

INFORME TÉCNICO

Medidas de prevención y control de la infección COVID-19 en la atención primaria, clínicas dentales y oficinas de farmacia: primera actualización

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Nota: por razones de operatividad, se han traducido exclusivamente los aspectos generales, así como los referentes a clínicas dentales. En el Documento original del Centro Europeo de prevención y Control de Enfermedades, pueden consultarse los relativos a asistencia médica en atención primaria y oficinas de farmacia.

Alcance de este documento

Este documento proporciona orientación sobre las medidas de prevención y control de infecciones (PCI) a los proveedores de atención médica en la Unión Europea / Espacio Económico Europeo (UE / EEE) y el Reino Unido (Reino Unido) al objeto de prevenir la infección por COVID-19.

Público objetivo

Trabajadores sanitarios en consultorios de medicina general (GP), clínicas de atención primaria, clínicas dentales y farmacias en la UE / EEE y el Reino Unido.

Antecedentes

Al 12 de octubre, los países de la UE / EEE y el Reino Unido han notificado 4 121 025 casos de COVID-19, incluidas 195 641 muertes [1]. Las tasas de notificación de casos de COVID-19 han aumentado de manera constante en la UE / EEE y el Reino Unido desde agosto de 2020 [2]. La situación epidemiológica actual en muchos países es preocupante, ya que plantea un riesgo creciente de infección por COVID-19 para las personas vulnerables (es decir, las personas con factores de riesgo de enfermedad grave por COVID-19, como los adultos mayores) y los trabajadores sanitarios, especialmente en la atención primaria. La información detallada sobre los casos de COVID-19 notificados hasta ahora está disponible en la página web del ECDC [3]. Las medidas de prevención y control de infecciones (PCI) son de vital importancia para proteger el funcionamiento de los servicios de salud a todos los niveles y mitigar el impacto en las poblaciones vulnerables. Aunque la gestión de posibles casos de COVID-19 suele estar guiada por políticas nacionales, la transmisión comunitaria está actualmente generalizada en la mayoría de los países de la UE / EEE y el Reino Unido.

Como resultado, los agentes sanitarios en la comunidad, como médicos de atención primaria, dentistas y farmacéuticos, corren el riesgo de verse expuestos al COVID-19. En la mayoría de los casos, se cree que los coronavirus se transmiten de persona a persona a través de gotitas respiratorias, ya sea inhaladas o depositadas en las superficies mucosas, incluidos los aerosoles producidos al toser y hablar. La transmisión a través del contacto con fómites contaminados se considera posible, aunque todavía no se ha documentado para el SARS-CoV-2 en investigaciones ambientales en entornos clínicos [4,5]. Se ha detectado SARS-CoV-2 en muestras respiratorias y fecales. El ARN del SARS-CoV-2 también se ha detectado en muestras de sangre, aunque en raras ocasiones, pero no hay evidencia de transmisión del SARS-CoV-2 a través del contacto con la sangre [6]. El papel relativo de la transmisión por gotitas, fómites y aerosoles para el SARS-CoV-2 y la transmisibilidad del SARSCoV-2 en diferentes etapas de la enfermedad siguen sin estar claros. Por lo tanto, se debe tener precaución al considerar estos elementos [7].

Cada vez existe mayor evidencia de que las personas con síntomas leves o asintomáticos contribuyen a la propagación del COVID-19 [8-10]. Se está informando cada vez más de infección asintomática a través de confirmación de laboratorio en muchos entornos clínicos [11-14]. Una reciente revisión de siete estudios considerados de bajo sesgo, estima la proporción de asintomáticos en el 31% (con un intervalo de confianza del 95%: 24-38%) [10]. En 2 estudios se encontró que la carga viral y la probabilidad de cultivo del SARS-CoV-2 viable eran similares en personas asintomáticas, lo que indicaría que las personas asintomáticas representan una fuente de SARS-CoV-2 transmisible [15,16].

Además, la posibilidad de transmisión de SARS-CoV-2 durante la etapa presintomática de COVID-19 ha sido bien documentada [17-21]. Varios estudios han indicado que las transmisiones secundarias pueden ocurrir desde tres días antes del inicio de los síntomas del caso [17, 22-24]. La proporción de transmisión presintomática de todos los casos de transmisión de un caso índice se estimó en 37% (intervalo de confianza (IC) del 95%: 16-52%) [25] y 44% [23]. Debido a la importancia de los individuos asintomáticos y presintomáticos en la transmisión de COVID-19, la OMS ha recomendado que en áreas con transmisión comunitaria de COVID-19, todos los trabajadores de la salud, incluidos

los trabajadores sanitarios en contacto clínico, deben usar mascarilla continuamente durante sus actividades de rutina durante todo el turno laboral [23].

Una revisión sistemática y un metaanálisis reciente estimaron que las mascarillas FFP2 /3 pueden tener un efecto protector mayor que las mascarillas quirúrgicas [26]. Sin embargo, esta conclusión se basa en un número limitado de observaciones y estudios y los autores asignaron un bajo nivel de certeza a esta conclusión. En caso de transmisión comunitaria generalizada y si existiera deficiencia de EPIs, es necesario que las mascarillas FFP2 / 3 estén priorizadas para aquellas actividades que tienen un mayor riesgo de transmisión del SARS-CoV-2, como son los procedimientos de generación de aerosoles (AGP) [27,28].

Orientación general para la prevención y el control de infecciones

Las siguientes medidas deben ser consideradas por todo el personal sanitario.

Formación

Todo el personal de salud, médico, dental o de farmacia debe estar informado y capacitado sobre:

- prácticas de higiene de manos
- prácticas de higiene respiratoria (mascarillas)
- el uso de EPI
- pautas de distanciamiento físico
- prácticas de limpieza y desinfección
- Síntomas de COVID-19 (tos, fiebre, dolor de garganta, mialgia y debilidad, dificultad para respirar, diarrea, náuseas y vómitos, pérdida del gusto y / o del olfato)
- riesgo de transmisión de COVID-19 de individuos asintomáticos y presintomáticos
- todos los procedimientos internos establecidos relacionados con COVID-19, incluidos los procedimientos a seguir cuando se identifica un posible caso (pautas para casos confirmados y casos probables para evitar el contacto con otros y con el personal)
- pautas para el autoaislamiento cuando se presentan síntomas de COVID-19.
- La capacitación para el personal nuevo y la capacitación de actualización para el personal actual sobre los puntos anteriores también deben ser considerado.

Medidas de prevención y control de la infección

- En prácticas grupales y en centros de salud comunitarios, considerar la posibilidad de designar a una persona responsable de la infección. medidas de prevención y control (PCI). deben desarrollarse y ponerse a disposición del personal procedimiento específicos para la prevención y manejo de la COVID-19.
- Un mecanismo para actualizar estos procedimientos de acuerdo con las últimas recomendaciones / evidencia debería implantarse, así como un procedimiento de comunicación eficaz para mantener actualizado a todo el personal.
- Se recomienda instalar mamparas de protección en los mostradores de la farmacia, en los mostradores de recepción de espacios clínicos como protección

contra gotitas respiratorias. El uso de estas mamparas no exime a los usuarios de mantener la distancia social ni del uso de mascarillas.

- Debe mantenerse una distancia física (al menos 1,5 metros, idealmente dos metros) entre personal y pacientes en recepción de área clínica y en farmacia. Valorar señalar con una marca esta distancia social recomendada.
- El uso de mascarillas por parte de los pacientes y del personal sanitario debe ser considerado en todo momento, como medida de control y protección personal. [23].
- El personal y los pacientes deben practicar la higiene de las manos con frecuencia y de forma meticulosa. Debe facilitarse soluciones o geles hidroalcohólicos, toallas de papel de un solo uso y señalizar convenientemente mediante carteles la información relativa a estas medidas.
- Se debe seguir escrupulosamente la higiene respiratoria, incluida la etiqueta adecuada para la tos. Esto implica toser o estornudar en un pañuelo de papel o en el codo. Si se utiliza un pañuelo, debe desecharse con cuidado después de un solo uso, seguido de higiene de manos.
- El EPI debe estar disponible en cantidad suficiente.
- Las superficies contaminadas deben limpiarse regularmente con un detergente neutro.
- Aumentar el número de intercambios de aire por hora reducirá el riesgo de transmisión del SARS-CoV-2 en espacios cerrados. Esto se puede lograr mediante ventilación natural (por ejemplo, abriendo puertas y ventanas) o ventilación mecánica, según el entorno [29].

Clínicas dentales

El siguiente apartado tiene la intención de proporcionar un esquema de principios para desarrollar una guía de procedimientos operativos más específicos para reducir el riesgo de transmisión de COVID-19 en clínicas dentales.

Antes de que llegue el paciente

- Se debe considerar la posibilidad de posponer la atención dental de rutina en áreas con alta transmisión comunitaria de COVID-19, debido a la posibilidad de transmisión desde pacientes asintomático y presintomático. Salvo urgencia, los pacientes deben evitar visitar una clínica dental si están experimentando síntomas compatibles con COVID-19.
- Si es necesaria la visita, el paciente debe comunicarse previamente con la clínica dental para definir el plan de tratamiento.
- Si es posible, los pacientes con COVID-19 confirmado que necesitan atención dental de emergencia o urgente deben ser derivados a un centro de atención dental designado.
- Se debe informar a los pacientes sobre los signos y síntomas de COVID-19 antes de su visita.
- Todos los pacientes deben ser evaluados de forma remota antes de acudir a una clínica dental. Debe existir un procedimiento de triaje previo
- Los pacientes deben acudir solos salvo que se trate de menores o requieran de asistencia (reducción de movilidad, discapacidad etc.)

Durante los cuidados

- Al visitar una clínica dental, los pacientes siempre deben mantener el distanciamiento físico (al menos 1,5 metros) con los demás pacientes que estén esperando. Una alternativa aún mejor es tener un solo paciente en la sala de espera a la vez.
- En áreas con alta transmisión comunitaria, los pacientes deben usar mascarillas tan pronto como ingresen al edificio y en todas las áreas comunes de la clínica dental.
- El conjunto de EPI sugerido para el personal y para la atención de todos los pacientes incluye:
 - mascarilla FFP2 / 3 (o una mascarilla quirúrgica si hay escasez de las anteriores)
 - gafas o pantalla facial
 - guantes
 - bata de manga larga impermeable.
- Las mascarillas FFP2 / 3 deben priorizarse para:
 - procedimientos de generación de aerosoles (AGP)^{1*}
 - cuando se atiende a pacientes que presentan síntomas compatibles con COVID-19 para quienes el tratamiento no puede ser diferido
 - cuando se atiende a pacientes que viven en el mismo hogar con un caso posible o confirmado de COVID-19.
- La elección entre una mascarilla FFP2 / 3 en lugar de una mascarilla quirúrgica debe estar respaldada por la evaluación del riesgo local, que contemple la prevalencia local de COVID-19 y la probabilidad de que en el tratamiento se vaya a generar aerosoles.
- Las actividades generadoras de aerosoles (AGP), por ejemplo, el uso de rotatorio de alta velocidad, deben evitarse tanto como sea posible (por ejemplo, recurriendo a alternativas técnicas que no produzcan aerosoles, si están disponibles). Cuando el procedimiento no se puede aplazar, el riesgo puede ser minimizado aplicando, por ejemplo, aislamiento de dique de goma, el uso de aspiradores de alto volumen, y programando los AGP de una manera que permita los protocolos de limpieza adecuados.
- Si se identifican síntomas compatibles con COVID-19 en un paciente durante el cuidado dental, el paciente debe ser gestionado siguiendo las directrices nacionales COVID-19.

Después de los cuidados

- El personal debe quitarse cuidadosamente el EPI siguiendo la secuencia y el procedimiento correctos.
- Se debe realizar una estricta higiene de las manos inmediatamente después de quitarse el EPI.
- El equipo no desechable debe desinfectarse de acuerdo con las instrucciones del fabricante.

* Dental procedures using high speed devices such as ultrasonic scalers and high speed drills (https://hpspubsrepo.blob.core.windows.net/hps-website/nss/2893/documents/1_tbp-lr-agp.pdf)

- Si se realizó un AGP, la habitación debe ser ventilada natural o mecánicamente antes de admitir un nuevo paciente; el método y el grado de ventilación requerido depende del tipo de procedimiento dental realizado, de los dispositivos anti aerosoles disponibles, del tamaño de la habitación y la presencia de ventanas. Cuando se dispone de un sistema de ventilación mecánica, el aire debe cambiarse de 6 a 10 veces por hora, según las normas nacionales. Cuando no se disponga de ventilación mecánica, las habitaciones deben estar ventiladas naturalmente a intervalos regulares, con el tiempo de ventilación requerido, dependiendo del tamaño de la habitación, el número de ventanas y puertas que se pueden abrir, la temperatura exterior y el flujo de aire [30-33]. Los requisitos precisos para el tipo y la duración de la ventilación antes del próximo paciente (especialmente importante si se realizó un AGP), deben seguir las recomendaciones nacionales y pueden estar sujetos a normativas sanitarias locales.
- Del mismo modo, las superficies u objetos contaminados con frecuencia en la habitación deben limpiarse y desinfectarse cuidadosamente antes de admitir a un nuevo paciente.
- El suelo y las superficies contaminadas deben limpiarse cuidadosamente con un detergente neutro, seguido de descontaminación de superficies con un desinfectante eficaz contra virus. Varios productos con actividad viricida están autorizados en los mercados nacionales y pueden utilizarse siguiendo las instrucciones del fabricante. Alternativamente, se puede recurrir al hipoclorito de sodio al 0,05% –0,1%, (dilución 1:50 si se usa lejía casera que generalmente tiene una concentración inicial de hipoclorito de sodio de 2,5 a 5%). Para las superficies que pueden ser dañadas por el hipoclorito de sodio, se pueden usar productos a base de etanol (al menos 70% de volumen) para descontaminar después de limpiar con un detergente neutro.
- La limpieza de inodoros, lavabos e instalaciones sanitarias debe realizarse con cuidado, evitando las salpicaduras. La desinfección debe realizarse después de la limpieza normal mediante la aplicación de un desinfectante eficaz contra virus o hipoclorito de sodio al 0,1%.
- Se recomienda el uso de equipo de limpieza desechable de un solo uso (por ejemplo, toallas desechables). Si no se dispone de equipo de limpieza desechable, los materiales de limpieza (pañuelo, esponja, etc.) deben colocarse en una solución desinfectante eficaz contra virus o hipoclorito de sodio al 0,1%.
- Se recomienda el uso de material específico para limpiar diferentes áreas de un consultorio / clínica dental.
- El proceso de limpieza debe ir de las áreas más limpias a las menos limpias (ejemplo de estas últimas: un área donde se ha realizado un AGP).
- El personal dedicado a la limpieza ambiental en entornos sanitarios debe usar EPI. El conjunto mínimo de EPI recomendado cuando se procede a la limpieza de instalaciones sanitarias con riesgo de contaminación por SARS-CoV-2 incluye:
 - mascarilla quirúrgica
 - bata resistente al agua desechable de manga larga
 - protección para los ojos (gafas o pantalla facial)
 - guantes.
- La higiene de las manos debe realizarse cada vez que se retire el EPI (guantes, mascarillas, etc.).
- El personal involucrado en la gestión de residuos debe usar EPI. Debe estar informado y capacitado en el uso correcto de EPI, en todos los procedimientos relevantes y conocer los riesgos involucrados. Los residuos deben manipularse de acuerdo con las normativas y regulaciones nacionales o locales.

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ECDC TECHNICAL REPORT

COVID-19 infection prevention and control measures for primary care, including general practitioner practices, dental clinics and pharmacy settings: first update

19 October 2020

Scope of this document

This document provides guidance on infection prevention and control (IPC) measures to healthcare providers in the European Union/European Economic Area (EU/EEA) and the United Kingdom (UK) in order to prevent COVID-19 infection.

Target audience

Healthcare workers in general practitioner (GP) offices, primary care clinics, dental offices/clinics, and pharmacies in the EU/EEA and the UK.

Background

As of 12 October, 4 121 025 cases of COVID-19 were reported by EU/EEA countries and the UK, including 195 641 deaths [1]. COVID-19 case notification rates have increased steadily across the EU/EEA and the UK since August 2020 [2]. The current epidemiological situation in many countries is concerning, as it poses an increasing risk of COVID-19 infection for vulnerable individuals (i.e. individuals with risk factors for severe COVID-19 disease, such as the elderly) and healthcare workers, particularly in primary care. Detailed information on COVID-19 cases reported so far are available on a dedicated ECDC webpage [3].

Infection prevention and control (IPC) measures are of critical importance for protecting the functioning of healthcare services at all levels and mitigating the impact on vulnerable populations. Although the management of possible COVID-19 cases is usually guided by national policies for specific healthcare facilities, community transmission is currently widespread in most EU/EEA countries and the UK. As a result, primary healthcare providers in the community, such as GPs, dentists and pharmacists, are at risk of being exposed to COVID-19.

In most instances, coronaviruses are believed to be transmitted from person-to-person via respiratory droplets, either being inhaled or deposited on mucosal surfaces, including aerosols produced when coughing and speaking. Aerosol-generating procedures increase the production of aerosols. Transmission through contact with contaminated fomites is considered possible, although it has not yet been documented for SARS-CoV-2, and cultivable SARS-CoV-2 has not been detected from fomites in environmental investigations in clinical settings [4,5]. SARS-CoV-2 has been detected in respiratory and faecal specimens. SARS-CoV-2 RNA has also been detected in blood specimens, albeit rarely, but there is no evidence of transmission of SARS-CoV-2 through contact with blood [6]. The relative role of droplet, fomite and aerosol transmission for SARS-CoV-2, and the transmissibility of SARS-CoV-2 at different stages of the disease remain unclear. Caution should therefore be exercised when considering these elements [7].

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There is increasing evidence that persons with mild or no symptoms contribute to the spread of COVID-19 [8-10]. Asymptomatic infection at time of laboratory confirmation has been reported from many settings [11-14]. A recent review of seven studies with little or no bias estimated this proportion at 31%, with a prediction interval from 24 to 38% [10]. The viral load and the probability to culture viable SARS-CoV-2 were found to be similar in symptomatic and asymptomatic persons in two studies, thus indicating that asymptomatic persons represent a source of transmissible SARS-CoV-2 [15,16].

Furthermore, the possibility of transmission of SARS-CoV-2 during the pre-symptomatic stage of COVID-19 has been well documented [17-21]. Several studies have indicated that secondary transmissions from an index case can occur up to three days before the onset of symptoms of the index case [17,22-24]. The proportion of pre-symptomatic transmission out of all occurrences of transmission from an index case was estimated at 37% (95% confidence interval (CI) 16–52%) [25] and 44% [23]. Because of the importance of asymptomatic and pre-symptomatic individuals in the transmission of COVID-19, WHO recommended that in areas with community transmission of COVID-19, all healthcare workers, including community health workers and caregivers who work in clinical areas should continuously wear a medical mask during their routine activities throughout the entire shift [23].

A recent systematic review and meta-analysis estimated that FFP2/3 respirators may have a stronger protective effect than medical face masks [26]. However, this conclusion was based on a limited number of observational studies and the authors assigned a low level of certainty to this conclusion. It is therefore unclear whether FFP2/3 respirators provide a better protection than medical face masks against other coronaviruses and other respiratory viruses such as influenza [27,28]. Therefore, a rational approach to the use of personal protective equipment (PPE) in the event of widespread community transmission and shortages of PPE necessitates that FFP2/3 respirators are prioritised for use during those care activities that have a higher perceived risk of transmission of SARS-CoV-2, such as aerosol-generating procedures (AGPs).

General infection prevention and control guidance

The following measures should be considered by all healthcare providers working in the community.

Training

- All staff working at general practitioner practices, dental offices/clinics and pharmacy settings should be informed and trained on:
 - hand hygiene practices
 - respiratory hygiene practices
 - the use of PPE
 - physical distancing guidelines
 - cleaning and disinfection practices
 - COVID-19 symptoms (cough, fever, sore throat, myalgia and weakness, difficulty to breath, diarrhoea, nausea and vomiting, loss of taste and/or smell)
 - risk of transmission of COVID-19 from asymptomatic and pre-symptomatic individuals
 - all internal procedures in place related to COVID-19, including procedures to be followed when a possible case is identified (pathways for confirmed/possible cases to avoid contact with non-possible cases and staff)
 - guidelines for self-isolation when having symptoms of COVID-19.
- Training for new staff and refresher training for current staff on the points above should also be considered.

Infection prevention and control measures

- In group practices and community health centres, consider appointing a person responsible for infection prevention and control (IPC) measures. Local procedures for the prevention and management of COVID-19 should be developed and made accessible to staff.
- A mechanism to update these procedures in accordance with the latest recommendations/evidence should be in place, as well as a communication procedure to keep all staff updated.
- Consider installing glass or plastic panels, e.g. at pharmacy counters, at reception desks, or in consultation rooms, as protection against respiratory droplets. If not available or possible, consider using face shields/visors as eye protection. Installation of glass/plastic panels or use of face shields/visors do not absolve patients/customers and healthcare providers/staff from respecting physical distance, and from the use of face masks where indicated (see below).

- Physical distance (at least 1.5 metres, ideally two metres) should be maintained between healthcare providers/staff and patients/customers, for example in pharmacies or at the reception of GP offices/clinics and dental offices/clinics. Markings on the ground or on surfaces can be considered to indicate the physical distance that must be respected.
- The use of face masks by patients/customers and by healthcare providers/staff should be strongly considered at all times, as a means of source control and for personal protection. In particular, face masks for personal protection should be used by individuals belonging to vulnerable groups, e.g. the elderly or those with underlying medical conditions [23].
- Hand hygiene should be practiced frequently and meticulously by staff, patients and customers. Easy access to hand-washing facilities, single-use paper towels and alcohol-based hand rub solutions should be available and visible in various areas. Signs/posters about hand hygiene and on how to perform it correctly should be displayed (e.g. at arrival, in the waiting room, in the toilets).
- Respiratory hygiene, including suitable cough etiquette, should be followed scrupulously. This entails coughing or sneezing into a tissue or into the elbow. If a tissue is used, it should be disposed of carefully after a single use and followed by hand hygiene.
- PPE should be available in sufficient quantity and sizes.
- Frequently touched surfaces should be regularly cleaned with a neutral detergent.
- Increasing the number of air exchanges per hour will decrease the risk of transmission of SARS-CoV-2 in closed spaces. This may be achieved by natural ventilation (e.g. opening doors and windows) or by mechanical ventilation, depending on the setting [29].

Staffing and workplace considerations

- Perform a needs assessment based on the IPC measures described above; if necessary, consider increasing the number of staff to cope with the current patient load. Shortages of staff can affect stress levels and compliance with IPC measures. Therefore, a plan to deal with work overload, anticipating possible sick leaves, should be in place.
- Staff presenting with symptoms that are compatible with COVID-19 should be allowed to stop working or not report to work, self-isolate at home, and should be advised to contact health authorities, e.g. for testing or if their symptoms worsen, in accordance with national procedures.
- The psychological health needs of the staff should be considered and addressed as necessary.
- Where possible, a mechanism to organise and assign teleworking should be considered, along with a mechanism to provide staff with the necessary equipment to carry out their normal workload remotely.
- Staff whose presence is not absolutely indispensable for running the clinic/practice and staff members in quarantine who are otherwise healthy and able to work, could be assigned to strengthen telemedicine services if these are offered.
- Staff with underlying health conditions (e.g. immunodeficiency, diabetes, etc.) should preferably be assigned to activities with little or no contact with the patients/customers (e.g. phone, email or online consultation), as feasible.
- The use of electronic devices (computerisation of procedures, telemedicine, etc.), touchless devices, a paperless office, and the introduction or revision of procedures to reduce physical contact with patients/customers – without compromising the quality of the offered services – should be considered. Data gathered and stored must be compliant with the [General Data Protection Regulation 2016/679](#) [30] of the European Parliament and of the Council of 27 April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data.
- A plan to keep track and control use of key supplies (e.g. PPE, cleaning and disinfection material, alcohol-based hand rub solution, etc.) should be in place to avoid misuse and/or overuse of limited resources.
- If possible, materials, objects, and devices should be stored in a manner that facilitates additional environmental cleaning, for example in a clean storage room. Staff should be informed and reminded accordingly.

General practitioner and other specialty primary care clinics and practices

The following advice provides an outline of principles for developing more individualised guidance or operating procedures to reduce the risk of transmission of COVID-19 in GP offices/clinics and other primary care providers in the community (e.g. internists, paediatricians, etc.). The organisation of general practices/clinics varies considerably across Europe, from solo practices, group practices with two to three general practitioners to large community health centres with multidisciplinary teams [31,32]. In addition, several countries have implemented a triaging system, which refers patients with symptoms compatible with COVID-19 to centralised COVID-19 treatment centres run by medical teams that also include GPs.

The role of GPs in controlling the spread of COVID-19 in the community is important because they have a pivotal role in testing for SARS-CoV-2 and tracing contacts; GPs may decide whether possible cases that they see get tested for SARS-CoV-2 and can initiate contact tracing through the local public health authorities [33]. In the community/primary care setting, testing should be expanded to include all, or the majority of, patients who show symptoms of acute respiratory infections compatible with COVID-19, including through the winter season of increased infectious respiratory disease.

In addition, continuity of care for diseases other than COVID-19 needs to be ensured to avoid collateral damage of measures to prevent COVID-19 transmission [34]. There are several reports from European countries and the US about a decrease in the number of patients treated for acute myocardial infarction by roughly 50% during the COVID-19 pandemic [35]. Similar decreases in the diagnosis of the most common types of cancer have been reported [36]. In addition, an increase of out-of-hospital cardiac arrests has been reported that may be related to suboptimal treatment of acute heart problems [37]. The reason for these observations is most likely that patients avoided or delayed seeking medical care because of fear for getting infected with COVID-19, or because they were discouraged to seek care for health issues that were not urgent because of concerns about spread COVID-19 within healthcare and the impact of COVID-19 on the availability of hospital beds.

Staffing considerations

- If possible and supported by the national legal framework, conducting an initial clinical assessment over the phone or internet (e.g. consultations, prescription refills, follow ups, etc.) can be considered. Self-swabbing and secure shipment of samples from possible cases should be supported.
- If possible and supported by the national legal framework, the assessment of possible COVID-19 patients requiring medical attention in primary care can be performed in dedicated, mainly centralised assessment centres, staffed with one GP per area. This helps to optimise IPC practices and preserve resources.
- If the assessment of patients in primary care follows a decentralised approach, staff in group practices and community health centres can be allocated to two different teams: one taking care of symptomatic COVID-19 patients, and the other taking care of all other patients.
- All GPs need to be familiar with protocols on COVID-19 IPC measures, diagnostic methods, treatment, follow-up, notification of cases, and contact tracing.

Before the patient arrives

- Patients should be informed about the signs and symptoms of COVID-19 before the visit and should ideally contact the GP office/clinic by phone in advance of the visit.
- Due to the importance of early detection of mild COVID-19 cases and contact tracing, patients with mild symptoms need to be tested, depending on national policies. Patients can be referred to centralised assessment centres for testing, or get tested directly at a GP office/clinic. If available, samples taken by self-swabbing are an alternative when combined with safe shipment to a designated microbiological testing facility.
- Patients seeking primary care services who are living in the same household as someone who displays symptoms of COVID-19, should follow the same procedures as symptomatic COVID-19 patients if they require a face-to-face consultation, irrespective of whether they have symptoms themselves or not.
- Dedicated home visiting services should be considered for vulnerable patients.
- If national policies do not require testing for patients who experience mild symptoms compatible with COVID-19, face-to-face consultations may not be required for such patients, in which case they should be advised about further measures:
 - Patients with mild symptoms compatible with COVID-19 should be advised to self-isolate at home, self-monitor for symptoms, and contact health authorities if their symptoms worsen, in accordance with national procedures.
 - Patients with severe symptoms compatible with COVID-19 should be informed on how to access appropriate hospital care.
- Patients should not be accompanied to the GP office/clinic unless necessary, for example if they have a reduced score for activities of daily living (ADLs). They should be informed about the fact that they should not be accompanied before their arrival or at the reception.
- A service for the prescription of medication without the presence of the patient should be in place, especially for prescription refills.
- A record of all staff members that have been in contact with possible or confirmed COVID-19 cases should be retained.

During the patient visit

- Separate paths for triaged and non-triaged patients can be considered, depending on the set-up, size and resources of the GP office/clinic. Procedures to separate possible COVID-19 cases from other patients should be in place if the clinic's set-up, size and resources allow for it. Such procedures should include dedicated staff, waiting rooms and examination rooms.
- If the patient has been tele-triaged and only comes in to get tested for COVID-19 and/or oximetry, performing all procedures directly outside the GP office/clinic should be considered. For example, testing could be performed with patients waiting in their cars or in a tent outside the building.
- During the influenza season, consider testing patients with acute respiratory infections for both SARS-CoV-2 and influenza (and, if possible, other respiratory viruses such as RSV) to inform clinical management and public health measures.
- When visiting a GP office/clinic, patients should always practice physical distancing (at least 1.5 metres) when other patients are waiting. An even better alternative is to only have one single patient in the waiting room at a time.
- In areas with community transmission of COVID-19, patients should wear face masks as soon as they enter the building and in particular in the waiting area. Inside the GP office/clinic, patients with symptoms compatible with COVID-19 should follow the COVID-19 paths for symptomatic patients, wearing a medical face mask to avoid transmitting COVID-19 to other persons (source control).
- Patients visiting the GP office/clinic should be asked to perform hand hygiene. Information on how to perform proper hand hygiene should be available. Handwashing facilities and/or alcohol-based hand rub solution should be readily available.
- Consider closing down areas in waiting rooms that have a playground or toys for children; remove the toys. Magazines, books or other non-essential objects that patients/companions may touch should also be removed.
- Healthcare professionals should wear PPE in the following situations:
 - when performing triage, examining or providing care to patients with symptoms compatible with COVID-19
 - when performing high-risk procedures (e.g. physical examination of the oropharynx or nasopharyngeal swabbing) in patients with or without symptoms compatible with COVID-19.
- The suggested set of PPE includes:
 - FFP2/3 respirator¹ (or medical face mask if there is a shortage of FFP2/3 respirators), and goggles or face shield.
 - In addition, consider the use of gloves and a long-sleeved gown, especially if there is a risk of exposure to body fluids.

If wearing gloves, these must be changed between patients, and meticulous hand hygiene must be performed before putting on and after removing PPE. If changing gloves between patients cannot be guaranteed, meticulous hand hygiene without using gloves is preferred over the prolonged use of gloves.

Patient follow-up and information

- If patients show mild symptoms compatible with COVID-19, they should be advised to self-isolate at home and self-monitor for severe symptoms. Patients should be advised on how to contact healthcare providers (e.g. GPs, hospital, dedicated COVID-19 tele-triage) if their symptoms worsen and in accordance with national procedures. As a possible option, patients that need close monitoring could be provided with devices for self-monitoring (e.g. oximeters), provided training on how to use these devices, and informed about follow-up procedures. Follow-ups can be done by phone, email, videoconference or, if available, through an electronic platform that allows patients to enter data into an electronic system that automatically alerts healthcare providers/staff.
- People with risk factors who could have severe outcomes from COVID-19 infection should be offered information on COVID-19 and what measures they should take to reduce their own risk of getting infected.
- Information on COVID-19 should be available for all types of patients/household members and in different formats (e.g. posters, infographics and leaflets). Attention should be paid to individuals with sensory impairment and different linguistic needs.
- It is important that confirmed or possible COVID-19 cases whose clinical situation allows them to stay at home are well informed of the symptoms that should make them seek medical attention, thus avoiding severe outcomes or inversely unnecessary visits to the healthcare centre. Patients/household members should be informed on how to self-monitor for symptoms.

¹ Due to the risk posed by asymptomatic and pre-symptomatic patients, the use of a facial filtering piece (FFP) respirator class 2 or 3 should also be considered when caring for patients without COVID-19-compatible symptoms during the COVID-19 pandemic.

After the patient leaves

- All rooms (e.g. waiting rooms and consultation rooms) visited by a possible or confirmed case of COVID-19 should be naturally or mechanically ventilated, depending on the setting [29]. When a mechanical ventilation system is in place, the air should be exchanged 6 to 10 times per hour, depending on the national standards [38-40]. Where mechanical ventilation is not available, the rooms need to be naturally ventilated at regular intervals, with the required ventilation time depending on the size of the room, the number of windows and doors that can be opened, the outside temperature and the airflow/wind [38,39]. The precise requirements for the type and duration of ventilation before the next patient, which is especially important if an AGP was performed, may be subject to an agreement with local health authorities.
- The floor and frequently touched surfaces of examination rooms that were visited by a possible or confirmed case of COVID-19 should be carefully cleaned with a neutral detergent, followed by decontamination of surfaces with a disinfectant effective against viruses. Several products with viricidal activity are licensed in the national markets and can be used following the manufacturer's instructions. Alternatively, 0.05%–0.1% sodium hypochlorite (NaClO), i.e. dilution 1:50 if household bleach is used (household bleach usually has an initial concentration of 2.5–5% sodium hypochlorite) can be used. For surfaces that can be damaged by sodium hypochlorite, products based on ethanol (at least 70% volume/volume) can be used for decontamination after cleaning with a neutral detergent.
- Cleaning of toilets, bathroom sinks and sanitary facilities needs to be carefully performed, avoiding splashes. Disinfection should take place after normal cleaning by applying a disinfectant effective against viruses, or 0.1% sodium hypochlorite.
- The use of single-use disposable cleaning equipment (e.g. disposable towels) is recommended. If disposable cleaning equipment is not available, the cleaning materials (cloth, sponge, etc.) should be placed in a disinfectant solution effective against viruses, or 0.1% sodium hypochlorite. If neither solution is available, the material should be discarded.
- If there is a shortage of cleaning equipment, the cleaning process should proceed from the cleanest to the least clean areas (example of the latter: an area where an aerosol generating procedure has been performed).
- Staff engaged in environmental cleaning in healthcare settings should wear PPE. The minimal PPE set listed below is suggested when cleaning healthcare facilities that are likely to be contaminated by SARS-CoV-2:
 - medical face mask
 - disposable long-sleeved water-resistant gown
 - eye protection (goggles or face shield)
 - gloves
- Hand hygiene should be performed every time PPE (gloves, face masks, etc.) is removed.
- Staff engaged in waste management should wear PPE. They should be informed and trained in the correct use of PPE, in all relevant procedures, and in the involved risks. Infectious clinical waste should be treated in accordance with healthcare facility policies and local regulations.

Dental offices and clinics

The following advice intends to provide an outline of principles for developing more individualised guidance or operating procedures to reduce the risk of transmission of COVID-19 in dental offices/clinics.

Before the patient arrives

- The possibility to postpone routine dental care should be considered in areas with high community transmission of COVID-19, due to the possibility of transmission by asymptomatic and pre-symptomatic patients. When possible, patients should avoid visiting a dental office/clinic if they are experiencing symptoms compatible with COVID-19.
- If a visit is necessary, patients should be encouraged to contact the dental office/clinic beforehand to define the best treatment plan, and should access the dental office/clinic only by appointment; visits should be scheduled with adequate time between appointments in order to minimise contact with other patients in the waiting room.
- A dedicated path for patients showing symptoms compatible with COVID-19 in need of emergency or urgent dental care should be in place, including appropriate protocols and procedures. If possible, patients with confirmed COVID-19 in need for emergency or urgent dental care should be referred to a designated dental care facility. These facilities usually have a dedicated COVID-19 path and dedicated well-ventilated room.
- Patients should be informed about signs and symptoms of COVID-19 before the visit. They should also receive information about the measures to reduce the risk of infection. Special communication strategies should be considered for patients with risk factors for severe outcome of COVID-19 infection.

- All patients should be triaged remotely before visiting a dental office/clinic. A procedure should be in place if a patient visits a dental office/clinic without previous appointment or triage (triage of symptoms, urgency of the consultation, patient placement, etc.).
- Patients should not be accompanied to the dental office/clinic unless necessary, for example if they have a reduced score for activities of daily living (ADLs). They should be informed about the fact that they should not be accompanied before their arrival or at the reception.

During dental care

- When visiting a dental office/clinic, patients should always practice physical distancing (at least 1.5 metres) when other patients are waiting. An even better alternative is to only have one single patient in the waiting room at a time.
- In areas with high community transmission, patients should wear face masks as soon as they enter the building and in all the common areas of dental practices.
- The suggested set of PPE for staff when caring for all patients includes:
 - an FFP2/3 respirator² (or a medical face mask if there is a shortage of respirators)
 - goggles or a face shield
 - gloves
 - and a long-sleeve, water-resistant gown.
- FFP2/3 respirators should be prioritised for:
 - aerosol-generating procedures (AGPs)³
 - when caring for patients showing COVID-19-compatible symptoms for whom treatment cannot be deferred
 - when caring for patients living in the same household with a possible or confirmed COVID-19 case.
- The choice between a FFP2/3 respirator rather than a medical face mask should be aided by an on-site risk assessment that takes into account the local prevalence of COVID-19 and the likelihood that the consultation will include an AGP.
- AGPs (e.g. high-speed dental drilling) should be avoided as much as possible (e.g. by using alternative non-aerosol-producing techniques if available). When the procedure cannot be deferred, the risk can be minimised by applying, for example, rubber dam isolation, the use of high-vacuum aspirators/suction, and scheduling AGPs in a way that allows for adequate time and proper cleaning protocols.
- If COVID-19-compatible symptoms are identified in a patient during dental care, the patient must be managed following the national or sub-national COVID-19 guidelines.

After the patient leaves

- PPE should be carefully removed by the staff following the correct sequence and procedure.
- Strict hand hygiene should be performed immediately after the removal of PPE.
- Non-disposable equipment should be disinfected in accordance with the manufacturer's instructions.
- If an AGP was performed, the room needs to be naturally or mechanically ventilated before admitting a new patient; the method and degree of required ventilation depends on the type of dental procedure, available anti-aerosol devices, the size of the room, and the presence of windows. When a mechanical ventilation system is in place, the air should be exchanged 6 to 10 times per hour, depending on the national standards. Where mechanical ventilation is not available, the rooms need to be naturally ventilated at regular intervals, with the required ventilation time depending on the size of the room, the number of windows and doors that can be opened, the outside temperature and the airflow/wind [38-41] (ref). The precise requirements for the type and duration of ventilation before the next patient, which is especially important if an AGP was performed, should follow national recommendations or may be subject to an agreement with local health authorities.
- Similarly, frequently touched surfaces or objects in the room should be carefully cleaned and disinfected before admitting a new patient.

² Due to the risk posed by asymptomatic and pre-symptomatic patients, the use of a facial filtering piece (FFP) respirator class 2 or 3 should also be considered when caring for patients without COVID-19-compatible symptoms during the COVID-19 pandemic.

³ Dental procedures using high speed devices such as ultrasonic scalers and high speed drills (https://hpspubsrepo.blob.core.windows.net/hps-website/nss/2893/documents/1_tbp-lr-agp.pdf)

- The floor and frequently touched surfaces of examination rooms that were visited by a possible or confirmed case of COVID-19 should be carefully cleaned with a neutral detergent, followed by decontamination of surfaces with a disinfectant effective against viruses. Several products with viricidal activity are licensed in the national markets and can be used following the manufacturer's instructions. Alternatively, 0.05%–0.1% sodium hypochlorite (NaClO), i.e. dilution 1:50 if household bleach is used (household bleach usually has an initial concentration of 2.5–5% sodium hypochlorite) can be used. For surfaces that can be damaged by sodium hypochlorite, products based on ethanol (at least 70% volume/volume) can be used for decontamination after cleaning with a neutral detergent.
- Cleaning of toilets, bathroom sinks and sanitary facilities needs to be carefully performed, avoiding splashes. Disinfection should take place after normal cleaning by applying a disinfectant effective against viruses, or 0.1% sodium hypochlorite.
- The use of single-use disposable cleaning equipment (e.g. disposable towels) is recommended. If disposable cleaning equipment is not available, the cleaning materials (cloth, sponge, etc.) should be placed in a disinfectant solution effective against viruses, or 0.1% sodium hypochlorite. If neither solution is available, the material should be discarded.
- The use of dedicated equipment for cleaning different areas of a dental office/clinic is recommended.
- If there is a shortage of cleaning equipment, the cleaning process should proceed from the cleanest to the less clean areas (example of the latter: an area where an AGP has been performed).
- Staff engaged in environmental cleaning in healthcare settings should wear PPE. The minimal PPE set listed below is suggested when cleaning healthcare facilities that are likely to be contaminated by SARS-CoV-2:
 - medical face mask
 - disposable long-sleeved water-resistant gown
 - eye protection (goggles or face shield)
 - gloves.
- Hand hygiene should be performed every time PPE (gloves, face masks, etc.) is removed.
- Staff engaged in waste management should wear PPE. They should be informed and trained in the correct use of PPE, in all relevant procedures, and in the involved risks. Waste should be handled in accordance with healthcare facility policies and national or local regulations [42].

Pharmacies

The following advice provides an outline of principles for developing more individualised guidance or operating procedures to reduce the risk of transmission of COVID-19 in pharmacies.

In the pharmacy

- Consider installing glass or plastic panels at the counters to protect the staff from respiratory droplets from customers. Installation of glass/plastic panels does not remove the need for staff and customers to respect physical distance.
- Signs at the entrance of the pharmacy should be considered, informing customers about the symptoms of COVID-19 and instructing them what to do if they experience symptoms (e.g. 'do not enter the pharmacy', 'call by phone instead and wait outside or in your vehicle', etc.).
- Pharmacy staff should consider wearing a medical face mask.

For the customers

- Customers should avoid visiting the pharmacy if they are experiencing symptoms compatible with COVID-19.
- Physical distance (at least 1.5 metres) between the customer and other people in the pharmacy (both staff and customers) should be guaranteed. To this end, the total number of customers in the pharmacy at any time may have to be restricted. When the maximum number of customers in the pharmacy is reached, further customers should queue outside of the pharmacy and respect physical distance (at least 1.5 metres) until the number of customers in the pharmacy is low enough for them to enter. Floor/ground markings indicating safe distancing can be considered, both in and out of the pharmacy.
- In areas of community transmission of COVID-19, consider requesting that all visiting customers wear a face mask inside the pharmacy and in queues (as a means of source control to prevent spread and for self-protection).
- Customers should be advised about further measures:
 - If they show mild symptoms compatible with COVID-19, they should be advised to self-isolate at home and self-monitor for symptoms. Customers should be advised to contact healthcare e.g. for testing or if their symptoms worsen, in accordance with national procedures.
 - If they show severe symptoms compatible with COVID-19, they should be advised to contact healthcare services promptly; alternatively, the pharmacist could contact healthcare services on their behalf. This should be done in accordance with national procedures.

Home delivery of medicines

- A simplified process for ordering medicines that require prescription (e.g. direct communication with the prescriber, digital transfer of prescriptions, etc.) should be considered where allowed.
- Home delivery of medicines should be considered to reduce the number of patients visiting the pharmacy.
- Before delivering medicines, pharmacists should always check with customers whether they, or any of their household members, are experiencing symptoms compatible with COVID-19 (such as fever and cough) or whether they are self-isolating or in quarantine.
- Physical distance should be maintained when medicines are delivered to a person's home.

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