NEW BRUNSWICK DENTAL SOCIETY RULE 1

REQUIREMENT FOR REGISTRATION FOR DENTISTES

1. The dentist must complete and submit an application form in either official language.

2. The dentist must meet the following requirements and provide proper documentations with the application proving eligibility:

    i) Hold a degree from an accredited school of dentistry or complete the NDEB equivalency process if graduated from a non accredited school.
    ii) Hold the the National Dental Examining Board of Canada certificate.
    iii) Apply for Malpractice Insurance under the malpractice plan of the Canadian Dental Association as master policy holder which plan is administered by Canadian Dental Service Plans Inc (CDSPI) in the minimum amount of *three* million dollars.
    iv) If currently or previously licensed in another juridictions, the applicant must be in good standing in these jurisdictions and must not be the subject of any pending complaint or sanctions that would result in the suspension, revocation, or cancellation of the applicant's registration or license to practice dentistry. The applicant is not entitled to be registered pending the final outcome. Applicants applying for temporary license for educational or or research purpose are required to provide letters of good standing only from current licensing juridictions.
    v) Be legally allowed to work as a dentist in Canada
    vi) Do not pose risk to vulnerable population

3. Applicable registration fee must be paid at the time of registration and are not refundable.

4. Repealed

5. In addition to the requirements above, a specialist must:
    i) Be a graduate of an CDA/ADA accredited dental program in a specialty recognized by the Canadian Dental Association
    ii) provide proof of having successfully completed the National Dental Specialty Examination (NDSE).
    iii) If the applicant doesn't hold the NDEB certificate, a restricted license to the specialty only will be issued.

6. The applicant must submit all documents to the Registrar prior to the scheduling of an interview at which time the license will be approved.

7. Lapse of Practice/Non-Initial Licensure

i) Any dentist last licensed by another Canadian Dental Regulatory Authority (the "last jurisdiction"), and not licensed in that last jurisdiction within three years (the "lapsed license"), in addition to proving good standing in that jurisdiction, must satisfy the Registrar that they are currently eligible for licensure in the last jurisdiction.

ii) Any New Brunswick dentist who has lapsed their license for more than three years, in addition to good standing, must be approved by the Registrar's office upon satisfying the conditions set by the registrar.

iii) Any dentist who has permitted their Canadian license to lapse for less than three years, in addition to demonstrating good standing, must complete thirty (30) hours of continuing education per lapsed year. In the case of a general dentist, the continuing education must be relevant to all facets of the general dentist's scope and in the case of a specialist, at least fifty (50) per cent must be related to the specialty. The continuing education must comply with Rule 2 and the CE requirements document.

iv) Any applicant who passed the NDEB exam over 3 years before applying for initial licensure in Canada must take the following NDEB exams: AFK, ACJ, NDECC within the 3 years prior to the licensing application.

v) Any New Brunswick dentist who has lapsed their NB license and who are or were licensed within the last three years in another Canadian jurisdiction must prove that they are in good standing with that juridiction.

RULE 2

NEW BRUNSWICK DENTAL SOCIETY
MANDATORY CONTINUING EDUCATION
EXIGENCES EN MATIÈRE DE FORMATION DENTAIRE CONTINUE

Dentists

As a prerequisite for ongoing licensure in New Brunswick, dentists will be required to obtain a minimum credit level of NBDS recognized continuing education credits as approved by the Board.

CE credits obtained prior to the beginning of a cycle do not count toward the requirements for that cycle.

Full-time university students, graduates, post-graduates and hospital residents are exempted from these requirements until successful completion of their program. In these cases, the cycle will commence on the date of graduation or completion of the program with a pro-rated requirement.

For licensed specialists, at least 50% of the required credits must be acquired through programs pertaining to the specialty in which the dentist is certified.

REPORTING & ELIGIBILITY OF CREDITS

It is the member's responsibility to ensure that credits for each continuing education course/program are reported accurately.

Records for each member will be maintained by the NBDS from the accurate information reported by members. Falsification of any information will be considered professional misconduct.

Dentistes

Comme condition préalable au permis permanent au Nouveau-Brunswick, les dentistes devront obtenir un minimum de crédits de cours de formation continue reconnus par le Conseil de la SDNB.

Les crédits de formation continue obtenus avant le début d'un cycle ne sont pas acceptés pour satisfaire aux exigences de ce cycle.

Ces dispositions ne s'appliquent pas aux étudiants universitaires à plein temps, aux étudiants de deuxième et troisième cycle et aux internes jusqu'à l'achèvement de leurs programmes. Dans leur cas, le cycle commencera à la date de l'obtention du diplôme ou l'achèvement du programme avec les exigences fixées au prorata.

Pour les spécialistes titulaires de permis, au moins 50 % des crédits exigés doivent être acquis dans le cadre de programmes liés à la spécialité dans laquelle le dentiste est agréé.

LE RAPPORT ET L'ADMISSIBILITÉ DES CRÉDITS

Il appartient aux membres de faire en sorte que les crédits de chaque cours ou programme de formation continue soient notés avec exactitude.

La Société tiendra le dossier de chaque membre, selon l'information fournie par ces derniers. Toute falsification sera considérée comme une faute professionnelle.

CE credits in excess of those required in a cycle cannot be carried forward to the next cycle. There may, however, be situations where exceptions are made at the discretion of the Registrar's office.

Les crédits de formation continue excédant le nombre requis dans un cycle ne peuvent être reportés au cycle suivant. Des exceptions peuvent toutefois être faites, à la discrétion du bureau du registraire.

The NBDS recognizes that there are many valid forms of self-directed continuing education and also recognizes that without standardized testing, the true level of continuing competence cannot be fully assessed. However**, for the purposes of monitoring the following sponsors of continuing education courses/seminars/lectures would be accepted for CE credits, on an hour for hour credit basis.**

La SDNB reconnaît qu'il existe de nombreuses formes de formation continue autodirigée. Elle reconnaît également qu'il est impossible d'évaluer pleinement le niveau réel de compétences sans avoir recours à des tests normalisés. Cependant, **à des fins de contrôle**, les promoteurs suivants **de cours, colloques ou conférences de formation continue seront reconnus ainsi que les crédits équivalant au nombre d'heures de cours :**

(a) All accredited dental schools, universities and colleges.

a) Toutes les écoles d'art dentaire, les universités et les collèges agréés.

(b) Provincial, state and national dental events, as well as those coordinated by a regional society of the New Brunswick Dental Society.

b) Les assemblées de niveau provincial, national et d'état ainsi que celles des sociétés régionales de la Société dentaire du Nouveau-Brunswick.

(c) Study clubs which have received approval from the New Brunswick Dental Society.

c) Les cercles d'étude approuvés par la Société dentaire du Nouveau-Brunswick.

(d) All Federal Government health agencies, including the military service.

d) Tous les organismes de santé du gouvernement fédéral, y compris le service militaire.

(e) All Provincial or local government departments of health or public health.

e) Tous les ministères provinciaux ou services municipaux de santé ou d'hygiène publique.

(f) All hospitals accredited by the Canadian Council of Hospital Accreditation.

f) Tous les hôpitaux agréés par le Conseil canadien d'agrément des établissements de santé.

(g) National or international dental organizations recognized by the Canadian Dental Association or the American Dental Association or the N. B. Dental Society (ie. AGD, FDI etc.)

g) Les organisations dentaires nationales ou internationales reconnues par l'Association dentaire canadienne, l'American Dental Association ou la Société dentaire du Nouveau-Brunswick (ex. l'AGD, la FDI, etc.)

(h) Other health care organizations.

h) D'autres organisations de soins de santé.

(i) Other sources as set in the CE requirements document.

i) Autres sources telles que définies dans le document des exigences de la formation continue

PROVINCIAL ANNUAL & NBDS BOARD OF DIRECTORS MEETINGS

Regional Society meetings NBDS Annual meetings and NBDS Board of Directors meetings will qualify for credits.

ASSEMBLÉES ANNUELLES PROVINCIALES ET RÉUNIONS DU CONSEIL D'ADMINISTRATION DE LA SDNB

Les assemblées annuelles provinciales et régionales, ainsi que les réunions du conseil d'administration de la SDNB procureront des crédits.

STUDY CLUBS

Study clubs, approved by the Registrar, must maintain attendance records for members and provide certificates to the attendees.

CERCLES D'ÉTUDE

Les cercles d'études approuvés par le registraire doivent tenir la fiche de présence des membres et fournir des certificats aux participants.

ONLINE COURSES AND PROFESSIONAL READINGS

Online courses qualify for an appropriate number of hours of continuing if they are supported by a certificate. Total credits **will be determined by the sponsor**.

Online continuing dental education that are not verified with a certificate must be approved the registrar to qualify for credits.

NOTE:
Questions pertaining to the continuing education requirements should be directed to the office of the Registrar.

All sections of the continuing education guidelines are subject to periodic review by the Registrar and the Board.

COURS EN LIGNE ET LECTURES PERTINENTES

Les cours en ligne sont acceptés pour un nombre approprié d'heures de formation continue si ils sont supporté par un certificat. Le nombre total

sera déterminé par le sponsor.

La formation dentaire continue qui n'est pas vérifiée par un certificat doit être approuvée par le registraire pour être admissible aux crédits.

NOTE :
Les questions relatives aux exigences en matière de formation continue devraient être adressées au bureau du registraire.

Tous les articles des lignes directrices en matière de formation continue peuvent être révisés périodiquement par le registraire et le conseil d'administration.

FAILURE TO PROVIDE EVIDENCE OF THE CE CYCLE REQUIREMENT

Failure to provide the NBDS with evidence of compliance with the cycle requirement in continuing dental education will lead to non-renewal of the licence to practise dentistry in New Brunswick until all requirements are met, unless compelling reasons, such as sickness or serious family or other situations, can be shown to have prevented the member from complying with this requirement.

Unless a situation as described above exists and is accepted by the Registrar's office, the following protocol will apply:

(a) The members will be notified by email, not later than January 31, that they have not met the requirement regarding mandatory continuing dental education for the cycle and that their licences will be suspended if the required material is not made available by March 1st.

(b) The members will be required to forward evidence of the required number of credits or provide evidence of extenuating circumstances which may have prevented attainment of the required credit hours by March 1st for consideration by the Registrar's office.

(c) The member will be informed by email that as of March 1st their license has been suspended and that the registrar has filed a complaint to the complaint committee.

MANQUE DE PREUVE D'AVOIR SATISFAIT AUX EXIGENCES DU CYCLE DE LA FC

Une personne qui néglige de fournir à la SDNB la preuve d'avoir satisfait les exigences du cycle en formation dentaire continue se verra refuser le renouvellement de son permis d'exercer la profession dentaire au Nouveau-Brunswick, jusqu'à ce que toutes les exigences soient satisfaites, à moins qu'il soit démontré que des raisons sérieuses telles que la maladie, de graves problèmes familiaux ou autres situations l'ont empêchée de se conformer aux exigences.

À moins d'une situation telle que mentionnée ci-dessus et acceptée par le bureau du registraire, les modalités suivantes seront appliquées :

a) Les membres seront avisés par courriel au plus tard le 31 janvier qu'ils ou elles n'ont pas satisfait aux exigences en matière de formation dentaire continue obligatoire pour le cycle et leurs permis ne seront pas renouvelés si l'information demandée n'est pas reçue au plus tard le 1er mars .

b) Les membres devront faire parvenir la preuve de l'obtention du nombre requis de crédits or fournir la preuve de circonstances atténuantes qui ont pu empêcher d'obtenir le nombre requis d'heures-crédits au plus tard le 1er mars pour être étudiée par le bureau du registraire.

c) Le membre sera informé par courriel qu'à compter du 1er mars que son permis a été suspendu et que le registraire a déposé une plainte au comité des plaintes.

Continuing Education Credits

1. The N.B.D.S. recognizes the following credit levels as the minimum level to be obtained by members of the dental care profession under its jurisdiction:

1.1 **Dentists** will need to obtain a minimum level of credits per cycle as determined by the continuing education guidelines.

1.2 Repealed - February 2024

1.3 (a) AGM - Attendance of the continuing education component of the Provincial AGM and NBDS Business meeting will qualify a member for a maximum of 15 credit hours per year (9 credits in approved courses and activities and 6 credits designated for attendance of the business meeting).

1.3 (b) Regional Meetings – Members who attend regional meetings will receive 3 credits per meeting.

1.3 (c) Extra-Provincial Meetings – Representatives attending extra-provincial meetings on behalf of the NBDS will receive 6 credit hours per day of meetings.

1.3 (d) NBDS Board Meetings – Members attending Board Meetings will receive a minimum of 4 credit hours and a maximum of 6 credit hours per day of meetings (exclusive of meals).

1.4 Self-Study courses and Professional Readings not accompanied by a sponsor corrected quiz will qualify for 1/2 a credit per hour.

Crédits de la formation continue

1. Les membres de la profession dentaire adhérant à la SDNB doivent obtenir au minimum les nombres d'unités suivants :

1.1 Les **dentistes** doivent obtenir un minimum unités par cycle tel que determins par lignes directrices de la formation continue.

1.2 Abrogée - Février 2024

1.3 (a) AGA – La présence à la partie sur la formation continue de l'AGA provinciale et de la réunion de la SDNB procure au membre un maximum de 15 heures-crédits par année (9 unités pour les activités et cours approuvés et 6 unités désignées pour la présence à la réunion).

1.3 (b) Réunions régionales – Les membres qui assistent aux réunions régionales obtiendront 3 unités de formation par réunion.

1.3 (c) Réunions à l'extérieur de la province – Les personnes représentant la SDNB à des réunions à l'extérieur de la province recevront 6 heures-crédits par journée de réunion.

1.3 (d) Réunions du conseil de la SDNB – Les membres assistant aux réunions du conseil d'administration obtiendront au minimum 4 heures-crédits et au maximum 6 heures-crédits par journée de réunion (repas exclus).

1.4 Les cours d'enseignement individuel et les lectures professionnelles non accompagnés d'un examen corrigé par un répondant procurent une demi-unité par heure.

CE REQUIREMENT INITIAL LICENSURE OR REINSTATEMENT

Any dentist applying for licensure in New Brunswick or re-licensure who is not currently licensed with another Canadian Regulatory Authority, shall submit to the Registrar's Office proof of thirty (30) hours of continuing education credits per each year or the pro-rated portion thereof, in which the applicant has not been licensed and in good standing. Non-initial applicants shall satisfy the Registrar's Office that such continuing education credits are relevant to all facets of a general dentist's scope of practice; where the applicant is a specialist, the continuing education credits shall be at least fifty (50) per cent related to his or her specialty.

CE FOR INSTRUCTORS

Dentists who have received prior approval from the Registrar to offer continuing education courses are entitled to obtain continuing education credits for the preparation and development of the course, as well as continuing education credits associated with the course. Regarding preparation and development, applicants are entitled to claim two hours for each hour of instruction to a maximum of eight hours. CE credits for the preparation of a specific course can only be claimed once.

NON APPROVED COURSES

If pre-approval of a course is not sought as provided for in the above section 1.6, dentists shall only be entitled to 1/3 of the continuing education credits which would have been awarded had the course been pre-approved by the Registrar.

2. Repealed

CE REQUIREMENT DOCUMENT

Members must refer and comply with to the ''CE requirements '' document.

ÉXIGENCE DE FORMATION CONTINUE POUR DEMANDE DE PÉRMIS INITIAL OR RETABLISSEMENT DE PÉRMIS.

Les dentistes non membres d'un organisme canadien de réglementation professionnelle qui demandent un permis d'exercice au Nouveau-Brunswick doivent fournir au registraire la preuve qu'ils ou elles ont suivi trente (30) heures de formation continue par année de non-exercice de la profession, ou l'équivalent calculé proportionnellement à la période de non-exercice de la profession. Les candidats n'ayant pas de permis initial doivent démontrer au registraire que leurs unités de formation continue sont reliées à tous les aspects du champ d'activité de dentiste généraliste. Pour les spécialistes, cinquante pour cent (50 %) des unités de formation continue doivent être reliées à la spécialité pour laquelle le permis d'exercice est demandé.

CREDIT DE FC POUR LES INSTRUCTEURS

Les dentistes offrant des cours en formation continue et ayant obtenu l'approbation du registraire au préalable sont autorisés à obtenir des crédits de formation continue pour la préparation et le développement du cours, aussi bien que des crédits de formation continue liés au cours. Concernant la préparation et le développement, les demandeurs sont autorisés à réclamer deux heures pour chaque heure d'instruction jusqu'à un maximum de huit heures. Les crédits de FC pour la préparation d'un cours spécifique ne peuvent être réclamés qu'une seule fois.

COURS NON APPROVÉS

Si l'approbation n'est pas obtenue au préalable selon l'article 1.6 ci-haut, les dentistes obtiendront seulement 1/3 des heures-crédits en formation continue qu'ils auraient reçues si l'approbation du registraire avait été obtenue au préalable.

2. Abbrogée

DOCUMENT DES '' EXIGENCES DE LA FORMATION CONTINUE''

Les membres doivent se référer et se conformer au document « Exigences CE ».

Dental Assistants

DENTAL ASSISTANTS CONTINUING EDUCATION REQUIREMENTS

7. All certified level II dental assistants must provi proof that they have completed a minimum of 12 continuing education credits by December 31st of the year in order to qualify for license renewal in the following year, with 6 of those being related to medical/dental issues.

Dental Assistants are responsible for uploading their CE certificates to the NBDS portal.

CE courses may include:

1. All accredited dental related programs, (including the NBDS conference sessions)
2. Local Provincial, National Dental, Dental Assisting/Hygiene Association sessions
3. Study clubs recognized by the NBDS Registrar
4. National Dental Specialty Organizations recognized by the CDA
5. First Aid and CPR
6. Other courses as approved by the Registrar

FAILURE TO PROVIDE EVIDENCE OF THE CE CYCLE REQUIREMENT

Failure to provide the NBDS with evidence of compliance with the CE equirement in will lead to non-renewal of the licence until all requirements are met, unless compelling reasons, such as sickness or serious family or other situations, can be shown to have prevented the member from complying with this requirement.

Unless a situation as described above exists and is accepted by the Registrar's office, the following protocol will apply:

(a) The person will be notified by email, not later than January 31, that they have not met the requirement regarding mandatory continuing dental education for the cycle and that their licences will not be suspended if the required material is not made available by March 1st.

(b) The person will be required to forward evidence of the required number of credits or provide evidence of extenuating circumstances which may have prevented attainment of the required credit hours by March 1st for consideration by the Registrar's office.

(c) The member will be informed by email that as of March 1st their license has been suspended.

Aides-dentistes

EXIGENCES DE FORMATION CONTINUE POUR LES AIDES-DENTISTES

7. Toutes les assistantes dentaires certifiées de niveau doivent fournir la preuve qu'ils/elles ont complété un minimum de 12 crédits de formation continue au 31 décembre de l'année afin de pouvoir bénéficier du renouvellement de leur permis pour l'année suivante, dont 6 étant liés au domaine médical/dentaire.

Les aides-dentistes sont responsables de télécharger leurs certificats CE sur le portail SDNB.

Les cours CE peuvent inclure :

1. Tous les programmes accrédités liés aux soins dentaires compris les séances de la conférence SDNB)
2. Séances des associations locales, provinciales, national de soins dentaires, d'assistance dentaire et d'hygiène
3. Clubs d'études reconnus par le registraire de la SD
4. Organisations nationales de spécialités dentair reconnues par l'ADC
5. Premiers soins et RCR
6. Autres cours approuvés par le registrai

MANQUE DE PREUVE D'AVOIR SATISFAIT AUX EXIGENCES DU CYCLE DE LA FC

Une personne qui néglige de fournir à la SDNB la preuve d'avoir satisfait les exigences de la FC ce verra refuser le renouvellement de son permis d'exercer jusqu'à ce que toutes les exigences soient satisfaites, à moins qu'il soit démontré que des raisons sérieuses telles que la maladie, de graves problèmes familiaux ou autres situations l'ont empêchée de se conformer aux exigences.

À moins d'une situation telle que mentionnée ci-dessus et acceptée par le bureau du registraire, les modalités suivantes seront appliquées :

a) Les personnes seront avisés par courriel au plus tard le 31 janvier qu'ils ou elles n'ont pas satisfait aux exigences en matière de formation dentaire continue obligatoire pour le cycle et leurs permis ne seront pas renouvelés si l'information demandée n'est pas reçue au plus tard le 1ier mars.

b) Les personnes devront faire parvenir la preuve de l'obtention du nombre requis de crédits or fournir la preuve de circonstances atténuantes qui ont pu empêcher d'obtenir le nombre requis d'heures-crédits au plus tard le 1ier mars pour être étudiée par le bureau du registraire.

c) Le membre sera informé par courriel qu'à compter du 1er mars que son permis a été suspendu

RULE 3

COMMUNICATION BETWEEN THE SPECIALIST AND REFERRING DENTIST

Where it is determined by the specialist, that the referred patient requires additional dental care outside his or her specialty, the specialist shall confer with the referring dentist to determine if the patient's dental needs will be met by the referring general dentist or another specialist.

When treatment is completed by the specialist, a report shall be forwarded to the referring general dentist.**[June 7, 2023]**

RULE 4

EDUCATIONAL LICENSURE

Dentistry Students

1. Subject to any other provisions of the Act and Bylaws, a person meeting the following criteria may be entered in the educational register and shall receive a license to practice dentistry:
   (i) The applicant shall apply for and complete the application form in either official language;
   (ii) The applicant shall produce the following with the completed application form to the Registrar's office:

   (a) Proof that the applicant is an undergraduate student who has successfully completed their "next to the last" year of a CDAC accredited and recognized dental program;

   (b) Applicable registration fee payable at the time of registration.

2. The license shall be valid for (1) year and is not renewable.

3. The applicant to the Educational Register be permitted to perform the following restrictive duties (only) under the direct supervision of a member:

   - The use of a high volume suction tube
   - The holding of lights for the polymerization of photo sensitive resins
   - Take dental x-rays without posing a diagnosis
   - The application of dental plaque disclosing solutions, the giving of oral health instructions
   - The application of anti-cariogenic agents
   - The taking of al impressions for study models
   - The application and removal of a rubber dam
   - The placement of pit and fissure sealants
   - The placement and removal of matrices and wedges
   - Polishing prior to application of anti-cariogenic agents
   - Polishing of clinical crown of teeth, with rubber cup or brush
   - The application of topical anesthetic
   - Preparation and placement of treatment liners
   - Post operative suture removal
   - Placement and removal of separator between teeth
   - Scaling
   - Root planing

4. The applicants who are entered on the Educational Register pursuant to section 11(1)(b) of the Act shall be issued a licence which is restricted to practicing only such dentistry as is set out above. However, the person on the Educational Register shall not under any circumstances be permitted to prescribe or dispense drugs.

Dental Assisting Students

1. Subject to any other provisions of the Act and Bylaws, a person meeting the following criteria may be entered in the educational register and shall receive a license to practice temporary as a level II dental Assistant:

   (i) The applicant shall apply for and complete the application form in either official language;

   (ii) The applicant shall provide proof of registration for the NDAEB written or CPE exam.

   (iii) The license shall be valid until the reception of the NDAEB exam results and can be renewed with the proof of registration for the next NDAEB exam.

NEW BRUNSWICK DENTAL SOCIETY

RULE 5

TRANSFER OF PATIENT DENTAL RECORDS

1. Transfer of Records: Records are only transferred on the written request of the patient or the patient's legal guardian. The enclosed "Transfer of Patient Records Consent Form" is the template endorsed by NBDS and includes categories so that patients may limit their request to some or all Records.
2. Items included: Records may include patient charts, radiographs, models, photographs and all written referral forms and correspondence with specialists and/or insurance companies;
3. Timely reply: Dentists have a legal and professional responsibility to provide the patient with a copy of their records in a timely manner. NBDS' position is that all requests be satisfied in a timely manner and no longer than the limit set out in the *Personal Health Information Privacy Access Act (PHIPAA)* (as of this date 30 business days from the date of the request);
4. Originals vs Copies: Dentists should retain original Records and only provide copies;
5. Professional Complaints: Original Records may be released to the Registrar, or his designate in connection with Complaints under the Act;
6. Police Warrants: Original Records may be released to the police in connection with investigations and/or the identification of persons upon presentation of a legal warrant. If possible, it is suggested that Dentists retain a copy of the Records released to police;
7. Fees: Dentists are referred to the NBDS Fee Guide (USC&LS codes (93211) and (02911-02919)) regarding the copying of records and the duplication of radiographs; (code 04912) for duplication of models. NBDS does not endorse "administration fees" as the patient should not be required to incur costs over and above the direct costs associated with the copying, duplicating, and transfer of their Records. Dentists may waive any fees payable. A maximum acceptable amount for fee should be $15.00 for each half-hour beyond the initial 2 hours (there can be no charge permitted for the first 2 hours). Custodians are also permitted to charge $0.25 per page copied.

8. Financial Disputes: If there is an unpaid account then Dentists may withhold the transfer of a patient's record to another custodian/dentist. However, Dentists must still make the record available to the patient if they request to examine it and must provide the patient with a copy as long as the fees permitted by the *PHIPAA,* and set out in the regulation, are paid. Further, Dentists have the overriding professional responsibility to transfer a patient's record despite an outstanding account or financial dispute if there is a possibility of harm to the patient if the patient's record is not transferred. In these situations, Dentists can seek payment of unpaid invoices and accounts through a small claim or other civil action.
9. Destruction of Records: The **Limitations of Actions Act**, effective May 2010, permits civil actions for 15 years and Dentists are required not to destroy Records during this 15 year period (15 years after the patient's 19th birthday, if a minor);
10. Electronic Records: A patient may consent to their Records being transmitted electronically, as long it is done in a secure and confidential manner.
11. Office Business Disputes: Copies of Records must be released at the patient's request. Dentists are not permitted to withhold the release of a patient's records with respect to a business dispute relating to a former partner or associate.

(Updated December 2022---following recommendation from lawyer Fred McElman, and adopted by Executive Committee---December 9th, 2022)

Transfer of Patient Records Consent Form

Dental office/Address:

Date:

I, _____ , hereby request the following from my dental records…
(Patient's name)

Check the following boxes(s):

☐ Chart Only
☐ Recent Radiographs (last 2 years)
☐ Models
☐ **C**omplete dental records including patient chart, radiographs, scans, models, photographs, and any other documents including referral letters and correspondence with specialists and/or insurance companies.

Check one of the following:

☐ Released into my possession
☐ Sent electronically (where possible) to the following email address _____
☐ Forwarded to the following dental office/dentist address:

I understand that only copies of my records and duplicates of my radiographs and models will be provided, and that if no duplicates can be made, that the originals will be forwarded to the address above and returned to the sending dentist. I agree to pay any fees related to the copying and transfer of my records, including the duplication of radiographs and models, if necessary.

_____
(Patient's signature)

RULE 6

PERMISSIBLE SKILLS FOR DENTAL ASSISTANTS

NON-CERTIFIED DENTAL ASSISTANTS

1. A Non-Certified dental assistant shall be permitted to perform the following duties:

(a) The reprocessing and sterilization of the dental instruments;

(b) Cleaning, disinfection and preparation of the operation rooms.

And

The following duties only under direct supervision and control of a dentist:[June 11, 2011]

(a) the use of high volume and low volume (saliva ejector) suction tubes; [June 2, 2012]

(b) the holding of lights for the polymerization of photo sensitive resins;

(c) the assisting of a dentist or dental hygienist in the placement or removal of a rubber dam;

(d) assisting patients in the use of dental plaque disclosing solutions including rinsing with disclosing solution or the use of chewable disclosing tablets; [June 2, 2012]

(e) the giving of oral health instructions and dietary counselling. [June 2, 2012]

CERTIFIED LEVEL II ASSISTANTS

2. A Certified Level II assistant shall be permitted to perform all the duties, tasks and functions which may be performed by a non-certified dental assistant and the following duties, tasks and functions which are to be performed under the DIRECT supervision and control of a dentist:

(a) the taking of preliminary impressions, [May 31, 2008]

(b) the application and removal of a rubber dam,

RÈGLE 6

COMPÉTENCES AUTORISÉES POUR LES ASSISTANTS ET ASSISTANTES DENTAIRES

AIDES-DENTISTES NON CERTIFIÉS

1. Les aides-dentistes non-certifiés peuvent exécuter les tâches suivantes:

(a) Le retraitement et la stérilisation des instruments dentaires;

(b) nettoyage, désinfection et préparation des salles d'opération.

Et

les tâches suivantes: uniquement sous la supervision et le contrôle directs d'un dentiste : [11 juin 2011]

(a) Manipuler la succion rapide et lente (aspirateur de salive). [2 juin 2012]

(b) Tenir un faisceau de lumière pour polymériser des résines photosensibles.

(c) Aider un dentiste ou un hygiéniste dentaire à poser ou à enlever une digue dentaire.

(d) Aider les patients à utiliser des solutions ou comprimés révélateurs de plaque dentaire, notamment à se rincer la bouche à l'aide de la solution. [2 juin 2012]

(e) Donner des conseils alimentaires et aussi ceux en santé buccodentaire. [2 juin 2012]

AIDES-DENTISTES CERTIFIÉS DE NIVEAU II

2. En plus des devoirs, tâches et fonctions d'un aide-dentiste non-certifié, un aide-dentiste certifié de niveau II peut accomplir les devoirs, tâches et fonctions qui suivent sous la surveillance et la direction DIRECTES d'un dentiste : [7 juin 2003] [10 juin 2006] [2 juin 2012]

(a) Prendre des empreintes préliminaires. [31 mai 2008]

(b) Poser et enlever des digues de caoutchouc.

(c) the placement of pit and fissure sealants, after assessment has been made for caries by dentist. Tooth preparation by chemical or physical means e.g. polishing and acid etching may be performed by Certified Level II Assistant. Assessment following placement to be made by dentist. This procedure, when limited to the teeth being sealed, shall not be intended or interpreted as an oral prophylaxis,

(c) Placer des résines pour fermer des puits et fissures, après examen par le dentiste afin de déterminer s'il y a ou non de la carie. La préparation par des moyens chimiques ou physiques, notamment par le polissage et le mordançage, peut être effectuée par un aide-dentiste certifié de niveau II. L'évaluation après la pose relève du dentiste. Lorsqu'elle est limitée aux dents qui sont scellées, cette procédure n'est pas interprétée comme une prophylaxie orale. [2 juin 2012]

(d) the placement and removal of matrices and wedges,

(d) Poser et enlever des matrices et des coins.

(e) polishing of clinical crowns and restorations with rubber cup or brush, prior to the application of anti-cariogenic agents, if and only if, the dentist or dental hygienist has made assessment as to presence or absence of calculus and the dentist or dental hygienist has removed this calculus [June 11, 2011]

(e) Polir les couronnes cliniques et restaurations des dents, à l'aide d'une cupule ou d'une brosse en caoutchouc, avant l'application d'agents anticarie, uniquement si le dentiste ou l'hygiéniste dentaire a déterminé s'il y avait présence ou non de tartre, lequel a été enlevé par le dentiste ou l'hygiéniste. [11 juin 2011]

(f) the application of topical anesthetic. [May 30, 1998]

(f) Appliquer des substances anesthésiques topiques. [30 mai 1998]

(g) preparation and placement of treatment liners where there is no pulpal involvement. [June 7, 2003] [June 2, 2012]

(g) Préparer et placer les ciments de base lorsque la pulpe dentaire n'est pas touchée. [7 juin 2003] [2 juin 2012]

(h) post operative suture removal. [June 7, 2003]

(h) Effectuer l'enlèvement postopératoire des points de suture. [7 juin 2003].

(i) application of desensitizing agents [June 10, 2006]

(i) Appliquer des substances désensibilisantes. [10 juin 2006]

(j) application of acid etching for restorative purposes [June 10, 2006]

(j) Appliquer des acides mordançages avant la restauration. [10 juin 2006] [2 juin 2012]

(k) fabrication, insertion of bleaching trays, dispensing the bleaching treatment with trays only to the patient. Oral assessment must be made by the dentist [June 10, 2006][June 11, 2011] [amended March 2025]

(k) fabrication, insertion des gouttières de blanchiment, délivrance du traitement de blanchiment avec gouttières seulement au patient. L'évaluation orale doit être faite par le dentiste [10 juin 2006] [11 juin 2011][modifié mars 2025]

(l) application of anti-cariogenic agents and anti-microbial agent to include silver diamon fluoride, in-office training by the dentist is recommended [June 11, 2011][modified March 2025]

(l) application d'agents anti-cariogènes et d'agents antimicrobiens incluant le fluorure d'argent diamon, une formation en cabinet par le dentiste est recommandée [11 juin 2011] [modifié en mars 2025]

(m) application of bonding agents [June 11, 2011]

(n) fabrication, of mouthguards and adjustments outside of the patient mouth [June 10, 2006] [Amended March, 2025]

(o) taking of digital impressions with scanners, no type of impression is defined, the dentist will make the determination of the final outcome of the scan [June 11, 2011][Amended March, 2025]

(p) try in and finishing of indirect restorations

(q) exposure of intra-oral and extra-oral dental radiographs. Exposure of panoramic and CBCT scan. [June 2, 2012][Amended March, 2025]

(r) taking of extra and intra-oral photographs [June 2, 2012]

(s) Taking facebow transfer records

(t) administer the plaque indice

(u) administer vitality test, under the direction of the dentist. Data collection only with no interpretation[March 2025]

(v) fabricate and insert occlusal rims, the dentist will be responsible for the adjustment of the occlusal rims

(w) removing periodontal dressing

(x) removing of the retraction cord

(y) making and trying of temporary, provisional restauration. Adjustment outside the mouth and cementation by the dentist

3. Repealed

(m) Application d'adhésifs dentaires. [11 juin 2011] [2 juin 2012]

(n) Fabrication, de protège-dents et ajustements à l'extérieur de la bouche du patient [10 juin 2006] [2 juin 2012][modifié mars 2025]

(o) Prise d'empreintes numériques avec des scanners, aucun type d'empreinte n'est défini, le dentiste déterminera le résultat final de l'analyse [11 juin 2011] [Modifié mars 2025]

(p) Essayage et finissage des restaurations indirectes. [11 juin 2011] [2 juin 2012]

(q) Exposer les radiographies dentaires intra-buccales et extra-buccales. Exposition du scan panoramique et CBCT. [2 juin 2012][Modifié en mars 2025][2 juin 2012]

(r) Prendre des photos extra et intra-buccales. [2 juin 2012]

(s) Prendre le transfer d'arc facial

(t) administrer l'indice de plaque

(u) administrer un test de vitalité, sous la direction du dentiste. Collecte de données uniquement sans interprétation[mars 2025]

(v) fabriquer et insérer des rebords occlusaux, le dentiste sera responsable de l'ajustement des rebords occlusaux

(w) retirer le pansement parodontal

(x) retrait du cordon de rétraction

(y) réalisation et essai de restaurations temporaires et provisoires. Ajustement hors de la bouche et cimentation par le dentiste

3. Abrogé

DENTAL ASSISTANTS WHO HAVE COMPLETED AN APPROVED ORTHODONTIC MODULE

4. Certified Level II dental assistants who have successfully completed an accredited orthodontic education module shall inform the NBDS and add the new skill to their license and shall under the direct supervision and control of a dentist, be permitted to perform in a dentist's office, in addition to the duties set out in section 2, the following intra-oral duties:

(a) placement and removal of separation between teeth;

(b) preparation of teeth for the placement of bonded attachments;

(c) placement of bondable orthodontic attachments;

(d) fitting and cementation of the bands; [May 27, 1995]

(e) placement and removal of archwires which have been formed by a member; [May 27, 1995]

(f) placement and removal of archwire accessories and ligatures; [May 27, 1995]

(g) removal of orthodontic brackets and bands from the teeth;

(h) removal of supragingival bulk cement and composite resins from teeth without the aid of a handpiece;

AIDES-DENTISTES QUI ONT SUIVI AVEC SUCCÈS UN MODULE APPROUVÉ EN ORTHODONTIE

4. Les aides-dentistes certifiés de niveau II qui ont suivi avec succès un module de formation en orthodontie accrédité doivent informer la SDNB et ajouter la nouvelle compétence à leur licence et doivent, sous la supervision et le contrôle directs d'un dentiste dans un cabinet dentaire, en plus des fonctions énoncées à l'alinéa

3b), accomplir les fonctions intra-buccales suivantes :

(a) Placer et enlever des séparateurs entre les dents.

(b) Préparer des dents pour le placement d'attachements liés par mordançage de l'émail.

(c) Placer des attachements orthodontiques liés par mordançage de l'émail.

(d) Faire l'ajustement et la cémentation de bagues d'orthodontie. [27 mai 1995]

(e) Effectuer la mise en place et l'enlèvement des fils métalliques orthodontiques des arcades dentaires et des ligatures orthodontiques. [27 mai 1995] [2 juin 2012]

(f) Effectuer la mise en place et l'enlèvement d'arcs en fils métalliques et de ligatures orthodontiques. [27 mai 1995]

(g) Enlever les fils métalliques orthodontiques des arcades dentaires. [2 juin 2012]

(h) Enlever l'excès de ciment sus-gingival et de résines composites des dents sans l'aide d'une pièce à main.

(i) tracing cephalometric X-Rays;

(j) instructions to patients on use of retainers, elastics, headgear, etc.

(k) the duties, tasks and functions for which she/he has received training in the orthodontic education module approved by the Board.

DENTAL ASSISTANTS WHO HAVE COMPLETED AN APPROVED PERIODONTIC MODULE

5. Certified Level II dental assistants who have successfully completed a periodontic education module at an accredited school shall inform the NBDS and add the new skill to their license under the direct supervision and control of a dentist, following a dentist periodontal assessment, be permitted to perform in a dentist's office, in addition to the duties set out in section 2 the following intra-oral duties:

(i) scaling and probing on patients who have:

a) healthy gingival and periodontal tissues;
b) plaque associated gingivitis;

c) pockets that are four (4) mm or less; [June 7, 2003]

(ii) the duties, tasks and functions for which she or he has received training in the accredited periodontic education module.

6. Repealed

7. Moved to rule 2

(i) Faire le relevé de tracés céphalométriques.

(j) Donner les instructions aux patients sur le mode d'utilisation des appareils de rétention, des élastiques, des dispositifs crânio-cervicaux de traction, etc. [2 juin 2012]

(k) Exécuter les devoirs, tâches et fonctions pour lesquels il a obtenu une formation dans le module d'orthodontie approuvé par le conseil d'administration.

AIDES-DENTISTES QUI ONT SUIVI AVEC SUCCÈS UN MODULE APPROUVÉ EN PARODONTOLOGIE

5. Les aides-dentistes certifiés de niveau II qui ont suivi avec succès un module de formation en parodontologie accrédité, doivent informer la SDNB et ajouter la nouvelle compétence à leur licence et doivent, sous le contrôle et supervision directes d'un dentiste, dans un cabinet dentaire, après une évaluation périodontique, en plus des fonctions énoncées dans la section 2 accomplir les fonctions intra-buccales suivantes:

(i) le détartrage et les sondages pour des patients présentant

a) des tissus gingivaux et périodontiques sains;
b) de la plaque dentaire reliée à la gingivite, et
c) des poches mesurant quatre (4) mm ou moins; [7 juin 2003] [2 juin 2012]

(ii) les devoirs, tâches et fonctions pour lesquels ils ont reçu une formation dans le module accrédité en parodontologie.

6. Abrogé

7. Déplacé aux régles 2

RULE 7

DESIGNATED CUSTODIAN OF PATIENT DENTAL RECORDS

Any practicing dentist who no longer maintains a license for any reason, including leave of absence, changing jurisdiction, or retirement, is required to contact the NBDS and provide written confirmation as to who is the designated custodian of the patient dental records for the departing dentist.

Failure to designate a custodian for dental records as required in this Rule will be subject to a Complaint by the Registrar as an act of Professional Misconduct.

Approved by the Board: March 21, 2015

RULE 8 :

Requirement for registration of a Professional Corporation

To register a professional corporation, the pre-requisites for registration set forth in the bylaws and in section 21 of the Act must all have been satisfied. An application must be submitted to the registrar and the following be provided:

1. Name of the corporation;
2. Date of incorporation;
3. Jurisdiction of incorporation;
4. Address of registered office;
5. Name of member appointed to represent the corporation;
6. Names and addresses of members of the Society who will be practicing dentistry on behalf of the corporation
7. Names, addresses and telephone numbers of all shareholders of the corporation;
8. Names, addresses and telephone numbers of all officers (President, Vice-President, Secretary-Treasurer, etc.) of the corporation and all directors of the corporation;
9. The following documents must be provided:

(a) A notarially certified copy of all articles of incorporation, articles of continuance and other charter documents of the corporation;

(b) A notarially certified copy of the most recent Notice of Directors and Notice of Registered Office required to be filed under the Business Corporations Act or equivalent documents under the laws of the incorporating jurisdiction;

(c) A notarially certified copy of any extra-provincial licence issued to the corporation under the Business Corporations Act;

(d) A Certificate of Status signed by the Director of the New Brunswick Corporations Branch in respect of the corporation;

(e) Form D appointing a member to represent the corporation;

(f) Any shareholder agreement or other agreement or proxy affecting voting rights, with respect to the corporation;

(g) Statement of the number of shares with the classes of shares owned by each, and, where the beneficial owner is different from the registered owner (as where the shares are held in trust), details with respect to both;

(h) A certified copy of a resolution of the board of directors of the corporation authorizing the making of this application; and

(i) A statement signed by all shareholders, officers and directors certifying that they and the corporation have complied with and agree to be bound by all of the requirements of the Act, the by-laws and the rules.

RULE 9
UNLICENSED REGULATED PROFESSIONALS IN DENTAL PRACTICES

1. The Board of the New Brunswick Dental Society directs the Registrar to cause an investigation by the Mediation Panel or Complaint's Committee pursuant to s. 35(1) of the *Act* on being notified that a regulated health professional has performed duties in a dental office without being licensed by the relevant regulated health authority.

2. The Board, in directing the above, acknowledges that the protection of public in the practice of dentistry, necessitates that Member Dentists be responsible for verifying that all regulated health professionals working in dental offices are licensed with the appropriate regulated health authority.

3. For greater clarity, this Rule applies to all regulated health professionals which may work in dental offices, including but not limited to Hygienists, Nurses, Physicians and Denturists.

4. When the Registrar causes an investigation into a report, as outlined above, and believes that the allegations are true, the following voluntary resolution is acceptable to resolve the matter at Mediation:

    a) A fine in the amount of $1,500.00 payable to the New Brunswick Dental Society; and publication in the NBDS Bulletin for the first offense;

    b) A fine in the amount of $2,000.00 payable to the New Brunswick

RÈGLE 9
PROFESSIONNELS RÉGLEMENTÉS SANS PERMIS DANS LES CABINETS DENTAIRES

1. Le conseil d'administration de la Société dentaire du Nouveau-Brunswick (SDNB) informe le registraire de mettre sur pied une enquête qui sera menée par le Comité de médiation ou le Comité des plaintes, conformément au paragraphe 35(1) de la *Loi*, quand il est mis au courant du fait qu'un professionnel de la santé réglementé a effectué des tâches dans un bureau de dentiste sans avoir reçu au préalable un permis de la régie de la santé réglementée pertinente.

2. Quand il entreprend la démarche susmentionnée, le conseil reconnaît que pour protéger les patients et patientes d'un cabinet dentaire, il est nécessaire que les dentistes membres s'assurent que tous les professionnels de la santé réglementés travaillant dans un bureau de dentiste détiennent un permis de la régie de la santé réglementée pertinente.

3. Aux fins de clarification, la présente règle s'applique à tous les professionnels de la santé, y compris, sans toutefois s'y limiter, les hygiénistes, les infirmières et infirmiers, les médecins et les denturologistes.

4. Lorsque le registraire demande qu'un rapport soit rédigé à la suite d'une enquête, comme souligné ci-dessus, et croit que les allégations sont vraies, le règlement volontaire suivant est acceptable pour résoudre la question lors de la médiation :

    a) Une amende de l'ordre de 1 500 $ payable à la Société dentaire du Nouveau-Brunswick et la publication dans le bulletin de la SDNB lors du premier délit;

    b) Une amende de l'ordre de 2 000 $ payable à la Société dentaire du

Dental Society; and publication in a newspaper for the second offense;

5. Third offenses are addressed by the Discipline Committee.

Nouveau-Brunswick et la publication dans un journal lors du deuxième délit.

5. Les cas de troisième délit seront dirigés vers le Comité de discipline.

RULE 10
CONTENTS OF AN EMERGENCY KIT IN A GENERAL DENTAL OFFICE AND CPR TRAINING REQUIREMENTS

1. The Board of the New Brunswick Dental Society has adopted the following items as standard contents of an emergency kit in a general dental office.

2. If any form of sedation is used in the dental office, additional equipment and supplies are required. Refer to the New Brunswick Sedation Guidelines for more detailed information.

3. The Board, in directing the above, acknowledges that the protection of the public in the practice of dentistry necessitates that Member Dentists be responsible but that being successful with any emergency requires a team approach.

    a) One person in the office is to be designated for the emergency kit – keeping it stocked and up to date with expiry dates. In addition, they should monitor the oxygen cylinder monthly to make sure it has an adequate supply and has not expired. The mask should also be checked.
    b) One person in the office is to be designated to call "911" and direct responders to the proper location in the event of an emergency.
    c) The dentist stays with the patient in distress.

RÈGLE 10
CONTENU DES TROUSSES D'URGENCE DANS LES CABINETS DE MÉDECINE DENTAIRE GÉNÉRALE ET NIVEAU DE RCR REQUIS

1. Le conseil d'administration de la Société dentaire du Nouveau-Brunswick considère que le contenu standard des trousses d'urgence de cabinets de médecine dentaire générale doit être composé des produits énumérés ci-après.

2. À noter que si la sédation est pratiquée dans le cabinet, d'autres fournitures et équipements seront nécessaires. Pour des renseignements plus détaillés, veuillez consulter les directives en matière de sédation au Nouveau-Brunswick.

3. En imposant ces recommandations, le conseil d'administration reconnaît que pour veiller à la protection du public sur le plan de la médecine dentaire, les dentistes membres doivent assumer leurs responsabilités. Le conseil souligne aussi que la bonne gestion des situations d'urgence nécessite une démarche d'équipe.

    a) Une personne au sein du cabinet doit être responsable de la trousse d'urgence. Elle doit veiller à ce qu'il ne manque rien à la trousse et contrôler les dates de péremption. De plus, elle doit vérifier la bouteille d'oxygène tous les mois pour s'assurer qu'elle est bien remplie et que la date de péremption n'est pas dépassée. Le masque doit également être vérifié.
    b) Une personne au sein du cabinet doit avoir la responsabilité de composer le 911 et d'orienter les intervenants au bon endroit en situation d'urgence.
    c) Le dentiste doit rester auprès du patient ou de la patiente en détresse.

4. The emergency kit is to contain the following:
    - AED (automatic external defibrillator) (required by 2023)
    - Oxygen tank with mask (E size cylinder)
    - Blood pressure cuff with gauge
    - Diphenhydramine tablets (pediatric, adult and 50 mg pills/injectable)
    - Chewable baby aspirin (4 x 81 milligrams)
    - Glucose tablets or gels (or orange juice)
    - Epinephrine in 1 mg ampules and syringes or prepared injectable product (i.e., EpiPen) for adults and children
    - Nitroglycerine spray
    - Salbutamol spray (Ventolin)
    - AeroChamber (recommended for use with Ventolin)
    - Finger pulse oxymeter

5. Depending on the type of procedure and need, some other medication may be considered for kit:
    - Atropine
    - Ephedrine
    - Hydrocortisone
    - Morphine or nitrous oxide
    - Naloxone
    - Temazepam
    - Flumazenil

6. Additional medication is required if the dental practice offers any variety of sedation.

7. Minimal CPR requirement for dentists: BLS for health care providers and oxygen training (Annual certification)

4. Les trousses d'urgence doivent être composées des éléments suivants :
    - DEA (défibrillateur externe automatique), obligatoire à partir de 2023
    - Bouteille d'oxygène et masque (bouteille de type E)
    - Brassard de tensiomètre avec jauge
    - Comprimés de Diphenhydramine (pour enfants, pour adultes, comprimés de 50 mg/solution injectable)
    - Acétylsalicylique à croquer pour enfants (4 x 81 mg)
    - Comprimés ou gélules de glucose (ou jus d'orange)
    - Ampoules ou seringues de 1 mg d'adrénaline ou solution injectable prête à l'emploi (comme EpiPen) pour adultes et enfants
    - Vaporisateur de nitroglycérine
    - Inhalateur de salbutamol (Ventolin)
    - AeroChamber[1] (recommandé pour l'inhalation de Ventolin)
    - Oxymetre de pouls

5. Il peut être utile d'ajouter d'autres médicaments à la trousse en fonction des besoins et du type d'interventions réalisées :
    - Atropine
    - Éphédrine
    - Hydrocortisone
    - Morphine ou oxyde nitreux
    - Naloxone
    - Témazepam
    - Flumazénil

6. D'autres médicaments doivent être ajoutés à la trousse si la sédation, peu importe sous quelle forme, est pratiquée dans le cabinet.

7. Exigence minimale de RCR pour les dentistes: SIR pour les professionnels de santé et formation en oxygene (Certification annuelle)

Rule 11
Use of Neuromodulators and fillers

SECTION I – NEUROMODULATORS FOR MYOFASCIAL PAIN AND PARAFUNCTION

Uses of neuromodulators may include treatment for the management of bruxism (diurnal or nocturnal parafunctional activity that includes tooth clenching or grinding.)

The use of neuromodulators may include treatment for the management of headaches, migraines, and temporomandibular disorders within the scope of the practice of dentistry.

1. **INITIAL QUALIFICATIONS/TRAINING**

NEW REGISTRANTS

a. For ambulatory patients over the age of 16, a member may apply for registration to perform dental services using neuromodulators limited for the management of bruxism [extraoral mastication muscles (temporalis and masseter)]. The applicant must submit evidence satisfactory to the Registrar that meets all of the following:

   i. completed an NBDS approved course of study, with formal evaluation on anatomy, pharmacology and physiology relevant to neuromodulator use;

   ii. completed an NBDS approved course of study, with formal evaluation on the diagnosis, etiology, techniques, administration, and risk management relevant to neuromodulator use for the management of bruxism with a minimum of 8 hours didactic instruction; and

   iii. completed an NBDS approved course of study with a minimum of 8 hours of clinical training, involving the use of neuromodulators.

b. For ambulatory patients over the age of 16, a member may apply for registration to perform dental services using neuromodulators for the management of myofascial pain and parafunction (not limited to bruxism). The applicant must submit evidence satisfactory to the Registrar that meets all of the following:

   i. completed an NBDS approved course of study, with formal evaluation on anatomy, pharmacology, and physiology relevant to neuromodulator use;

   ii. completed an NBDS approved course of study, with formal evaluation on the diagnosis, etiology, techniques, administration, and risk management specific to neuromodulator use for the management of myofascial pain and parafunction with a minimum of 8 hours didactic instruction; and

   iii. completed an NBDS approved course of study with a minimum of 8 hours of clinical training, involving the use of neuromodulators for the management of myofascial pain and parafunction, including supervised direct treatment by the member on patients.

2. **CONTINUING COMPETENCE**

ALL MEMBERS

a. Must maintain a separate log of all patient management involving neuromodulators. Log must be available at request of Registrar and must include the following:

   i. patient name;

   ii. purpose; and

   iii. neuromodulator type and dosage used.

b. Must complete a Dental Regulatory Authority (DRA) recognized course of study specific to the use of neuromodulators in each continuing education cycle as defined in the NBDS Rules for Continuing Education of Dentists.

c. Evidence satisfactory to the Registrar of continuing competency must be available on NBDS request.

SECTION II – NEUROMODULATORS FOR OTHER USES

The use of neuromodulators will be considered for upper facial purposes only if the member limits the use of the neuromodulator to the frontalis muscle, the glabellar complex, procerus, the corrugators supercilii, and orbicularis oculi.

The use of neuromodulators will be considered for mid-facial, lower facial and the neck purposes only if a member limits the use of the neuromodulator to superficial muscles in these areas (levator labii superioris alaeque nasi, levator labii superioris, nasalis, zygomaticus major and minor, risorius, levator and depressor anguli oris, buccinator, orbicularis oris, levator and depressor labii superioris, mentalis and platysma).

1. **INITIAL QUALIFICATIONS/TRAINING**

NEW REGISTRANTS

a. For ambulatory patients over the age of 16, a member may apply for registration to perform dental services using neuromodulators for treatment involving the upper face. The applicant must submit evidence satisfactory to the Registrar that meets all of the following:

   i. completed an NBDS approved course of study, with formal evaluation on anatomy, pharmacology, and physiology relevant to neuromodulator use;

ii. completed an NBDS approved course of study, with formal evaluation on the diagnosis, etiology, techniques, administration, and risk management relevant to neuromodulator use for the superficial upper facial muscles with a minimum of 8 hours didactic instruction; and

iii. completed an NBDS approved course of study with a minimum of 8 hours of clinical training involving the use of neuromodulators.

b. For ambulatory patients over the age of 16, a member may apply for registration to perform dental services using neuromodulators for treatment involving the mid-face, lower face, and the neck. The applicant must submit evidence satisfactory to the Registrar that meets all of the following:

i. completed an NBDS approved course of study, with formal evaluation on anatomy, pharmacology, and physiology relevant to neuromodulator use;

ii. completed an NBDS approved course of study, with formal evaluation on the diagnosis, etiology, techniques, administration, and risk management relevant to neuromodulator use for the mid-face, lower face, and neck with a minimum of 8 hours didactic instruction; and

iii. completed an NBDS approved course of study with a minimum of 8 hours of clinical training, involving the use of neuromodulators for treatment of the mid-face, lower face, and neck, including supervised direct treatment by the member on patients.

2. **CONTINUING COMPETENCE**

ALL MEMBERS

a. Must maintain a separate contemporaneous log of all patient treatment involving neuromodulators. Log must be available at request of Registrar and must include the following:

i. patient name;

ii. purpose; and

iii. neuromodulator type and dosage used.

b. Must complete a DRA recognized course of study specific to the use of neuromodulators in the members continuing education cycle as defined in the NBDS Rules for Continuing Education of Dentists.

c. Evidence satisfactory to the Registrar of continuing competency must be available on NBDS request.

SECTION III – DERMAL FILLERS

The use of dermal fillers for the treatment of the naso-labial fold, lip augmentation, gingival augmentation, and other areas of the face, including but not limited to: malar enhancement, treatment of the nasojugal groove, and the treatment of glabellar, laugh and marionette lines.

Use of non-resorbable fillers is restricted to Oral and Maxillofacial surgeons.

1. INITIAL QUALIFICATIONS/TRAINING

NEW REGISTRANTS

a. For ambulatory adult patients, a member may apply for registration to perform dental services for the use of facial dermal fillers.

b. The applicant must submit evidence satisfactory to the Registrar that meets all of the following:

   i. completed an NBDS approved course of study, with formal evaluation on anatomy, pharmacology, and physiology relevant to dermal filler use;

   ii. completed a course of study, recognized by the NBDS, with a minimum of 8 hours of didactic instruction specific to the use and treatment of facial dermal fillers in the last five years; and

   iii. completed an NBDS approved course of study with a minimum of 8 hours of clinical training, involving the use of dermal fillers, including supervised direct treatment by the member on a minimum of 5 patients.

2. CONTINUING COMPETENCE

ALL MEMBERS

a. Must maintain a separate log of all patient treatment involving dermal fillers. Log must be available at request of Registrar and must include the following:

   i. patient name;

   ii. purpose; and

   iii. dermal filler type, concentration and specific anatomical locations administered.

b. Must complete a DRA recognized course of study specific to the use of dermal fillers in the members continuing education cycle as defined in the NBDS Rules for Continuing Education of Dentists.

c. Evidence satisfactory to the Registrar of continuing competency must be available on NBDS request.

SECTION IV – RECORDKEEPING

1. A member shall record in the patient chart all treatment contemporaneous with neuromodulator and/or dermal filler use, including but not limited to:

    a. medical history and clinical examination;
    b. review of patient motivation and expectations;
    c. informed consent identifying risks and benefits specific to patient circumstances;
    d. comprehensive treatment plan;
    e. neuromodulator type, dosage and specific anatomical locations administered (as applicable);
    f. dermal filler type, concentration and specific anatomical locations administered (as applicable);
    g. pre-operative diagnostic and post-operative photographs; and
    h. any adverse reactions or incidences during or after neuromodulator and/or dermal filler administration.

SECTION V – MEMBER MARKETING OF NEUROMODULATORS AND DERMAL FILLERS

1. A member shall not advertise, market, or make any representation by any means whatever for the purpose of promoting directly or indirectly the sale, provision of treatment or services related to neuromodulators and/or dermal fillers except in compliance with federal Food and Drug Act, Food and Drug Regulations, Health Canada Policies, NBDS *Code of Ethics* and any NBDS standard of practice.

SECTION VI – REGISTRY OF MEMBERS AUTHORIZED FOR THE USE OF NEUROMODULATORS AND DERMAL FILLERS

1. The Registrar shall include a member on the public registry if they are registered to provide dental services for the use of neuromodulators and dermal fillers utilizing one or more of the following treatment areas in a format approved by the Registrar:

    a. neuromodulators for myofascial pain and parafunction;
        i. neuromodulator use limited to the management of bruxism;
        ii. neuromodulator use for the management of myofascial pain and parafunction.

    b. neuromodulators for other uses:
        i. upper face.
        ii. mid-face, lower face, and neck.

    c. facial dermal fillers

2. A member shall be registered to provide dental services using one or more of the dental services listed in subsection VI (1) if:
    a. is on the current public registry; or
    b. completed and signed application in the form approved by the Board;
    c. evidence satisfactory to the Registrar of identity and current legal name;
    d. evidence satisfactory to the Registrar the member meets the registration requirements set out in this Standard of Practice;
    e. payment of applicable registration fees;
    f. payment of any other outstanding fine, fee, debt or levy owed by the applicant to the NBDS; and
    g. any other information that in the opinion of the Registrar is required to review the registration application of a member.

3. A member shall have his or her name removed from this registry if in the opinion of the Registrar;
    a. the member submits a written notice of cancellation of the permit in a form approved by the Board;
    b. there is evidence the member is utilizing neuromodulator and/or dermal filler modalities beyond the conditions provided in this Standard of Practice;
    c. the member fails to meet the continuing competency requirements set out in this Standard of Practice; or
    d. any other situation where there is evidence the member presents a potential risk to patients or the public in the utilization of these modalities.

4. Nothing in this section shall be interpreted as in any way affecting the ability of the Registrar to include additional restrictions, conditions or limitations on a member registered to provide dental services using one or more of the dental services listed in subsection VI (1).

SECTION XI - APPEAL OF A REGISTRATION DECISION BY THE REGISTRAR

1. A member may appeal a registration decision by the Registrar to the NBDS Board.

    a. An applicant has thirty days from written notification of the decision to send an appeal submission to the NBDS Board along with a non-refundable appeal fee (SCHEDULE A).

    b. The Board shall select two members to compose part of an appeal committee by its own process. The appeal committee third member must be a public representative.

    c. The appeal committee shall schedule the appeal review within sixty days of receiving the appeal.

    d. The appeal committee shall provide the applicant with written notice of the date, time and place of the review.

    e. In reviewing the decision appeal, the appeal committee shall consider only the following:

        i. original application and supporting documentation;

        ii. Registrar's written decision and reasons for decision;

        iii. applicant written appeal submission and supporting documents; and

        iv. Registrar's written response to appeal submission.

    f. The appeal committee may make the following determinations:

        i. confirm the Registrar's decision;

        ii. vary the Registrar's decision with a decision the appeal committee determines appropriate; or

        iii. refer the matter back to the Registrar for further consideration with direction.

    g. The appeal committee shall provide the Registrar and the member with a written decision and reason for decision within thirty days of making the decision.

2. The Registrar shall implement any decision of the appeal committee within a time period dependent on the nature of the decision.

SECTION XII – NOTIFICATION OF CHANGE

1. A member shall notify the Registrar in a form approved by the Board of any change in name, contact information or location providing treatment using neuromodulators and/or dermal fillers within fifteen days of the change.

APPENDIX A

Approved Education Courses (Subject to change by the Registrar)

Pacific Training Institute for Facial Aesthetics Vancouver, BC https://ptifa.com/

University of Alberta, Edmonton, AB https://www.ualberta.ca/school-of-dentistry/continuing-dental-education/aesthetics-program/neuromodulators-fillers.html

The Botox Course- Dr. Andrew Dargie – https://thebotoxcourse.com/

RULE 12

X-RAY MACHINE AND RADIATION EQUIPMENT INSPECTIONS

1. All inspections of x-ray machines required pursuant to Bylaw No. 3-8, section 9, shall meet inspection protocols established by the Society and shall be completed by an inspection service provider designated by the Society to perform such inspections.

2. Further to Bylaw No 3-8 section 10, all costs of inspections done pursuant to Bylaw 3-8, section 9, shall be the responsibility of the owner and be invoiced by the Society to the owner who shall pay such invoices within 30 days

RÈGLE 12

INSPECTIONS DE MACHINES À RAYONS X ET D'ÉQUIPEMENTS À RAYONNEMENT

1. Toutes les inspections d'appareils à rayons X requises en vertu de l'article 9 du Règlement no 3-8 doivent respecter les protocoles d'inspection établis par la Société et doivent être effectuées par un fournisseur de services d'inspection désigné par la Société pour effectuer ces inspections.

2. Conformément au Règlement No 3-8, article 10, tous les coûts des inspections effectuées conformément au Règlement 3-8, article 9, seront à la charge du propriétaire et seront facturés par la Société au propriétaire qui devra payer ces factures dans les 30 jours

March/Mars 2024

New Brunswick Dental Society
Société Dentaire du Nouveau-Brunswick

NEW BRUNSWICK COLLEGE OF DENTAL HYGIENISTS
ORDRE DES HYGIÉNISTES DENTAIRES DU NOUVEAU-BRUNSWICK

Rule 13

STANDARD OF PRACTICE

Infection Prevention and Control

IPAC

This document is the standard of practice in relation to infection control and prevention. Since contravention of this standard may be considered professional misconduct, dental healthcare providers must be familiar with this document. Steps must be taken by every dental/hygiene practice to identify an infection prevention and control officer that will be responsible for the implementation of the standard and the training deemed necessary to every dental healthcare provider associated with the practice.

New Brunswick Dental Society

Board approved

April 2025

This document was reviewed by the New Brunswick Dental Society's Peer Review Committee in collaboration with the New Brunswick College of Dental Hygienists. The NBDS and the NBCDH would like to personally thank the committee members for their dedication and commitment to this document.

2014 Revised (2020)(2024-2025)

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Introduction

Infection prevention and control is an important part of safe patient care. Concerns about the possible spread of blood-borne diseases, and the impact of emerging, highly contagious respiratory and other illnesses, require practitioners to establish, evaluate, continually update and monitor their infection prevention and control strategies and protocols.
This standard reflects current knowledge of the transmission of infection, and how to prevent and control it.

Important

In this document, the following assumptions have been made:

- The terms “dental health care provider” (DHCP) and “staff” are used interchangeably. “Staff” encompasses all persons conducting activities within, or associated with, dental offices and includes dentists, dental hygienists, dental assistants, anaesthetists and other support persons.
- The term “dental office” includes any facility in which oral health care is provided, such as traditional dental practices, dental hygiene practices, mobile dental or dental hygiene practices, community and school based dental clinics, and residential care centers and other institutional settings.
- DHCPs are trained to take precautions to protect patients and staff. In addition to previous instructions, it’s important that all DHCPs receive office specific training in infection prevention and control as part of their orientation, and whenever new tasks, procedures or equipment are introduced. In office training and reviews of protocols are recommended on an annual basis for all staff. It is required that one staff person be appointed to manage the dental office’s infection prevention and control program (IPAC OFFICER) and ensure that it remains current. While infection prevention and control are the responsibility of all DHCPs, implementation and oversight rests with the practice owner and the responsible dentist or the responsible dental hygienist.

Purpose of the Document

This document is not a step-by-step manual on how to implement specific infection control practices or procedures, nor does it endorse the use of specific infection control products or manufacturers. Rather, it is intended to provide all DHCPs with the knowledge of principles and standards to inform and properly implement necessary infection prevention and control measures in a safe and effective manner, including standards of practice that must be met. These are reflected throughout the body of the document using "must" statements rather than "should" statements.

This document consolidates published recommendations from government and other agencies, regulatory bodies and professional associations.

Wherever possible, recommendations are based on data from well-designed scientific studies. However, some infection prevention and control practices routinely used by health care practitioners cannot be rigorously examined for ethical or logistical reasons. In the absence of scientific evidence for such practices, certain recommendations are based on strong theoretical rationale, suggestive evidence or opinions of respected authorities. In addition, some recommendations are derived from provincial and federal regulations.

Accordingly, this document presents the minimal standards reflecting the best evidence and expert opinion available at the time of writing.

Professional and Regulatory

This document is the standard of practice in relation to infection control and prevention. Since contravention of this standard may be considered professional misconduct, dental healthcare providers must be familiar with this document. Steps must be taken by every dental/hygiene practice to identify an infection prevention and control officer that will be responsible for the implementation of the standard and the training deemed necessary to every dental healthcare provider associated with the practice.

Practice owners have an obligation to maintain the standards of practice of the profession and, accordingly, must ensure that recommended infection prevention and control procedures are carried out in their offices.

DHCPs have an obligation to maintain the standards of practice of the profession and must maintain current knowledge of infection prevention and control procedures and apply and maintain them appropriately and consistently. To this end, it is the practice owner's responsibility to ensure that staff are adequately trained in infection prevention and control procedures, and that the necessary supplies and equipment are available, fully operational, up-to-date and routinely monitored for efficacy.

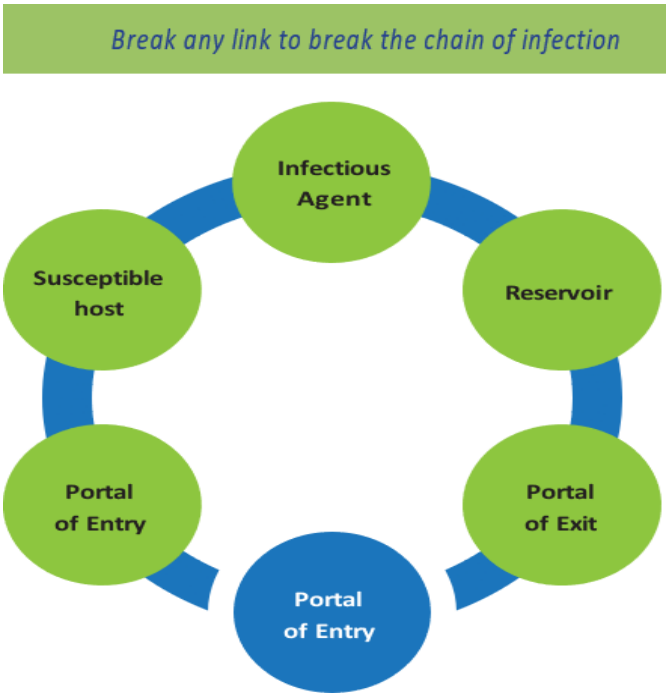
In addition to professional obligations, practice owners also have an ethical duty to maintain a safe and healthy office environment for both patients and staff, and to adhere to all rules and regulations related to the operation of a dental practice, including workplace health and safety, and environmental protection.

Transmission of Microorganisms

To transmit an organism or infection, three elements must be present:

1. A microorganism
2. A susceptible host
3. A way for microorganisms to be transmitted

Understanding the modes of transmission of infection is necessary for designing and implementing effective infection prevention and control strategies. Dental patients and DHCPs can be exposed to pathogenic microorganisms, including viruses (e.g. HBV, HCV, HIV, human herpes viruses, human papillomavirus), bacteria (e.g. Mycobacterium tuberculosis, staphylococci, streptococci) and other microbes that colonize or infect the oral cavity and respiratory tract.



In the dental office, the main modes of transmission of microorganisms are:

- *direct transmission* – direct physical contact with blood, oral fluids or other materials
- *indirect transmission* – contact with an intermediate contaminated object, such as a dental instrument, equipment or an environmental surface
- *droplet* – contact of oral, nasal or conjunctival mucosa with droplets, spatter or spray containing microorganisms generated from an infected person, such as by coughing, sneezing or talking
- *aerosol* – particles of respirable size (<10um) generated by both humans and environmental sources that can remain viable and airborne for extended periods in the indoor environment. In dentistry, aerosols are commonly generated using handpieces, ultrasonic scalers and air/water syringes.

The risk of infection because of a dental procedure is extremely low, but it represents an important patient safety consideration. By understanding how diseases are transmitted and applying infection prevention and control (IPAC) principles, DHCPs can develop strategies to interrupt the transmission of microorganisms among patients and DHCPs, and from dental instruments, handpieces, devices and equipment

Principles of Infection Prevention and Control (IPAC)

IPAC principles include:

- patient assessment;
- following Routine Practices;
- using barrier techniques to protect both patients and DHCPs;
- applying the principles of cleaning, disinfection, sterilization and storage of dental instruments;
- environmental cleaning;
- care of the overall office setting;
- safe handling and disposal of waste.

KEY PRINCIPLE:
DHCPs must maintain current knowledge of best practices in infection prevention and control and apply it appropriately and consistently to ensure protection of staff and patients.

An overall IPAC program should focus on strategies to reduce the risk of transmission.

These strategies include:

a) identifying, communicating and implementing standards and guidelines by setting specific policies and procedures;
b) effective occupational health and safety programs for all DHCPs, such as written procedures for the workplace and guidance on immunization;
c) educating DHCPs, as well as patients and their families, about everyone's role in infection prevention;
d) on-going review of policies and procedures, and evaluation of the IPAC program

PART A: Patient Safety

1. Screening of Patients

From time to time, patients who are unwell may present themselves at the dental office. Their health may relate to a
dental problem, such as an oral infection or a postoperative complication, but it may also relate to a non-dental problem, such as a severe respiratory illness (e.g. influenza) or simply a bad cold.

To protect other patients and DHCPs from the spread of microorganisms, patients who appear to be ill must be rescheduled if possible. If their dental condition is of an urgent nature, every effort must be made to separate them from other patients by seating them in a secluded operatory as soon as possible. In this way, the spread of microorganisms by direct or droplet transmission can be minimized.

Another opportunity to screen for ill patients is when confirming dental appointments in advance. If staff learn that a particular patient has a fever or cough, dental appointments should be rescheduled.

2. Routine Practices

Health Canada uses the term "Routine Practices" to describe basic standards of infection prevention and control that
are required for safe patient care. A similar term, "Standard Precautions," is used by the Centers for Disease Control and Prevention in the United States. Routine Practices synthesize the major principles of "universal precautions," which are designed to reduce the risk of transmitting pathogens that are blood-borne, and those of "body substance precautions,"
which are designed to reduce the risk of transmitting pathogens from moist body substances.

Routine Practices are based on the concept that all patients are potentially infective, even when asymptomatic, and that
the same safe standards of practice should routinely apply to contact with blood, body fluids and secretions (e.g. saliva), mucous membranes and non-intact skin. In addition, instruments in direct contact with these fluids and tissues are
potentially contaminated with infectious agents.
Adherence to Routine Practices protects both DHCPs and patients.

There are four principles that are inherent in Routine Practices:

a. risk assessment
b. hand hygiene
c. use of personal protective equipment
d. safe handling and disposal of sharps and contaminated waste

a. Risk Assessment

The first step in the effective use of Routine Practices is to perform a risk assessment.
This **must** be done before each interaction with the patient to determine the interventions that are required to prevent the transmission of infection.

The risk of transmission of microorganisms will vary, depending on the type of dental procedure to be performed and the likelihood of exposure to blood, body fluids and secretions, mucous membranes and non-intact skin. Additional factors to consider include:

- the health status of the patient;
- the characteristics of the patient, such as level of cooperativeness.
- the physical environment and resources available;
- the immune status of the DHCP.

Procedures involving exposure to blood, body fluids and secretions, mucous membranes and non-intact skin require the use of appropriate personal protective equipment. On the other hand, procedures involving no anticipated exposure may require fewer precautions.

IMPORTANT
Perform a risk assessment before each interaction with the patient to determine the interventions that are required to prevent the transmission of infection.

b. Hand Hygiene

Hand hygiene is the single most important measure for preventing the transmission of microorganisms. The term "hand hygiene" has replaced "hand washing" and includes the use of plain or antimicrobial soap with running water, as well as alcohol-based hand rub.

1. When must hand hygiene occur and with what type of product?

Hand hygiene must be performed by washing with plain or antimicrobial soap and running water, or by using a 70-90% alcohol-based hand rub. Both methods are equally effective, unless hands are visibly soiled (including with powder from gloves) or contaminated with body fluids, in which case hands must be washed with soap and water. Hand hygiene must be performed:

- following personal body functions (e.g. blowing nose or using washroom);
- when entering the clinic (for the patient and the staff)
- before and after direct contact with individual patients;
- before putting on and after removing gloves;
- after contact with environmental surfaces, instruments or other equipment in the dental operatory

- after contact with dental laboratory materials or equipment;
- before and after eating or drinking.

IMPORTANT

Contamination may involve areas beyond the hands(e.g. forearms). Use professional judgment regarding the extent of contamination and ensure affected areas are decontaminated appropriately. If you think your hands or other skin surfaces have become contaminated with body fluids, wash with soap and water to remove organic matter.

Liquid soap must be provided in disposable pump dispensers. Bar soap **must not** be used. Hand lotion to prevent dry or cracked skin also should be available in disposable pump dispensers. Petroleum-based hand lotions should not be used because they can affect glove integrity. To avoid contamination, disposable pump dispensers of liquid products **must** be discarded when empty and not "topped-up" or refilled. Reports have been documented in the scientific literature of disposable soap dispensers becoming contaminated with gram-negative bacterial species. Despite perceptions to the contrary, alcohol-based hand rubs have been shown to be less irritating to skin than soap and water. Select a product that contains emollients.

IMPORTANT

There is sufficient evidence that alcohol-based hand rubs are equally effective as washing with soap and water, except in cases where the hands are visibly soiled or contaminated with body fluids. In this case, hand washing with soap and water is necessary to remove organic matter.

2. How must hand hygiene be done?

i. When using soap and water for routine care:

- Wet hands with warm, not hot, water.
- Apply adequate amount of soap to achieve later.
- Rub vigorously for a minimum of 20 seconds, covering all surfaces of hands and fingers. Pay particular attention to fingertips, between fingers, backs of hands and base of thumbs, which are the most missed.
- Rinse well with running water.
- Dry thoroughly with a disposable paper towel. Turn off taps with towel and discard towel in a bin.

IMPORTANT

Over the counter products are not recommended. Select products that are designed for use in a healthcare setting. Avoid the use of hand jewelry and artificial nails. Jewelry interferes with proper hand hygiene, can make donning gloves more difficult and increases the risk of gloves tearing. Artificial nails have been implicated in hospital outbreaks involving fungal and bacterial infections.

ii. When using antimicrobial soap and water for surgical procedures (see Part E, Section 10 for more details):

- Remove all hand and wrist jewelry.
- Clean under nails. A disposable manicure stick may be used, but nailbrushes are not recommended, as they can become contaminated and damage the skin around the nails. Nails must be short enough to allow thorough cleaning underneath and not cause glove tears.
- Wash hands and forearms to the elbows thoroughly for the length of time recommended by the manufacturer (usually two to five minutes).
- Rinse off soap and dry hands thoroughly before donning sterile gloves.

iii. When using an alcohol-based hand rub for routine care:

- Apply the product to one palm and rub both hands together for at least the minimum time interval indicated by the manufacturer, covering all surfaces of hands and fingers, until they are dry.

iv. When using an alcohol-based surgical hand rub for surgical procedures:

- Remove all hand and wrist jewelry.
- Ensure that the alcohol-based hand rub selected has been approved for surgical hand disinfection.
- Apply the product to dry hands only and follow the manufacturer's instructions.
- Allow hands to dry thoroughly before donning sterile gloves.

Hand hygiene facilities must be located as close as possible to all dental operatories and preferably in clear sight of patients. If they are out of sight, patients must be made aware that hand hygiene is taking or has taken place.

In addition:

- Soap dispensers must be placed at every sink.
- Alcohol-based hand rub dispensers must be strategically located for ease of use.
- Disposable towels must be readily available at each facility.
- Taps must be turned off with the aid of a paper towel to avoid recontamination of hands. If renovating, consider installing hands-free faucets.
- A hand wash sink should not be used for any other purpose.

IMPORTANT

The use of gloves does not preclude the need for careful hand hygiene.

c. Personal Protective Equipment for Patients

1. General considerations

DHCPs wear personal protective equipment (PPE) to shield their own tissues from exposure to potentially infectious material. This also protects patients by preventing the DHCP from becoming a vector for the transmission of microorganisms from patient to patient.

Additional protective barriers and techniques should be employed to shield patients from potentially infectious material.

2. Protective eyewear

Large particle droplets of water, saliva, blood, microorganism and other debris are created using dental handpieces, ultrasonic instruments and air/water syringes. This visible spray typically travels only a short distance and settles out quickly, landing on nearby surfaces, including the operatory countertops and equipment, as well as the DHCP and patient.

Patients must be provided with protective eyewear to shield their eyes from spatter and debris created during dental procedures. Protective eyewear must be worn throughout the dental appointment, then cleaned and disinfected after use and whenever visibly contaminated.

3. Protective draping

Single-use bibs or drapes must be used to protect the patient's clothing and reduce their exposure to spatter and debris created during dental procedures. Single-use strips may be used to secure bibs and drapes, in place of reusable daisy chains.

4. Use of rubber dam and high-volume suction

Appropriate efforts must be made to minimize the spread of droplets, spatter and spray created during dental procedures. Accordingly, a rubber dam must be used whenever feasible, and high-volume suction must be used whenever the creation of droplets, spatter and spray is possible. The evacuation device must have an opening of at least 8 mm and be capable of quickly removing a large amount of air — up to 100 cubic feet of air per minute to be considered high volume suction.

The use of rubber dams and high-volume suction also minimizes the ingestion or inhalation of contaminated material and debris.

5. Latex sensitivity and allergies

Dental patients with true latex allergies may react to common dental products such as gloves, rubber dams, prophylaxis cups, orthodontic elastics and some medication vials. When taking medical history, patients must be asked questions relating to possible latex allergies.

This includes asking whether a true latex allergy has been diagnosed. Additional questions should probe for a history of common predisposing conditions for latex allergies, such as other allergies (e.g. avocados, kiwis, hazelnuts, bananas) or early latex exposure related to medical treatment (e.g. spina bifida, urogenital anomalies).

Patients with a true latex allergy **must** be treated in an environment where contact with latex proteins, either directly or airborne, is kept as low as reasonably achievable. When performing hand hygiene, alcohol-based sanitizers are not sufficient for removing latex particles; therefore, hands must be thoroughly washed with soap and water prior to contact with latex-sensitive patients.

All latex-containing materials or devices must be removed from the operatory or adequately covered and isolated.

IMPORTANT

Check labels of dental products for latex content. Many items are available in latex-free form.

d. Safe Handling and Disposal of Sharps

Extreme care **must** be always taken to ensure patients are protected from injuries involving sharp objects. Sharps must be kept out of the reach of patients and safely collected in a clearly labeled puncture-resistant container. These sharps containers must be placed immediately adjacent to the point of use. Sharps must be disposed of immediately following use at the end of the procedure.

(See "Exposure Prevention" on p. 21 for more about sharps handling.)

3. Additional Precautions

Routine Practices may not be sufficient for patients who are infected or colonized with certain microorganisms that pose special problems in blocking their transmission. The term "Additional Precautions" is used to describe measures that are taken in addition to Routine Practices to interrupt the transmission of such microorganisms. They include the physical separation of infected or colonized patients from other individuals and the use of protective barriers (e.g. gowns, gloves, masks) to prevent or limit the transmission of the infectious agent.

These Additional Precautions are of relevance in health care institutions, where they may be determined by local infection prevention and control committees and monitors. For example, in an institutional setting, patients may be at increased risk of becoming infected or colonized with methicillin-resistant Staphylococcus aureus (MRSA), vancomycin-resistant enterococcus (VRE) or respiratory tract viruses (e.g. influenza).

In an ambulatory setting, such as a dental office, Additional Precautions are required for patients who are known or suspected of having an infection that can be transmitted by large respiratory droplets. Examples of microorganisms that can be transmitted in this fashion include respiratory tract viruses, rubella, mumps and Bordetella pertussis. Patients who are known or suspected of having an infection that can be transmitted by large respiratory droplets must be offered a mask and hand hygiene upon presentation, maintain a two-meter

separation from other people and be removed from the reception/waiting area and seated in a secluded operatory as soon as possible. In this way, the spread of such microorganisms by droplet transmission can be minimized.

KEY PRINCIPLE:
DHCPs must ensure that recommended infection prevention and control procedures, including routine practices, are applied in all aspects of their practice.

4. Human Rights and Confidentiality

The New Brunswick Human Rights Act provides for equal rights and opportunities and freedom from discrimination based on race, colour, religion, national origin, ancestry, place of origin, age, physical disability mental disability, marital status, sexual orientation, sex, social condition, political belief or activity.

DHCPs are prohibited from discriminating against patients. This includes using extraordinary and unnecessary infection control or other measures that are not used for other patients. DHCPs may be required to modify Routine Practices based on the risks associated with certain dental procedures, provided that they are employed for all patients undergoing the same procedures.

The information contained in patient records is confidential and must not be released to anyone without the consent of the patient, or his/her authorized representative, or as required or allowed by law. Therefore, it is important to remember that patient records must be stored securely, locked and not left unattended or in public areas of the office.
Sensitive medical information must not be recorded in the front of the patient's chart, where it could easily be seen by others. A medical alert must be coded in such a way that only staff recognizes the significance of the information, while the exact nature of the condition must be documented within the patient's chart.

If patient records are computerized, login and password protection must be used to prevent unauthorized access. In addition, screen savers and other measures must be employed to ensure information on computer screens is not visible to other patients in the office.

It is the responsibility of the practice owner to ensure that all staff are knowledgeable about and take appropriate steps to protect patient confidentiality.

More information can be found on the NBDS Website NBDS privacy guidelines

Part B: Dental Health Care Providers' Responsibilities and Safety

1. Education and Training

DHCPs are more likely to comply with infection prevention and control protocols if they understand the rationale for them. It is important that all DHCPs receive office-specific training in infection prevention and control as part of their orientation, and whenever new tasks, procedures or equipment are introduced. This training should be supplemented whenever necessary and reviewed at least annually by means of staff meetings, attendance at continuing education courses and through self-learning programs.

IMPORTANT

Facilities must name an IPAC officer

to ensure that Education and training is performed.

All DHCPs must receive training that includes information about their exposure risks, infection prevention and control strategies specific to their occupational tasks, and the management of any work-related illness or injury.
It is also recommended that this document, as well as key reference materials identified in it, form part of an in-office infection prevention and control manual.

2. Immunization

Immunizations substantially reduce the number of DHCPs susceptible to infectious diseases, as well as the potential for disease transmission to other staff and patients.
Therefore, immunizations are an essential part of infection prevention and control programs.

All DHCPs should be adequately immunized against the following diseases:

- hepatitis B
- influenza
- measles
- diphtheria
- mumps
- pertussis
- rubella
- tetanus
- varicella
- polio

It is important that all DHCPs know their personal immunization status and ensure that it is up to date. In this regard, DHCPs must consult with their family physician about the need for immunizations, as well as baseline and annual tuberculosis skin testing. In addition, the Canadian Immunization Guide sets out recommendations and schedules for adults, including those engaged in the provision of health care.
Hepatitis B is the most important vaccine-preventable infectious disease for all workers engaged in health care. The

risk of being infected is a consequence of the prevalence of virus carriers in the population receiving care, the frequency of exposure to blood and other body fluids, and the contagiousness of hepatitis B virus (HBV). Therefore, immunization against HBV is strongly recommended for all DHCPs who may be exposed to blood, body fluids or injury involving sharps.
Serological testing for anti-HBs should be conducted 1 to 2 months after completion of the 3-dose vaccination series to establish antibody response. DHCPs who fail to develop an adequate antibody response should complete a second vaccination series, followed by retesting for anti-HBs. DHCPs who fail to respond to the second vaccination series must be tested for HBsAg.

Non-responders to vaccination who are HBsAg-negative should be counselled regarding precautions to prevent HBV infection and the need to obtain immunoglobulin prophylaxis for any known or probable parenteral exposure to HBsAg-positive blood. DHCPs who are HBsAg-positive must seek guidance from their regulatory body regarding necessary and reasonable steps to prevent HBV transmission to others and the need for medical evaluation. DHCPs who might perform exposure-prone procedures must be assessed on a case-by-case basis regarding the need for possible work restrictions.

KEY PRINCIPLE:

DHCPs who perform exposure-prone procedures have an ethical obligation to know their serologic status. If infected, DHCPs must seek guidance from their regulatory body with respect to the potential for transmission of their infection to their patients.

NBDS guidelines (Exposure Prone Procedures)(Members with Bloodborne Viruses)

3. Illness and Work Restrictions

DHCPs are usually concerned about contracting illnesses in the dental office.

Such occurrences can be minimized by practicing the principles discussed in this document, including:

- ensuring adequate and appropriate immunization of all DHCPs;
- triaging patients and rescheduling those who are ill;
- adhering to Routine Practices, including effective hand hygiene before and after each patient contact.

As already noted, hand hygiene is the single most important measure for preventing the transmission of microorganisms, protecting both DHCPs and patients.

Please refer to Part A: Patient Safety for detailed information regarding recommended hand hygiene procedures.

Unique situations that might warrant particular attention by a DHCP include:

- Dermatitis – When the protective skin barrier is broken, as occurs with chapped hands or eczema, the DHCP is at increased risk of acquiring and transmitting infection through the exposed area. Good skin care must always be practiced. Any areas of dermatitis must be covered with bandages, in addition to wearing gloves.
- Immunocompromised staff – These DHCPs are at increased risk of becoming infected and may suffer more severe consequences. They might also be at risk of shedding viruses (e.g. influenza) for prolonged periods. Where feasible, job functions and associated exposure risks should be considered.

DHCPs who have an upper respiratory illness (e.g. common cold) must take the necessary precautions to prevent the transmission of microorganisms to patients and other staff. This includes practicing respiratory etiquette by covering their coughs and sneezes with their elbow or a tissue rather than with their hands and discarding used tissues immediately. Additionally, continuous diligent hand hygiene is critically important. DHCPs who have severe respiratory illness with fever (e.g. influenza), acute viral gastroenteritis with vomiting and/or diarrhea, or acute conjunctivitis must stay at home until their symptoms have subsided.

DHCPs who have oral and/or nasal herpes simplex infections (i.e. cold sores) must pay particular attention to hand hygiene and not touch the affected area. In this situation, the use of a mask might help to remind the worker not to touch the lesions. A mask must be worn at all time in the dental operatories and the sterilization centre.

4. Exposure Prevention

The primary method of preventing the transmission of blood-borne pathogens (e.g. HBV, HCV and HIV) to DHCPs is by avoiding occupational exposures to blood, saliva and other bodily fluids. In the dental office, exposure may occur through percutaneous injuries (e.g. needle-sticks or cuts with sharp objects), by contact with the mucous membranes of the eyes, nose and mouth, or by contact with non-intact skin (e.g. exposed skin that is abraded, chapped or has signs of dermatitis).

Most exposures are preventable by following Routine Practices, which include the use of personal protective equipment (PPE), such as gloves, protective eyewear, masks, closed-toe shoes and protective clothing, and safe work habits for the handling and disposal of sharps.

PPE must be used consistently during the treatment of patients, as well as the care of instruments and equipment. Cuts, abrasions or dermatitis constitute a breach in the skin's protective barrier. During work, non-intact skin must be covered with a waterproof bandage or protective dressing (e.g. Opsite, Tegaderm), which must be changed as needed. Large cuts might require medical assessment and re-evaluation of work duties.

Percutaneous injuries pose the greatest risk of transmission of blood-borne pathogens to DHCPs. Best practices to prevent such injuries include the following:

- Always use extreme caution when passing sharps during four-handed dentistry. Consider the use of a "safe zone" for transferring instruments rather than passing instruments hand to hand.
- Needles must remain capped prior to use.
- Needles must not be bent, recapped or otherwise manipulated by using both hands.
- Following use, needles must be recapped as soon as possible by using a one-handed scoop technique or a commercial recapping device.
- When suturing, tissues must be retracted using appropriate instruments (e.g. retractor, dental mirror), rather than fingers.
- Remove burs from handpieces immediately following the procedure.
- Identify and remove all sharps from trays before processing instruments.
- Used sharps must be collected in a clearly labelled puncture-resistant container which must be located at the point of use.
- When removing debris from contaminated instruments by hand, heavy-duty utility gloves, appropriate clothing and long-handled brushes must be used.

IMPORTANT

Where a syringe and needle are being used multiple times on the same patient, safe recapping of needle is preferred to prolonged exposure to an unprotected needle.

5. Personal Protective Equipment for DHCPs

i. General considerations

Personal protective equipment (PPE) is worn to shield the exposed tissues of DHCPs from exposure to potentially infectious material. PPE serves as a barrier to protect the skin of the hands and arms from exposure to splashing, spraying or spatter of blood, saliva or other body fluids, and from introducing microorganisms into deeper tissues by traumatic injuries. Such equipment also protects the conjunctival mucosa of the eyes, as well as the lining mucosa of the respiratory tract.

Primary barriers include gloves, protective eyewear, masks and protective clothing. Protective clothing must not be worn outside of the office. Single-use barriers, such as gloves and masks, must be discarded immediately after use.

IMPORTANT

Gloves and masks must be task and patient specific and discarded immediately after use.

ii. Gloves

Gloves are worn to protect the hands of the DHCP from contamination. Since gloves are not completely free from leaks and may tear, their use does not replace the need for hand hygiene. Therefore, effective hand hygiene protocols must be followed before donning gloves and after removing them.

In the dental office:

- Gloves must be worn when contact with mucous membranes, non-intact skin or body fluid is anticipated.
- The same pair of gloves must not be used for more than one patient.
- Gloves must be put on immediately before the activity for which they are indicated.
- Gloves must be removed and discarded immediately after the activity for which they were used, and hand hygiene must be performed.
- Gloves must not be worn outside any room or area where they are required for personal protection.
- Gloves must not be washed and reused.
- Double-gloving may be utilized for some specific procedures, which may involve the handling of multiple sharp instruments or during longer appointments.
- The issue of protocol for double gloving is unresolved as the body of evidence for this practice is small. Professional judgment must be used when assessing the risk of a procedure and whether double gloving may be appropriate.

iii. Protective eyewear

The conjunctival mucosa of DHCPs must be protected from spatter and debris created during dental procedures by wearing appropriate eyewear with side shields or face shields.

Protective eyewear must be cleaned and disinfected between patients and whenever it becomes noticeably contaminated. An eye-washing station must be available in the dental office for both DHCPs and patients to aid in managing contact with any body fluid or dental chemical/ solvent.

iv. Masks

Appropriate masks that cover the nose and mouth must be worn during dental procedures to protect the respiratory mucosa of DHCPs from contact with potentially contaminated droplet material. Masks lose efficiency over time, as they become moist from DHCP's breathing.

Accordingly, masks must be changed between each patient or sooner if they become visibly soiled. Face shields are not an appropriate substitute for masks.

Additionally, masks must not be worn around the neck. Due to spatter or splashing that could occur around the neck area when treating other patients, the chance of contamination may be increased which, in turn, reduces the level of protection to the DHCP.

Important

Specialized masks (N95) must be used when appropriate or when dictated by the Dental Regulatory or the New Brunswick Public Health Authorities.

v. Protective clothing

Spatter or spray from dental procedures can contaminate fabric of long-sleeved garments and lead to cloth-borne transmission of pathogens. Provided that the skin of a DHCP's forearms is unbroken and intact, short-sleeved scrubs should be worn to prevent cross-contamination between patients and when exposed to spatter or spray, forearms must be washed with soap and water. Long sleeved garments are intended to be patient-specific items of protective clothing and should be removed prior to seeing the next patient. This includes gowns and lab coats. If the skin of the DHCP's forearms is not intact, long-sleeved garments are recommended. This includes gowns and lab coats, which are meant to be worn over regular clinic clothing, such as uniforms, scrubs or street clothing.
It is the responsibility of the practice owner to develop a policy that protective clothing worn during patient care procedures must not be worn outside the dental office. The policy should include cleaning of protective clothing. New offices are encouraged to have a washer and dryer in the dental clinic.

vi. Latex sensitivity and allergies

Latex is commonly used in the manufacture of gloves and in dental products, including rubber dams, prophylaxis cups, orthodontic elastics and some medication vials. Skin irritations can be confused with true allergy to latex. Most skin reactions involving gloves are, in fact, irritant contact dermatitis, and not allergic reactions to latex.

Adverse reactions involving latex gloves range from mild to serious and can include:

- irritant contact dermatitis;
- delayed hypersensitivity reactions (allergic contact dermatitis);
- immediate allergic reactions

Mild contact dermatitis can be managed by changing the types or brands of soap, towels or gloves, rinsing hands thoroughly after washing, use of lotions, and performing proper hand hygiene.

Delayed hypersensitivity reactions require referral to a medical dermatologist and using washed (powderless) low-protein latex gloves or non-latex gloves.

Powder-free gloves reduce the lifetime exposure risk to latex allergies for patients and practitioners and are therefore preferred. Immediate allergic reactions necessitate emergency medical care and subsequent referral to a medical dermatologist, as well as using only non-latex, powder-free gloves and avoiding all latex products in the workplace and at home.

Surgical gloves are recommended for intense dental surgery.

6. Minimizing Droplet Spatter

By their very nature, the provision of dental services can involve the creation of droplets, spatter and spray contaminated with blood, saliva, other body fluids and debris. As previously noted, a rubber dam must be used whenever feasible and high-volume suction must be used whenever the creation of droplets, spatter and spray is possible.

7. Exposure Management

Blood-borne pathogens, such as HBV, HCV and HIV, can be transmitted to DHCPs through occupational exposures to blood, saliva and other body fluids. Significant exposures must be handled in a prompt and organized fashion. For this reason, an exposure management protocol is an important component of an in-office infection prevention and control manual.

IMPORTANT

All dental practices must have an exposure management protocol in place.
It should be reviewed annually to ensure it is familiar to all DHCPs.

Significant exposures include percutaneous injuries with contaminated needles, burs or other sharp instruments, as well as accidents in which blood, saliva or other body fluids are splashed onto non-intact skin or the mucosa of the eyes, nose or mouth. However, percutaneous injuries pose the greatest risk of transmission of blood-borne pathogens to DHCPs.

In the event of significant exposure, immediate first-aid measures must be instituted:

- For percutaneous injuries, allow the wound to bleed briefly and freely. Then, gently wash the wound with soap and water, and bandage as needed.
- For exposures involving the eyes, nose or mouth, flush the area with copious amounts of water.
- For exposures involving non-intact skin, wash the site with soap and water.

Any kind of occupational injury must be reported to the practice owner or the responsible dentist. However, in all cases involving a significant exposure, the practice owner must assess the source patient's status and risk for blood-borne illnesses by reviewing the medical history and, if necessary, asking her/ him additional questions. If the patient's HBV, HCV or HIV status is unknown, or if the patient presents with known risk factors, then her/his co-operation must be sought to clarify such information. Every reasonable effort must be made to obtain the patient's informed consent to be tested for HBV, HCV and HIV. This can be accomplished by referring the patient to her/his family physician for consultation, or the emergency department for an assessment of risk factors and any blood tests that are considered necessary. If the patient refuses, then the status of the exposition must be from an unknown source.

At the same time, the injured DHCP must be immediately referred to her/his family physician, an infectious disease specialist or hospital emergency department for counseling, baseline blood tests and, if deemed necessary, post-exposure prophylaxis.

If necessary, post-exposure prophylaxis must be administered as soon as possible. For example, in the event of a high-risk exposure to HIV infection, antiretroviral drugs must be administered within hours.

All cases involving significant exposure must be documented, including:

- name of the exposed DHCP and details regarding her/his vaccination status;
- date and time of the exposure;
- nature of the exposure, including the dental procedure being performed, extent of the exposure and the immediate action taken;
- name of the source and details regarding known or suspected status related to blood-borne pathogens;
- follow-up counseling and post-exposure management.

See Part I: Exposure Management and Prophylaxis

8. Occupational Health and Safety Requirements and Workplace Hazardous Materials Information System (WHMIS)

Under New Brunswick's Occupational Health & Safety Act, there is a general duty for an employer to establish written procedures for the health and safety of employees. These procedures may include, but are not limited to, the following:

- safe work practices and working conditions;
- proper hygiene practices and the use of hygiene facilities;
- control of infections.

Employees must work in compliance with the legislation and use or wear any equipment, protective devices or clothing required by the employer.

WHMIS is a national communication standard that deals with hazardous materials in the workplace. Any workplace, including a dental office that uses materials classified as controlled products under federal legislation is required to:

- supply labels for all controlled products that do not have them;
- ensure Material Safety Data Sheets (MSDS) are available for these products;
- educate and train workers about hazardous materials in the workplace.

Employers are strongly recommended to uphold WHMIS standards in their workplace; accordingly, every practice owner must be familiar with the legislation and review with all staff on an annual basis. A safety data sheet binder must be present with the safety data sheet of the products being used in the dental clinic; from the dental materials to the cleaning products.

9. Prohibition of Eating and Drinking in Non-Designated Areas

The consumption of all foods and beverages must be restricted to designated areas (e.g. lunch area, staff lounge) or outside the dental office. Eating and drinking in operatories, instrument processing areas and in-office dental laboratories must be prohibited.

Part C: Cleaning, Disinfection and Sterilization of Patient Care Items

I. General Considerations

The goals of safe processing of reusable patient care items (dental instruments, hand pieces, devices and equipment) include:

- preventing transmission of microorganisms to DHCPs and patients;
- minimizing damage to patient care items from foreign material or inappropriate handling;
- safe handling of chemical disinfectants.

Contaminated instruments must always be handled carefully to prevent percutaneous injuries.

All instruments **must** be properly cleaned, rinsed, dried and inspected prior to either disinfection or sterilization. Health Canada outlines how manufacturers of reusable devices **must** include information on how the device is to be disinfected, cleaned and sterilized.

After cleaning*, instruments must be rinsed with water to remove detergent residue and visually inspected to ensure all debris has been removed.

Patient care items are categorized as critical, semi-critical or non-critical, depending on the potential risk for infection associated with their intended use. This classification determines their processing requirements.

Semi-critical instruments or devices that have been exposed to blood or have the potential to be exposed to blood **must** be treated as critical. DHCP **must** use professional judgment for every instrument, device and surface for their specific practices to ensure that the standards are met.

Sharpening of Instruments: Sharpening of contaminated instruments presents a risk for disease transmission through accidental exposures. Sterilized instruments that require sharpening must be sharpened at point of care to maintain sterility using a sterilizable sharpening stone or card. If using a non-sterilizable sharpening stone or card, instruments must be sterile prior to sharpening and reprocessed and sterilized after sharpening. These stones or cards must be cleaned after use and appropriately stored according to manufacturer's instructions.

Risks Classification Table (see glossary for additional examples)

Category	Definition	Processing
Critical Items	Items that penetrate soft tissue or bone, enter into or contact normally sterile tissue or bloodstream (e.g. surgical instruments and surgical burs, implantable devices, periodontal instruments)	Cleaning* followed by sterilization
Semi-critical items	Items that contact mucous membranes or non-intact skin (e.g. mouth mirrors, amalgam condensers, facebow forks, reusable impression trays, X-ray film holders)	Cleaning* followed by sterilization or high-level disinfection (as a minimum) Sterilizations the preferred method.†
Non-critical items	Items that contact skin, but no mucous membranes or do not directly contact the patient (e.g. radiograph head/cone, bib clips, blood pressure cuff, pulse oximeter, patient safety glasses)	Cleaning* followed by low- or intermediate-level disinfection

† The majority of semi-critical items used in dentistry are heat-tolerant and must always be heat-sterilized between uses. If a semi-critical item is heat-sensitive, at a minimum it must be processed using high-level disinfection.

* Cleaning entails the removal of debris (e.g. organic and inorganic matter). This is achieved either by scrubbing with a surfactant, detergent and water, or by an automated process (e.g. ultrasonic cleaner or washer with a cleaning solution). This step is essential, as residual organic debris will compromise the disinfection and sterilization process.

MANAGING CONTAMINATION

Patient Care Items (Modified Spaulding Classification)

Category	Description	Examples	Management
CRITICAL ITEMS	Penetrates soft tissue or bone	• Air/water syringe tips • Anesthetic syringes • Endodontic instruments,including files (hand and rotary) and reamers • Gauze for surgery • Dental implant instruments • Metal matrix bands prior to use • Mouth mirrors(when used during a procedure where tissue is cut or manipulated) • Orthodontic bands prior to use • Periodontal instruments including ultrasonic tips • Restorative / operative instruments • Rotary burs and diamonds • Dental dam clamps • Scalers • Stainless steel crowns prior to use • Surgical instruments • Surgical suction tips	Items that are not single-use disposable **must** be sterilized and stored wrapped until point of care. Single-use disposable items **must** not be reprocessed. Follow manufacturer's instructions regarding sterilization prior to use.
SEMI-CRITICAL ITEMS	Touches intact mucous membrane or non-intact skin	• Articulating ribbon holder • Handpieces • Crown removing instruments • Dental dam frame and forceps • Impression trays • Lab burs • Nasal hoods • Orthodontic pliers • Facebow • Laboratory knives and spatulas	Items that are not single-use disposable **must** be sterilized and stored wrapped until point of care. Single-use disposable items **must** not be reprocessed. Follow manufacturer's instructions regarding sterilization prior to use.
NON-CRITICAL ITEMS	Contacts intact skin only	• Blood pressure cuffs • Curing Lights • Lead aprons • Intra-oral camera and radiograph sensors • Dental dam punch • Laboratory specific instruments	Items **must** be protected with a barrier Barriers must be changed after each patient

ENVIRONMENTAL SURFACES

Category	Description	Examples	Management
CLINICAL CONTACT SURFACES	Direct contact with DHCP or other personnel's hands, patient-care items or patient skin	• Dental chairs • Keyboard and mouse • Dental units and countertops • Doorknobs • Drawer and cupboard handles Radiographic equipment	Protect with surface barrier or disinfect with intermediate-level disinfectant.
HOUSEKEEPING SURFACES	Inadvertent contact with DHCP or other personnel's hands, patient-care items or dental appliances	• Floors • Sinks • Walls	Frequent cleaning is based on use. If contaminated by blood or saliva use intermediate-level disinfection.

Process	Result	Examples for Dentistry	Specific Indications	Comments
Sterilization	Kills all forms of pathogenic microorganisms, including bacteria, fungi, viruses and spores	Steam Dry Heat	Critical and semi-critical	Steam sterilization is the preferred method. The sterilization process **must** be audited and monitored with mechanical, chemical and biological indicators.
High-level disinfection (HLD) All disinfectants **must** have a Drug Identification Number (DIN) from Health Canada	Kills vegetative bacteria, mycobacteria, fungi, enveloped and non- enveloped viruses, but not necessarily bacterial spores	2% glutaraldehyde 7% accelerated hydrogen peroxide, 6% hydrogen peroxide 0.2% peracetic acid 0.55% ortho-pthalaldehyde	Heat-sensitive, semi-critical items	**Not for use on environmental surfaces.** Follow manufacturer's instructions regarding dilution, instrument preparation, immersion time, temperature and changing of solutions. Glutaraldehyde is non-corrosive to metals and compatible with most materials. Extremely irritating to skin and mucous membranes. Use in well-ventilated areas. Hydrogen peroxide is active in presence of organic matter, but is corrosive to aluminum, brass, copper, and zinc.

Process	Result	Examples for Dentistry	Specific Indications	Comments
INTERMEDIATE LEVEL DISINFECTION	Destroys all vegetative bacteria, mycobacteria, most viruses and most fungi, but not bacterial spores	**Chlorine-based products** *Sodium hypochlorite diluted in-office, chlorine dioxide, commercial preparations with surfactants*	Surfaces	Low cost, fast acting, readily available Corrosive to metals and may destroy fabrics Inactivated if surface not well cleaned before use Irritating to exposed skin and mucous membranes Chlorine dioxide is poor cleaner
		Halogens *(sodium bromide & chlorine)*	Hard Surfaces Only	Unstable when diluted, **must** be prepared
		Hydrogen peroxide, 0.5% accelerated	Environmental surfaces only	Fast acting Simple to mix Minimal storage space required Nonirritating Odourless
		Iodophors *(iodine combined with surfactant)*	Environmental surfaces only	Effective for bioburden removal Stable and effective Slow fungicidal activity An oxidizing agent which will accelerate rusting of metal instruments
		Quaternary ammonium compounds with alcohols *("dual" or "synergized")*	Environmental surfaces only	Relatively expensive Stains fabrics and synthetic materials Corrosive to exposed skin and mucous membranes
		Phenolics *("complex "or "synthetic" containing multiple phenolic agents)*	Environmental surfaces only	Unstable when diluted and must be prepared daily Generally non- irritating Non-corrosive Older generation had narrow spectrum Inactivated by anionic detergents and organic matter Can damage some materials Rapid evaporation Residual biocidal action Available with detergents May be absorbed through skin or

				by latex Degrades plastics with prolonged contact Leaves a film on disinfected surfaces or etches glass surfaces
Low-level disinfection (LLD) All disinfectants (except household bleach) **must** have a Drug Identification Number (DIN) from Health Canada	Kills most vegetative bacteria, as well as some fungi and enveloped viruses. **Cannot** be relied on to kill mycobacteria, including Mycobacterium tuberculosis or bacterial spores	Chlorine-based products (e.g. diluted sodium hypochlorite or household bleach – 1:50 or 1000 PPM) 0.5% accelerated hydrogen peroxide, 3% hydrogen peroxide 60 to 95% alcohols Some iodophors, phenolics and quaternary ammonium compounds	Non-critical items and environmental surfaces	Follow the manufacturer's instructions regarding concentration and contact time. Diluted household bleach is inexpensive and readily available but **must** be prepared daily. Items and surfaces **must** be cleaned first, as chlorine-based products are inactivated by organic material. Corrosive to metals and may destroy fabrics. Hydrogen peroxide is active in the presence of organic matter, but is corrosive to aluminum, brass, copper and zinc. Alcohol is fast-acting but is flammable and evaporate quickly. Items and surfaces **must** be cleaned first, as alcohol is inactivated by organic material. May harden plastic and rubber. Quaternary ammonium compounds are used for disinfecting non-critical equipment and environmental surfaces, but not instruments. They require careful dilution, as they may support microbial growth.
Cleaning	Physical removal of soil, dust and foreign material.	Soap and water, detergents and enzymatic cleaners 0.5% accelerated hydrogen peroxide Quaternary ammonium compounds	All reusable items	Follow manufacturer's instructions regarding concentration and contact time.

If a product is received from the manufacturer who has guaranteed the instrument's sterility, it need not be sterilized prior to initial use. Newly purchased non-sterile critical and semi-critical items **must** be inspected and processed according to manufacturer's instructions prior to use. Any product that comes in a clean state that the manufacturer indicates is ready for use does not need to be sterilized if it is used directly from the new package.

Sterilization

The sterilization section or the medical device reprocessing area must include the sterilizer and related supplies, with adequate space for loading, unloading and cooling down. The area may also include biological indicators and incubators for conducting spore tests, as well as enclosed storage for sterile and single-use disposable items. Heat-tolerant instruments are usually sterilized by steam under pressure (i.e. autoclave), which is dependable and economical.
Other means include dry heat or unsaturated chemical vapor. All sterilization must be performed by using medical sterilization equipment registered with Health Canada. Sterilization times, temperatures and other operating parameters recommended by the manufacturer of the equipment used, as well as instructions for correct use of containers, wraps, and chemical or biological indicators must always be followed.

Air Quality

The *Occupational Health and Safety Regulation* (91-191) respecting control of exposure to biological and chemical agents provides Threshold Limit Values (TLVs) for chemical agents (e.g. gluteraldehyde). A TLV is the maximum airborne concentration of a chemical agent to which a worker is exposed at any time. If control measures are not available during reprocessing involving a chemical agent, air sampling should ensure that the regulated limit has not been exceeded for the chemical being used.

Offices must ensure proper air exchange and ventilation to meet CSA standards and manufacturer's recommendations for products.

2. Processing of Critical and Semi-Critical Items

Instrument sterilization requires multiple steps. Sterilization is a complex process requiring specialized equipment, adequate space, qualified staff and regular monitoring for quality assurance. Correct sorting, cleaning, drying, packaging, sterilizer loading procedures and sterilization methods must be followed to ensure that all instruments are adequately processed and safe for reuse on patients. Processing of specialized instruments (e.g. channeled or bored instruments) must be completed according to the manufacturer's instructions.

All instruments must be processed in a central area of the dental office that is designed to facilitate quality control and ensure safety. The instrument processing area must have clear separation of clean and dirty areas with separate sections for:

- receiving, cleaning and decontamination;
- preparation and packaging;
- sterilization;
- drying/cooling;
- storage.

Care **must** be taken to avoid cross-contamination when using sterilizer equipment (e.g. controls, buttons, cassette handles, exterior surfaces).

Dirty Area

1. Receiving, cleaning and decontamination

To prevent percutaneous injuries, contaminated instruments should be placed in a cassette or puncture-resistant container at the point of use and then transported to the instrument processing area. Instruments must be covered when exiting the operatories. Reusable instruments must be received, sorted, cleaned and rinsed in one section of the processing area.

The use of automated cleaning equipment can increase productivity, improve cleaning effectiveness and decrease worker exposure to blood and body fluids provided that the manufacturer's instructions are strictly followed. Thus, using automated equipment can be safer and more efficient than manually cleaning contaminated instruments.

Gross debris must be removed from instruments prior to placement in an ultrasonic cleaner. In addition, ultrasonic cleaning solutions must be changed daily or more frequently if they become visibly soiled. Automated washers do not require pre-soaking or scrubbing of most instruments.

If cleaning cannot be performed immediately, instruments must be placed in a puncture-resistant holding container and soaked with a detergent or an enzymatic cleaner to prevent drying of organic material. This makes subsequent cleaning easier and less time-consuming. Liquid chemical sterilant or high-level disinfectants (e.g. glutaraldehyde, ortho-phthalaldehyde) must not be used as holding solutions, due to the fixative nature of these chemicals making surfaces more difficult to clean, as well as their general toxicity.

To avoid injury from sharp instruments, the following precautions must be taken:

- Wear puncture-resistant, heavy-duty utility gloves when handling or manually cleaning contaminated instruments.
- Do not reach into trays or containers holding sharp instruments that cannot be seen (e.g. sinks filled with soapy water in which sharp instruments have been placed). Instead, use a strainer-type basket to hold instruments, as well as forceps to remove them.
- Wear a mask, protective eyewear or face shield, and gown or jacket to protect from splashing.

Clean Area

1. Preparation and packaging

In another section of the processing area, cleaned instruments must be inspected and dried, assembled into sets or trays, and packaged for sterilization. Critical and semi-critical instruments (refer to p. 26) must be processed in a manner that will maintain sterility during storage. Suitable packaging materials include wrapped perforated instrument cassettes, peel pouches of plastic or paper, and woven or nonwoven sterilization wraps. Packaging materials must be designed for the type of sterilization process being used. Hinged instruments must be processed open and unlocked.

2. Storage

Sterile and single-use disposable items must be stored in an enclosed space, such as closed or covered cabinets. They must not be stored under sinks or in other locations where they might become wet and contaminated.

Storage practices for packaged sterilized instruments may be either date or event related. Dating assists in the recall of instruments should concerns arise with the results of sterilization tests. Some healthcare facilities date every sterilized package and use shelf-life practices (e.g. “first in, first out”). Others use event-related practices. The latter approach recognizes that the packaged instruments should remain sterile indefinitely, unless an event causes them to become contaminated (e.g. torn or wet packaging).

Packages containing sterile instruments must be inspected before use to verify barrier integrity and dryness. If packaging is compromised, the instruments **must** be cleaned, packaged and sterilized again.

IMPORTANT

Critical instruments must be processed in a manner that will maintain sterility during storage.

This includes ensuring that the integrity of the package is maintained.

3. Sterilization of Unpackaged Instruments

An unpackaged cycle (sometimes called “flash sterilization”) is a method for sterilizing patient care items for urgent or unplanned use. Flash sterilization must only be used under the following conditions:

- thorough cleaning and drying of instruments precede the unpackaged cycle;
- mechanical parameters are checked and an internal chemical indicator is used for each cycle;
- care is taken to avoid thermal injury to staff or patients;
- items are transported aseptically to the point of use to maintain sterility.

Because of the potential for serious infections, flash sterilization **must not** be used for implantable devices. When sterile items are left open to the air, they can quickly become contaminated. Therefore, critical instruments that are sterilized unpackaged must be used immediately and not stored. Sufficient inventories of critical instruments must be maintained to avoid the need for flash sterilization.

Semi-critical instruments that are sterilized unpackaged on a tray or in a container system **must** be used immediately or within a short time. Storage, even temporary, of unpackaged semi-critical instruments is not acceptable because it permits exposure to dust, airborne organisms and other unnecessary contamination before use on patients.

All instruments used in placing dental implants must be quarantined after sterilization until the results of biological monitoring are known. Accordingly, unpackaged or flash sterilization of instruments used in the placing of implants is inadequate and **must not** be used. Flash sterilization must not be routinely used in the dental office.

IMPORTANT

Historically, bead sterilizers have been used in dentistry to treat small metallic instruments, such as endodontic files. These devices cannot assure sterility, creating the risk of cross-contamination if instruments are used between patients. The usage of a bead sterilizer for sterilizing purposes in a dental clinic is prohibited by the NBDS.

4. Processing of Heat Sensitive Items

Most semi-critical items (refer to p. 26) used in dentistry are available in heat-tolerant or disposable alternatives. If the use of a heat-sensitive semi-critical item is unavoidable, then such items must be cleaned and then receive high-level disinfection, which may be achieved by immersion in a liquid chemical germicide (e.g. 2% glutaraldehyde, 7% accelerated hydrogen peroxide, 6% hydrogen peroxide, 0.2% peracetic acid or 0.55% ortho-phthalaldehyde).

Liquid chemical germicides are highly toxic and their effectiveness cannot be verified with biological indicators. Accordingly, the manufacturer's instructions regarding dilution, instrument preparation, immersion time, temperature and the changing of solutions must be followed carefully. In addition, appropriate precautions must be taken to safeguard staff, including the use of closed containers to limit vapour release, adequate ventilation and chemical resistant gloves, aprons, goggles and face shields. Following liquid immersion, instruments must be thoroughly rinsed with sterile water to remove toxic or irritating residues and then dried with clean towels. Liquid chemical germicides must not be used for applications other than those indicated in their label instructions, and they must not be used as an environmental surface disinfectant or instrument-holding solution.

NOTE:

When using liquid chemical germicides, the use of liquid germicide test strips must be used to confirm that the minimum effective concentration is within the potency range present to achieve sterilization.

5. Processing of Non-Critical Items

Non-critical items (refer to p. 26) pose the least risk of transmission of infection, as they either have no contact with the patient or contact only intact skin, which serves as an effective barrier to microorganisms. Non-critical items must be cleaned after use or, if contaminated, cleaned and then disinfected with an appropriate low-level disinfectant (e.g. chlorine-based products, 0.5% accelerated hydrogen peroxide, 3% hydrogen peroxide, 60 to 95% alcohols, iodophors, phenolics or quaternary ammonium compounds).

Cleaning and disinfection of some non-critical items may be difficult or could damage surfaces. It may be preferable to use disposable barriers or single use barriers to protect these surfaces.

6. Equipment Use and Preventive Maintenance

Tabletop sterilizers undergo frequent use, and wear and tear. The manufacturer's recommendations must be consulted for guidance on a preventive maintenance program, including regular inspection of gaskets and seals.

7. Monitoring of Sterilization in the Dental Office

1. Mechanical indicators are the gauges or displays on the sterilizer for cycle time, temperature and pressure. Some tabletop sterilizers have recording devices that print out these parameters, which is preferred. All new sterilizers should have this feature. Mechanical indicators must be checked and recorded for each load if possible.

2. Chemical indicators (i.e. internal and external) use sensitive chemicals to assess physical conditions during the sterilization process. For example, heat-sensitive tape applied to the outside of a package, changes colour rapidly when a given temperature is reached. This signifies that the package has undergone a sterilization cycle although it does not ensure that sterilization has been achieved.

A sterilizing agent has more difficulty penetrating a hollow object, such as a handpiece, than it does a solid object, such as a dental mirror. Air that is trapped inside these hollow areas cannot be easily removed, thus hindering the sterilizing agent's contact with the internal surface of the instrument.

In addition, when items are packaged, the sterilizing agent takes longer to penetrate the instruments. The packaging envelops the instruments, creating a hollow area into which the sterilizing agent **must** be drawn or forced in. For these reasons, both internal and external chemical indicators must be used to detect penetration into the package. A Class V chemical indicator inside a process challenge device (PCD) must be placed in each sterilization cycle and the results must be kept in a registry.

A process challenge device is a key element in the quality assurance testing of dental office sterilizers. It is used to monitor the performance of the sterilization process. The process challenge device simulates an equal or greater challenge than the most difficult instrument/item routinely processed in a sterilization cycle. A PCD is a device that can be bought for multiple usage or one that can be fabricated for a single use.

Example of a PCD device

In addition, for negative pressure sterilizers (type B), a test with chemical indicator type 2 (Bowie Dick) must be carried out daily in an empty sterilizer chamber. Please refer to the Glossary for further information on chemical indicator classifications.

NOTE:

Mechanical and chemical indicators do not ensure that sterilization has been achieved. They merely offer verification that the necessary conditions have been met. However, they can also provide an early warning of a problem. If either mechanical or chemical indicators demonstrate inadequate processing, then none of the items in the load should be used until they are reprocessed.

3. **Biological indicators** (BIs or spore tests) are the most accepted means for monitoring sterilization because they directly assess the procedure's effectiveness in killing the most resistant microorganisms. The spores used are more resistant and present in greater numbers than the common microbial contaminants found on patient care items. Therefore, an inactivated BI signifies that other potential pathogens in the load have been killed.

   Biological indicators must be used daily for every sterilizer in the clinic. This test must be performed during the most challenging cycle and must be done inside a process challenge device (PCD). The PCD must contain the BI and a Class V indicator.

   Spore tests may be conducted using an in-office system available through most dental suppliers. However, an independent lab **must** be used for a monthly test to confirm that in-office procedures are accurate and effective. In addition, if a load contains implantable devices or instruments used to place implants, it **must** be monitored with a BI, and these items should be quarantined until the test results are known. Follow the manufacturer's directions concerning the appropriate placement of the BI in the sterilizer.

8. Traceability

Traceability of instruments in dentistry is crucial for several reasons.

- Ensuring that instruments are properly sterilized and tracked helps prevent cross-contamination and the spread of infections between patients.
- By keeping detailed records of the sterilization process, dental practices can guarantee that all instruments used are safe and sterile, providing a higher level of care for patients.
- In the event of a sterilization failure or a patient complaint, traceability allows dental practices to quickly identify and address any issues, minimizing potential risks and liabilities.
- Automated traceability systems can streamline the sterilization process, making it easier to manage and verify the status of instruments, thus improving overall efficiency in the dental practice. But a good manual system will also do the job.

Every load must be documented using a load log to demonstrate:

- Date
- Sterilizer number (identification of the machine used)
- Load number
- Initials of the person loading
- Initials of the person unloading
- Results of the Class V indicator, internal and external indicators and the BI test (once a day)
- Description of the problem (if any) and actions taken to correct

In every load, each package must be identified with a code that identifies it to the load. Example: date: load #, etc.

Every office must have a protocol for recall and traceability that includes:

- Labelling or written code
- Load logs
- Method of transferring information from labels or code to patient charts, manually or electronically

In the event of a positive BI or failed spore test

Remove the sterilizer from service. Review all records of mechanical and chemical indicators since the last negative BI, as well as sterilization procedures to determine whether operator error could be responsible. In the absence of a mechanical failure, common reasons for a positive BI include overloading, failing to provide adequate package separation and using incorrect or excessive packaging material. Repeat the spore test

immediately. This must be done after addressing any procedural problems and correctly loading the sterilizer, and by using the same cycle that produced the failure. While waiting for the repeat test results, the sterilizer must remain out of service. If the dental office does not have a second sterilizer, a colleague may be able to assist, or a dental supply company may lend one.

If the repeat spore test is negative, and mechanical and chemical indicators demonstrate adequate processing, then the sterilizer may be put back into service.

If the repeat spore test is positive, and all sterilization procedures have been performed correctly, then the sterilizer must remain out of service until it has been inspected, repaired and successfully rechallenged with BI tests in three consecutive empty chamber sterilization cycles. In addition, all items from suspect loads dating back to the last negative BI should be recalled, to the extent possible, and reprocessed.

IMPORTANT

The daily operation of every sterilizer must be reviewed and documented. A record must be kept for this purpose for a recommended 3 years indicating "operating as required", or noting any malfunctions and follow-up action taken

9. Monitoring of Ultrasonic Instrument Cleaners

Testing the efficiency of an ultrasonic cleaner is essential to ensure it is working correctly. One common method is the **foil test**. Here's how you can perform it.

- Fill the ultrasonic cleaner tank with water and add a small amount of cleaning solution.
- Cut a piece of aluminum foil to fit the size of the tank.
- Suspend the foil in the tank, ensuring it does not touch the bottom or sides.
- Turn on the ultrasonic cleaner and let it run for about one minute.
- Remove the foil and examine it. If the cleaner is working properly, the foil should have small holes and a crinkled appearance where the cavitation bubbles have impacted it.

Additional Tips

Perform this test periodically to ensure consistent performance. Another simple test is to observe the surface of the water for ripples or sonic waves when the cleaner is on.

Automatic washer should have a wash test performed on a regular basis to ensure that the washer is working properly.

Part D: Environmental Infection Control and Waste Management

1. General Considerations

Environmental surfaces in the dental operatory do not come into contact with the patient and do not pose a direct risk to their safety. However, surfaces such as light handles and drawer knobs can become contaminated during patient care, acting as reservoirs of microorganisms. Transmission usually occurs through hand contact or by touching the surface with a contaminated instrument. When this happens, microorganisms can be transferred to other instruments, other environmental surfaces, or to the hands, nose, mouth and eyes of patients and DHCPs.

Proper hand hygiene and the use of personal protective equipment are essential to minimizing the transfer of microorganisms. In addition, the use of barriers or cleaning and disinfection of environmental surfaces will guard against such transferal.

DHCPs must take particular care in the handling of patients' charts to ensure that they do not become vehicles for cross-contamination. This is particularly important because paper charts are transported by staff members to numerous areas in an office and are difficult to effectively clean and disinfect. Environmental surfaces are divided into clinical contact surfaces and housekeeping surfaces. Methods for Cleaning, Disinfection and Sterilization of Patient Care Items and Environmental Surfaces can be found on page 30..

2. Clinical Contact Surfaces

Clinical contact surfaces are frequently touched during patient care. They can become contaminated by direct spray or spatter generated during dental procedures or by contact with a DHCP's gloved hands or contaminated instruments. Examples of clinical contact surfaces include:

- chair controls and switches
- drawer and faucet handles
- light handles and switches
- countertops
- radiography equipment
- pens
- chairside computers
- keyboards and monitors
- telephones
- doorknobs
- reusable containers of dental materials
- safety glasses - those worn by staff and those worn by patients

- bib clips

Clinical contact surfaces must be cleaned and disinfected at the beginning of the workday, between patients and at the end of the workday using an appropriate low-level disinfectant. To facilitate this, treatment areas must be well-organized and kept free of unnecessary equipment and supplies, especially on countertops. Staff must take appropriate precautions, (including wearing gloves), while cleaning and disinfecting surfaces to prevent occupational exposure to infectious agents, pathogens and hazardous chemicals.

Alternatively, clinical contact surfaces and equipment can be protected from contamination by using barriers. Barriers are particularly effective for those surfaces that are difficult to clean and disinfect, due to their shape, surface or material characteristics.

Suitable barrier materials include:

- clear plastic wrap
- plastic tubing
- plastic bags
- plastic-backed paper
- plastic sheets
- other moisture-proof materials
- overgloves

Since barriers can become contaminated during dental procedures, they must be discarded (using gloves) on a routine basis (e.g. between patients) and when visibly soiled or damaged. At a minimum, following barrier removal, the underlying surfaces must be examined to ensure they did not inadvertently become contaminated. Those that did must be cleaned and disinfected. Otherwise, clean barriers must be placed prior to the next patient.

3. Housekeeping Surfaces

Housekeeping surfaces, such as floors and walls, have a limited risk of disease transmission. Accordingly, these surfaces usually require only periodic cleaning with diluted detergents. If a surface is suspected to have become contaminated with blood, saliva or other bodily fluids, it must be cleaned first and then disinfected with an appropriate low-level disinfectant (e.g. household bleach diluted 1:50 or accelerated hydrogen peroxide). DHCPs must take appropriate precautions, including wearing gloves, for this purpose.

From a general housekeeping point of view, floors must be cleaned regularly and spills must be cleaned up promptly. Cleaning tools, such as mop heads, must be rinsed after use and allowed to dry before they are used. Fresh cleaning solutions must be made each day, discarding any that remain and allowing the container to dry between usage . In this way, the risk of these solutions becoming reservoirs for microorganisms can be minimized.

IMPORTANT

Carpeting and cloth furnishings are difficult to clean and cannot be reliably disinfected. They must not be used in patient treatment or instruments preparation areas.

4. Management of Waste

For the purposes of infection control, waste from dental offices can be divided into two categories: biomedical waste and general office waste. New Brunswick guidelines under the *Clean Environment Act* and WHMIS dictate that biomedical ("hazardous") waste **must** be handled and disposed of in a manner that avoids transmission of potential infections. Therefore, it is necessary to understand the differences between these types of waste, so that they can be separated, stored and disposed of appropriately.

i. Biomedical Waste

Biomedical waste is classified as hazardous waste and **must not** be disposed of with regular garbage. It **must** be handled safely to protect human health and the environment. In general, all biomedical waste **must** be:

- stored in colour-coded containers that are marked with the universal biohazard symbol;
- released to an approved biomedical waste carrier for disposal.

Biomedical waste can be further divided into anatomical and non-anatomical waste.

a. Anatomical waste (i.e. human tissue)

The generation of anatomical waste is normally limited to oral surgeons and periodontists, such as in the course of harvesting human tissue for treatment. Anatomical waste must be separated and collected in a red liner bag that is labelled with the universal biohazard symbol. This waste must then be stored in an enclosed storage area, such as a stand-alone refrigeration/freezer unit, that is marked "Biomedical Waste Storage Area" and displays the universal biohazard symbol. This storage area must be separate from other supply areas, locked and maintained at a temperature at or below 4 degrees Celsius. Once accumulated, anatomical waste **must** only be released to an approved biomedical waste carrier for disposal.

NOTE:

Extracted teeth are not classified as biomedical waste and should be handled differently. Please refer to the section below, "Handling of Extracted Teeth".

b. Non-anatomical waste

(i.e. sharps and blood-soaked materials)

Sharps (e.g. needles, syringes with needles, scalpel blades, clinical glass) must be separated and collected in a yellow puncture-resistant, leak proof container that is specifically designed for their management and labelled with the universal biohazard symbol. Once the container has reached the designated capacity, it **must** only be released to an approved biomedical waste carrier for disposal.

Non-anatomical waste includes blood-soaked materials that release liquid or semi-liquid blood if compressed. It must be separated and collected in a yellow liner bag that is labelled with the universal biohazard symbol. If blood-soaked materials are to remain on site for more than four days, they must be stored like anatomical waste in a refrigerated storage area that is marked "Biomedical Waste Storage Area" and displays the universal biohazard symbol.

Once accumulated, blood-soaked materials **must** only be released to an approved biomedical waste carrier for disposal.

In most instances, items such as gauze, cotton rolls and examination gloves that have come in contact with blood, saliva or other bodily fluids are not classified as biomedical waste. Provided that the item does not release liquid or semi-liquid blood if compressed, it must be considered as general office waste.

ii. General Office Waste

General office waste is no more infective than residential waste. Therefore, most soiled items generated in dental offices do not require any special disposal methods, other than careful containment and removal.

Recommendations for all types of general office waste include:

- Ensure all garbage containers are waterproof and have tight-fitting lids, preferably operated by a foot pedal. Open wastebaskets might be dangerous if children are around them.
- Use plastic bags to line the garbage containers. The use of double bagging is not necessary, unless the integrity of the bag is jeopardized or the outside is visibly soiled.
- Do not overfill garbage containers.
- Do not place sharp, hard or heavy objects into plastic bags that could cause them to burst.

Certain types of waste generated in dental offices can be detrimental to the environment if not properly handled, and their disposal is subject to provincial regulations and municipal bylaws. In addition to biomedical waste, this includes waste that contains mercury, silver, lead and other chemicals. For further information regarding the disposal of these types of waste, contact the local office of the NB Department of Environment and Local Government.

iii. Handling of Extracted Teeth

Extracted teeth without amalgam fillings may be disposed as general office waste. Extracted teeth with amalgam fillings must be treated as mercury-containing waste and disposed accordingly.

If being sent to a dental laboratory for shade or size comparisons, extracted teeth must be cleaned and surface disinfected with an appropriate low-level disinfectant. Extracted teeth being collected for use in pre-clinical education training must be cleaned of visible blood and gross debris and maintained in a hydrated state in a closed container during transportation.

Part E: Equipment and Area-Specific Practice

I. Dental Unit Waterlines

Dental unit waterlines are made of narrow-bore plastic tubing that carry water to handpieces, ultrasonic instruments and air/water syringes. They can become heavily colonized with waterborne microorganisms, including bacteria, fungi and protozoa, which form a biofilm on the interior surface of the waterline. However, they are not a supportive environment for bacteria commonly found in the oral cavity.

High numbers of these opportunistic microorganisms are not necessarily dangerous to the general population, unless the patient or DHCP is a susceptible host. This includes people who are immune compromised (e.g. persons living with HIV, persons undergoing oncology treatment or organ transplantation procedures) and those with cystic fibrosis, chronic bronchitis and bronchiectasis.
The use of monitoring systems can help to ensure dental waterline quality. The potential risk of infection from dental unit waterline microorganisms can be effectively reduced to counts like those in potable water standards by following regular waterline maintenance procedures.

(a) For offices using communal water supplies:

- Waterline heaters **must not** be used, as the heat encourages the growth of microorganisms.
- All waterlines **must** be purged at the beginning of each workday by flushing them thoroughly with water for at least two to three minutes. Before purging is carried out, handpieces, air/water syringe tips and ultrasonic tips **must** be removed from the waterlines.
- Handpieces using water coolant **must** be run for 20 to 30 seconds after patient care in order to purge all potentially contaminated air and water. The handpiece **must** then be removed and, following cleaning and disinfection of clinical contact surfaces, another sterilized handpiece may be attached for use with the next patient.

NOTE:
Sterile water or sterile saline delivered through a sterilized device must be used when irrigating open surgical sites and whenever bone is cut during invasive surgical procedures. Appropriate devices, such as bulb syringes or single-use disposable products, must be used to deliver sterile irrigation solutions since general waterline sterility cannot be ensured.

(b) For offices using closed or other water delivery systems:

The manufacturer's instructions related to dental units and equipment **must** be followed for daily and weekly maintenance.

(c) Loss of Potable Water

Boiling water advisories occur whenever public health officials determine that municipally delivered tap

water is unsafe to drink. Circumstances that compromise the safety of the municipal water system include compromises in the distribution system (e.g., water-main breaks), water treatment system failures and natural disasters (e.g., floods, hurricanes or earthquakes.

During a boiling water advisory, the following precautions must be taken:

- Public water must not be delivered to the patient through the dental unit, ultrasonic scaler or other devices or equipment.
- Utilization of an alternative water sources through a closed delivery systems.
- Postpone treatment delivery, if necessary.
- Patients must not rinse their mouths with tap water; bottled or distilled water must be used instead.

- When the boiling water advisory is cancelled, all incoming public water system lines, including any taps or other water- lines in the dental office, must be flushed for 1-5 minutes. The dental unit waterlines in all dental units and equipment must be disinfected according to the manufacturer's instructions prior to usage. There may be public health advisories which may require further measures.

2. Dental Handpieces and Other Intra-oral Devices

Several dental devices that contact mucous membranes are attached to the air or waterlines of the dental unit, including:

- High and low-speed handpieces;
- prophylaxis angles;
- ultrasonic and sonic instruments;
- air abrasion devices;
- air/water syringe tips.

These devices have the potential of becoming contaminated by retracting oral fluids into their internal compartments. Such fluids can then be expelled into the oral cavity of another patient during subsequent use. To flush out any patient material that might have entered the turbine or air and waterlines, these devices must be activated to discharge air and water for a minimum of 20 to 30 seconds after each patient.

Dental handpieces and other intraoral devices that are attached to air or waterlines **must** be sterilized after each patient use. The manufacturer's instructions for cleaning, lubricating and sterilizing these devices should be strictly followed. Some instrument components are permanently attached to dental unit waterlines (e.g. electric handpiece motors, handles for ultrasonic devices, and attachments for saliva ejectors, high-volume suction and air/water syringes). Such components must be covered with barriers that are changed after each patient use. If the item is contaminated or suspected to have been contaminated, it **must** be cleaned and disinfected with an appropriate low-level disinfectant, or barriers placed, before the next patient is seated in the operatory.

3. Saliva Ejectors

Backflow from a low-volume saliva ejector can occur when a patient closes his or her lips around the tip, forming a seal that creates a partial vacuum. This backflow can result in microorganisms from the suction lines entering the patient's mouth, a potential source of cross-contamination. **Therefore, DHCPs must not allow patients to close their mouths over the saliva ejector tip.** In addition, specially designed saliva ejectors exist that do not allow a negative pressure to form around the tip.

Suction lines **must** be purged between patients by aspirating water or an appropriate cleaning solution, thereby removing loosely adherent debris and microorganisms. At least once per week, suction lines **must** be flushed out with an enzymatic cleaner or appropriate cleaning solution. Suction traps must be inspected and cleaned on a routine basis.

4. Single-Use Devices

Single-use (i.e. disposable) devices are designed to be used on one patient and then discarded and not to be reprocessed and used on another patient. Examples include syringe needles, prophylaxis cups and brushes, and certain orthodontic brackets. Some items, such as prophylaxis angles, high-volume suction tips and air/water syringe tips are commonly available in single-use forms.
Single-use devices are usually not heat-tolerant and cannot be reliably cleaned or disinfected. Therefore, they must be disposed of appropriately after single use. Expire date must also be respected.

5. Dental Radiographic Equipment

When taking radiographs, appropriate steps must be taken to prevent cross-contamination of equipment and environmental surfaces with blood or saliva. This includes the use of gloves when taking radiographs and handling contaminated film packets. Accessories for taking intraoral radiographs (e.g. film-holders and positioning devices) **must** be sterilized between patients. Care must be taken to avoid placing or removing a lead apron with contaminated gloves. The use of over gloves or de-gloving followed by hand hygiene is recommended.

Radiography equipment (e.g. tube heads and control panels) must be protected with surface barriers that are changed after each patient use. If barriers are not used, equipment that has come into contact with the DHCP's gloved hands or contaminated film packets must be cleaned and disinfected after each patient use.

After a radiograph is exposed, the film packet must be dried with disposable gauze or a paper towel to remove blood or excess saliva and then placed in a container, such as a disposable cup, for transport to the developing area.

The film packet may be disinfected with an appropriate low-level disinfectant before opening to develop the film. Alternatively, a contaminated film packet may be opened using gloves. The film must be dropped onto a clean surface without touching it and the empty packet must be discarded, being careful to avoid contamination. Gloves must then be removed before developing the film.

Another option is to use a barrier pouch to prevent contamination of the film packet. If used, the film packet must be carefully removed from the pouch to avoid contamination and then placed in a container for transport to the developing area.

Care must be taken to avoid contamination of the developing equipment. Protective barriers must be used or, alternatively, any surfaces that become contaminated must be cleaned and disinfected with an appropriate low-level disinfectant.

6. Digital Radiography Sensors and Intraoral Cameras

Digital radiography sensors and intraoral cameras may come into contact with mucous membranes. Accordingly, these devices must be cleaned and disinfected between patients. Manufacturer's instructions must be followed for the disinfection of phosphor plates. Alternatively, digital radiography sensors and intraoral cameras must be protected with barriers to reduce gross contamination. However, following barrier removal, the underlying surface must be examined and if found contaminated, they must be cleaned and disinfected.

As with other dental equipment, the manufacturer's instructions must be followed regarding the use of appropriate barriers and recommended sterilization and disinfection procedures for these devices.

7. Lasers and Electrosurgery Equipment

During surgical procedures, the use of lasers and electro- surgery equipment causes thermal destruction of tissues, creating a smoke by-product that may contain viable microorganisms. In addition, lasers transfer electromagnetic energy into the tissues, resulting in the release of a heated plume that includes particles, gases, tissue debris, viruses and offensive odours.

DHCPs must take appropriate precautions to avoid inhaling or otherwise coming into contact with laser plumes and electrosurgery smoke, including the use of:

- Routine Practices (e.g. appropriate masks and face shields);
- central room suction units with in-line filters to collect particulate matter;
- dedicated mechanical smoke exhaust systems with a high-efficiency filter to remove substantial amounts of laser plume particles.

8. Dental Laboratory Asepsis

Dental prostheses and appliances, as well as items used in their fabrication (e.g. impressions, occlusion rims, bite registrations), are potential sources for cross-contamination. They must be handled in a manner that prevents exposure of patients, DHCPs or the office environment to infectious agents.

Effective communication and coordination between the dental office and the commercial dental laboratory will ensure that:

- appropriate cleaning and disinfection procedures are performed in the dental office or the commercial dental laboratory;

- materials are not damaged or distorted because of overexposure to disinfectants;
- disinfection procedures are not unnecessarily duplicated.

Impressions, prostheses or appliances must be cleaned and disinfected as soon as possible after removal from the patient's mouth, before drying of blood or other organic debris. The manufacturer's instructions regarding the stability of specific materials during disinfection must be consulted. Wet impressions or appliances must be placed in an impervious bag prior to transportation to a commercial dental laboratory.

Heat-tolerant semi-critical items used in the mouth, such as impression trays or facebow forks, must be sterilized after each patient use. Other items that do not normally come in contact with the patient, but frequently become contaminated, such as articulators and case pans, must be cleaned and disinfected according to the manufacturer's instructions. Items used in the typical in-office dental laboratory, such as burs, polishing points, rag wheels, laboratory knives and dental lathes, frequently become contaminated during adjustments to prostheses and appliances. These items **must** be sterilized, cleaned and disinfected or discarded after use.

Finished prostheses and appliances delivered to the patient **must** be free of contamination. This can be accomplished with an appropriate low-level disinfectant by either the commercial dental laboratory or dental office.

9. Handling of Biopsy Specimens

To protect people handling and transporting biopsy specimens, the specimen(s) **must** be placed in a sturdy, leak proof container that has a secure lid and is clearly labelled with the universal biohazard symbol. Care must be taken when collecting the specimen to avoid contaminating the outside of the container. If the outside of the container is suspected to be or has been contaminated, it **must** be cleaned and disinfected or placed in an impervious bag prior to transportation.

10. General and Surgical Aseptic Technique

The mouth is considered a clean-contaminated environment and the patient's own defenses (e.g. antibacterial enzymes in saliva and immune responses) play a large role in healing and preventing infection after a dental procedure. Infection is usually the result of the patient's own oral flora.

Aseptic technique is a term used to describe practices that prevent microbial contamination. These practices include environmental cleaning, effective hand hygiene, wearing appropriate clinical attire (e.g. gloves, protective eyewear, masks, gowns), proper handling of clean instruments, wrapping and sterilization, proper handling of sterile instruments as they are unwrapped, preventing sterile instruments from being contaminated from environmental sources, and properly administering medicines.
Surgical aseptic technique refers to practices that render and maintain objects and the surrounding area maximally free of microorganisms, prevent contamination of a wound, isolate the operative site from the surrounding unsterile physical environment, and create a sterile field to perform surgery as safely as possible (e.g. draping where appropriate).

For minor dental procedures, hand hygiene is performed, sterile instruments are placed at a clean chair-side area and care is taken to avoid placing unsterile equipment near sterile items. Depending on the complexity of the procedure, the chair-side area is separated into clean or sterile versus contaminated areas. Once the procedure begins, items are no longer sterile due to contamination with organisms from the patient's mouth, but the goal is to keep the tray and instruments as clean as possible, and to avoid contamination from other sources. When hands or gloves contact certain surfaces that are frequently touched by others, microorganisms can be transferred to instruments or other environmental surfaces, and to the eyes, nose or mouth. For major dental procedures (like other surgical procedures), the patient is prepared, hand hygiene is performed, sterile gloves are worn, and all items that go onto the sterile field are kept sterile, including instruments, materials and supplies that come in contact with the surgical site. Every item handled by the dental surgeon **must** be sterile or have a protective sterile covering.

In addition to following routine practices, and performing appropriate disinfection and sterilization of dental instruments and devices, DHCPs reduce the risk of transferring bacteria from the environment to patients by adhering to some basic steps:

- Prepare and organize work procedures so that all the required equipment is gathered for the task.
- Sterile instruments and devices **must** be stored in an enclosed space, such asclosed or covered cabinets. They **must** remain wrapped until ready foruse.
- Spatially separate work areas and equipment into "clean" versus "contaminated"; "sterile" versus "unsterile".
- Use protective covers and barriers ac- cording to approved office-specific work procedures.
- If an item is needed for a procedure, but not on the procedure tray, it must only be retrieved using transfer forceps or by first ensuring that the DHCP's hands are clean.
- Gloves **must** be put on immediately before initiating the procedure for the patient.
- If you observe or suspect that gloves have become torn or perforated, remove them, perform hand hygiene and re-glove where appropriate.

Maintaining aseptic technique is a co-operative responsibility of the entire dental team. Each member **must** develop a professional conscience for infection prevention and control, as well as a willingness to supervise and be supervised by others regarding aseptic techniques.

IMPORTANT

If an item is needed for a procedure, but not on the procedure tray, it must only be retrieved using transfer forceps or by first ensuring that the DHCP's hands are clean. Transfer forceps must always be readily available

KEY PRINCIPLE: DHCPs must utilize appropriate equipment and employ routine cleaning, prevent disease transmission and ensure patient safety.

Part F: Additional Considerations for Alternative Practice Settings

Alternative practice settings include any setting where dental or dental hygiene services may be provided that are not confined to a conventional clinical operatory. These settings may include, but are not limited to, the following:

- Group homes
- Long term care/residential care facilities
- Rehabilitation facilities
- Private residences
- Community centres
- Educational facilities
- Hospitals
- Mobile dental/dental hygiene clinics

Due to the lack of standardized dental equipment and patient care equipment (dental units, dedicated waterlines and suction, etc.) available in many of these settings, DHCPs **must** take appropriate measures to ensure that infection control protocols are followed, and patient safety is maintained. It is the responsibility of the DHCP to check with any alternative practice setting/institution to review sterilizing policy before practice begins.

The following topics must be carefully considered when providing oral care in alternative care settings:

1. Disposal of biomedical waste

Biomedical waste is classified as hazardous waste and **must not** be disposed with regular garbage. It **must** be handled safely to protect human health and the environment. In general, all biomedical waste **must** be:

- stored in colour-coded containers that are marked with the universal biohazard symbol;
- released to an approved biomedical waste carrier for disposal.

Biomedical waste can be further divided into anatomical and non-anatomical waste. Refer to "Management of Waste" Page 41 for instructions on disposal of biomedical waste items.

2. Disposal of environmentally hazardous waste

Certain types of waste generated in dental offices can be detrimental to the environment if not properly handled, and their disposal is subject to federal and provincial regulations and municipal bylaws. In addition to biomedical waste, this includes waste that contains mercury, silver, lead and other chemicals. Mercury-containing items must be treated as hazardous materials and should not be thrown in the garbage, and liquid mercury should never be poured down the drain.

3. Disposal of sharps

Sharps (e.g. needles, syringes with needles, scalpel blades, clinical glass) **must** be separated and collected in a puncture-resistant, leakproof container that is specifically designed for their management and labelled with the universal biohazard symbol. Once the container has reached the designated capacity, it **must** only be released to an approved biomedical waste carrier for disposal.

4. Transportation of contaminated and sterile equipment

When transporting instruments between practice settings, contaminated instruments **must** be packaged in sealed, sturdy, leakproof containers to prevent cross-contamination. Similarly, sterile instruments **must** be transported in sealed packages to maintain sterility until opened for use on site. Disposable sharps such as needles and blades must be removed and disposed of in an appropriate puncture-resistant sharps container at point of use, prior to transportation. Soiled instruments **must** be handled in a manner that reduces the risk of exposure and/or injury to personnel and clients/patients/residents, or contamination of environmental surfaces. A process must be in place to ensure that instruments that have been reprocessed (sterilized) can be differentiated from those that have not been reprocessed (e.g. color-coding).

Part G: Glossary of Infection Prevention and Control Terms

Additional precautions: A term used to describe infection prevention and control interventions that are taken in addition to Routine Practices for certain pathogens or clinical presentations, based on the method of transmission (e.g. contact, droplet, airborne).

Aerosol: Particles of respirable size (<10um) generated by both humans and environmental sources that can remain viable and airborne for extended periods, commonly generated in dentistry during use of hand pieces, ultrasonic scalers, and air/water syringes.

Asepsis: The absence of pathogenic (i.e. disease- producing) microorganisms.

Aseptic technique: A term used to describe practices that prevent microbial contamination.

Biological indicator (BI): A device that is used to monitor the sterilization process, which consists of a standardized population of bacterial spores known to be resistant to the mode of sterilization being monitored. BIs indicate that all the parameters necessary for sterilization were present.

Chemical indicator (CI): A monitoring device that is designed to respond with a chemical or physical change to one or more of the sterilization process parameters. CIs do not verify sterility, but they do assist in the detection of potential sterilization failures, which could result from incorrect packaging, incorrect loading of the sterilizer or equipment malfunction. There are several classes of CIs:

> **Classe 1 Process indicator:** An external indicator that is used to demonstrate that an item has been exposed to a sterilization process, and to distinguish between processed and non-processed items. Class 1 CIs are usually applied to or visible on the outside of packages (e.g. sterilization tape or packaging printed with colour changing ink). Class 1 CIs are directly exposed to the sterilization environment, so they usually fail only when there is a gross malfunction of the sterilizer.
>
> **Classe 2 Specialty indicator:** An indicator that is designed for use in specific test procedures in special sterilizers (e.g. dynamic air-removal sterilizers). Examples of Class 2 CIs include **Bowie Dick** and Dart products, which are used for steam sterilizers and Type B sterilizers.
>
> **Classe 3 Single-parameter indicator:** An internal indicator that responds to only one critical parameter of the sterilization process, usually time or temperature. It is important to note that the sterilization process has more than one critical parameter, and all of them **must** be reached for sterilization to occur.
>
> **Classe 4 Multi-parameter indicator:** An internal indicator that responds to two or more critical parameters of the sterilization process.

Classe 5 Integrating indicator: An internal indicator that responds to all critical parameters of the sterilization process, heat, time and pressure. Class 5 CIs are correlated to the performance of biological indicators (BIs).

Cleaning: The physical removal of foreign material (i.e. organic and inorganic matter) from an object or item using water and mechanical action, with or without detergents. Cleaning removes rather than kills microorganisms. Cleaning and then rinsing is performed before further processing.

Decontamination: A process of cleaning, followed by inactivation of pathogenic microorganisms from objects to render them safe to handle.

DHCP: Dental health care provider.

Disinfection: A process that kills most pathogenic micro-organisms but rarely kills all bacterial spores. Disinfection is achieved through pasteurization or the use of some chemical agents (i.e. disinfectants). The term falls between physical cleaning and sterilization. There are various levels of disinfection:

- **High-Level Disinfection (HLD):** A process capable of killing vegetative bacteria, mycobacteria (including Mycobacterium tuberculosis), fungi, and enveloped and non-enveloped viruses, as well as some, but not necessarily all, bacterial spores. HLD is considered to be the minimum level of decontamination required for semi-critical patient care items. HLD is performed after items are thoroughly cleaned and rinsed. HLDs include 2% glutaraldehyde, 7% accelerated hydrogen peroxide, 6% hydrogen peroxide, 0.2% peracetic acid and 0.55% ortho-phthalaldehyde.

- **Intermediate Level Disinfection (ILD):** A process that kills all microbial pathogens, except bacterial endo-spores, when used according to labelling. ILDs include ethylalcohol or isopropyl alcohol, hypochlorites, iodine and iodophors.

- **Low-Level Disinfection (LLD):** A process capable of killing most vegetative bacteria, as well as some fungi and enveloped viruses. LLD is the minimum level of decontamination required for non-critical patient care items and some environmental surfaces. LLD is performed after items are thoroughly cleaned and rinsed. LLDs include chlorine-based products (e.g. diluted household bleach), 0.5% accelerated hydrogen peroxide, 3% hydrogen peroxide, 60 to 95% alcohol, iodophors, phenolics or quaternary ammonium compounds.

Droplets: Small particles of moisture (e.g. spatter) generated when a person coughs or sneezes, or when water is converted to a fine mist by an aerator or shower head. Intermediate in size between drops and droplet nuclei, these particles, although they may still contain infectious microorganisms, tend to quickly settle out from the air so that any risk of disease transmission is generally limited to persons and surfaces near the droplet source.

Exposure-prone procedures (EPPs): A term used for the purpose of managing the risk of transmitting blood-borne pathogens. These are procedures during which transmission of HBV, HCV or HIV from a health care worker to patients is most likely to occur. Exposure-prone procedures (EPPs) are invasive procedures where there is a risk that injury to the dental health care provider may result in the exposure of the patient's open tissues to the blood of the dental health

care provider. Any dental health care provider with HBV, HCV or HIV is restricted from performing EPPs in the high-risk exposure procedure until their condition is managed as per the NBDS policies on infectious diseases. There would be no restrictions on performing procedures in the moderate or low risk categories.

High risk exposure-prone procedures

- All surgical procedures (hard and soft tissue including suturing)
- Periodontal scaling and root planning

Moderate risk exposure-prone procedures

- Locally anaesthetized operative, prosthetic and endodontic procedures
- IV insertion
- IM injections

Low risk exposure-prone procedures

- Gloved oral examinations
- Routine preventive procedures
- Pit & fissure sealants
- Topical fluoride
- Prophylaxis
- Diagnostic procedures
- Orthodontic procedures
- Prosthetic procedures (e.g. dentures)
- Cosmetic procedures (e.g. bleaching) not requiring local anesthesia

Implantable devices: A **dental implantable device** refers to a medical device that is surgically placed into the jawbone to support dental prosthetics like crowns, bridges, or dentures. These devices are typically made of biocompatible materials such as titanium, which allows them to integrate with the bone through a process called osseointegration.
Implantable devices that have been prepared and packaged by the manufacturer and are received pre-sterilized do not require re-sterilization. Implantable devices are not intended for reuse. If an implantable device has been used in a patient's mouth it **must not** be reused.

Infection and Prevention Control Officer (IPAC Officer): this person is responsible for the education and the training of the IPAC standard. This person is named by the responsible dentist or the owner of the dental/dental hygiene clinic.

Process Challenge Device (PCD): A process challenge device is a key element in the quality assurance testing of dental office sterilizers. It is used to monitor the performance of the sterilization process. The process challenge device simulates an equal or greater challenge than the most difficult instrument/item routinely processed in a sterilization cycle. A PCD is a device that can be bought for multiple usage or one that can be fabricated for a single use.

Personal protective equipment (PPE): Specialized clothing or equipment worn by staff and patients for protection against hazards.

Reusable device: A device that has been designed by the manufacturer, through the selection of materials and/or components, to be reused.

Risk class: The class assigned to patient care items based on the potential risk for infection associated with their intended use. The risk class determines the processing requirements of an item. The risk classes are as follows:

Critical items: Items that penetrate soft tissue or bone enter into or contact normally sterile tissue or the bloodstream. Critical items present a high risk of infection if the item is contaminated with any type of microorganism, including bacterial spores. Processing of critical items involves meticulous cleaning followed by sterilization.

Examples of instruments that are considered critical include (note this is not an exhaustive list):

- Air/water syringe tips
- Anesthetic syringes
- Endodontic instruments, including files, reamers, broaches
- Handpieces
- Metal matrix bands
- Periodontal instruments including ultrasonic tips
- Polishing cups, points and mandrels
- Restorative and operative instruments
- Rotary burs and diamonds
- Rubber dam clamps
- Stainless steel crowns
- Surgical suction tips

Semi-critical items: Items that contact mucous membranes or non-intact skin, but ordinarily do not penetrate them. Processing semi-critical items involves meticulous cleaning followed by sterilization (preferred) or high-level disinfection (minimum). Semi-critical instruments or devices that have been exposed to blood or have the potential to be exposed to blood **must** be treated as critical. DHCPs **must** use their professional judgment for every instrument, device and surface for their specific practices to ensure that these Guidelines are being met.

Examples of instruments that are considered semi- critical include (note this is not an exhaustive list):

- Articulating paper holders
- Crown removing instruments
- Impression trays
- Lab burs
- Mixing spatulas

- Nasal hoods (e.g. for use with nitrous oxide)
- Orthodontic pliers
- Rubber dam frame and clamp forceps
- Suction tips other than for surgery (does not include single-use saliva ejectors)

Non-critical items: Items that contact intact skin, but not mucous membranes, or do not directly contact the patient. Processing of non-critical items involves cleaning followed by low-level disinfection.

Examples of instruments that are considered noncritical include (note this is not an exhaustive list):

- Curing Lights
- Bib clips
- Light handle covers
- Laboratory knives and spatulas
- Rubber dam punch
- Shade guides

Routine practices: A term used to describe basic standards of infection prevention and control that are required for safe patient care. Routine Practices are based on the concept that all patients are potentially infective, even when asymptomatic, and that the same safe standards of practice should routinely apply to contact with blood, body fluids and secretions (e.g. saliva), mucous mem- branes and non-intact skin.

Single-use/disposable device: A device that has been designed by the manufacturer for single-use only.

Spatter: Visible drops of liquid or body fluid that are expelled forcibly into the air and settle out quickly, as distinguished from particles of an aerosol, which remain airborne indefinitely.

Sterilization: A validated process that kills all pathogenic microorganisms, including bacteria, fungi, viruses and spores.

Ultrasonic cleaner: A machine that cleans patient care items by the cavitations produced by ultrasound waves.

Part H: Additional Resources

Best Management Practices for Hazardous Dental Waste Disposal

Nova Scotia Dental Association
OHS-20181204-NSDA-HazardousWasteDocuments.pdf

Guidelines for the Management of Biomedical Waste in Canada

Guidelines for the Management of Biomedical Waste in Canada

Public Health Agency of Canada 2024

Canadian Immunization Guide - Canada.ca

Decontamination and reprocessing of medical devices for health-care facilities

Aide-Memoire
WHO-UHL-IHS-IPC-2022.4-eng.pdf
WHO 1-118 BenedettaFinal5

New National Standard of Canada CAN/CSA-Z314-18 Canadian medical device reprocessing

Slide 1

Infection Control in Dental Settings

Centers for Disease Control and Prevention
Summary of Infection Prevention Practices in Dental Settings: Basic Expectations for Safe Care

Manufacturers Information for Reprocessing Reusable Devices

Guidance Document: Information to Be Provided by Manufacturers for the Reprocessing and Sterilization of Reusable Medical Devices - Canada.ca

Workplace Hazardous Materials Information System Regulation - Occupational Health and Safety Act (New Brunswick Regulation 88-221)

88-221 - Workplace Hazardous Materials Information System

WHMIS/SIMDUT training

WHMIS (GHS) Online Training | Danatec.com
WHMIS Certificate - Workplace Hazardous Materials Safety Training
WHMIS Online Certification | 1 Hour | Recognized Across Canada
WHMIS Online Training Course and Certification

Part I: Exposure Management and Prophylaxis

Percutaneous Injury

Exposure to blood or saliva by percutaneous injury is the greatest risk for acquiring a blood-borne pathogen in the dental health-care setting. Every effort should be made by all DHCP to avoid percutaneous injury.

Significant exposures must be dealt with immediately. A significant exposure exists whenever any of the following events occurs:

- Percutaneous injury, where the skin of the DHCP is punctured (i.e. blood is drawn).
- Blood, saliva or other body fluid is splashed onto non- intact skin (dermatitis, cuts or abrasions).
- Blood, saliva or other body fluid is splashed onto mucosa of the eyes, the mouth or the nose.

The steps in managing significant exposure are:

1. Remove gloves or immediate clothing, if necessary, to assess the extent of the injury.
2. First-aid must be administered, if necessary, for percutaneous exposures.
3. Immediately wash the area, including the puncture or wound using antimicrobial soap and water. Exposed eye, mouth
   or nose mucosa must be flushed with copious amounts of water. The application of caustic agents such as bleach, or the injection of antiseptic agents into the wound is not advisable.
4. Report the injury to the Infection Control Officer, (IPAC officer), who is often the practice owner, who must then contact the appropriate health-care professional for advice and possible referral, and begin the necessary documentation. Ensure that the confidentiality of the health and personal data is strictly maintained.

Documentation must include **(see template, Exposure documentation)**

- The name of the exposed DHCP, and details regarding the exposed person's vaccination status.
- The date and time of the exposure.
- The nature of the exposure, including the dental procedure being performed, the extent of the exposure, and immediate action taken.
- The name and health status of the source person, including details regarding any infectious diseases known or suspected.
- Referral for follow-up counseling and post-exposure management, as necessary.

Post-Exposure Prophylaxis

Every significant exposure must be evaluated by a qualified health-care professional for the potential to transmit a blood borne pathogen. The assessment of risk of transmission will be based on:

- The type and amount of body fluid or tissue involved.
- The nature of the exposure (e.g., percutaneous injury, mucous membrane or non-intact skin exposure).
- The known or unknown infection status of the source.
- The susceptibility of the exposed person.

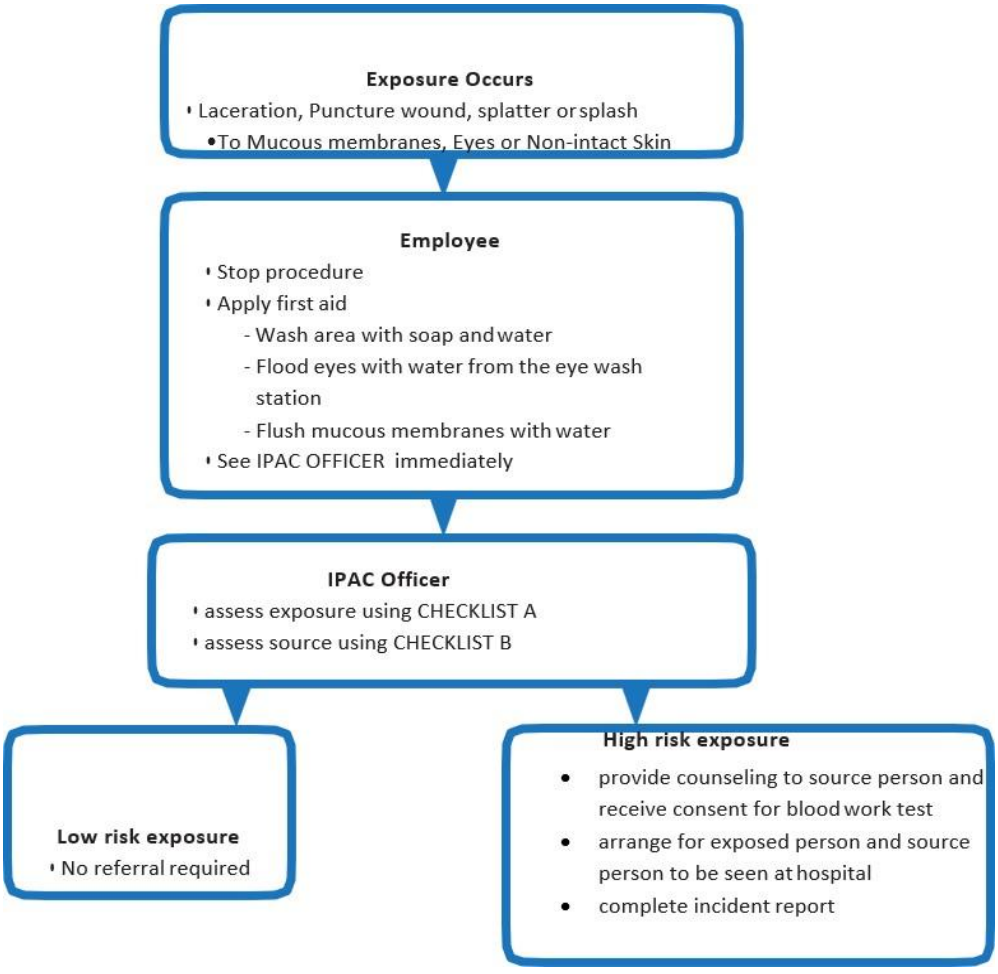
All these factors must be considered in determining the need for further follow-up care, including Post- Exposure Prophylaxis (PEP).

If the need to administer PEP is determined to be necessary, it must be done as soon as possible after the exposure. For example, anti-retroviral drugs to treat an HIV exposure must be given within one to two hours after the exposure.

The PEP regimen considered will be determined by the health-care professional contacted by the Infection Control Officer following the exposure. The PEP regimen must be consistent with current infection prevention and control guidelines, as recommended by the Public Health Agency of Canada.

As well as having a written office Infection and Prevention Control Program and identifying an Infection Control Officer (IPAC Officer) the appropriate arrangements and contact health- care personnel must be determined well before an actual significant exposure occurs.

Management of Needlestick and Mucous Membranes Exposition



Needlestick Exposure Information and Consent

An accidental needle stick injury has occurred to our staff. Sometimes this injury may expose them to a source person's blood. This may lead to an infection. To reduce the risk of infection after injury it is important to know if the source person is infected with certain organisms. These include Hepatitis B, Hepatitis C and Human Immunodeficiency Virus (the virus thought to cause AIDS).

Given any positive risk factors, we ask you to go to the hospital to allow an immediate blood test to be taken so that we can determine if there is a risk of passing on an infection from you to our employee.

Our office has policies and procedures in place to reduce injuries to employees. However, when accidents occur, we want to ensure that our employees receive proper care. We appreciate your cooperation in helping us to achieve this.

Consent to contact family physician for infectious disease blood test results

The above information has been reviewed and explained to me, and I consent to have my blood test at the hospital and the results be communicated to the medical personnel treating the affected staff.

Source person's name

Signature

Date:

Infection Control Officer

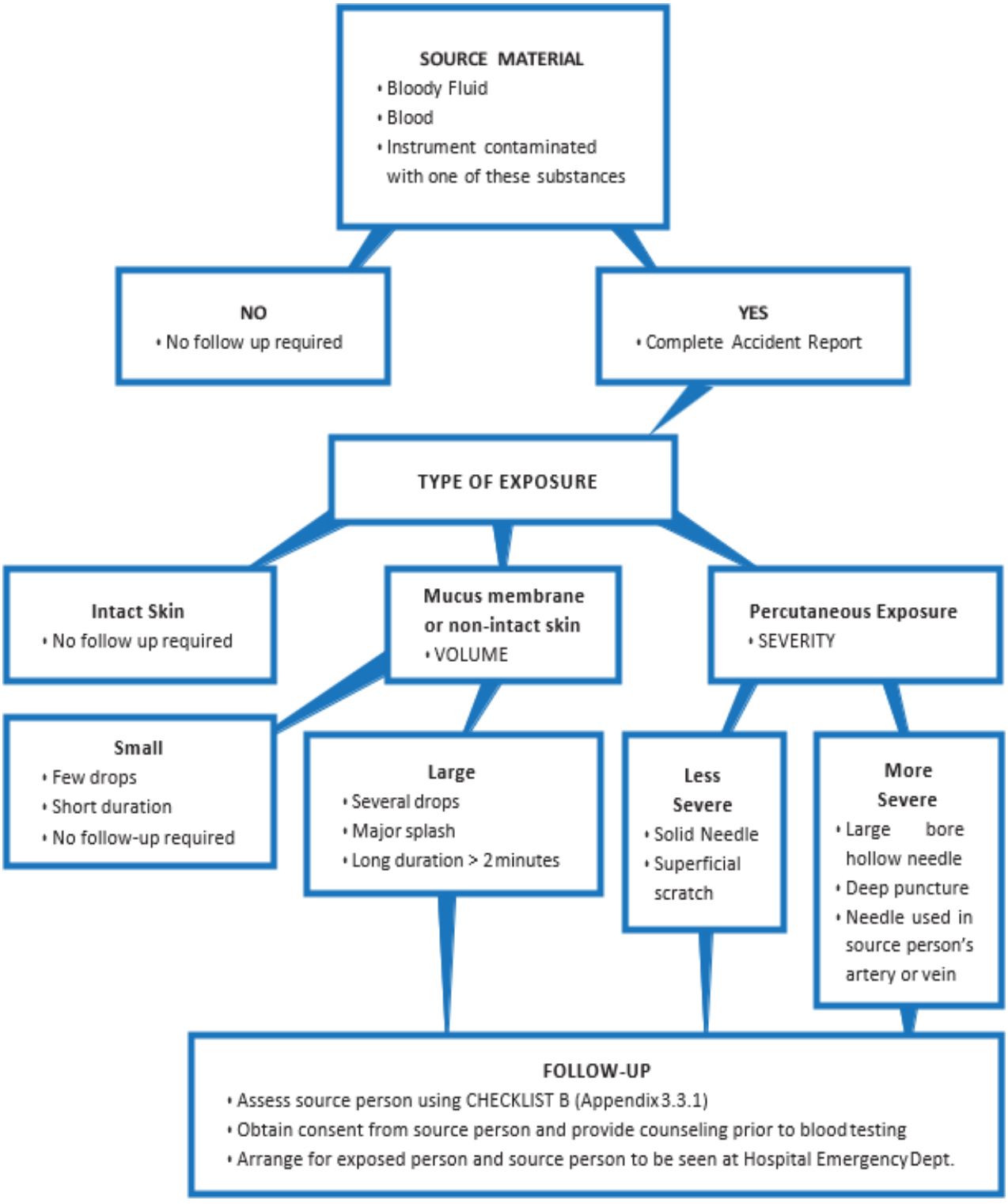
Signature

Witness Name

Witness Signature

CHECKLIST A

To Assess Exposure to the Risk of Infection (completed by the Infection Control Officer)



Medical Follow-Up to Needlestick and Mucous Membrane Exposures

The Following Procedures will be directed by the IPAC Officer:

1. **Medical management** of the injury.
2. **Referral of the source person** to the family physician or emergency physician for testing for Hepatitis B surface antigen, Hepatitis C surface antigen, and HIV antibodies. HIV testing will be done with appropriate pre- and post- counseling and informed consent.
3. **Referral of the exposed person** to the family physician or emergency physician for testing for Hepatitis B surface antibodies (if vaccinated) or Hepatitis B surface antigen (if not vaccinated), Hepatitis C antibodies, and HIV antibodies and to determine the need for Post-Exposure Prophylaxis.
4. **Documentation** of the following information (see template Exposure documentation) in the employees' confidential medical file:
   - date and time of exposure
   - details of the procedure being performed by the employee at the time of exposure
   - details of exposure including amount of fluid or material, type of fluid or material, and severity of exposure
   - details of exposure source
   - details of counseling, post-exposure management and follow-up
5. **Follow-up care** of the employee (see template Exposure and follow up care document) including counseling, medical evaluation and blood tests at 6 weeks, 3 months, and 6 months.

CHECKLIST B

To Assess Source Person After Exposure (Completed by Infection Control Officer)

❑ Inform the source person of the reason for the enquiry and allow them to read Needlestick Exposure Information and consent form

❑ Evaluate the source person's risk of blood-borne infection by reviewing their medical history for clinical symptoms and asking them for additional information.

Do you know if you are Hepatitis B, C or HIV positive or have any risk factors for exposure to viruses?

Hepatitis B ❑ Yes ❑ No ❑ Not sure Date Diagnosed _____

Hepatitis C ❑ Yes ❑ No ❑ Not sure Date Diagnosed _____

HIV ❑ Yes ❑ No ❑ Not sure Date Diagnosed _____

Risk Factors ❑ Yes ❑ No ❑ Not sure

Risk factors may include:

a) IV drug use/shared needles
b) Receiving blood products
c) Multiple sex partners and/or sex partners who have one or more of the listed risk factors
d) Unprotected/unsafe sex

❑ Request source person's consent to go for blood testing of their Hepatitis B/C and HIV status.

Source person's family physician

Dr._____ Telephone Number _____

Address _____

Test results will be sent to the treating physician overseeing our staff member.

Exposure Documentation

Name of Exposed Person:		
Hepatitis B vaccination completed:	**Date**:	**Post-vaccination titre**: mIU/mL
Date and **Time** of Exposure:		

Procedure being performed:

Where and how exposure occurred:

Did exposure involve a sharp device: ❒ No ❒ Yes

Type and brand of device: _____

How and when during handling exposure occurred: _____

Extent of the exposure (describe): _____

_____

❒ Blood ❒ Saliva ❒ Other body fluid Describe: _____

Percutaneous injury

- ▶ Depth of wound: _____
- ▶ Gauge of needle: _____
- ▶ Was fluid injected: ❒ No ❒ Yes

Skin or mucous membrane exposure

- ▶ Estimated volume of fluid: _____
- ▶ Duration of contact: _____
- ▶ Condition of skin: ❒ Intact ❒ Chapped ❒ Abraded

Source person information

- ▶ Known infectious disease(s): HIV ❒ No ❒ Yes ❒ Possible
- ▶ Anti-retroviral therapy: ❒ No ❒ Yes Viral Load: _____

Exposure and Follow up Documentation care

*(NOTE: Confidentiality of this form **MUST** be ensured, i.e. only those people who need to see this form may do so)*

Follow-up care (describe in detail):

Date Y/m/d	Caregiver	Action Taken

Notes

New Brunswick Dental Society

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Rule 14

Standard of Practice

Code of Ethics

Dentists shall take reasonable steps to ensure that the Dental Act and the Bylaws of the NBDS are respected by all persons, employees, shareholders or associates who work with them in the practice of the profession. This document may be used by the NBDS or other bodies in determining whether appropriate standards of practice and professional responsibilities have been maintained.

New Brunswick Dental Society
Board Approved
October 2024

Index

The New Brunswick Dental Society would like to thank the College of Physicians and Surgeons of New Brunswick for their assistance in the preparation of this document.

Fundamental Responsibilities

1. Consider first the patient's wellbeing.

2. Treat the patient with dignity and as someone worthy of respect.

   Respect for people is a fundamental principle that excludes not only exploitation and discrimination but also discourteousness and insensitivity.

3. Practise dentistry with competence and integrity, and in the absence of incompetency. Practise following the scientific standards recognized in dental medicine.

4. Seek constantly to deepen your knowledge to maintain and improve your professional attitudes, knowledge and skills.

5. Fight against any influence or interference that may undermine your professional integrity.

6. Promote and maintain your own health and wellbeing.

Responsibilities Toward Patients

1. Recognize conflicts of interest arising during your professional activities and duties and resolve them in your patients' best interests.

2. Advise your patient when your personal values will influence the recommendations or dental treatment that the patient wishes or needs.

If the refusal or delay of treatment may cause harm to the patient, the dentist has an obligation to refer the patient to another specialist dentist without delay.

3. Refrain from exploiting patients for personal gain.

4. Take all reasonable measures to avoid causing harm to patients; if a patient suffers any harm, reveal it to them.

5. Recognize your limits and, if needed, recommend or request additional services and advice.

6. Set fair professional fees. **Dentists shall advise their patients of the approximate cost of their services before the start of treatment and refrain from requiring advance payment in full for services.**

7. Dentists and their staff shall follow generally recognized rules for hygiene and asepsis.

8. Refrain from meddling in your patients' personal affairs.

9. Dentists shall perform a service or provide a prescription only if these are required from a dental point of view.

10. Dentists shall refrain from taking any action or making any diagnosis without sufficient knowledge of the underlying facts.

Interruption in the Patient-Dentist Relationship

1. Accept patients without any discrimination (i.e.: age, disability, gender expression or identity, genetic characteristics, language, marital or family status, medical disorder, ethnic origin, political affiliation, race, religion, sex, sexual orientation, socioeconomic status).

2. Provide all appropriate assistance possible to anyone in urgent need of dental care.

3. Dentists shall not, except for a fair and reasonable motive, cease treating a patient.

4. Should treatment cease, dentists shall advise patients of their intention and ensure that this cessation of service does not have a negative effect on their patients' health.

Communication, Decision-Making and Consent

1. Provide your patients the information they need to make informed decisions on their dental care and answer their questions to the best of your skill. Use language that the patient can understand. Use terms that are both simple and exact.

To allow patients to provide fully informed consent, dentists are under the obligation to provide them with all information that, from the patients' point of view, will affect their decision.

2. Dentists shall set and present fair and reasonable fees, taking into consideration the time needed for a treatment, its difficulty or any exceptional skills needed.

3. Give patients the information needed to understand fees and payment methods.

4. If a treatment plan needs to be modified, the dentist shall inform the patient immediately if any additional fees are involved.

5. Make all reasonable efforts to communicate with your patients in a way that ensures that the information exchanged is understood.

Fully informed consent requires good communication.

6. Inform your patient or the responsible person of the scope and methods of treatment justified by the patient's condition and their costs and get their agreement.

7. Inform the patient as soon as possible of any complication or incident that occurs and provide the patient with the care required and the financial implications.

8. Respect the patient's right to accept or refuse any recommended dental care.

9. Respect the autonomy of minors who are authorized to give their consent for treatment.

A patient aged sixteen (16) or older has the same rights as an adult with respect to all aspects of medical care, including consent for or refusal of a treatment and confidentiality. A child under sixteen years of age has the same rights if the dentist believes the child to be capable of consenting to the treatment and if the treatment is in the child's interest.

10. Agree to reasonable requests from your patients who wish to obtain a second opinion from a dentist or specialist of their choice.

11. When the intentions of an incompetent patient are unknown and in the absence of any official mechanism for making decisions on treatment, perform the acts deemed to be in compliance with the patient's values or, if the patient's values are not known, in the patient's best interests.

12. Dentists shall maintain their professional independence and avoid any situation involving a conflict of interest. Should a conflict of interest occur, dentists shall cease treatment, advise the patient and ask whether the patient authorizes them to continue.

Respect for Privacy and Confidentiality

1. Protect your patients' *Personal Health Information*.

2. Provide patients with reasonable information, taking into account the circumstances, on the reason for collection, use and disclosure of personal information on their health.

3. Know your patients' rights with respect to the collection, use, disclosure and accessibility of personal information on their dental health; ensure that this information is recorded correctly.

4. In public, refrain from discussing patients or making comments about them that could be reasonably deemed to reveal confidential information about them or to allow others to identify them.

5. Disclose your patients' *Personal Health Information* to a third party only with the patients' consent, or when required by law, for example, when maintaining confidentiality risks causing serious injury to third parties or, in the case of incompetent patients, to the patients themselves. As well, all reasonable steps must be taken to advise patients of any breach in the usual requirements of confidentiality.

6. On the patient's request, provide to the patient or a third party a copy of the patient's dental chart, unless there is a convincing reason to believe that the information in the chart will cause serious injury to the patient or to someone else.

7. Dentists shall respect the secrecy of all confidential information. Dentists may be released from such secrecy with the patient's authorization or if ordered by law.

8. Dentists shall ensure that their staff respect professional confidentiality.

Responsibilities Toward the NBDS and Your Colleagues

1. Dentists shall reply as soon as possible to any correspondence from the Registrar's office.

2. Dentists shall not betray the good faith of a colleague or be guilty of an abuse of trust.

3. When consulted by a colleague, provide your substantiated opinion and your recommendations, confirmed in writing, as soon as possible.

4. Dentists and their staff shall take all reasonable means to enforce the *Dental Act* of NB, as well as the NBDS's bylaws, standards and guidelines.

5. Assume the responsibility to present the general positions of the profession in interpreting scientific knowledge to the public; when an opinion contrary to the general opinion of the profession is presented, this must be specified.

The public must be protected from rash opinions.

Responsibilities Toward the Profession

1. **Recognize that self-regulation of the profession is a privilege and that each dentist has a responsibility to constantly deserve this privilege and to support its institutions**.

2. Be willing to teach students of dental medicine, residents, other colleagues and other health professionals, and to learn from them.

3. Refrain from damaging the reputation of colleagues for personal reasons, but report to the proper authorities any unprofessional conduct by colleagues.

4. Be willing to participate in peer critical reviews and to submit to them yourself. Establish links, contracts and agreements only when you can maintain your professional integrity and protect your patients' interests.

5. Refrain from promoting, as a member of the dental profession, any service (except your own) or product for your personal gain.

6. Do not hide from colleagues the diagnostic or therapeutic agents and procedures that you use.

7. Treat your colleagues with dignity and as someone worthy of respect.

8. Dentists shall provide appropriate supervision for their employees.

9. Avoid any false representation of your level of competence.

10. Show integrity.

11. Make sure that you have an emergency service system in place to give patients access.

Responsibilities Toward Yourself

1. Ask for help from colleagues and duly qualified professionals when experiencing personal problems that may negatively affect the services that you provide to patients, society or the profession.

2. Protect and improve your own health and wellbeing. To this end, identify the stress factors in your professional and personal life that can be managed. Develop and adopt adequate stress management strategies.