June 1, 2020

Re: Canadian Dental Association (CDA) Return to Practice Office Manual V1 May 10, 2020

Dear CDA Board of Directors,

Thank you for sharing Version One (1) of the Return-to-Practice Office Manual with the Canadian Dental Assistants’ Association (CDAA). We understand the objective of this document is to be a useful reference tool with regards to the challenges of re-opening dental offices during the Covid-19 pandemic and that the version CDAA received is the CDA branded version which was also sent to CDA affiliate members in Quebec and shared with interested organizations. We further understand that this document is meant to be a reference tool for your Corporate members to use as they see fit, and that CDA anticipates updating this document as new information becomes available.

CDAA was disappointed to learn that the Return-to-Practice Office Manual had been prepared without review by all oral health team professionals, despite the introduction noting that these guidelines are “…for use by Canadian dentists and the dental team…” and despite the impact COVID-19 has had and will have on all members of the dental team as they transition back to work.

To support CDA as they prepare future iterations of this Manual in response to the evolving pandemic, CDAA has taken the time to carefully review Version 1 and provides the following:

General Comments:
• CDAA suggests that it would have been preferable for CDA to consult with the organizations representing oral health team members prior to disseminating the final document to ensure alignment with guidelines being prepared for other oral health professions. Clear, consistent, non-contradictory guidelines will improve understanding, compliance and consistent application by all members of the oral health team, improving safety for both team members and more importantly, patients.

• It is important to recognize that all oral health professionals are at risk as they respond to Covid-19. Dental Assistants are at the same risk as other dental clinicians and in this unprecedented and uncertain environment, it is important that dental assistants be recognized as the 3rd clinical oral healthcare team member. To ensure patient safety and the health and safety of dental team members, dental assistants need to be consulted on documents that affect the staff in the dental practice, so that we can provide our unique knowledge of what we do in the dental office.

• CDAA appreciates CDA’s commitment to basing their directives on scientific evidence and expert opinions. CDAA questions, however, if the experts consulted were experts for all oral health professions? Surely, consulting with educators and experts on dental assisting would have provided
CDA with additional insight specific to our profession and how these guidelines impact the activities and responsibilities of dental assistants. **CDAA would be pleased to provide CDA with experts in dental assisting who could assist with improving future iterations of the Return-to-Practice Office Manual.**

- CDAA understands the Covid-19 situation is evolving rapidly as the results of emerging studies impact the response to the pandemic. We are concerned, however, the Manual states “the document will be updated accordingly…” With multiple iterations; potential conflict with guidelines prepared by other oral health professions; and rapidly changing public health directives, there is a risk of confusion and as a result, non-compliance among dental staff as they struggle to understand which guidelines take priority and which version is the most current. **Numerous studies have shown that primary barriers to adhering to new policies or protocols include unclear communications; changing information; conflicting information; and a resulting lack of understanding.**

- The CDA Manual correctly states where evidence is lacking, dental clinicians should err on the side of caution. It may be months or years before the scientific community has verified evidence of Covid-19 modes of transmission. CDAA understands how new and unprecedented the Covid-19 virus is and how difficult it is to make decisions based on incomplete, unverified and sometimes contradictory evidence. Without verified evidence about how the Covid-19 virus is transmitted or how it mutates, members of the dental team will be at risk. **Until there is scientific proof and in order to protect the dental team and patients, this lack of evidence would suggest that the safest return-to-practice would be for emergency services only and that non-emergent aerosol generating procedures (AGPs) not be provided at this time. It is not business as usual for patients nor for members of the dental team.**

- CDAA suggests the checklists in the Manual should have more of an explanation as to exactly what duties and processes should be carried out by each member of the dental team.

- CDAA recommends the Manual include printable, picture posters that clearly show proper illustrations of donning and doffing Personal Protective Equipment (PPE), hand washing, **social distancing and respiratory etiquette.** Strong examples include those recently released by the American Dental Association2 and Public Health Ontario3.

- CDAA recommends the Manual include clear, concise and printable check lists and/or flow chart posters demonstrating procedures for set-up, delivery and clean-up for each different level of contamination (i.e.: aerosol generating procedures versus non-aerosol generating procedures) and these posters be posted in the dental office in areas where they are clearly visible to all dental office staff.

- As dental professionals return to practice, CDAA recommends **paid sick leave be investigated by provincial authorities** to reduce pressure on staff to come to work sick, which could increase the risk of infecting other members of the office or patients. **CDAA understands this is not within**
the scope of the *Manual* or your members, but encourages CDA to champion the need for paid sick leave for all members of the dental team.

**Enforcement:**

- Asking dental practitioners to use their clinical judgement in applying guidelines to their practice will likely result in the Pareto Principle (80/20 rule) being fulfilled. Based on financial considerations many will choose to do less than the minimum required. There is no way to guarantee all dental practitioners will put safety above financial concerns unless they are required to do so and that requirement is enforced and strict oversight is applied. **The CDAA suggests all oral health practitioners work collaboratively with provincial regulators to implement oversight to ensure dental practitioners are complying with health and safety guidelines and that severe penalties be implemented for non-compliance.** This is a new working environment and the health and safety of patients, dental team members, and the communities they live in, must take precedence. CDAA is aware that some provincial dental hygiene associations have established an anonymous phone line to facilitate reporting of non-compliance. Any *Manual* revision should include instructions on how oral healthcare providers and patients can report non-compliance with guidelines; timelines around reporting; accountability; and privacy reporting protections and considerations. **CDAA recommends the *Manual* clearly outline the steps for reporting non-compliance or risky practices in the dental office.**

- The *Manual* does not clearly outline which member of the dental team is responsible for ensuring physical distancing is maintained both in the office common areas (such as luncheon rooms which are often very small) and especially in the waiting room. **CDAA suggests the Administrative/Receptionist position will be the primary staff member to ensure physical distancing is being followed.** CDAA suggests the *Manual* clearly indicate that the Administrator/Receptionist should advise patients to wait in their vehicle if they arrive by vehicle until the team is ready to seat them in the operatory; for patients arriving by public transportation that she/he plans the schedule so that physical distancing can be maintained in the waiting room. **In addition, CDAA is concerned about how physical distancing will be maintained in sterilization areas and recommends the *Manual* clearly outline how 2 meters of distance will be accomplished in those areas.**

- The *Manual* currently does not comment on the amount of additional time members of the dental team will need to ensure compliance with the guidelines throughout their workday. **CDAA suggests the *Manual* provide specific time allocations to be linked to completing the activities described.**

**Screening:**

- The CDA *Manual* correctly states that asymptomatic patients will not be identified with screening but only acknowledges specific risk factors that determine if a patient is low, medium or high risk for Covid-19. **This doesn’t account for community and unknown transmission of the disease. During the pandemic we need to treat everyone as medium risk. High risk patients should not be seen in a community health setting and require that any emergency treatment be provided in a negative pressure room with every possible precaution and the highest level of personal protective equipment (PPE).**
The CDA Manual notes that “It’s about knowing who’s in your chair and where they’ve been.” The CDAA believes this is contrary to the basis of Infection Prevention and Control (IPC), which assumes all patients to be potentially infectious.

The CDAA recommends the Manual include updated storage guidelines for all daily staff screening forms, taking into consideration privacy statutes and timelines for retention of records.

Following a determination that a patient is at moderate risk for Covid-19, CDAA recommends the appointment be deferred for 14 days. Following this determination, there should be no additional options beyond re-book ing the appointment (see flow chart, page 11). CDAA recommends updating this flow chart and removing the arrows below “defer 14 days” for patients assessed as moderate risk.

Common Areas in the Dental Office:

Reception and waiting area – the Manual indicates these areas must “clean and disinfect. Clean surfaces with detergent or soap & water prior to initial disinfection. Disinfect touch surfaces at least twice daily, including chairs, tables, door handles, light switches, clothes hangers, bathroom countertops and fixtures, staff-room surfaces, lab areas, etc.” The Manual does not provide a clear description as to which member of the dental team will be responsible for this cleaning and disinfecting. CDAA is concerned Administrative staff will be expected to perform these activities, yet these individuals may have no formal training in IPC. CDAA recommends the Manual describe clearly which member of the dental team is responsible for cleaning and disinfecting the reception and waiting areas and that the individual has received formal training in IPC to reduce the risk to patients.

Common Staff areas – the Manual indicates that staff “Encourage physical distancing.” Given the public health protocols issued across Canada, CDAA recommends the Manual clearly states “enable physical distancing of 2 meters in common staff areas in accordance with public health protocols.” CDAA further suggests CDA members be encouraged to examine the layout of their dental offices to allow for a room for staff to change into/out of their uniforms; donning and doffing personal protective equipment; storage for personal items; dedicated staff washrooms and break areas.

Receiving deliveries - “Wipe entirely the exterior of every box delivered with a paper towel and soap & water solution or sanitizing wipe”; “Boxes remain untouched for 15 minutes prior to being opened”; “Clean all surfaces that were touched by deliveries with soap and water mix or sanitizing wipes.” CDAA recommends the Manual describe clearly which member of the dental team is responsible for cleaning and disinfecting deliveries and that the individual has received formal training in IPC to reduce the risk to patients and team members.

Staff Preparation – The Manual notes: “dental office staff should be prepared to adopt infection prevention measures wholeheartedly” CDAA suggests “be prepared” is not specific enough and could be result in various interpretations. Also, CDAA recommends paid, mandatory
training be made available to dental team members so that all individuals meet the same preparedness threshold. In order to prepare, time allocations should be linked clearly to infection prevention activities and described in the Manual.

Personal Protective Equipment (PPE):

- Dental Assistants in some provinces perform independent patient care such as taking radiographs, taking impressions, rubber cup prophylaxis, minor scaling, pit and fissure sealants, ortho bracket bonding, application of topical anesthetic, application of rubber dam clamps and dams, etc. – all activities that involve dental splatter and aerosols. **CDAA recommends the Manual must stress that employers must ensure their clinical staff are protected with the highest level of PPE or they should not be offering these services.**

- PPE is to protect both the wearer and the patient. Employers who chose to open their dental practice without the ability to provide the appropriate PPE or who are limiting the use of PPE by their staff are putting the staff and the public at risk. The **CDAA recommends the Manual clearly state the need for appropriate PPE and the consequences of limiting the use of PPE.**

- The CDAA recommends the Manual mirror the American Dental Association guidelines which recommend laundry facilities or laundry services at work be provided by the employer to ensure contaminated scrubs, gowns, scrub caps, lab coats are not transmitting disease to the homes of the dental health team and risking increase of community transmission.

- **CDAA recommends the Manual clearly state that gowns, caps, masks, gloves must be changed between patients to avoid cross-contamination and transmission of infection.** CDAA has been advised that some employers are telling their staff to wear them until they are visibly soiled, ignoring the fact that contamination is most often not visible. This puts the patient and the staff member at risk. If the clinical judgement of a dental practitioner is resulting in this kind of practice then we can be assured that leaving this up to each individual employer to decide what is and what is not acceptable, is putting patients and staff at risk.\(^4\)

- The Manual recommends that office staff wear scrubs. The **CDAA recommends the Manual should clearly state that office/Administrative staff must also don scrubs (or other dedicated office wear) upon entering the dental office and remove at the end of the day prior to leaving the office, in the same manner as the oral health professionals.**

- During the Appointment – the Manual is not clear on the use of PPE during the period of time between when patients arrive and when a patient is seated in the operatory. There is no mention of the use of PPE by staff when they greet the patient and escort them to the operatory, only references “chair-side staff don mask before entering operatory.” **CDAA recommends a "soft start" as referenced in the American Dental Association guidelines so staff can experience run-throughs and address weak areas and inconsistencies.**
Dental Air Quality:

- The *Manual* refers to research on contamination and airborne transmission in use of dental equipment that was done on bacteria, not viruses. Viruses are smaller and can stay suspended longer. Covid-19 is more virulent than any bacteria or virus the dental industry has previously encountered. During dental treatments, the dental team must exercise the utmost caution in air quality control during this pandemic. Dental air quality doesn’t change from province to province and having differing guidelines in each province with regard to air quality protocols is not in the best interest of public safety. **CDAA recommends standardized air changes per hour and corresponding settle times until a dental assistant can enter and disinfect, be instituted across all provincial/territorial jurisdictions.**

- The CDAA recommends all dental practices have their HVAC systems evaluated for air changes per hour (ACH) before re-opening to ensure the proper settle time is determined and proper additional operatory alterations are made prior to offering aerosol generating procedures (AGPs). This is for public safety and the safety of dental staff.

- The CDAA recommends all dental practices be required to post the air changes per hour (ACH) information visible to all dental staff, so staff members can determine wait time.

- The *Manual* currently states that “any splatter must be controlled with high volume evacuation (HVE)” and “combined with 4-handed dentistry using HVE.” **CDAA recommends this be amended to: “combined with 4-handed dentistry using HVE, which requires the constant presence of a trained dental assistant.”**

- Hygiene appointment – the *Manual* indicates “hand scaling” and “HVE at all times.” It is unclear, based on the description, if this appointment will also now require the constant presence of a dental assistant. **CDAA recommends the *Manual* provide clear directives/expectations on this aspect of the hygiene appointment.**

- The *Manual* provides confusing instructions regarding safety protocols as they relate to aerosol generating procedures and sealed rubber dams. Page 4 notes that “If these (AGP) procedures are required, they must be performed in a closed operatory with full precautions…” and “For many procedures, potentially infectious aerosols can be virtually eliminated as follows: …Apply a sealed rubber dam to isolate the procedure area…” Further, “When the treatment proceeds with use of high-speed instruments and other aerosolizing procedures, the aerosols created will only contain tooth debris and no infectious saliva, minimizing the risk of infectious aerosols. This management combined with 4-handed dentistry using HVE will minimize risk of infectious aerosols and is expected to be suitable for patients in the low risk category for COVID-19.” On page 6, however, Table 2 supports the description above, but makes no mention of the requirement of closed rooms. Also, on page 11 at the base of the decision schema, the *Manual* indicates the use of a sealed rubber dam circumvents the necessity for a closed treatment room. **CDAA suggests the statements on pages 4 and 11 are contradictory and that the Table on page 6 be amended to include directives on closed rooms.** In a dental office with multiple open concept/partial wall operatories, HVEs may not be strong enough to eliminate all of the circulating infectious aerosols. Further, dental dams can tear – a situation that could put many patients and staff members at risk in an open
concept/partial wall operatory environment. Given the Manual notes that “Research is currently underway to quantify the risks of this approach” related to aerosol generating procedures, the CDAA recommends that until more data is compiled and more is scientifically known about aerosols and Covid-19, the Manual should not imply that the use of sealed rubber dams circumvents the necessity of a closed room operatory and that aerosol generating procedures only take place in closed rooms using sealed rubber dams to isolate the procedure area.

CDAA is aware that many of the issues your Manual touches upon are strictly regulatory in nature and/or fall under the jurisdiction of provincial health authorities, however, providing broad comments from the perspective of dental assisting is important to raise awareness and understanding of what dental assistants will advocate for in their respective jurisdictions.

Provincial dental associations are also issuing return to practice manuals. CDAA has noted that some of these manuals recommend that a member of the dental staff be dedicated full-time to cleaning the dental offices throughout the day. CDAA is concerned that these types of directives will increase the hiring of untrained individuals into the dental practice and that these untrained individuals will put themselves, staff members and the community at significant risk given that they will not have completed appropriate and comprehensive infection prevention and control training.

Thank you again for sharing the first iteration of the CDA Return to Practice Office Manual. The CDAA was pleased to review and provide comment. We remain available to CDA to provide our expert advice and guidance from a dental assisting perspective. As always, we remain committed to ensuring the health and safety of dental assisting practitioners, dental team members, and most importantly, patients.

Your colleagues in oral health,

The CDAA Board of Directors

cc. Canadian Dental Regulatory Authorities Federation of Canada (CDRAF)
Canadian Dental Assisting Regulatory Authorities (CDARA)


4 https://www.cnesst.gouv.qc.ca/salle-de-presse/covid-19/Pages/ourils-soins-buccodentaires.aspx