30th March 2020 @ 13.00hrs (V02.0)

Standard Operating Procedure: Planning for Urgent Dental Care During the COVID-19 Pandemic

NHS England & NHS Improvement - East of England

For Reference

Inventory of Guidance Documents in this SOP

Infection Prevention & Control

- COVID-19: guidance for primary care
- Latest guidance on infection prevention and control
- COVID-19: personal protective equipment use for non-aerosol generating procedures
- Coronavirus FAQs

Antimicrobial Guidance

- National Dental Antimicrobials Guidance

Office of Chief Dental Officer

- Issue 3 of the Chief Dental Officer guidance

Obtaining NHS.net email address

- To request an nhs.net email address

Remote conferencing

- BMJ article on conferencing
- Information Commissioner's guidance
- GDC guidance

COVID-19 Assessment

- COVID-19 advice and information

Contact Information

Enquiries & comments: England.dentaleast@nhs.net

Clinical Triage Service referrals: england.covid19triageeast@nhs.net

Data reporting sheet: to be supplied

Introduction

In these unprecedented times, dental professionals are asked to pull together and work as a collaborative group both within dental care services and out into the wider healthcare services.

With this in mind, this Standard Operating Procedure (SOP) sets out the provision of dental services to be implemented from the above date. In addition, there is further information available in Issue 3 of the Chief Dental Officer guidance found here. This document is prepared in order to implement the same across NHS England & Improvement East of England. Please see current GDC guidance at Appendix 1.

Aims and Objectives

The **aim** of the Urgent Dental Care service (UDC) for East of England is to provide an accessible and equitable pathway for residents (including temporary residents) that need to access urgent and emergency dental care in and out of regular service hours. The service will ensure that all callers are assessed, triaged and dispositioned to the most appropriate service or offered appropriate advice.

The **objectives** are to:

- ensure appropriate access to UDCs across East of England
- ensure high quality service to residents
- ensure consistent and appropriate disposition of residents who call the triage service
- provide management information and data recording to ensure the Service is meeting the needs of the population
- ensure that the UDC works within a 'whole system' approach to providing access routes to emergency and urgent dental care by ensuring effective interfaces and consistent protocols with NHS 111 and clinical services in particular in and out of hours clinical services commissioned by NHSE/I.
- foster innovation and continuous improvement in all aspects of delivery of the Service
- reduce the number of inappropriate referrals to Emergency Departments and Urgent Care Centres.

Key Principles:

1. Flexible arrangements, rapidly developing
2. Care limited to Emergencies and Urgent dental care
3. Best interests of patients
4. Protecting the population and dental team
5. Protecting NHS frontline staff
6. Dental teams to keep up to date with current guidance

7. All patients who will benefit from treatment will be able to access it and those who will not benefit will not access it

National Guidance is due to be sent in the near future related to remote prescribing. In the meantime, please refer to Appendices 2 & 3 for immediate arrangements, but please institute the national guidance as soon as it becomes available.

Please also refer to the National Dental Antimicrobials Guidance: https://www.gov.uk/guidance/dental-antimicrobial-stewardship-toolkit

Key Aims in Current Circumstances

1. Dental Treatment in Primary Care

All routine care in primary care dental services is to be stopped and deferred until otherwise advised. All urgent care provision is to be managed as per the guidance which follows below under Urgent Dental Care Service.

All practices, either individually or collaboratively, are to establish a remote urgent dental care service, providing triaging by telephone or other appropriate means for their patients with urgent needs during usual working hours and, wherever possible, treating with:

- Advice
- Analgesia
- Antimicrobial means where appropriate (see also Appendix 3)

In NHS England and NHS Improvement East of England, to provide the best urgent care service needs to our patients in this unprecedented time, we would like to remind practices that they are to remain open during normal working hours to offer a priority first tier triage for their practice patients as set out above. This can be arranged either individually or by local arrangement.

2. Urgent Dental Care Services

For Urgent Dental Care, an email should be sent to:
england.covid19triageeast@nhs.net

When sending this email complete the pro-forma at Appendix 4 and send via secure NHS.net email whilst keeping a copy for your own records as this will constitute part of the patient records. If you do not already have an nhs.net email account, please access: https://portal.nhs.net/Registration#/dentistry

For those wishing to volunteer to provide premises as an Urgent Dental Care centre or deployment of dental professionals to a centre, please send an email to:

n.stolls@nhs.net

Indicative Treatment

Emergency and urgent primary dental care to achieve the treatment of the following conditions:

A. Emergency:

- Life threatening emergencies, e.g. airway restriction or breathing/ swallowing difficulties due to facial swelling
- Uncontrollable dental haemorrhage following extractions that cannot possibly be dealt with within the Urgent Dental Care Centres;
- Rapidly increasing swelling around the throat or eye which causes immediate threat to life;
- Trauma to head and neck to include dental arches that requires maxillofacial services.

For all the above emergencies follows the route shown below for Emergency Dental Care.

B. Urgent: (see triage information at Appendix 5)

- Trauma such as dento-alveolar injuries or avulsion of a permanent tooth
- Oro-facial swelling that is significant and worsening but does not present realistic threat to life
- Post extraction haemorrhage that is not controllable by local measures but does not present realistic threat to life
- Dental conditions that have resulted in acute and severe systemic illness
- Severe dental and facial pain: that is pain that cannot be controlled by the patient following self-help advice or the use of appropriate antimicrobials. For further information see appendix 3.
- Fractured teeth or tooth with pulpal exposure
- Dental and soft tissue infections without a systemic effect
- Oro-dental conditions that are likely to exacerbate systemic medical conditions

Possible list of treatments which could be provided include:

Assessment and Diagnosis

- examination, assessment and advice;
- radiographic examination and radiological report;

Interventive Treatments

- dressing of teeth and palliative treatment;

- re-implantation of a luxated or subluxated permanent tooth following trauma with any necessary endodontic treatment being delayed until aerosol generating procedure (AGP) avoidance has been removed;
- extraction of teeth where no aerosol will be created;
- provision of post-operative care including treatment of infected sockets;
- urgent treatment for acute conditions of the gingivae or oral mucosa, including treatment for pericoronitis or for ulcers and herpetic lesions, and any necessary oral hygiene instruction in connection with such treatment;
- incising an abscess;
- other treatment immediately necessary as a result of trauma;

3. Dental Treatment in Secondary Care

Limited only to emergency situations that cannot be treated in primary care and would benefit from assessment by secondary care colleagues as posing a realistic immediate threat to life.

4. Orthodontic Services: Limited to urgent care. (See BOS Covid-19 Orthodontic Emergencies Protocol at Appendix 6)

5. Prison Services: linked to established medical procedures – arrangements to be confirmed.

6. Care in Residential and Nursing Homes and domiciliary care: arrangements to be confirmed.

The Managed Clinical Networks will be engaged to provide assistance in their respective disciplines to the Urgent Dental Care (UDC) system. Details of this will be included in later versions of this document.

Key priorities in current circumstances

- Switch to "total triage" and remote consultation – phone/video utilizing Emergency Care and Urgent Care triaging teams. For further information see BMJ article: BMJ article and https://www.nhsx.nhs.uk/key-information-and-tools/information-governance-guidance/health-care-professionals
- Stop routine care
- Follow Office of Chief Dental Officer guidance (as updated)
- If treatment is deemed as required, attending clinician to assess situation and determine the risk of generating an aerosol at any point during the procedure. If such a risk is deemed more likely than not, to consider use of simple treatment means through antibiotics or incise and drain, for example, rather than generate aerosol.

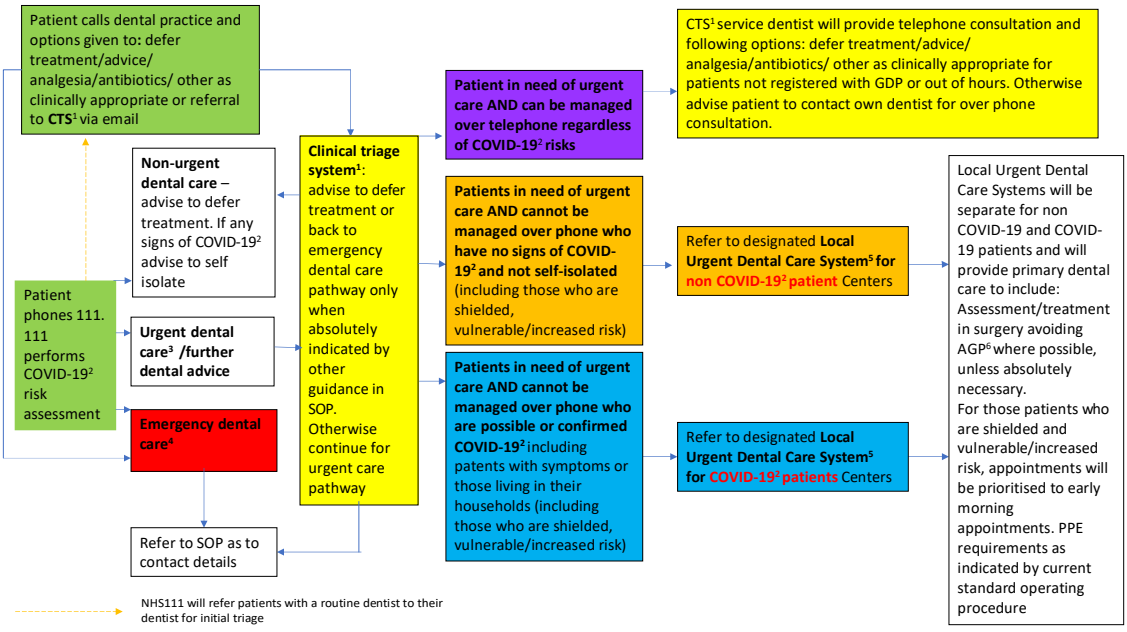
1. Triaging

General Dental Practices are responsible for triaging regular routine dental attenders, this includes a COVID assessment of the patient, either individually or by local arrangement. A COVID assessment for patients will be completed at 1st stage triage (either NHS 111 or by a General Dental Practitioner), at 2nd stage triage with the clinical triage system and prior to any clinical assessment in the Urgent Dental Care practices. Please refer to the following guidance for details on this – note this may be subject to change: https://www.nhs.uk/conditions/coronavirus-covid-19/self-isolation-advice/ Please also see Appendix 8.

Any patient who is not a regular routine dental attender or presents outside of normal surgery opening hours with a dental emergency will contact NHS111.

For any patient who after triaging by their GDP or NHS111 is considered to require urgent or emergency care which cannot realistically be treated remotely must be referred on to the Urgent Dental Care triaging system through the pro-forma at Appendix 4.

The Clinical Triage Service will further assess the patient, including a full medical history and COVID assessment, to determine whether the patient requires urgent dental care. At this stage the patient will either be passed to the Urgent Dental Care service or if the Clinical Triage Service considers that the patient does not require urgent dental care this will be recorded and appropriate advice given to the patient. If a patient at any stage requires emergency dental care, they must be referred to the appropriate service using the details below. Patients who require emergency medical attention will be diverted back into NHS 111.



(Algorithm and key available at Appendix 7)

The patient will be categorised by the Clinical Triage Service into one of four groups shown below:

Patient Groups

For further information on Patient Groups, please see Issue 3 Preparedness Letter from the Office of the Chief Dental Officer

a) Patients who are possible or confirmed COVID-19 patients- including patients with symptoms, or those living in their household.
b) Patients who are shielded- those who are at most significant risk from COVID-19
c) Patients who are vulnerable/at increased risk from COVID-19
d) Patients who do not fit one of the above categories

All patients who are referred to an Urgent Dental Care (UDC) centre by the Clinical Triage Service will have the following information recorded and sent in advance to the Urgent Dental Care centre:

- COVID-19 assessment
- **Full** and **thorough** history of patient complaint
- Updated **comprehensive** medical history. This may be attained from their general dental practitioner.
- This information is to be will be emailed using a secure nhs.net account to the Urgent Dental Care system.

2. Choice of Urgent Dental Care centre for patients to be seen

Patients will be directed to an Urgent Dental Care centre appointed by NHS England depending on their COVID 19 assessment and their patient group (as detailed above). Time of appointment will be considered for each patient, for example patients in groups b) and c) will be offered appointments at the beginning of the day, prior to any patient in group d).

Patient group a) Practices

Potentially initially, 6 sites across East of England for the delivery of urgent dental care. All sites/staff trained and using FFP3 masks for delivery of dental care in line with current guidance. 2 sites in each of Essex, East Anglia and Herts BLMK. Further centres to be developed as required. Details about recommended equipment and materials for each site can be found in Appendix 9.

Patient appointments to be 1 hour per patient to allow appropriate time to don/doff PPE; 3 patients per session with time at the end of the session to clean down. Practice to be of sufficient size and location to ensure safe passage for patient and supporting dental team. Team to be made up of 3 appropriately trained and equipped members; one dentist and 2 DCPs.

Patient group b) c) and d) Practices

- General dental practices appointed by NHS England as non-COVID Urgent Dental Care Centres in line with the guidance at Issue 3 Preparedness Letter of CDO guidance.

3. Out of Hours Services

In the circumstances of a patient contact being outside of normal working hours, the patient will follow the normal route of contacting NHS111 where they will be triaged and referred on to those services already commissioned under Out of Hours Services, except for those who are considered COVID-19 patients who will be referred to the COVID-19 Urgent Dental Care service.

4. Emergency Care

If a General Dental Practitioner, NHS111 or the clinical triage system triage a patient who is deemed to require emergency dental care that is presenting a realistic or immediate threat to life, the patient should not be referred to the Urgent Dental Care system.

For patients requiring emergency dental care that presents a realistic or immediate threat to life please contact:

Essex:	Broomfield Hospital, Chelmsford – Tel: 01245 362000 and ask to be put through to Maxillofacial Department On Call
East Anglia	Addenbrookes Hospital, Cambridge – Tel: 01223 245151 and ask to be put through to Maxillofacial Department On Call
Herts BLMK	Luton and Dunstable Hospital- Tel 01582 491166 and ask to be put through to Maxillofacial Department On Call or through the electronic referral management system in the normal fashion

Latest IOMS guidance is located in Appendix 10 along with the 2-week wait referral triaging spreadsheet in Appendix 11 supplied by Essex Oral Surgery MCN. Please use this spreadsheet to indicate the relative risk assessment of patients into the 2-week wait system. This is to be used as an indicative guide, not to make a definitive decision.

5. Infection Control

Principles of infection control will be followed in accordance with latest guidance:

- COVID-19: guidance for primary care
- Latest guidance on infection prevention and control
- COVID-19: personal protective equipment use for non-aerosol generating procedures https://www.gov.uk/government/publications/covid-19-personal-protective-equipment-use-for-non-aerosol-generating-procedures

Sites seeing and treating COVID-19 positive patients and those symptomatic with COVID-19 or living in their households will require appropriate PPE. This may change in line with national guidance.

- When to use face masks or FFP3: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/874411/When_to_use_face_mask_or_FFP3.pdf

Or at Appendix 12

Training via a “train the trainer” approach to the fitting of FFP3 masks will be made available as soon as possible.

6. Data Collection and Reporting

The Urgent Care Dental service will supply data reporting as required by NHSE/I to support service delivery, future planning and patient benefits and continuity.

Data requirements, data reporting sheets and routs for data returns will be confirmed in due course.

Appendix 1 – COVID19: GDC Update 26th March 2020

View online version

General Dental Council

GDC Update

Responding to COVID-19: providing treatment in uncertain times

As the COVID-19 crisis continues to develop, the challenges facing dental professionals are changing. The importance of effective infection control within dental primary care settings remains, but that is leading to a rapid reduction in the treatment being offered, reinforced by guidance to practices operating within the NHS, which non-NHS practitioners will also want to take into account.

This note updates and clarifies GDC guidance in three areas:

- Dental professionals working in non-dental settings.
- Remote advice and prescribing.
- Treatment in dental primary care settings.

In all these areas, the GDC has no interest in second guessing clinical judgements which take account of this guidance and are based on an appropriate assessment of the risks involved.

Dental professionals working in non-dental settings

The NHS is increasingly asking dental professionals to be ready to support the wider COVID-19 response by using their professional skills and experience outside the normal range of dental and oral health activities. As a regulator, we want to support that activity and our registrants taking part in it, while of course keeping to the fundamental need to do so in ways which support patient safety.

When a dental professional is providing support to the wider NHS, the same basic principles apply as in any other situation: the test is whether they are trained, competent and indemnified for the tasks they undertake.

There are many tasks in the wider health service which can be performed by dental professionals drawing on their existing professional skills and experience. Registrants should satisfy themselves that they are competent to perform the tasks being asked of them, or are given the training necessary to equip them to do so. We understand that

the health services are preparing guidance on the mapping between dental skills and wider medical tasks, which registrants will want to take into account.

We expect registrants to make a considered judgement about whether they are trained and competent; we do not expect them to limit themselves to the specific activities set out in their scope of practice. That doesn't make scope of practice irrelevant: it will be a useful starting point for considering what wider tasks are appropriate, but it does not in itself constrain dental professionals' ability to support the COVID-19 response.

Indemnity should not be an issue where support of this kind is being provided to the NHS, since the Coronavirus Act provides cover for any liabilities beyond the scope of existing cover. We understand that some indemnifiers may choose to offer extended cover; registrants should ensure that they check with their indemnity provider and, if appropriate, with the relevant NHS authority that coverage is in place by one route or the other.

Remote advice and prescribing

Where patients cannot come to a dental surgery, dental professionals may be asked to provide advice remotely and to work with patients to defer the need for active treatment through the use of pain control and antimicrobial treatment. The basic principles of our guidance on remote consultation and prescribing continue to apply, but in the specific circumstances of COVID-19, the key requirement is to make an appropriate risk assessment. That risk assessment should be recorded and should take into account the infection risk of COVID-19, both from and to the patient, as well the apparent seriousness of the need for treatment and the extent to which it has been possible to make a clinical assessment. Where appropriate, it should also take account of NHS guidance on treatment which should and should not be offered in a primary care setting.

Treatment in dental primary care settings

For the duration of the COVID-19 epidemic, infection control is of paramount importance and even greater than normal care will need to be taken to minimise the risk of infection to, from, or between patients and between members of the dental team. In many cases, the right approach will be to stop providing treatment altogether.

Practitioners providing NHS services will of course need to adhere to the directions given by their nation's Chief Dental Officer; other practitioners will want to take that into account in making decisions. From a regulatory perspective, the central question is again whether an appropriate risk assessment has been made. If treatment is offered, it will be important to record the specific precautions in place to ensure that the risk is appropriately managed for the particular treatment envisaged.

Stefan Czerniawski

Executive Director, Strategy, GDC

Appendix 2 – Remote Prescribing for Patients

All prescriptions sent remotely should only be sent to a pharmacy agreed with the patient and from the list of pharmacies provided here:

To obtain an NHS.net email address, follow this link. Alternatively, dental teams should consider a local approach that is agreed between themselves and in collaboration and agreement with local pharmacies whilst considering any relevant guidance, such as that by the GDC.

Information for Dentists:

- Complete prescription as normal, sign and scan. Attach a copy to the patient's clinical records.
- Contact pharmacy via phone or by other appropriate means to advise them you will be emailing scanned prescription.
- Send scanned version from secure NHS email address to secure NHS pharmacy email address.
- Keep your own log of the scanned prescription you have sent.
- Post the original signed prescription WITHIN 72 hours to the pharmacy.
- Contact the pharmacy to confirm receipt of original prescription and record.
- If you don't have access to a scanner, download free app 'cam scanner' on smart phone to scan prescription into a PDF format and send prescription from secure NHS.net email address to secure NHS.net pharmacy email address
- If you require further guidance around prescribing contact your local maxillofacial colleague.
- Please refer to the Standard Operating Procedure: Planning for Urgent Dental Care during the COVID19 pandemic document for further guidance.

Details are as follows:

REMOTE PRESCRIBING	
Step 1 →	• Complete prescription and sign • Scan copy and email securely to pharmacy email address • Attach copy to patient's clinical records
Step 2→	• Send original signed copy to pharmacy postal address within 72 hours • Log all sent prescriptions, confirming receipt with pharmacy

Information for patients:

- Patients with COVID – 19 symptoms or those who are living in a household with anyone with COVID -19 should be advised **not to attend** the pharmacy.

- Ask patients if they have a friend/relative/volunteer (not with COVID-19 symptoms or living in a household with anyone with COVID-19 symptoms) to collect the dispensed medication.
- Record in the notes what arrangements the patient has made to have the prescription collected.

We value your support and hope that this healthcare collaboration and sharing of information will improve the experiences for both patients and healthcare staff.

Appendix 3- Indicative Antimicrobial Prescribing

This is recommended guidance form the Essex Oral Surgery Managed Clinical Network. Please consider any current National Guidance as to the issuing of antimicrobials throughout the period of COVID-19.

Please also refer to the National Dental Antimicrobials Guidance: https://www.gov.uk/guidance/dental-antimicrobial-stewardship-toolkit

First line option for patients who are not allergic to penicillin:

Amoxicillin 500mg tds AND Metronidazole 400mg tds for 7 days

For patient who are **ALLERGIC** to penicillin the options are:

OR

Clarithromycin 500mg bd AND Metronidazole 400mg tds for 7 days

OR

Clindamycin 300mg qds AND Metronidazole 400mg tds for 7 days

OR

Erythromycin 500mg tds AND Metronidazole 400mg tds for 7 days

Please note the BNF can be accessed at www.bnf.org.

Appendix 4 – Proforma for referring of patients (for clinical use)

See also:

- **Information below**
- **Spreadsheet for referral:**

Patient Triage System

To be completed by referring GDP, Clinical Triage Service or Urgent Dental Care system- for further information, see Appendix

Patient Name:

DoB:

Contact details:

Complaint:

History of Presenting Complaint and/or previous treatment:

Previous Dental History (where applicable):

Relevant Medical History:

Examination Details (where applicable):

Extra-oral:

Intra-oral:

Radiographic Report (image included as available):

Diagnosis:

Treatment provided (copy of patient record can be included where applicable):

If prescription provided, include medication, dosage, duration and prescription number:

Review or further treatment required:

Information

This form will be used to pass information in respect of patient care when any clinical advice or intervention takes place. Thus, the form can then be provided to the patient's General Dental Practitioner, (where applicable) to be inserted within their clinical records. It is, therefore, important to maintain this form and all other associated forms in secure fashion and complete and pass on contemporaneously. All forms to be disseminated only by secure email using NHS.net.

Each completed form is to be saved with an appropriate file name, to include the patient's name, date of birth and date of care provided before being sent onwards.

It is expected that only some sections will be completed, depending on circumstances. For example, a telephone consultation will result in limited details, whereas a video consultation will provide more information that can be appropriately sent onwards. If there are relevant radiographic images that can be included within this record, they should be attached appropriately within the body

It is expected that, if the patient has been provided advice and care within the Urgent Dental Care Service, this record will be more complete. It is important that all relevant information is captured, such that it can be conveyed on to the General Dental Practitioner (where applicable).

All records should also be saved by the treating clinician at each stage.

Where the patient does not have their own General Dental Practitioner, the Clinical Triager or Urgent Dental Care clinician is to retain this record within their own dental practice records and advise the patient that this has been done in the event that they then attend a dentist.

Appendix 5- Triage Information

Due to the coronavirus outbreak and in accordance with instructions the Chief Dental Officer, only patients with severe symptoms of infection, bleeding or trauma will be seen for emergency dental treatment at the present time. If you are experiencing severe pain you may be asked to take medication for 48hrs and to phone back if symptoms persist. Dentists should operate on the basis of providing Advice, Analgesia and Anti-microbials where possible.

PAIN

Are you able to manage the pain with pain relief?

Yes: Continue over the counter analgesics as appropriate.

No: Consider whether there is an indication for antibiotic prescription (although this is not a conventional treatment pathway for pain, if symptoms are suggestive of an infection, consider antibiotics as treatment modality).

Ask the patient to phone back if symptoms do not improve after 48 hours or if a swelling appears - then follow the swelling guidance below.

If patient is unable to manage pain with over the counter analgesics and there is no other feasible method of controlling the pain then consider referral to Clinical Triage Service.

POST EXTRACTION BLEEDING

Give initial normal post-operative instructions.

Blood stained saliva is normal, and a slight ooze may be present for up to 24hrs after an extraction.
Patients should apply constant, direct pressure for a minimum of 20 minutes over the extraction site with swab/gauze/clean handkerchief.

Patients who are experiencing a post extraction bleed, and had the extraction within the last working day, should return to their general dental practitioner for management if they are COVID-19 symptom free.

If despite multiple attempts to achieve haemostasis with direct pressure is not successful and the extent of bleeding does not present a realistic threat to life (patient feels systemically well, generally fit and healthy), then refer to the Clinical Triage Service.

If there is uncontrollable bleeding following dental extractions (mouthfuls of blood) refer to the emergency dental service or A&E (out of hours) as set out at Emergency Care.

Assess the patient's medical history for any underlying condition that could predispose to bleeding. Consider the duration of the bleed and possibility of infection. Have a low threshold for onwards referral of a long duration bleed or any relevant medical conditions.

SWELLING

Does the swelling extend to your eye/neck?

Attempt to examine by video call if possible

Yes: Does the swelling affect vision, mild difficulties in swallowing/breathing or mouth opening? (Limited mouth opening if patient cannot open wider than 2 fingers width). If yes, then refer patient to the Urgent Dental Care system.

If swelling presents a realistic threat to life such as; bilateral neck swelling, voice changes, difficulty breathing, swallowing or drooling then refer to the emergency dental care pathway.

No: Prescribe appropriate antimicrobials taking the usual precautions around allergies and consider referral to local Urgent Dental Care system.

In cases of cellulitis or mild swellings, the patient can be asked to outline the swelling with marker, in order to review and re-assess for any improvement.

SOFT TISSUE LESIONS / ULCERS

Examine by video call if possible

Take a detailed history which includes; Size, shape, site, number, duration, frequency, pain, precipitating/relieving factors, other potential surfaces involved (eyes/genitals/skin)

Attempt to manage conservatively with appropriate medication. If lesion/ulcer has been present for 14 days with no obvious cause refer to the clinical triage system.

If there are clear signs of oral cancer after initial assessment, refer to clinical triage system.
Some signs of oral cancer include but are not limited to: Paraesthesia/anaesthesia along a particular nerve distribution, persistent ulcer, persistent red/white patch, bleeding, fixation.

TRAUMA

If patient has experienced facial trauma, refer to the Clinical Triage System if appropriate.

If patient has experienced trauma with loss of consciousness/vomiting/nausea/stiffness of neck/ or blurred/double vision, refer to the emergency dental care system.

Patients who have avulsed a permanent tooth should be instructed to replant it if possible and be seen for management as soon as possible.

- Pick it up by the crown
- If dirty wash briefly (10 seconds) under cold running water
- Re implant the tooth if possible

- If the tooth is to be transported to the clinic it should be placed in a small container of the patient's own saliva or milk

Patients with other dental trauma requiring management (according to dental trauma guidelines) such as luxation/intrusion/extrusion injuries or fractured with teeth pulpal exposure, these should be referred to the Clinical Triage System.

The range of conditions provided for by local Urgent Dental Care (UDC) systems will be found in the current SOP – please refer here as it is subject to change which the current evolving situation.

FOR ALL PATIENTS REFERRED TO THE LOCAL URGENT DENTAL CARE SYSTEMS THEY WILL NEED:

1. COVID-19 risk assessment
2. **Full** and **thorough** history of patient complaint
3. Updated **comprehensive** medical history this may be attained from their general dental practitioner and emailed using an nhs.net account to the Urgent Dental Care System.

Please go to following website for up-to-date COVID-19 symptoms and advice.
https://www.nhs.uk/conditions/coronavirus-covid-19/self-isolation-advice/

a high temperature – this means you feel hot to touch on your chest or back (you do not need to measure your temperature)
a new, continuous cough – this means coughing a lot for more than an hour, or 3 or more coughing episodes in 24 hours (if you usually have a cough, it may be worse than usual)

If you have symptoms of coronavirus, you'll need to self-isolate for 7 days.
After 7 days:
- if you do not have a high temperature, you do not need to self-isolate
- if you still have a high temperature, keep self-isolating until your temperature returns to normal

You do not need to self-isolate if you just have a cough after 7 days. A cough can last for several weeks after the infection has gone.

If you live with someone who has symptoms
If you live with someone who has symptoms, you'll need to self-isolate for 14 days from the day their symptoms started. This is because it can take 14 days for symptoms to appear.
If more than 1 person at home has symptoms, self-isolate for 14 days from the day the first person started having symptoms.
If you get symptoms, self-isolate for 7 days from when your symptoms start, even if it means you're self-isolating for longer than 14 days.
If you do not get symptoms, you can stop self-isolating after 14 days.

Appendix 6 –BOS Covid-19 Orthodontic Emergencies Protocol (25th March 2020)

In light of the most recent evidence on the spread of covid-19 in relation to AGP's, the PEE available and to prevent transmission of the disease, we have created an emergency orthodontic protocol to deal with all but the most urgent orthodontic problems.

Most orthodontic appliances can be left in situ for some months without detriment to the patient if the patient continues with the usual after care instructions;

- **Exemplary oral hygiene** – brushing 3 times a day with their standard toothbrush, followed by interproximal brush use. As an adjunct, use of a fluoride mouthrinse eg. Fluoriguard (225ppm), once a day.
- **Low sugar diet** - Where possible avoid all snacking on sugars and drinks with ADDED SUGAR. Fizzy drinks should be avoided in particular.
- **Avoid hard, sticky and hard foodstuffs** that could break the brace wire or fracture brackets (debond) off a tooth.

Patients may ring in the coming weeks with pain, problems and loose wires. At present, the best advice is to avoid all but the most essential mouth procedures to limit spread of the disease to the wider population.

In the event of a patient needing to attend with an orthodontic emergency, the following protocol has been put together to help best treat the patient and keep staff members safe.

Upon receiving a call it would be wise to have a member of the orthodontic team speak to the patient or parent (either immediately or at a later agreed time) to identify the problem and determine if a visit to the practice is essential;

1. Are they in pain?
2. What is the problem?
3. Identify if it is something the patient can deal with at home?
4. Verify that they have an acute orthodontic problem that is affecting lifestyle?

If the practice/unit member contacting the patient is not a clinician and is in doubt about the triaging of the urgency a suitably qualified health care professional (HPC) should be informed to assist the decision making.
The following information should be obtained

1. A summary of the issue
2. Any medical issues that may impact on the decision making
3. Photos of the problem taken on a smartphone and sent to the team by the route determined by that unit.

Once the appropriate information is received
1. Advice should be given over the phone (+/- video calling) where possible
2. Arrangements made to see patients where necessary (see justifiable issues below)

Please refer to your local area arrangements regarding emergency care. This may be local or in secondary care units.

Common 'emergency' brace problems and solutions:
If you are an orthodontic patient following the advice contained here PLEASE where possible contact your orthodontic HCP first to ensure that you are carrying out procedures safely and not preducing other aspects of your orthodontic appliance
If you are a dental health practitioner seeing a patient please consider these guides for safe practice

- Full PPE is advised (see link here)
- Patients only attend at the time of their appointment
- Patients must not bring other family members with them
- Patients should wait outside the practice until their appointment can commence
- Patients should leave the unit immediately after their appointment
- Units must make all emergency appointments long enough to ensure there is adequate time for cleaning and management of clinical waste
- Patients should wash their hands or use of hand sanitiser on entering the unit.

Wires digging in
Home advice

- If a thin wire, it may be possible for the patient or family member to use tweezers to replace wire in the tube/band or tweezers and a nail clipper/scissors to shorten the long end
- It may be that a thin wire is the correct size but may have rotated round the teeth so that it is short on one side and long on the other. Using tweezers a pencil with a rubber on the end or a teaspoon, it may be possible to push the wire back round to prevent the long end digging in.
- If the wire is very thick and stiff (discuss with your HCP) it may not be possible to cut the wire with home instruments. If this is the case it may be necessary to cover the wire to prevent it being sharp. Relief wax/silicone may be sent to you or you can buy it online (Orthodontic Wax) Failing that using a wax covering from hard cheese (baby-bell, cheddar), Blue tack or even chewing gum may help

In clinic advice

- Trim and adjust as simply as possible. (Distal end cutter if available – wire cutters and forceps to hold the loose end if not)

Broken bonded retainers
Home advice

- Push wire back down towards the tooth as much as possible. (Fingers or tweezers)
- Cover with best medium available (Ortho wax, Cheese wax, Blu tack, chewing gum)
- Cut the exposed unbonded wire using tweezers and nail clippers/scissors
- Gently pull the wire to remove the whole retainer
- Advise greater use of removable retainers if present

In clinic advice

- Trim wire
- Remove wire
- Advise greater use of removable retainers if present

Lost Retainers

Home advice

- Contact HPC – it may be that your unit has access to your final moulds and can make a new retainer remotely which can be posted out to you
- If it is not possible to get a replacement retainer you could consider ordering online a 'boil in the bag' (heat mouldable) gumshield to use and wear at night to reduce the risk of relapse (unwanted tooth movement). It should be noted that these appliances aren't specifically designed to hold teeth in position so the manufacturer cannot be held responsible for any relapse. Please contact your HCP before investing in this strategy to ensure all aspects of this compromise for retention are understood

● In clinic advice - Do not visit unit

Gold Chains

Home advice

- If the gold chain was recently place and is now dangling down, it may be possible to cut it short. Gold is quite a soft metal and it may be possible to cut the chain using some nail scissors or nail clippers. Always hold the loose end with tweezers or similar item. If possible, leave at least 5 links through the gum so it can used later by your orthodontic team
- If you have a none dissolvable coloured stitch discuss with your HPC about the feasibility of removing it at home using nail scissors to prevent a minor infection in the gum.

In clinic advice - Do not visit unit

Orthognathic Post-Op

Home advice

- Discuss with your local hospital team your specific concern/problems for the best advice
- Consult yourjawsrugery.com for general post op advice (Here)
- Stop or reduce post surgery elastic wear as advised by your HPC.

In clinic advice

- Ensure patient doesn't have acute infection/swelling/infected plate.
- Stop or reduce post op elastic wear as you see fit.
- Reassure patient about continuity of treatment at next visit.
- Do not provide any active orthodontic tooth movement

Aligner therapy
Home advice

- If your current aligner is in good order keep wearing it as much as possible
- If your current aligner is broken or ill fitting, step back to your previous aligner
- If neither option is open to you, ring you HPC for advice.
  It may be possible to have a new aligner at the correct stage made for you and sent out to you
- Or with advice from your HPC a 'boil in the bag' (heat mouldable) gumshield to use and wear at night to reduce the risk of relapse (unwanted tooth movement). It should be noted that these appliances aren't specifically designed to hold teeth in position so the manufacturer cannot be held responsible for any relapse. Please contact your HCP before investing in this strategy to ensure all aspects of this compromise for retention are understood

In clinic advice - Do not visit unit

Bracket off
This is not urgent unless it is causing trauma to the soft tissues.
● Home advice

- ○ It may be possible your HPC can guide the you on how to remove the bracket from the wire via video if it is causing trauma.
- ○ It may be the possible to leave the bracket if it is not causing any problems at present. Consider contacting your HPC for advice.

In clinic advice -○ Do not visit unit

Elastic Bands
● Home advice

- At this time if you run low or out of elastics your HPC may either send you a some more out via the post or advice cessation of wear.

In clinic advice - Do not visit unit

Band off
Home advice

- If band is very loose your HPC may be able to talk you through removal of the band and trimming of the wire depending upon your stage of treatment.
- It may also be also be the case your HPC advises you to leave the band in place. If this occurs please ensure you adhere to good oral hygiene and a low sugar diet to prevent decay under the band and around your tooth.

In clinic advice

- Remove band and trim any excess wire to the distal aspect of the last back tooth with a bracket or band on.

Band off Quadhelixes, RME, TPA +/- Nance
Home advice

- Discuss with your HPC about the nature of the looseness and take advice accordingly.
- **Push band back onto tooth if it will locate and** ensure you adhere to good oral hygiene and a low sugar diet to prevent decay under the band and around your tooth.
- Remove appliance

In clinic advice Do not visit unit

Removable/Functional appliances
Home advice
- Check for comfort and retention
- If unsure about how much to continue to wear the appliance discuss with your HPC
- If fractured or ill-fitting do not wear the appliance
-

In clinic advice - Do not visit unit

Separators
Home advice
- These should be removed at the earliest opportunity - Attempt removal with end of safety pin, small paper clip or wooden tooth pick

In clinic advice - Do not visit unit

Lost module(s)
Home advice
- No action required – try and make wire where the module has been lost secure with dental wax, cheese wax or blu tack and chewing gum

In clinic advice - Do not visit unit

Temporary anchorage Devices TADS
Home advice
- HPC may assist you in removing and springs or elastic chain moving the teeth
-

In clinic advice - Remove

Headgear
Home advice - Stop wear
In clinic advice ○-Do not visit unit
•

Lost spring
Home advice - No treatment required
In clinic advice - Do not visit unit

Fractured/Frayed power chain
Home advice

- Accept situation– most power chain will denature in 4-6 weeks and become passive
- Remove power chain with tweezers if necessary
- Cut fayed end as short as possible to improve comfort

In clinic advice - Do not visit unit

•

Exposed end of wire tie – long ligature or short ligature.

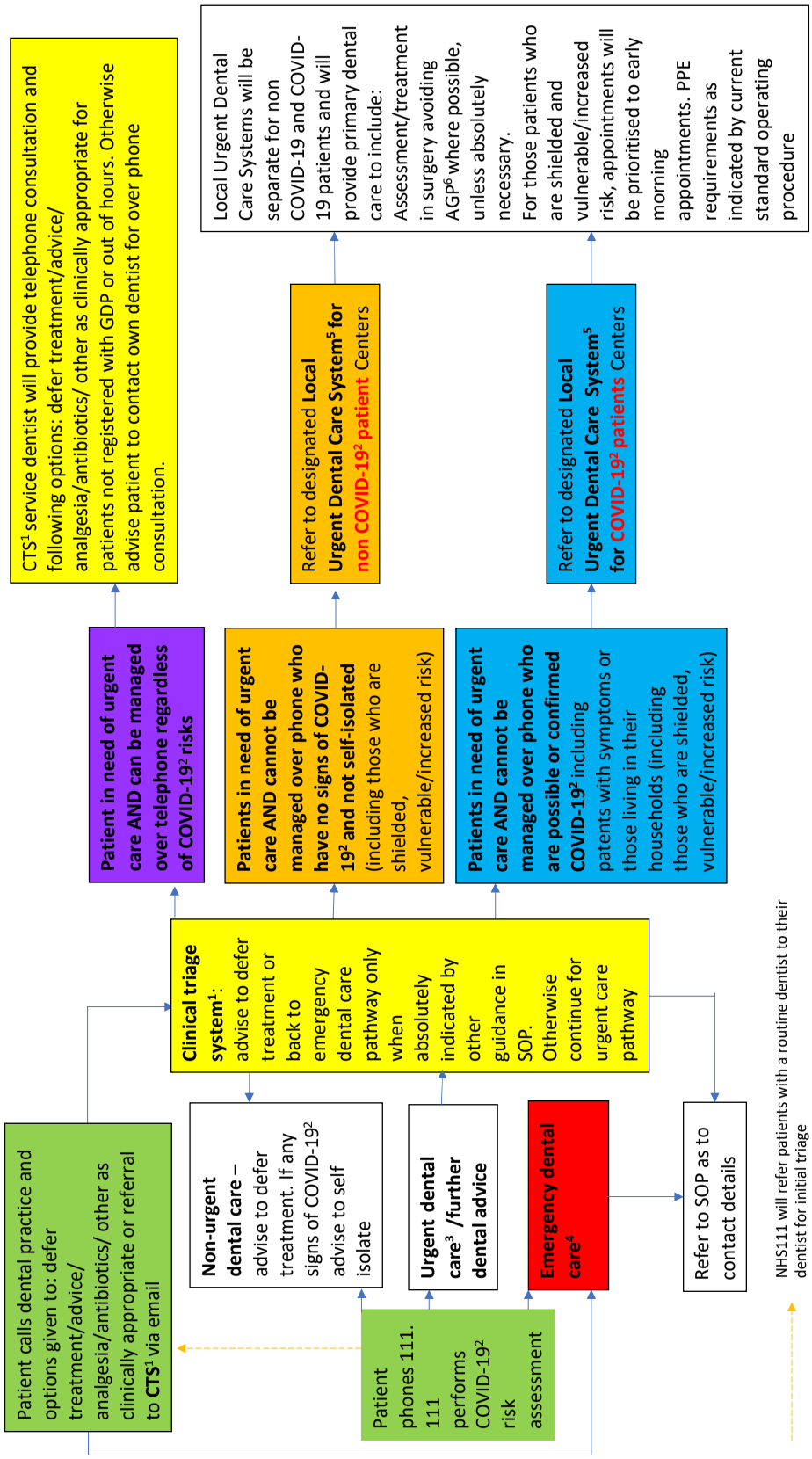
Home advice

- Re-tuck sharp end under wire/bracket using tea spoon or tweezers
- Remove wire if broken with tweezers if possible
- Cut fayed end as short as possible to improve comfort with nail cutters or scissors
- Cover for comfort using Ortho wax, Cheese wax, Blu tack, chewing gum

•

In clinic advice - Do not visit unit

Appendix 7 -Triaging Algorithm



Appendix 7 - continued

Algorithm for triaging key

1. Clinical Triage Service
2. A new continuous cough or high temp > 37.8oC
3. Urgent Dental Care:
    i) Severe dental and facial pain not controlled by over-the-counter preparations;
    ii) Dental and soft tissue acute infection
4. Emergency Dental Care –
    i) Uncontrollable dental hemorrhage following extractions
    ii) Rapidly increasing swelling around the throat or eye
    iii) iii)Trauma to head and neck to include dental arches.
5. Details of Local Urgent Dental Care Systems will become available in the East of England
6. Aerosol generating procedures

Appendix 8 – Coronavirus Symptoms

Please go to following website for up-to-date COVID-19 symptoms and advice.
https://www.nhs.uk/conditions/coronavirus-covid-19/self-isolation-advice/

a high temperature – this means you feel hot to touch on your chest or back (you do not need to measure your temperature)
a new, continuous cough – this means coughing a lot for more than an hour, or 3 or more coughing episodes in 24 hours (if you usually have a cough, it may be worse than usual)

If you have symptoms of coronavirus, you'll need to self-isolate for 7 days.
After 7 days:

- if you do not have a high temperature, you do not need to self-isolate
- if you still have a high temperature, keep self-isolating until your temperature returns to normal

You do not need to self-isolate if you just have a cough after 7 days. A cough can last for several weeks after the infection has gone.

If you live with someone who has symptoms
If you live with someone who has symptoms, you'll need to self-isolate for 14 days from the day their symptoms started. This is because it can take 14 days for symptoms to appear.
If more than 1 person at home has symptoms, self-isolate for 14 days from the day the first person started having symptoms.
If you get symptoms, self-isolate for 7 days from when your symptoms start, even if it means you're self-isolating for longer than 14 days.
If you do not get symptoms, you can stop self-isolating after 14 days.

Appendix 9 – Suggested arrangements for Urgent Dental Care centres

PROPOSED STAFFING

- Each session will be comprised of 4 staff members, each with a specific designated role
    1. `The treating dentist
    2. The 'dirty' nurse in surgery assisting the dentist
    3. The 'clean' nurse in surgery, to assist with opening drawers etc to prevent unnecessary direct contamination of surfaces
    4. A third nurse outside of the surgery, to develop radiographs and retrieve emergency drugs if necessary or retrieve any equipment / materials outside of the surgery that were not planned for

PATIENT TRAVEL THROUGH THE PRACTICE

- Only one patient to enter the practice at any given time. Any additional attendees should be asked to wait outside, potentially in their car
- Consider taking the patient's temperature at the point of entry
- No doors should be touched by the patient to enter / leave the building / rooms
- Minimise the distance the patient will travel through the practice
- A treating surgery will ideally be located in close proximity to the main entrance / exit as well as designated patient toilet facilities
- The patient should not travel through any unnecessary areas within the practice
- If the patient is accompanied, the companion is to be asked to wait outside in a suitable environment such as a car.

DENTAL TEAM TRAVEL THROUGH THE PRACTICE

- Avoid any air conditioning wherever possible
- Designated rooms / areas should be identified as DON and DOFF areas and these remain fixed. The DON area is for dressing in appropriate Personal Protective Equipment (PPE). The DOFF area is to remove PPE.
- Ideally two treatment rooms should be allowed, in order to allow any aerosol to settle between patients, and the use of these two rooms is to be alternated. Currently, it is considered that any aerosol present takes 30 minutes to settle. Consider the guidance here as to aerosol management, particularly at Section 2.3, 6.4 and 6.5.
- The team travels from a treatment room (after treating a patient) to the designated DOFF room in order to de-gown
- From this room, the team travels to the designated DON room in order to gown-up
- The team then travels to the next treatment room

Recommended PPE

- Scrubs
- Surgical gown
- Surgical gloves
- FFP3 mask
- Ear loop / hand tie face mask
- Wrap around goggles
- Hair net
- Protective shoe covers
- In addition, a fluid resistant mask can be used over the FFP3 mask which can then be discarded after each contact to allow the FFP3 mask to remain in situ.
- For all PPE, please keep updated as to current guidance

Suggested Protocol for Developing Radiographs

For wet film and phosphor plate radiographic films:

- 'Dirty' nurse places cleaned radiographic film in a sealed box held by 'clean' nurse
- 'Clean' nurse passes this box to nurse outside of surgery who develops radiograph

For CCD's proceed as usual with barrier protection

With the above in mind, below are lists of the proposed materials / instruments to be made available within the clinics.

Proposed Materials	Proposed Instruments
Glass Ionomer Cement, e.g. Fuji XI or equivalent	Mirror
Articulating paper	Straight probe
Floss	BPE probe
Gauze	Tweezers
Scalpels	Hand excavator
Monojet irrigation syringes	Carver
Ledermix or equivalent	Flat plastic
Non-setting Calcium Hydroxide	Ball burnisher
Calcium Hydroxide lining for pulp capping	Plugger
Cotton pellets	Spatula
Post-operative XLA bite packs	Hand scaler
Post-operative XLA instructions	Scissors

Surgicel or equivalent	Rubber dam sheet
Alvogyl or equivalent	Rubber dam clamps
Chlorhexidine mouthwash	Rubber dam frame
Saline	Rubber dam forceps
Patient bibs	Radiograph films and barrier envelopes
Cotton wool rolls	Radiograph holders
Safety needles, long and short	Extraction forceps
Local Anaesthetic plungers	Suction tips
Local anaesthetic, e.g. Articaine, Lidocaine, Scandonest	Cotton rolls
Topical anaesthesia	Endodontic files (if extirpation can be completed without AGP)
Micro brushes	Prescription
	Patient short visor frame and shield

Use safe work practices to protect yourself and limit the spread of infection

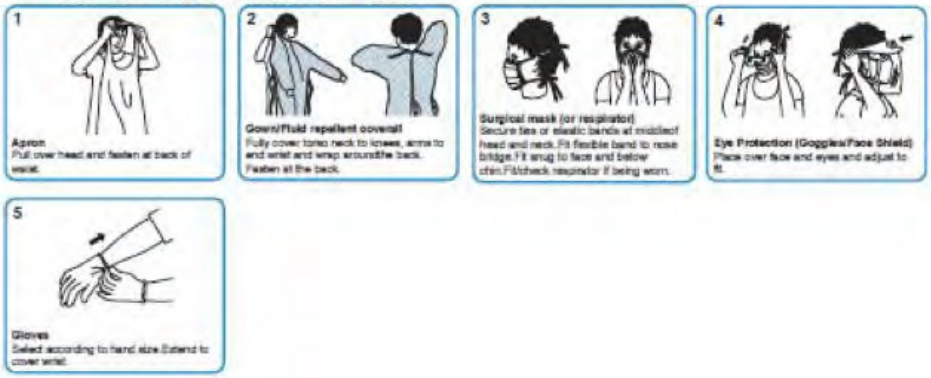
- Keep hands away from face and PPE being worn.
- Change gloves when torn or heavily contaminated.
- Limit surfaces touched in the patient environment.
- Regularly perform hand hygiene.
- Always clean hands after removing gloves.

NB Masks and goggles are not routinely recommended for contact precautions. Consider the use of these under standard infection control precautions or if there are other routes of transmission.

The type of PPE used will vary based on the type of exposure anticipated, and not all items of PPE will be required.
The order for putting on PPE is Apron or Gown, Surgical Mask, Eye Protection (where required) and Gloves.
The order for removing PPE is Gloves, Apron or Gown, Eye Protection, Surgical Mask.

1. Putting on Personal Protective Equipment (PPE).

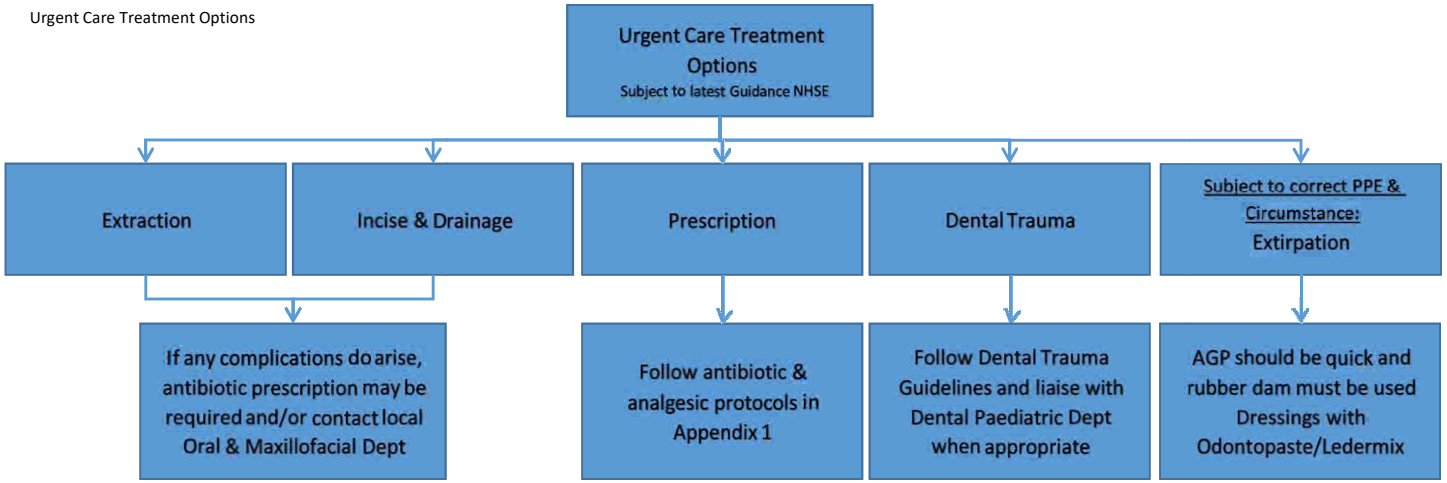
- **Perform hand hygiene before putting on PPE**



2. Removing Personal Protective Equipment (PPE)

- **Perform hand hygiene immediately on removal.**
- **All PPE should be removed before leaving the area and disposed of as healthcare waste.**

Urgent Care Treatment Options



Circumstances to Extirpate & Evidence Base:

- Patients who are medically compromised
  - Anticoagulated[1] patients or Congenital Bleeding Disorder patients[2]
    - If patient has unstable INR, INR >4 or has not skipped the morning dose of NOAC
  - Bisphosphonates and monoclonal antibodies[3,4]
    - Patients who have had or are receiving Intravenous bisphosphonate medication and Anti-TNF treatments (Rheumatoid Arthritis) and therefore at high risk of osteonecrosis.
    - Patients on oral bisphosphonates with other immunosuppressives such as steroids or chemotherapeutic agents who are at a high risk of osteonecrosis
    - Patients on oral bisphosphonates who smoke or are diabetics
  - Oncology patients[5]
    - Patients at risk of Osteoradionecrosis. (patients with a history of head and neck radiotherapy)
- Tooth where there is a substantial increased risk of damage to adjacent anatomical structures if extracted
  - Pneumatisation of sinus, close proximity to Antrum or Inferior dental nerve
- Teeth with root resorption and/or ankylosis
  - Depending on the type of resorption; extirpation may be indicated.[6]
- Patients with aesthetic concerns/anterior teeth displaying symptoms
  - This could be due to existing pathology or previous/current trauma[7]
- Unsuccessful attempts at extraction and symptoms remain
- Abnormal root morphology likely to compromise the ease of extraction
  - In such cases, extirpation may be possible - to at the very least decrease the pressure within the pulpal system[8]

Ajmal Zubair

1- http://www.sdcep.org.uk/wp-content/uploads/2015/09/SDCEP-AnticoagulantsGuidance.pdf
2- Anderson, J., Brewer, A., Creagh, D. et al. Guidance on the dental management of patients with haemophilia and congenital bleeding disorders. Br Dent J 215, 497–504 (2013). https://doi.org/10.1038/sj.bdj.2013.1097
3- Guidance Scottish Dental Clinical Effectiveness Programme March 2017 http://www.sdcep.org.uk/published-guidance/medication-related-osteonecrosis-of-the-jaw/
4- NICE Guidance Feb 2018 https://www.nice.org.uk/guidance/ta464
5- Kumar, N. (2019). Updated clinical guidelines on the oral management of oncology patients. Faculty Dental Journal, 10(2), 62–65. https://doi.org/10.1308/rcsfdj.2019.62
6- Darcey, J., Qualtrough, A. Resorption: part 2. Diagnosis and management. Br Dent J 214, 493–509 (2013). https://doi.org/10.1038/sj.bdj.2013.482
7- Andreasen, J.O., Lauridsen, E., Gerds, T.A. and Ahrensburg, S.S. (2012), Dental Trauma Guide: A source of evidence-based treatment guidelines for dental trauma. Dental Traumatology, 28: 345-350. doi:10.1111/j.1600-9657.2011.01059_1.x
8- Carrotte, P. Endodontics: Part 3 Treatment of endodontic emergencies. Br Dent J 197, 299–305 (2004). https://doi.org/10.1038/sj.bdj.4811641

D.A. Languages Ltd. is your provider for telephone interpreting.

D.A. Languages Limited
Interpreting & Translation Services

Make a note of your 'Department PIN' here:

Step 1 – Call **0330 088 2443** direct from your phone.

Step 2 – Enter your 'Department's PIN', followed by the # key; you can then enter the PIN of the language you require (see alphabetised list below). Press 1 for an interpreter, or 4 to speak to a specific interpreter (see next step).

Step 3 – Once connected, take note of the interpreter ID number (you can use this to connect to the same interpreter for future calls). To connect to any third parties, dial 9 and then the number you wish to connect to.

Step 4 – Leave feedback on interpreter at the end of the call. You will have 8 seconds to do this. From 1 (lowest rating) to 5 (highest rating).

Language	Code	Language	Code	Language	Code
Afghan Pashto	216	Indebele	049	Portuguese	077
Afrikaans	211	Indonesian	129	Punjabi	033
Albanian	065	Italian	008	Romanian	029
Amharic	004	Japanese	122	Russian	074
Arabic	013	Kannada	203	Sanskrit	092
Armenian	035	Khassonke	099	Seraiki	128
Azeri	006	Khmer	232	Serbian	108
Bambara	087	Kibajuni	086	Sesotho	206
Basse	223	Kibembe	204	Shona	207
Belarusian	037	Kikongo	096	Sinhalese	016
Bengali	078	Kinyarwanda	058	Slovak	018
Bosnian	100	Kirundi	054	Slovenian	230
Bravanese	241	Kituba	127	Somake	238
Bulgarian	040	Konkani	224	Somali	063
Burmese	231	Korean	071	Spanish	038
Catalan	213	Kosovan	210	Swahili	041
Chinese Cantonese	061	Krio	011	Swedish	042
Chinese Mandarin	046	Kurdish Bahdini	021	Sylheti	111
Congolese Swahili	201	Kurdish Kurmanji	059	Tagalog	212
Croatian	106	Kurdish Sorani	025	Taiwanese	102
Czech	024	Lari	088	Tamil	051
Danish	217	Latvian	079	Telugu	125
Dari	043	Lingala	026	Thai	120
Dioula	007	Lithuanian	020	Tigre	036
Dutch	104	Luganda	019	Tigrinya	022
Estonian	228	Macedonian	031	Tswana	208
Evie	064	Malay	205	Turkish	066
Farsi	012	Malayalam	123	Turkish- Cypriot	209
Filipino	202	Malinke	055	Turkmen	229
Finnish	233	Mandinka	053	Twi	219
Flemish	103	Marhi	056	Ukrainian	060
French	048	Mauritian Creole	235	Urdu	014
Fula/Fulani/Poular	062	Mina	059	Uzbek	242
Georgian	080	Mirpuri	101	Vietnamese	034
German	002	Moldovan	073	Welsh	220
Greek	027	Mongolian	218	Wolof	057
Guajarati	084	Nepalese	030	Xhosa	094
Hausa	121	Norwegian	227	Yiddish	236
Hebrew	221	Oromo	090	Yoruba	132
Hindi	032	Pahari	052	Zaghawa	225
Hungarian	019	Pashto	015	Zulu	028
Ibibio	131	Patwa	107		
Igbo	240	Polish	075		

If you have any issues, please press # to connect to the operator. If you are unable to connect to the telephone interpreting line, please call the switchboard on 0161 928 2533

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Interpreting & Translation Services

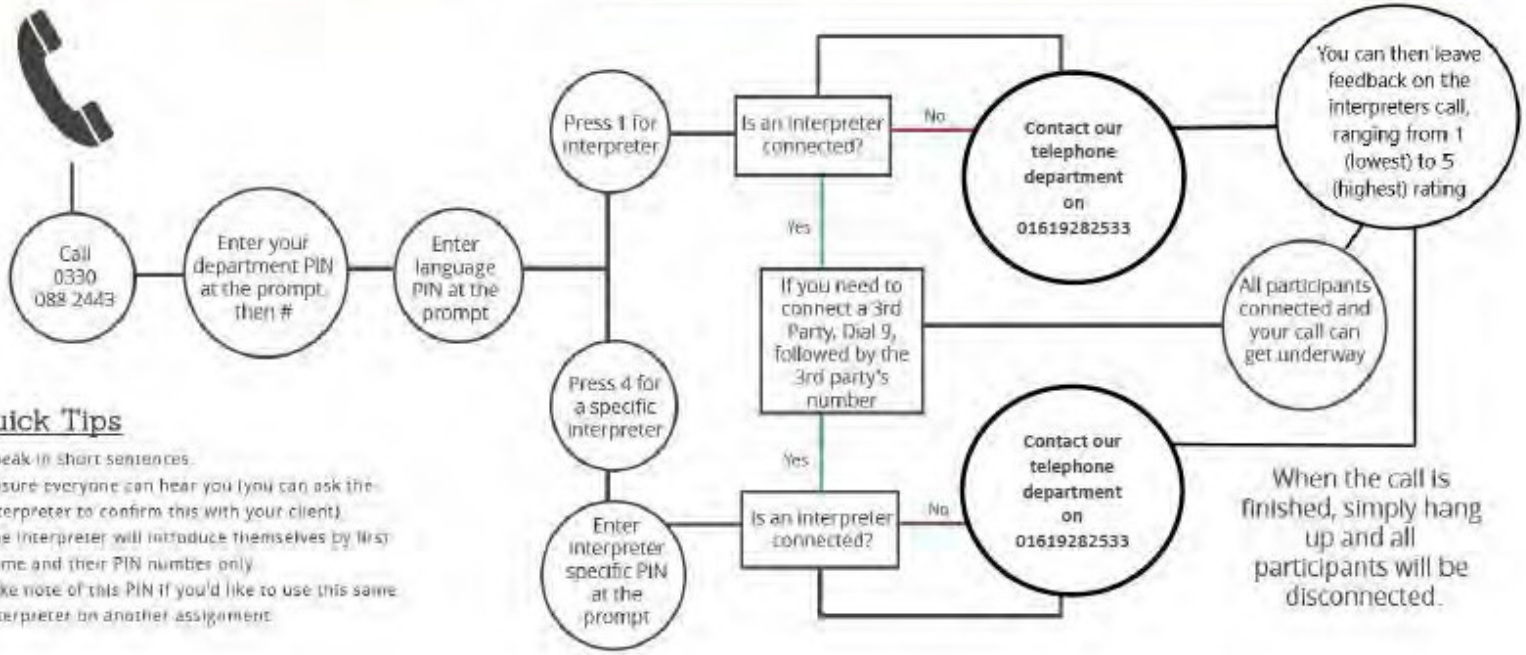
D.A. Languages Ltd.

Telephone Interpreting: Quick Client User Guide

D.A. Languages Ltd. provides its Telephone Interpreting services via an automated system that runs 24/7.

If you need an operator, DA staff man the lines during in-office hours 9am-5.30pm Mon-Fri.

A form containing the Language PINs you need will be provided separate from this document.



Quick Tips

- Speak in short sentences.
- Ensure everyone can hear you (you can ask the interpreter to confirm this with your client).
- The interpreter will introduce themselves by first name and their PIN number only.
- Take note of this PIN if you'd like to use this same interpreter on another assignment.

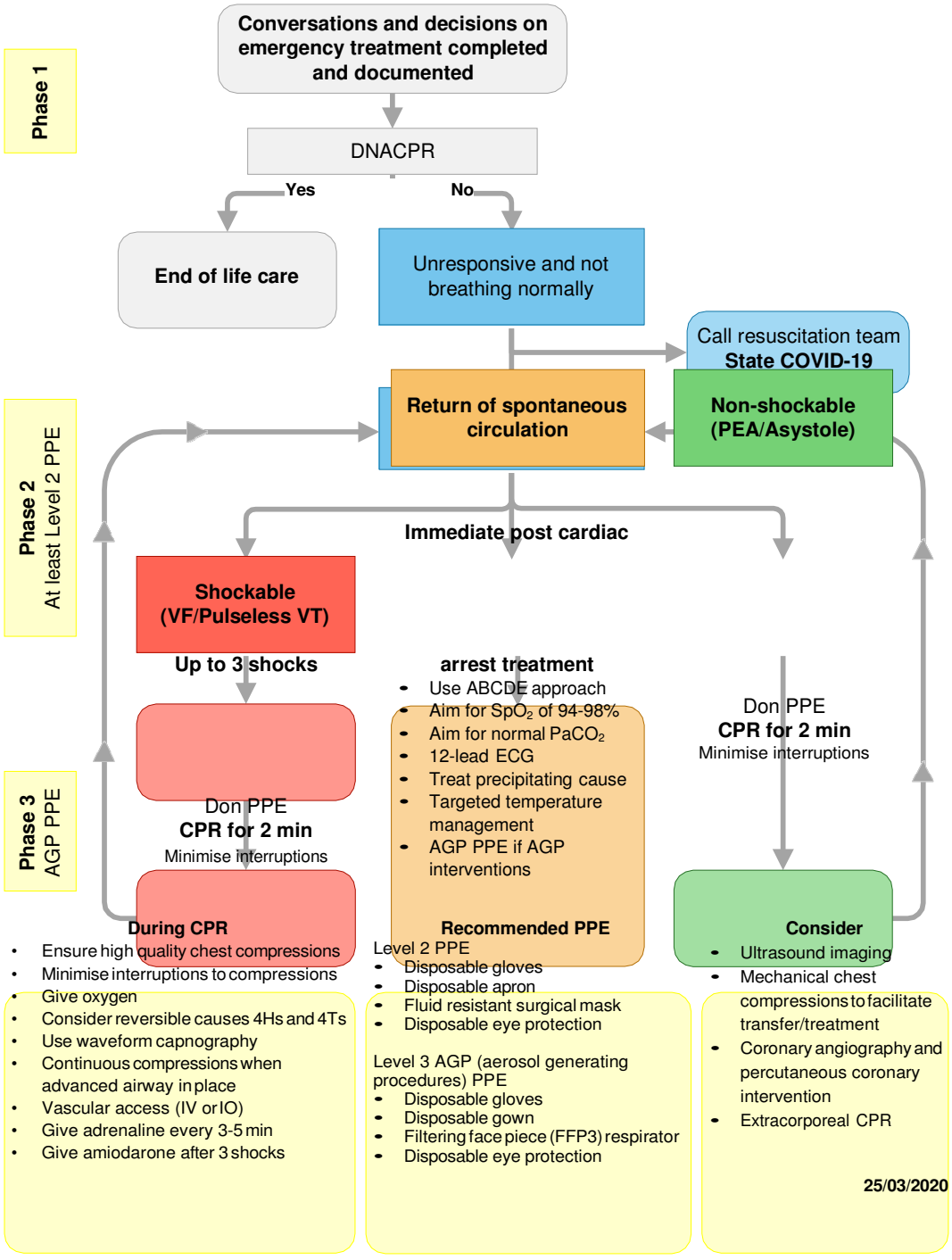
Suggested Protocol if a Patient becomes unwell during an appointment in a non-COVID Urgent Dental Care centre

If COVID-19 is considered possible when an appointment is already in progress, assess a suitable and safe point to bring any treatment to a close.

1. Isolate patient in surgery you are treating away from other patients. Provide mask and gloves for the patient and chaperone to put on. Provide bottle of water and tissues. Advise others not to enter the area. Put out isolation notices to prevent entry
2. If the patient is critically ill or requires emergency medical care, an ambulance should be requested, and the 999-call handler informed of COVID-19 risk. Normal medical emergency training is appropriate especially oxygen and asthma care if appropriate. Support breathing as primary concern.
3. Otherwise withdraw from the area, wash hands thoroughly with soap and water. Change PPE and discard in clinical waste. Don new PPE and apron.
4. If they are so unwell they cannot leave ask them where they have been in the building and clean all touched surfaces, open all doors, and windows. Turn up heating. Recruit help for other duties, such as reception.
5. Send all other patients home after updating their contact numbers/details. Once patients gone, shut practice. Put up PRACTICE CLOSED sign on front door.
6. Advise patient to contact NHS111 from their mobile in designated isolation area: –patient will need to state where they are calling from and provide contact details for the practice. If no patient mobile, staff to call on practice phone and relay responses to NHS111.
7. While waiting for advice from NHS111, communicate with the patient from outside area to check status. If you need to enter the area, wear personal protective equipment (PPE) in line with standard infection control precautions, gloves, disposable apron and surgical mask and keep exposure to a minimum. All PPE should be disposed of as clinical waste.
8. If a healthcare professional is required to enter the area to offer assistance, they should wear disposable gloves, disposable aprons and fluid-resistant surgical face masks.
9. When patient has left the building, clean surgeries thoroughly and ALL communal areas down to front door and time allowed for aerosols to settle.

Resuscitation Council UK

Adult Advanced Life Support for COVID-19 patients



Resuscitation Council UK

Resuscitation Council UK Statement on COVID-19 In relation to CPR and resuscitation in Paediatrics

This statement is for healthcare professionals who are performing CPR in a healthcare setting and members of the public who are performing CPR in a community setting.

We are aware that paediatric cardiac arrest is unlikely to be caused by a cardiac problem and is more likely to be a respiratory one, making ventilations crucial to the child's chances of survival. However, for those not trained in paediatric resuscitation, the most important thing is to act quickly to ensure the child gets the treatment they need in the critical situation.

In-hospital resuscitation

The Resuscitation Council UK Statement on COVID-19 in relation to CPR and resuscitation in healthcare settings advice for in-hospital cardiac arrest is relevant to all ages. Mouth-to-mouth ventilations should not be necessary as equipment is available for bag-mask ventilation/intubation and must be immediately available for any child/infant at risk of deterioration/cardiac arrest in the hospital setting.

Out-of-hospital resuscitation

For out-of-hospital cardiac arrest, the importance of calling an ambulance and taking immediate action cannot be stressed highly enough. If a child is not breathing normally and no actions are taken, their heart will stop and full cardiac arrest will occur. Therefore, if there is any doubt about what to do, the guidance in the Resuscitation Council UK Statement on COVID-19 in relation to CPR and resuscitation in first aid and community settings should be used.

It is likely that the child/infant having an out-of-hospital cardiac arrest will be known to you. We accept that doing rescue breaths will increase the risk of transmitting the COVID-19 virus, either to the rescuer or the child/infant. However, this risk is small compared to the risk of taking no action as this will result in certain cardiac arrest and the death of the child.

resus.org.uk
enquiries@resus.org.uk
020 7388 4678

5th Floor, Tavistock House North
Tavistock Square, London WC1H 9HR
Registered Charity Number 1168914

Appendix 10- IMOS Guidance

Advice for IMOS services under the current nationwide lockdown as produced by the oral Surgery Managed Clincial Network.

Collating BDA/BAOMS/BAOS guidance for dentists and for oral surgical procedures and utilising a common-sense approach with the primary intent of the government's guidance

1. Decrease footfall of patients reduce travel
2. Stop spread of COVID-19
3. Protect patients and staff

We are advising all IMOS services to cancel all but absolute emergencies. Please go through your lists and cancel all routine appointments. Merely symptomatic teeth is not an absolute indication. Contact patients and rationalise and advise. Where possible non-interventive advice medical management and symptom control should be first choice. Where intervention is deemed absolutely essential (and these will be the exception not the rule) in order to manage the patient outside the hospital services to minimise pressure on what will soon be an overwhelmed hospital service, proceed with appropriate PPE/FFP3/Visors etc. There is no pathway to upstage to Level 3 unless life threatening. Level 3 staff are being retrained to provide help with potential surge of ITU cases.

Reduce the number of clinicians assigned on a daily rota to minimise exposure.

Ensure adequate slot time (up to 60 minutes) is given to each contact with a patient to ensure no crowding and maintain distancing.

Telephone clinics to ensure a quiet environment and to encourage social distancing amongst staff members. Telephone clinics to rationalise attendances. As far as possible defer any surgical intervention

Where possible each clinician will be limited to one session of patient exposure per day.

Clinics to be booked 1-2 weeks in advance only to account for potential staff shortages.

In the exceptional case where surgical intervention is deemed necessary and a potential AGP is planned, please use appropriate protective devices as prescribed and try to schedule procedures for the end of the day to allow extended deep cleaning after.

Entry into and out of the room being used for procedures should be restricted.

Encourage patients to attend alone or with one attendant in the case of the elderly. Avoid bringing children to the appointments.

Limit paperwork that is out in the open.

There should be a pen for patients and a pen dedicated for clinical use.

Deep cleaning after every patient contact.

Keep a record of all telephone and face to face contacts. Register all cancellations.

Where feasible follow up telephone calls to reassure and reassess at appropriate interval after first contact is advisable.

Arrange rebooking prioritisation exercise as Low, Medium and High-Risk cases and rebook in order from high to low; only when lockdown has been completely lifted.

Assign clinician time to triage cases.

The Managed Clinical Network (MCN) does not have the remit to procure PPE/FFP3 masks for the Level 2 Service providers and performers. These will need to be sourced directly by the provider through NHS supply chain or otherwise as previously advised.

These are very tough times requiring tough decisions and tough measures. Let us support the government in restricting this pandemic.

The LDC the LDN and PHE and the BDA have made the appropriate representation to NHSE and Govt Agencies to consider the financial issues that will ensue. Providers should receive notification in this regard soon.

Appendix 11 – OMFS 2 Week Wait Telephone Spreadsheet

Attached is a spreadsheet provided by Essex Oral Surgery Managed Clinical Network to assist in determining relative risk in respect of cancer and, thereby inform a referral for an opinion:

Appendix 12- When to use a surgical face mask or FFP3 respirator

Table 1: Transmission based precautions (TBPs): Personal protective equipment (PPE) for care of patients with pandemic COVID-19

	Entry to cohort area (only if necessary) no patient contact*	Within 1 metre of a patient with possible/confirmed COVID-19*	High risk units where AGPs are being conducted eg: ICU/ITU/HDU	Aerosol generating procedures (any setting)
Disposable Gloves	No	Yes	Yes	Yes
Disposable Plastic Apron	No	Yes	Yes	No
Disposable Gown	No	No	No	Yes
Fluid-resistant (Type IIR) surgical mask (FRSM)	Yes	Yes	No	No
Filtering face piece (class 3) (FFP3) respirator	No	No	Yes	Yes
Disposable Eye protection	No	Risk assessment	Yes	Yes

*Personal protective equipment (PPE) for close patient contact (within 1 metre) also applies to the collection of nasal or nasopharyngeal swabs.

Public Health England

When to use a surgical face mask or FFP3 respirator

When caring for patients with **suspected or confirmed COVID-19,** all healthcare workers need to – prior to any patient interaction – assess the infectious risk posed to themselves and wear the appropriate personal protective equipment (PPE) to minimise that risk.

When to use a surgical face mask

In cohorted area (but no patient contact)

For example:
Cleaning the room, equipment cleaning, discharge patient room cleaning, etc

PPE to be worn
- Surgical face mask (along with other designated PPE for cleaning)

Close patient contact (within one metre)

For example:
Providing patient care, direct home care visit, diagnostic imaging, phlebotomy services, physiotherapy, etc

PPE to be worn
- Surgical face mask
- Apron
- Gloves
- Eye protection (if risk of contamination of eyes by splashes or droplets)

When to use an FFP3 respirator

When carrying out aerosol generating procedures (AGP) on a patient with possible or confirmed COVID-19

In high risk areas where AGPs are being conducted (eg: ICU)

The AGP list is:
- Intubation, extubation and related procedures such as manual ventilation and open suctioning
- Tracheotomy/tracheostomy procedures (insertion/open suctioning/removal)
- Bronchoscopy
- Surgery and post-mortem procedures involving high-speed devices
- Some dental procedures (such as high-speed drilling)
- Non-Invasive Ventilation (NIV) such as Bi-level Positive Airway Pressure (BiPAP) and Continuous Positive Airway Pressure ventilation (CPAP)
- High-Frequency Oscillating Ventilation (HFOV)
- High Flow Nasal Oxygen (HFNO), also called High Flow Nasal Cannula
- Induction of sputum

PPE to be worn
- FFP3 respirator
- Long sleeved disposable gown
- Gloves
- Disposable eye protection

Always fit check the respirator

REMEMBER
- PPE should be put on and removed in an order that minimises the potential for self-contamination
- The order for PPE removal is gloves, hand hygiene apron or gown, eye protection, hand hygiene, surgical face mask or FFP3 respirator, hand hygiene

These images are for illustrative purposes only. Always follow the manufacturer's instructions.

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