acutely sick (for example, has trouble breathing) the client may require medical attention. Refer the client to Health Link 811 or to a medical facility.

- In case of medical emergency call 911.

If guardians or caregivers are necessary for clients receiving treatment, they should also be screened for signs and symptoms of COVID-19 during client check-in and should not be allowed entry into the facility if signs and symptoms are present (e.g., fever, cough, shortness of breath, sore throat). Guardians or caregivers should not be allowed in the dental office if perceived to be at a high risk of contracting COVID-19 (e.g. having a pre-existing medically compromised condition). **Any person accompanying a client should be provided a mask and sign an informed consent form if they are staying in the clinic during treatment. Clients should be asked to minimize the number of people accompanying them to an appointment. Assess and provide appropriate level of PPE if guardian or caregiver is required to remain in the treatment room.**

If a client becomes symptomatic while onsite, the following requirements apply:

- A client who develops cough, fever, shortness of breath, runny nose, or sore throat while at the site should be given a mask and sent home immediately. They should be instructed to avoid public transportation if possible.
- Clients should complete the [AHS online self-assessment tool](#) once they have returned home and be tested for COVID-19.
- Once a symptomatic individual has left the site, clean and disinfect all surfaces and areas with which they may have come into contact.
- The employer should immediately assess and record the names of all close contacts of the symptomatic client within the clinic setting. This information will be necessary if the symptomatic client later tests positive for COVID-19.

References:

- [Health Canada Infection Prevention and Control for Covid-19 Second Interim Guidance for Acute Healthcare Settings](#)
- [Alberta Health Services Point of Care Risk Assessment \(PCRA\)](#)

Informed Consent

Created: May 3, 2020

Revised: May 14, 2020

Dental hygienists **must** inform the client of their treatment options including the advantages and disadvantages, significant risks and cost, and whether it is appropriate to consider a referral to another health care provider prior to treatment commencing. During the pandemic, this also includes discussing potential risks associated with treatment from aerosols being produced in the facility and acknowledging modifications to procedures for risk mitigation.

All clients must be provided with a client consent to read and sign before providing treatment. An example of a consent form that can be modified for your use is found at: [ADA&C Client Consent Form](#)

DURING CLINICAL CARE

Clinical Treatment

Created: May 3, 2020

Revised: May 14, 2020, June 12, 2020

Aerosol generating procedures (AGPs) can generate aerosols that consist of small droplet nuclei in high concentration and present a risk for airborne transmission of pathogens that would not otherwise be spread by the airborne route (e.g. SARS-CoV-2, influenza). Some instruments used for clinical procedures, including **powered instrumentation, air polishers, high speed handpieces, lasers, low speed handpieces and the air-water syringe** have the potential to produce aerosols. Dental hygienists are responsible to evaluate the procedures they perform for production of aerosols and incorporate strategies to minimize the risks associated with pathogenic aerosols.

Limit or avoid AGPs by substituting for an appropriate procedure with the least likelihood of producing aerosols. **If an AGP is necessary for client treatment and the health benefit of performing the AGP outweighs the risk of exposure of aerosols into the environment, dental hygienists may provide the AGP.** The risk of aerosols being introduced into the environment must be mitigated through controls identified in an OHS hazard assessment specific to the practice setting.

Dental hygiene procedures that are at low risk of generating aerosols have the potential of creating droplets. Utilize [droplet and contact precautions](#) to mitigate this risk.

Use your professional judgement to determine whether an AGP is necessary for client care.

If AGPs are necessary for client care, minimize the time spent on the procedures and perform them closer to the beginning of the appointment to allow for any aerosols produced to settle (dependent on individual facility air changes per hour). Minimize movement into and out of treatment areas as well as between treatment areas and non-clinical areas.

Use high volume evacuation (HVE) or equivalent to control aerosols at the source of their production. The CRDHA does not recommend substituting saliva ejectors for HVE to control aerosols.

The following chart lists some common procedures associated with aerosol production and identifies some examples of risk mitigation strategies. This list is not exhaustive and does not replace the requirement to conduct a practice-specific hazard assessment. The strategies used in your clinic should reflect your clinic's own hazard assessment.

Procedures at Risk for Aerosol Generation	Examples of Risk Mitigation During Clinical Procedure
<ul style="list-style-type: none">Powered instrumentation (e.g. ultrasonic scaler)	<ul style="list-style-type: none">Substitute with hand scalingUse HVE to control aerosols and sprayFour-handed dentistry technique
<ul style="list-style-type: none">Air polishers	<ul style="list-style-type: none">Substitute with polishing using a low speed handpieceUse HVEFour-handed dentistry technique

Procedures at Risk for Aerosol Generation	Examples of Risk Mitigation During Clinical Procedure
<ul style="list-style-type: none"> High speed handpieces 	<ul style="list-style-type: none"> Substitute with another instrument Use HVE Four-handed dentistry technique Use of isolation technique such as a dental dam
<ul style="list-style-type: none"> Low speed handpieces (e.g. polishing) 	<ul style="list-style-type: none"> Use selective polish instead of full mouth polish Use HVE to control droplets, spatter and potential aerosols Do not use combination of air-water syringe to rinse
<ul style="list-style-type: none"> Air-water syringe 	<ul style="list-style-type: none"> Substitute rinsing with a monojet syringe instead If air-water syringe is required, use with HVE Limit using air and water combined
<ul style="list-style-type: none"> Intra-oral radiographs 	<ul style="list-style-type: none"> Use extra-oral radiographs if possible Assess client for risk of gag response Employ strategies to avoid stimulation of coughing and vomiting
<ul style="list-style-type: none"> Impressions 	<ul style="list-style-type: none"> Assess client for risk of gag response Defer treatment if possible Employ strategies to avoid stimulation of coughing and vomiting Increase caution when handling, cleaning and disinfecting impressions
<ul style="list-style-type: none"> Intra-oral oral hygiene instruction 	<ul style="list-style-type: none"> Demonstrate oral hygiene instruction using props extra-orally Consider pre-procedural rinse
<ul style="list-style-type: none"> Lasers 	<ul style="list-style-type: none"> Substitute with hand scaling Use HVE if tip initiation is anticipated Ensure ventilation is adequate to mitigate risk of laser plume Use appropriate PPE where aerosols/laser plume are anticipated

Occupational Health and Safety (OHS) Controls for AGPs

Created: May 14, 2020

Revised: June 12, 2020

The following section identifies ways to minimize the risks associated with pathogenic aerosols using OHS controls (engineering controls, administrative controls and personal protective equipment). The list of controls included in this document is not exhaustive and your practice may incorporate other controls to address the risks associated with COVID-19 as identified in the workplace’s hazard assessment.

For more information about hazard assessments and controls:

- [Hazard Assessment and Control: a handbook for Alberta employers and workers](#)

Engineering Controls

Created: June 12, 2020

Engineering controls are those OHS controls that relate to designs or modifications to practices, equipment, ventilation systems, and processes that reduce the source of exposure.

Air Changes per Hour (ACH)

Created: May 14, 2020

Revised: June 12, 2020

The time required for aerosol clearance is determined by air changes per hour (ACH). ACH in a space can be affected by many factors including the physical layout of the office, the ventilation systems and the height of the ceiling, among other factors. Depending on the ACH, it can take from over 3 hours (180 minutes) to less than 10 minutes. ACH in a clinical setting can be determined by HVAC/ventilation professionals and can be modified, if needed. **The CRDHA recommends having the ACH assessed in practices that are performing aerosol generating procedures.** Refer to the chart below to determine time required for removal of aerosols when ACH is known.

Air changes per hour (ACH)	Time (minutes) required for removal 99.9% efficiency
2	207
4	104
6-7	69
8	52
10-11	41
12-14	35
15-19	28
20	21
50	8

Adapted from: Centers for Disease Control and Prevent, Guidelines for Environmental Infection Control in Health-Care Facilities (2003): Table B.1. Air changes/hour (ACH) and time required for airborne-contaminant removal by efficiency. Available at: <https://www.cdc.gov/infectioncontrol/guidelines/environmental/appendix/air.html#tableb1>

Facility Layout

Created: June 12, 2020

At this time, there has been no requirement for dental or dental hygiene clinics to have floor-to-ceiling walls or treatment room doors that can be closed. Offices may incorporate these design changes if they choose or may address aerosols through other OHS controls.

High Volume Evacuation (HVE)

Created: May 3, 2020

Revised: May 14, 2020; June 12, 2020

Use HVE or equivalent to minimize the spread of droplets, spatter, spray and aerosols generated during dental hygiene procedures. HVE should be used for procedures that could potentially produce aerosols but **must be used for procedures at high risk for aerosol generation**, such as during the use of powered instrumentation, air polishing, high and low speed handpieces, lasers with an initiated tip and combined

air and water from the air-water syringe. Dental hygienists may use the four-handed dentistry technique during AGPs to facilitate use of HVE.

Waterlines and Suction Lines

Created: May 3, 2020

Ensure waterlines are run for 2 minutes each day prior to providing client care and run water lines for 20 seconds between clients. Suction lines must be aspirated with water or enzymatic solution between clients to reduce likelihood of infectious material backflow. Follow manufacturer's instructions for use regarding weekly maintenance of suction lines.

Saliva Ejectors

Created: May 3, 2020

Revised: June 12, 2020

Backflow can occur when using a saliva ejector. If using a saliva ejector, mitigate the risk for backflow occurring by ensuring the client does not close lips around saliva ejector. **Saliva ejectors are not an appropriate substitute for HVE during AGPs.**

Administrative Controls

Created: June 12, 2020

Administrative controls are the controls outlined in the risk assessment that alter the way the work is done, including timing of work, policies and other rules, and work practices such as standards and operating procedures.

Administrative controls discussed in other sections of this document include:

- [Evaluate local public health risk](#)
- [Pre-screening and screening of clients](#)
- [Staff screening](#)
- [Booking client appointments](#)
- [Staff training](#)
- [Point of care risk assessment](#)
- [Donning and doffing procedures to prevent contamination](#)
- [Enhanced environmental cleaning and disinfecting](#)

Pre-procedural Mouth Rinse

Created: May 3, 2020

Revised: June 12, 2020

A preprocedural mouth rinse for 30-60 seconds, using an effective antiseptic mouth rinse should be performed by the client and expectorated into the same dispensing cup prior to examination and procedures within the oral cavity. This will not eradicate viruses or bacteria but may reduce the viral load.

- Mouth rinses containing 1% hydrogen peroxide or 0.2% povidone have been shown to have a potential effect on COVID-19 ([ADA](#)).

Hand Hygiene

Created: May 3, 2020

Revised: May 14, 2020; May 26, 2020; June 12, 2020

Proper hand hygiene must be performed before and after any client contact or contact with a client's environment. Dental hygiene practice settings should promote and facilitate frequent and proper hand hygiene for staff and clients.

Dental hygienists must wash their hands often with soap and water for at least 20 seconds or use an alcohol-based hand sanitizer (greater than 60% alcohol content). Hand washing with soap and water is required if hands are visibly dirty.

Glove-use alone is not a substitute for hand hygiene. Hands should be cleaned before and after using gloves.

Resources for proper hand hygiene include:

- [AHS Hand Hygiene](#)
- [AHS 4 Moments of Hand Hygiene](#)
- [CDC Hand Hygiene in Healthcare Settings](#)
- [American Dental Association Hand Hygiene for the dental team](#)

Resource for selection of hand sanitizer:

- [Health Canada Hard-surface disinfectants and hand sanitizers \(COVID-19\): List of hand sanitizers authorized by Health Canada](#)

Personal Protective Equipment (PPE)

Created: May 3, 2020

Revised: May 14, 2020; May 26, 2020; June 12, 2020

All staff providing direct client care or working in client care areas must wear a surgical/procedure mask continuously, at all times and in all areas of the workplace if they are either involved in direct client contact or cannot maintain adequate physical distancing (6ft/2m) from clients and co-workers. Continuous masking reduces the risk of transmitting of COVID-19 from individuals in the asymptomatic phase

PPE consists of protective clothing, gloves, masks, and eye protection (e.g., goggles, face shields, visors on masks) that can be used to provide a barrier to help prevent potential exposure to infectious disease. Employers have a responsibility under [Occupational Health and Safety](#) to ensure that workers are properly trained on appropriate use of PPE.

The risk for dental hygienists in providing dental hygiene services for droplet and contact transmission may be higher than other health professions. To reduce the risk, adhere to [routine practices and additional precautions](#) including the applicable [droplet and contact precautions](#). Until further evidence is available on the transmission of COVID-19 through aerosols, the CRDHA recommends that **fitted N95 masks or equivalent are utilized for all aerosol generating procedures. If appropriate PPE is unavailable, oral health services must not be performed.**

Use PPE as per manufacturer's instructions for use. Manufacturers may have guidelines for use of PPE during times of shortage. Refer to these instructions for information about length of time for

use and ability for PPE to be adequately decontaminated. Other questions about appropriateness of PPE can also be directed to [Occupational Health and Safety](#). It is inappropriate to use PPE in a way that has not been identified by the manufacturer or approved by Occupational Health and Safety.

The following PPE requirements were adapted from the [CDC IPC Guidance for Dental Settings During COVID-19](#) and the [Government of Canada Personal Protective Equipment Against COVID-19](#). For additional questions on PPE, refer to [AHS PPE FAQ](#).

Setting	Individual	Activity	PPE
Client treatment room	Dental hygienist	Aerosol generating procedures	<ul style="list-style-type: none"> • N95 mask or equivalent. <ul style="list-style-type: none"> ○ If N95 mask is unavailable, use a Level 3 surgical mask with a face shield • Protective clothing (gown or alternative) • Bouffant/head covering • Gloves • Eye protection • Shoe covers (optional)
		Non-aerosol generating procedures	<ul style="list-style-type: none"> • Level 1-3 surgical mask dependent on procedure and risk (see chart below) • Protective clothing (gown or alternative) • Gloves • Eye protection

Masks

Created: May 3, 2020

Revised: May 14, 2020; May 26, 2020; June 12, 2020

Masks must be selected based on the risks associated with the procedures being completed. The following chart identifies the different levels of masks and respirators. American Society for Testing and Materials (ASTM) rates masks according to several parameters including resistance to penetration of fluids, breathability, bacterial filtration efficiency and filtration of sub-micron particles. Refer to manufacturer's instructions for use of the masks available to you.

Mask	Indications	Use
N95	Used for procedures likely to produce aerosols	All AGPs
ASTM- Level 3	Used for procedures where heavy levels of spray and/or spatter (not aerosol) may occur	Use when there is a high risk of sprays and/or spatter exposure
ASTM- Level 2	Used for procedures where moderate levels of spray and/or spatter (not aerosol) may occur	Use when there is a moderate risk of sprays and/or spatter exposure
ASTM- Level 1	Used for procedures with low levels of spray and/or spatter (not aerosol), client or staff isolation. Provides minimal protection	General use for procedures and exams that do not involve aerosols, spray or spatter

Adapted from the College of Dental Hygienists of Ontario

For further information on mask and face shield guidelines for clients without signs or symptoms of COVID-19, please reference:

- [Health Canada Masks and Respirators During COVID-19](#)
- [American Dental Association Guidelines](#)

N95 masks must be professionally fitted in accordance with OHS and CSA guidelines. The OHS Code Sections 247-250 reference respirator standards with respect to selection of equipment, storage and use, quality of breathing air and effective facial seal. Section 250 references effective facial seal and the necessity of fit testing.

Protective Clothing

Created: May 3, 2020

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Protective clothing can be reusable or disposable and is meant to be worn over regular clinic clothing, such as uniforms or scrubs. Protective clothing must be changed at least daily or if it becomes soiled or contaminated. Protective clothing is considered contaminated if splash, spray, spatter and/or droplets were created during the procedure. Therefore, gowns need to be changed between patients if procedures such as hand scaling or AGPs were performed. Single-use disposable protective clothing must only be worn for one client (according to manufacturer's instructions for use).

Protective clothing can include gowns and [alternatives identified by Health Canada](#) that meet the following criteria:

- Moisture-resistant or moisture-impervious fabric
- Full coverage of the practitioner from neck to knees when seated
- Sleeves with elastic cuffs that fit under the cuff of the examination glove
- Secures at the neck and waist, preferably at the back
- Can be donned and doffed properly to avoid cross-contamination

If reusable, protective clothing will need to be laundered as per manufacturer instructions between uses (refer to [AHS Linen in Community-based Services](#)).

Eye Protection

Created: May 3, 2020

Revised: May 14, 2020; May 26, 2020; June 12, 2020

Eye protection includes goggles, safety glasses with side shields or a full-face shield that covers the front and sides of the face. Personal eyeglasses and contact lenses alone are not considered adequate eye protection but may be worn beneath eye protection. If N95 respirators are required but not available and level 3 surgical masks are used, wear a full-face shield.

Gloves

Created: May 3, 2020

Revised: May 14, 2020; May 26, 2020; June 12, 2020

Gloves are a single use disposable item that must be changed if they become torn or heavily contaminated. Keep open boxes of gloves in closed compartments.

Donning and Doffing of PPE

Created: May 3, 2020

Revised: May 14, 2020; June 12, 2020

Donning and doffing must be done in a way to prevent contamination of the dental hygienist. Dental hygienists and staff must be trained in effective donning and doffing procedures to minimize risk of cross-contamination. If contaminated PPE is touched, perform hand hygiene with soap and water. Training and practice using your healthcare facility's procedure is critical. The following are examples of proper donning and doffing processes:

- [CRDHA donning and doffing](#)
- [AHS Donning](#)
- [AHS Doffing](#)
- [AHS Donning & Doffing PPE Video](#)
- [CDC recommendations](#)

AFTER CLINICAL CARE

Record Keeping

Created: May 3, 2020; June 12, 2020

Maintain quality control measures through documenting instrument reprocessing as per [Alberta Dental Association and College's \(ADA&C\) Standard of Practice: Infection Prevention and Control Standards and Risk Management for Dentistry](#). Offices may wish to audit their current sterilization processes to ensure tracking of information is clear and easily accessible should contact tracing for a client be required.

Client charting will include answers to screening questions, the name of the clinician who provided treatment, and date, load and sterilizer used for instrumentation. Paper charts should be kept outside of the operatory to reduce risk of contamination.

Documentation should include your rationale for the necessity to provide AGPs based on client assessment. Office policies and procedures should outline the risk mitigation strategies (OHS controls) dental hygienists use when performing AGPs.

Enhanced Environmental Cleaning and Disinfection

Created: May 3, 2020

Revised: May 11, 2020

Refer to your clinic's policies and procedures in the Infection Prevention and Control manual for environmental cleaning. This manual must be in compliance with the [ADA&C's Standard of Practice: Infection Prevention and Control Standards and Risk Management for Dentistry](#), which was adopted by the CRDHA for dental hygiene practice. Policies and procedures may need to be modified to address increased risks associated with the COVID-19 pandemic.

Staff should ensure that hand hygiene has been performed before touching any equipment. Clean and disinfect:

- Any shared client care equipment (e.g., blood pressure cuffs, thermometers) prior to use by a different client.

- All staff equipment (e.g., computer carts and/or screens, medication carts, charting desks or tables, computer screens, telephones, touch screens, chair arms) at least daily and when visibly soiled.

Enhanced cleaning of all surfaces and instruments must include wearing gloves, a mask and face shield or eye protection:

- All clinical contact surfaces must be cleaned and disinfected OR single-use surface covers must be replaced between clients.
 - Cleaning refers to the removal of visible soil. Cleaning does not kill germs but is highly effective at removing them from a surface.
 - Disinfecting refers to using a chemical to kill germs on a surface. Disinfecting is only effective after surfaces have been cleaned.
- Use disinfectants that have a Drug Identification Number (DIN) or Natural Product Number (NPN) issued by Health Canada and do so in accordance with label instructions.
 - Look for an 8-digit number (normally found near the bottom of a disinfectant's label).
 - For disinfection recommendations, refer to [Health Canada: Hard surface disinfectants](#)
 - Follow manufacturer's instructions for use.
- Single use surface covers must be applied with clean hands (hands that have recently had hand hygiene performed on them) and must be removed and discarded, using single-use protective gloves, between clients.
 - If using surface covers, all surfaces must be inspected for evidence of contamination following their removal and cleaned and disinfected if contaminated.
- Components of dental devices that are permanently attached to the dental unit water lines (e.g., electric handpiece motors, handles for ultrasonic devices attachments for saliva ejectors, etc.) must be disinfected or covered with surface barriers that are changed after each use.
- Radiographic equipment (e.g., tube heads and control panel) must be cleaned and disinfected between clients or protected with surface barriers that are changed between clients.
- Items that are not single-use disposable, must be sterilized and stored in a clean, dry, covered area and may be handled with clean hands.
- Use disposable equipment where possible. Single-use disposable items must not be reprocessed.

Follow the manufacturer's instructions for difficult to clean items, or consult with Alberta Health Services (AHS) Infection Prevention and Control (IPC) or refer to the [ADA&C Standard of Practice: Infection Prevention and Control Standards and Risk Management in Dentistry](#).

All IPC concerns, for all settings, are being addressed by Alberta Health Services through their central intake email: continuingcare@albertahealthservices.ca.

For additional recommendations on disinfection of hard surfaces, refer to

- [AH Reprocessing Standards](#)
- [IPAC Canada Recommendations](#)
- [Health Canada](#)
- [Government of Canada](#)
- [Products that meet EPA's criteria for use against SARS-CoV-2](#)

Going Home After a Workday

Created: May 3, 2020

Revised: June 10, 2020

Dental hygienists should change from scrubs and shoes to personal clothing before exiting the clinic. Any protective clothing (including scrubs) should be transported in a moisture-impervious bag which is either laundered with the scrubs or safely discarded. Upon arriving home, dental hygienists should wash scrubs (separately from all other household laundry) and immediately shower. Office attire should not be worn outside the office.

Resources:

- [AHS Linen in Community-based Services](#)
- [CRDHA Laundering of Reusable Linens](#)

Additional Resources:

Alberta Health Services

- Alberta Health Services. Interim IPC Recommendations COVID-19
<https://www.albertahealthservices.ca/assets/healthinfo/ipc/hi-ipc-emerging-issues-ncov.pdf>
- Alberta Health Services. Novel Coronavirus (COVID-19) Frequently Asked Questions – Staff
<https://www.albertahealthservices.ca/assets/info/ppih/if-ppih-ncov-2019-staff-faq.pdf>
- Alberta Health Services. novel coronavirus (COVID-19)
www.albertahealthservices.ca/topics/Page16944.aspx
- Alberta Health Services Aerosol-Generating Medical Procedure Guidance Tool
<https://www.albertahealthservices.ca/topics/Page17091.aspx>

Alberta Health

- CMOH 16-2020 including Appendix A, Workplace Guidance for Community Health Care Settings
<https://open.alberta.ca/publications/cmoh-order-16-2020-2020-covid-19-response>
- COVID-19 Orders and Legislation
<https://www.alberta.ca/covid-19-orders-and-legislation.aspx>
- Public health disease management guidelines : coronavirus – COVID-19
<https://open.alberta.ca/publications/coronavirus-covid-19>
- COVID-19 info for Albertans
www.alberta.ca/coronavirus-info-for-albertans.aspx
- COVID-19 General Relaunch Guidance
<https://www.alberta.ca/assets/documents/covid-19-workplace-guidance-for-business-owners.pdf>

Health Canada

- Coronavirus Disease (COVID-19): Outbreak Update
www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection.html

Centres for Disease Control (US)

- Guidance for Dental Settings
<https://www.cdc.gov/coronavirus/2019-ncov/hcp/dental-settings.html>

- Interim U.S. Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to COVID-19
<https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html>
- Recommended Guidance for Extended Use and Limited Reuse of N95 Filtering Facepiece Respirators in Healthcare Settings
<https://www.cdc.gov/niosh/topics/hcwcontrols/recommendedguidanceextuse.html>
- Decontamination and Reuse of Filtering Facepiece Respirators
<https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/decontamination-reuse-respirators.html>
- Coronavirus (COVID-19)
www.cdc.gov/coronavirus/2019-ncov/index.html

European Centre for Disease Prevention and Control

- COVID-19
www.ecdc.europa.eu/en/novel-coronavirus-china

World Health Organization

- Coronavirus (COVID-19) Pandemic
www.who.int/emergencies/diseases/novel-coronavirus-2019

Associations

- Canadian Dental Hygiene Association Coronavirus (COVID-19)
https://www.cdha.ca/cdha/News-Events_folder/Safety_Alerts/CDHA/News-Events_folder/Safety_Alerts/Safety_Alerts.aspx?hkey=e0e7dd5a-a058-4371-ad8c-7e9fb54039cb
- Canadian Dental Association
<https://www.cda-adc.ca/en/about/covid-19/action/>
- American Dental Hygienists Association Interim Guidance on Return to Work
https://www.adha.org/resources-docs/ADHA_TaskForceReport.pdf
- American Dental Association Return to Work Toolkit
https://pages.ada.org/return-to-work-toolkit-american-dental-association?utm_campaign=covid-19-Return-to-Work-Toolkit&utm_source=adaorg-ada-news&utm_medium=adanews&utm_content=covid-19-interim-return-to-work&_ga=2.21568379.1559139315.1587996041-2052206056.1577053930
- Australian Dental Association
<https://www.ada.org.au/Covid-19-Portal/Dental-Professionals>

IPAC-Canada

- Conservation and Decontamination N95 Facemasks and PPE <https://ipac-canada.org/reprocessing-of-ppe.php>

LitCovid

- Curated literature hub for tracking up-to-date scientific information about the 2019 novel Coronavirus
<https://www.ncbi.nlm.nih.gov/research/coronavirus/>

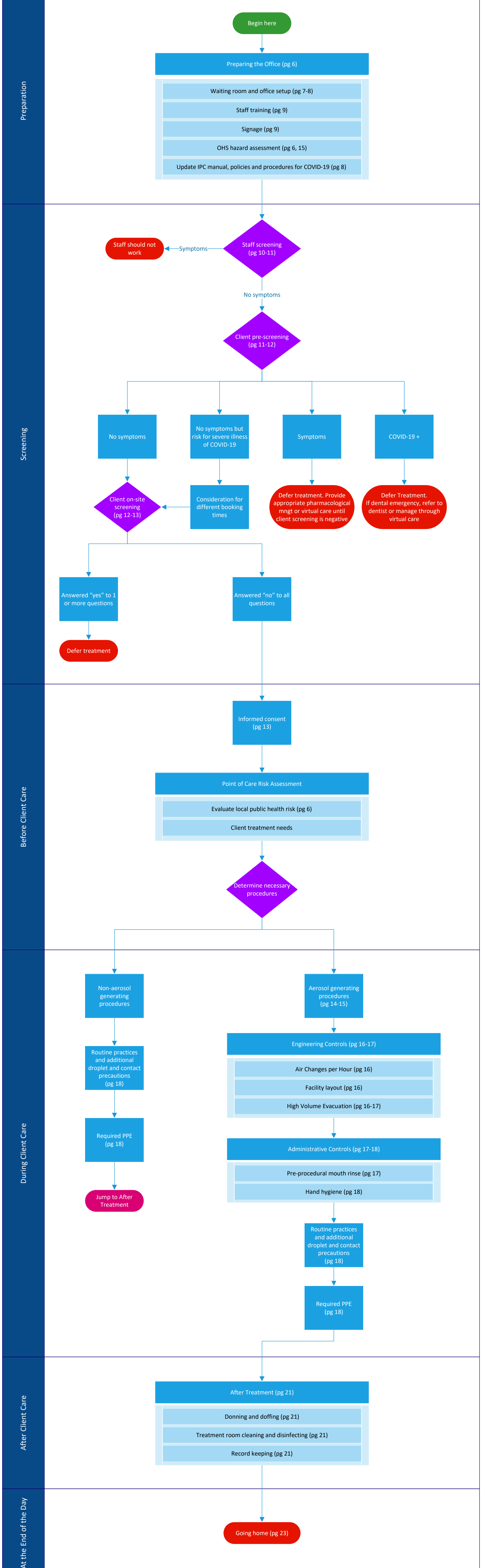
Research

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- Suen LKP, Guo YP, Tong DWK, et al. Self-contamination during doffing of personal protective equipment by healthcare workers to prevent Ebola transmission. *Antimicrob Resist Infect Control.* 2018;7:157.
- Mumma JM, Durso FT, Ferguson AN, et al. Human Factors Risk Analyses of a Doffing Protocol for Ebola-Level Personal Protective Equipment: Mapping Errors to Contamination. *Clin Infect Dis.* 2018;66(6):950-958.
- Beam EL, Gibbs SG, Boulter KC, Beckerdite ME, Smith PW. A method for evaluating health care workers' personal protective equipment technique. *Am J Infect Control.* 2011;39(5):415-420.
- Chughtai AA, Chen X, Macintyre CR. Risk of self-contamination during doffing of personal protective equipment. *Am J Infect Control.* 2018;46(12):1329-1334. doi:10.1016/j.ajic.2018.06.003
- Pre-Treatment Mouth Rinses for Dental Patients With Suspected SARS or COVID-19: Clinical Effectiveness and Guidelines
<https://covid.cadth.ca/treatment/pre-treatment-mouth-rinses-for-dental-patients-with-suspected-sars-or-covid-19-clinical-effectiveness-and-guidelines/>
- Severe Acute Respiratory Syndrome (SARS) and the GDP. Part II: Implications for GDPs
<https://www.ncbi.nlm.nih.gov/pubmed/15311240>
- Aerosol and Splatter Contamination From the Operative Site During Ultrasonic Scaling
<https://www.ncbi.nlm.nih.gov/pubmed/9766105>
- Hazards of Laser Smoke During Endodontic Therapy
<https://www.ncbi.nlm.nih.gov/pubmed/7643041>
- Tooth Polishing: The Current Status
<https://www.ncbi.nlm.nih.gov/pubmed/26392683>

Appendix A: Flowchart and Case Studies



COVID-19 Return to Work Guidelines for Dental Hygienists



Preparation

Screening

Before Client Care

During Client Care

After Client Care

At the End of the Day

Case Study 1 - Low Risk Community

John, 65-year-old, presents for a dental hygiene appointment. Review of his medical history indicates he was recently diagnosed with type II diabetes that is being managed with medication. He smokes 25 cigarettes per day. He complains of generalized bleeding and tender gums, and sensitivity on the upper left side when eating sweets. He is scheduled for a knee replacement in one month and needs dental clearance. John indicates his oral hygiene has slid and he is lacking motivation with brushing and flossing as a result of being laid off during COVID-19. His last dental hygiene appointment was two years ago.

Point of care Risk Assessment to determine treatment for John

Community Profile: Local hospital has no cases of COVID-19 receiving care.	
Health benefit of providing dental hygiene care	Management of risk of exposure of aerosols into environment
<ul style="list-style-type: none"> • Several factors in the client profile put this client at an increased risk of periodontitis. Client is a smoker, recently diagnosed diabetic, tender bleeding gums, poor oral hygiene, overdue for dental hygiene therapy. • The clinician can achieve the reduction of subgingival biofilm and calculus removal which will address inflammation present in gingival tissue. • The use of the ultrasonic scaler will reduce the amount of time this individual will need to be in the dental hygiene environment, thus reducing overall risk to the client. • Use of intra-oral radiographs to detect caries and bone loss. • The use of a slow speed hand piece will be beneficial in order to removed residual stain and reduce time in chair for the client. 	<ul style="list-style-type: none"> • Evaluation of local public health COVID-19 cases indicates low risk of community spread • Dental hygiene practice has implemented engineering and administrative controls including 4-handed dentistry technique for HVE use during aerosol generating procedures • Pre-Screening of client and staff • Pre-procedural rinses • Evaluation of client for gag response • Employ strategies to avoid stimulation of coughing and vomiting • Appropriate PPE available for AGP (N95, gown, face shield, gloves, bouffant)
<u>Dental hygienist's rationale for treatment plan:</u>	
Based on this point of care risk assessment, the dental hygienist can justify that the health benefit of providing AGPs outweighs the risk of generating aerosols.	

Case Study 2 - High Risk Community, outbreak of COVID-19 in community.

John, 65-year-old, presents for a dental hygiene appointment. Review of his medical history indicates he was recently diagnosed with type II diabetes that is being managed with medication. He smokes 25 cigarettes per day. He complains of generalized bleeding and tender gums, and sensitivity on the upper left side when eating sweets. He is scheduled for a knee replacement in one month and needs dental clearance. John indicates his oral hygiene has slid and he is lacking motivation with brushing and flossing as a result of being laid off during COVID-19. His last dental hygiene appointment was two years ago.

Point of Care Risk Assessment to Determine Treatment for John

Community Profile: Local hospital is reporting an increase of active COVID-19 cases being admitted due to recent outbreak.	
Health benefit of providing dental hygiene care	Management of risk of exposure of aerosols into environment
<ul style="list-style-type: none"> • Several factors in the client profile put this client at an increased risk of periodontitis. Client is a smoker, recently diagnosed diabetic, tender bleeding gums, poor oral hygiene, overdue for dental hygiene therapy. • Hand scaling can achieve debridement and reduction in inflammation, with longer appointment time. • The clinician can achieve the reduction of subgingival biofilm and calculus removal which will address inflammation present in gingival tissue. • Use of extra-oral radiograph. 	<ul style="list-style-type: none"> • Evaluation of local public health COVID-19 cases indicates high risk of community spread due to recent outbreak. <ul style="list-style-type: none"> ○ Dental hygiene practice has administrative policy in place to restrict AGPs in times of community outbreak to reduce OHS risk to workers and clients • HVE is used during aerosol generating procedures, however there is a shortage of staff to provide additional support through 4-handed dentistry • Pre-Screening of client and staff • Pre procedural rinses • Appropriate PPE is very low for AGPs, but PPE for non-AGPs is currently in stock (Level 2 mask, gown, face shield, gloves, bouffant)
<p><u>Dental hygienist's rationale for treatment plan:</u></p> <p>Based on this point of care risk assessment, the dental hygienist cannot justify that the health benefit of providing AGPs outweighs the risk of generating aerosols. The community transmission of COVID-19 is high, the office policy limits AGPs in times of community outbreak, 4-handed dentistry is not an option due to lack of staff, and the office is running low on appropriate PPE for AGPs.</p> <p>If during treatment it is identified that an AGP is required (e.g. powered instrumentation or low-speed handpiece for polishing), the client can be rebooked for that treatment at a time it is safe to perform AGPs (i.e. community spread is low). Dental hygiene care with non-AGPs can be provided at this time based on the client's need (e.g. risk of periodontitis, upcoming surgery).</p>	

EXAMPLE: 65 year old smoker, type 2 Diabetes, scheduled for knee replacement

