ImmediaDent Infection Control Manual

Infection Control Training
*Mandatory training requirements, Nature of the Threat*

Exposure Control
*Personal Protective Equipment, Hand Hygiene, Postexposure Protocol*

Environmental Infection Control
*Disinfectants, Treatment Room Protocols, Dental Unit Waterline Maintenance*

Medical Waste, Laboratory Precautions

Appendices

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## Table of Contents

Mandatory Infection Control Training

- Mandatory IC Training: Who ................................................................. 4
- Mandatory IC Training: When ............................................................ 4

Nature of the threat: Infectious agents encountered in dental health-care settings ........ 5

Breaking the Chain of Infection ......................................................................... 7

Administrative Controls: Workplace Restrictions and Immunizations .................. 9
  - Medical Work Restrictions .................................................................. 9

Immunization Program ......................................................................................... 11

Exposure Control: Personal Protective Equipment, Hand Hygiene, and Postexposure
  Protocol ......................................................................................................... 12
  - Preventing Exposures to BBF and OPIM: an overview ......................... 12
  - Hand Hygiene ......................................................................................... 12
  - Personal Protective Equipment (PPE) ...................................................... 13
  - Latex Allergy and Dermatitis in DHCP ................................................ 14
  - Postexposure protocol .......................................................................... 14
  - Postexposure Medical Evaluation: Overview ...................................... 15

Environmental Infection Control ........................................................................ 16
  - General information ............................................................................. 16
  - Disinfectants ......................................................................................... 16
  - Personal protective equipment (PPE) .................................................... 16
  - Barrier use ............................................................................................. 16
  - General housekeeping .......................................................................... 16
  - Blood spills ............................................................................................ 17
  - Carpeting and cloth furnishings ............................................................ 17
  - Medical waste disposal (also see “Medical Waste” section below) ....... 17
  - Nonclinical personnel (visitors) in treatment area ................................. 18

Treatment Room Protocols ................................................................................ 18
  - Asepsis During Treatment ................................................................. 19
  - After Treatment Protocol ...................................................................... 20
  - Dental Unit Waterline Maintenance ..................................................... 20

Medical Waste ................................................................................................... 22
  - Handling of Biopsy Specimens and Extracted Teeth ......................... 22
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laboratory Precautions</td>
<td>24</td>
</tr>
<tr>
<td>Sterilization and Instrument Processing</td>
<td>25</td>
</tr>
<tr>
<td>Handpieces, Parenteral Medications, Suction Devices, and Surgical Irrigation</td>
<td>27</td>
</tr>
<tr>
<td>Dental Handpieces and Suction Devices</td>
<td>27</td>
</tr>
<tr>
<td>Parenteral Medications</td>
<td>27</td>
</tr>
<tr>
<td>Biopsy Containers (see also section on Medical Waste)</td>
<td>27</td>
</tr>
<tr>
<td>Practice Inspection Form</td>
<td>28</td>
</tr>
<tr>
<td>Safety / Infection Control Violation Report</td>
<td>34</td>
</tr>
<tr>
<td>Autoclave Monitor Log</td>
<td>35</td>
</tr>
</tbody>
</table>
**Mandatory Infection Control (IC) Training**

**Who**

All staff that have contact with patients must undergo mandatory IC Training. This includes all clinical staff such as assistants, hygienists, and laboratory technicians. It also includes administrative staff who make appointments and discuss financial arrangements with patients, as well as those who handle patient charts. Adhering to proper infection control practices will enable staff to do their jobs in a safe and effective manner.

**When**

All staff must receive training in safety and infection control procedures. This training must be received shortly after being hired and annually thereafter.

Failure to remain current in IC training can result in suspension of clinical privileges or other action. Continued failure to comply with requirement could lead to dismissal. We take safety and infection control seriously, and we cannot protect staff or patients unless all personnel are properly trained.
Nature of the Threat: Infectious Agents in Dental Healthcare Settings

Transmission of infectious agents in the dental setting can normally be prevented through the use of standard precautions. It is worth noting that there are some uncommon clinical situations that require a higher level of infection control precautions. One example is the case of a patient with active tuberculosis. Such a patient cannot receive routine dental treatment in a normal setting and requires special precautions. Theoretically, almost any infectious disease could be transmitted in the dental setting. However, there are a few that are of primary importance. These include hepatitis B, hepatitis C, HIV, tuberculosis.

An exposure is said to exist when a health care worker has come in contact with potentially infectious material. An accidental needlestick is an example of a percutaneous exposure. Percutaneous means “through the skin” and refers to any injury in which the skin is penetrated. Other exposures can occur when blood or contaminated liquid from a dental evacuation system splashes in an assistant’s eye or can even include airborne infections spread by aerosols generated by a dental handpiece (or by a patient’s sneeze or cough).

Infection does not always occur following exposure. The risk of infection following exposure is determined by a number of factors, including inoculum size (how big a “dose” of organisms the person is exposed to), method of exposure, and susceptibility. Inoculum size is important, and is the reason why hollow needles (which can carry a larger number of pathogens due to the hollow channel or lumen within the needle) are much more effective in transmitting infection than solid instruments such as suture needles or curettes.

In order to better understand the nature of the threat, this section summarizes some of the more important diseases that may be encountered in the dental setting.

Viral hepatitis. Hepatitis is a generic term that means “inflammation of the liver.” Hepatitis can be caused by viral and bacterial infections, other parasites, or exposure to chemicals and drugs (such as alcohol). Viral hepatitis is a risk for all healthcare workers. Although new treatments are available, they are not permanent cures. It is far better to prevent transmission in the first place by observing proper infection control procedures and being immunized against hepatitis B. Three types of viral hepatitis are important in dentistry.

- Hepatitis B. Hepatitis B is caused by the hepatitis B virus (HBV). The viral particles may remain infectious for a week in dried blood at room temperature. Thus, contact with contaminated surfaces may allow the virus to infect the health care worker through cuts and abrasions on the skin. Such transmission from environmental surfaces has been documented to occur in settings such as hemodialysis units. Hepatitis B is the most infectious bloodborne pathogen likely to be encountered in the dental workplace. For this reason, it is the target organism for infection control measures. If IC measures are effective in preventing the transmission of hepatitis B, they will probably be effective in preventing the transmission of other diseases.

It is important to note that anyone can be a carrier of HBV. HBV carriers are at greatly increased risk for hepatocellular carcinoma, cirrhosis, and transmission to family members.
All dental health care personnel (DHCP) must be vaccinated against hepatitis B prior to contact with patients, unless the DHCP has completed a waiver of vaccination described in the Immunization Program section. If you do not wish to be immunized, you must sign a waiver form stating that you decline (refuse) to receive the vaccine.

- **Hepatitis C.** Hepatitis C (HCV) is the most common cause of so-called “non-A, non-B hepatitis.” One of the things that distinguishes HCV from HBV is the fact that approximately 80% of HCV infections result in a chronic carrier state. Risk factors for HCV include exposure to blood and body fluids (BBF) (needlesticks, sharing needles, etc.) and multiple sex partners. In many cases, no risk factor can be identified.

- **Hepatitis D.** Hepatitis D (HDV) is unique in that the virus (formerly known as the delta agent) can only replicate in the presence of the hepatitis B virus. Patients infected with both HBV and HDV sometimes have a particularly severe form of hepatitis known as *fulminant hepatitis*. Since HDV requires co-infection with HBV, it is likely that vaccination against HBV will also provide protection against HDV.

**Human Immunodeficiency Virus (HIV).** Routes of HIV transmission include contact with contaminated BBF or other potentially infectious material (OPIM), various sexual practices, and vertical transmission from mother to child. HIV positive individuals may remain relatively symptom-free for years.

**Other infections.** When discussing disease transmission in the dental setting, the focus is naturally upon those infections with the most serious consequences such as AIDS and HBV. However, common diseases such as the common cold, influenza, various herpes viruses, and STDs may also be transmitted. The safeguards taken to prevent transmission of HBV, for example, will also reduce the chances for transmission of other, more common pathogens. While not life-threatening (usually), diseases such as the common cold and herpetic skin infections may be debilitating and unpleasant for dental healthcare workers (and their families).
Breaking the Chain of Infection

Infectious diseases are spread by direct contact between individuals, via airborne droplets, or on contaminated surfaces or instruments. One of the most important routes of transmission in the dental workplace is exposure to blood and body fluids (BBF), as well as other potentially infectious material (OPIM). Blood is the most important fluid. Blood is usually found in saliva, due to gingival bleeding. Therefore, all saliva is considered a potentially infectious material and must be treated with caution. Specifically, BBF can be spread via aerosols generated by handpieces and ultrasonic scalers, by percutaneous injuries (e.g., needlestick injuries), or by direct contact with blood, body fluids, or other potentially infectious material.

The goal of infection control is to break the chain of infection. There are a number of strategies for doing this, but most involve reduction (or elimination) of the microbial “dose” that the patient or dental health care personnel (DHCP) is exposed to.

One of the oldest infection control strategies is to kill the organisms so as to render them harmless. This can be accomplished by a variety of methods. The choice of methods depends on the nature and use of the material to be sterilized.

Patient Care Instruments

Patient care instruments can be classified as critical, semi-critical, and noncritical.

- **Critical instruments** are those which penetrate soft tissue, contact bone, or otherwise gain access to normally sterile tissue. This group includes scalpel blades, burs, curettes, and suture needles. Critical items represent the highest risk for disease transmission. Therefore, they must be heat sterilized in a steam autoclave. Dental handpieces are treated as critical items and always require heat sterilization.

- **Semi-critical items** contact mucous membranes or non-intact skin but will not penetrate soft tissue. This includes dental mirrors, impression trays, and amalgam condensers. Semicritical items pose a lower risk for transmission. However, if semicritical items are heat-tolerant, they should also be heat-sterilized. If the item may be damaged by heat, it must receive high-level disinfection (see below).

- **Noncritical items** contact intact skin and include items such as blood pressure cuffs. Noncritical items pose the lowest risk for disease transmission.

Disinfectants

Different levels or types of disinfectant may be required for different applications. The EPA rates disinfectants regarding their effectiveness. An acceptable surface disinfectant should kill Mycobacterium tuberculosis. Such disinfectants are known as tuberculocidal.

Barriers

Barriers are another method of breaking the chain of infection. Barriers are especially useful in areas which are difficult to clean because of surface gaps and irregularities. For example, plastic
barriers must be used to cover the digital radiography sensor and handpiece holders. Personal protective equipment (PPE) might be viewed as a barrier to cover the DHCP. PPE should include full length gloves, gowns, protective eyewear, close-fitting mask, and other items as required. These are described in detail in a subsequent section.

**Hand Hygiene**

Hand hygiene is one of the most important infection control methods. In addition to protecting the patient, you will also protect yourself. Hand hygiene techniques are described in detail in a subsequent section.

**Immunization**

Immunization is also an important technique in infection control. Specific immunizations for specific diseases are discussed in a subsequent section. All DHCP should avail themselves of these safe and effective methods to protect themselves and their families.
Administrative Controls: Workplace Restrictions and Immunizations

*Administrative controls* are methods of infection control that depend on administrative actions. For example, someone with active TB is forbidden from treating patients. This is an administrative rule or control. Other examples include work restrictions for healthcare workers who have certain contagious conditions.

**Medical Work Restrictions**

The presence of certain medical conditions may cause DHCP to be excluded from clinical duties. Decisions regarding medical restriction shall be based on epidemiologic evidence and CDC recommendations. Selected medical conditions and related work restrictions are shown below in Table 1.

This is not exhaustive and other conditions and recommendations may be found in the CDC’s *Guidelines for Infection Control in Dental Health-Care Settings (2003)*. The following table lists some conditions that may necessitate work restriction.

<table>
<thead>
<tr>
<th>Disease/condition</th>
<th>Work Restriction</th>
<th>Duration of Restriction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conjunctivitis</td>
<td>No patient contact</td>
<td>Until discharge ceases</td>
</tr>
<tr>
<td>Cytomegalovirus infection</td>
<td>No restriction</td>
<td></td>
</tr>
<tr>
<td>Dermatitis</td>
<td>Seek appropriate medical care; clinic unit managers shall make judgment as to whether condition precludes patient contact</td>
<td></td>
</tr>
<tr>
<td>Diarrhea</td>
<td>No patient contact</td>
<td>Until symptoms resolve</td>
</tr>
<tr>
<td>Diarrhea, salmonellosis</td>
<td>No patient contact</td>
<td>Until symptoms resolve</td>
</tr>
<tr>
<td>Hepatitis A</td>
<td>No patient contact</td>
<td>Until 7 days after onset of Jaundice</td>
</tr>
<tr>
<td>Hepatitis B (e antigenemia)</td>
<td>No invasive procedures until counsel from review panel sought</td>
<td>Until HBeAg negative; check for latest CDC, state and local regs</td>
</tr>
<tr>
<td>Hepatitis C</td>
<td>No restriction</td>
<td></td>
</tr>
<tr>
<td>HIV infection</td>
<td>No invasive procedures until counsel from review panel sought</td>
<td></td>
</tr>
<tr>
<td>Measles, active</td>
<td>Exclude from duty</td>
<td>Until 7 days after rash appears</td>
</tr>
<tr>
<td>Meningococcal infection</td>
<td>Exclude from duty</td>
<td>Until 24 hrs after start of effective therapy</td>
</tr>
<tr>
<td>Mumps, active</td>
<td>Exclude from duty</td>
<td>Until 9 days after onset of parotitis</td>
</tr>
<tr>
<td>Staph aureus infection/MRSA, draining skin lesion</td>
<td>No patient contact</td>
<td>Until lesions have resolved or a release obtained from Doctor</td>
</tr>
<tr>
<td>Strep infection, Group A</td>
<td>No patient contact</td>
<td>Until 24 hrs after therapy begun</td>
</tr>
<tr>
<td>Disease/condition</td>
<td>Work Restriction</td>
<td>Duration of Restriction</td>
</tr>
<tr>
<td>-------------------------</td>
<td>------------------------------------------------</td>
<td>------------------------------</td>
</tr>
<tr>
<td>Tuberculosis, active</td>
<td>Exclude from duty</td>
<td>Until proved noninfectious</td>
</tr>
<tr>
<td>Tuberculosis, PPD converter</td>
<td>No restriction</td>
<td></td>
</tr>
<tr>
<td>Varicella, active</td>
<td>Exclude from duty</td>
<td>Until all lesions dry and crust</td>
</tr>
<tr>
<td>Zoster (shingles)</td>
<td>Cover lesions, restrict from care of immunocompromised patient</td>
<td>Until all lesions dry and crust</td>
</tr>
</tbody>
</table>

Table 1: CDC Recommendations on work restrictions for healthcare personnel. MMWR RR-17
**Immunization Program**

Immunization is one method to protect DHCP from possible work-related infections. ImmediaDent has an active immunization program based upon CDC recommendations. A Hepatitis B vaccination is required for all clinical staff, however all DHCP are strongly urged to receive the following vaccinations: influenza, measles (live-virus), mumps (live-virus), rubella (live-virus), ands varicella-zoster (live-virus). More details concerning these recommendations can be found in Table 2 below.

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Dose schedule</th>
<th>Indications</th>
<th>Precautions</th>
<th>Special Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>HBV</td>
<td>3-dose schedule at 0, 1, 6 mos in deltoid</td>
<td>DHCP at risk for BBF</td>
<td>Allergy to baker’s yeast</td>
<td>No adverse effect if given to HBV-infected person; should be tested 1-2 mos post-vaccine to determine serologic status</td>
</tr>
<tr>
<td>Influenza</td>
<td>Annual single-dose</td>
<td>DHCP at ImmediaDent</td>
<td>Allergy to eggs or other vaccine components</td>
<td></td>
</tr>
<tr>
<td>Measles (live-vaccine)</td>
<td>2 dose regimen</td>
<td>No reliable history of infection or serologic evidence of immunity; DHCP born before 1957 considered immune</td>
<td>Pregnancy, immunocompromised status; allergy to gelatin or neomycin</td>
<td>MMR (measles-mumps-rubella) is recommended vaccine for these three diseases</td>
</tr>
<tr>
<td>Mumps</td>
<td>&quot;</td>
<td>&quot;</td>
<td>&quot;</td>
<td>&quot;</td>
</tr>
<tr>
<td>Rubella</td>
<td>&quot;</td>
<td>&quot;</td>
<td>&quot;</td>
<td>&quot;</td>
</tr>
<tr>
<td>Varicella-zoster</td>
<td>2 doses 4-8 wks apart</td>
<td>No reliable history of varicella infection or serologic evidence of immunity</td>
<td>As with MMR; avoid salicylate use (aspirin) for 6 weeks after vaccination</td>
<td>71-93% of U.S.- born persons are immune; may consider testing before vaccination</td>
</tr>
</tbody>
</table>

Non-clinical individuals refusing HepB immunizations must sign a formal letter indicating that they have declined the opportunity to be immunized, despite being aware of the health risks that this entails.

A file containing records of immunizations and letters of declination shall be maintained by home office. This file shall be reviewed annually for errors and omissions.
Exposure Control: Personal Protective Equipment, Hand Hygiene, and Post-exposure Protocol

Preventing Exposures to blood and body fluids (BBF) and other potentially infections material (OPIM): Overview

The following procedures are recommended by the CDC and required by ImmediaDent to prevent or reduce such exposures:

- CDC approved standard precautions (i.e., universal precautions) shall be used for all patient encounters. The underlying assumption is that any patient may be a source of a bloodborne pathogen.
- Engineering controls should be used (e.g., sharp containers, needle shields or recapping devices, self-sheathing IV needles) to prevent percutaneous injuries from sharps (burs, blades, needles, etc.) whenever such items are used.
- If engineering controls are not available for a given application, extreme care must be used when handling such objects.
- Be especially wary of unpredicted movements by the patient (sedation may be considered in some cases).
- In case of an exposure, follow the written ImmediaDent post-exposure protocol (described below).
- If you observe unsafe conditions or practices, or have an idea as to how workplace practices might be made safer, please communicate these to your supervisor or exposure control coordinator.
- ImmediaDent will strive to provide employees with safe instruments and devices and will evaluate the need for updated instruments and devices on an ongoing basis.
- Used sharps should be placed in puncture-resistant sharps containers that are clearly marked with the biohazard symbol; these containers should be readily accessible.
- Do not recap needles in such a way that the needle is pointing toward any part of your body; instead, use a scoop technique or device that permits one-handed recapping.

Hand Hygiene

Hand hygiene is a critical aspect of proper infection control. All DHCP should develop good hand hygiene habits. The following protocols must be used by all DHCP at ImmediaDent:

- Hands should be washed for a minimum of 15 seconds with an antimicrobial soap when visibly soiled; an acceptable soap is 4% chlorhexidine (CHX; Hibiclens)
- If hands are not visibly soiled, an alcohol-based hand rub (AHR) can be used in lieu of soap (follow manufacturer’s instructions; generally, these agents are applied to the hands, which are then rubbed together vigorously for at least 15 seconds or until dry).
- Regardless of method, make sure the agent reaches all surfaces of hands, between fingers, etc.
- Hands should be washed with CHX or cleaned with an AHR at the following times:
  - when visibly soiled;
  - after touching surfaces likely to be contaminated (including work surfaces in the operatory, such as cabinetry);
before and after treating each patient (i.e., hand hygiene should be performed before donning gloves and immediately after removing gloves); and
before performing surgical procedures a more intense surgical hand antisepsis must be performed. Soap reservoirs should be washed and dried before refilling.

- Hand lotions may be desirable to prevent chapping and dryness (although compatibility of lotion and antiseptic and glove should be considered; some oil emollients affect glove integrity – see below).
- Fingernails should be short; no artificial nails should be worn.
- Rings with raised stones or facets should not be worn as these may cause breaks in the glove surface.

Personal Protective Equipment (PPE)

Personal protective equipment is a very important part of IC protocols. All DHCP are to wear PPE suitable for the particular activity in which they are engaged. Remember that PPE is also required during laboratory procedures in which contact with contaminated materials is likely.

Masks, Eyewear and Faceshields

- A properly fitted surgical mask and protective eyewear (with side shields) should be worn during procedures likely to cause splashing or splattering of blood; this includes various cleanup duties as well as direct patient care (e.g., cleaning plaster traps and evacuation systems)
- Change masks between patients or during the care of a single patient if the mask becomes soiled or wet
- If you change the mask, you must first remove your gloves; do not touch your mask with your gloved hand
- Clean and disinfect face shields, if used, and protective eyewear
- Face shields may be considered in addition to surgical masks in the case of procedures likely to produce excessive splatter (e.g., use of ultrasonic scaler)

Protective Clothing

- Protective clothing should be worn during patient care and other duties in which splatter or contact with potentially infectious material is likely
- Gowns should completely cover personal clothing and/or skin that is likely to come into contact with potentially infectious material
- Protective gowns should be changed if soiled or wet
- All PPE must be removed when leaving the treatment area

Glove Protocol

- Wear examination or surgical gloves when the potential exists for contact with potentially infectious material
- Hands should be washed prior to donning gloves and immediately after removing them
- Gloves should NEVER be washed
- No faceted jewelry should be worn under gloves
- No artificial nails should be worn under gloves
- Remove gloves that exhibit tears or punctures
• It is desirable to change gloves during long procedures (>60 minutes); while CDC has not identified an optimal time for changing gloves, it is well established that glove integrity deteriorates with time (increased formation of small “pinholes” in the glove)
• Gloves should be worn during surgery and during other procedures that are lengthy and involve a good deal of bleeding (e.g., periodontal surgery, extraction of teeth, certain cases of scaling and root planing)
• Gloves should be selected that fit the operator well
• If you begin to experience hand fatigue, cramping, or carpal tunnel-like symptoms (e.g., numbness), try a slightly larger glove (or different brand glove)
• If you notice signs of dermatitis on your hands (cracking, itching, redness), notify your supervisor or exposure control coordinator and appropriate alternative gloves and/or soap will be provided (see section on contact dermatitis below)
• When removing gloves, be careful not to allow “glove juice” to splatter on instruments or patients; do NOT discard used gloves on instruments that are to be used again (as when leaving the patient to find clinical personnel)
• Soiled gloves should be discarded immediately and should not contact any critical or semicritical items (defined below)
• Consult with manufacturer as needed regarding materials incompatibility with gloves

Latex Allergy and Dermatitis in DHCP

With increased use of latex gloves, there has been a corresponding increase in the frequency of latex allergy and contact dermatitis in healthcare workers. This is a serious and growing problem, but there are steps that can be taken to reduce its impact.

• DHCP should watch for signs that might indicate a latex allergy or dermatitis. Symptoms include itching, redness, rash, dryness, fissures/cracking, hyperkeratosis, and swelling. Other symptoms may include general allergic symptoms referred to the respiratory and other systems, such as sneezing, wheezing, hives (urticaria), and red, watery eyes.
• Medical consultation should be sought if you have these symptoms.
• Patients may also be allergic to latex and they should be identified by history.
• In rare cases, life-threatening emergencies (e.g., anaphylaxis) may occur and will require prompt treatment.

Post-exposure Protocol

Exposure prevention is best accomplished by an active ongoing education program and an active post-exposure program that includes incident analysis.

• Upon exposure, whether percutaneous (needlestick) or contact of BBF or OPIM with mucous membranes or broken skin, DHCP will interrupt treatment and inform his/her supervisor.
• A specific protocol is then to be activated which involves testing of both the DHCP and source patient for evidence of bloodborne infection.
• The designated exposure control coordinator will be notified of all exposures.
• The DHCP will be referred for evaluation and, if necessary, treatment (if the source patient tests positive for certain bloodborne diseases, post-exposure prophylaxis must reduce the chance of disease transmission to the DHCP).
• The DHCP will report the incident to his/her supervisor. A log of these incidents shall be maintained by the practice. This log shall include the date and time of exposure, the details of the procedure being performed, the details of the exposure, details of the exposure source, details of the exposed person and counseling, post-exposure management and follow-up.
• In cases of exposure to active TB, a baseline TB skin test shall be obtained (this also applies to administrative personnel who may have come in contact with the case); this will be repeated in three months.

Post-exposure Medical Evaluation

• ImmediaDent (i.e., employer)
  o Sends exposed DHCP for testing
• DHCP (i.e., the individual who was exposed)
  o Reports for evaluation and testing (with consent only)
  o Receives own and source individual’s test results of any condition resulting from the exposure that will require further evaluation or treatment
• Source Patient (i.e., the individual whose blood the DHCP was exposed to)
  o Taken to hospital laboratory for testing
  o Consents or refuses testing
• Medical Professional (i.e., the one who performs the evaluation and testing)
  o Arranges for testing of DHCP (assuming that consent is given) OR receives relevant information about source patient’s HBV and HIV status
  o Informs exposed DHCP of:
    ▪ Results of source patient testing
    ▪ Results of evaluation
    ▪ Any condition (relating to the exposure) that requires further treatment or evaluation
  o Gives written opinion to ImmediaDent that employee was informed of results and of any further evaluation or treatment needed
  o All other diagnoses and physical findings shall remain confidential and will not be included in the written opinion
Environmental Infection Control

This section contains both general and specific recommendations regarding asepsis in the dental workplace.

General Information

- **Disinfectants**
  - Only EPA-registered disinfectants are to be used for general environmental IC. These shall be rated “tuberculocidal” to provide intermediate level disinfection. High-level disinfectants (so-called “cold sterilants”) are not to be used for general disinfection of environmental surfaces. Please remember that bacterial endospores and the HBV can persist for extended periods on environmental surfaces such as counters, etc.

- **Personal Protective Equipment (PPE)**
  - Personal protective equipment should be worn when performing housekeeping and clean-up duties. At a minimum this should include protective clothing (standard clinic gown), protective eyewear (the level depending upon the danger of splash and splatter of BBF and OPIM; in extreme cases when handling large amounts of contaminated liquid, a face shield must be worn), and gloves. For normal clean-up use, puncture resistant gloves are to be used and should be constructed of a relatively heavy material (e.g., nitrile).

- **Barrier Use**
  - Barriers should be used to protect clinical surfaces that cannot be easily cleaned. Such surfaces include the handles of the operatory light, the bracket tray/arm/handpiece console, and dental chair. These barrier bags can be used to bag general trash upon completion of the procedure.
  - In case any clinical surface (that might be touched during a procedure or is in close proximity to the field of operation) cannot be covered with a barrier, it must be disinfected using an intermediate-level (tuberculocidal) EPA-registered disinfectant. Visible blood and debris must be removed.

General Housekeeping

- Floors, walls, and sinks must be cleaned with detergent/water or an EPA-registered hospital disinfectant/detergent on a regular basis. The schedule is to be based on the nature of the facility, patient flow, types of procedures performed, degree of contamination, etc. In any case, such surfaces must be cleaned if visibly soiled and no less frequently than weekly. Such cleaning solutions should be prepared fresh before use and changed as needed during the cleaning process.

  - **During Business Hours**: Each operatory is “turned” upon completion of a patient procedure to sanitize the room in preparation for an incoming patient. Environmental surfaces are sterilized using disinfecting solution which is generally administered using a spray bottle or through the use of disinfecting wipes. Commonly used private label items from Patterson Dental Supply are listed below:
    - pdCARE™ Disinfecting Wipe (item# 087-7209)
- pdCARE™ Surface Disinfectant (item# 085-0610)
- pdCARE™ Surface Disinfectant (item# 085-0602)

- **After Normal Business Hours:** A housekeeping services vendor is employed to clean and sanitize office and work spaces while the practice is closed. Housekeeping staff complete a customized checklist of general cleaning tasks to be completed prior to opening of the practice the next day. An outline of minimum requirements is provided to the vendor so that they can direct their staff in completing work.
  
  - Mop heads and cleaning cloths must be cleaned after use and allowed to thoroughly dry before next use, unless single-use disposable items are used.
  - All clinical areas are to be inspected after cleaning by a Lead Patient Coordinator (LPC) general cleanliness and report performance problems to the home office.
  - Operatories should generally be free of extraneous materials to facilitate cleaning and disinfection. Loose items should be placed in drawers or other storage.

- **Blood Spills**
  - Spills of blood or other grossly contaminated liquid (e.g., as might be encountered when cleaning a plaster trap) should be cleaned with an intermediate-level (tuberculocidal) EPA-registered disinfectant.

- **Carpeting and Cloth Furnishings**
  - Carpeting and cloth-upholstered furniture or surfaces shall not be used in dental treatment rooms, sterilization/instrument processing areas, and dental laboratories.

- **Medical Waste Disposal (also see “Medical Waste” section below)**
  - All medical waste shall be disposed of in accordance with current federal, state, and local regulations and policies.
  - All DHCP who handle such waste must be trained in proper handling and disposal procedures, and must be trained in general IC, including the threat of BBF, postexposure protocol, etc.
  - General medical waste shall be placed in leakproof bags that are color-coded and clearly marked with the universal biohazard symbol.
  - Sharps shall only be placed in special, color-coded sharps containers. These shall be leakproof, puncture-resistant, and clearly marked with the universal biohazard symbol. During disposal or movement of the container, it should be securely closed to prevent spillage. In the event of a sharps container spill, extreme caution should be exercised in cleaning the area (which must be secured and made free of foot traffic until the clean-up is completed).
  - Liquid medical waste, including blood, can be poured into a drain connected to the public sanitary sewer system, in compliance with local and state regulations. When pouring large quantities of liquid, extreme care should be exercised and adequate PPE should be worn, including a face shield.
• **Nonclinical Personnel (Visitors) in Treatment Area**
  o Generally, the only persons that are permitted in the dental operatory are the patient and ImmediaDent DHCP.
  o There may be occasions when it is necessary or desirable for others to be present during treatment (e.g., parents of a young child, adult children of an elderly patient)
  o This should only be done when, in the judgment of the attending dentist, it is absolutely necessary.
  o When such individuals are permitted into the treatment area, they must wear the same PPE as the operator.

**Treatment Room Protocols**

- Clean gloves must be worn during room preparation and instrument setup (sterile gloves should be worn when setting up for surgical and endodontic procedures).
- Flush dental unit waterlines for 3 minutes at the beginning of each clinical session.
- Cover the following surfaces with barriers:
  o dental chair (use large bag)
  o bracket table and handpiece holder (use large bag)
  o operating light handles (small plastic covers)
  o air/water syringes and evacuators (saliva ejector and HVE)
  o ultrasonic unit and other equipment (e.g., amalgamator)
- In the event that barriers are not available for any of the above, these items must be disinfected prior to use using either the Spray-Wipe-Spray method or disinfectant wipes (either method is acceptable):
  o **Spray-Wipe-Spray (SWS)**
    - Spray an EPA-registered intermediate level (tuberculocidal) disinfectant on 4 x 4 gauze sponge.
    - Wipe surfaces until no debris is seen.
    - Spray surface with EPA-registered intermediate level (tuberculocidal) disinfectant (such as ProPhene®) and allow to remain on surface until dry (or the spray may be wiped off after remaining for 10 minutes, if desired).
    - The operating light lens should be free of streaks and droplets (if the lens is easily removable, it should be removed for cleaning).
  o **Disinfectant Wipes**
    - Disinfectant wipes containing a tuberculocidal EPA-registered disinfectant are available in the practice and may be used in lieu of SWS protocol, if directed by your supervisor
    - Thoroughly wet surfaces with a surface disinfectant wipe and allow to dry for 10 minutes.
    - Place sterile cassette on bracket tray, but do not open until patient is seated.
Asepsis During Treatment

- Hands must be washed at the start of each day, before and after gloving, and after touching contaminated objects or surfaces. Thoroughly wash the hands and wrists with an antiseptic soap for a minimum of 15 seconds and dry completely before donning gloves. A surgical scrub is required before surgery (see section on Hand Hygiene).
  - An acceptable alternative for routine clinical care (but not presurgical scrub) is the use of an alcohol handrub (AHR). The recommended amount of the AHR is placed on the hands, which are then vigorously rubbed together until dry.
  - If you experience dermatitis or irritation of the skin of the hands, consult your supervisor and seek medical advice ASAP.
  - Prior to washing hands and donning gloves, faceted rings and watches should be removed.
- Operator and assistant must wear PPE, consisting of gown, protective eyewear, properly fitted mask, and gloves. The mask should be fitted to the contours of the face. In cases where an unusual amount of splatter may be expected, it may be prudent to wear a face shield in addition to a mask.
- Once gloves have come into contact with blood, bodily fluid or OPIM, they are considered contaminated. Do not touch the chart, door handles, telephones, etc. while wearing contaminated gloves. Contaminated gloves should not be worn outside of the operatory.
- Gowns and masks should be changed when visibly soiled or wet.
- Gloves must be changed immediately if punctured or torn. Since gloves develop pinholes over time, gloves should be changed during long procedures at least hourly and preferably every 30 minutes.
- Exposure to blood or other PIM should be promptly reported to your supervisor. This includes needlestick injuries and similar circumstances. In addition to receiving appropriate medical attention, it is important that each event be analyzed to determine how to prevent a recurrence.
- Needles should be safely recapped after each use (use approved method, such as one-handed scoop). Sharps should be discarded in the sharps container. Sharps should be handled with forceps or other devices to prevent accidental injury. Empty anesthetic cartridges are considered to be sharps.
- The handpiece should be placed in the holder in such a manner as to reduce the chance of being stuck with the bur. When you are done with the handpiece, the bur should be immediately removed.
- Impressions should be properly disinfected before sending to the laboratory, using a suitable disinfectant. The disinfectant shall be approved for use in such applications by the manufacturer of the impression material.
- Proper aseptic protocol is required when taking and viewing radiographs.
- To reduce aerosol contamination, the high-volume evacuator and rubber dam should be used whenever possible, particularly when the high-speed handpiece and ultrasonic scaler are in use.
- **Water from the dental unit (e.g., handpiece or air/water syringe) should not be used as an irrigant during endodontic and surgical procedures. Instead, use sterile water or saline for this purpose.**
After Treatment Protocol

- Dentist: Remove gloves, wash hands thoroughly, and remove mask. Complete progress notes and all required documentation.
- Assistant (or whoever will clean treatment room): Using heavy nitrile gloves, gown, and mask (plus face shield, if needed), ensure that all instruments are returned to the cassette, which is then closed and locked.
- Ensure that all sharps are placed in the sharps container, if this has not already been done. This includes burs and anesthetic cartridges.
- Remove all barriers and non-sharp disposables and discard.
- Run cleaner (as specified by the equipment maintenance personnel) through vacuum system (both HVE and saliva injector) at end of day. Valves should be wide open.
- The following surfaces must be cleaned and disinfected using the SWS technique or disinfectant wipes (as described above):
  - Chair: arm rests (if not covered by barrier)
  - Light: handles, switch, and lens (make sure there are no streaks or droplets left on light lens; clean only after light has cooled)
  - Unit: handpiece holders, tubing, controls, switches, tray surface, HVE/saliva ejector valves, air/water syringe, composite curing light
  - Other work surfaces: counter tops, soap dispenser, sink and faucet, computer, monitor, mouse and keyboard, and any other equipment that may have been touched during a procedure
  - Note: any surface covered with a barrier need not be disinfected UNLESS visibly contaminated with potentially infectious material. The only exception to this are the air/water syringes, saliva ejectors, and HVEs; these must be disinfected even if covered with barrier
- When using a closed system (see section on Dental Unit Waterline Maintenance for definition of a closed system), the handpiece and air/water syringe lines should be flushed (water allowed to run into a sink) for 30 seconds at the end of each clinical session.

Dental Unit Waterline Maintenance

There is evidence that biofilms often form in dental unit waterlines. The source of most of these organisms is from the water supply. The health consequences of the biofilm are not known, but it is clear that large numbers of bacteria are released into the water when such biofilms are present. Such organisms could, conceivably, pose a threat to patients or dental healthcare workers. Therefore, precautions must be taken to protect the safety of all concerned. Each practice will endeavor to periodically test the waterlines to ensure that the effluent meets EPA standards for drinking water quality, as specified in the CDC Guidelines.

The water systems may be divided into open and closed systems. The two systems require different protocols to maintain acceptable water quality and are described below. The effluent (water) from dental units in the practices will be monitored periodically using an in-office test kit such as the Millipore HPC Total Count Sampler (product# MHPC10025).

- **Open systems.** Open systems are connected to the city water supply. The ImmediaDent protocol for open water systems requires that the handpiece and air/water syringe be
flushed for 3 minutes prior to each clinical session. Following treatment, the lines should be flushed for 20-30 seconds (with high-speed handpiece attached).

- **Closed systems.** Closed systems are not connected to the city water supply but have a bottle that serves as a water source. When using a closed system, the handpiece and air/water syringe lines should be flushed (run into a sink) for 30 seconds at the end of each clinical session. Chemical treatments are intermittently added to the dental unit water. Commonly used chemicals include A-dec ICX™ Tablet Waterline Treatment (product# 90.1064.00) or Sterisol, Inc. Citrisil Blue Tablets (product# C20-B).

*Safety precautions.* Consult with the dental unit manufacturer for appropriate methods and equipment to maintain the recommended quality of dental water. Follow recommendations for monitoring water quality provided by the manufacturer of the unit or waterline treatment product.
Medical Waste

Waste generated in ImmediaDent practices can generally be separated into regulated and non-regulated medical waste. The CDC states that the “majority of soiled items in dental offices are general medical waste and thus can be disposed of with ordinary waste. Examples include used gloves, masks, gowns, lightly soiled gauze or cotton rolls, and environmental barriers (e.g., plastic sheets and bags) used to cover equipment during treatment.” While it is true that any item that has had contact with blood is potentially infective, the CDC further states that “treating all such waste as infective is neither necessary nor practical.”

Regulated medical waste, on the other hand, carries risk of infectivity and is subject to special rules governing storage, transportation, and disposal. Examples of such waste include extracted teeth, sharps (blades, burs, needles, cartridges), excised tissues, and materials that are “soaked or saturated” with blood or bodily fluids or OPIM.

At ImmediaDent, we have elected to err on the side of safety and treat all materials that are contaminated with blood as regulated medical waste. This would include masks, gloves, disposable gowns, gauze, etc. All such waste is to be placed into the appropriate regulated medical waste containers and disposed of according to protocols described elsewhere. If you are in doubt as to whether a particular item should be placed in a regulated waste container, err on the side of caution and treat it as regulated waste.

- Sharps should be placed in a purpose-built, color-coded, puncture-resistant container that is prominently marked with the universal biohazard symbol. Sharps containers should also have tight-fitting, secure lids that permit safe transportation to a disposal facility.

- Non-sharp regulated waste may be safely placed in a heavy gauge, leak-proof bag. Such bags should be securely closed prior to transport.

- Liquid waste (such as blood and liquid from evacuators and plaster traps) may be disposed of in the sanitary sewage system in accordance with local and state regulations. When disposing of such liquids, DHCP must wear suitable PPE, including a face shield to prevent contact with the eyes or mouth in the event of splashes and spills.

Handling of Biopsy Specimens and Extracted Teeth

The following procedures shall be followed when handling human tissue or biopsy specimens:

- The unsterile biopsy container should not be placed on the sterile drape or in proximity to sterile instruments.
- Instruments (such as tissue forceps) which touch the biopsy container (and/or formalin solution) are no longer considered sterile and must not touch sterile instruments or the patient’s tissues.
- During surgery, a second assistant or some other DHCP must open the container to allow the specimen to be deposited; the unsterile outer surface of the container should not be
touched by the operator or surgical assistant (if this occurs, the individual must remove gloves, wash hands, and re-glove before resuming surgery).

- During transport, the tissue specimen must be contained in a purpose-built, leak proof container, labeled poison.
- If the outer surface of the specimen container is visibly contaminated, it should be cleaned and disinfected, and the container placed in a biohazard bag.
- The formalin solution poses a significant health hazard and must not come into contact with DHCP or patient skin or mucosa.

The following procedures should be followed when dealing with extracted teeth:

- Extracted teeth should be disposed of as medical waste unless returned to the patient or used for educational purposes.
- Before being used for educational purposes, extracted teeth should be heat-sterilized (unless they contain amalgam).
- Such teeth must be cleaned and placed in a leak proof and puncture-proof container marked with biohazard symbol.
- Extracted teeth containing amalgam shall not be placed with medical waste that is to be incinerated.
- In the absence of clear recommendations, high-level disinfection (using sodium hypochlorite or similar agent) shall be used to disinfect teeth to be used for preclinical courses.
- Amalgam-containing teeth should be discarded in the same manner as mercury waste (after surface disinfection).
Laboratory Precautions

Dental impressions and prostheses that have been in the mouth shall be considered contaminated with BBF. Therefore, special precautions must be taken when working with these materials. In the laboratory, all DHCP shall follow the following protocols:

- PPE must be worn when handling or working with items, until they have been disinfected.
- All impressions and prostheses shall be disinfected in the practice before being transported to the laboratory using an EPA-registered disinfectant of at least intermediate activity (tuberculocidal).
- Dental lab supervisory personnel should consult with manufacturers regarding the stability of specific impression materials in the presence of disinfectants.
- When materials (such as impressions) are sent to off-site laboratories, a note should be included that describes the disinfectant protocol used.
- All disinfectants should be used for the time recommended by the manufacturer.
- It may be convenient to place the impression in an impervious container or bag after treatment (while still wet with the disinfectant), if this is acceptable according to the manufacturer of the impression material.
- Clean and heat-sterilize all heat tolerant materials used intraorally (e.g., impression trays, facebow forks).
- CDC recommends following manufacturers’ recommendations regarding instruments and materials that become contaminated but do not normally contact the patient. This would include laboratory burs, polishing points, rag wheels, articulators, laboratory work pans, and lathes/chucks. Heat-tolerant items should be heat-sterilized. If heat-intolerant, items should be cleaned and disinfected with a disinfectant possessing tuberculocidal activity.
- If ultrasonic cleaners are used to clean prostheses or other items which are to be inserted in the patient’s mouth, they must first be placed in a sealed, impervious receptacle containing cleaner. The practice will take steps to ensure that the receptacles used are of such a design that they remain impervious during operation of the ultrasonic device.
- The ultrasonic cleaners in the sterilization areas will be drained and cleaned daily. If the holding tank or reservoir is removable and heat tolerant, it shall be heat-sterilized. If not, it shall be disinfected using an EPA-registered tuberculocidal disinfectant.
- Like all spaces, the laboratories shall be inspected weekly by the designated staff member in charge of the particular laboratory.
Sterilization and Instrument Processing

Instrument Transport

– Instruments should be in puncture-proof container that will prevent accidental percutaneous injuries during transport.
– Contaminated fluids should not be allowed to leak; if spills occur, they must be reported and cleaned/disinfected ASAP.
– Clean PPE must be worn when leaving the treatment area with a load of contaminated instruments.

Instrument Processing Areas

– All instruments should be processed in a designated area that is divided physically or spatially into the following distinct areas:
  • Receiving, cleaning, decontamination
  • Presterilization preparation and packaging
  • Sterilization
  • Storage

Instrument Categories

• Critical items shall be heat-sterilized
  – These items/instruments penetrate soft tissue and bone
  – Dental handpieces are included in this group
• Semi-critical items shall be heat-sterilized unless heat-intolerant; if heat intolerant, then high-level disinfection is mandatory
  – These items/instruments touch mucosa and nonintact skin
  – Heat-tolerant items should be substituted, if possible

Sterilization Process

• All sterilizing units must be registered with the practice
• Correct time/temperature settings must be used
• Gauges should be observed during operation
• Mechanical, chemical, and biological monitors should be used (per manufacturer’s instructions) to monitor sterilization process
• Monitor each load with mechanical and chemical indicators
• Monitor weekly using biological indicators and control
• A log must be maintained of all biological tests
• Monitor each load that contains an implantable device
• Follow protocol in event of positive spore test
• Loads must be marked so that they can be identified in case of positive spore test
**Instrument Storage**

- After sterilization, the instrument packs must be placed in a clean, dry, covered storage area
- Should be marked with date processed to facilitate retrieval in case of positive spore test
- Storage is “event-related” – if packaging is intact, sterility is assumed

**Flash Sterilization**

- Normally, instruments should be packaged prior to sterilization
- So-called “flash sterilization” should be avoided and only employed as an emergency procedure
- If used, instrument should be dried in autoclave and taken immediately to area of use
- Transport aseptically and protect DHCP against burns from hot items

**Protocol for Positive Spore Test**

- Remove sterilizer from service
- All instruments run in that batch must be pulled from inventory and re-sterilized (this is why all sterilized packages must be clearly marked with the processing date)
- Review process to identify possible operator error
- Retest unit with biological indicator and control
- If repeat test is negative and chemical/mechanical indicators OK, place unit back in service
- The exposure control coordinator shall be notified of all positive spore tests and other instances of possible autoclave malfunction
Handpieces, Parenteral Medications, Suction Devices, and Surgical Irrigation

Dental Handpieces and Suction Devices

Dental handpieces do not actually penetrate intact mucosa and are therefore classified as semicritical items. Despite this, all dental handpieces MUST be cleaned, lubricated, and heat-sterilized between patients. At ImmediaDent, the manufacturer’s instructions must be followed regarding the manner in which this is to be done. No handpiece will be used in ImmediaDent practices if it is incapable of withstanding heat sterilization. Following use, high-speed handpieces should be run (with a bur in the chuck and with irrigant flowing) for approximately 20-30 seconds to clear the lines. Hold the handpiece over the sink or other container to catch the water. PPE should be worn during this procedure.

Suction devices used for surgery should be sterilized. If used for nonsurgical procedures, then single-use items are acceptable. If a saliva ejector is being used, the patient should be directed NOT to close his or her lips around the tips as this may result in material from the suction system entering the mouth. When possible, saliva ejector and high-volume evacuation (HVE) valves (the devices that the suction tips plug into) should be removable and sterilizable, especially if the treatment room is used for surgical procedures. If this is not feasible, the valves should be cleaned thoroughly with an intermediate-level EPA-registered hospital disinfectant.

Parenteral Medications

Parenteral medications pose special hazards as they are injected directly into the patient’s body. To reduce the possibility of contamination, single-dose vials should be used whenever possible. If multi-use vials are used, the medications should be “drawn up” at a site distant from the actual treatment area. Prior to drawing up medications, the diaphragm (rubber top) should be thoroughly wiped with 70% alcohol and permitted to dry or wiped dry with a sterile gauze sponge. The vial should be kept stored in a secure, locked area where it is not subject to aerosols, etc., that might contaminate the top. Therefore, such vials should never be kept in treatment rooms or near ultrasonic cleaners in sterilization areas.

Biopsy Containers (see also section on Medical Waste)

Biopsy containers must be kept tightly sealed, as they usually contain formalin or some other toxic tissue preservative. They must be clearly marked with the universal biohazard symbol. During surgery, it is helpful if a second assistant can open the vial while the operator or first assistant drops the specimen into the container. This prevents the surgical team from touching the surface of the vial. Such contact will: 1) contaminate the outer surface of the vial (which must be disinfected with a tuberculocidal disinfectant before sending to the laboratory) and 2) contaminate the surgeon’s gloves with whatever organisms are on the surface of the container. These organisms can then be introduced into the patient’s mouth or biopsy site.
## Practice Inspection Form

<table>
<thead>
<tr>
<th>Practice Location:</th>
<th>Inspector/Date:</th>
<th>Page 1 of 6</th>
</tr>
</thead>
</table>

### Infection Control Inspection Form

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General Information</strong></td>
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<tr>
<td>Are all staff current in infection control training? Is there a log indicating who took what and when they took it?</td>
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<tr>
<td>Have all received the hepatitis B vaccine?</td>
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<tr>
<td>Is there a designated exposure control coordinator?</td>
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<tr>
<td>Is there a copy of the ImmediaDent Infection Control Plan on-site?</td>
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<tr>
<td>Are intermediate-level (tuberculocidal) disinfectants used on clinical surfaces?</td>
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<tr>
<td>Are clinical contact surfaces covered with barriers (e.g., chairs, light handles and other areas as practical)? Are such barriers changed between patients?</td>
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<tr>
<td>The practice is in a generally clean condition</td>
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<tr>
<td><strong>Exposure Control: Treatment Areas</strong></td>
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<tr>
<td>Intermediate-level (tuberculocidal) disinfectant used for clinical surfaces</td>
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<tr>
<td>Barriers used for chair, light handles, and bracket tray / handpiece holder</td>
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<tr>
<td>Patient and staff wearing protective eyewear with sideshields during treatment; walk around the practice and observe patients being treated to verify this.</td>
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<td>Paper documents are protected from contamination during treatment.</td>
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<tr>
<td>Appropriate glove use: sterile gloves for surgical procedures, degloving done away from instruments, contaminated gloves not used to touch clean surfaces</td>
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<tr>
<td>Hands properly washed before donning and after removing gloves. Observe staff preparing to see patients to verify this.</td>
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<td>Full length gowns used when splatter expected</td>
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<tr>
<td>Gowns and other PPE removed when departing clinical area</td>
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<tr>
<td>Are masks properly fitted to faces, covering the mouth and nose?</td>
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<tr>
<td>When recapping necessary, are cardboard shields and one-handed technique are used?</td>
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<td></td>
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<tr>
<td>Question</td>
<td>Answer</td>
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<td>-------------------------------------------------------------------------</td>
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<tr>
<td>When procuring additional supplies during procedure, assistant or operator removes gloves and re-gloves as needed (or uses overgloves, if appropriate)?</td>
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<tr>
<td>Is PPE used during post-treatment cleanup?</td>
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<tr>
<td>Are heavy-duty nitrile gloves available for use during cleanup and are they used when needed?</td>
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<tr>
<td><strong>Sterilization and Instrument Processing</strong></td>
<td></td>
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<tr>
<td>Are instruments transported safely (e.g., covered)?</td>
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<tr>
<td>Is an autoclave log kept? Is it current?</td>
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<tr>
<td>Is the sterilization / instrument processing area divided into a clean and dirty area?</td>
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<tr>
<td>Are the instrument packages/cassettes marked to permit identification by sterilization load and date (in case of autoclave failure)? Pull some representative instrument packs to check this.</td>
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<tr>
<td>Is there a lid placed on the ultrasonic cleaner during operation?</td>
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<tr>
<td>Is there a “holding” solution for soaking instruments that cannot be processed immediately?</td>
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<tr>
<td>Are sterile instruments stored in intact</td>
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</tbody>
</table>
packs/wrapped cassettes in a clean, protected area? Pull some packs and examine for breaks in package integrity.

<table>
<thead>
<tr>
<th>Medical Waste Disposal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are sharps discarded in a puncture- and leak-proof container that is marked with the biohazard sign?</td>
</tr>
</tbody>
</table>

Is regulated medical waste placed in bags clearly marked with the universal biohazard symbol?

Is the regulated medical waste disposed of by an outside contractor? Which one?

Upon inspecting random kits or instruments, is blood or tissue observed?

<table>
<thead>
<tr>
<th>Laboratory Precautions, Radiology, and Suction/Irrigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are all impressions disinfected before entering the laboratory? Is an intermediate-level (tuberculocidal) disinfectant used?</td>
</tr>
</tbody>
</table>

Are dentures and other prostheses disinfected in a safe manner (not in bath of ultrasonic, unless in sealed bag)?

Are sterile rag wheels and non-contaminated pumice used for polishing dentures and other items? Are laboratory burs and other such items heat-sterilized?

Is PPE worn while in the laboratory?
<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are sterilization ultrasonic cleaners drained and cleaned daily?</td>
<td></td>
</tr>
<tr>
<td>Are radiologic positioning devices (XCP instruments) heat-sterilized?</td>
<td></td>
</tr>
<tr>
<td>Are barriers in use when taking radiographs (for tube head, etc.)?</td>
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<tr>
<td>Are appropriate precautions taken when handling radiographic imaging sensors (gloves, sleeve for sensor, etc.)?</td>
<td></td>
</tr>
<tr>
<td>Are patients observed to close their lips around saliva ejectors?</td>
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</tr>
<tr>
<td>Is sterile water or saline used for irrigation during surgery (including tooth extraction) and endodontics? Ask to see the sterile water – ensure that it is not actually distilled water, which is unacceptable for this purpose.</td>
<td></td>
</tr>
<tr>
<td>What is done with extracted teeth?</td>
<td></td>
</tr>
<tr>
<td>If teeth are used for educational purposes, are they heat-sterilized before such use assuming they do not contain amalgam)?</td>
<td></td>
</tr>
<tr>
<td>Are biopsy containers tightly sealed and marked with biohazard symbol?</td>
<td></td>
</tr>
<tr>
<td>Is a protocol followed to prevent</td>
<td></td>
</tr>
</tbody>
</table>
contamination of the outside of the biopsy container? Ask about this. If the outside of the container becomes contaminated, what is the protocol?
Safety / Infection Control Violation Report

Name of individual reporting violation: ______________________

Name of violator: ________________________________

Date: ________________________________

Location: ________________________________

Nature of violation:

Route to: ________________________________
### Autoclave Monitor Log

**Autoclave Model and Serial No.:** __________________________________________________________

<table>
<thead>
<tr>
<th>Date</th>
<th>Type of Test (e.g., Attest) and incubation time (e.g., 24 hrs)</th>
<th>Result*</th>
<th>Interpretation (autoclave function properly = OK; test tube + = failure)</th>
<th>Failure Protocol Initiated</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Test Tube + or -</td>
<td>Control Tube + or -</td>
<td>Yes</td>
</tr>
<tr>
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