European view on infection control

Dental Tribune looks at AESIC, a new organisation focusing on infection control, and speaks to one of the founding members about its aims and aspirations.

Infection control in the dental setting is a fundamental topic in terms of patient safety and regulatory compliance. However, in a European context, it is very difficult to have a consensus across the member states as each country has its own directives.

This is where the Association for European Safety & Infection Control in Dentistry (AESIC) comes in. Recently established, AESIC is a European organisation for information on infection prevention, infection control and hygiene within dentistry. The AESIC mission statement is to be the leading European source of information on safety, infection prevention and infection control for academia, corporations, policy-makers and clinicians alike.

Even though the organisation is still in its infancy, it is bringing together the leading minds in the arena of infection control to campaign for consistency in infection control policy across the European member states. One such mind is Mikael Zimmerman, one of the foremost academics behind quality assurance in Swedish dentistry. He is the author of more than 50 papers on cross infection control and has on several occasions been an advisor to the Swedish Foreign Ministry on hygiene and infection control. Mikael has also worked as advisor to the Swedish Armed Forces in the development of the new Medical Care System to be used by The Nordic Battle Group.

Speaking to Dental Tribune about the founding of AESIC, Mikael was very pleased with how the organisation was shaping up: “We have been talking about the need for a European organisation to focus on infection control for several years – we have been meeting and talking to industrial companies and academics about the idea for a while. Infectious diseases are a very big issue and healthcare associated infections are a big issue. And maybe the biggest issue of all is the development of antibiotic resistance and we have a lot of European norms giving us information about what infection control ought to be in all 27 member countries. And although we have many common norms and directives, there are also 27 different national recommendations.

“It’s a bit strange that we can’t get European countries to work together on the issue of infection control and antibiotic resistance so we thought that AESIC was a good idea to get some common ground where can we start the discussion – what do we agree about?”

Mikael calls AESIC an ‘interimistic’ association as although it now exists, AESIC won’t be fully established until its first meeting in Leids on November 19th, where a board will be elected. Mikael said: “So far it has a lot of practical issues such as founding the association, getting bank accounts in place and attracting members, trying to figure out how to work with other associations, setting up the website and e-newsletter system... things like that.”

The plan for AESIC is that it will be an all-inclusive community for dental professionals and manufacturers across Europe to come together and have a place to be able to discuss issues surrounding infection control. “We want to include everybody concerned with infection control who works within the dental team. At the moment we are targeting mainly dental professionals, the unique thing is to get users, producers, academics and those working in a regulatory capacity to come together and work with each other to contribute towards the best practice for infection control.”

To get the association off the ground, AESIC has eight founding members from dental industry: • Durr Dental AG • Henry Schein • Hu-Friedy Manufacturing BV • Nitram Dental a/s • Scifan GmbH • Schülke + • Smile-On Ltd • W&H Buermooos GmbH

With this in place, it has allowed AESIC to find other partners as well as being the recruitment process for members. To help with this all of the eight founding members will receive a specific number of free member places to distribute to customers, partners and anyone who could both benefit from and participate to the organisation.

Mikael told DT about the various events and means of communication AESIC is setting up for members: “We have established our website – www.aesic.eu. Our plan for that is that it will be the number one resource for information and advice for infection control for everyone involved in dentistry across Europe.

“We have also established an e-newsletter – it’s still in its very early stages, but we have had good feedback from subscribers so we know we are going in the right direction.”

Mikael added: “The most important thing though this year is the meeting in November: we are planning on top of meeting to establish a board and formulate a constitution that we will run a one-day conference with a clinically-oriented topic for one half and a more industrial aspect for the other half of the day. Of course both of them will focus on getting very best for the patient. We will try to bring in key opinion leaders and discuss what is the state of the art in infection control and where do we need to go further?”

To find out more about AESIC and to become a member, go to www.aesic.eu.
Simple Ideas for eliminating the risk of cross-infection

Kathy Porter, Senior Dental Nurse (Decontamination) at Birmingham Dental Hospital, describes the common cross infection threats faced by everyone in the dental practice and “Best Practice” for eliminating them.

Threats from these potential hazards are frequently overlooked, maybe even ignored, even though they represent a significant risk to all concerned.

There cannot be a dental practice in the country that is unaware of the cross infection risks posed by inadequate decontamination and subsequent sterilisation of their dental equipment. Therefore, the routine use of ultrasonic cleaners, washer disinfectors, various types of autoclave or steam steriliser is taken for granted. However there may be many equally dangerous, hidden, threats lying undiscovered and neglected on virtually every hard surface within the practice, certainly within the clinical areas.

What are these risks?

Virtually every day, each individual is exposed to countless millions of microorganisms which might be covering the surfaces of every piece of equipment they come into contact with. The hidden hands – probably the most important vector for the transmission of infection between patients and the practice’s team members.

Indirect contact – via an inanimate carrier (eg crawling or flying insects or an inanimate object) which has become contaminated with infected organisms.

Inhalation – whereby pathogenic microorganisms are exhaled or discharged into the atmosphere by an infected person and then inhaled by another person (eg the common cold).

Direct contact – when one person infects another person by direct person-to-person contact (eg chicken pox).

Ingestion – when microorganisms capable of infecting the gastro-intestinal tract are ingested (eg “common” stomach bugs).

Many of the above can be relatively easily prevented by taking appropriate basic hygiene precautions. These include washing hands between patients and wearing appropriate protective clothing (disposable gloves, face masks, etc). Such precautions protect the patient from the dentist and visa versa. However, not all of them! Some of the above, those involving intermediaries eg inanimate objects, necessitate the thorough implementation of appropriate and effective cleaning regimes in between patients.

The Chain of Infection

The Chain of Infection was first described by Storr and Clayton-Kent in 2004. It consists of the source of the infection, the mode by which it is spread, the person at risk and any potential points of entry. The easiest way to break this chain is by interrupting the mode by which it is spread.

Because hands represent the most important vector for the transmission of infection between patients and members of the practice team, the single most effective way to prevent the spread of pathogenic microorganisms within any clinical environment is effective hand washing. This should be performed for at least two minutes when entering and leaving the clinical area, between patients, after visiting the toilet, when changing gloves and whenever one’s hands are visibly soiled. Alcohol gels can be used on visibly clean hands, but if infection begins they cause a build up. Therefore, they should never be used solely, as an alternative to effective hand washing with soap and water, and it is never acceptable to wash or gel gloves with a view to reusing them. Gloves should always be replaced in between patients.

Best Practice for hard surfaces

Ideally, all basic decontamination processes for small items of equipment etc should take place away from any other activities, preferably in two dedicated decontamination rooms with a clearly defined route from dirty to clean. This is not possible for larger items of equipment, fixtures and furnishings however. Therefore, wherever possible, any work surfaces and equipment should be impermeable and easily cleanable. The work surfaces and floor coverings should be continuous, non-slip and ideally seamless. Wherever possible, carpets should be avoided within any clinical or associated areas. Gowning should be used between the floors and walls to prevent any dust and dirt accumulating in corners and crevices, with any unavoidable joins welded or sealed shut.

A thorough and effective cleaning protocol can be easily based upon utilising simple techniques employing disposable clothes moistened with either clean water or a suitable alcohol-based or alcohol-free disinfectant. Alcohol-free wipes are particularly suitable for alcohol susceptible surfaces eg the leather and synthetic upholstery of dental chairs, plastics, vinyl etc. Wherever possible, cleaning using dry clothes should be avoided because this creates dust, which can form another hazard.

Should any blood contamination occur, one per cent sodium hypochlorite with a yield of 1,000 ppm free chlorine is recommended (unless the PCT policy advises something else). However an even higher free chlorine yield of 10000 ppm is better still. Contact times should be reasonably prolonged and instigated as quickly as possible. Care should be taken to avoid corrosive damage to metal fittings etc. Use of alcohol within the same cleaning process is not recommended because it binds blood and protein to metal surfaces.

Even if they appear uncontaminated, all clinical areas should be cleaned in between patients using disposable cloths or microfiber materials. The areas and equipment to be cleaned in between patients include all the work surfaces, chairs, curving lights, inspection lights, keyboards and mice, hand controls, X-ray units, trolleys, spittoons and aspirators. Disposable single-use protective covers are available for use on many of these items, but they should not be considered or used in place of implementing a thorough and regular cleaning protocol. Therefore, in between patients they should still be removed and the underlying surfaces cleaned.

The main areas and items of equipment to be cleaned after each session include taps, drainage points, splashbacks, cupboard doors and sinks. While items of furniture that need to be cleaned regularly include wood blinds, door handles, incidental chairs and furniture.

Hard surface disinfectants

Nowadays, more environmentally friendly materials (eg Ammonium Chlorides and Ethanol) are available compared with the unpleasant smelling and aggressive chemicals (glu-
the waste, mess and inconvenience associated with aerosol spray disinfectants.

Finally
To implement best practice for infection control, dental surgeries must identify all the potential sources of infection and transmission routes within their practices, and adopt appropriate protocols to break the chain. To ensure these protocols are actioned properly it is vitally important that all new staff members are thoroughly trained in this essential component of practice life. This training must be accurately documented, along with the practice infection control policy, and made available for external audit upon request. Both the policy and the training must be updated and reviewed regularly, at least once a year, and these reviews documented.

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Cleaning up

One way of making sure infection control procedures are carried out properly is to delegate the management of the process to a company dedicated to providing a guaranteed decontamination service. Ken Turley explains.

Infection control is an essential element of any modern dental practice. It is also part of the duty of care; there is a legal obligation to ensure that when a patient consents to dental treatment they receive a standard of care that puts them above any reasonable risk of contamination.

As practice managers will be aware, staff have a statutory duty of care to ensure that all instruments and equipment are safe for use, have undergone a thorough process of cleaning/disinfection, sterilisation and storage, and that any instrument is free from contamination from blood or other body fluids.

The practice’s infection control policy, which all staff should be familiarised with and guided by at all times, forms the basis of a training and reference guide for staff, particularly during their inductions. There should also be a nominated lead member of staff responsible for infection control and decontamination. If the practice has yet to draft their Infection Control policy, it is advised to consult with an expert provider of decontamination services who can help formulate the document correctly.

Follow the rules

Within the policy, the correct procedure for decontamination of instruments should be recorded. There is the need for a clearly defined cycle that ensures reusable items are rendered safe for further use and for staff to handle: this method of reprocessing is detailed in the HTM 01-05 document. It is essential that there is a systematic approach to this process by having clear ‘dirty’ and ‘clean’ zones in the surgery to avoid the cross contamination of used instruments with clean ones.

HTM 01-05 states that, wherever possible, disposable items should be used. Single use items will be clearly marked as such, and reusing such items can seriously affect their safety, performance and effectiveness. Instruments that are difficult to clean, such as matrix bands, saliva ejectors, aspirator tips and three-in-one tips should be considered for replacement by single-use items if appropriate.

Where single-use items are not practical, instruments and appliances must be processed using the correct procedure. This is the only way of ensuring the equipment is free of any possible contamination and therefore safe to use.

The decontamination process

Any instrument contaminated with blood or saliva must be completely clean before it can be sterilised. Manual cleaning is considered to be unsuitable, primarily because of the lack of reproducibility of the conditions. There is, however, still the need for manual inspection after the decontamination process has been completed, to ensure the instruments have been successfully reprocessed.

Washer disinfectors are considered to be the best solution to the cleaning process because they offer a validated, controlled and efficient process of cleaning instruments compared with manual cleaning and most ultrasonic baths. These machines are fully automated and provide a reproducible and validated cycle of cleaning and disinfection. Always consult with a reputable manufacturer on type, requirement, installation etc to ensure you have the right machine and that you and your team fully understand how to gain the most from their use.

Careful loading of the instrument is required, as incorrect loading will inhibit the machine’s ability to clean effectively:

- Do not overload instrument carriers or overlap instruments.
- Open instrument hinges and avoid carriers or overlap instruments.
- Never place the ‘dirty’ end of instruments into the ‘clean’ end of a device.

There is, however, still the need to manually load items into the washer disinfector by the operator. This is particularly important to ensure that all staff are aware of best practice.

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For manual sterilisation, care should be taken to observe the manufacturer’s instructions. All items must be disinfected. A record needs to be kept of the temperature (optimally 134° C) and pressure acheived during the cycle and modern machines will do so automatically; there is one solution to storing data, with a wireless data logging system that can be connected directly to the practice’s computer system.

For dentistry, the two standard types of autoclaves are Type N (non-vacuum) and Type B (vacuum). There is one UK manufacturer who has developed a hybrid B and N steriliser, giving practices greater flexibility in their decontamination options.

Safe storage

Once satisfied that the instrument has been successfully cleaned, storing it safely is vital in preventing the recontamination by pathogens. This is an area of instrument decontamination that must be rigorously controlled and a dedicated storage area, separate from the clinical area, is required to meet ‘best practice’ standards. There needs to be a clear rotation system of ‘first-in first-out’ so instruments are used within the time limit stated in HTM 01-05.

Using trays covered with lids is a practical way for storing and transporting instruments, while pouches are useful for instruments that are used less frequently. By organising instruments into treatment bundles, it is possible for the surgery to identify the cost of decontamination for specific services. This could become a useful method of business cost diagnostics.

The reprocessing of instruments is an integral part of the decontamination procedures of a surgery. Naturally, the new regulations that apply to dentistry will entail a greater burden of administration upon an already busy management team. One solution is to delegate the management of the process to a company dedicated to providing a guaranteed decontamination service to the practice that covers all aspects, from supplies to surgery design.

About the author

Ken Turley is the founding director of the YoYo Dental Practice Group. Following a 13-year military career, Ken worked globally in the mobile telecommunications industry until 2003 when he became managing director of Sabodenta, a 35-year-old hospital autoclave company providing decontamination equipment which he later acquired and re-branded as YoYo in 2008.