Consultation Question:

Do you support the proposed Supplementary risk management principles for oral health during the COVID-19 pandemic? If you do not support the draft, please share your concerns, reasons for your view, and proposed alternatives if you have any.

On behalf of Auckland District Health, thank you for the opportunity to provide feedback on the draft Infection Prevention and Control Practice Standard Supplement. Providing such an opportunity enables a greater understanding of recommendations by professional bodies alongside current and evolving implementation plans by DHBs. It also supports the move to Living with COVID-19.

Please find attached the ADHB flowcharts for OP and Diagnostics with separate procedural pathways for your reference which have been established in keeping with the Health 'Risk Assessment and Categorisation of Healthcare Workers Exposed to COVID-19' (October 2021).

The 'move away' from the focus on AGP's as being the principle risk in dental practice is welcomed and reflects the increasing body of evidence to support this.

While we acknowledge the objective of the principles outlined and broadly support the changes, we would like to make two recommendations. These recommendations relate to:

- The alignment to vaccination status in screening and subsequent PPE guidelines
- The absence of Rapid Antigen Testing within the guidelines

Screening & use of vaccination

While we recognise that vaccination status directly impacts patient and whānau risk of contracting COVID-19, under the Ministry of Health 'Risk Assessment and Categorisation of Healthcare Workers Exposed to COVID-19' (October 2021), it does not directly contribute to risk for staff of contracting COVID-19.

Given the recommendations within the risk assessment and the intent to limit any barriers to access, considering vaccination status has the potential to increase inequities in access to dental services. We believe the better approach is to identify low and high-risk patients through screening and to then consider the nature of the interaction before determining the PPE requirements.

This would be in alignment with the recent published MoH advice on this issue – "Ministry of Health position statement on pre-consultation testing of unvaccinated individuals in healthcare settings" https://www.health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-information-health-professionals/covid-19-advice-all-health-professionals#position

The MOH Risk Assessment (see below) demonstrates the low risk to healthcare workers if having brief interactions (less than 15 minutes) with an unmasked patient that are not aerosol-generating, even when the said health care worker is wearing a surgical mask. The risk remains consistently low for interactions longer than 15 minutes and a P2/N95 mask is worn (this does not require further PPE/or cleaning changes however).

Table 2: Risk assessment and categorisation of healthcare worker

Note: All exposure category decisions are based on a local risk assessment. This matrix should be seen as guidance only. The highest risk duration or proximity parameter met should be used (e.g., face-to-face trumps <30min in the room and >1.5m) Case = confirmed positive case in a patient, staff member or other person in the health care environment. **No increased risk** = transient, not face-to-face, limited contact that does not meet the definition of face-to-face contact. PPE = Personal protective equipment	**Low Risk Exposure** • Shared indoor space: In general, more than 1.5m apart and under 30 minutes cumulative in 24 hours OR • Exposure outdoors: less than 1.5m for more than 30 minutes & no AGP/AGB				**Moderate Risk Exposure** • Any face-to-face contact/care within 1.5 metres and less than cumulative 15 minutes in 24 hours OR • In general, shared indoor space more than 1.5m away for greater than cumulative 30 mins in 24 hours OR • Based on agreed documented individual risk assessment including assessments of occupational exposures and of the physical environment		**High Risk Exposure** • Prolonged face-to-face contact within 1.5 metres and greater than cumulative 15 minutes in 24 hours OR • Contact with multiple COVID-19 confirmed cases/suspected cases/probable cases		**Highest Risk Exposure** • Aerosol generating behaviours (AGBs from the case e.g., uncontrolled coughing, singing, shouting, exercise) where the person is not able to adopt respiratory etiquette OR • Direct exposure to the mouth/nose/eyes with infectious body fluids (e.g., coughed, sneezed, vomited on) from the case[1] OR • Aerosol generating procedures (AGPs) during procedure or settle time	
	Vaccination status of the healthcare worker									
	Partial or none		**Full[2]**		**Partial or none**	**Full**	**Partial or none**	**Full**	**Partial or none**	**Full**
No effective PPE worn by staff member or case (no PPE or PPE with major breaches such as mask below nose)	Level II Based on risk assessment	Level III	Level I Based on risk assessment	Level II	Level III	Level II	Level IV	Level III	Level IV	
Medical mask only worn by staff member • Case not wearing mask	Level II		Level I		Level II	Level I	Level III	Level II	Level IV	
Medical mask worn by staff member AND • Case wearing mask	Level I		Level I		Level I	Level I	Level II	Level I	Level IV	
Staff member in P2/N95 but no eye protection with no breaches	Level I		Level I		Level I	Level I	Level I	Level I	Level IV or Level III with individualised risk assessment[3]	
Staff member in P2/N95 and eye protection with no breaches	**No increased risk** over background – general surveillance testing should continue									

Note: Eye protection may be recommended for IPC purposes to reduce transmission risk in the workplace, but not wearing eye protection does not constitute sufficient exposure risk to warrant inclusion in exposure event criteria EXCEPT when aerosol generating procedures are being undertaken or aerosol generating behaviours result in direct exposure to the eyes. However, employees should follow all IPC guidance provided by their employers at all times and this may include the routine use of eye protection.

Laboratory staff (technicians, scientists, pathologists and support staff) handling COVID-19 specimens, where a breach in best laboratory practice has occurred, should report the exposure to the senior scientist on duty, who may seek guidance from the on-call clinical microbiologist if required.

Use of gown/apron and gloves should be risk assessed based on individual incident, exposure to body substance and chances of environmental contamination.

[1] Staff who are cleaning up spillage or toilets used by cases who have vomiting, or diarrhoea need an individualised risk assessment.
[2] Full = is greater than or equal to 7 days following 2nd dose (https://www.health.govt.nz/our-work/immunisation-handbook-2020/5-coronavirus-disease-covid-19#23-5)
[3] Degree of controls in the environment need to be taken into consideration: e.g., controlled intubation in ICU less risk than acute resuscitation situation; and degree of exposure, e.g., patient use of unvented CPAP but in otherwise controlled environment would be lower risk. Alternative actions include potential to review at day 5 regarding return to work or classification as lower risk.

Risk Assessment and Categorisation of Healthcare Workers Exposed to COVID-19 – version 2.0 Page 2 of 4

With this in mind, we recommend two levels of risk and PPE requirements – High and Low. The higher level is appropriate for patients undergoing dental surgery and those with Covid like symptoms and the decision to proceed.

Rapid Antigen Testing

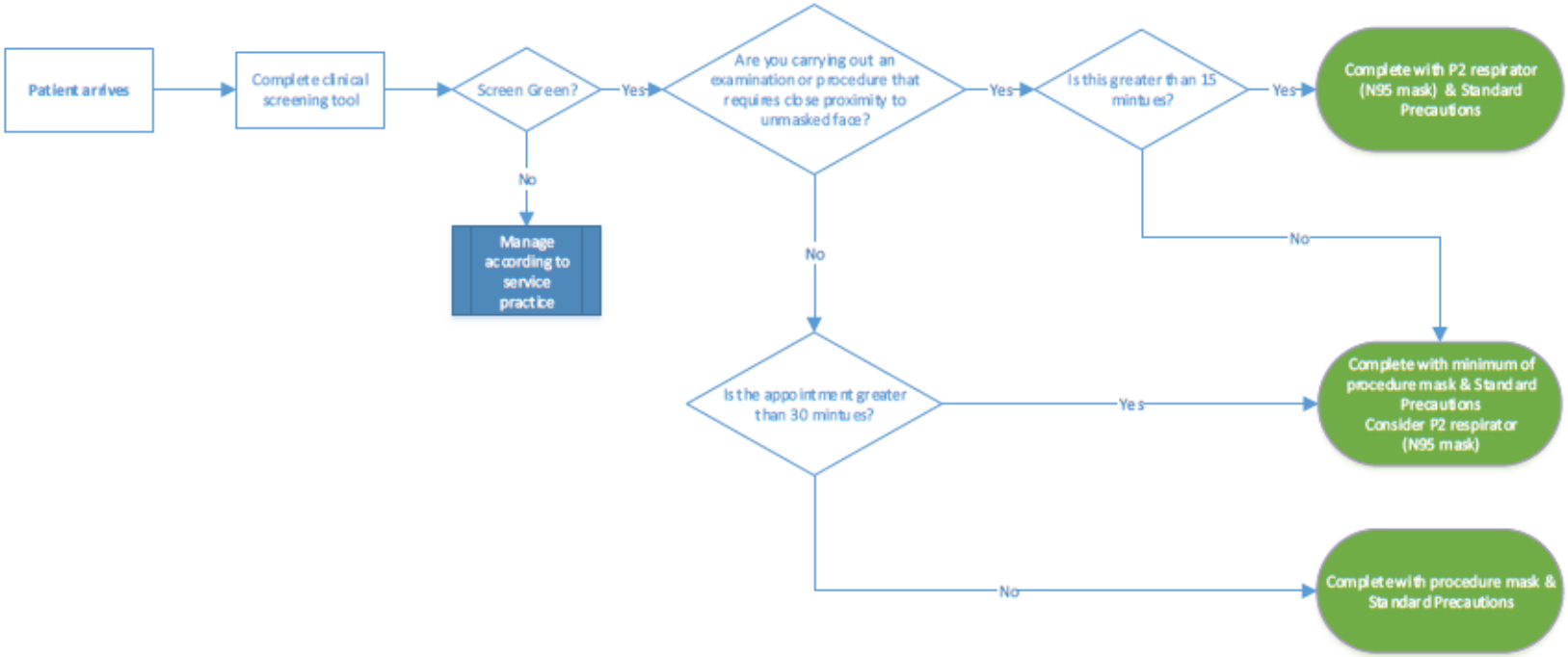
With these recommendations in mind, PCR tests within the past 72 hours are supported for patients undergoing dental surgery whe there is moderate community incidence of COVID. For patients attending surgery who do not have a PCR result and who screen as low risk, it is recommended that Rapid Antigen Testing be recommended to provide an additional layer of protection. For all patients undergoing an examination, a rapid antigen test increases the likelihood of identifying patients who may have COVID-19 as an additional control to screening questions.

Conclusion

Auckland DHB recommends that:

- The moderate risk category is removed
- If the moderate risk group is retained then the PPE and room stand-down requirement need to reflect Ministry of Health guidance
- For moderate community incidence of COVID - Rapid Antigen Testing be considered to provide an additional later of protection for patients in the surgical setting - but only for procedures requiring dental surgery (AGP).

GUIDANCE FOR COVID SCREENING & TESTING FOR OUTPATIENT & DIAGNOSTIC APPOINTMENTS



Included in this process

- All outpatient appointments and procedures that do not meet 'Identified Procedures and Surgery' process

Note re attending carers and support people :

If for a child appointment – questions asked for both child and attending carer.

If for a vulnerable adult – questions asked for both patient and attending carer/support person.

Note re mask selection:

Process ensures low level exposure criteria met as per: MOH Risk Assessment and Categorisation of Healthcare Workers Exposed to COVID-19 (29Oct21)

Low, medium-low and medium community prevalance
Version: 1.0
Date: 29/11/21
Author: Duncan Bliss
Approved by: Mike Shepherd

Haere Mai Welcome | Manaaki Respect | Tūhono Together | Angamua Aim High

Dental Coucil Feeback 29th November 2021 – D Bliss, M Shepherd, H Trengrove, A Jones

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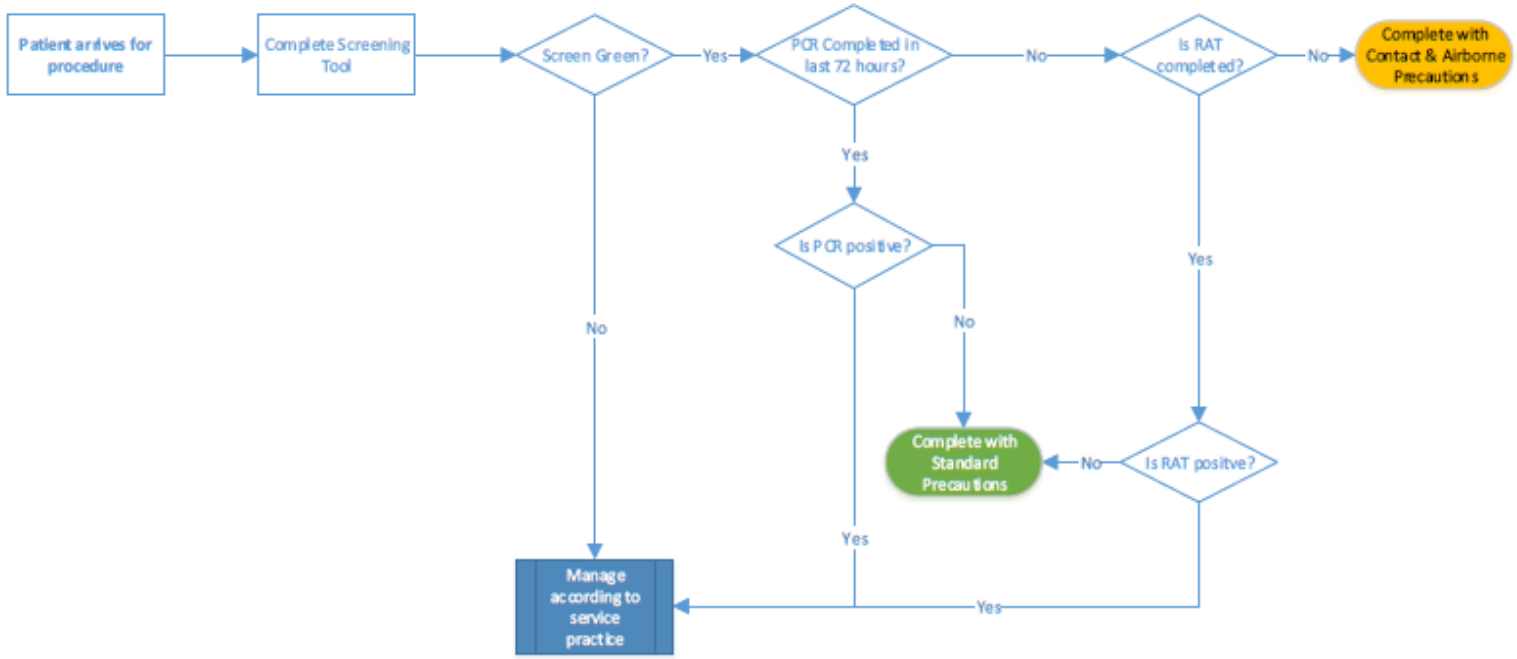
Auckland DHB

GUIDANCE FOR COVID SCREENING & TESTING FOR IDENTIFIED PROCEDURES & SURGERY



Included in this process

- All procedures in Operating Procedures
- Cardiac Interventions
- Interventional Radiology
- Women in labour
- A respiratory procedure
- An exercise test
- An endoscopy
- A bronchoscopy

Note re attending carers and support people :
Use this algorithm for child/vulnerable adult. Please use outpatient and diagnostic process forattending carer/support person.

Note re vaccination status
For clinicians, it is recommended that when a patient is not fully vaccinated, you encourage patient to consider vaccination.

All levels of community prevalance
V1.0 25 November 2021 FINAL

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