Summary of: Reporting of occupational exposures to blood and body fluids in the primary dental care setting in Scotland: an evaluation of current practice and attitudes

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FULL PAPER DETAILS

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Objectives To evaluate experience, practice and beliefs regarding occupational exposures to blood and oral fluids among a random sample of 300 dentists working in Scotland's NHS primary dental services. **Method** A cross-sectional postal survey assessed occupational exposure policies and procedures, recent occupational exposure incidence and current management. Beliefs were measured using constructs from the theory of planned behaviour, shown to influence behaviour in this population. **Results** Forty-two percent of dentists responded. Fourteen percent had sustained an occupational exposure in the previous 12 months; of those, 35% did not report their exposure. All respondents' practices had protocols in place for managing and reporting dental team member sharps injuries. Most (82%) had protocols for mucocutaneous exposures. Less than half (48%) had a protocol for managing and reporting patient exposures to blood or saliva. Dentists placed significantly more importance (z-score -4.44, p value <0.001) and necessity (z-score -4.17, p value <0.001) on reporting patient exposure than dentist occupational exposure. **Conclusion** This study suggests that while dentists generally have positive beliefs about reporting occupational exposures, there are gaps in practice.

EDITOR'S SUMMARY

Virtually all our actions are guided by risk, or more accurately our perception of risk. This applies equally to our working and non-working lives. What is the risk in committing a criminal act, for example? It may be a moral dilemma, it may be the sanctions applied if we are apprehended. What is the balance between risk and consequence? And then there is fear; fear also plays an important part here. What is the fear of taking the risk?

With the rise in awareness of new blood borne pathogens in the mid to late twentieth century came the attendant need for a much greater understanding of their possible transmission and, of course, the risks they posed to patient, practitioner, team and the interactions between the parties. Initially this created huge anxieties. I well remember in the 1980s witnessing a colleague dressed like an Apollo astronaut preparing to treat a patient who was HIV-positive. As we now know, the risk was in actuality minimal: the fear was palpable.

Now, these several decades on a very different approach has prevailed thanks to scientific method, rational understanding and common sense. Yet real risks do remain, have to be minimised and, if converted to incident, reported and appropriately treated. This paper is a valuable step in both quantifying the number of those incidents which create a risk of cross-infection in dental practice as well as providing clues to the judgement of the risk that they pose to those involved. Interestingly, as highlighted in both the paper and in David Croser's commentary, the professionalism of those surveyed indicates that they took the risk to patients more seriously than that to themselves.

However laudable this approach may be there remains the serious need to ensure that the risks to dental personnel are regarded as real and present threats to their welfare and possibly their livelihoods, as indeed they may be to patients. Although the fear of the risk may have subsided, due regard for the consequences

of not taking appropriate action should not be diminished through a misplaced complacency. Further research should help to illuminate this and prompt additional professional awareness.

The full paper can be accessed from the *BDJ* website (www.bdj.co.uk), under 'Research' in the table of contents for Volume 217 issue 4.

Stephen Hancocks
Editor-in-Chief

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IN BRIEF

- Stresses members of the dental team are at risk of exposure to blood borne viruses such as HIV and hepatitis C in their everyday working lives and an awareness of such risks is vital for the prevention of infection.
- Suggests that while dentists generally have positive beliefs about reporting occupational exposures, there are gaps in practice.

COMMENTARY

Anyone who undertakes exposure-prone procedures (EPPs) in a dental setting is required to assess their risk of transmitting disease to a patient during treatment. If such a risk is perceived, the healthcare worker (HCW) has an obligation to obtain the advice of an independent physician and to stop working if such a risk can be demonstrated, or as a precaution until an adequate level of patient safety can be demonstrated.

There is an obvious and clear financial disadvantage for any dentist who is unable to practise normally – even though the lack of income can be partly offset by statutory sickness benefits and income protection insurance.

The study by Leavy *et al.* demonstrates the dental profession's highly ethical stance to ensure that the interests of the patient are protected when the risk of exposure to a blood borne pathogen is recognised. The appetite by the HCW to report a similar episode in which they may have been exposed is apparently not as strong.

Supposing that there had been an occupational health doctor available in the room next to the one where the risk of exposure had arisen, there would have been no barrier to obtaining an independent risk assessment. In reality that medical assessment may be at some distance. The process of getting both the clinician and the patient assessed and any necessary post-exposure prophylaxis started, could be quite lengthy and surgery time would inevitably be lost (and the income too).

It would be intriguing to know how many participating practices in the study had the name and telephone number of their nearest clinic offering post-exposure assessment and whether the

dental team had ever trained to deal with the situation in much the same way as they would train for other medical emergencies.

An efficient post-exposure protocol together with standard infection control protocols permits the dental team to treat all patients without discrimination. It is a tribute to the professionalism of the UK's dental profession that they adopted such a high ethical standard on behalf of their patients long before the Government was able to do anything similar for members of the dental profession with HIV who wished to return to work following treatment to eliminate the risk of transmitting HIV to their patients.

The regulatory changes announced in 2013 now align the management of the HCW with HIV to that adopted for HCWs with hepatitis B and/or hepatitis C.

David Croser
Communications Manager
for Dental Protection

AUTHOR QUESTIONS AND ANSWERS**1. Why did you undertake this research?**

Prevalence rates of blood borne viruses such as HIV and Hepatitis C continue to increase across the UK. In the busy dental surgery environment of the twenty-first century members of the dental team are at continued risk of potential exposure to such infectious agents. We undertook this research in order to gain a better understanding of how dentists in Scotland manage occupational exposures to blood and saliva in primary dental care – in particular in relation to their reporting of such incidents. Furthermore, as there is little available in the literature pertaining to dentists' attitudes and beliefs towards reporting such workplace exposures, we set out to explore this in our study.

2. What would you like to do next in this area to follow on from this work?

The scope could be extended to include other dental registrants including dental and orthodontic therapists, hygienists, dental nurses as well as decontamination staff members. Furthermore, a comparison of dental team members working in a wider variety of settings (eg university and teaching hospitals) across different nations and regions (eg England, Wales and Northern Ireland) may prove a worthwhile and interesting venture and provide further data for comparative purposes. As highlighted in our study, any further research on this topic would ideally include a larger population sample. Further work might also elaborate on the role of occupational health services and the potential challenges facing this service as highlighted by some of our respondents. Leading on from this study, there may be an exciting opportunity to develop and evaluate targeted educational interventions to encourage a change in behaviour (eg guidance, CPD courses and talks etc).