CSI Dental Office
Infection Control for 2010

Presented by Leslie Canham, CDA, RDA

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Effective infection control can interrupt the spread of epidemiologically important diseases from patient to dental healthcare worker, from dental healthcare worker to patient, and from patient to patient.

- Centers for Disease Control

Criminal Microbes and Desperate Office Germs:

- Cytomegalovirus
- Human Immunodeficiency Virus (HIV)
- Hepatitis B
- Mycobacterium tuberculosis
- Hepatitis C
- Staphylococci
- Herpes simplex virus types 1 and 2
- Streptococci
- Plus other viruses and bacteria that colonize or infect the oral cavity and respiratory tract

Meet MRSA (Pronounced MERSA)

MRSA is the term used to describe a number of strains of the bacteria, Staphylococcus aureus, that are resistant to a number of antibiotics, including methicillin and other more common antibiotics. *Staphylococcus aureus*, often referred to as "staph," are bacteria commonly carried on the skin or in the nose of healthy people. Approximately 25% to 30% of the population is colonized in the nose with staph bacteria. Sometimes, staph can cause an infection. Colonized means bacteria are present but not causing an infection.

Standard Precautions

Apply to contact with blood, all body fluids, secretions and excretions (except sweat), regardless of whether they contain blood, non intact skin, and mucous membranes. Similar to universal precautions, standard precautions are used for care of all patients regardless of their diagnoses or personal infectious status.

Break the Chain of Infection

- Hand Hygiene Protocols Selection and correct application of products.
- Environmental Surface Disinfection
  - Selecting disinfectants: Low level = least effective, Intermediate level “hospital disinfectant” = better. Cleaning surfaces-Removal of all visible blood, inorganic, and organic matter can be as critical as the germicidal activity of the disinfecting agent.- Centers for Disease Control
- Barriers For dental units, digital radiography sensors, and other high-technology instruments.
- Survivor Sterilization room
  - Classification of instruments: Critical, Semi-Critical and Non Critical
  - Proper cleaning and lubrication of instruments
  - Wrapping instruments and use of chemical indicators
  - Products and procedures for liquid “cold” sterilization of instruments that cannot withstand heat.
- Sterilizers Proper placement of instruments in chamber, follow manufacturer’s instructions for use, perform recommended maintenance, spore testing conducted weekly to verify sterilization.
To Set Up an Infection Control Program for your Office

Use the forms provided with this handout:

1. Instrument Processing Protocol
2. Written Protocol for Exposure Incidents
3. Table 1 of the 2003 CDC Guidelines-Suggested Work Restrictions
4. Appendix B of the 2003 CDC Guidelines-Immunizations
5. OSAP ICIP Infection Control Checklist (this resource was reprinted with permission of OSAP. OSAP is a nonprofit organization which provides information and education on dental infection control and office safety. For more information, please call 1-888-298-6727.)
6. Resources Page

The CDC Guidelines for Infection Control in Dental Healthcare Settings include information about educating and protecting Dental HealthCare Workers. Print a copy of the Guidelines and review each area with your team.

- Initial OSHA training provided
- Annual Bloodborne Pathogen training
- Policy on work restrictions (See Table 1- CDC Guidelines)
- Transmission of Bloodborne Pathogens
- Immunization of DHCW (See Appendix B- CDC Guidelines)
- Exposure incidents
- Hand hygiene and contact dermatitis
- Sterilization and disinfection of patient care items
- Environment infection control
  (For choosing disinfectants see the "List of Chemical Disinfectants" on the Resources page)

Appoint an Infection Control Coordinator. The responsibilities the Infection Control Coordinator are:

- Review the office infection control for employee and patient safety
- Plan and organize an infection control and safety meeting
- Provide information to employees about OSHA, infection control, immunizations and protective attire
- Learn the key federal and state regulations for infection control (OSHA and Dental Board)
Follow these steps to meet CDC Guidelines

1. Conduct OSHA Bloodborne Pathogen Training
   Review the Bloodborne Pathogen Standard, either read it or take a course. Training is documented and repeated annually

2. Explain Work restrictions
   For employees who are infected with or are exposed to major infectious diseases in the absence of state or local regulations-(see Table 1 of the CDC guidelines)

3. Explanation of how Bloodborne Pathogens are transmitted in a dental office
   Modes of transmission

4. Explanation of the benefits of immunizations
   Hepatitis B
   Influenza
   (see Appendix B of CDC Guidelines)

5. Explain Exposure Incident Protocol
   Needlesticks
   Bites
   Splashes to mucous membranes or non intact skin
   (see the Exposure Incident Protocol form)

6. Discuss Hand Hygiene and Contact Dermatitis
   Alcohol Hand Sanitizers
   Soap
   Gloves Integrity
   Types of gloves
   Utility Gloves
   Exam Gloves
   Nitrile
   Sterile Surgeon Gloves
   Over gloves
   Contact Dermatitis

7. Review Sterilization and Disinfection of Patient Care Items
   Classification of instruments
   Instrument Processing Protocol (form attached)
   Methods of sterilization or disinfection
   Storage
   Spore Testing

8. Review Environment Infection Control
   Clinical contact and Housekeeping surfaces
   Disinfectants
   Barriers
Written Protocol for Instrument Processing

Don personal protective equipment – protective gown or apron, chemical resistant utility gloves, face mask, and protective eyewear – when processing contaminated dental instruments.

Step One - Transporting

Transport contaminated instruments on a tray to the sterilization area. Do not carry contaminated sharp instruments by hand.

Step Two – Cleaning

Place instruments in an ultrasonic unit or instrument washer for ______________minutes.
- If manual scrubbing is necessary, use a long-handled brush.
- If instruments cannot be cleaned immediately presoak in ______________.
- Visually inspect instruments for residual debris and damage; re-clean/replace as necessary.
- Make sure that instruments are rinsed and dried thoroughly prior to packaging.
- Follow manufacturer’s recommendations to lubricate and/or use rust inhibitors as needed.

Step Three – Packaging

After cleaning, instruments must be packaged or wrapped before sterilization if they are not to be used immediately after being sterilized. The packages/wraps must remain sealed until the day they will be used and must be stored in a way so as to prevent contamination.
- Packaging/wrap materials should be designed for the type of sterilization process being used.
- Loose instruments should be packaged so that they lay in a single layer, and not wrapped up so tightly as to prevent exposure to the sterilizing agent.
- Hinged instruments should be processed opened and unlocked.
- Use chemical indicators to distinguish processed vs. unprocessed instruments.
- Conduct biological monitoring (spore testing) weekly to evaluate the effectiveness of the sterilizer.

Step Four – Sterilizing

Place instruments in sterilizer and use the______________cycle for_______minutes
- Load the sterilizer according to manufacturers’ instructions. Do not overload. Use the manufacturers’ recommended cycle times for wrapped instruments.
- Allow packages to dry before removing them from the sterilizer.
- Allow packages to cool before handling.

Step 5 – Storing

Store instruments in a clean, dry environment to maintain the integrity of the package. Rotate packages so that those with the oldest sterilization dates are used first.
- Clean supplies/instruments should be stored in closed cabinets.
- Dental supplies/instruments should not be stored under sinks or in other locations that they might become wet or torn.
- Packages containing sterile supplies should be inspected before use to verify barrier integrity and dryness.
- If packaging is compromised, instruments should be re-cleaned, repackaged, and sterilized again.
Exposure Incident Protocol

OSHA defines an *exposure incident* as a specific incident involving contact with blood or other potentially infectious materials (OPIM) to the eye, mouth, other mucous membrane, non-intact skin, or parenteral under the skin (e.g. needlestick) that occurs during the performance of an employee’s duties.

When an exposure incident occurs, immediate action must be taken to assure compliance with the OSHA Bloodborne Pathogen Standard and to expedite medical treatment for the exposed employee.

1. **Provide immediate care to the exposure site.**
   - Wash wounds and skin with soap and water.
   - Flush mucous membranes with water.
   - DO NOT USE Instrument involved on patient!
   - Employee must report incident immediately to supervisor/employer

2. **Determine risk associated with exposure by**
   - Type of fluid (e.g., blood, visibly bloody fluid, or other potentially infectious fluid or tissue).
   - Type of exposure (e.g., percutaneous injury, mucous membranes or non-intact skin exposure, or bites resulting in blood exposure).

3. **Evaluate exposure source**
   - Assess the risk of infection using available information.
   - The source individual (patient) must be asked if they know their Hepatitis B, C, or HIV status, if not known, ask the patient to consent to testing.

4. **The exposed employee is referred as soon as possible** to a health care provider who will follow the current recommendations of the U.S. Public Health Service Centers for Disease Control and Prevention recommendations for testing, medical examination, prophylaxis and counseling procedures.
   - Note “ASAP” because certain interventions that may be indicated must be initiated promptly to be effective.
   - The exposed employee may refuse any medical evaluation, testing, or follow-up recommendation. This refusal is documented.

5. **Send all of the following with the exposed employee to the health care provider:**
   - A copy of the Bloodborne Pathogen Standard.
   - A description of the exposed employee’s duties as they relate to the exposure incident. (Accidental Bodily Fluid Exposure Form)
   - Documentation of the route(s) of exposure and circumstances under which exposure occurred. (Accidental Bodily Fluid Exposure Form).
   - All medical records relevant to the appropriate treatment of the employee including HBV vaccination status records and source individual’s HBV/HCV/HIV status, if known.
   - Name, address and policy number of worker’s compensation carrier. (Recommended-not OSHA required)

6. **Health Care Provider (HCP)**
   - Evaluates exposure incident.
   - Arranges for testing of employee and source individual (if status not already known).
   - Notifies employee of results of all testing.
   - Provides counseling and post-exposure prophylaxis.
   - Evaluates reported illnesses.
   - HCP sends written opinion to employer:
     - Documentation that employee was informed of evaluation results and the need for further follow-up.
     - Whether Hepatitis B vaccine is indicated and if vaccine was received.

7. **Employer**
   - Receives HCP’s written opinion.
   - Provides copy of HCP written opinion to employee (within 15 days of completed evaluation).
   - Documents events on
     - Employee Accident/Body Fluid Exposure and Follow-Up Form and Employee Medical Record Form.
     - If the exposure incident involved a sharp, a Sharps Injury Log is completed within 14 days.
   - Treat all blood test results for employee and source individual as confidential.
TABLE 1. Suggested work restrictions for health-care personnel infected with or exposed to major infectious diseases in health-care settings, in the absence of state and local regulations *

<table>
<thead>
<tr>
<th>Disease/problem</th>
<th>Work restriction</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conjunctivitis</td>
<td>Restrict from patient contact and contact with patient’s environment.</td>
<td>Until discharge ceases</td>
</tr>
<tr>
<td>Cytomegalovirus infection</td>
<td>No restriction</td>
<td></td>
</tr>
<tr>
<td>Diarrheal disease</td>
<td>Acute stage (diarrhea with other symptoms)</td>
<td>Restrict from patient contact, contact with patient’s environment, and food-handling.</td>
</tr>
<tr>
<td></td>
<td>Convalescent stage, Salmonella species</td>
<td>Restrict from care of patients at high risk.</td>
</tr>
<tr>
<td>Enteroviral infection</td>
<td>Restrict from care of infants, neonates, and immunocompromised patients and their environments.</td>
<td>Until symptoms resolve</td>
</tr>
<tr>
<td>Hepatitis A</td>
<td>Restrict from patient contact, contact with patient’s environment, and food-handling.</td>
<td>Until 7 days after onset of jaundice</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>Personnel with acute or chronic hepatitis B surface antigenemia who do not perform exposure-prone procedures</td>
<td>No restriction (^\d) refer to state regulations. Standard precautions should always be followed.</td>
</tr>
<tr>
<td></td>
<td>Personnel with acute or chronic hepatitis B e antigenemia who perform exposure-prone procedures</td>
<td>Do not perform exposure-prone invasive procedures until counsel from an expert review panel has been sought; panel should review and recommend procedures that personnel can perform, taking into account specific procedures as well as skill and technique. Standard precautions should always be observed. Refer to state and local regulations or recommendations.</td>
</tr>
<tr>
<td>Hepatitis C</td>
<td>No restrictions on professional activity (^\d) HCV-positive health-care personnel should follow aseptic technique and standard precautions.</td>
<td></td>
</tr>
<tr>
<td>Herpes simplex</td>
<td>Genital</td>
<td>No restriction</td>
</tr>
<tr>
<td></td>
<td>Hands (herpetic whitlow)</td>
<td>Restrict from patient contact and contact with patient’s environment.</td>
</tr>
<tr>
<td></td>
<td>Orofacial</td>
<td>Evaluate need to restrict from care of patients at high risk.</td>
</tr>
<tr>
<td>Human immunodeficiency virus; personnel who perform exposure-prone procedures</td>
<td>Do not perform exposure-prone invasive procedures until counsel from an expert review panel has been sought; panel should review and recommend procedures that personnel can perform, taking into account specific procedures as well as skill and technique. Standard precautions should always be observed. Refer to state and local regulations or recommendations.</td>
<td></td>
</tr>
<tr>
<td>Measles</td>
<td>Active</td>
<td>Exclude from duty</td>
</tr>
<tr>
<td></td>
<td>Postexposure (susceptible personnel)</td>
<td>Exclude from duty</td>
</tr>
<tr>
<td>Meningococcal infection</td>
<td>Exclude from duty</td>
<td>Until 24 hours after start of effective therapy</td>
</tr>
<tr>
<td>Mumps</td>
<td>Active</td>
<td>Exclude from duty</td>
</tr>
<tr>
<td></td>
<td>Postexposure (susceptible personnel)</td>
<td>Exclude from duty</td>
</tr>
</tbody>
</table>


* Modified from recommendations of the Advisory Committee on Immunization Practices (ACIP).

\(^\d\) Unless epidemiologically linked to transmission of infection.

\(^\d\) Those susceptible to varicella and who are at increased risk of complications of varicella (e.g., neonates and immunocompromised persons of any age).

\(^\d\) Patients at high risk as defined by ACIP for complications of influenza.
TABLE 1. (Continued) Suggested work restrictions for health-care personnel infected with or exposed to major infectious diseases

<table>
<thead>
<tr>
<th>Disease/problem</th>
<th>Work restriction</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pediculosis</td>
<td>Restrict from patient contact</td>
<td>Until treated and observed to be free of adult and immature lice.</td>
</tr>
<tr>
<td>Pertussis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Active</td>
<td>Exclude from duty</td>
<td>From beginning of catarrhal stage through third week after onset of paroxysms, or until 5 days after start of effective antibiotic therapy.</td>
</tr>
<tr>
<td>Postexposure (asymptomatic personnel)</td>
<td>No restriction, prophylaxis recommended</td>
<td>Until 5 days after start of effective antibiotic therapy.</td>
</tr>
<tr>
<td>Postexposure (symptomatic personnel)</td>
<td>Exclude from duty</td>
<td></td>
</tr>
<tr>
<td>Rubella</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Active</td>
<td>Exclude from duty</td>
<td>Until 5 days after rash appears.</td>
</tr>
<tr>
<td>Postexposure (susceptible personnel)</td>
<td>Exclude from duty</td>
<td>From seventh day after first exposure through twenty-first day after last exposure.</td>
</tr>
<tr>
<td>Staphylococcus aureus infection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Active, draining skin lesions</td>
<td>Restrict from contact with patients and patient’s environment or food handling.</td>
<td>Until lesions have resolved.</td>
</tr>
<tr>
<td>Carrier state</td>
<td>No restriction unless personnel are epidemiologically linked to transmission of the organism</td>
<td></td>
</tr>
<tr>
<td>Streptococcal infection, group A</td>
<td>Restrict from patient care, contact with patient’s environment, and food-handling.</td>
<td>Until 24 hours after adequate treatment started.</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Active disease</td>
<td>Exclude from duty</td>
<td>Until proved noninfectious.</td>
</tr>
<tr>
<td>PPD converter</td>
<td>No restriction</td>
<td></td>
</tr>
<tr>
<td>Varicella (chicken pox)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Active</td>
<td>Exclude from duty</td>
<td>Until all lesions dry and crust.</td>
</tr>
<tr>
<td>Postexposure (susceptible personnel)</td>
<td>Exclude from duty</td>
<td>From tenth day after first exposure through twenty-first day (twenty-eighth day if varicella-zoster immune globulin [VZIG] administered) after last exposure.</td>
</tr>
<tr>
<td>Zoster (shingles)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Localized, in healthy person</td>
<td>Cover lesions, restrict from care of patients‡ at high risk</td>
<td>Until all lesions dry and crust.</td>
</tr>
<tr>
<td>Generalized or localized in immunosuppressed person</td>
<td>Restrict from patient contact</td>
<td>Until all lesions dry and crust.</td>
</tr>
<tr>
<td>Postexposure (susceptible personnel)</td>
<td>Restrict from patient contact</td>
<td>From tenth day after first exposure through twenty-first day (twenty-eighth day if VZIG administered) after last exposure; or, if varicella occurs, when lesions crust and dry.</td>
</tr>
<tr>
<td>Viral respiratory infection, acute febrile</td>
<td>Consider excluding from the care of patients at high risk‡</td>
<td>Until acute symptoms resolve.</td>
</tr>
</tbody>
</table>


* Modified from recommendations of the Advisory Committee on Immunization Practices (ACIP).
† Unless epidemiologically linked to transmission of infection.
‡ Those susceptible to varicella and who are at increased risk of complications of varicella (e.g., neonates and immunocompromised persons of any age).
§ Patients at high risk as defined by ACIP for complications of influenza.
## Appendix B

**Immunizations Strongly Recommended for Health-Care Personnel (HCP)**

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Dose schedule</th>
<th>Indications</th>
<th>Major precautions and contraindications</th>
<th>Special considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis B recombinant vaccine</td>
<td>Three-dose schedule administered intramuscularly (IM) in the deltoid; 0.5 mL (0.5 mL); second dose administered 1 month after first dose; third dose administered 4 months after second. Booster doses are not necessary for persons who have developed adequate antibodies to hepatitis B surface antigen (anti-HBs).</td>
<td>Health-care personnel (HCP) at risk for exposure to blood and body fluids.</td>
<td>History of anaphylactic reaction to common baker’s yeast. Pregnancy is not a contraindication.</td>
<td>No therapeutic or adverse effects on hepatitis B virus (HBV)-infected persons; cost-effectiveness of prevaccination screening for susceptibility to HBV depends on costs of vaccination and antibody testing and prevalence of immunity in the group of potential vaccinees; health-care personnel who have ongoing contact with patients or blood should be tested 1–2 months after completing the vaccination series to determine serologic response. If vaccination does not induce adequate anti-HBs (&gt;10 mIU/mL), a second vaccine series should be administered.</td>
</tr>
<tr>
<td>Influenza vaccine (inactivated)</td>
<td>Annual single-dose vaccination IM with current vaccine.</td>
<td>HCP who have contact with patients at high risk or who work in chronic-care facilities; HCP aged ≥50 years or who have high-risk medical conditions.</td>
<td>History of anaphylactic hypersensitivity to eggs or to other components of the vaccine.</td>
<td>Recommended for women who will be in the second or third trimesters of pregnancy during the influenza season and women in any stage of pregnancy who have chronic medical conditions that are associated with an increased risk of influenza.</td>
</tr>
<tr>
<td>Measles live-virus vaccine</td>
<td>One dose administered subcutaneously (SC); second dose ≥4 weeks later.</td>
<td>HCP who were born during or after 1957 without documentation of 1) receipt of 2 doses of live vaccine on or after their first birthday; 2) physician-diagnosed measles, or 3) laboratory evidence of immunity. Vaccine should also be considered for all HCP who have no proof of immunity, including those born before 1957.</td>
<td>Pregnancy; immunocompromised state (including human immunodeficiency virus [HIV]-infected persons with severe immunosuppression); history of anaphylactic reactions after gelatin ingestion or receipt of neomycin; or recent receipt of antibody-containing blood products.</td>
<td>Measles, mumps, rubella (MMR) is the recommended vaccine.</td>
</tr>
<tr>
<td>Mumps live-virus vaccine</td>
<td>One dose SC; no booster.</td>
<td>HCP believed susceptible can be vaccinated; adults born before 1957 can be considered immune.</td>
<td>Pregnancy; immunocompromised state; history of anaphylactic reaction after gelatin ingestion or receipt of neomycin.</td>
<td>Women pregnant when vaccinated or who become pregnant within 4 weeks of vaccination should be counseled regarding theoretic risks to the fetus; however, the risk of rubella vaccine-associated malformations among these women is negligible. MMR is the recommended vaccine.</td>
</tr>
<tr>
<td>Rubella live-virus vaccine</td>
<td>One dose SC; no booster.</td>
<td>HCP, both male and female, who lack documentation of receipt of live vaccine on or after their first birthday, or lack of laboratory evidence of immunity can be vaccinated. Adults born before 1957 can be considered immune, except women of childbearing age.</td>
<td>Pregnancy; immunocompromised state; history of anaphylactic reaction after receipt of neomycin.</td>
<td></td>
</tr>
<tr>
<td>Varicella-zoster live-virus vaccine</td>
<td>Two 0.5 mL doses SC 4–8 weeks apart if aged ≥13 years.</td>
<td>HCP without reliable history of varicella or laboratory evidence of varicella immunity.</td>
<td>Pregnancy; immunocompromised state; history of anaphylactic reaction after receipt of neomycin or gelatin; recent receipt of antibody-containing blood products; salicylate use should be avoided for 6 weeks after vaccination.</td>
<td>Because 71%–93% of U.S.-born persons without a history of varicella are immune, serologic testing before vaccination might be cost-effective.</td>
</tr>
</tbody>
</table>

### Sources
- CDC. Immunization of health-care workers: recommendations of the Advisory Committee on Immunization Practices (ACIP) and the Hospital Infection Control Practices Advisory Committee (HICPAC). MMWR 1997;46(No. RR-16).
- A federal standard issued in December 1991 under the Occupational Safety and Health Act mandates that hepatitis B vaccine be made available at the employer’s expense to all HCP occupationally exposed to blood or other potentially infectious materials. The Occupational Safety and Health Administration requires that employers make available hepatitis B vaccinations, evaluations, and follow-up procedures in accordance with current CDC recommendations.
- Persons immunocompromised because of immune deficiencies, HIV infection, leukemia, lymphoma, generalized malignancy; or persons receiving immunosuppressive therapy with corticosteroids, alkylating drugs, antimetabolites; or persons receiving radiation.
- Vaccination of pregnant women after the first trimester might be preferred to avoid coincidental association with spontaneous abortions, which are most common during the first trimester. However, no adverse fetal effects have been associated with influenza vaccination.
- A live attenuated influenza vaccine (LAIV) is FDA-approved for healthy persons aged 5-49 years. Because of the possibility of transmission of vaccine viruses from recipients of LAIV to other persons and in the absence of data on the risk of illness and among immunocompromised persons infected with LAIV viruses, the inactivated influenza vaccine is preferred for HCP who have close contact with immunocompromised persons.
The U.S. Centers for Disease Control and Prevention (CDC) recently released expanded recommendations for infection control in dental settings. Published in the December 19, 2003, edition of Morbidity and Mortality Weekly Report, “Guidelines for Infection Control in Dental Health-Care Settings — 2003” offers both science-based and strong theoretical advice designed to prevent or reduce the risk of disease transmission from patient to dental worker, from dental worker to patient, and from patient to patient. The document consolidates and updates previous recommendations from CDC and other agencies and discusses concerns not addressed in earlier recommendations for dentistry. To view the full document, visit www.cdc.gov/OralHealth/infectioncontrol/guidelines/index.htm.

Major additions and changes to the 2003 guidelines include:
- application of standard precautions rather than universal precautions;
- work restrictions for dental healthcare personnel infected with or occupationally exposed to infectious diseases;
- management of occupational exposures to bloodborne pathogens such as hepatitis B virus (HBV), hepatitis C virus (HCV); and human immunodeficiency virus (HIV);
- selection and use of devices with sharps safety features;
- hand-hygienie products and surgical hand antisepsis;
- contact dermatitis and latex hypersensitivity;
- sterilization of unwrapped instruments (“flash” cycles);
- dental water quality;
- dental radiography;
- aseptic technique for parenteral medications;
- oral surgical procedures;
- tuberculosis (TB); and
- infection control program evaluation.

The new CDC guidelines apply to all paid or unpaid dental healthcare personnel (DHCP) who might be occupationally exposed to blood and body fluids by direct contact or through contact with contaminated supplies, equipment, environmental surfaces, water, or air. Although the guidelines focus mainly on outpatient dental settings, the recommended infection control practices can be applied to all settings where dental treatment is provided.

This month’s Infection Control In Practice turns CDC’s comprehensive, 66-page guideline into a checklist for use in your practice setting. If you can answer “yes” to all the questions in this list, your infection control program is up to date.

Learning Objectives
- Learn new and expanded recommendations for dental infection control from the Centers for Disease Control and Prevention
- Be able to review your office policies, procedures, written programs, records, and training schedules and content to ensure that they reflect the most current public health recommendations for infection control dental settings
### Personnel Health Elements of an Infection Control Program

- Does the practice setting have a written health program for DHCP?
- Does this written program specify policies, procedures, and guidelines for:
  - education and training?
  - immunizations?
  - exposure prevention and postexposure management?
  - medical conditions, occupational illness, and related work restrictions?
  - contact dermatitis and latex hypersensitivity?
  - maintenance of records, data management, and confidentiality?
- Have referral arrangements been established with a qualified healthcare professional/facility to ensure prompt and appropriate delivery of preventive services, occupationally related medical services, and postexposure management with any necessary medical follow-up?
- Is a list of all required and recommended immunizations for dental workers maintained?
  - When was this list last updated?
  - date: __________________
- Is it consistent with the latest recommendations from public health agencies on appropriate immunizations for healthcare workers?
- Have at-risk DHCP been referred to the facility’s prearranged qualified healthcare professional or to their own healthcare professional to receive appropriate immunizations?
- Is baseline tuberculin skin testing provided for clinical DHCP who might have contact with persons with suspected or confirmed infectious TB?
- Is a comprehensive postexposure management and medical follow-up program in place?
- Does this program:
  - include policies and procedures for prompt reporting, evaluation, counseling, treatment, and medical follow-up of occupational exposures?

### Education and training

- Have DHCP been educated and trained on their risk of occupational exposure to potentially infectious agents and the necessary infection-control procedures/protocols to safely perform their assigned duties?
- Was this training provided:
  - at the time of initial employment?
  - when new tasks or procedures affect occupational exposure?
  - at least annually?
- Were the training materials and procedures clear and easy to understand?

### Postexposure management

- Do DHCP know to report occupational injuries and exposures immediately?
- When an occupational exposure occurs, is an exposure incident report created listing:
  - date and time of exposure;
  - details of the procedure being performed, including how and where the exposure occurred; if related to a sharp device, the type and brand of device and how and when the exposure occurred in the course of handling/using the device;
  - details of the exposure, including type and amount of fluid or material and the severity of the exposure (for example, for percutaneous exposure, the depth of the injury and whether fluid was injected; for a skin or mucous membrane exposure, the estimated volume of material and the condition of the skin [chapped, cut, abraded, intact]);
  - details about the exposure source (whether the source material contained HBV, HCV, or HIV; if the source patient is HIV-positive, the stage of disease, history of antiretroviral medication, viral load, drug resistance, if known);
  - details about the exposed person (vaccination and vaccine-response status); and

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#### OSAP Check-Up: 2003 CDC Guidelines

(continued from page 1)
Infection Control In Practice is a resource prepared for clinicians by the Organization for Safety and Asepsis Procedures with the assistance and expertise of its member-contributors. OSAP is a nonprofit, independent organization providing information and education on infection control and occupational health and safety to dental care settings worldwide.

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Preventing Transmission of Bloodborne Pathogens

HBV vaccination
- Have DHCP been informed of the risks of HBV transmission and the availability of the hepatitis B virus (HBV) vaccine?
- Have DHCP been offered the HBV vaccination series?
- Was serologic testing performed 1-2 months after vaccination to confirm immunity?
- Did DHCP who declined vaccination sign a declination form for their medical record file?

Medical conditions, work-related illness, and work restrictions
- Does the practice setting have comprehensive written policies on work restrictions and exclusions that include a statement of authority defining who can implement such policies?
- Are these policies readily available to DHCP?
- Do these policies encourage workers to seek appropriate preventive and curative care and to report any illnesses, medical conditions, or treatments that can make them more susceptible to opportunistic infection or exposures?
- Do these policies protect against lost wages, benefits, or job status in the event of such an illness or medical condition?
- Are policies and procedures in place for evaluating, diagnosing, and managing workers with suspected or known occupational contact dermatitis?
- Does the facility’s policy provide for definitive diagnosis and management advice (for example, treatment, work restrictions, and accommodations) by a qualified healthcare professional?

Records maintenance, data management, and confidentiality
- Does the practice setting establish and keep confidential DHCP medical records, such as immunization records and documentation of tests received as a result of occupational exposure?
- Is the practice setting in compliance with all applicable federal, state, and local laws for medical recordkeeping and confidentiality?

IN PRACTICE
Infection Control
continued on page 4
Hand Hygiene

- Are hands washed with a nonantimicrobial or antimicrobial soap and water when they are visibly dirty or contaminated with blood or other potentially infectious material?
- Is hand hygiene performed:
  - after accidental barehanded touching of inanimate objects likely to be contaminated by blood, saliva, or respiratory secretions?
  - before and after treating each patient?
  - before donning gloves?
  - immediately after removing gloves?
- Before oral surgical procedures, is surgical hand antisepsis performed before donning sterile surgeon’s gloves? (Surgical hand antisepsis involves using either (a) an antimicrobial soap and water or (b) a plain soap and water handwash followed by an alcohol-based hand rub with persistent activity.)
- Are liquid hand-care products stored in either disposable closed containers or closed containers that can be washed and dried before refilling?
- Are refillable containers always washed and dried (and not simply “topped off”) before refilling?
- Are hand lotions used to prevent skin dryness associated with handwashing?
- Are the lotions used during the clinic day compatible with the antimicrobials in hand hygiene products?
- Are DHCP fingernails kept short, with smooth, filed edges to allow thorough cleaning and prevent glove tears?
- Are artificial fingernails discouraged among DHCP in the practice setting?
- If it affects glove donning or fit, is hand or nail jewelry removed for patient care?

Personal Protective Equipment

- Is task-appropriate personal protective equipment (PPE) worn when exposure to blood and body fluids is expected?
- Is barrier protection (including gloves, mask, eyewear, and gown) removed before departing work areas such as operating rooms, the instrument processing room, or the dental lab?

Face and eye protection

When performing procedures likely to cause splash or spatter:

- Are surgical masks worn?
- Is eye protection with solid side shields or a face shield worn to protect mucous membranes of the eyes, nose, and mouth?
- Are masks changed between patients?
- Are masks changed during patient treatment if they become wet?
- Between patients, is reusable face protection (eyewear, face shields) cleaned and disinfected according to the disinfectant manufacturer’s directions?

Protective clothing

- Is protective clothing worn over street clothes or uniforms to protect against splash or spatter?
- Is protective clothing changed when it is visibly soiled or penetrated by blood or other potentially infectious fluids?

Gloves

- Are medical gloves worn when contact with body fluids is expected?
- Are sterile surgeon’s gloves worn when performing or assisting on oral surgical procedures?
- Is a new pair of medical gloves worn for each patient?
- Are gloves removed promptly after use, and is hand hygiene performed immediately thereafter?
- Are torn, cut, or punctured gloves removed as soon as possible and hands immediately washed before regloving?
- Are gloves available in the correct size and readily accessible?
- Are puncture-/chemical-resistant utility gloves worn when processing instruments and performing housekeeping tasks that involve contact with body fluids?

Contact Dermatitis and Latex Allergy

- Have DHCP been informed of the signs, symptoms, and diagnoses of skin reactions associated with frequent hand hygiene and glove use?
- Are all patients in the practice setting screened for latex allergy?
- Can a latex-safe environment be provided for patients and DHCP with latex allergy?
- Are latex-free emergency treatment kits available and accessible at all times?

Sterilization and Disinfection of Patient-Care Items

- Are only FDA-cleared medical devices used for heat sterilization?
- Are manufacturer instructions for operation always followed? (Hint: Posting procedural checklists near the equipment can help ensure that devices are used correctly.)
- Are all reusable critical dental instruments cleaned, dried, packaged, and then heat-sterilized before use?
Are all reusable heat-tolerant semicritical dental instruments cleaned and then heat-sterilized before use?

Are items and instrument packages correctly and loosely loaded into the sterilizer to allow penetration of the sterilizing agent?

Are instrument packages allowed to dry in the sterilizer before they are handled? (This prevents contamination.)

Have heat-sensitive semicritical instruments been replaced with heat-tolerant or disposable versions?

If heat-sensitive instruments are used in patient care, are they cleaned and then processed using an FDA-cleared sterilant/high-level disinfectant or an FDA-cleared low-temperature sterilization method? Note: Never use liquid chemical sterilants/high-level disinfectants for environmental surface disinfection or as holding solutions.

Are the manufacturer’s instructions for preparation, use, and reuse of chemical sterilants/high-level disinfectants always followed?

Have all DHCP been trained on OSHA guidelines for exposure to chemical disinfectants/sterilants?

Have areas and tasks that have potential for such exposure been identified?

Are single-use disposable instruments used on only one patient and then properly discarded?

Are all noncritical patient-care items barrier-protected during use? Alternatively, are they cleaned (or if visibly soiled, cleaned and disinfected) after each use?

Is an EPA-registered hospital disinfectant used to clean/disinfect noncritical patient-care items that are not barrier-protected during use?

If noncritical patient-care items are visibly contaminated with blood, are the items properly cleaned to remove soil, then disinfected using an EPA-registered hospital disinfectant with a tuberculocidal claim?

**The instrument processing area**

- Does the practice setting have a designated central processing area?
  - Is the area divided physically, or at least spatially, into separate areas for:
    - receiving, cleaning, and decontamination;
    - preparation and packaging;
    - sterilization; and
    - storage.

- Are work practice controls used to minimize handling of loose contaminated instruments during transport to the instrument processing area? For example:
  - Are instruments transported in a covered container?
  - Are dental team members trained to use work practices that prevent contamination of clean areas? For example:
  - Are sterilized instrument packs and clean supplies stored away from the area where contaminated instruments are held or cleaned?

**Receiving, cleaning, and decontamination work area**

- Are dental instruments and devices cleaned of all visible blood and other contamination before they are sterilized or disinfected?
  - Is automated cleaning equipment (such as an ultrasonic cleaner or washer-disinfector) used to remove debris, improve cleaning effectiveness, and decrease worker exposure to blood?
  - Are work practice controls (such as a long-handled brush) used to minimize contact with sharp instruments if manual cleaning is necessary?

- Are puncture-/chemical-resistant utility gloves worn when handling contaminated instruments and performing instrument cleaning and decontamination procedures?
  - Is appropriate PPE (a mask, protective eyewear, and protective clothing) worn when splashing or spraying is anticipated during cleaning?

**Preparation and packaging**

- After cleaning, are critical and semicritical instruments inspected for remaining debris?

- Before sterilization, are instruments and other patient-care items packaged using an FDA-cleared container system or wrap that is compatible with the type of sterilization process used? (Packaging instruments in cassettes or trays before sterilization maintains their sterility after the sterilization cycle.)

- Is an internal chemical indicator placed inside each instrument package prior to sterilization?

- If the internal indicator is not visible from outside the package, is an external indicator affixed to the pack?

- Are packages labeled with the date and if multiple sterilizers are used within the facility, the sterilizer used? (This simplifies retrieval of processed items in case of a sterilization failure.)

**Unwrapped instruments**

Although not recommended for routine instrument processing, certain circumstances may demand that instruments be processed unpackaged (for example, the only available instrument falls to the floor during patient care). If it is necessary to sterilize instruments without packaging, for example, using a flash cycle:

- Are instruments cleaned and dried before the unwrapped sterilization cycle?

- Are mechanical and chemical indicators used for each unwrapped sterilization cycle? (Place an internal chemical indicator among the instruments or items to be sterilized.)

- Are unwrapped instruments allowed to dry and cool in the sterilizer before they are handled? (This prevents contamination and thermal injury.)

- Are unwrapped semicritical instruments sterilized on a tray or in container system?

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OSAP Chart & Checklist

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- Are critical instruments that are sterilized without packaging handled to maintain sterility during removal from the sterilizer and transport to the point of use? For example:
  - Are they transported to the operating room in a sterile covered container?
- Are sterilized, unwrapped critical instruments used immediately after they have cooled? (Do not store critical instruments unwrapped.)

**Implantable devices**
- Are implantable devices always packaged for sterilization?
- Is a biological indicator always included in each package containing an implantable device?
- Are biological monitoring results received and recorded before the implantable device is surgically placed?

*Do not surface-disinfect, use liquid chemical sterilants, or use ethylene oxide on handpieces and other intraoral instruments that can be removed from dental unit air lines and waterlines.*

**Sterilization monitoring**
- Are mechanical, chemical, and biological monitors used according to the manufacturer’s instructions to ensure the effectiveness of the sterilization process?
- Is each load monitored with mechanical and chemical indicators?
- Is a chemical indicator placed on the inside of each instrument package to be sterilized?
  - If the internal indicator is not visible from the outside, is another chemical indicator added to the outside of package?
- If mechanical or chemical indicators suggest inadequate processing, are instruments pulled from recirculation, repackaged, and sterilized again with new indicators?
- Are sterilizers monitored at least weekly using a biological indicator and a matching control? (Using both a test and a control indicator from the same lot ensures that factors outside of the sterilization process have not affected the spores’ ability to be cultured.)
  - Is the test indicator placed within an instrument pack and sterilized with a normal load?
  - Is the control indicator — which is not subjected to a sterilization cycle — incubated at the same time as the test indicator?
- If a spore test comes back positive, are proper troubleshooting procedures implemented? (For a flowchart on managing sterilization failures, visit www.osap.org/resource/extra/sterifail.htm)
- Are sterilization records (mechanical, chemical, and biological) maintained in compliance with state and local regulations?

**Storing patient-care items**
- Are sterile items and dental supplies stored in covered or closed cabinets to minimize the chance of contamination?
- Are wrapped packages of sterilized instruments examined before they are opened to ensure the packaging (and sterility of the instruments inside) has not been compromised?
  - If packaging has been compromised, are the contents recleaned, repacked, and resterilized?
- Does the practice setting use either date- (“first in, first out”) or event-related storage for wrapped, sterilized instruments and devices? (Both methods are considered acceptable.)

**Managing Environmental Surfaces**
- Are surface barriers used to protect clinical contact surfaces from contamination, especially those that are difficult to clean?
  - Are surface barriers changed between patients?
- If they are not barrier protected during patient care, are clinical contact surfaces cleaned and disinfected between patient appointments?
- For clinical contact surfaces that are not visibly contaminated with blood, are surfaces cleaned and then disinfected using an EPA-registered hospital disinfectant with (a) HIV and HBV kill (at minimum) and/or (b) tuberculocidal activity?
- Are clinical contact surfaces that are visibly contaminated with blood cleaned and then disinfected using a hospital disinfectant with tuberculocidal activity?
- Prior to disinfection, are manufacturer instructions for precleaning surfaces followed closely?
- After cleaning, is the disinfectant allowed to remain on the treated surface for the contact time stated on the product’s label?
- Is appropriate PPE in place when cleaning and disinfecting environmental surfaces? For example:
  - puncture- and chemical-resistant utility gloves,
  - protective clothing (such as a gown, jacket, or lab coat), and
  - face protection (protective eyewear/face shield with a mask).
- Are housekeeping surfaces such as floors, walls, and sinks routinely cleaned using either a detergent and water or an EPA-registered hospital disinfectant/detergent?
- Are cleaning schedules set by the nature of the housekeeping surface, the type and degree of contamination, and if appropriate, location in the facility?
- Are housekeeping surfaces cleaned and disinfected when visibly soiled?
- Are mops or cloths cleaned after use and allowed to dry before reuse, or are single-use, disposable mop heads or cloths used to clean housekeeping surfaces?
- Are fresh cleaning or EPA-registered disinfecting solutions prepared daily.
and as instructed by the manufacturer?

- Are walls, blinds, and window curtains in patient-care areas cleaned when they are visibly dusty or soiled?
- Are surfaces contaminated by spills of blood or blood-contaminated fluids first cleaned and then decontaminated?
- After cleaning, is an EPA-registered hospital disinfectant with HBV and HIV label claims (minimum) and/or tuberculocidal activity used for disinfection, depending on size of spill and surface porosity?

**Extracted teeth**

- Are extracted teeth disposed of within the practice setting treated as regulated medical waste? (If the teeth are returned to the patient, waste disposal regulations do not apply.)
- Are extracted teeth containing amalgam discarded in regulated medical waste containers that will not be incinerated? (Incineration releases mercury vapor from amalgam, creating a hazard.)
- When extracted teeth will be used in educational settings or sent to a dental lab:
  - Are extracted teeth cleaned and placed in a leakproof container with solution to maintain hydration during transport?
  - Is the transport container labeled with the biohazard symbol?
  - Are teeth that do not contain amalgam heat-sterilized before they are used for educational purposes?

**Dental Handpieces, Other Devices Attached to Air Lines and Waterlines**

- Are handpieces and other intraoral instruments that can be removed from the air and waterlines of dental units cleaned and then heat-sterilized between patients?
- Are manufacturer’s instructions for cleaning, lubrication, and sterilization of other such intraoral instruments followed every time the instruments are processed for reuse? (Failure to follow manufacturer instructions can void equipment warranties.)

**Dental Radiography**

- Are gloves worn by dental workers when exposing radiographs and handling contaminated film packets?
- Is other PPE (such as protective eyewear, mask, and gown) also worn if spattering of body fluids is likely?
- Are heat-tolerant or disposable film-holders, positioners, and other intraoral devices used whenever possible?
- Are heat-tolerant radiographic accessories cleaned and then heat-sterilized?
- If any heat-sensitive semicritical devices are used, are they (at minimum) cleaned and high-level disinfected according to recommendations by the dental unit manufacturer?

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*Do not advise patients to close their lips tightly around the tip of the saliva ejector to evacuate oral fluids. It can cause oral fluids to retract.*

*Regulated Medical Waste*

- Does the practice setting have a written medical waste management program that outlines proper disposal of regulated medical waste as dictated by federal, state, and local regulations?
- Are DHCP who handle and dispose of regulated medical waste trained in proper handling and disposal methods?
  - Are they informed of the possible health and safety hazards associated with medical waste?
- Are leakproof, color-coded/biohazard-labeled containers (for example, biohazard bags) used to contain nonsharp regulated medical waste?
- Are sharp items (needles, scalpels, orthodontic bands, broken metal instruments, burs) placed in a puncture-resistant, leakproof, color-coded/biohazard-labeled sharps container?
  - Are sharps containers closed immediately before they are removed or replaced to prevent contaminated sharps from spilling or protruding?
- If allowed by state and local law, are blood, suctioned fluids, and other liquid waste carefully poured down a drain connected to a sanitary sewer system?
- Are gloves, face protection (mask with protective eyewear/face shield), and protective clothing worn when performing this task?

**Dental Unit Waterlines, Biofilm, and Water Quality**

- Does the water used in routine patient treatment meet EPA standards for drinking water (that is, less than 500 CFU/mL of heterotrophic water bacteria)?
- Are the products and protocols recommended by your dental unit manufacturer used to maintain water quality?
- Are recommendations for monitoring water quality followed? (Obtain and follow monitoring schedules recommended by the dental unit manufacturer and/or the maker of the waterline treatment device/chemical.)
- For devices that are connected to the dental water system and enter the patient’s mouth, are water and air discharged for at least 20-30 seconds after use on each patient? (Such devices include handpieces, ultrasonic scalers, and air/water syringes.)
- If the dental unit is equipped with antiretraction mechanisms, are the unit manufacturer's recommendations for periodic maintenance followed?
- Are staff aware of procedures to follow in the event of a boil-water advisory? (See the OSAP Practice Tip, p. 12.)
OSAP Chart & Checklist

OSAP Check-Up: 2003 CDC Guidelines  continued from page 7

Avoid using carpeting and cloth upholstery in operatories, labs, and instrument processing areas.

Digital radiography
If your practice setting uses a digital x-ray system with intraoral sensors:

- Are equipment manufacturer instructions for cleaning, disinfection, and/or sterilization of digital radiology sensors and for protection of associated computer hardware followed?
- Are FDA-cleared barriers used on sensors to protect them from contamination during use on a patient?
- After use on a patient, are sensors cleaned and then either heat-sterilized or immersed in a liquid sterilant/high-level disinfectant for the contact time recommended by the manufacturer?

If sensors cannot tolerate heat or liquid chemical immersion:

- Are sensors cleaned and then disinfected using an FDA-registered hospital disinfectant?
- After use on a patient, are sensors removed and sensors cleaned and then disinfected using an EPA-registered hospital disinfectant with a tuberculocidal claim?

Aseptic Technique for Parenteral Medications

- Are IV bags, tubings, and connections used for one patient only and disposed of appropriately?
- Is medication from any syringe administered to only one patient?
- Are single-dose vials of parenteral medications used whenever possible?

- Is any medication remaining in a single-use vial discarded with the vial after use on one patient (rather than saved for later use)?
  If multidose vials are used:
  - Is the access diaphragm cleansed with 70% alcohol before inserting a device into the vial?
  - Are only sterile devices used to access multiple-dose vials?
  - Except by the sterile device, is contact with the access diaphragm avoided?
  - Are needles and syringes used to access a multidose vial always sterile? (Never reuse a syringe even if the needle is changed.)
  - Are multidose vials stored away from the immediate patient treatment area to prevent inadvertent contamination by spray or spatter?
  - Are multidose vials immediately discarded if their sterility is compromised?

Single-Use (Disposable) Devices

- Are single-use devices used for one patient only and then properly discarded?

Oral Surgical Procedures

- Is surgical hand antisepsis performed before gloving by all dental workers participating in an oral surgical procedure? (Surgical hand antisepsis involves using either (a) an antimicrobial soap and water or (b) a plain soap and water handwash followed by alcohol-based hand rub with persistent activity.)
- Are sterile surgeon’s gloves worn when performing oral surgical procedures?
- Is sterile saline or sterile water used as a coolant/irrigant during oral surgical procedures?
- Are sterile irrigating fluids delivered using devices specifically designed for that purpose, for example, a bulb or sterile irrigating syringe, single-use disposable products, or sterile water delivery systems with disposable or sterilizable tubing?

Biopsy Specimens

- Are biopsy specimens placed in a sturdy, leakproof container for transport?
- Is the container labeled with the biohazard symbol?
- If the outside of a biopsy specimen container becomes visibly contaminated, is it either cleaned and disinfected or placed in an impervious bag labeled with the biohazard symbol?

Dental Laboratory

- Is PPE worn when handling items that have not been decontaminated?
- Is specific information on disinfection included in laboratory cases when laboratory cases are sent from the dental facility to an off-site lab and back?
- Unless the sender indicates that they have been disinfected, are all dental prostheses and prosthodontic materials (such as impressions, bite registrations, occlusal rims, and extracted teeth) cleaned, disinfected using an EPA-registered hospital disinfectant with tuberculocidal activity, and rinsed?

- Are manufacturers been consulted on the stability of specific impression materials relative to disinfection procedures?
- Are heat-tolerant items used in the mouth (such as metal impression trays and face-bow forks) clean and heat-sterilized after use on a patient?
- Are manufacturer instructions followed for cleaning and sterilizing or disinfecting items that do not normally contact the patient but become contaminated during laboratory procedures (for example, burs, polishing points, rag wheels, articulators, case pans, and lathes)?
- If manufacturer instructions are not available, are items processed according to the degree of contamination?
- Are heat-tolerant items cleaned and heat-sterilized, or are they cleaned and then disinfected using an EPA-registered hospital disinfectant?
Tuberculosis and Dentistry

- Does your practice setting have a written TB infection-control plan?
- Are all dental team members trained to know the signs and symptoms of TB as well as how it is transmitted?
- Is a baseline tuberculin skin test performed for all dental workers who might have contact with persons with suspected or confirmed active TB?
- Is each patient assessed for history or symptoms of TB? Are findings documented on the medical history form?

If a patient with active or suspected TB arrives for treatment:

- Is the patient evaluated away from other patients and dental workers?
- When not being evaluated, is the patient asked to wear a surgical mask and instructed to cover his or her mouth and nose when coughing or sneezing?
- Is elective dental treatment deferred until the patient is noninfectious?
- Are patients in need of urgent dental care referred to a previously identified facility with TB engineering controls and a respiratory protection program?

For DHCP who may have active TB:

- Are personnel with a deep, productive cough lasting longer than three weeks referred for medical evaluation? This is especially important when other signs or symptoms consistent with active TB are present (for example, weight loss, night sweats, fatigue, bloody sputum, anorexia, and fever).
- Are such DHCP instructed not to return to work until a physician determines that the worker does not have TB or is no longer infectious?
- Has a community risk-assessment been performed for your practice setting?

Evaluating Your Infection Control Program

- Is a plan for evaluating the practice setting’s infection control program in place?

A LOOK INSIDE:

- Job Categories identify who within your practice needs to learn and apply each chapter.
- Examining the Issues explains why each set of practices and procedures is important.
- A comprehensive Glossary and list of Terms You Should Know define important words and phrases you will come across in each chapter.
- Step by Step instructions explain how to perform common procedures in practice.
- Common Questions and Answers outlines areas where clarification or clinical judgment may be needed.
- Exercises in Understanding brings recommended procedures right into your practice setting.
- Recommended Reading and Resources points you toward related info in the scientific literature and on the World Wide Web.
- Self-Tests at the end of each chapter make sure you’re familiar with the material before moving on.

OSAP has created a 170-page, all-inclusive workbook to walk users through the new and expanded 2003 infection control guidelines. Each chapter contains practical, how-to instructions, charts and checklists, pictures and captions, answers to common questions, and guidance for making sound clinical judgments. Suggested retail price, $69.95. 10 hours of CE credit available.
Leslie's Resources for CSI Dental Office-Infection Control for 2010

WISHA Bloodborne Pathogen Training Kit


WISHA Washington Industrial Safety and Health Act www.lni.wa.gov/safety/

Centers for Disease Control “Guidelines for Infection Control in Dental Health-Care Settings – 2003 www.cdc.gov/oralhealth/InfectionControl/guidelines/index.htm

WISHA Posters Required and Recommended www.lni.wa.gov/IPUB/101-054-000.pdf

OSHA Manuals
- American Dental Association Regulatory Compliance Manual www.ADA.org
- Build your own using OSHA model plans www.osha.gov/Publications/osha3186.pdf

Post Exposure Evaluation Protocol

CDC Post Exposure Protocol http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5011a1.htm
HIV Post Exposure www.cdc.gov/mmwr/preview/mmwrhtml/rr5409a1.htm
CDC National Clinicians Hotline 888-448-4911

Personal Protective Equipment (Face and Eye protection)
www.osha.gov/SLTC/etools/eyeandface/index.html

Evacuation Plans and Procedures
www.osha.gov/SLTC/etools/evacuation/index.html

List of Chemical Disinfectants/Sterilants
www.epa.gov/oppad001/chemregindex.htm
http://osap.affiniscape.com/displaycommon.cfm?an=1&subarticlenbr=369

Other OSHA and Infection Control Training Resources:
Leslie Canham OSHA Training System DVD and Workbook www.lesliecanham.com
OSAP www.osap.org From Policy to Practice: OSAP’s Guide to the Guidelines
- Workbook
- Interactive Guide to the to CDC Guidelines select “Ask Lily”
- Video – “If Saliva Were Red”

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