Standard Operating Procedure for Urgent Minor Oral Surgery (MOS) provision during COVID-19 Response

This Standard Operating Procedure (SOP) should be read alongside the Novel Coronavirus (COVID-19) local guidance and Urgent Dental Care (East Midlands) SOP refreshed 16th April 2020

1. Scope for MOS provision during the COVID-19 pandemic

1.1 Service provision will be based on principles laid out in the Novel Coronavirus (COVID-19) local guidance and standard operating procedure Urgent Dental Care (East Midlands) in reducing face to face contact to a minimum, maintaining social distancing and providing care only when advice analgesics and antibiotics are not an option or have been tried appropriately and failed.

1.2 This service is intended;

a) to provide urgent care for those already in the MOS referral pathway who are now presenting with urgent problems. Treatment can only be provided in relation to the original referral and where these teeth are now causing symptoms that cannot be dealt with by advice, analgesia and antibiotics.

Type of work at this time may include

i) *Dento- Alveolar Surgery* - will include:

- Surgical removal of grossly decayed teeth
- Removal of symptomatic teeth uncontrolled by Advice, Analgesia and Antibiotics (AAA)
- Removal of buried or retained roots which are symptomatic and uncontrolled by AAA

ii) *Third Molar Surgery*- Requiring a simple surgical approach if AAA has not controlled symptoms and include:

- Unrestorable caries
- Non-treatable pulpal and/or periapical pathology
- Abscess
- Internal/external resorption of the tooth or adjacent teeth
- Fracture of the tooth.

b) to provide support for issues that arise as a result of urgent care provision which require MOS intervention e.g. post extraction removal of roots, repair of Oroantral Fistula (OAF).

1.3 The procedures will be undertaken with local anaesthetic. Sedation will not be offered at this time due to the need for chaperones and extended procedure time.

1.4 Apicectomies will not be offered during the pandemic. Antibiotics or extraction will be offered for teeth causing symptoms uncontrollable by AAA due to extended procedure time and risk of post-operative issues.

1.5 Pre- Orthodontic oral surgery will not be offered during the COVID- 19 Pandemic as this is not considered urgent treatment.

2. Referral pathways

2.1 Referral from Urgent Dental Care (UDC) Centre

This would be an option if for example, an extraction has been undertaken leading to the requirement for dento-alveolar surgery where the benefits of immediate MOS referral and treatment outweighs the risks of delaying treatment given the current COVID-19 outbreak.

An onward referral would be made from the UDC via the RMS to the nearest MOS provision

2.2 Patients already on MOS waiting list

This pathway is for patients who have already been referred to MOS prior to COVID-19 lockdown.

Patients on the list with urgent issues could contact either their referring practitioner or their MOS provider

a) If a referring practitioner or the MOS practitioner receives the call, they should assess the current situation and apply AAA. If the patient is having issues with the tooth referred for MOS provision and AAA will not resolve the situation or has failed, referral should be made via RMS to Tier 2 led triage marking as MOS referral and including radiographs from original referral. In these instances, Tier 2 will then refer directly to UDC for MOS appointment.

b) On receipt at UDC, information must be re-considered by the Oral Surgery Performer alongside the referral details, including radiographs, to assess
   i) whether the benefits of immediate MOS treatment outweighs the risks of delaying treatment given the current Covid-19 outbreak.
   ii) whether this case will definitely need an Aerosol generating procedure (AGP) for completion in the hands of an oral surgery performer. This will allow appropriate appointment times to be booked.

3. Urgent MOS Provision

3.1 Practitioners should follow the guidance laid out in the Novel coronavirus (COVID-19) local guidance and standard operating procedure Urgent Dental Care (East Midlands) in relation to UDC treatment centres.

3.2 In addition the following principles should apply

- Treatment for patients with COVID-19 symptoms, or living with someone with COVID-19 symptoms should be delayed by at least 14 days. Symptoms should be managed by AAA (Advice, Analgesia and Anti-microbials if appropriate), ideally by referring clinician. If their treatment cannot be delayed and becomes an emergency, then they need to be seen in referred to hospital setting/designated Symptomatic.

- AGPs should be avoided and must only be used when absolutely necessary.

  It may be that not all urgent MOS referrals will in the hands of an oral surgery performer require an AGP and that the option of slow handpieces and local irrigation could be utilised to reduce AGPs (not a surgical handpiece).

- The main principle of treatment should be to ensure:
  - the reduction of visits; pre-op visits eliminated via telephone triage - e.g. anticoagulant adjustment, steroid cover/managing patient expectations.
  - the reduction of aerosol; use of slow hand-piece with local irrigation should be considered as a means to reduce aerosol.
  - reduction of potential post-op/subsequent complications - e.g. use of clear post-operative information (verbal and written), the use of resorbable sutures, antibiotic prescription where appropriate, telephone review for at-risk bisphosphonate-related osteonecrosis of the jaw (BRONJ) patients.

4. Implementation of provision

4.1 It is envisaged that this provision will provide 3 to 4 additional slots of activity during the week (equivalent to 1 session) at an AGP site. However, it is recognised that this is dependent on location, availability of staff, stand down time required after an AGP and number of surgeries.

4.2 Practices may choose for example to:

a) Set up a specific MOS session once a week running alongside a regular non AGP/AGP session.
b) Replace a non AGP/AGP session with an MOS session (if surgery space/social distancing issues dictate dual sessions cannot be run)
c) Plan AGP sessions to include a mixture of restorative and surgical AGPs.

4.3 The specific approach to be implemented at each site will be agreed with NHSE.

4.4 After implementation the process will be monitored and reviewed after 2 weeks to assess need and capacity.

4.5 The service will be expanded as appropriate in relation to need and in line with PPE provision.