Dear Dental Council,

While I appreciate that there is urgency in updating the infection control practice standard, it strikes me that this proposal may not have fully considered this impact these new standards would have upon the vulnerable in our society. The statement that "*Stand down time is required for only high and moderate risk patients, irrespective of the care provided*" appears to be at odds with care being provided overseas, where they have been successfully managing COVID in a dental setting. For example the UK approach (which is cited often in the draft document) is very clear that a room stand down period is only required after a very limited range of Aerosol Generating Procedures (AGPs) - there is simply no justification for room stand down when no AGP has been performed. I work full time in a hospital dental department, we are already stretched to capacity. I can appreciate that stand down is sometimes necessary, however unnecessary stand down will make our wait list longer for no reason and people in need will suffer.

I note also that there are several inconsistencies with in the draft document which have the potential to make the standard unworkable within a DHB setting. The DHBs have developed Infection Prevention Protocols in conjunction with local and national infection prevention specialists - the draft DCNZ guidelines appear at odds with these guidelines. Has there been an NZ infection prevention specialist involved in the creation of these guidelines? The draft document references the UK government guidelines & the Scottish Dental Clinical Effective Programme guidelines yet does not follow these guidelines – no explanation is made within the draft standards as to why this in the case.

My focus is on hospital paediatric dentistry and I note that the proposal is very vague as to how I should go about treating vulnerable children, the draft standards are likely to further induce barriers for care for this vulnerable group. It is not possible to schedule treatment for this group at the end of the day (as suggested in the draft) and the reduction to clinical throughput by having them treated in the morning (as is usual practice) has the potential to cause the recall wait times to blow out. Therefore it is likely these vulnerable children will not get dental assessment or treatment in a timely manner if these standards are implemented as drafted.

Finally I am unclear why additional single use aprons or gowns are required for all procedures for those already identified as not having COVID epidemiological risk factors. In the draft standards *"For low and moderate risk patients, practitioners have the option of wearing a long sleeve or short sleeve gown. When long sleeve gowns are used, change between patients. When short sleeve gowns are used: change between patients OR alternatively wear a plastic apron over the short sleeve gown and change the apron between patients".* This does not seem to match hospital infection prevention protocols and has the potential to chew up huge amounts of PPE resource which may not then be available for high risk patients, not to mention the environmental impact of wasteful use of PPE.

Thank you for considering my feedback on this important update to our standards.

Yours Sincerely,

Ted Piercy

Hospital Dental Surgeon