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Subject:	Infection Prevention and Control Guidelines
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Hello All,

Further to our discussion during our monthly Zoom meeting I would like to suggest an amendment to the "Current IPC Standards".

Specifically I would like to address the proposal that all items must be held in incubation until a biological indicator shows the load was successfully sterilized or else every bag must be itemized and recorded in the patient chart. Please find my discussion on this topic below:

1. I understand that part of the reason the government has suggested this, is that they would like the standards for medical care to be the same throughout the province whether the patient is being seen in a private practice setting or an OR hospital setting. However, this is like comparing apples to grapefruits and not apples to apples.

-A surgery in an OR is sterile and so is the site. In a dental office where the patient is having an MO filling done, that is not a sterile site at all.

-Placing a mirror, a rubber dam frame, a hand piece to polish, etc is more akin to a fork at a restaurant than it is a sterile surgery in an OR setting.

-A better comparison for the items listed above is a tongue depressor at a physician's office. I have yet to see (and don't plan to see in the near future) individually bagged tongue depressors with the sterilization date marked on them. Instead they are kept in a semi- open container in their exam rooms (similar to a fork and knife at a restaurant).

2. Reasons given for these changes include public perception/protection.

-Let's all assume a worst case scenario where a patient (Patient A) contracts a virus such as HIV and as part of the pubic health investigation they feel it came from a dental appointment and in the investigation they need to see what other patient's were exposed to instruments run through the same sterilization cycle as what was used on Patient A (because maybe the sterilizer was not functioning correctly). If Patient A had a simple filling done he likely required 8-12 different bags to be opened as part of this procedure. These 8-12 bags would not have all come through the same sterilizer cycle and even though we know what load each of his bags came through we have no way to cross-reference how many bags were in each of those loads and when the next time those bags were used. From a public health perspective it does not even help us.

-From a public perception standpoint some would argue that patient's love to know that each of the items opened for them are recorded. I would argue that this makes no difference. If I had a patient who was really concerned about whether their instruments were sterilized i could show them my log book which would show that every cycle will have a Class V indicator showing that the sterilizer has reached temperature, pressure, and time. There is also the indicator on each bag, a log book showing that a BI was run in the office each day for each sterilizer (and a control as well), and also the outside confirmation from the College of Dentistry. This is more than sufficient. It would also help to sow public health in the example above that the patient could nt have contracted HIV through the dental office.

3. Cost to the system

I understand that our expenses can not be the sole reason we may Infection Prevention and Control decisions. If that was the case, many providers would still not be wearing gloves. However, whenever we have an increased

expense this will eventually get passed along to the patients. Dentistry is already unaffordable for many, and making large changes like this with no research to justify how they save the patient/public are an added barrier to care. This change alone will cost the average dental office over $15,000.00-$30,000.00 a year. This cost will be passed along. With no research to justify this change I am not sure how we can increase the barriers to care (and increase the risk of morbidity and mortality from inability to seek care) for the public of Saskatchewan. Just as with our discussion on motors for hand pieces, if there is no research to support a change how can we justify a change when the whole basis of dentistry is to make evidence based decisions.

4. My suggestion

I think the proposal can be left as is but amended to only include procedures where bone will be exposed, a graft will be placed, or a sterile device will be left intraorally. This may need worded better but would include:

Surgical Root Canals, Placement of Implants or TADS, Surgical extractions which will require removal of bone or the raising of a flap, periodontal surgeries where the periosteum or bone will be exposed, soft and hard tissue grafts, removal of bony lesions or removal of soft tissue lesions down to periosteum. I am sure there are several others that would fit this category as well.

As for all the other procedures (scaling, fillings, crowns, dentures, etc.) I think a Class V indicator in every load, BI run daily, external weekly BI, Indicators on the bags is more than sufficient to confirm everything we use is safe to the patient.

Just my thoughts and I am sure we can discuss further leading up to fall Council and at the meetings as well.

Drew