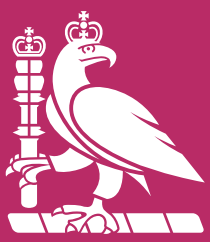

Royal College of Surgeons

FACULTY OF DENTAL SURGERY

Recommendations for Special Care Dentistry during the recovery phase of the COVID-19 pandemic

June 2020

www.rcseng.ac.uk/dental-faculties/fds/coronavirus/

1. Scope of document

This document provides advice and guidance to support the delivery of oral health care during the COVID-19 recovery and is intended for use by dental teams working in England.

2. General principles

The decision to postpone routine dental care during the COVID-19 pandemic, will inevitably have created a considerable backlog of incompletely treated dental disease in the population as a whole.

Beginning a road to recovery will require a new way of thinking. This will not be a 'return to normal'. As part of this recovery, clinicians will need to completely re-evaluate how services are prioritised and delivered. Relieving pain must take priority over routine dental care services, especially where environmental issues and other considerations inevitably result in fewer patients being able to be treated in the same time frame. This will not be comfortable, but it is necessary.

As we move forwards during the recovery phase of the COVID-19 pandemic, our philosophy will be to:

- Provide urgent dental care following an effective system of triage and prioritisation.
- Reduce footfall into clinics in order to maintain social distancing, thus protecting staff and patients.
- Increase our use of health technology to deliver remote consultations and to support self-care.
- Renew our focus on prevention for every patient, at every opportunity.
- Support the commissioning of evidence-based oral healthcare interventions in primary care, community and secondary care.
- Provide evidence-based, lower Aerosol Generating Procedure (AGP) oral health care in preference to higher AGP procedures, wherever possible.
- Ensure services are accessible to all, including those who may be shielded, socially vulnerable or have safeguarding concerns.

Recommendation

- Clinical urgency must take priority over referral to treat (RTT) times. Whilst the latter remains relevant, clinical teams must be able to prioritise care on the basis of clinical urgency.

3. Delivery of prevention

Every person should continue to receive tailored oral health advice in line with *Delivering Better Oral Health.*[1] Oral health advice can be given as part of a remote consultation. Never has there been a more important time to invest in regional programmes of prevention. With oral health services under pressure to manage existing disease, it is critical that we maximise efforts to prevent new disease.

4. Management of patients requiring special care dentistry

Patients should continue to be triaged according to the RCSEng Surgical Priorities, published at the start of the pandemic, in order to support patient prioritisation:

Category 1a – Emergency, Treatment needed within 24 hours

Category 1b – Urgent, Treatment needed within 72 hours

Category 2 – Treatment that can be delayed 4 weeks

Category 3 – Treatment that can be delayed for up to 3 months

Category 4 – Treatment that can be delayed for more than 3 months

Patients requiring level 2 or 3 care should be referred to the locally agreed care providers.

5. Treatment modalities

a) Local anaesthesia

Treatment under local anaesthesia is safe to proceed

b) Inhalation and intravenous sedation

Inhalation sedation and intravenous sedation (&/- supplemental oxygen) are not currently considered AGPs by PHE.

It is the nature of the dental procedure(s) carried out under sedation which determine the necessary level of PPE.

The AGP evidence review will continue to be updated in light of emerging evidence for this new pathogen.

c) Treatment under general anaesthesia

Many patients with additional needs cannot be treated unless care is provided under general anaesthetic (GA). During the COVID-19 pandemic, all elective activity was cancelled so that theatre space, equipment and manpower could be redeployed as part of the NHS wide COVID-19 response.

It will be challenging to re-establish access to theatre time and this is likely to take place in a phased approach to allow for the return of redeployed staff and currently repurposed theatre/ recovery space. Failure to provide increased access to GA will result in an increased pressure on the wider system with increased calls to 111, attendances at A&E and calls to General Medical Practitioners.

Elective patients should be admitted and pre-operatively assessed in line with national and local guidance.

Airway management should not change in response to the COVID-19 crisis. Clinical urgency must take priority over Referral to Treatment (RTT) when selecting patients for admission. Sessional use of FFP3 can be employed, in line with PHE guidance[2] for the operating surgeon and scrubbed assistant.

GDS and CDS colleagues should provide ongoing support and Advice, Analgesia and, if indicated, prescription of Antimicrobials (AAA) whilst a patient is waiting for treatment under GA. Use of silver diamine fluoride, atraumatic restorative technique and other non-AGE treatments should be considered, where cooperation allows. Such treatments may arrest the progression of disease and reduce symptoms prior to admission.

6. Care of medically complex patients

For patients with medical ‘red flags’, discussions with their medical team may help decision making and should be encouraged.

Priority should be given to:

- Patients with underlying medical conditions which place them at greater risk of complications arising from any subsequent infection if the tooth is not treated (see ‘red flag’ list below).
- Patients with additional needs such as those with learning disabilities or autistic spectrum condition, where dental pain is having a severe impact on the patient with evidence of adverse behaviours such as self-harming.

The list below, although not exhaustive, provides examples of potential ‘red flag’ conditions that may exacerbate/complicate an adult’s presenting dental condition and should be taken into consideration when justifying the need for urgent dental care:

- Increased risk of bleeding from medications or conditions (eg congenital and acquired bleeding disorders)
- Increased risk of infection (eg poorly controlled diabetes mellitus, systemic immunosuppression)
- At increased risk of infective endocarditis
- Under treatment for or living with cancer

7. Shielded patients

There are people who are identified as being at significantly increased risk from COVID-19.[3] The decision to bring these patients into a hospital or dental clinic environment during the recovery phase should be decided after careful consideration of the risks and benefits: Clinically extremely vulnerable people may include the following people.

- Solid organ transplant recipients.
- People with specific cancers:
  - » People with cancer who are undergoing active chemotherapy;
  - » People with lung cancer who are undergoing radical radiotherapy;
  - » People with cancers of the blood or bone marrow such as leukaemia, lymphoma or myeloma who are at any stage of treatment;
  - » People having immunotherapy or other continuing antibody treatments for cancer;
  - » People having other targeted cancer treatments which can affect the immune system, such as protein kinase inhibitors or parp inhibitors;
  - » People who have had bone marrow or stem cell transplants in the last six months, or who are still taking immunosuppression drugs.
- People with severe respiratory conditions including all cystic fibrosis, severe asthma and severe chronic obstructive pulmonary (COPD).
- People with rare diseases that significantly increase the risk of infections (such as severe combined immunodeficiency [SCID], homozygous sickle cell).
- People on immunosuppression therapies sufficient to significantly increase risk of infection.
- Women who are pregnant with significant heart disease, congenital or acquired.

These patients may require care in a in a separate geographical location to non-shielded patients or treated at the beginning of clinical sessions. Medically complex patients should have their oral health needs met as an integrated part of their general health, thus minimising the need for additional contacts in the dental environment. Mouth Care Matters[4] is essential for all in-patients and those in residential care.

8. Safeguarding vulnerable adults

The responsibility to safeguard patients continues during the pandemic and its aftermath. There is evidence that people may be at increased risk of abuse, particularly domestic violence and abuse.[5] Existing local safeguarding policies and procedures should be followed.

9. Pre-assessment of patients prior to face-to-face contact

- Consideration should be given to history taking via virtual means prior to attendance to minimise face-to-face time required in the clinic.
- COVID-19 screening questions[6] should be asked of both the patient and escort at the pre-assessment and again on attendance.
- Non-urgent treatment for patients who are displaying COVID-19 symptoms or who have swab tested positive for COVID-19 or who have close contact with a COVID-19 case (ie in their household and therefore should be self-isolating) should be deferred.
- It is recommended that patients attend alone unless an escort is essential for support.

10. Workforce

It is anticipated there will be significant workforce issues that may challenge capacity to provide dental care. These may include:

- temporary/permanent reductions in the overall availability of dental team members due to shielding, self-isolating, child-care demands, or mental health considerations;
- the need to change working patterns, such as extending the working day, to compensate for less 'efficient' clinic usage than previously possible;
- the impact on undergraduate and postgraduate clinical training which could have serious longer-term implications for the workforce.

There are existing workforce challenges, with insufficient Specialists and Consultants in Special Care Dentistry to manage current demand for care.

Oral health needs assessments should be updated in order to better understand this shortfall and facilitate workforce planning.

11. References

1. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/605266/Delivering_better_oral_health.pdf
2. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/886668/COVID-19_Infection_prevention_and_control_guidance_complete.pdf
3. www.gov.uk/government/publications/guidance-on-shielding-and-protecting-extremely-vulnerable-persons-from-covid-19/guidance-on-shielding-and-protecting-extremely-vulnerable-persons-from-covid-19
4. http://mouthcarematters.hee.nhs.uk/wp-content/uploads/sites/6/2019/12/MCM-toolkit-2019-V9.pdf

5. www.baos.org.uk/wp-content/uploads/2020/04/BAOS-BAOMS-Joint-Advice-re-Dom-Abuse-27-4-20.pdf

6. www.sdcep.org.uk/published-guidance/covid-19-practice-recovery/

Acknowledgements

The development and production of this guidance was led by Mrs Avril Macpherson and Mr Andrew Kwasnicki in collaboration with the British Society for Disability and Oral Health and colleagues in Special Care Dentistry.