

# **The Dental Council of New Zealand**

## **Code of Practice**

### **Control of Cross Infection in Dental Practice**

**May 2008**

**Primarily based on the NZDA Code of Practice: Control of Cross Infection in  
Dental Practice, August 2007**

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## 1 Rationale and purpose of the code

The objective of this code of practice is to protect patients and dental health care personnel against the risks of cross infection in the clinical dental surgery environment. The major risk of infection to dental health care personnel is the repeated exposure to blood and to mixtures of blood and saliva, which may be contaminated with a wide variety of microorganisms including blood-borne viruses. Patients carrying blood-borne viruses may be asymptomatic and unaware of their carrier or infectious status. Medical histories and physical examinations cannot reliably identify all carriers of blood-borne diseases.

**All blood and saliva must be considered infectious. Screening of patients may not detect all potentially infectious agents.**

## 2 Transmissible major viral infections (TMVI)

The following information provides a brief overview of the transmissible major viral infections (TMVI) oral health practitioners should be aware of. For further information refer to the Dental Council's code of practice on transmissible major viral infections.

- In New Zealand, *Hepatitis B Virus (HBV)* infection is endemic. Asymptomatic carriers of HBV with no history of clinical hepatitis or jaundice are prevalent in some geographic areas and amongst certain ethnic groups, particularly Maori, other Polynesians, Chinese and people of South East Asian descent.
- The *Hepatitis C Virus (HCV)* is blood-borne and transmitted in similar ways to HBV; measures to control HBV cross infection should also be effective in controlling HCV.
- The *Human Immunodeficiency Virus (HIV)* is also of concern because of the serious consequences of this infection, although transmission in the dental surgery environment is extremely unlikely because of its low prevalence in New Zealand and relatively lower infectivity.

Infection control measures designed to protect against the asymptomatic HBV carrier should protect patients and dental health care personnel against other blood-borne infectious agents including HIV, and are the appropriate model for dental practice. However, disinfection regimens that inactivate HBV may not inactivate more resistant micro-organisms such as *Mycobacterium tuberculosis*.

## 3 Responsibility/implementation

Oral health professionals have a professional responsibility to ensure the safety of their patients, colleagues and support staff. The introduction and implementation of this code requires all staff to be thoroughly trained and fully informed of the code. Practice procedures in infection control should be reviewed, reinforced and updated regularly, with copies of the code document available in the surgery.

The principle embodied in this code of practice document is to treat all body fluids, such as blood and saliva, as potentially infectious.

Standard precautions and procedures are those that dental health care personnel **must** follow when in contact with biological hazards from contamination with patient body fluids. These precautions and procedures provide protection from any potential pathogen(s) that may be present in body fluids. The following guidelines **must** be applied for **all** patient consultations.

## **4 Guidelines for standard precautions and procedures**

### **4.1 Medical history**

A thorough medical history should be obtained from all patients at the initial patient appointment. The history **must** be reviewed and if necessary, updated at subsequent visits as appropriate. The medical history will assist in determining health disorders relevant to proposed dental treatments, but cannot be relied upon to identify patients who are asymptomatic carriers and who are unaware of their infectious state.

### **4.2 Vaccination**

All clinical dental personnel should be vaccinated against HBV as this is the most effective method of personal protection against acquiring HBV infection from patients. Vaccination does not, however, reduce the need for strict adherence to effective infection control practices, as other chronic virus carrier states are known to exist for which there is no vaccine available.

### **4.3 Personal hygiene**

Fingernails should be short and clean. Rings, watches and arm jewellery should not be worn.

Hands and forearms **must** be washed using surgical soap and/or an antiseptic hand-wash and dried with a single use disposable paper towel. This reduces the numbers of resident and transient micro-organisms which are capable of transmitting disease. Hand washing should occur before and after every patient contact.

Any cuts or open skin lesions **must** be covered with a waterproof dressing. Dental health care workers who have exudative lesions or weeping dermatitis of the lower arms/hands or face, should refrain from direct patient contact until the condition is resolved.

Protective clothing such as uniforms should be clean, or replaced promptly if soiled.

Food and drink **must not** be consumed in the clinical and sterilising areas.

### **4.4 Personal protective equipment**

The Health and Safety in the Workplace Act requires compliance with the wearing of personal protective equipment (PPE) by health care workers when dealing with biological hazards in their workplace.

#### **Gloves**

Latex or their equivalent non-sterile, disposable, properly fitting gloves **must** be worn for all patient examinations and procedures unless extraordinary circumstances apply.

Gloves are single use items and **must not** be used on another patient. They should be replaced as soon as possible if damaged. If soiled, gloved hands can be washed clean during treatment of the same patient. However, repeated washing may damage the integrity of the glove barrier, and changing of gloves is recommended in this situation. It is mandatory to change gloves before treatment of another patient.

### **Masks/chin-length shields**

Facemasks **must** be routinely worn during dental treatments that could result in the creation of an aerosol containing saliva and/or blood. This includes procedures in which there is use of high-speed hand-pieces, ultrasonic scalers, manipulation with sharp cutting instruments during periodontal treatments and prophylaxis, spraying air and water into the patient's mouth during treatment, and intraoral surgical procedures.

Masks/shields **must** be changed when they become wet or visibly contaminated with blood and/or saliva. In situations where a heavy aerosol is generated, masks/shields may need to be changed during the course of the treatment. Changing the mask/shield between patients also prevents a potential route of cross-infection if the gloved hand accidentally touches a contaminated face mask/shield.

### **Protective eyewear**

Protective eyewear **must** be worn to protect eyes and mucous membranes from damage from macroscopic particles, chemical injury, and microbial infection. Eyewear **must** be impact resistant and should have solid side shields to afford peripheral protection. Protective eyewear should not distort vision and **must** be able to be decontaminated with a cleaning agent/disinfectant between patients.

Patients should be requested to wear protective eyewear during their treatment.

### **Outer Protective clothing**

For clinical practice, outer protective clothing should be worn when undertaking procedures that involve the likelihood of body fluid contamination. The protective garment should be fluid resistant but need not be fluid proof. It should be made of material that does not permit blood or other potentially infectious materials to pass through or reach the dental health care worker, clothes or epithelial or mucosal tissues, ie ideally a disposable, semi-pervious, non-woven gown.

Protective garments **must** be replaced when visibly soiled and should be changed at least daily.

Protective garments and protective equipment **must not** be worn outside the clinical area.

## **4.5 Procedure following needle-stick injury**

### **Immediate care following injury**

If the infectious status of the patient is unknown the injured person **must**:

- Clean and irrigate the wound thoroughly with running water (10 minutes) and then wash the area with soap and water.
- Encourage bleeding, but do not traumatise the area.
- Apply aqueous betadine (povidone-iodine) to the site and cover.
- If an employee, notify their employer.
- At a convenient time in the next few days the injured person should have blood drawn for a baseline screen for HBV, HCV and HIV.

The practitioner/employer should:

- make an assessment of the likelihood that the patient has HBV, HCV or HIV infection

- assess the likelihood that the injury would have transmitted infection were the patient infected
- assess the type of injury – a splash injury carries extremely low risk of transmission whereas a deep penetrating injury with a hollow bore needle containing blood carries a higher risk of viral transmission
- promptly seek advice from an Infectious Diseases Consultant if the patient is thought likely to have HBV, HCV or HIV infection and the injury is considered likely to transmit infection
- explain the nature of the injury and the reasons for concern to the patient and request consent from the patient for blood testing (the patient has the right to decline testing)
- keep a complete record of the event.

If the patient is already known to be HBV, HCV or HIV positive at the time of injury, in addition to the steps above, the practitioner/employer **must** immediately contact the on-call Infectious Diseases Registrar or Consultant at your local major hospital for a risk assessment and recommendations for action. If the patient source is known to be HIV positive, this is extremely important as prophylactic treatment should be started within 2 hours of an injury with a significant risk of transmitting infection.

#### **4.6 Work methods**

Transmission of infection can potentially occur from patients to dental care personnel and vice versa by a number of pathways in the dental surgery environment. Work habits of the dental care team **must** be developed so that the risks of cross infection are minimised.

The concept of a primary clinical area around the patient **must** be developed. This area includes the work surfaces of both the oral health professional and the assistant, but excludes, for example, clinical notes, computers and x-ray viewers, which should be kept away from the primary clinical working area.

Contamination can be spread beyond the primary clinical area by touching instruments, equipment and furniture outside the primary clinical working area during treatment. To prevent this, touching surfaces, stored instruments and materials by contaminated gloved hands should be avoided. Overgloves or transfer forceps may be used to transfer additional instruments to the primary clinical area.

A system of sterile instrument delivery (such as a tray system) should be developed. Each patient's treatment should be carefully planned so that all the instruments and materials necessary are available within the primary clinical area, to further reduce the potential for surface contamination.

It is unnecessary and impractical to adopt measures of asepsis and control of cross infection that are more appropriate for an operating theatre environment. However, where surgical procedures are being undertaken, the sterility of instruments should be further maintained by:

- use of packaged sterile gloves
- use of disposable sterile surgical drapes on bracket tops
- maintaining a no-touch technique.

There is a danger of contamination being spread via aerosols, therefore critical items outside the primary clinical area should be stored under cover or removed from the

bench tops. Drawers and cupboards should not remain open during treatment, otherwise contents should be considered to have become contaminated.

Effective sterilisation and disinfection of potentially contaminated equipment and surfaces **must** be carried out between all patient treatments.

Disposable materials and equipment should be used where appropriate. All single-use items **must** be properly discarded after use into appropriate containers.

A new sterile disposable needle and a new cartridge of local anaesthetic **must** be used for each patient requiring local anaesthetic.

Particular care should be taken to avoid needle-stick injuries and cuts from sharp items. Needle-stick injuries offer the greatest potential for serious cross infection and re-sheathing needles increases the risk of unintentional needle-stick injuries. Gloves do not provide protection against this injury.

When re-capping the dental syringe, a one-handed technique **must** be used - either a scoop technique or preferably with a protective re-capping device. Needle re-capping **must** never involve two hands because of the potential for injury. Workflow practices should be developed to minimise cross-reaching by assistants and the risk of inadvertent needle-stick injury.

In order to reduce the risk of disease transmission in the dental environment, the spread of blood and saliva can be minimised by reducing the generation of aerosols and splatter and reducing the bacterial load. This can be achieved by:

- the use of a high-volume evacuator which exhausts externally during aerosol-creating procedures such as ultrasonic and airturbine procedures
- the use of a rubber dam to reduce the risk of contamination by infective aerosols (use whenever possible to isolate an area of the patient's mouth during treatment)
- the use of an antimicrobial mouthwash by the patient for 30 seconds prior to any intraoral procedure, especially high speed instrumentation – this reduces the numbers of resident and transient microorganisms which are capable of transmitting disease.

#### **4.7 Sterilisation, disinfection and decontamination**

- *Sterilisation* is the complete destruction of all micro-organisms on an inanimate object or instrument.
- *Disinfection* is the destruction of organisms in the non-spore or vegetative state using either heat and water (thermal), or chemical means.
- *Decontamination* is the cleaning - either through manual or mechanical method - of visible dirt or bioburden.

Decontamination **must** occur prior to disinfection or sterilisation procedures.

Sterilisation is the desired process for all reusable instruments and equipment that can withstand the process regardless of the intended use. Disinfection of reusable instruments **must not** be carried out as a substitute for sterilisation.

All instruments used in invasive procedures (eg endodontic files, forceps and elevators) **must** be sterile at the point of use. Prior to their use or reuse such items of equipment **must** be cleaned, wrapped, sterilised and stored in a manner which maintains its sterility.

All other instruments and equipment **must** be sterilised between uses unless they are incapable of withstanding a sterilisation process. Items incapable of being effectively sterilised for reuse **must** be single use and disposable.

Multiple use equipment incapable of being sterilised (eg electric motors, x-ray heads and composite curing lights) may require the use of an instrument sheath or sleeve, or protective barrier to create a barrier for use of that item during procedures. Such items **must** be disinfected between uses.

All used instruments are to be thoroughly cleaned before any sterilisation procedure. Autoclaving of instruments that have not been cleaned bakes the blood and mucus onto them, which may leave viable bacterial and viral contamination underneath and within the baked layer. The steam does not have access to these organisms.

### **An Autoclave MUST be used for Sterilisation**

All reusable, heat-stable instruments and other items that come into contact with the patient's blood, saliva, or mucous membranes, **must** be sterilised before re-use. All hand-pieces **must** be sterilised. Most re-useable dental instruments are heat stable and should withstand repeated exposure to heat sterilisation cycles.

The autoclave **must** be loaded and operated according to the manufacturer's instructions; an incorrectly stacked or overloaded steriliser will be inefficient, preventing total access to the instruments by the steam.

*Note:* Items that are not heat stable (eg. plastic saliva ejectors, some x-ray film holders, and polishing cups) should be single use and discarded after use.

### **Controls MUST be performed**

To ensure the effectiveness of the sterilising cycle initially, the autoclave should be calibrated by the supplier and the whole sterilisation process from cleaning through to packaging and loading validated by the oral health professional.

### **Validation**

An on-site chemical and biological test to establish that the loaded autoclave will consistently achieve sterilisation. *(AS/NZS 4815:2006 Appendix G is an acceptable validation procedure.)*

An autoclave should be re-calibrated following service, and the sterilisation process also revalidated following service and any modification of technique, packaging, load size or content, also any technical changes to the autoclave. If there is no deviation from the verified sterilising process, sterility of processed instruments can be assumed.

As confirmation that instruments have been exposed to the verified sterilisation process, chemical indicators should be included in every load/package. Any change in colour (eg lightening) may indicate that the autoclave has become inefficient and cannot be relied upon to produce acceptable sterility.

Monthly biological testing of the autoclave is suggested to confirm ongoing validation of the sterilisation process.

Clear and adequate records should be kept of routine testing of the autoclave.

**Any failure of a biological test indicates a need for revalidation or for the servicing of the autoclave.**

*Note:* Instruments that are to be stored should be sterilised in correctly sealed packaging that is intended for this purpose. Pins, staples or paper clips should not be used as these puncture the wrap, permitting entry of microorganisms. Sterile packaged instruments should be correctly stored in a designated area where sterility is not compromised.

Some earlier models of autoclave are not designed to take packaged instruments as they do not have a drying cycle. If instruments from such autoclaves are packaged and sealed after autoclaving to prevent them from being contaminated, they cannot be considered to be sterile.

## **4.8 Cleaning & Disinfection**

### **Environmental Surfaces**

Surfaces most likely to become contaminated with bioburden (body fluid/soilage/splatter) as a result of treatment procedures **must** be cleaned and then disinfected immediately after each patient treatment. These surfaces include, but are not limited to, the patient chair, dental tray, spittoon, overhead light handle, x-ray head and any items/surfaces which have been contaminated with bioburden from dental personnel gloves, eg composite syringes, capsules, spatulas, mixing slabs, curing light surfaces and drawer handles.

Disposable contact wrap or commercially available “fitted” covers, where applicable, can be used on frequently contaminated surfaces. The wrap/cover **must** be changed between patients. Where sterility of instruments is to be maintained, the tray top **must** be covered with a sterile drape.

*Note:* The use of a disinfectant on, for example, a bracket top does not result in a sterile surface and if incorrectly used, merely functions as a cleaner. Where sterility of instruments is to be maintained, they should not be placed in contact with such a disinfected but non-sterile bracket top. The bracket top should be covered with a disposable sterile plastic drape. These are readily available and inexpensive, providing a sterile surface from which to work.

### **Selection of Cleaning Agents**

These agents are solutions used for cleaning all items of equipment and environmental surfaces. They also assist in the removal of bioburden which **must** always occur prior to any disinfecting process.

Cleaning agents for manual cleaning should be:

- biodegradable
- non-corrosive
- non-toxic
- non-abrasive
- low foaming
- free rinsing
- preferably liquid
- mildly alkaline (pH range 8.0-10.8) to assist in protein breakdown

In addition, cleaning agents should not contain any of the following agents:

- perfumes
- chlorine
- fatty soaps
- glycerine
- lanolin
- optical brighteners

Cleaning agents **must** be labelled correctly, displaying the agent's name, directions for use, and the expiry date. Material safety data sheets (MSDS) should be held for each cleaning product.

### **Making up cleaning solutions**

Cleaning solutions can be purchased either as bulk concentrated solution or as a ready-to-use solution in a dispenser. Bulk concentrated solution may be financially practical; however, the following points need to be considered:

- 1 An accurate protocol for the correct dilution/strength of the working solution needs to be developed and correct measuring devices used.
- 2 Labelling of dispenser containers **must** be correct.
- 3 Hygienic handling and correct storage of bulk concentrated solution containers are necessary to minimise contamination and spoilage of contents.
- 4 Containers used to finally dispense the cleaning agent should themselves be either discarded after use or cleaned/disinfected in an appropriate manner to further prevent contamination and bacterial growth in the solution with potential for cross-infection.

Ready-to-use solution is advantageous because appropriate labelling of the product is self-evident, and errors in dilution strength are avoided.

### **Cleaning cloths**

Cloths should be disposable, used once and discarded. Cloths should be damp but not dripping, to avoid further dilution of the cleaning solution.

### **Excessive bioburden**

Where there is heavy soilage by body fluids/mucous splatter, the bioburden **must** be first cleaned away using paper towels with gloved hands, and disposed of into the rubbish. The area is then treated as any other contaminated surface.

### **Technique**

Items/surfaces are to be cleaned, followed by application of a disinfectant. The disinfectant **must** be left wet on the surfaces so that the required contact time can be achieved for adequate surface disinfection. After the required contact time the disinfectant is then wiped away.

If a combined detergent/disinfectant is used, the product should be used once to clean away soilage and then reapplied and left wet on the surfaces for the contact time required for disinfection. The detergent/disinfectant is then wiped away.

*Notes:*

- 1 Pump spray is preferred to aerosol fine mist spray as the release of aerosols should be controlled as much as possible.
- 2 Manufacturers' recommendations regarding contact times **must** be followed to ensure effectiveness.
- 3 Surfaces that are not, and will not, be touched or otherwise contaminated during patient treatments, need not be cleaned and disinfected between each patient but should be cleaned and disinfected at the end of the work day.

**Delicate surfaces (eg around light and chair switches)**

The cleaning agent and/or disinfectant should be applied using a damp cloth and then on to the surface. Excess solution should not be applied, as it can seep into joints and cracks, making drying more difficult and potentially damaging equipment.

**Selection of chemical disinfectant agents**

Factors that determine the effectiveness of chemical disinfectants include:

- *Satisfactory contact:* Disinfection is not possible unless the solution has direct and complete contact with all surfaces for the correct length of time.
- *Avoiding neutralization:* Hard water, plastic, rubber, organic waste/bioburden and many detergents reduce the effectiveness of many chemical disinfectants.
- *Concentration:* A solution reconstituted below the recommended strength will not be fully effective; higher concentrations are not necessarily more efficacious and are a waste of resources.
- *Stability:* Diluted solutions may deteriorate with age. The expiry date on the container **must** be checked before use.
- *Speed of action:* Some chemical disinfectants destroy micro-organisms more readily than others.
- *Range of action:* Not all chemical disinfectants destroy the same range of micro-organisms.
- *Cost:* Using a chemical disinfectant inappropriately is expensive and inefficient.

**Commonly used disinfectants in the dental setting**

***Hypochlorites (eg Milton, Domestos, Presept)***

Hypochlorites (NaOCl) destroy a wide range of micro-organisms and are effective against the Hepatitis B and HIV viruses. Their activity is reduced in the presence of organic matter, and they are corrosive at concentrations necessary for environmental disinfection.

*For use on environmental surfaces – 1000ppm free chlorine or 0.1%*

To make up a 1000ppm solution that is stable for 1-30 days, dilute a 5.25% NaOCl solution by one part bleach to 15 parts water. This solution **must** then be stored in a closed brown bottle. The solution should be dispensed into squeegee bottles on a daily basis and any unused solution discarded at the end of the day.

*For use directly on blood and body fluids – 10,000ppm or 1%*

*Caution:* Care **must** be taken to obtain the correct dilutions.

*Not recommended* for upholstery (may cause bleaching or fading), bench-top units, chrome and other metal surfaces.

*Recommended* for floors, ceramic basins, body fluid contamination.

*Contact time* 10 minutes.

### **Alcohol**

Isopropanol or ethanol in 70% - 90% solution is suitable to rapidly disinfect **physically clean surfaces** and some clinical equipment. It evaporates quickly leaving the surface dry, but penetrates organic material poorly. Alcohol destroys most viruses but not spores.

*Caution:* These solutions are flammable. The solutions **must** be stored in a cool, well ventilated area. Care **must** be taken when spraying solution for alcohol dispersion into the atmosphere. Squeegee bottles are more appropriate than spray bottles. Alcohol damages the shellac mounting of lensed instruments and tends to swell and harden rubber and certain types of plastic tubing after prolonged and repeated use. It can also bleach rubber and plastic tiles.

*Not recommended* for delicate monitoring or electronic equipment.

*Recommended* for physically clean bench tops, chrome and stainless steel surfaces and ceramic basins.

*Contact time* at least two minutes is necessary to destroy HIV.

Phenolics and quaternary ammonium compounds

These two groups are used mainly in detergents. Their ability to kill microbes at varying strengths remains difficult to verify, but their ability to inactivate bacteria through destruction of cell walls is proven. The effectiveness of both groups is influenced adversely by hard water and by soap.

*Recommended* for floors, bench tops, walls, furniture.

*Note:* Environmental surfaces, floors and walls should be smooth to facilitate cleaning. Carpet is not allowable in the clinical environment.

*Contact time* 10 minutes.

## **4.9 Water lines**

Many dental unit water lines contain retraction valves to prevent dripping, and the potential exists for infectious material to enter the water lines. The water supply to hand-pieces, air/water syringes and ultrasonic scalers should be flushed for 30 seconds prior to the commencement of treatment each day and for 20 seconds after each patient.

Additional steps may also be taken to ensure non-contamination of water lines. These include:

- the installation of anti-retraction valves (one-way flow check valves) to prevent fluid aspiration and reduce the potential for transfer of potentially infective material into the public water supply. (This may be required by Local Body Regulations.) Routine maintenance of these valves is necessary to ensure their effectiveness.

- fitting a water bottle to the dental unit to supply all water lines allows the use of distilled water, and also provides the ability to flush through and disinfect water lines daily.

#### **4.10 Disposal of wastes**

Contaminated sharp disposables (such as needles, used steel burs, scalpels and local anaesthetic cartridges) **must** be handled with extreme care to avoid injuries. They **must** be placed in a rigid impervious container which can be sealed prior to disposal.

Sharps containers shall meet the requirements specified in AS/NZS 4261:1994 and AS/NZS 4261:1994A as appropriate.

All contaminated disposables, including waste drugs and other surgical waste, should be placed in a secure container. Disposal is not permitted in general refuse services provided by the local authority. Commercial management for the disposal of hazardous medical waste is available in most major centres in New Zealand, and is recommended.

Liquid wastes should be disposed of by carefully pouring into the sewerage drainage system followed by a free flow of running water, eg flushed down a toilet or sluice.

*Note:* Territorial Local Authority Regulations apply to the final disposal of the various categories of waste, in accordance with the New Zealand Standard 4304:2002 *Management of Health Care Waste*. Oral health practitioners are strongly encouraged to contact their Territorial Local Authority for specific instructions on the disposal of clinical waste.

#### **4.11 Technical laboratory items/Contaminated items for dispatch**

Impressions and appliances should be rinsed under running water to remove saliva and visible blood. They should then be sealed in a suitable container (eg an autoclave pouch), and labelled as disinfected or not disinfected prior to dispatch to the laboratory, which should in turn, apply its own code for the control of cross infection.

In the laboratory, technicians should wear gloves when handling contaminated items.

Completed appliances should be disinfected before insertion.

*Note:* Because the compatibility of disinfectants with an ever-increasing range of impression materials varies, manufacturers' recommendations for proper disinfection should be followed.

#### **4.12 Instruments for repair**

All heat-stable instruments, including hand-pieces, should be cleaned and sterilised and sealed in a suitable container (eg an autoclave pouch) before being sent for repair. For the service person's information, the instrument should be labelled as "sterile".

## 5 Bibliography/Further reading

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- 10 Code of Practice for Cleaning, Disinfecting and Sterilising Reusable Medical and Surgical Instruments and Equipment, and Maintenance of Associated Environments in Health Care Facilities, AS 4187, 1994.
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  - i) Chapter 88, Dental Office
  - ii) Section E Cleaning, Disinfection and Sterilisation
- 12 Applied Microbiology for Nurses, Gould and Brooker, 2000. Chapter 5, pages 103-112
- 13 Infection Control Recommendations for the Dental Office and the Dental Laboratory, American Dental Association (ADA) Council on Scientific Affairs and ADA Council on Dental Practice, Journal American Dental Association, 1992: 123(8) (Supplement).
- 14 Australian/New Zealand Standard AS/NZS 4815:2006 *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.*
- 15 Dental Council of New Zealand Code of Practice on Transmissible Viral Infections (September 2007)

## 6 Compliance check list

### **General**

- Staff training
- Documented infection control policy
- Policy reviewed, reinforced, updated
- Practice follows “standard Precautions”
- Bioburden removed prior to disinfection or sterilization
- Hepatitis vaccination for staff or signed declination
- Staff aware of cuts and needle-stick potential
- Current medical histories for patients

### **Personal hygiene**

- Staff fingernails short and clean
- No personal jewellery
- Efficient hand washing before and after treatments
- Cuts and open skin lesions covered

### **Personal protective equipment**

- New pair of gloves per patient

### **Work methods**

- Work methods minimize risk of cross infection
- Designated primary clinical area
- No cross contamination of primary clinical area
- All environmental surfaces, floors and walls smooth and easily cleaned
- Sterilised instruments segregated
- Required instruments available in the primary clinical area
- Staff wear protective glasses and barrier face masks
- Patients offered protective eyewear
- Outer protective clothing worn/launched/disposable/confined to surgery
- No food or drink in the clinical areas
- Disposable local anaesthetic and needles
- Protocol to be implemented for needle-stick/sharps injury/body fluid splash – OSH
- Documentation of all needle-stick/sharps injury/body fluid splash – OSH

### **Sterilisation, cleaning and disinfection**

- Only sterile instruments penetrate tissues
- All heat stable instruments sterilized
- All heat sensitive equipment disposable and discarded
- Cleaning and disinfecting agents stored correctly
- Instruments pre-cleaned, autoclave correctly loaded, stacked, suitable water
- Autoclave maintained, calibrated and sterilisation process validated
- Water lines flushed/anti-retraction valves/bottled sterile water
- Correct disposal of sharps, contaminated disposables, liquid wastes
- Impressions and models rinsed, disinfected and contained for transport
- Instruments and hand-pieces sterilized before dispatch for repair