MINISTRY OF HEALTH
MANATŪ HAUORA

Dental Council
Te Kaunihera Tiaki Niho

Guidelines for oral health services at COVID-19 Alert Level 2

20 September 2021

Context

The purpose of this document is to describe the conditions within which oral health services can be provided during the New Zealand government COVID-19 Alert Level 2 to protect the safety of your patients, the community, yourself and staff.

The Alert Level system can be activated at a localised or regional level, or nationally. Follow the COVID-19 guideline relevant to the government's alert level applicable to the location in which you practise, and associated travel rules.

The COVID-19 alert settings, related risk assessments (such as the Ministry of Health's Higher Index of Suspicion), and infection prevention and control advice may change based on experiences, learnings and new evidence that becomes available. The Council will continue to work closely with the Ministry of Health, review and update the guidelines to reflect any changes, and inform practitioners of changes made.

While we are in COVID-19 Alert Level 2

Under level 2, you can provide oral health care for your patients that ensures a balance between patients' access to care and protecting public safety by limiting opportunities for COVID-19 community spread.

Patients are in either a low or high risk category for care, depending on their responses to the risk assessment questions detailed on page 4.

For the moment, PPE requirements for fully vaccinated oral health practitioners and staff, and the risk assessment and patient management of fully vaccinated patients remain the same as those for unvaccinated people, until a larger proportion of the community has been fully vaccinated.

General comments on PPE

- The Guidelines for oral health services at COVID-19 Alert Level 2 should be read in conjunction with the existing Infection prevention and control practice standard (IPC). There have been no changes to the Council's 2016 IPC practice standard. This guideline sets out additional IPC measures that apply during COVID-19 Alert Level 2.
- All team members within the treatment room/area during treatment, must wear the appropriate PPE.
- All used PPE must be discarded as clinical waste (defined as controlled waste in the Council's infection prevention and control practice standard).
- Where a N95 or P2 particulate respirator is used, clinical staff and oral health practitioners must have received training in fit checking and undergo fit testing before use.
- A fit check should be done by the wearer every time. Fit testing must also be undertaken annually and when a different brand is introduced, and when there are significant changes to the wearer's facial features such as significant weight changes or dental work.
- Independent fit testers are available via: https://nzohs.org.nz/commit2fit/.
- Ministry of Health guidance on how to perform a fit check is included as Appendix 3. Further guidance on fit testing of N95 masks can be found here.

Steps in assessing a patient for care

For ALL patients ask the risk assessment questions on page 4 of these guidelines, before scheduling an appointment, and record the patient's responses in their record.

This assessment will determine whether you need to take extra infection prevention and control precautions because the patient is at risk of having COVID-19, or has potentially been exposed to COVID-19 in the past 14 days and therefore has a risk, although very low, of being a pre-symptomatic or an asymptomatic COVID-19 case.

When the patient arrives for their appointment, confirm their responses to the questions asked when scheduling, and record the patient's responses in their record.

Within the context of limiting the spread of any COVID-19 community transmission, for patients with COVID like symptoms or epidemiological risks, encourage them to defer their care if not urgent.

Risk assessment questions

Do you have a confirmed diagnosis of COVID-19?

Are you a probable COVID-19 case?

Are you required to self-isolate and/or waiting for COVID-19 test results?

Yes to ANY → High risk patient

No to ALL

- Do you have new or worsening respiratory symptoms including one of the following: new or worsening cough, sneezing and runny nose, sore throat, fever, temporary loss of smell or altered sense of taste, shortness of breath?
- Do you have any of the less common symptoms, such as: diarrhoea, headache, muscle aches, nausea, vomiting, malaise, chest pain, abdominal pain, joint pain or confusion/irritability - where there is no other likely diagnosis?

No to ALL → Low risk patient

Yes to ANY

In the 14 days before the start of your symptoms have you:

- had close contact* with someone who is a probable or confirmed COVID-19 case?
- been in attendance at a current location of interest?
- travelled internationally (excluding travel by air from a country/area with which New Zealand has quarantine-free travel (QFT))?
- had direct contact with someone who has travelled overseas (excluding travel by air from a QFT country/area). This includes border staff, quarantine and isolation facility staff, and international aircraft and shipping vessel crew, except those who have travelled exclusively between New Zealand and QFT destinations?
- exited an MIQ facility (excluding recovered COVID-19 cases)?
- worked on an international aircraft or shipping vessel (excluding aircraft from a QFT country/area)?
- cleaned at an international airport or maritime port in areas/conveniences visited by international arrivals (excluding areas/conveniences for travellers by air from a QFT country/area)?
- worked in cold storage areas of facilities that receive imported chilled and frozen goods directly from an international or maritime port?
- travelled from an area with an evolving community outbreak (including in New Zealand and any other country/area with which New Zealand has QFT)?**

Yes to ANY → High risk patient

No to ALL → Low risk patient

*a close contact is defined in Appendix 2 of the guidelines

** travel from an area with Alert level 3 or 4 restrictions

Treatment requirements

1. Low risk patient

Apply standard precautions as per the Infection Prevention and Control (IPC) Practice Standard.

The treatment can be performed in a dental practice setting or wherever the patient is normally treated, as long as all necessary PPE is used.

Minimum PPE required:

- Surgical mask (Level 2 at minimum, ideally Type IIR or above)[1]
- Eye protection (Safety glasses that have (1) side vents; or (2) goggles; or (3) prescription glasses covered with a full face shield/visor. Prescription glasses alone are not considered as eye protection)
- Gloves
- Outer protective clothing[2] as per the IPC practice standard (for example a gown, tunic over your street clothing or uniform).

Aim to schedule and manage patients to limit their contact with others and the time they spend in a common area.

If a patient is considered a 'low risk patient' but has respiratory symptoms:

- If a 'low risk patient' has respiratory symptoms, consider whether treatment can be deferred until the patient has recovered
- If treatment cannot be deferred:
    - provide the patient with a surgical mask to wear when they arrive at the practice
    - keep them 2 metres away from others or move them directly into a single room if available
    - provide staff with a surgical mask as well.

[1] Type IIR surgical masks has a liquid-repellent layer offering additional protection against particulate matter and infectious splashes, and prevents strike through of fluids greater than 120mmgh. Type IIR meets the EN14683 standards.

[2] Outer protective clothing is to be made from material that does not permit blood or other potentially infectious material to reach clothes or skin underneath

When providing care for a low risk patient (as defined on pages 4) that **will generate an aerosol**:

- Close the door wherever possible.
- Use measures aimed at reducing the extent and contamination of aerosol and splatter **wherever possible**.

  For example, high volume evacuation systems (HVE), and use of dental dam*.

  The cumulative impact of using all these measures significantly decreases the amount of aerosol and the level of infectious agents contained within it. Ideally practitioners should use all three measures wherever possible.

  This may mean involving a dental assistant when possible, to handle the HVE when aerosol is generated.

  All rotary handpieces generate aerosols, regardless of whether the motor is electric or air-driven (with or without water). Other aerosol generating instruments commonly used in oral health care include ultrasonic and sonic scalers, triplex syringe, air-abrasion and air-polishing etc.

*also commonly referred to as rubber dam

2. High risk patient

You can provide oral health care for your patients that ensures a balance between patients' access to care and protecting public safety by limiting opportunities for COVID-19 community spread.

Aim to schedule and manage high risk patients so as to limit the opportunity for contact with other patients and team members (e.g. at the end of the day or session).

For non-aerosol generating procedures:

Room requirements: a single room, door closed.

Minimum PPE required:

- N95 or FFP2 mask (single use)[3,4]
- Eye protection (Full face shield/visor **over any of the following** (1) safety glasses that have side vents, or (2) goggles, or (3) prescription glasses)
- Gloves
- Long sleeve impervious gowns[5].

For aerosol generating procedures:

Room requirements:

The patient should be treated in an Airborne Infection Isolation Room (AIIR).[6]

If an AIIR is not available, treat the patient in a single room with a door which should remain closed. This room should not be positively pressured to the outside corridor. A portable HEPA filtration unit, if available, may be used in this setting and it would provide an additional measure of infection prevention during the assessment and treatment of the patient.

Follow the stand down time described on page 8 after completing the aerosol generating procedures, before cleaning.

Minimum PPE required:

- N95 or FFP2 mask (single use)[3,4]
- Eye protection (Full face shield/visor **over any of the following** (1) safety glasses that have side vents, or (2) goggles, or (3) prescription glasses)
- Gloves
- Long sleeve impervious gowns[5].

[3] Aerosol generating procedures should be avoided where possible. If such a procedure is absolutely essential, appropriate PPE is required. This requirement is due to the prolonged nature of such procedures and the close proximity of the operator. These are distinctive features of the aerosol generating procedures used in clinical dentistry

[4] Respiratory protection can also be achieved using: full face reusable respirator, supplied air respirator (SAR), powered air-purifying respirator (PAPR), or FFP3 respirators. Users should be trained how to don, use, doff and decontaminate these appropriately to prevent agent transfer

[5] Change at least between patients

[6] An AIIR is a single-occupancy patient-care room, formerly, a negative pressure isolation room. https://www.cdc.gov/infectioncontrol/guidelines/isolation/glossary.html

Post aerosol generating procedures stand down time before cleaning, for **high risk patients**

Aerosol Generating Procedures (AGPs) can promote the generation of small particles (<5 µm). These fine particles remain suspended in the air for longer periods than larger particles and can be inhaled resulting in a risk of airborne transmission.

A stand down period after AGPs, before cleaning, is therefore required as specified below.[7]

Air changes per hour (ACH)	1-5 or unknown	6-9	≥ 10
Stand down period after AGPs **(room remains closed with no staff in room) before cleaning**	• Standard: 30 minutes* • High volume evacuation (HVE) used: 25 minutes • HVE & dental dam used: 20 minutes *When ventilation is poor (e.g. 1-2 ACH) or ACH is unknown, use of high volume suction is considered essential. If this is not possible, a stand down period of up to 60 minutes should be considered, or an alternative procedure adopted.	• Standard: 20 minutes • HVE used: 15 minutes • HVE & dental dam used: 10 minutes	• Standard: 15 minutes • HVE and/or dental dam used: 10 minutes

[7] Adapted from NHS COVID-19 Infection prevention and control dental appendix. Available on: https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/covid-19-infection-prevention-and-control-dental-appendix#post-agp-downtime

Assessing and managing high risk patients

1. **Triage these patients by phone** and decide whether they require care.

   If the patient's dental condition can be accurately diagnosed and effectively managed without needing to see the patient, then that is best. Effective management of the patient's dental condition may be possible with medication alone.

   If in your professional judgement you need to see the patient for a face-to-face assessment and/or treatment, to effectively manage their dental condition, you can see the patient if you can meet the room and PPE requirements for high risk patients.

   If you are unable to meet the room or PPE requirements, and the patient requires care, then refer the patient to where they can receive this.

2. If you need to see a high risk patient:

   - Schedule and manage the patient in a way that minimises face-to-face interaction with others (e.g. at the end of day or session).

   - **Limit aerosol-generating procedures where possible**. All rotary handpieces generate aerosols, regardless of whether the motor is electric or air-driven (with or without water). Other aerosol generating instruments commonly used in oral health care include ultrasonic and sonic scalers, triplex syringe, air-abrasion and air-polishing etc.

   - When aerosol-generating procedures are required:
     - Wear at minimum an N95 or FFP2 mask[4], gloves, a long sleeved impervious gown, and eye protection – a full face shield/visor over any of the following: (1) safety glasses that have side vents, or (2) goggles, or (3) prescription glasses.
     - Room requirements are specified on page 7.
     - Use measures aimed at reducing the extent and contamination of aerosol and splatter as appropriate, for example, high volume evacuation systems, and use of rubber dam.
     - Preferably use a slow speed handpiece that operates at ≤ 40000 rpm, and where possible turn the chip air off, to minimise the aerosol generated during the procedure
     - Observe the relevant stand down time before cleaning specified on page 8.

3. If over-the-counter or prescription medication is required for high risk patients:

   - Prescriptions can be sent to the pharmacy for collection without the patient presenting at the dental surgery.
   - Where prescriptions are issued to probable or COVID-positive patients, please ask the patient not to attend the pharmacy themselves to pick it up – they should send a family member or arrange delivery by the pharmacy (delivery may incur a cost).
   - Follow the rules for electronic prescriptions to support virtual care in the community, published 2020.

[4] Respiratory protection can also be achieved using: full face reusable respirator, supplied air respirator (SAR), powered air-purifying respirator (PAPR), or FFP3 respirators. Users should be trained how to don, use, doff and decontaminate these appropriately to prevent agent transfer

Steps to limit transmission for all patients

Patient scheduling and management

- Continue to assess patients for any COVID-19 symptoms before booking, and when they arrive for their appointment; similarly, for a support person that may be attending.

  If the support person presents a high risk for COVID-19, and no alternative support person is available, ensure the support person wear a surgical mask before entering the practice.

- Schedule and manage patients to limit the time they will spend in a common area and their contact with others. For example, when a patient arrives, you may consider asking them to wait outside of the practice area until their appointment time, and escorting them directly into the clinical area, where possible.

- Ask patients to arrive as close as possible to their appointment time.

- Limit points of entry into the facility.

- Ensure patients and contractors wear their own mask/face covering when entering the practice. Immediately offer them a mask if they are not wearing their own mask/face covering when entering the practice.

- Post visual alerts (e.g. signs, posters) at the entrance and in strategic places (e.g. waiting areas, elevators) to provide patients and health care practitioners with instructions (in appropriate languages) about hand hygiene, respiratory hygiene, and cough etiquette.

- Instructions should include to cough into the crook of your elbow or to use tissues to cover nose and mouth when coughing or sneezing, to dispose of tissues and contaminated items in lined, no-touch waste receptacles, and how and when to perform hand hygiene.

- Provide supplies for respiratory hygiene and cough etiquette, including alcohol-based hand rub (ABHR) with 60-95% alcohol, tissues, and lined, no-touch receptacles for disposal, at healthcare facility entrances, waiting rooms, and patient check-ins.

- Request patients to wash their hands (where facilities allow) or ‘hand sanitise’ on arrival and departure from the clinic.

- All staff members must wear a surgical mask when in the practice and not engaged in clinical activity (PPE requirements apply providing patient care).

- Practise 2 metre physical distancing wherever possible and practical (between staff; between staff and patients; and patients and patients).

  For multi chair clinics, ensure enough space is maintained in the clinic so that patients and their support person are able to maintain a distance of at least 2 metres from others when entering and exiting the clinic.

- Limit the number of people providing patient support in the treatment area to one. Offer the support person a surgical mask instead of their own mask/face covering.

- Be generous with appointment times to allow careful, unrushed attention to IPC procedures. A general ‘slow-down’ approach is recommended overall.

Waiting areas

- All unnecessary items should be removed from the waiting room, such as magazines and toys, and surfaces kept clear and clean.
- 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 as described in the Dental Council's Transmission Based Precautions – Cleaning section contained in the Infection Prevention and Control Practice Standard.

Contact tracing

- 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 enable contact tracing.
- Practices must prominently display the New Zealand COVID Tracer QR code at the entrance of the facility, and encourage people to scan in.

Team management

- If team members are unwell, they should stay home.
- Consider introducing measures to monitor your own health and that of your team.
- Consider organising team members so that they work within a team 'bubble' when delivering clinical care, to limit the number of potential close contacts between clinical team members and to make tracing of team members to patients simpler.
- Limit your social interaction outside of work as much as possible; and suggest clinical team members (including those with decontamination duties) do the same.
- Ensure your team members understand the risks associated with dental practice during COVID-19 Alert Levels, and the measures you are taking to mitigate the risks.

Hand hygiene

- All clinical team members 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.
- Clinical team members should perform hand hygiene by washing hands with soap and water for at least 20 seconds or using ABHR with 60-95% alcohol 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.

Personal protective equipment

- Select appropriate PPE in accordance with the PPE requirements specified in this document, at minimum.
- Do not wear your outer protective wear, like scrubs/gown/tunic, outside of the practice setting.
- Oral health care practitioners must have received 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.

  This is of particular importance for staff members not usually wearing PPE, or introducing new types of PPE into the practice, such as an N95 mask or PAPR.[4]
- Any reusable PPE must be properly cleaned, decontaminated, and maintained after and between uses.
- Discard all PPE as clinical waste.

[4] Respiratory protection can also be achieved using: full face reusable respirator, supplied air respirator (SAR), powered air-purifying respirator (PAPR), or FFP3 respirators. Users should be trained how to don, use, doff and decontaminate these appropriately to prevent agent transfer

Additional steps to limit transmission when providing care for high risk patients

For high risk patients, additional steps should be taken to limit the risk of transmission.

To minimise risk practitioners must:

- use telehealth when possible
- encourage patient respiratory hygiene by providing a facemask, tissues, and ability to wash their hands
- isolate symptomatic patients as soon as possible. Place high risk patients in separate room with door closed and private bathroom (where possible)
- protect healthcare personnel
- emphasise hand hygiene
- limit the number of staff providing their care.

During treatment

- For high risk patients, when possible, no support people should be in the treatment room. If necessary, limit to one support person and offer them a surgical mask instead of their own mask/face covering.

- If the patient wants to keep their extracted tooth, clean and disinfect the tooth.

Cleaning and decontamination

- Appropriate PPE should be worn for cleaning down the room. At minimum outer protective clothing as per the IPC practice standard, gloves, surgical mask and protective eyewear.

- Wipe down hard surfaces using a two-step process: first with detergent and water, then hospital grade disinfectant[8] with activity against respiratory virus, including COVID-19.

- After treating a high risk patient when aerosol generating procedures have occurred, the room should remain closed for a stand down period before cleaning. Stand down times are specified on page 8.

- Remove any linen that has been used into linen bags for hot washing.

- Remove and discard PPE as clinical waste (taken off in the following order: gloves, hand hygiene, gown or plastic apron – if used, hand hygiene, protective eyewear (if separate from mask), hand hygiene, mask, hand hygiene).[9]

- Perform hand hygiene thoroughly to elbows.

[8] Based on current available literature - inactivation of COVID-19 on surfaces within 1 minute by using 62-71% ethanol, 0.5% hydrogen peroxide or 0.1%sodium hypochlorite

[9] https://www.health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-novel-coronavirus-information-specific-audiences/general-cleaning-information-following-suspected-probable-or-confirmed-case-covid-19

Risk assessment	Low risk patient	High risk patient	
PPE	• Surgical mask (Level 2 at minimum, ideally Type IIR or above) [1] • Eye protection[2] • Gloves • Outer protective clothing as per the IPC practice standard If patient has respiratory symptoms and the dental treatment cannot be deferred: ○ on arrival to the practice provide the patient with a surgical mask to wear ○ keep them 2 metres away from others or move them directly into a single room if available. ○ if your staff cannot maintain the 2 metre physical distancing then provide them with a surgical mask as well.	**Non-aerosol** generating procedures: • N95 or FFP2 mask (single use) [3,4] • Eye protection[5] • Gloves • Long sleeved impervious gowns[6]	**Aerosol** generating procedures: • N95 or FFP2 mask (single use) [3,4] • Eye protection[5] • Gloves • Long sleeved impervious gowns[6]
Room requirements	eg dental surgery Standard precautions apply, as per IPC practice standard	**Non-aerosol** generating procedures: • Single room • Door closed	**Aerosol** generating procedures: The patient should be treated in an Airborne Infection Isolation Room (AIIR).[7] If an AIIR is not available, treat the patient in a single room with a door which should remain closed. This room should not be positively pressured to the outside corridor.

1 Type IIR surgical masks has a liquid-repellent layer offering additional protection against particulate matter and infectious splashes, and prevents strike through of fluids greater than 120mmgh. Type IIR meets the EN14683 standards

2 Safety glasses that have side vents; or goggles; or prescription glasses covered with a full face shield/visor

3 Respiratory protection can also be achieved using: full face reusable respirator, supplied air respirator (SAR), powered air-purifying respirator (PAPR), or FFP3 respirators. Users should be trained how to don, use, doff and decontaminate these appropriately to prevent agent transfer

4 Aerosol generating procedures should be avoided where possible. If such a procedure is absolutely essential, appropriate PPE is required. This requirement is due to the prolonged nature of such procedures and the close proximity of the operator. These are distinctive features of the aerosol generating procedures used in clinical dentistry

5 Full face shield/visor **over any of the following** (1) safety glasses, or (2) goggles, or (3) prescription glasses

6 Change at least between patients

7 An AIIR is a single-occupancy patient-care room, formerly, a negative pressure isolation room. https://www.cdc.gov/infectioncontrol/guidelines/isolation/glossary.html

			A portable HEPA filtration unit, if available, may be used in this setting and it would provide an additional measure of infection prevention during the assessment and treatment of the patient. Follow the stand down time described on page 8 after completing the aerosol generating procedures, before cleaning.

Close contact definition

Assessment of ‘close contact’ involves a public health risk assessment that considers multiple factors*, usually by a public health unit team led by a medical officer of health.

A person may be considered a close contact if they have exposure to the same air as a confirmed (or probable) case during the case’s infectious period that is assessed as significant, without appropriate personal protective equipment (PPE). Exposure to the same air may include those in a setting immediately after the case, as well as while the case was present. Face-to-face exposure in an enclosed environment that is more than fleeting, and face-to-face contact outdoors within 2 metres for more than 15 minutes, will usually be considered close contact.

In addition, any person with the following exposure will usually be considered a close contact:

- direct contact with the bodily fluids or the laboratory specimens of a case
- living in the same household or household-like setting (e.g., shared section of in a hostel) with a case
- having been seated on an aircraft within 2 metres of a case (for economy class this would mean 2 seats in any direction including seats across the aisle, other classes would require further assessment)
- aircraft crew exposed to a case (a risk assessment conducted by the public health unit in collaboration with the airline is required to identify which crew should be managed as close contacts).

*Factors that contribute to the public health risk assessment of the level of exposure include (but are not limited to) those related to:

- setting: duration, proximity, ventilation (e.g., indoor/outdoor, ventilation system, airflow), crowding/ability to physical distance, length of time, type of activity (e.g. eating/drinking, singing, shouting, talking, exercising)
- case: infectiousness, level of symptoms, face coverings, hand hygiene, age (e.g., child vs adult)
- contact: mitigating features (all wearing face coverings correctly, using hand sanitizer, vaccination status)

Criteria to be considered recovered from COVID-19

A person with mild to moderate disease is considered recovered form COVID-19 infection when they meet all of the following criteria:

- It has been at least 14 days since the onset of the COVID-19 symptoms
- They have been symptom-free for at least 72 hours

- They have been cleared by the health professional responsible for their monitoring.[1]

Normal risk classification applies (low, high) when considering care for these patients.

Different criteria are used to decide when a person who has been hospitalised with COVID – 19 can be considered recovered.

[1] https://www.health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-current-situation/covid-19-current-cases

Appendix 3

Ministry of Health guidance on how to perform a fit check (also called user-seal check)

1. Place the P2/N95 particulate respirator on your face.
2. Place the headband or ties over your head and at the base of your neck.
3. Compress the particulate respirator to ensure a seal across your face, cheeks and the bridge of your nose.
4. Check the positive pressure seal of the respirator by gently exhaling. If air escapes, the respirator needs to be adjusted.
5. Check the negative pressure seal of the respirator by gently inhaling. If the respirator is not drawn in towards your face, or air leaks around the face seal, readjust the respirator and repeat process, or check for defects in the respirator.
6. Always refer to the manufacturer's instructions for fit checking of individual brands and types of P2/N95 respirators.
7. If you are unable to achieve a good facial seal do not proceed with the activity. Possible reasons include:
    - the respirator has not been put on properly e.g. headbands are incorrectly positioned, hair or earrings are caught in the seal
    - the respirator is the incorrect size or type for your face
    - facial hair* (including a 1–2-day beard growth can interfere with an adequate seal)
8. If you cannot achieve a good facial seal after working through the possible reasons listed, speak to your team leader. An alternative style or size of respirator may need to be sourced.
9. To prevent failure of the respirator, once you have the respirator in the correct place and have achieved a good seal, do not touch the front of the mask or re-adjust it.

Further information on the different masks and how to use safely see: role of masks and respirators in health and disability care settings.

Appendix 4

Changes between 20 September 2021 and 7 September 2021 versions

20 September 2021 version	
p4	Updated patient risk assessment questions to link higher index of suspicion criteria to COVID-19 symptoms, and alignment of wording to MOH criteria Updated COVID-19 respiratory and less common symptoms
p5	Surgical mask requirements for low-medium risk patients undergoing non-aerosol procedures change to Level 2 at minimum**, ideally type IIR** Type IIR surgical masks has a liquid-repellent layer offering additional protection against particulate matter and infectious splashes, and prevents strike through of fluids greater than 120mmgh. Type IIR meets the EN14683 standards.
p10	All staff members must wear a surgical mask when in the practice and not engaged in clinical activity (additional PPE requirements apply when providing patient care).
p13	Removal of gown requirement for cleaning and decontamination – outer protective wear still required as per the IPC practice standard
p16-17	Definition of close contact and criteria for recovery updated