

Items for Joe to bring to the attention of the ODA

An Infection Control Lapse

No matter what constitutes the revised Standard or Guideline for Infection Prevention and Control (IPAC) in the dental office, it is important that the Ministry of Health, District Health Units, the RCDSO, the ODA and dental practitioners have a clear and unambiguous understanding of what constitutes an Infection Control Lapse.

Until 2018, the definition of an Infection Control Lapse as proposed by the Ministry of Health was that the medical officer of health or designate believes on *reasonable and probable* grounds that a deviation from an IPAC standard of care has or may result in infectious disease transmission to the premises' clients, attendees or staff through exposure to blood, body fluids and/or potentially infectious lesions. (1)

In 2018, the definition of an IPAC lapse was changed to the following. "An IPAC lapse is defined as a failure to follow IPAC practices resulting in a *risk* of transmission of infectious diseases to clients, attendees, or staff through exposure to blood, body fluids, secretions, excretions, mucous membranes, non-intact skin, or contaminated equipment and soiled items. (2)

It appears that the current definition has been expanded to include other routes of exposure and rather than be based on *reasonable and probable* grounds it now depends on a *risk* of transmission. In its Health Hazard Response Protocol 2018, the Ministry of Health defines *risk* as "The probability of an adverse health outcome resulting from exposure to a hazard and the measure of the degree of hazard, defined as a combination of probability and severity of adverse effects on organizational performance, health, property, the environment, or other things of value." (3)

Even with the new definition, an IPAC lapse very much depends on the subjective *probability* of an infection occurring. Assessing whether the probability or the likelihood of an infection happening requires a thorough understanding of the specific incident promoting the idea of a lapse. Such an understanding should include a familiarity with the clinical circumstances surrounding the incident, a detailed knowledge of the scientific literature linking the incident to disease transmission, and if none exists being able to use surrogate investigations to assist in determining the probability of an IPAC lapse.

It is suggested that making such a determination should not rest solely with Ministry of Health officials or with staff from District Health Units. It must include an appropriately knowledgeable member of the dental profession acting on behalf of the RCDSO and the involved practitioner. The ODA could have a representative acting in an observer capacity. Together these individuals should review all the known facts relating to the incident, present their reasons why or why not a probability for infection occurs, and agree as to whether or not a probability of an infection occurring does exist. Only if there is agreement that the probability does exist, should the failure to follow an IPAC practice be treated as a health hazard.

From the above it will be appreciated that what constitutes an Infection Control Lapse is dynamic and fluid as it depends on assessing circumstances and events that are unique to a clinical practice at a specific time in its operation. The identification of a lapse has far reaching and often disturbing consequences, so assessing the probability of its existence ought to be a multidisciplinary exercise.

Practice Guidelines and Standards

It is not known if the RCDSO or the ODA have assessed to what degree existing IPAC recommendations have altered the frequency and severity of blood-borne infections associated with dental practices. Without such information the usefulness of existing protocols has not been proven, and the reason for adopting new ones becomes highly questionable. It must be appreciated by all concerned that doing audits on the completion of IPAC procedures is **not** practicing infection control. It simply provides an assurance that certain functions have been undertaken whether justified or not.

According to the Society for Healthcare Epidemiology of America, "The collection, analysis and dissemination of surveillance data has been shown to be the single most important factor in the prevention of nosocomial infections." (4) Unfortunately, there are no surveillance programs concentrating on infections of dental origin. This absence means that most recommendations relating to dental infection control have limited scientific support but are based almost exclusively on the collective opinions of experts.

Such an approach has flaws. Experts who have invested a considerable amount of time and energy in studying a subject have personal, professional and financial commitments to it, which might promote personal opinions rather than unbiased advice. (5). Therefore, it should be no surprise that a committee of experts-without clearly defined procedures- is liable to create guidelines which are dominated by, "group dynamics, dominant and outspoken personalities, and organizational and specialty politics." (6) It must be emphasized that the majority of IPAC recommendations prepared by the Ministry of Health and the RCDSO suffer from these deficiencies.

A Standard of Practice which applies to all dentists and all patients must be supported by scientific evidence and developed by an unassailable process. Since dental IPAC procedures do not have these criteria, they must be flexible enough to permit the clinicians who disagree with them, to accommodate the needs of individual patients by making choices other than those contained within the guidelines or standards. (7).

It would be incumbent on the ODA to relate to its members that recommendations on dental infection control should clearly identify:

- The individuals and experts used in their development,
- The strength and weaknesses of the available evidence,
- The expected outcomes and how they will be evaluated,
- The expected and potential side effects,
- The costs of implementation,
- What reasonable alternatives were considered. (8,9)

Failure to accomplish these criteria will have an adverse effect on the validity of the recommendations.

In this regard it appears that only two of the numerous recommendations on IPAC pertinent to dentistry are supported by validated clinical investigations. One concerns the importance of handwashing and the other relates to the single use of injectable fluids. These ought to be Standards of Care, while all other recommendations qualify as clinical guidelines subject to interpretation by the attending practitioner.

References

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