Dental Council
Te Kaunihera Tiaki Niho

17 November 2014

Dear practitioner

Consultation on a proposed Transmissible Major Viral Infections Code of Practice

The Dental Council ('the Council') established the Transmissible Major Viral Infections (TMVI) working group to assist in the review of the Council's current TMVI code of practice. The working group was tasked to investigate and report on local and international TMVI guidelines, policies and research, and develop a draft TMVI code of practice.

The working group's report and the draft TMVI code were submitted to the Council at its October meeting. The working group's recommendations and the draft TMVI code of practice were approved by the Council for consultation with stakeholders.

Consequently, the Council is seeking feedback on a draft of the proposed TMVI code of practice, enclosed as Attachment 1.

Consultation Questions

Stakeholders are invited to comment on the proposed TMVI code of practice by responding to the following questions:

Q1. Do you agree/disagree with the proposed TMVI code of practice? If you disagree, please detail why.

Q2. Does any element of the proposed TMVI code of practice require clarification or further guidance? Please explain.

Q3. Do you have any further comments on the proposed TMVI Code of Practice?

In accordance with the Council's *Guidelines on Consultation*, the consultation document has been made available to all practitioners, relevant associations and societies, the Ministry of Health, District Health Boards, educational institutions and other organisations with an interest in this area. The objective of the consultation is to gather views from stakeholders to inform the Council's decision on the proposed Transmissible Major Viral Infections Code of Practice. The consultation document will also be published on the Council's website, with a similar invitation to comment.

The Council seeks any comments on the proposal by the close of business on **30 January 2015**.

Responses should be sent to:

Dental Council
PO Box 10-448
Wellington 6143
Fax: 04 499 1668
Email: consultations@dcnz.org.nz

Yours sincerely

Marie Warner
Chief Executive

Consultation Document for the proposed Transmissible Major Viral Infections Code of Practice

Issued: 17 November 2014

Submission closing date: 30 January 2015

Dental Council
Te Kaunihera Tiaki Niho

Proposed Transmissible Major Viral Infections Code of Practice

1.0 Introduction

In March 2014 the Dental Council ('the Council') established the Transmissible Major Viral Infections (TMVI) working group to assist in the review of the Council's current TMVI code of practice. The working group was tasked to investigate and report on local and international TMVI guidelines, policies and research, and develop a draft TMVI code of practice.

The working group comprised of:

- Prof Anita Nolan (Chair), registered Oral Medicine Specialist, Professor of Oral Medicine, Head of Oral Health at AUT University. Anita is also a member of the Council's Standards Review Committee.
- Dr Kim Gear - registered Oral Medicine Specialist and General Dentist, practising in Auckland.
- Dr Arlo Upton – registered with Medical Council of New Zealand (MCNZ) with vocational scope of practice in Internal Medicine (infectious diseases) and Pathology (clinical microbiology), Clinical Microbiologist - Labtests Auckland and employed by Counties Manukau District Health Board for viral hepatitis clinic.

The working group reviewed local and international policy documents used in the initial work stream investigations related to the TMVI code of practice, along with additional relevant literature, and held discussions with the Medical Council of New Zealand related to their TMVI guidelines review.

The documents reviewed by the working group are listed in the References section of the draft TMVI code of practice.

The working group's report and the draft TMVI code of practice were considered by the Council at its October meeting. The working group's recommendations and the draft TMVI code of practice were approved by the Council for consultation with stakeholders.

Consequently, the Council is seeking feedback on a draft of the proposed TMVI code of practice from stakeholders.

2.0 Purpose of the TMVI code of practice

The primary purpose of the proposed TMVI code of practice is to clearly communicate standards and processes to prevent transmission of hepatitis B (HBV), hepatitis C (HCV) and human immunodeficiency virus (HIV) from practitioner to patient only, with the principal aim of protecting patients.

Standards related to preventing transmission of infection (including TMVIs) among all individuals in the clinical environment can be found in *The Dental Council Control of Cross Infection in Dental Practice* code of practice.

This clear separation of the two standards is consistent with the approach taken in reviewed local and international TMVI guidelines and policies.

2.1 Who the TMVI code of practice applies to

The proposed TMVI code of practice will apply to all registered oral health practitioners: dentists, dental specialists, dental therapists, dental hygienists and orthodontic auxiliaries, dental technicians, and clinical dental technicians.

Several recommendations are proposed within the TMVI code of practice related to students and non-registered staff. The Council recognises that neither students nor non-registered staff are regulated under the Health Practitioners Competence Assurance Act 2003 ('the Act'), and compliance by these groups cannot be monitored.

However, these recommendations communicate the Council's expectation that these groups' practice should align with the TMVI standards for registered oral health practitioners, for the protection of the health and safety of patients.

3.0 Summary of principal changes within the revised TMVI code of practice

The interpretation of the requirements in the proposed TMVI code is as follows:

Must – A requirement expressed as "must" is a minimum standard that all oral health practitioners must adhere to and comply with.

Should – A requirement expressed as "should" is a strong recommendation, but compliance will not be monitored.

3.1 Exposure–prone procedures

Transmission of TMVI's from practitioner to patient is at greatest risk of occurring when exposure – prone procedures (EPPs) are performed by an infected practitioner. EPPs present a risk of injury to the practitioner's hands that may result in the exposure of the patient's tissues to the blood of the practitioner.

The majority of procedures performed by oral health practitioners are exposure-prone procedures.

The following definition of an exposure –prone procedures (EPP) is proposed in the draft TMVI code of practice, as standard 4.1:

"The simultaneous presence of a health-care provider's hands and a needle or other sharp instrument or object (e.g. bone spicule or tooth), in a poorly visualised or highly confined anatomic site, including the mouth"

This definition is consistent with the definition of an EPP from local and international sources reviewed.

3.2 HBV Vaccination

Immunisation is a key means of protection against HBV.

The proposed TMVI code of practice recommends that oral health practitioners, non-registered staff and students be vaccinated for HBV if not already immune and not infected, and be re-tested

following vaccination to confirm immunity. Documented evidence of immunity to HBV is recommended for oral health practitioners.

Although HBV vaccination primarily protects the recipient against HBV infection, it decreases the likelihood of transmission of HBV to patients by reducing the incidence of HBV infection among practitioners, thus protecting the public.

For non–registered staff this recommendation is primarily for their own protection.

3.3 HBV, HCV and HIV testing requirements

Key to preventing the transmission of a TMVI from a practitioner to a patient is the practitioner knowing their status in relation to HBV, HCV and HIV.

A summary of the proposed requirements for oral health practitioners related to HBV, HCV and HIV testing, follows:

Registration applicants

It is proposed that all oral health practitioner registration applicants **must:**

- seek testing to determine their serological status in relation to HCV and HIV; and
- supply evidence of immunity to HBV or undergo testing to determine serological status in relation to HBV.

It is further recommended that the above testing first occurs before prospective oral health practitioners commence any Council-accredited programme of study; in the interests of public safety and in fairness to infected student practitioners whose status may affect their ability to register and practise in the future.

Registered oral health practitioners

Registered oral health practitioners who know they are not infected with HBV, HCV or HIV:

- the proposed TMVI code of practice does not require testing unless the practitioner may have been exposed to HBV,HCV or HIV through personal risk behaviour, non-occupational exposure to blood products or occupational accidents (eg contaminated sharps injury).

In the event of exposure to HBV, HCV or HIV, oral health practitioners:

- must seek testing to determine their serological status; and
- should seek medical advice regarding appropriate exposure–prone prophylaxis following exposure (a table of post-exposure prophylactic regimes is provided within the proposed TMVI code of practice), and follow-up requirements.

If a positive test result (as the indicator of infection), is received for HBV, HCV or HIV the practitioner **must**:

- stop performing exposure-prone procedures (EPPs) immediately and not recommence performing EPPs until permitted by the Council; and
- promptly advise the Registrar of the Council; and
- consult a medical practitioner for determination of further tests and referral to a specialist medical practitioner/s for ongoing care; and

- undergo further testing to confirm infection and determine viral load, as the measure of infectivity; and

- submit results of further tests and related medical reports to the Registrar of the Council.

This required practitioner response is summarised as a flow diagram and provided as Appendix A to the proposed TMVI code of practice.

The proposed TMVI code of practice defines a positive test result and details further testing requirements to confirm infection and determine viral load (as the indicator of the level of infectivity).

3.4 Care of the infected practitioner

The proposed TMVI code of practice states that an infected oral health practitioner should be under the regular care of a specialist medical practitioner/s, such as a specialist infectious diseases physician, specialist gastroenterologist or hepatologist, or similar, for ongoing care.

3.5 TMVI panel

The Council is proposing to establish a TMVI panel of subject-matter experts to review individual cases of TMVI infected practitioners, make recommendations to the Council regarding any proposed limitations on practice, if required, and provide oversight of the practitioner's case.

The TMVI panel would provide the expertise required to consider the complexities of infected practitioner cases and reliably judge the most appropriate medical management and limitations on practice (if any) for recommendation to the Council. This would ensure a consistent approach to the interpretation of standards and the management of infected practitioner cases.

It is proposed that the TMVI panel and the infected practitioner's specialist medical practitioner work collaboratively to support and rehabilitate the infected practitioner. A major benefit of this collaborative approach is that the Council would be able to rely on the judgment and oversight of both the specialist practitioner/s and the members of the TMVI panel in the management of a TMVI infected practitioner.

The principle of a TMVI expert-panel to oversee practitioner cases and advise the regulatory body on proposed limitations to the infected practitioner's practice is consistent with reviewed local and international TMVI guidelines and policies.

3.6 Notification obligations to the Council and limitations and conditions on practice

A registered health practitioner and an employer of an oral health practitioner have a legal obligation under the Act to notify the Council of any doubts about a practitioner's fitness to practise and if the practitioner may be unable to perform the functions required of their profession.

In the proposed TMVI code of practice a practitioner with a positive test result for HBV, HBC and HIV must immediately stop performing EPPs, notify the Registrar of the Council and can only recommence performing EPPs following the Council's permission.

The Council could impose limitations or conditions on practice, if necessary, following consideration of the TMVI panel recommendations.

Factors to be considered by the TMVI panel in determining the necessity and nature of proposed limitations or conditions on practice are listed within the proposed TMVI code of practice, along with proposed viral load levels that the TMVI panel may consider safe for a practitioner to perform EPP's.

3.7 Notification obligations of infected status to patients

There is no requirement for oral health practitioners to inform patients of their HBV, HCV or HIV status. An oral health practitioner, like any other person, has the right to privacy and confidentiality where there is no risk to the public.

However, an oral health practitioner must inform a patient of his/her (the practitioner's) infected status subsequent to an injury while performing EPPs, if advised to do so by the TMVI panel.

4.0 Consultation Questions

Stakeholders are invited to comment on the proposed TMVI code of practice by responding to the following questions:

Q1. Do you agree/disagree with the proposed TMVI code of practice? If you disagree, please detail why.

Q2. Does any element of the proposed TMVI code of practice require clarification or further guidance? Please explain.

Q3. Do you have any further comments on the proposed TMVI code of practice?

Attachment 1

DRAFT

Transmissible Major Viral Infections

Code of Practice

Dental Council
Te Kaunihera Tiaki Niho

Contents

1. Purpose

1.1 Registered oral health practitioners have a responsibility to put their patients' interests first, and to protect those interests by practising safely and providing good care. A key element of safe practice is preventing transmission of hepatitis B virus (HBV), hepatitis C virus (HCV) and human immunodeficiency virus (HIV) to patients.

1.2 HBV, HCV and HIV can be collectively termed 'Transmissible Major Viral Infections' (TMVIs).

1.3 The purpose of the *Transmissible Major Viral Infections Code of Practice* (the code) is to set minimum standards for registered oral health practitioners to ensure the transmission of TMVIs is prevented, *specifically* from practitioner to patient.

1.4 The code applies to dentists, dental specialists, dental hygienists, dental therapists, clinical dental technicians, dental technicians and orthodontic auxiliaries.

1.5 The greatest risk of transmission of TMVIs to patients within oral health practice occurs when an infected practitioner performs exposure-prone procedures.

1.6 The Code of Health and Disability Services Consumers' Rights provides that every consumer has the right to have services provided with reasonable care and skill (Right 4(1)) and that comply with legal, professional, ethical, and other relevant standards (Right 4(2)).

1.7 The Dental Council ('the Council') believes that these standards best ensure a balance between safeguarding the public, and the rights and interests of oral health practitioners.

1.8 Patients with HBV, HCV or HIV **must** not be refused care because of their infection or sero-positive status unless other appropriate arrangements are made by the oral health practitioner for the care of that individual.

2. Interpretation of requirements

Must – A requirement expressed as "must" is a minimum standard that all oral health practitioners must adhere to and comply with.

Should – A requirement expressed as "should" is a strong recommendation, but compliance will not be monitored.

3. Adherence to standard precautions and cross infection control practices

3.1 The available medical and scientific literature shows that the most effective means of preventing HBV, HCV and HIV transmission in health care settings is by strict adherence to standard precautions and established cross infection control practices, including the appropriate use of barrier precautions and the safe handling of sharp instruments. Standard precautions decrease the opportunity of direct exposure to blood and body fluids for both practitioners and patients.

3.2 *The Dental Council Control of Cross Infection in Dental Practice* Code of Practice sets out standard precautions and cross infection control practices to prevent infection (including TMVI's) among all individuals in the clinical environment; while the TMVI code sets out the minimum standards to prevent transmission of TMVI's from a practitioner to a patient.

4. Exposure-prone procedures

4.1 Exposure–prone procedures (EPPs) can be defined as:

The simultaneous presence of a health-care provider's hands and a needle or other sharp instrument or object (e.g. bone spicule or tooth), in a poorly visualised or highly confined anatomic site, including the mouth.

4.2 EPPs present a risk of injury to the health care provider's hands that may result in the exposure of the patient's tissues to the blood of the health care provider.

5. Initial testing for HBV, HCV and HIV

5.1 All oral health practitioner registration applicants **must** seek testing to determine their serological status in relation to HCV and HIV. Registration applicants **must also** either supply: evidence of immunity to HBV; or undergo testing to determine serological status in relation to HBV.

5.2 It is **strongly recommended** that this testing first occurs before prospective oral health practitioners commence any Council-accredited programme of study, particularly those programmes during which exposure prone procedures are performed routinely.

5.3 This recommendation is made in the interests of both student and public safety. Infection with these viruses may affect a practitioner's ability to register and practise in the future.

5.4 Testing for HBV, HCV and HIV infection at regular intervals is not required, unless prescribed by a medical practitioner.

6. HBV Vaccination

6.1 Immunisation is a key means of protection against HBV.

6.2 All oral health practitioners **should** be vaccinated for HBV if testing confirms they are not already immune and not infected; and re-tested to confirm immunity following vaccination.

6.3 Evidence of immunity to HBV infection is demonstrated by the presence of antibodies to the HBV surface antigen (Anti-HBs) and absence of the HBV surface antigen (HBsAg).

6.4 All oral health practitioners **should** have documented evidence of their immunity to HBV infection, i.e. a documented antibody level of >10IU/L at some point after infection and/or vaccination.

6.5 Once immunity to HBV is established, re-testing is only required in the event of an exposure to HBV through personal risk behaviour, non-occupational exposure to blood products or occupational accidents (e.g. contaminated sharps injury).

6.6 If vaccination does not successfully establish immunity, oral health practitioners **should be**:

(a) referred for specialist advice, perhaps for consideration of alternative methods of vaccine administration, and

(b) be offered HBV specific immunoglobulin following recognised exposure to HBV infection.

6.7 It is **strongly recommended** that all students are vaccinated for HBV if not already immune and not infected, and re-tested to confirm immunity following vaccination.

7. Following exposure

7.1 Oral health practitioners who may have been exposed to HBV, HCV or HIV through personal risk behaviour, non-occupational exposure to blood products or occupational accidents (e.g. contaminated sharps injury) **must** seek testing to determine their serological status. This applies even when immunity to HBV has previously been determined.

7.2 In the event of a contaminated sharps injury to a practitioner as a result of an accidental EPP, the oral health practitioner **must** follow:

(a) *The procedure following needle-stick injury* on pg.10 of the *Dental Council Control of Cross Infection in Dental Practice* Code of Practice, as applicable, to safeguard their own health, and

(b) The procedure detailed in 12.1 of this code, to safeguard the patient's health.

7.3 All oral health practitioners **should** seek medical advice regarding appropriate post-exposure prophylaxis following exposure to TMVI's and follow-up requirements; this is especially important for practitioners who do not have immunity to HBV.

Post-exposure prophylaxis		
HBV	HCV	HIV
Post-exposure vaccination and immunoglobulin should be offered by a medical practitioner, as appropriate, within 72 hours of exposure to HBV (or 7 days in some exceptional circumstances).	There is no post-exposure prophylactic regime following exposure to HCV at this time.	Post-exposure prophylaxis with anti-viral medications should be offered by a medical practitioner, as appropriate, as soon as possible following exposure to HIV.

7.4 It is strongly recommended that students who may have been exposed to HBV, HCV or HIV through personal risk behaviour, non-occupational exposure to blood products or occupational accidents (e.g. contaminated sharps injury) should seek testing to determine their serological status and obtain medical advice regarding appropriate post-exposure prophylaxis.

8. Positive test results for HBV, HCV and HIV

8.1 An oral health practitioner with a positive test result which indicates HBV, HCV or HIV infection, must do the following:

- stop performing EPPs immediately and not recommence performing EPPs until permitted by the Council; and
- promptly advise the Registrar of the Council; and
- consult a medical practitioner for determination of further tests and referral to a specialist medical practitioner/s for ongoing care; and
- undergo further testing to confirm infection and determine viral load, as the measure of infectivity; and
- submit further test results and related medical reports to the Registrar of the Council.

8.2 An infected practitioner's case will be referred to the TMVI panel who will make recommendations to the Council regarding any proposed limitations on practice, if required, and provide oversight of the practitioner's case with the purpose of supporting and rehabilitating the practitioner.

8.3 An oral health practitioner who is infected with HBV, HCV or HIV, or with a test result indicating HBV, HCV or HIV infection, **must not** continue to practise merely on the basis of his/her own assessment**. Permission from the Council is required before a practitioner can recommence performing EPPs.**

8.4 If infection with HBV, HCV or HIV is confirmed, an oral health practitioner should be under the regular care of a suitably qualified specialist medical practitioner/s, such as a specialist infectious diseases physician, specialist gastroenterologist or hepatologist, or similar.

8.5 The specialist medical practitioner/s responsible for the care of the infected practitioner should work collaboratively with the TMVI panel in the support and rehabilitation of the infected practitioner.

8.6 The required practitioner response following positive test results for HBV, HCV and HIV is summarised as a flow diagram and provided as Appendix A.

HBV

8.7 An oral health practitioner who tests positively for HBsAg and/or HBeAg or who has an isolated positive test result for anti-HBc in the absence of HBsAg and anti-HBs must undergo an HBV DNA test, to confirm active infection and measure viral load.

8.8 If the HBV viral load is greater than 1000 IU/ml, this is considered infectious.

8.9 If the HBV viral load is maintained at a level lower than 1000 IU/ml, the Council will likely allow an infected oral health practitioner to perform exposure-prone procedures.

8.10 Permission from the Council is required before a practitioner can recommence EPPs.

8.11 It is expected that the majority of HBV infected practitioners could achieve adequate viral suppression with long-term viral therapy.

HCV

8.12 Anti-HCV (hepatitis C virus antibodies) do not neutralise the hepatitis C virus and do not provide protection against this viral infection.

8.13 An oral health practitioner who tests positively for anti-HCV **must** undergo an HCV RNA test to confirm their infectious status.

8.14 A positive test result for HCV RNA indicates infected status.

8.15 Oral health practitioners **must** be HCV RNA negative (non-infected) to perform exposure-prone procedures.

8.16 Permission from the Council is required before a practitioner can recommence EPPs.

8.17 It is expected that the majority of HCV infected practitioners will be treated and cured (HCV RNA negative).

HIV

8.18 An oral health practitioner who tests positively for the presence of HIV antibodies and/or HIV antigen **must** undergo a western blot and/or a HIV RNA test to confirm infection and an HIV RNA test to determine viral load.

8.19 Oral health practitioners **must** have an undetectable level of HIV RNA to perform exposure-prone procedures. The undetectable level of HIV RNA is defined by the lowest detectable level of the assay used.

8.20 Permission from the Council is required before a practitioner can recommence EPPs.

8.21 It is expected that the majority of HIV infected practitioners could achieve adequate viral suppression with long-term anti-viral therapy.

9. Registration and limitations on practice

9.1 HBV, HCV or HIV infection alone does not justify refusing registration of an oral health practitioner; limiting their scope of practice; or placing conditions on their practice.

9.2 Limitations or conditions on practice, if any, shall be determined on a case by case basis, after consideration of all influencing factors which include, but are not limited to:

- the virus the oral health practitioner is infected with
- the concentration of the virus in the oral health practitioner's blood
- the ability of anti-viral treatment to be able to control the oral health practitioner's viral load below levels of recognised risk of transmission
- the arrangements put in place to ensure consistent effective treatment and regular monitoring

- the nature of the procedures the oral health practitioner performs
- the availability of prompt care for patients in the event of an EPP accident.

9.3 The Council may exercise its statutory functions to impose conditions on an oral health practitioner's scope of practice; or suspend the practitioner's registration, if that practitioner has not modified their practice in order to safeguard patients, as required by the Council.

10. Notification obligations

10.1 In accordance with Section 45 of the Health Practitioners Competence Assurance Act 2003:

- Any registered oral health practitioner who knows or suspects he/she is infected with HBV, HCV or HIV must inform the Registrar of the Council.
- Any registered health practitioner who has reason to believe an HBV, HCV or HIV infected oral health practitioner is not complying with their obligation under the Code or any l Council requirements, must promptly give the Registrar of the Council written notice of all the circumstances. The same obligation applies to any organisation that supplies health services, any employer of the infected practitioner, or any medical officer of health.
- Any registered health practitioner who has reasonable grounds to believe a registered oral health practitioner is infected with HBV, HCV or HIV, and that the infected practitioner is unable to perform the functions required of them because of that infection, must promptly give the Registrar of the Council written notice of all the circumstances. The same obligation applies to any organisation that supplies health services, any employer of the infected practitioner, or any medical officer of health.

10.2 Oral health practitioners are not required to inform patients of their HBV, HCV or HIV status. An oral health practitioner, like any other person, has the right to privacy and confidentiality where there is no risk to the public.

10.3 An infected oral health practitioner must inform a patient of his/her (the practitioner's) infected status subsequent to an injury while performing EPPs, if advised to do so by the TMVI panel.

11. Obligations to non-registered staff

11.1 It is **strongly recommended** that all non-registered staff assisting with clinical activities are tested to determine their status in relation to HBV at the start of employment, with the purpose of encouraging vaccination, primarily for their own protection.

11.2 It is **strongly recommended** that all non-registered staff members assisting with clinical activities are vaccinated for HBV if not immune and not infected when tested, and re-tested to confirm immunity following vaccination.

11.3 Testing to determine serological status in relation to HIV and HCV for non-registered staff members is recommended only following their exposure to HIV or HCV.

11.4 It is **strongly recommended** that all non-registered staff who may have been exposed to HBV, HCV or HIV through personal risk behaviour, non- occupational exposure to blood products or occupational accidents (e.g. contaminated sharps injury) should seek testing to determine their serological status and obtain medical advice regarding appropriate post-exposure prophylaxis.

12. Patients who may have been exposed to HBV, HCV or HIV

12.1 If a patient has been exposed to the blood of an oral health practitioner as a result of injury to the practitioner during an exposure-prone procedure, regardless of whether the practitioner is known to be infected with a TMVI or not, the oral health practitioner **must:**

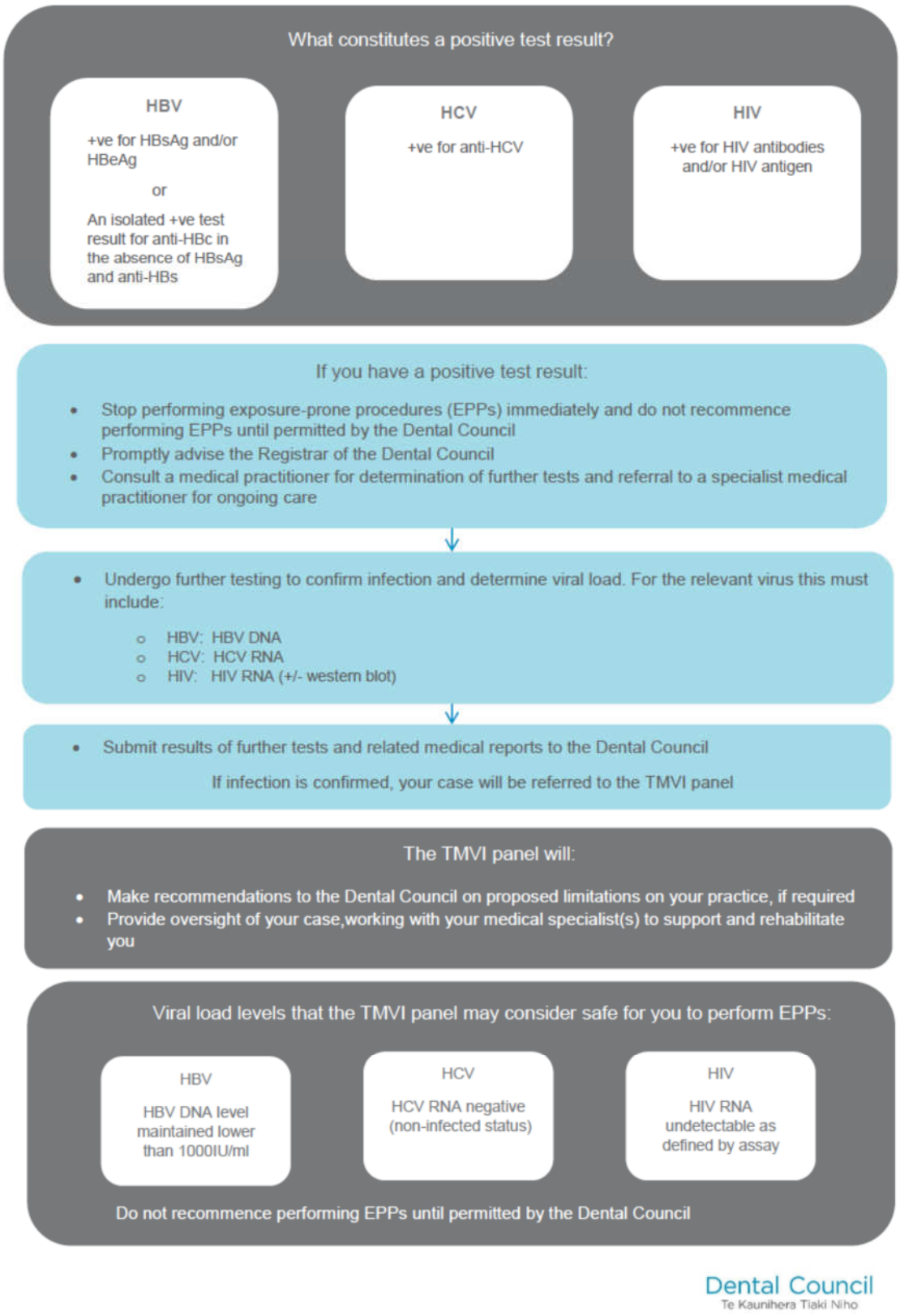
- inform the patient of the suspected exposure; and
- recommend the patient seek immediate advice from an infectious diseases specialist regarding testing to determine their serological status in relation to HBV, HCV and HIV, appropriate post-exposure prophylaxis and follow up requirements; this advice may be sought from the Infectious Diseases Team (or Emergency Department) of their regional hospital[1]; and
- inform the infectious diseases specialist who is advising the patient, of their (the practitioner's) serological status in relation to HBV, HCV and HIV; and
- undergo testing for HBV, HCV and HIV themselves to determine their serological status at the time of the EPP injury; and
- document the exposure: the details of the patient, date, time and nature of the exposure, actions taken and patient consent, or refusal, for medical advice; and
- Complete relevant ACC forms.

12.2 In the event of sero-conversion of the patient, all reasonable efforts **should** be made to confirm that the virus strain transmitted is identical in the exposed patient and the individual source of the infection.

12.3 If a patient has been exposed to the blood of a student or non-registered staff member as a result of an EPP injury, the protocol in 12.1 above is recommended.

[1] A list of Regional Hospital contact numbers is provided in Appendix B

Appendix A: The required practitioner response following positive test results for HBV, HCV and HIV



Appendix B: Regional hospital contact details

Northland, Auckland	Auckland City Hospital	(09) 367 0000
Bay of Plenty, Tairawhiti	Tauranga Hospital	(07) 579 8000
Waikato	Waikato Hospital	(07) 389 8899
Hawkes Bay	Hastings Hospital	(06) 878 8109
Taranaki (advice provided by Christchurch)	Christchurch Hospital	(03) 364 0640
Wanganui, Manawatu	Palmerston North Hospital	(06) 356 9169
Wellington, Wairarapa	Wellington Hospital	(04) 385 5999
Nelson- Marlborough	Nelson Hospital	(03) 546 1800
Canterbury, West Coast	Christchurch Hospital	(03) 364 0640
Otago, Southland	Dunedin Hospital	(03) 474 0999

References

1. Australian Government Department of Health and Ageing: *Australian national guidelines for the management of health care workers known to be infected with blood-borne viruses. (2012)*

   http://www.health.gov.au/internet/main/publishing.nsf/Content/36D4D796D31081EBCA257BF0001DE6B7/$File/Guidelines-BBV-feb12.pdf

2. Australian Health Practitioner Regulation Agency: *Public Consultation Guidelines for the regulatory management of registered health practitioners and students infected with blood-borne viruses (July 2014)*

   http://www.ahpra.gov.au/News/Consultations.aspx

3. Cadmus SI, Okoje VN, Taiwo BO, van Sollingen D. Exposure of dentists to *mycobacterium tuberculosis*, Ibadan, Nigeria. *Emerging Infectious Diseases.*2010; 16(9):1479-1481.

   http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3294986/pdf/10-0447_finalD.pdf

4. Dental Council Of New Zealand *Code of Practice*: *Transmissible Major Viral Infections* for dental hygienists, dental therapists, orthodontic auxiliary, dental technicians and clinical dental technicians (2007)

   http://www.dentalcouncil.org.nz/Documents/Codes/COP_TransmissibleMajorViralInfections_Generic.pdf

5. Department of Health, Social Service and Public Safety *Guidance on Health Clearance for Tuberculosis, Hepatitis B, Hepatitis C and HIV for New Healthcare Workers with Direct Clinical Contact with Patients* (2009)

   www.dhsspsni.gov.uk/healthcare-workers-guidance.doc

   Link to original U.K Policy document:

   http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_073132

6. Department of Health, Social Service and Public Safety *Hepatitis C infected healthcare workers: Guidance on the prevention of healthcare-related hepatitis C and workplace management of hepatitis C infected clinical healthcare workers* June 2011

   http://www.dhsspsni.gov.uk/hss-md-9-2011-guidance.pdf

7. *Health Regulatory Authorities of New Zealand (HRANZ) forum joint guidelines for registered health care workers on transmissible major viral infections*(2005)

   http://www.mcnz.org.nz/assets/News-and-Publications/Statements/TMVI-HRANZ-_guidelines.pdf

8. *Management of HIV-infected Healthcare Workers The Report of the Tripartite Working Group* April 2011

   https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216126/dh_131574.pdf

9. Medical Council of New Zealand *Guidelines for health Care Workers(HCWs) on transmissible major viral infections – Draft 1*

10. Ministry Of Health *Guidelines for Tuberculosis Control in New Zealand*

    2010 http://www.health.govt.nz/system/files/documents/publications/guidelines-tuberculosis-control-new-zealand_0.pdf

11. NZDA News *TB Key points for dental practice*. Volume 138, March 2008;138:18-20

12. Public Health England *The Management of HIV infected Healthcare Workers who perform exposure prone procedures: updated guidance*, January 2014

    http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1317140704390

13. The Association of Canadian Faculties of Dentistry ACFD Guidelines For Infectious Diseases And Health Care Workers (2009)

    http://www.acfd.ca/en/publications/InfectiousDiseaseGuidelines.html

14. The New Zealand Dental Association, The Dental Council of New Zealand *Code of Practice: Transmissible Major Viral Infections* for dentists/dental specialists (2006)

    http://www.nzda.org.nz/pub/resources/cop_majorViral.pdf

15. U.S. Department of Health and Human Services Centers for Disease Control and Prevention *Recommendations for preventing transmission of human immunodeficiency virus and hepatitis B virus to patients during exposure-prone invasive procedures*". MMWR 1991; 40(No.RR-8) http://www.cdc.gov/mmwr/preview/mmwrhtml/00014845.htm

16. U.S. Department of Health and Human Services Centers for Disease Control and Prevention *Updated CDC Recommendations for the management of Hepatitis B Virus-Infected Health- Care providers and Students* (2012)

    http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6103a1.htm

17. Von Arx DP, Husain A. Oral Tuberculosis. *British Dental Journal* 200; 190(8):420 – 422

    http://www.nature.com/bdj/journal/v190/n8/pdf/4800991a.pdf