18 November, 2015

To whom it may concern

Please find following our submission on the proposed Infection Prevention and Control Practice Standard.

We have combined our concerns with this standard with information about the similar standard released by the NZDA this year. We feel that as both of these standards share many factors and indeed some members of the working group, it was relevant to include mention of both.

Our area of concern is specifically around the recommendations covering the "Cleaning of surfaces in the contaminated zone."

We find that in this area the standard is in opposition to several of the "five ethical principles that practitioners must adhere to at all times." In particular we think the Standard is directly in conflict with these principles:

- put patient interests' first
- ensure safe practice
- provide good care
- maintain public trust and confidence

We would welcome the opportunity to discuss this further and would request we be kept up to date with progress in further formulating the Standard.

Yours sincerely

Steve Ardagh
Chief Executive/Director
Eagle Protect (formerly Medical House Ltd)

16 November, 2015

Submission on the proposed Infection Prevention and Control Practice Standard.

Preface

Eagle Protect (formerly Medical House) has been servicing the NZ Dental Industry since 2009. We supply over half of the dental centres in NZ with single-use consumables.

Our area of concern is specifically around the recommendations covering the "*Cleaning of surfaces in the contaminated zone*."

We believe that the proposed Infection Prevention and Control Practice Standard is not in keeping with several of the "*five ethical principles that practitioners must adhere to at all times*."
i.e. Practitioners must:

- put patient interests' first
- ensure safe practice
- communicate effectively
- provide good care
- maintain public trust and confidence

We believe that the NZDA 2015 Infection Control Code of Practice and the proposed DCNZ Standard are a step backwards in terms of patient safety and the dental profession integrity, and is at odds with many international body recommendations including the US CDC, and the CDSBC, (cited as a reference in the DCNZ Draft Code.)

We are concerned at the influence of some supply companies whose representative has been included in both NZDA and DCNZ advisory groups.

Discussion

The DCNZ ***DRAFT Infection Prevention and Control Practice Standard***, says in part:

"Clean work surfaces in the contaminated zones and equipment surfaces with a neutral clinical detergent (in a warm solution or wipes)…" *It goes on to note…*
"Note: Disinfection of work and equipment surfaces in the contaminated zone, following effective cleaning between patients, is not required, as the risk of transmission is considered negligible."

Response: There is no corroborating data provided for the claim the risk is negligible or the acceptable level of risk that is considered to be negligible.

The DCNZ ***Consultation Document for the proposed Infection Prevention and Control Practice Standard,*** says in part:

"The compliance measures of the draft practice standard state all work surfaces in the various contaminated zones in the dental practice environment, and equipment surfaces are to be cleaned with a neutral clinical detergent prior to patient treatment." (*Here the number 4 is appended to refer*

to a link to the CDSBC Infection Control Guidelines - this link does not work. But investigation of the CDSBC document of similar title seems to at odds with this DCNZ recommendation.)

"The risk of transmission of infectious agents from environmental surfaces following appropriate and effective cleaning procedures is negligible, and for that reason the draft practice standard does not require disinfection of these surfaces prior to patient treatment, or in-between patients, in its compliance measures."

Effective disinfection of the dental environment is achieved by following the product manufacturer's specifications for use. This typically includes: applying the disinfectant to a pre-cleaned and dried surface; preparing to the correct dilution; and being left in contact with the surface being disinfected for the correct length of time. Due to the limited time available between patients, effective disinfection of environmental surfaces in the dental environment might typically only be achievable at the beginning of the day, at the end of a clinical session, and at the end of the day.

Response: We believe the recommendation around "limited time available," is based on slower acting *older* generation disinfectants that require long surface contact times which are not a realistic option in the time available between patients. There are now disinfectants that can achieve measured results in disinfection of the key contaminants in very short time periods so are able to fit within the busy practice reality. These fit within the Low to Intermediate level disinfectant as recommended in the *CDC - Guidelines for Infection Control in Dental Health-Care Settings - 2003* and the *CDSBC Infection Prevention and Control Guidelines - July 2012*

(See additional notes below re CDC and CDSBC recommendations for the use of low and intermediate level disinfectants.)

In **2014** the NZDA issued the **Code of Practice: Infection Prevention and Control in Dental Practice.** Under the heading - *Cleaning following patient contact*, subhead - *Cleaning the contaminated zone*, it stated:

The lack of good research data on the potential for transmission of infective agents from contaminated surfaces to patients has resulted in debate as to the need (or otherwise) for disinfection as part of the decontamination of environmental surfaces. Applying the principle that all patients are potentially infectious and combining this with the fact that operative dentistry results in aerosol production, which may contaminate surfaces the NZDA recommends that cleaning of the contaminated zone include both cleaning and disinfection.
Any surface likely to have become contaminated (those within the contaminated zone) during treatment must be thoroughly cleaned and then disinfected following each patient treatment.

In **2015** the NZDA issued the **Code of Practice: Infection Prevention and Control in Dental Practice.** Under the heading - *Cleaning following patient contact*, subhead - *Cleaning the contaminated zone*, it stated:

The lack of good research data on the potential for transmission of infective agents from contaminated surfaces to patients has resulted in debate as to the need (or otherwise) for disinfection as part of the decontamination of environmental surfaces. Balancing the potential risks against the practicalities of surface disinfection the NZDA recommends that the contaminated zone is cleaned with a suitable clinical detergent between patients and disinfected as necessary when the manufacturer's instructions for use can be correctly adhered to.
Surfaces that are visibly soiled with blood or saliva should be cleaned and then disinfected.

Response: Both versions (2014 and 2015) of the NZDA COP cite, "*lack of good research data*," but the safety first approach taken in 2014 has changed to a, "*balancing potential risks*" approach in 2015. (We raise this here as we assume there is some attempt to align the NZDA COP with the DCNZ Standard?)

Additional notes:

1. The CDC (US Centers for Disease Control and Prevention) recommendation states: "If barriers are not used, surfaces should be cleaned and disinfected between patients by using an EPA-registered hospital disinfectant with an HIV, HBV claim (i.e., low-level disinfectant) or a tuberculocidal claim (i.e., intermediate-level disinfectant). Intermediate-level disinfectant should be used when the surface is visibly contaminated with blood or OPIM." (Note: OPIM = other potentially infectious materials.)

2. The CDSBC recommendation states, "Clinical contact surfaces should be cleaned and disinfected between patients and at the end of the workday using an appropriate low-level disinfectant."

3. In addition - while the DCNZ states in the consultation document that, "*Effective disinfection of the dental environment is achieved by following the product manufacturer's specifications for use*." Disinfection daily, weekly or at all is not discussed in the Draft Standard, except to say that it is not necessary.

Summary

We believe the New Zealand Dental Sector should take the approach of safety first and align the recommendations around "Cleaning of surfaces in the contaminated zone," with other major international bodies. Specifically: Example taken from the CDSBC…

If barriers are not used, "Clinical contact surfaces should be cleaned and disinfected between patients and at the end of the workday using an appropriate low-level disinfectant."

The Draft states in part - "*In accordance with the ethical principles of the Standards Framework, 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 the transmission of disease causing (infectious) agents, such as bacteria, viruses and fungi…*"

We would argue that the non-requirement to use disinfectant between patients based on, "*the limited time available between patients,"* is more of a business consideration than a safety one.

It should be noted that many modern disinfectants are able to reach the "low level disinfectant" and "intermediate level disinfectant" standards required in the US and Canadian standards within 60 secs of application time, so in any case do not impinge on the availability of time in a modern practice environment.

16 November, 2015

Steve Ardagh
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