I am concerned that the proposed IPC measures are unworkable, at times contradictory, and on holistic appraisal provide significant barriers to accessing care in a suitable way for vulnerable and special needs patients.

Firstly, being a DHB employee, I provide dental care to a strict IPC standard as set out both by the DCNZ current standard, and the guidelines set by the DHB infection prevention control team, specifically in response to COVID. I am concerned that the proposed DCNZ IPC standard is considerably different to standards laid out for other medical and surgical specialties within the DHB and internationally, and are so overzealous they are largely unworkable.

This is of particular concern with the patients that I see as a special care dentist. My patients already find access to care difficult, are underserved and over represented with respect to oral disease, and many of these patients are also likely to be unvaccinated. A considerable proportion of my patients are used to rigid treatment regimes, same room, time, practitioner, order of operations etc. While donning PPE may be of little consequence for the general public, this may be the difference between my patients accepting care or not. These small changes make a monumental difference; are likely to increase dental fear; reduce access to conservative care; and have a flow on effect necessitating more invasive treatment, resulting in increased demand on an already completely over stretched general anaesthetic service. I have no doubt this will result in poorer patient outcomes for many years to come.

I am particularly concerned about the proposal of standing down individual clinic “single rooms” as opposed to multi-rooms which are exempt from a stand-down period. Honestly, this just seems like a loophole that has been created to be exploited, rather than based on sound scientific evidence for any tangible benefit to patient safety, and it undermines the credibility of the whole proposal. Additionally, this stand-down based on clinic capacity (rather than any actual infection risk) will serve to reduce service provision and access of secondary and tertiary services, increase waiting list times, and once again worsen patient outcomes.

Given the negative individual and population level oral health impact this standard will cause without any significant benefit (as no other specialty seems to share this level of IPC), I would like to propose, at the very least, that DHB oral health services are exempt from these guidelines and rather able to follow the standards as set-out by the hospital infection control specialist teams which are far more fit for purpose than this current proposal.

Should you wish to have any further information please don’t hesitate to contact me,

Kind regards,

Ceridwen Benn
Special Care (SND) Registrar
Senior Dentist

Hutt Hospital Dental Dept
High Street Lower Hutt