Consultations
Dental Council
PO Box 10-448
Wellington 6140

29 November 2021

New Zealand
Dental Assoc.

NZDA House,195 Main Highway
Ellerslie, Auckland 1051
PO Box 28084
Remuera, Auckland 1541
New Zealand
tel. +64 9 579 8001
fax. +64 9 580 0010

Sent via email only

Submission:
Consultation on proposed supplement to the IPC practice standard: Supplementary risk management principles for oral health during the COVID-19 pandemic

The Association's Board thanks you for the opportunity to comment on the following question:

Do you support the proposed Supplementary risk management principles for oral health during the COVID-19 pandemic? If you do not support the draft, please share your concerns, reasons for your view, and proposed alternatives if you have any.

The Association supports the overall intent of the supplementary document. The 'hierarchy of controls for COVID-19 risk management in dentistry' (summarised in fig1) is, in principle a concise way to present this information for consultation. But we wish to share the following concerns:

1. **Section: Introduction**

   "The Dental Council has an expectation that oral health practitioners will not refuse to treat those who are unvaccinated."

   (i) This statement of an all-encompassing expectation is of significant concern to us.

   (ii) The Association requests the Council reconsiders making such an unqualified type statement of expectation.

   (iii) It is clear unvaccinated patients, as a group, carry a considerably higher rate of COVID infection. They present greater risk and whilst some risks to practitioner can be mitigated, it remains early days in terms of the evidence relating to actual risk and mitigation strategies.

   (iv) Additionally, the statement sets a level of expectation that is not future proofed. New COVID variants will likely emerge, with new infectivity rates and vaccines may or may not be readily available; the population may or may not be vaccinated.

(v) Mostly though, in the context of today, the statement made gives no consideration to individual practitioners who personally have (or who have staff or family, who have) a higher susceptibility to COVID and / or to the likelihood of more serious outcomes from contracting COVID.

(vi) The Association recommends amending this statement to better indicate the likely future ongoing changing nature of expectations and to better consider any practitioners who either themselves are immunocompromised or have family/staff who are.

(vii) We request the Council amend the statement to read:

"At this time, the Dental Council has an expectation that oral health practitioners will consider all the risk factors prior to accepting or declining to treat unvaccinated patients. Practitioners are to follow all recommendations made within this Supplement to the Infection Prevention and Control Practice Standard''.

Or

"The Dental Council has an expectation that oral health practitioners will consider all the relevant risk factors in the management of patients during the Covid pandemic. Following risk assessment, appropriate management may include referral of the patient or deferral of treatment. Practitioners are to follow all recommendations made within this Supplement to the Infection Prevention and Control Practice Standard''.

(viii) The Association also notes the Ministry of Health has very recently stated:
'Individuals cannot be refused access to health care. Restrictions to access to health care must be informed by a risk assessment, and the onus is upon the provider to justify that the risks are sufficiently high to support those restrictions' [2.]

2. Statement page 2

"As with every health care interaction, practitioners need to assess the risk to their own safety and that of their staff and implement appropriate evidence-based measures commensurate with the level of that risk."

(i) The Association agrees with this statement and this statement reinforces the points we have raised earlier. (Section 1 of this submission)

(ii) Council is presenting to practitioners a supplement to a mandatory standard and outlining the need for practitioners to base their actions on evidence-based measures. This proposed supplement relates to matters that carry hugely significant risks to practitioners and to their patients; risks that have considerable possible consequences. There are some 'acknowledgements' listed at the conclusion of the supplement to the standard.

(iii) The Association and its practitioner members expect and request that a comprehensive evidence based, referenced document should be provided. Please append to this Standard the references to all the evidence base that was considered by Council and those writing the supplement to the IPC practice standard. Doing so will better allow practitioners to assess risk and thereby meet and or understand the requirements of the proposed document. Furthermore, the Association requests that Council maintains a comprehensive online and current resource of evidence that it uses in making determinations on suitability of care.

(iv) With regards to measures commensurate with the level of risk, such measures may include deferring and / or declining to provide care and referring non-vaccinated patients

elsewhere. If so, then (as per point 1 above), that needs to be clearly expressed in this document.

(v) For completeness, in the event of practitioner's own risk assessment leading to the declination of treatment to an unvaccinated patient, there should be a section in this regarding referral of patients/ ensuring patients access care elsewhere.

3. Section: Planning using infection control measures

"Figure 1: Application of the hierarchy of controls for COVID-19 risk management in dentistry".

(i) There is no direct connection between the hierarchy cascade (fig1) and any consideration of the following as control measures that collectively assist to reduce the risk of COVID-19 transmission.

- the urgent or non-urgent nature of proposed or required treatment.
- deferring and /or declining treatment.

In our view this is a deficit in the proposed supplement and the Association requests more clarification be provided with the document.

(ii) While there is emerging international evidence that comparative to general airborne means of transmission, too great an emphasis may have been placed on the importance of AGP's in the transmission of SAR-CoV-2.[1] The Association believes that in this document the Council is inferring all patient interactions should be treated in a manner that does not differentiate between those that are AGP's and those that are not. The Association supports that view at this time and the emphasis being on the actual patient risk factors as described in Fig 3.

4. Section: **Screening**

"Patients present an unknown risk until respiratory and epidemiological risk factors have been assessed. A patient's risk may be reduced depending on:

- *lack of symptoms*
- *their vaccination status*
- *or a negative COVID-19 test result within 72 hrs of their appointment, without symptoms."*

(i) The patient's overall risk must also include the intended treatment (i.e whether deferred treatment is a possibility) and only once that is clearly identified, can the overall risk be fully assessed.

(ii) The second bullet point alludes to the fact that vaccination status DOES alter the level of risk. The Association recommends, as per either option given in Section 1 (vii) of this submission.

(iii) With regards to obtaining a negative COVID-19 test, the Association recommends dropping the time frame to 48 hours and asks why the Council have not specified the test to be a PCR test?

(iv) The Association also wishes that Council would distinguish between PCR and Saliva Testing / Rapid Antigen Testing given that the accuracy of the latter two is reportedly inferior to the former.

"*Figure 2: Patient screening for COVID-19"*

(v) Symptomatic or asymptomatic, non-vaccinated patients will eventually incur higher fees to compensate practices for the extra PPE, cleaning and room stand down. This is a supplement to a standard, (not the actual standard). It is a public document, readily accessible and accessed by the public and media. There is considerable interest from the public with regards to the provision of safe and affordable care.

(vi) Would Council be agreeable to including, within this document, an acknowledgement that the actions now required to keep patients and practitioners safe will likely incur additional costs.

5. Section: Facilities

"Follow a 2-step cleaning and disinfecting process for moderate and high-risk patients."

(i) The Association recommends Council provide more clarity as to what a 2-step cleaning and disinfecting process entails.

6. Section: Stand down time

"Stand down time is required for only high and moderate risk patients"

(i) Compliance with this requirement has resulted in a significant reduction in clinical output, productivity, and income for dental practice. Would Council be agreeable to including, within this document, an indication that the actions now required to keep patients and practitioners safe will likely incur additional costs.

"For moderate and high-risk patients:

- *Wait at least 10 minutes after the patient has left the room before following a 2-step cleaning and disinfecting process. Figure 3 illustrates the stand down requirements."*

(ii) The Association requests the source of the "10 minutes" recommendation in the literature.

7. Section: Patient management

"Offer the support person a medical mask instead of their own mask/face covering."

(i) The Association requests that Council issue a statement of support for clinics who struggle to achieve compliance from support people refusing to wear a mask or have an exemption (especially if they screen as high risk or are accompanying a child under the age of sixteen and are required for consenting to treatment).

8. Section: Team management

"Screen staff daily for symptoms of COVID-19."

(i) Do practices need to maintain a record of this for auditing purposes?

9. Section: ***"Figure 3: Patient management, room, PPE and stand down time requirements"***

"Patient has no known clinical or COVID-19 epidemiological risk factors, but there is no evidence that the patient is fully vaccinated"

(ii) What will the term 'fully-vaccinated' mean with the imminent arrival of booster doses of the vaccine?

"This means the outer protective clothing you normally wear (gown, scrubs, tunics etc.) It can be short sleeve or long sleeve. When long sleeve, change between patients. When short sleeve, change between patients OR alternatively wear a plastic apron over it and change the apron between patients…"

(iii) When dentists are required to discard plastic aprons between every low-risk or medium risk patient, amounting to two plastic aprons, (essentially regardless of their risk profile or the procedure being undertaken) for every patient who is treated across the entire country:
   a. can Council claim that environmental concerns have been adequately accounted for and where is the evidence that doing so is going to reduce cross infection?
   b. could the references related to this be provided please?
   c. could the need to use plastic aprons be removed from being a standard requirement for low-risk patients?

(iv) Stand down time.
The requirement for a stand-down period for all of the moderate risk patients will impact heavily on the delivery of services, especially in 'single room' (the vast majority) of clinical environments. It is notable that this requirement is specifically excluded from multi-chair clinics on the basis of 'barriers to access care'. This seems inconsistent the room stand-down requirements as stipulated in the references used (UK Public Health Guidance and the SDCEP)

10. For patients confirmed to be infected:

- *an Airborne Infection Isolation Room (AIIR) is preferred If not available, treat the patient in a single room, well ventilated, door closed and not positively pressured"*

(i) For clinics unable to fulfil these requirements, will this constitute a legitimate reason to turn patients away without fear of repercussions?

11. Footnote 6,

"*Disposable respirators can be used during a session, up to 4 hours – and must be changed when visibly dirty, damaged, or wet."*

(i) Can Council elaborate if that means for the same patient or on different patients over the course of four hours?

(ii) And if on different patients, what procedures are acceptable during this time frame?

12. Section: **Multi chair clinics**

"support people are low risk."

(i) This will be an issue for parents and support people who are non-vaccinated. Can Council verify whether or not this will be grounds for refusing to treat the patient?

"stand down times do not apply."

(ii) While this is welcome news for multi-chair clinics, where is the scientific evidence for this guidance and what difference do these clinics constitute to others who must abide by stand down periods?

"*Multi chair clinics treating moderate risk patients over the age of 12, must meet the room and stand down requirements as defined in Figure 3.*"

(iv) Has Council considered how will this affect educational institutions?

(v) At this time all patients under 12 years of age are effectively being classed as Moderate Risk (with the added requirements to mitigate such risk) because all children under 12 are ineligible for vaccination.
Has Council fully considered the access to care issues this will further exacerbate?

13. Section: Acknowledgements

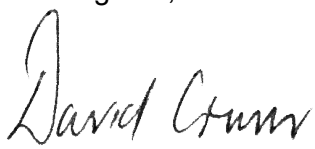
Listed references.

(i) Was this section intended to be identified as References? There seems to be a notable absence of treatment-specific risk, with some emerging evidence that AGPs may not hold as much risk as previously though (Hamilton *et al.* 2021). Yet this is omitted here. The NZDA would appreciate some feedback as to whether this evidence was considered, and if not, why not? NZDA would also appreciate any 'other' literature that was considered in the production of this document be referenced and appended to the document.

14. Further concern

The extremely short consultation period has excluded us from being able to actually compare the existing IPC Practice Standard and this supplement to the Standard. We acknowledge the one-day advance copy of the consultation document and the Zoom briefing allowing some immediate pre-release comment.
The Association always attempts to provide considered and comprehensive feedback to Council consultation documents. The inclusion of the Association at the earlier stages of consultation scoping and early drafts of documents (as they are being developed) would lead to optimal consultation and better outcomes.

Kind regards,



David Crum ONZM
Chief Executive | NZDA

Reference

1. Hamilton, F. Arnold, D. Bzdek, BR. Dodd,J. AERATOR group, Reid, J. Maskell, N. "Aerosol generating procedures: are they of relevance for transmission of SARS-CoV-2?". The Lancet. (9):
2. Ministry of Health position statement on routine pre-consultation testing of unvaccinated individuals in healthcare settings. 25 November 2021 Version 2.0