A new study has revealed that old-fashioned, manual faucets work better than new hands-free faucets.

The latest electronic-eye sensors to automatically detect hands and dispense pre-set amounts of water have been installed in the USA based Johns Hopkins Hospital, however a study has shown that they were more likely to be contaminated with one of the most common and hazardous bacteria in hospitals compared to old-style fixtures with separate handles for hot and cold water.

"Newer is not necessarily better when it comes to infection control in hospitals, especially when it comes to warding off potential hazards from water-borne bacteria, such as Legionella species," Lisa Maragakis, MD, M.P.H. senior study investigator and infectious disease specialist, was quoted. "New devices, even faucets, however well-intentioned in their make-up and purpose, have the potential for unintended consequences, which is why constant surveillance is needed," says Maragakis, director of hospital epidemiology and infection control at Hopkins Hospital and an assistant professor at the Johns Hopkins University School of Medicine.

Although the new style high-tech faucets cut daily water consumption by well over half, Johns Hopkins researchers identified Legionella growing in 50 per cent of cultured water samples, which were collected from 20 electronic-eye faucets. In comparison, the bacteria were found in only 15 per cent of water cultures from 20 traditional, manual faucets. Reports even stated that weekly water culture results also showed half the amount of bacterial growth of any kind in the manual faucets than in the electronic models.

The precise reason as to why there is a higher percentage in bacterial growth on the hands-free taps is still unknown; however, researchers have suggested that the valves offer additional surfaces for bacteria to become trapped and grow.

The Johns Hopkins researchers presented their findings at the annual meeting of the Society for Health Care Epidemiology (SHEA) in Dallas in April.

Infection control experts behind the latest study say that the electronic devices were widely introduced in patient care and public areas of hospitals across the United States, where the idea was to prevent bacterial spread from people touching the faucet’s water handles with their dirty hands.

Reports have stated that as a result of the study, which was conducted over a seven-week period from December 2008 to January 2009, Johns Hopkins facilities engineers removed all 20 newer faucets from patient care areas and replaced them with manual types. A hundred similar electronic faucets are also being replaced throughout the hospital, and hospital leadership elected to use traditional fixtures – some 1,080 of them – in all patient care areas in the new clinical buildings currently under construction at Johns Hopkins’ East Baltimore campus. The new buildings are set to open in 2012.

Lead study investigator Emily Sydnor, MD, a fellow in infectious diseases at Johns Hopkins, says Legionella bacteria, commonly found in water supplied from public utilities, rarely cause illness in people with healthy immune systems, but pose a real risk of infection in hospital patients whose immune systems are weakened from cancer chemotherapy, anti-rejection drugs after organ transplant, or from diseases such as HIV/AIDS.
Infection prevention
Richard Mugrave discusses cleaning and disinfection

Substandard hygiene procedures used in the medical profession should never be tolerated. It not only puts your patients in danger, it can also put you and your team at risk. It is necessary, therefore, to enlist the use of the most efficient methods of infection prevention in your surgery. To this end, it is essential that your dental team are fully trained in all methods of decontamination and informed as to the different types of harmful bacteria that can lead to diseases, such as MRSA and C.diff. Furthermore, relevant inoculations should be taken by all staff and recorded.

Before any decontamination regimes can proceed, it is important to remove and replace all disposable equipment in the surgery after each patient. Then, all areas and instruments should be ‘zoned’ into ‘clean’ and ‘dirty’ sections. It is worth noting that you should always clean from the cleanest to the dirtiest areas when decontaminating any surface.

Decontamination can be used as an umbrella term to incorporate cleaning, disinfection and sterilisation procedures. In the dental profession, this is necessary for maintaining the hygiene of surfaces and the reprocessing of instruments.

Cleaning
This removes foreign particles, such as dust, from surfaces. It is also the preliminary step in reprocessing instruments, and should be done as soon as possible after their use. It is vital for the successful sterilisation of equipment as debris can shield microbes from the steam of the autoclave.

Disinfection
This process aims to kill pathogens or render them inert. It is most often achieved using bactericidal cleaning agents that are effective against a wide range of microorganisms.

Sterilisation
The ultimate stage in instrument reprocessing, sterilisation destroys all forms of microbial life, including bacterial spores. It is a process crucial for those ‘critical risk’
Cleaning removes foreign particles such as dirt from surfaces. This is enough time for harmful bacteria and viruses to be destroyed, but nowhere near enough to fix any proteins.

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Cleaning is the primary step in reprocessing instruments and implants that penetrate human tissue, as this is where the highest chance of infection lies. The autoclave has proved to be one of the most effective methods of sterilisation. It involves the use of a machine that subjects instruments to high pressure saturated steam created using RO (reverse osmosis) water or distilled water in the reservoir.

When you look for products to aid you in your cleaning regime, it is important to remember the type of materials you are cleaning and disinfecting. Sensitive materials in the surgery, such as leather and soft PVC are vulnerable to strong alcoholic chemicals, so gentle, alcohol-free solutions would be advisable. Tougher materials, such as glass, ceramics and laminate work surfaces can be cleaned and disinfected with alcohol-based products; however it would be prudent to use aldehyde-free solutions.

The largest area in the surgery is the floor and, as such, it is a potential field for pathogens to thrive. Look into using a powerful disinfectant with strong particle loosening properties. In addition, floors vary greatly in material, so when purchasing a cleaner and disinfectant, it is worth making sure it has high material compatibility.

Successful cleaning and disinfection products frequently contain alcohol and yet, section 6.57 of the Department of Health’s HTM 01-05 regulations recommend caution when using alcohol based products, especially on stainless steel, as alcohol has been shown to bind blood and fix protein and biofilm. Clarification is needed here as this only occurs if the appliance is in contact with an alcohol-based solution for at least fifteen minutes. However, using such a disinfectant will only be in contact for a maximum of one or two minutes with the surface. This is enough for alcohol to dry on the surface, enabling bacteria and viruses to remain on the surface without being destroyed.

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The increased awareness of decontamination and cross infection control procedures within dentistry and legislative demands for compliance with HTM 01-05 have made practices consider their obligations in regard to infection control more seriously. Of all the aspects of decontamination mentioned in the guidelines one area that practices may be unaware of is their need to comply with a minimum standard of water quality, both in terms of the water going into their treatment centre and certainly in regard to the output quality of that water ie the water that goes into the patient’s mouth.

The problem of biofilm contamination of DUWLs has long been an issue in dentistry, research as early as 1963 first raised concerns and since then numerous studies have concluded that biofilm is prevalent in dental unit water lines (DUWLs). This is mainly due to the fact that in the majority of today’s most commonly used treatment centres, water is delivered via small bore tubing, providing an ideal environment for the development of bacterial biofilms². The biofilm itself gives rise to problems in two key areas: one, the physical restriction of the flow in narrow lumens and two: in significant numbers of planktonic bacteria in the output water.

Biofilm

The term biofilm refers to a collection of microorganisms that adhere to a surface and are surrounded by a protective and adherent slime (known as the extracellular matrix) which is secreted by the bacteria. Biofilms are particularly prevalent in water containing low concentrations of solids and low levels of nutrients. As well as DUWLs, biofilm can be found in streams and rivers, cooling towers and piped water systems etc.

Biofilms form when a few individual bacteria in the free floating (planktonic) state in water adhere to a solid surface such as the wall of a pipe or tube. The initial attraction to the surface is weak, but subsequent bacteria continue to adhere directly to those already attached and behaviour of the aggregated organisms changes and starts to produce an extra-cellular matrix. This in turn increases adhesion and enables more planktonic bacteria to adhere easily to the film, and so the process continues, increasing levels of biofilm and causing water quality levels to fall below those required by the guidelines.

Significance of biofilms in the dental practice

Biofilm is difficult to identify, remove or control because the susceptibility of biofilms to external agents such as detergents and disinfectants is quite small when compared with that of individual planktonic organisms and each biofilm bacterium requires only small amounts of nutrients in order to survive and flourish. Furthermore, the design of today’s most commonly used treatment centres makes the dental unit water line the ideal substrate for biofilm growth.

DUWLs provide an ideal environment for the growth of bacterial biofilms for the following reasons:

• They are non-toxic; the materials used for tubing are selected for their non toxic properties and flexibility to suit the mechanical operation of dental units. Low toxicity to humans also means
low toxicity to bacteria.

* Water has a low flow rate; the small bore tubes used in dental units provide water at a typical flow rate of 30ml/min. The behaviour of water flowing through a tube means that the linear flow rate decreases from the centre of the tube to its wall. Low linear flow rates favour bacterial adhesion.

* Water flows intermittently; water only flows through the tube when instruments are in use, causing minimal disruption of the growing biofilm.

* Regular replacement of supernatant liquid: when instruments are used or the system is flushed, fresh liquid is brought into contact with the film, bringing with it nutrients and new recruits to join the film. The liquid moving downstream towards the distal end of the system carries bacteria released by the maturing film to the end of the system carries bacteria as they can thrive in this temperature range.

* The surgery provides an ideal temperature range: dental surgeries are normally maintained at "room temperature" for the comfort of patients and staff. This is good news for the film-forming bacteria as they can thrive in this temperature range.

Why is biofilm bad for the practice?

The presence of biofilm is bad news for the dental practice on a number of practical levels not least because the quality of output water is covered by HTM 01-05 guidance and the presence of biofilm makes compliance with this standard very difficult. The existence of biofilm can lead to a reduction in water flow and even tube blockage leading to unit downtime and repair costs. In addition, biofilm can potentially accommodate large numbers of bacteria without any noticeable change in colour or smell and these symptoms are not an accurate indication of whether water lines are contamination free.

The guidelines do clearly state the acceptable maximum level of microbiological contamination in section 6.79 *Where monitoring is carried out the microbiological contamination expressed as TVC (total viable count), the number of viable bacteria per millilitre of water [cfu/ml] should be expected to lie in the range 100 to 200 cfu/ml.* This is similar to the quality that would be expected for mains supplies or bottled water.

The guidelines then go on to indicate a range of measures that can be used to reduce contamination and include the emptying and storage of water bottles at the end of each work day, the use of disinfectants "periodically" as a prevention measure, although no definition of "periodically" is provided and the flushing of water lines; *"for two minutes at the beginning and end of the working day and after breaks. They should also be flushed for 20–30 seconds between patients."* Despite this recommendation however, the guidance acknowledges that flushing has little effect on biofilm build-up.

How clean is your water?

For many years the problem of biofilm in DUWLs has been studied and data collected that clearly demonstrates the presence of biofilm reduces water quality, making it unlikely to meet the minimum standards required by HTM01-05. In a study by Walker et al 2000, 95 per cent of samples taken from DUWLs had contamination levels above the current standard for EU drinking water. So in order to establish the quality of output water a practice needs to be aware of the quality of its input water and then regularly monitor levels of contamination.

Biofilms form when a few individual bacteria in the free floating (planktonic) state in water adhere to a solid surface such as the wall of a pipe or tube

"Where monitoring is carried out the microbiological contamination expressed as TVC (total viable count), the number of viable bacteria per millilitre of water [cfu/ml] should be expected to lie in the range 100 to 200 cfu/ml."
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tamination.

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make up biofilm, inhibiting re-
growth of the film and enabling a
system to maintain water quality of < 200 cfu/ml in line with HTA-01-05 section 6.79, subject to in-
put water quality.

Biofilm was grown in a flow
 cell using bacteria obtained from
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ples and allowed to develop for
10 weeks, the images show that
the Pseudomonas aeruginosa
biofilm was effectively removed
by the product flowing through
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References
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film contamination of dental units and au-
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The hands are a dental practitioner’s most important tool and as such need to adhere to the same stringent methods of cleaning as all other equipment used in the surgery. Both patients and staff can be put at serious risk of infection from pathogenic invaders as a result of lethal bacteria being spread around the practice environment by touch. This makes good hygiene protocols a must to prevent infection transmission within a clinical environment.

For instance, it is essential that before any surgery begins, any cuts or lesions on the clinician’s hands must be securely covered with a waterproof dressing before touching a patient’s mouth, as blood or saliva born viruses can enter or leave the body via open wounds.

The simplest method to ensure the removal of germs is the thorough washing of hands, and if you use the correct hand washing procedure with just hot water and soap, you should be able to destroy the majority of bacteria.

All jewellery should be removed before washing as pathogens also collect on them. The best washing procedure for your hands using soap and water should involve:

- Rubbing palms together, including wrists
- Rub the right palm over the back of the left hand, and left palm over the back of the right hand
- Rub palms together, with fingers interlaced
- Rub the backs of the fingers to opposing palms with fingers interlaced
- Rotational rubbing of thumbs clasped in opposite palms
- Rotational rubbing of fingertips in palms

This should take around 50 seconds and is more effective with a liquid wash solution. You should then rinse your hands thoroughly under running water. It is essential that this procedure is performed meticulously not only after visiting the toilet and before handling food or drink but also upon entering the surgery, before putting on gloves, after removing gloves, before leaving the surgery and after clearing a working area or handling any instruments.

Washing is made more effective when combined with the use of gloves and disinfecting alcohol rubs. The latter is very effective in reducing the spread of lethal bacteria such as MRSA on the hands of dental staff.

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However, there may be some side effects in the regular use of skin-cleansing products, as it can be detrimental to the condition of the skin. Indeed, weaker skin is more prone to irritation. To this end, a delicate balance is required to ensure that hands not only remain hygienic, but also that the professional does not suffer any ill effects.

Allergies are also a severe issue for many people, and these can be linked to perfumes, colours and materials, such as latex. Those with such allergies can struggle to deal with them in a clinical environment, as the materials that trigger them are so crucial to the infection control procedures used in many surgeries.

To help this, use soap-free hand washes and find a rub that can minimise dryness and irritation. In addition, at the end of each surgical session after washing and drying your hands, enlist the use of a water-based moisturising cream or lotion to maintain healthy skin on hands and arms.

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About the author

Richard Musgrave

Richard Musgrave brought his knowledge and experience to Schüke six years ago. Initially working to develop both the range of infection control products as well as the range of infection control training division. Richard is now responsible for the UK marketing team. He attributes the success of Schüke to the quality of its products and its dedication to providing the best possible support to the dental profession, both in the UK and abroad. This commitment is demonstrated through Schüke’s association with key leading companies such as Dental Protection Limited.

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How we did it

Dental Tribune talks to practice manager Janet Edwards on infection control

With all the changes to dentistry with HTM 01-05 and CQC, one practice has adopted the guidelines to suit them and work with their practice and not against it.

The changes that have been made at Hoghton Street Dental Practice has generated masses of attention; practice manager Janet Edwards has been invited to speak at this year's BDA conference and Schülke UK used Hoghton Street Dental Practice for the re-filming of their training packages in infection control.

Janet talked to Dental Tribune about their experience and how they achieved and managed to comply in the best way that they could...

"In the beginning we went in to it blind with just the BDA guidance on infection control. To enable us to create a sterilisation room we took over another part of the building that our practice was in. We relied a lot on our equipment supplier, Eschmann, and Martin Loftus, Business Development Manager at Eschmann, was a great help. Martin helped us with the design, setting up the flow through and the completion of the room. Initially we had looked at dividing the room in to two rooms but due to practicalities, it was decided that it was best to leave it as it was. In the room itself we’ve got four underbench washers and four autoclaves and at my other branch site I’ve got three underbench washers and three autoclaves. We basically complied with best standards."

However, complying with best standards wasn’t the only thing that Janet’s practice did. After the draft of HTM 01-05 came out in 2008, and Martin Fulford, BDS MPri DGDG FIRMS, had audited for the practice, advising on training issues and even magnifying lights, Janet started making additional advances towards infection control that have since made her practices stand out.

"When the room was up and running we developed our own system that enabled us to trace instruments: This way if there is ever a query about a patient over a blood born virus we can prove that the tray that the patient had been treated with had gone through that particular washer, on that particular cycle, in that particular autoclave and we would know that the daily tests had been carried out on all the equipment. Basically, we validate the disinfection and sterilisation for patient instruments."

I believe no one else does this and we’ve had quite a few practices coming in to see how we work it and how we’ve developed it and they’ve taken some ideas away with them."

Issues However, as with any form of change, there were issues along the way, as Janet explained:

“One of the issues that was noticed when the washers were in use was that the number of hand piece repairs were in

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Another point to remember is cost. With changes to your practice comes a price, such as setting up the room, the costs of running machines and changing your electricity supply.

“Many machines that are used could overload the current supply that a practice has and this is a cost that people need to be aware of,” Janet said.

Going back to validation, Janet explained the process of having the machines validated and serviced, the daily and weekly tests for protein residue and how the washer disinfectors and the autoclaves need to have printers or data capture loggers. Janet described how they’d not only got printers on the autoclaves but how they’ve also got data capture on the washer disinfecter: “The data is downloaded on a monthly basis and saved on two different computers so we’ve got it backed up.”

The traceability side of things is something extra that the practice offers, but ultimately it’s a backup for the practice.

Rotation system

Janet’s practice also has a heat seal machine for the bagging and storage of instruments, and looking into finer details they have a tray rotation system to ensure that no trays are forgotten about. Janet also explained that if a practice has just been using autoclaves in the past they would be used to a 12-15 minute cycle: however, with a washer disinfecter the cycle time can be up to an hour.

are the sorts of things that people need to be aware of.”

“You have to look at the number of instruments that you’ve got and the turnaround time of getting those instruments back; we had to increase on the number of instruments that we had in the practice and that added to the costs. These did notice with the patients was that when we moved to the instruments being bagged in the heat machine and breaking the seal in front of them, we had comments from patients saying “that’s new isn’t it?”. When they do notice we explain to them that once the instruments have been sterilised this is how they’re stored so they don’t get dirty before they enter the patients’ mouth.”

“In the end I think it’s important that you do as much as you possibly can with the premises and circumstances that you’ve got; at the end of the day it’s one of those things that we can’t avoid.”

Janet will be speaking on Thursday 19th May 2011 at the British Dental Conference and Exhibition at the Manchester Central Convention Complex (MCCC), Manchester, (Thursday 19, Friday 20 and Saturday 21 May 2011).