



**DRAFT CODE OF PRACTICE
RE INFECTION CONTROL**

**SUBMISSION TO DENTAL PRACTICE BOARD OF VICTORIA
BY AUSTRALIAN DENTAL ASSOCIATION VICTORIAN BRANCH INC.
SEPTEMBER 2004**



KEY POINTS

- The ADAVB welcomes the new Code of Practice on Infection Control and supports the Board in addressing this key area of patient and provider safety.
- The Code contains elements drawn from the CDNA Guidelines, and certain of these could be presented more consistently.
- The Code should indicate that some practices and providers will need to follow AS4187 when oral treatment is provided under hospital treatment conditions e.g. day stay surgical care.
- The Health Records and Privacy Acts make it clear that where organisations hold health information, a higher standard of confidentiality applies than for any other kinds of information. The Dental Practice Act has established that there are two parts to the Register, a public part and a confidential part. If a condition is placed on a practitioner's registration as a consequence of them having a blood-borne disease, we believe that this must be recorded in the confidential section.
- The ADAVB is concerned that recording a condition on the public register for infected dental care providers, will actually increase the likelihood that such people will not report their infective status. It may also result in patients seeking treatment elsewhere and so reduce overall access to care, thus conflicting with a key Board objective.
- The ADAVB urges the DPBV to enter into discussions with the MPBV with a view to enabling registered dental care providers to have access to the same support and conditions that apply to medical practitioners and students via the Victorian Doctors Health Program. The ADAVB is willing to commit resources and to work with the DPBV to provide this support.
- We suggest that prescribing of tracking is not necessary if a practice can demonstrate that it has a system that checks the autoclave before a batch is returned to the surgery. This can be acknowledged in a log book.



INTRODUCTION

The Branch welcomes the opportunity to comment on the Board’s draft Code of Practice COP006 regarding Infection Control. We especially note the elevation of the previous infection control document from an information paper to the status of a Code of Practice, which we fully support.

The ADAVB and ADA Inc. Infection Control Committees have reviewed both the proposed Infection Control Code of Practice COP006 and the Infection Control Information sheet.

In general both documents appear well written, fair and reasonable.

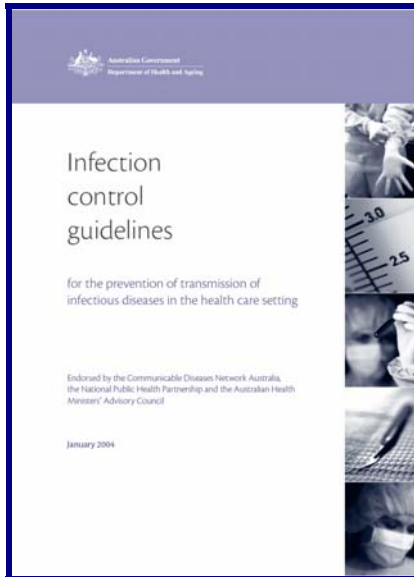
We note that in the Board’s Annual Report 2002/03, Infection Control complaints have consistently appeared in the top three over the last three years, although thankfully overall numbers of such complaints have been declining. From a public health and safety perspective, there is no question that the Board has a responsibility to provide guidance to registered persons regarding their infection control obligations. The ADAVB has always supported the Board in this aspect of its work, and we have been pleased to highlight our members’ obligations under prevailing standards, as amended from time to time. Further, the Branch has allocated considerable resources to assist members to comply in this area.

Complaints received (by type)

Type of complaint	Number of complaints 2002-2003	Number of complaints 2001-02	Number of complaints 2000-01
Quality of work	47	63	25
Advertising	12	35	17
Infection control	22	24	28
Illegal practice	8	17	7
Fees	4	11	6
Financial deception	8	8	1
Informed consent	16	8	9
Intimidation	-	7	1
Failure of communication	-	5	5
Misrepresentation	-	3	3
Overservicing	1	3	2
Fitness to practise	-	1	-
Falsifying documents	-	1	1
Breach of conditions on registration	1	1	-
Breach of confidence	-	1	1
Record-keeping	2	1	-
Finding of guilt in court proceedings	1	-	1
Sexual misconduct	1	1	1
Miscellaneous	5	5	6
TOTAL	144	195	114



ADOPTION OF FEDERAL STANDARDS



Our Federal (ADA Inc) Committee notes that in some parts of the draft Code, the language used is at variance with that commonly used by each of Standards Australia and the CDNA in their Infection Control Guidelines. Both documents have been formally supported by the ADA.

As these are the two key source documents referenced by the Code, it has been suggested that some modification of the Code may be desirable to bring it into line with them. Specific examples of desirable adjustments are offered below.

There is an error of omission in section 7b, the word 'Zealand' as in 'New Zealand' is missing.

Page 1 Section 6 is adapted from CDNA 2004 Guidelines Part 1, however some wording and accent changes have been made and there appear to be some significant omissions.

We suggest that the CDNA wording should be used wherever possible in the interests of clarity and national consistency.

6a should read “applying basic measures of Infection Control (observing ... and from what)” deleting “etc”, as this has no legal meaning.

6b should read “adopting quality ... (... such as a documented infection control program in which staff are educated and regularly retrained... that affect the delivery of dental care)”.

6C should read “developing effective work practices and procedures that prevent the transmission of infectious agents – such as correct handwashing and personal hygiene, use of personal protective equipment and environmental hygiene including the design and maintenance of premises ...”, but delete ‘blood products’ later in the text.

Dentists do not use blood products except in a hospital or day care facility where blood transfusion might be ordered. Such transfusions would be supervised by a transfusionist and probably given by a nurse. The dentist would never handle the bag of blood or platelets or white cells (or other blood products).

Also add “environmental cleaning and spills management and protection for dental care providers including health status records, immunisation and testing of immune status”.



DIGITAL DOCUMENTATION

The ADAVB welcomes the flexibility offered in not requiring a hard copy of the documentation at the practice. Many practices would not be well placed to offer their staff online or desktop access to these key references however.

The Code would desirably require that the registered dental care provider who is providing the treatment must have access to the key reference documents and work in accordance with the Code and the standards it refers to, so that where the proprietor of the practice is not a registered person, the Board has some jurisdiction and control over their compliance.

The Systematic Operating Procedures (SOP) manual prepared by the ADAVB and offered to members via the Branch's website, is referenced in the Code, and this is appreciated.

Technical and other problems have recently required the Branch to rebuild its website in another environment. This has resulted in the URL for the SOP being changed, so that the reference may require rewording. Perhaps something along the lines of

“See www.adavb.com.au under member services / infection control.”

The ADAVB is updating the current version of the SOP in the light of the recent changes to infection control standards, and the new version is expected to be available by early in 2005 (if not sooner). The website reference suggested above will remain valid after the change to the new SOP.

The screenshot shows a web browser window with the address <http://www.adavb.com.au/>. The page features a navigation menu on the left with links such as 'find a dentist', 'news', 'dental FAQ's', 'member services', 'careers', 'events', 'related sites', 'who we are', 'site search', and 'feedback'. The main content area is titled 'Infection Control Member Services' and includes a section for 'Systematic Operating Procedures' with the following text:

The 'Systematic Operating Procedures - Protocols For Infection Control In Dental Practices' provides dental staff with a procedure based approach to the implementation of infection control in dental practices. The practice has a legal, ethical, and moral obligation to implement suitable infection control practices. These practices should be implemented in a harmonious manner providing increased efficiencies to the practice.

The ADA protocols have been developed to aid in the implementation of these procedures. They include discussions of the legislation and background papers from which the protocols were developed.

Ansell Medical is the proud sponsor of the 'Systematic Operating Procedures - Protocols For Infection Control In Dental Practices'. The Ansell website can be viewed at <http://www.ansell.com>

Information about PDF Documents

- To download the Acrobat files you may use the (free) Adobe Acrobat Reader which is available from the Adobe Website: <http://www.adobe.com> Old versions of the reader should be upgraded to avoid error messages.
- Once the Acrobat Reader has been installed it should open whenever you click on a link to a PDF document in your web browser (e.g. Netscape or Internet Explorer). PDF documents are larger than ordinary web pages, and take longer to open.
- If you need to copy and paste text from a PDF document, or to view the information later, you may find it useful to save a copy of the document on your own computer. To do this, instead of clicking to open the

Dental Awareness Month is a community awareness program coordinated and funded by the Australian Dental Association and selected sponsors. The emphasis for the 2004 campaign is "Beyond Teeth".



OTHER STANDARDS

There may be some instances where guidelines for instrument processing need to be in accordance with AS/NZ 4187. This would apply where dental procedures were conducted in a day procedures centre or hospital. As there is now at least one Victorian dental practice that has been registered as a day procedures centre, and there are many dentists who make use of commercially run centres (e.g. Surgicentre) or private hospital facilities, it has been suggested that AS/NZ 4187 could also be added to the list of externally referenced source documents. While this may not be universally applicable, some practitioners may need to operate under those guidelines and so the addition of a line to point 7b is suggested as follows:

“Some practices and providers will need to follow AS4187 when dental treatment is provided under hospital treatment conditions e.g. day stay surgical care.”

IMMUNE STATUS

There will be some concerns amongst registered persons at the proposed declaration regarding viral status.

Information on the Register

This concern will arise in particular due to section 23 of the Information Paper, under which a practitioner with a blood borne virus will have a condition placed on his or her registration, which in turn will become part of the 'public register'. Discussions with DPBV President Dr Gerard Condon suggest that this condition will be quite vague and not indicate a disease status. Perhaps something along the lines of 'Dr R has a condition placed on his registration'.

It is evident that under section 16(6) of the Dental Practice Act 1999, the DPBV is obliged to include on the Register, “any current condition, limitation or restriction imposed on the registration of the person”. It is also evident from the wording of section 16(9) that there are at least two parts to the Register, a public part and another part not open to the public. This section reads:

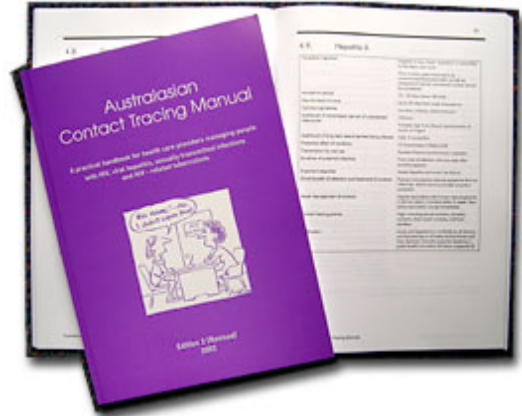
“A registered dental care provider’s or dental student’s private address **must not appear on that part of the register which is open to the public for inspection, ...**”

Since privacy considerations have obviously been taken into account as regards publication of the residential address of the registered person, it is clear that similar privacy considerations need to be addressed in relation to confidential health information. Indeed, Victorian government agencies have special obligations with regard to the observance of health privacy principles enshrined in the Victorian Health Records Act.



We also favour a less punitive approach to dealing with an infected health-care worker, and question the need to identify these individuals on the register, if they are well managed by the appropriate health professionals.

In a manual published by the Sydney Sexual Diseases Centre in 2002, confidentiality and discrimination issues associated with infectious diseases were highlighted. In particular, the following segment is quoted to argue a case for not publishing information on the Register about a registered person having conditions imposed on their registration in connection with an infectious disease.



“Discrimination is a real threat to persons with HIV/AIDS, hepatitis C and some other infections. Confidentiality is paramount to secure the cooperation and confidence of persons with or at risk of infection. Strengthening of statutory guarantees of confidentiality, including infection status, underpins the efficacious outcome of contact tracing programs for the index case, contact, and practitioner.

*Guarantees of confidentiality should be adopted in agency policy and procedures and should be publicised to the agency’s clientele. **From December 2001 Australian federal law imposes a legal duty to protect the privacy of any personal information held by agencies in the private and non-government sectors, and higher standards of privacy are required in relation to health information (emphasis added).** The Privacy Amendment (Private Sector) Act 2000 covers the manner in which an agency collects, stores, uses and discloses personal information. ...*

... Discrimination on the basis of infection with HIV, any STI or hepatitis C, actual or presumed, direct or indirect, is unlawful. Legislation, policies and guidelines at all levels of government exist to protect against discrimination and stigmatisation and to provide redress where they occur.

Discrimination, in this context occurs when

- *a person who has, or is thought to have, an infection is treated less favourably than a person who does not in the same or similar circumstances; or*
- *a requirement, condition or practice that appears to be neutral, in fact has a disproportionate impact on a person who has, or is thought to have, an infection or is one with which they cannot comply and is not reasonable in the circumstances.*



In the health care setting, discrimination can be subtle or overt. Best practice guidelines should determine the work practices and professional interactions of health care workers and each individual worker should think about the circumstances in which discrimination might occur.

Good clinical and health care practice means having a sound knowledge of the infection and applying this to any discussion about a person's current health status and their behaviours. It is important that service providers accept and monitor their own biases and personal attitudes, so that their behaviour does not have a negative impact on the person with whom they are working. This also allows the health care worker to concentrate on the person's clinical needs, assess and respond to them effectively and provide appropriate education.

Discussing both current and past risk behaviour requires a great deal of sensitivity. A greater understanding of the issues enables health care workers to answer questions and provide education on:

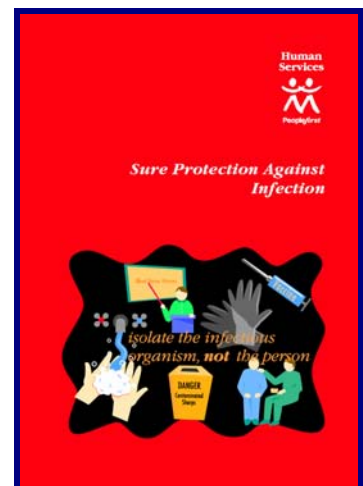
- *transmission risks;*
- *social, physical and psychological effects of licit and illicit drug use;*
- *the effectiveness of and access to treatments; and*
- *the broad range of issues that affect people with the infection and those around them."*

Source: Australasian Contact Tracing Manual, 2nd Edition (revised), Sydney Sexual Health Centre et al, 2002 (pp 42-43).

While the extract reproduced above was written from the perspective of possible discrimination by health care providers against infected patients, we urge the Board to consider these issues of discrimination in relation to infected dental care providers and the proposed disclosure of information concerning a condition being placed on their practice.

The Victorian Department of Human Services has published guidance for its own employees about infection control, which discusses its obligations as an employer and those of its employees, in the following terms:

"The Health Act 1958 also does not permit discrimination against a person on the grounds that they have an infectious disease and protects the person's privacy and liberty. However the Act also states that persons who have an infectious disease need to take reasonable measures to protect others from being infected.





n line with the Occupational Health and Safety Act 1985 employers have an obligation to provide and maintain a work environment for employees that, so far as is practicable, is safe and without risks to health. The provision of infection control procedures, equipment, training and information to staff falls within this duty of care. Employees also have an obligation to take all reasonable measures available to protect their own health and safety and anyone else who may be affected by their acts in the workplace.”

From these comments it would seem that existing OHS legislation already adequately deals with this issue of a registered person’s rights and obligations where they have a blood borne disease.

In meeting its obligation to protect public health and safety, the Board is also bound by the Act to address its objective of promoting access to care. We suggest that publishing a condition on the register for infected practitioners may discourage patients from seeking treatment from those persons, and so increase pressures on waiting lists elsewhere, whilst also potentially making a provider’s practice non-viable.

It may also have the effect of discouraging providers reporting to the Board that they have an infectious disease. A registered person is not likely to volunteer such information if they believe it will lead to either their deregistration or to loss of livelihood, particularly when they can rationally present a view that they are not a risk to the public, because they have exemplary infection control procedures. The result here could be that the issue is driven underground and practitioners with an infectious disease do not seek the assistance they need in properly managing their condition and their practice. This would obviously put the public at risk, particularly when proper management will virtually eliminate any risk to the public. The converse is that careless management increases the risk significantly.

We understand that the Victorian Doctors Health Program (VDHP), administered under the aegis of the Medical Practitioners Board of Victoria (MPBV) but in partnership with the AMA Victoria, allows for a practitioner to enter into a practice management agreement with the coordinator of the VDHP, Jack Warhaft, on the very clear understanding that if the agreement is breached, the matter can be formally notified to the Board. This means that no condition is attached to the practitioner’s entry in the Medical Register, unless they breach the obligations under the practice management agreement.

The consequence of a formal notification is that a panel will hear the evidence, and probably be obliged to impose conditions on the practice. Those conditions, once imposed, must be included in the public register and made available for scrutiny by the public. That is a significant incentive for practitioners to comply with the practice management agreements.



It is acknowledged that the success of this program depends very much on the credibility of the VDHP. Reports from those experienced in dealing with this program indicate that any disciplinary tribunal would be justified in entrusting their complete confidence in the work they perform. Their role is very difficult, yet it successfully strikes a balance between the need to support an infected practitioner, whilst also controlling the risk they pose to the public.

The client management agreement reached through the VDHP is not something that is noted on the register. It is a management agreement, rather than a condition imposed on a practitioner's registration. There is no need to make that information publicly available on a web site or in the register.

The ADAVB therefore urges the DPBV to enter into discussions with the MPBV with a view to enabling registered dental care providers to have access to the same support and conditions that apply to medical practitioners and students via the VDHP. The Branch has put a proposal to the DPBV to trial access of dentists to the VDHP.

Even here, caution would be required with any proposed entry on the Register. If for example, the Register were to bear a statement that "this practitioner's registration is subject to a practice management agreement", that could be enough to persuade the public to choose another practitioner. This would not be fair, and, given the increased use by the public of Internet search facilities, it could become a genuine problem that would again drive infected practitioners 'underground'.

We accept that there is a greater risk of an undergraduate performing a procedure which can become exposure prone, and endorse the principle that students should be tested. If they are found to be carriers of blood-borne viruses then they should be discouraged from completing the course.

The Branch accepts the definition of exposure prone as given in the glossary (G3) of 'Infection Control in the Health Care Setting'. This definition reads as follows

"exposure prone procedures are a subset of invasive procedures characterised by the potential for direct contact between the skin (usually finger or thumb) of the health-care worker (HCW) and sharp surgical instruments, needles, or sharp tissues (spicules of bone or teeth) in body cavities or in poorly visualised or confined body sites (including the mouth). In the broader sense, and for the purpose of these guidelines, an exposure prone procedure is considered to be any situation where there is a potentially high risk of transmission of blood-borne disease from a HCW to patients during medical or dental procedures."

We believe the Board should endorse this definition in its Code.



The ADAVB considers that most experienced dentists can practise dentistry without having a situation where there is a 'potentially high risk of transmission of blood-borne disease from HCW care worker to patient during a dental procedure'. As such, we believe the declaration to be made by the dentist should indicate that the dentist, having been aware of his/her blood-borne virus status at the commencement of practice (a condition of initial registration) is prepared to state that they do not intend to undertake exposure prone procedures. This eliminates the need for annual testing.

If a dentist is involved in an accident, where the transmission of a blood-borne virus is a risk, they have a responsibility to undertake a blood test and must consider their obligations towards the patient. This obligation could also be highlighted in the Code.

Counseling option

The Code seems to imply that only disciplinary action is available to the Board where non-compliance is in evidence. The Board has shown its willingness to provide counseling in appropriate circumstances, and it may be preferable for the Code to allow for this or other less draconian responses, and wording such as the following could be considered:

“The Board will take any action(s) necessary to ensure compliance with this infection control policy and may institute disciplinary or legal proceedings against practitioners or practice owners who fail to comply with its requirements.”

The use of counseling is discussed further below, under Supported Measures.

Standard Precautions

Some Members have suggested that if the Dental Practice Board of Victoria is going to insist on dentists knowing their blood-borne viral status, it would be reasonable to expect a dentist to request a blood test for a patient before undertaking an exposure prone procedure?

Standard precautions were meant to work in both directions; protecting practitioners from infection by patients, and vice versa. If there is to be a higher standard applied to practitioners than to their patients, this will lead to resentment, and an undermining of support for standard precautions.

“As the infection status of a client or staff member is unknown the best way to prevent infection is to:

- *Assume that everyone is potentially infectious and treat everyone in the same way by practising infection control procedures.”*

(Source: Sure Protection Against Infection, DHS 2000 pp 2-3)



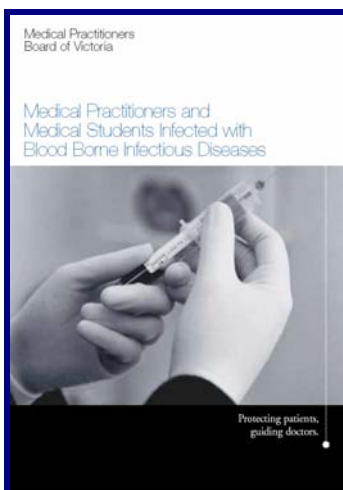
Supported measures

We support:

- undergraduate testing of all students, and counseling, including career counseling, where a student is found to have a blood-borne disease;
- an education campaign for all registered dental care providers that reduces exposure prone procedures; and
- all dentists having an initial blood test, but with follow-up tests then based on professional judgment of risks, both professional and social.

No frequency for testing is specified, however it could be inferred from the draft Code that annual testing is required given that an annual declaration is being sought. We believe yearly testing is excessive. It is noteworthy that the MPBV does not specify the frequency of testing for medical practitioners and students either.

The MPBV has adopted a policy regarding “Medical Practitioners and Medical Students Infected with Blood Borne Infectious Disease”, which contains some significant parallels for consideration by the DPBV. This document highlights the expectation that “*All medical practitioners and medical students should know their HIV, HBV and HCV antibody status.*”



It also notes that:

“Doctors are at risk from contracting infections from their patients. They should therefore protect themselves and their patients by:

- *Adhering to current infection control guidelines and protocols*
- *Being immunised against HBV at the earliest possible opportunity in their career and preferably before commencing clinical contact. They should ensure that they have responded by having post-vaccination testing.*
- *Following post-exposure protocols, including seeking expert advice about early management and practice modification. Medical practitioners and medical students who carry a blood borne virus:*
- *Have an ethical duty to review their practice of medicine, health risks and health status.*

They should obtain and follow the advice of their treating specialist and must never rely on their own assessment of the risk that their condition may pose to patients.

- *Should not perform any exposure prone procedures if they have been infected with a blood borne virus and are viraemic. A specialist medical practitioner must ascertain whether the infected practitioner or student is viraemic, using the most sensitive tests available.*
- *Those who are not viraemic should not perform exposure prone procedures unless they have been given specific approval by their treating specialist.”*



The MPBV policy and guidelines paper includes the following comment about the links between dental treatment and Hepatitis and HIV infections:

“Evidence of practitioner to patient transmission includes HBV transmission to a patient from an infected surgeon in cardiothoracic surgery, pelvic surgery, lower uterine segment caesarean section and dental surgery. HCV transmission has been epidemiologically linked to transmission in cardiothoracic surgery and endoscopy and HIV transmission has been rarely epidemiologically linked with orthopaedic surgery and dental practice.(2) (MPBV p.5)



Under Section 37 of the Medical Practice Act 1994, a doctor is required to report to the appropriate registration authority when they are treating a registered health practitioner and they:

- (1) form the opinion that the person is suffering from an illness or condition which has seriously impaired or may seriously impair that health practitioner’s ability to practice as a registered health practitioner of that class: and
- (2) may result in the public being put at risk.

The Public, and indeed registered persons, will expect that the same standards will apply with regard to infected health care workers regardless of their area or field of practice. A comparison of the positions taken by each of the Dental and Medical Practitioners Boards suggests that better alignment could be achieved. The following table summarises the key points of agreement and difference.

Dimensions	Draft DPBV Code re Infection Control	MPBV Policy on Blood Borne Infectious Diseases
Knowing status	“9. Every practitioner who undertakes exposure prone procedures must: a. know his or her status for blood borne viruses such as hepatitis B, hepatitis C and human immunodeficiency virus...”	“All medical practitioners and medical students should know their HIV, HBV and HCV antibody status” (p.2)



Dimensions	Draft DPBV Code re Infection Control	MPBV Policy on Blood Borne Infectious Diseases
Declaration	“9. Every practitioner who undertakes exposure prone procedures must: ... b. declare that he/she is aware of that infectivity status and undertakes to act in ways that minimize risk to the public ...”	No declaration required
Exposure Prone Procedures	See 9a above	Medical practitioners and medical students who carry a blood-borne virus: ... should not perform any exposure prone procedures if they have been infected with a blood borne virus and are viraemic...” (p.2)
Immunisation	Not mentioned.	“Medical practitioners and medical students should be immunised against HBV at the earliest possible opportunity in their career and preferably before commencing clinical contact” (p.8)
Students	Not mentioned	“An infected medical student whose health is not impaired should be permitted to complete his or her training and to graduate, subject to complying with the requirements of the course. However, he or she should be provided with comprehensive counseling, including career counseling, and must not engage in any exposure prone procedures.” (p.10)
Notification	Required – handled confidentially (Refer item 23 in Information document)	Encouraged
Condition on Register	Yes - condition appears on “public register” but not explicit (Refer Item 23 in Information document)	Not unless terms of confidential VDHP agreement are breached.



TRACKING



Hospital practice and office practice differ. The systems required are not the same, and types of patients and resources, especially staffing and administration, also differ.

Small office-based practices provide access to care and should be supported. There is a growing trend for dentists and non-dentists to not wish to own small practices - often due to the burden and cost of compliance with regulations.

The Australian Dental Association favours a non-prescriptive approach with an encouragement to solve problems in an innovative way.

It would seem that prescribing of tracking is not necessary if a practice can demonstrate that it has a system that checks the autoclave before each and every batch is returned to the surgery. This can be acknowledged in a log book.

Tracking will become an indemnity issue if it becomes a requirement of the Board.

There was a recent article on instrument tracking by Dr Lawrence Walsh in the Federal News Bulletin June 2004, in which the requirements differed from those outlined by the DPBV at the recent DPBV/ADAVB ICC meeting. DPBV representatives confirmed at that meeting that 'contents of load' was not required to be noted in a 'sterilizer logbook'. This is in contrast with the Walsh article Page 14, column 2, "Contents of logbook to document sterilization process ... (fifth bullet point) Nature of load (number of packs, instrument cassettes, etc)". Clarification and confirmation on this matter would be welcome.



If the above checks are in place, tracking is not supported, as it offers no extra benefit, but does add extra costs.

END



ATTACHMENTS

- Draft DPBV Code of Practice on Infection Control
- Draft DPBV Information on Infection Control
- Previous DPBV Standard re Infection Control
- ADA Inc. Policy Statement on Infection Control
- Extract from Medical Practice Act 1994 – S.37 Reporting of Ill-Health of Health Practitioners



Infection control

Code of Practice No: C006
Issue Date: XXXX
Next Review Date: XXXX



D R A F T

PREAMBLE

Purpose

1. This code of practice has been developed pursuant to section 69(1)(e) of the *Dental Practice Act 1999* (the Act). Its purpose is to ensure that dental care providers practise in a way that maintains and enhances public health and safety by ensuring that the risk of the spread of infectious diseases is minimized.

Scope

2. This code applies to all persons with current registration under the Act.

REVIEW

3. This code of practice will be reviewed and updated regularly to ensure it accords with legislation, national and international standards and any developments in the provision of dental care.

INTRODUCTION

4. Many infectious agents are present in health care settings.
5. The purpose of infection control is to prevent the transmission of these disease-producing microorganisms:
 - from one patient to another;
 - from dental care provider to patient;
 - from patient to dental care provider or other staff (such as an assistant, receptionist, laboratory technician).
6. Effective infection control requires attention to the following matters:
 - a. applying basic infection control strategies (e.g. observing standard and additional precautions, identifying hazards and minimizing risks, identifying who is at risk and from what etc);
 - b. adopting quality management practices (e.g. administrative arrangements such as an infection control program, educating and training staff, understanding the ethical and legal considerations that affect the delivery of health care);
 - c. developing effective work practices and procedures that prevent the transmission of infectious agents (e.g. personal hygiene (such as handwashing, use of personal protective equipment) and environmental hygiene (such as the design and maintenance of premises, management of clinical wastes, handling and disposal of sharps, handling of blood and blood products, the management of incidents involving exposure to blood or body fluids etc);
 - d. managing infectious diseases (this includes identifying the major risk factors and establishing management procedures for patients, dental care providers and their staff, instruments, the practice etc);
 - e. identifying infection control strategies in a specialized health care setting such as dental premises (i.e. identifying the major risk factors and management procedures that specifically pertain to dental practice).

[Adapted from Commonwealth Government Department of Health & Ageing *Infection control guidelines for the prevention of transmission of infectious diseases in the health care setting*]



Infection control

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D R A F T

REQUIREMENTS

Documentation

7. Every place where dental care is being provided must have the following three documents in either hard copy or electronic form. "Electronic form" includes guaranteed internet access. Every working practitioner must have access to these documents:
- a. the Commonwealth Government Department of Health and Ageing's *Infection control guidelines for the prevention of infectious diseases in the health care setting* (published January 2004);
 - b. the Australian and New Zealand Standard **AS/NZS4815:2001** *Office-based health care facilities not involved in complex patient procedures and processes – cleaning, disinfecting and sterilizing reusable medical and surgical instruments and equipment, and maintenance of the associated environment* (as amended from time to time);
 - c. a manual setting out the infection control protocols and procedures used in that practice.

Zealand

Behaviours

8. Every practitioner must:
- d. ensure the premises in which he or she practises are kept in a clean and hygienic state to prevent the spread of infectious disease;
 - e. ensure that in attending a patient he or she takes such steps as are practicable to prevent or contain the spread of infectious disease; and
 - f. act in accordance with the requirements set out in the three documents referred to at point 7 above.

Infectivity status declaration

9. Every practitioner who undertakes exposure prone procedures must:
- g. know his or her status for blood borne viruses (such as hepatitis B, hepatitis C and human immunodeficiency virus); and
 - h. declare that he/she is aware of that infectivity status and undertakes to act in ways that minimize risk to the public. Such a declaration will be required when a person applies to register for the first time, or applies to have his or her registration restored or renewed, or applies for registration in a different division of the register.

NON-COMPLIANCE

10. The Board will take disciplinary action against practitioners who fail to comply with these infection control requirements.

RESOURCES

11. Department of Health & Ageing's *Infection control guidelines* is available online at:
<http://www.icg.health.gov.au>
12. Standards Australia documents are available from:
19-25 Raglan Street, South Melbourne Victoria 3205
☎ 1300 65 46 46
<http://www.standards.com.au>



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D R A F T

13. Dental Practice Board of Victoria's publications are available from:

<http://www.dentorac.vic.gov.au>

+61 3 9694 9900

14. An example of a procedures manual for infection control in dental practices can be found at the Australian Dental Association Victorian Branch Inc's website at:

<http://www.adavb.com.au/DIR145/adamain.nsf>

*See www.adavb.com.au under
member services / infection control.*



**Infection control
Information**

Issue Date: xxxx



D R A F T

Purpose of this document

1. This document provides background information about the infection control standards that registered dental care providers (DCPs) are required to follow.
2. It should be read in conjunction with the Board's Code of Practice on Infection Control (C006).

Background

3. Maintaining a safe environment for patients, dental care providers and staff is an important aspect of the professional responsibilities of practitioners.
4. The code of practice has been developed to help ensure that a standard of infection control is maintained within practices that minimizes the risk to the health and safety of the public.
5. Successful infection control is based on good hygiene around a range of practices that arise from identifying hazards and implementing risk management for those hazards. This involves understanding:
 - the infectious agents;
 - the work practices that prevent the transmission of infection in different settings; and
 - management systems that support effective work practices.

Documentation required

6. The code of practice identifies 3 key documents that DCPs need.

Document 1: Commonwealth Government Department of Health and Ageing's *Infection control guidelines for the prevention of transmission of infectious diseases in the health care setting*

7. This document establishes the principles of infection control; covers the design of premises, choice and type of equipment used (sharps reduction, ease of cleaning and sterilizing), occupational health and safety considerations, safe disposal of clinical waste, regular monitoring of infections, effective and ongoing education and training programs for all levels of staff, the incorporation of infection control into a comprehensive quality management program; as well as providing current technical information for infection control.

Document 2: AS/NZ 4815:2001 *Office-based health care facilities not involved in complex patient procedures and processes – cleaning, disinfecting and sterilizing reusable medical and surgical instruments and equipment, and maintenance of the associated environment*

8. Together these two documents establish the basic principles behind successful infection control. They provide the rationale against which individual dental practices can develop and implement their own effective protocols and systems for infection control.

Document 3: Procedures manual

9. This document is a detailed guide to the day to day implementation of the infection control principles and techniques, having regard to the local situation and the resources of the particular practice.
10. It records how staff are to go about carrying out the infection control process in their daily work.



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11. It must be accessible to all staff and be maintained so that it is current and accurate.
12. All staff must be well trained in the protocols set out in the manual and must follow them.

Behaviours

13. Under the terms of the *Equal Opportunity Act 1995* a dental care provider cannot refuse to treat a person on the grounds of impairment. (Part of the definition of impairment in that Act is "... the presence in the body of organisms that may cause disease"). This means that a person cannot be refused treatment on the grounds that he or she has Hepatitis B or Hepatitis C or human immunodeficiency virus or is a carrier of one or more of these diseases.
14. The use of Standard Precautions (as detailed in the *Infection control guidelines* publication) will minimize the transmission of infection for all patients including known carriers or individuals with clinical disease.

Infectivity status

15. The code specifies that all DCPs who undertake exposure prone procedures must know their antibody status for Hepatitis B, Hepatitis C and human immunodeficiency viruses.
16. Exposure prone procedures are defined in the Glossary of the *Infection control guidelines* as:
A subset of 'invasive procedures' characterised by the potential for direct contact between the skin (usually finger or thumb) of the health care worker (HCW) and sharp surgical instruments, needles, or sharp tissues (spicules of bone or teeth) in body cavities or in poorly visualised or confined body sites (including the mouth). In the broader sense, and for the purpose of these guidelines, an exposure-prone procedure is considered to be any situation where there is a potentially high risk of transmission of bloodborne disease from HCW to patient during medical or dental procedures.
[see Glossary page G-3]
17. That document also defines an invasive procedure, which is:
Any procedure that pierces skin or mucous membrane or enters a body cavity or organ. This includes surgical entry into tissues, cavities or organs, or repair of traumatic injuries.
[see Glossary page G-5]
18. Modification of work practices through risk reduction techniques, such as using instruments rather than fingers for retraction during local anaesthesia, can reduce the number of potential exposure prone procedures.
19. The Board will require practitioners to sign a declaration that, if they are performing exposure-prone procedures, they will be aware of their infectivity status. Such a declaration will be required when a person applies to register for the first time, or applies to have his or her registration restored or renewed, or applies for registration in a different division of the register.
20. Practitioners will be required to make the following declaration:
"I declare that:
 - if I am performing exposure prone procedures I will be aware of my infectivity status in relation to Hepatitis B virus, Hepatitis C virus, human immunodeficiency virus and other viruses that are transmissible by blood or other body fluids; and
 - if I become aware that I have a blood borne virus, I undertake to attend an infectious diseases physician, to obtain and follow the advice I am given and to



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follow the risk reduction techniques and infection control standards endorsed by the Board;

I understand that failure to do so could lead to the Board taking disciplinary action against me."

21. The requirement for this additional undertaking will take effect from the date of issue of the code of practice.

What should practitioners who have a blood borne virus do and what role does the Board have?

22. Dental care providers who carry a blood borne virus, have a professional and ethical responsibility to review the way they practice dentistry to ensure that they minimize the likelihood of transmission of infection to their patients.

23. They should:

- obtain and follow the advice of their treating specialist physician;
- generally avoid exposure prone procedures if they are viraemic;
- advise the Board. Practitioners with a blood borne virus have a responsibility to review their work practices and this is most effectively done in co-operation with the Board and, where appropriate, their treating physician. All such notifications will be handled confidentially. There is provision in the *Dental Practice Act 1999* (section 33) for the Board and the practitioner to determine by mutual agreement, a set of restrictions on the individual's practice that will protect the public while enabling the practitioner to remain in the profession. Precisely what those restrictions will be is determined on an individual basis, after discussion and careful consideration of all the relevant factors. The restrictions will be reviewed regularly. A practitioner will have a condition placed on his or her registration (typically a general statement, not identifying the nature of the illness) and this will become part of the public register. (For more information please contact the Chief Executive Officer of the Board, Mr Peter Gardner).

Resources to assist in the implementation of the code of practice

24. The Board will produce a document (along the lines of its current publication for dental prosthetists *Infection Control for Dental Prosthetists*) to assist in the practical implementation of the code of practice. Of course such a document would be a guide to the standards and cannot be considered as a substitute for the documents required under the code.

25. The Australian Dental Association Victorian Branch Inc has available on its website a comprehensive document which provides the framework for a procedures manual. This document can be customized to suit the particular dental practice.

Obtaining the documents referred to in the code of practice

26. Department of Health & Ageing's *Infection control guidelines* is available online at:

<http://www.icg.health.gov.au>

27. Standards Australia documents are available from:
19-25 Raglan Street, South Melbourne Victoria 3205
☎ 1300 65 46 46

<http://www.standards.com.au>



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28. Dental Practice Board of Victoria's publications are available from:

<http://www.dentorac.vic.gov.au>

+61 3 9694 9900

29. For an example of a procedures manual for infection control in dental practice see the Australian Dental Association Victorian Branch Inc's *Systematic Operating Procedures – Protocols For Infection Control In Dental Practice* which is available at:

<http://www.adavb.com.au/DIR145/adamain.nsf>

Replace this URL with:

["http://www.adavb.com.au"](http://www.adavb.com.au)

Look under Member Services / Infection Control"



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NEW INFECTION CONTROL STANDARD

Until very recently the Board has relied on two documents to establish appropriate standards for infection control. These are:

1. The NH&MRC's *Infection Control in the Health Care Setting*; and
2. Australian Standard AS4187.

Both these documents have been accepted by all major stakeholders as reasonable minimum standards required for dental surgeries to prevent the spread of infection. Both documents are made more palatable by the fact that they have been written by independent bodies. They are comparable with international standards.

In a joint exercise involving Standards Australia and Standards New Zealand, AS4187 has now been rewritten as AS/NZS 4815:2001, specifically for the small office-based practice. Larger operations (for example, the Dental Hospital) would still be covered by AS4187. Peripheral clinics would be required to comply with AS/NZS4815:2001.

There are a number of changes in AS/NZS 4815:2001, particularly those relating to autoclaves, which at first appear unwieldy yet, once implemented, should make the day-to-day running of a small office-based practice easier.

- Calibration of the autoclave by a skilled person will be required:
 - upon commissioning;
 - at 6–12 month intervals; or
 - after repair.
- Parameter monitoring (time, temperature, pressure) is required:
 - on commissioning;
 - after repair; and
 - for every cycle.

This can be done manually or by a printer. Class 4, 5 or 6 indicators can be used instead of manual monitoring.

- Time at temperature is to be determined at:
 - commissioning;
 - installation;
 - calibration;
 - validation; and
 - after repair.
- Chemical indicators are to be used on the outside of each pack (or each load if unwrapped):
 - on commissioning; and
 - after repair.



- Biological (spore or enzyme) indicators:
 - on commissioning;
 - after repair;
 - at validation; and
 - at revalidation.

- Closed door drying cycles are required for wrapped goods.

The calibration and validation process will initially take approximately half a day of a technician's time and half a day of the practice staffs. Protocols and manuals relating to this process have to be written.

Other changes include the use of alcohol-based hand wipes instead of hand washing, and more onerous record-keeping details for each autoclave load.

The Board has adopted AS/NZS 4815:2001 (with the exception of parts of section 8.5.2) as a document which it will utilise in interpreting infection control requirements for office practice.

Exceptions

The Board accepts the important issues of validation, calibration and testing frequency described in Table 7 of the document but rejects the need for batch control numbers as described in section 8.5.2.1 for bagged instruments required to be sterile at the time of use. All that is required is 8.5.2.1.a (which refers to the steriliser identification number and would not be required if there were only one steriliser) and 8.5.2.1.b (the date of sterilisation). If the practitioner is using unbagged instruments intended as a sterile product at the time of use, a batch control number is required for the unbagged instruments. Further, sections 8.5.2.2.c and 8.5.2.2.f are not relevant to small office practice and are therefore excluded.

All practitioners should be make themselves familiar with AS/NZS 4815:2001. Copies can be obtained from Standards Australia, 19-25 Raglan Street, South Melbourne 3205 (Telephone 9693 3555)



AUSTRALIAN DENTAL ASSOCIATION INC.

POLICY STATEMENT

INFECTION CONTROL

1. Introduction

- 1.1 The public concern over the transmission of blood-borne viruses has focussed attention on [cross] infection control. Various authorities have developed guidelines to minimise the risk of exposure to infection. State Dental Boards have used such guidelines to evaluate the professional conduct of dentists.
- 1.2 Dentistry is performed in settings ranging from hospitals, offices, mobile vans and is provided to bed-ridden patients. Any guideline must allow for such situations, as well as cost benefit versus risk analysis, and some degree of flexibility in managing risk.

2 Policy

- 2.1 The Australian Dental Association Inc. [ADA] encourages all dentists and dental health care workers to take all practical measures to minimise the risk of disease transmission within the dental environment.
- 2.2 The ADA encourages any authority which develops regulations, codes, guidelines and/or standards to seek expert dental opinion.
- 2.3 The ADA accepts the broad guidelines of the following documents, provided always that regulatory authorities allow for a flexible approach to the management of risk in varying dental environments:
 - 2.3.1 National Health & Medical Research Council's [NHMRC] "Infection Control in the Health Care Setting : Guidelines for the Prevention of Transmission of Infectious Diseases" [April 1996].
 - 2.3.2 AS/NZS 4815 "Office based healthcare facilities not involved in complex patient procedures and processes - Cleaning, disinfecting and sterilising re-useable medical and surgical instruments and equipment, and maintenance of the associated environment" with the exception of parts of Section 8.5.2 [refer Item 4.1.6.3.1 of Minutes of Federal Executive meeting held May 2/3, 2001].
 - 2.3.3 NHMRC "Creutzfeldt-Jakob Disease and Other Human Transmissible Spongiform Encephalopathies : Guidelines on Patient Management and Infection Control".

Policy Statement 5.1

Infection Control

Adopted by ADA Federal Council, November 15/16, 2001



Medical Practice Act 1994 No. 23

* * * * *

S. 36 amended by
No. 27/2000
s. 18(a)(b)(g)(i)(ii),
repealed by No.
14/2002 s. 14.

37. Reporting of ill-health of health practitioners

- (1) If a registered medical practitioner—
 - (a) is treating a person whom she or he believes to be a registered health practitioner; and
 - (b) forms the opinion that the person is suffering from an illness or condition which—
 - (i) has seriously impaired or may seriously impair that health practitioner's ability to practise as a registered health practitioner of that class; and
 - (ii) may result in the public being put at risk—

the medical practitioner must so notify the body responsible for the registration of that health practitioner.

- (2) In this section and in section 38, "registered health practitioner" means a person who belongs to any one or more of the following classes of people—
 - (a) medical practitioners registered under the **Medical Practice Act 1994**;
 - (b) nurses registered under the **Nurses Act 1993**;
 - (c) registered dental care providers within the meaning of the **Dental Practice Act 1999**;
 - (d) pharmacists registered under the **Pharmacists Act 1974**;
 - (e) physiotherapists registered under the **Physiotherapists Registration Act 1998**;
 - (f) a chiropractor registered under the **Chiropractors Registration Act 1996**;
 - (fa) an osteopath registered under the **Osteopaths Registration Act 1996**;
 - (g) medical imaging technologists, radiation therapy technologists and nuclear medicine technologists

S. 37(2)(c) substituted by No. 26/1999 s. 107 (Sch. Item 6 (as amended by No. 27/2000 s. 40(b))).

S. 37(2)(e) amended by No. 27/2000 s. 20.

S. 37(2)(f) substituted by No. 63/1996 s. 98 (Sch. Item 2).

S. 37(2)(fa) inserted by No. 75/1996 s. 96.



Medical Practice Act 1994 No. 23

registered under section 108AL of the **Health Act 1958**.

(h) psychologists registered under section 6, 7 or 8 of the **Psychologists Registration Act 2000**.

(3) A medical practitioner is not subject to any civil or criminal liability for making a report under this section, if the report is made in good faith.

38. Immunity from liability

A registered health practitioner in a working or treating relationship with a medical practitioner is not subject to any civil liability for reporting to the Board that she or he believes a registered medical practitioner to be incapacitated, if the report is made in good faith.

S. 37(2)(h) Inserted
by No. 41/2000
s. 102 (Sch. Item 5).