EXHIBIT 57 - STANDARD 5-1
ORANGE COUNTY COMMUNITY COLLEGE

DEPARTMENT OF DENTAL HYGIENE

INFECTION CONTROL PROTOCOL

1/2023

PREAMBLE

This protocol was developed following the guidelines of the American Dental Education Association (ADEA).

Purpose:

The purpose of infection control policies and procedures is to minimize the risk of transmission of bloodborne pathogens to patients and dental health care workers (DHCW) in the dental care environment.

This goal will be achieved by:

A. Current immunization against hepatitis B and other appropriate diseases for clinical personnel.

B. Educating and training in the principles and practice of infection control in dentistry.

C. Preventing parenteral, mucous membrane, and non-intact skin exposures of patients and DHCW to blood and other body fluids containing visible blood. Saliva in a dental setting is predictably bloody.

D. Controlling contamination of items and personnel in clinic environments by consistent use of aseptic techniques, including the use of barrier techniques.

E. Using to the fullest extent feasible intrinsically safe substances, procedures, or devices as primary methods to reduce worker exposures to harmful substances.

I. IMPORTANT DEFINITIONS

Engineering Controls: Controls (e.g., Sharps Disposal Containers, self-sheathing needles) that isolate or remove the bloodborne pathogens hazard from the workplace.

Exposure Incident: A specific eye, mouth, and other mucous membrane, non-intact skin, or parenteral contact with blood or other potentially infectious materials that results from the performance of an employee's duties.

Occupational Exposure: Anticipated skin, eye, mucous membrane, or parenteral contact with infectious materials.

Other Potentially Infectious Materials (in addition to blood): Semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, saliva in dental procedures, and any body fluid that is visibly contaminated with blood.

Personal Protective Equipment: Specialized clothing or equipment worn for protection against a hazard (in dentistry, generally gloves, masks, eye protection and gowns). General work clothes (e.g., uniforms, pants, shirts or blouses) not protective against a hazard are not "appropriate".

Regulated Waste: Liquid or semi-liquid blood or other potentially infectious materials; contaminated items that would release blood other potentially infectious materials in a liquid or semi-liquid state if compressed; items that are caked with dried blood or other infectious materials capable of releasing these materials during handling; contaminated sharps; and pathological and microbiological wastes containing blood or other infectious materials.

Work Practice Controls: Controls that reduce the likelihood of exposure by altering the manner in which a task is performed (e.g., prohibiting two-handed needle capping).

DHCW: DHCW is used throughout this protocol and refers to Dental Health Care Workers.

II. INFECTION CONTROL PLAN

A. Exposure Determination

1. Job classifications in which all employees and students have occupational exposure:

   . dental hygiene clinical faculty
   . all dental hygiene students

2. Job classifications in which some employees have occupational exposure:

   . janitorial staff

3. Tasks/procedures performed by employees in the above "2" category in which occupational exposure may occur:

   . cleaning the clinic
   . picking up garbage

B. Implementation

1. Dissemination of information

   a. Faculty

      1.) monthly department meetings
      2.) memos

   b. Students

      1.) Lecture - 4 hours - POHS I
      2.) Visuals: tapes, CD, DVD, Webinar
      3.) Memos

2. Observation of compliance successes and deficiencies in clinic.

3. Cooperation in compliance is evaluated during each clinic session.

4. Faculty and students can, at any time, comment and/or make suggestions on any aspect of the infection control protocol. Anonymity will be respected.

   At least yearly, the clinical coordinator will re-evaluate, review, and update the infection control/clinic protocol.

C. Procedures for Handling Exposure Incidents

1. Occupational exposures

   a. Contaminated needle stick

   b. Puncture wound from a contaminated sharp dental instrument.

   c. Contamination of any obviously open wound, non-intact skin, or the mucous membrane by saliva, blood or a mixture of both saliva and blood.

2. Exposure to patient's blood or saliva on the unbroken skin is not considered significant.

3. Protocol for Post Exposure Evaluation and Treatment:

   a. Immediately cleanse wound with soap and water, allowing wound to bleed freely into sink to wash away contaminants. Stop bleeding and cover wound. For mucous membrane exposure, flush with water.

   b. Immediately report the injury to a clinical instructor and/or the clinical coordinator.

   c. If exposure occurs in a clinical setting off-campus, the exposure should be reported and evaluated at that site by the agency's employee health services emergency department. A copy of the agency's report should be brought back to the College.

   d. If the exposure occurs on-campus, exposed faculty or students will be referred to the campus Wellness Center (College Commons building, second floor, ext. 4870) for immediate attention. (**Exception**: Fridays, after 4 P.M., the exposed individual will be referred directly to the Orange Regional Medical Center emergency room for treatment).

   e. A confidential "Exposure Incident Report" form (Appendix D) must be completed by the exposed student in conjunction with the assigned clinical instructor. Exposed faculty will be responsible for completing their own form. The forms should be filed with the clinical coordinator and department chair within 24 hours of the incident. Documentation of the incident will also be done at the Wellness Center.

   f. Post-Exposure Evaluation shall consist of:

      a. documentation of the incident

      b. documentation of the source individual (if obtained)

      c. evaluation by a Health Care Professional

      d. maintaining confidentiality regarding all medical information.

      <u>NOTE</u>: Please refer to the current CDC Guidelines in the Student Handbook for information regarding specific post-exposure recommendations.

D. Post-Exposure Evaluation of Exposure Hazard

The "report of incidence" includes documentation of the route and circumstances of the exposure. Evaluation will determine if engineering and/or work practice controls need to be added or changed to eliminate an exposure hazard.

III. METHODS OF COMPLIANCE

A. "Standard Precautions," as defined by CDC, refer to a set of precautions designed to prevent transmission of HIV, HBV, HCV and other bloodborne pathogens in health care settings. Under standard precautions, blood and certain body fluids of **all** patients are considered potentially infectious for HIV, HBV, HCV and other bloodborne pathogens.

Although saliva and sputum has not been found to be a mode of transmission, special precautions, are recommended for dentistry. Standard precautions apply to managing saliva and sputum in dental settings because during dental procedures contamination of saliva and sputum with blood is predictable.

Rationale: Given the limitations of routine health history information, it is unlikely that dental personnel will know the infectious disease status of patients because:

1. Many infected patients are unaware that they are infected and that their blood may be capable of transmitting certain infectious disease.

2. Some patients will not reveal known infectious diseases to health care providers.

3. Health care providers cannot interpret negative findings from a comprehensive examination to mean that the patient is presently "infectious disease-free" or will remain so upon subsequent clinical visits.

Furthermore, it has been recommended that all dental health care providers use those infection control measures shown effective in minimizing hepatitis B transmission between patients and/or personnel because such measures are also effective for controlling other bloodborne infectious agents. This infection control plan has been developed to meet that standard.

B. This protocol is necessary and sufficient for routine patient treatment and for treatment of hepatitis B and C carriers, HIV antibody-positive patients, diagnosed AIDS patients, and patients with other known bloodborne infectious diseases.

C. Infection control procedures are not based on the patient's serologic status for any particular infection.

D. Engineering and Work Practice Controls

1. **Personal Hygiene:** The following guidelines apply to **all** clinical students and faculty.

   a. Hair must be cleared away from the face.
   b. Facial hair must be covered by a face mask or shield.
   c. Jewelry must not be worn during patient treatment. This includes body piercing ornamentation and tongue bars.
   d. Nails must be clean and short.

   Rationale: Hair and nails are known to harbor higher levels of bacteria than skin. Long nails are more difficult to clean and may potentially penetrate gloves. DHCW with injured or cracked skin, erosions, or eczema on hands or arms should exercise additional caution such as using mild soaps and lotion until the lesions are healed.

2. **Hand Hygiene:** Hand hygiene is mandatory (1) before treatment, (2) between patients, (3) after glove removal, (4) during treatment if an object is touched that might be contaminated by another patient's blood or saliva, and (5) before leaving the operatory.

   The following is the recommended procedure for hand hygiene for routine dental procedures in the clinic and for routine laboratory work with contaminated items:

   For Initial Handwash:

   a. If necessary, remove visible debris from hands and arms with appropriate cleaner/solvent. Do not abrade skin by using a brush or sharp instrument.

   b. Wet hands and wrists under cool running water.

   c. Dispense sufficient soap to cover hands and wrists.

   d. Rub the hand wash gently onto all areas, with particular emphasis on areas around nails and between fingers, for 15 seconds minimum before rinsing under cool water.

   e. Repeat steps c and d twice; then dry thoroughly with paper towels.

   Note: Dispensers for hand soap must be emptied and washed before refilling. Do not add soap to a partially empty dispenser (to top off). Studies have found that bacterial biofilms grow on the layer between the new and old product. (dentalcare.com, Guidelines for Infection Control in Dental Health Care Settings, revised 2013)

   f. Alcohol hand rub may be used for subsequent cleansings provided your hands are not visibly soiled. Hand washing with medical grade soap must be done at the end of clinic.

      Rationale: Hand washing is an extremely effective procedure for the prevention of many infections that are acquired from the transmission of organisms on the hands. "Residual" antiseptic handwash has a long-lasting antimicrobial effect on the skin that improves with more frequent use throughout the day.

3. Needle Recapping and Use of Cannulas.

   To prevent needle-stick injuries, needles and cannulas are not to be recapped by hand. Needles can be safely covered in two ways:

   a. Use a Needle Cap Safety Holder when using a syringe for local infiltration anesthesia.
   b. Use the one-handed scoop technique for an Irrigating Syringe or similar cannula device.

4. Sharps Disposal

    a. Approved Sharps Containers are used and are centrally located in the dispensary area.
    b. Dispose of used needles, cannulas, and cartridges in the Sharps containers.
    c. Do not bend or break needle or stylus before disposing.
    d. Take used armamentarium to the Sharps container on a tray (not by hand).

5. Eating, drinking, smoking, applying cosmetics or lip balm, and handling contact lenses are prohibited in the clinic and lab.

6. Food and drink may not be kept in the clinic.

    Food and drink may not be kept in the lab while lab procedures are being performed.

7. Splashing, spraying, spattering and generation of droplets of exposure material is to be minimized. Specific detail is given in the section titled "Patient Treatment".

8. Equipment which may become contaminated shall be decontaminated.

    Specific detail is given in the section entitled "Preparing for the Patient" and "Clean-Up After Patient Treatment"

9. A centrally located eyewash station is available for use in the Clinic when needed (across from Unit 8). Never place items in front of the eyewash station. There is also an eyewash unit mounted on the sink faucet in the Lab.

10. All clinic faculty and students wear radiation monitoring badges (dosimetry badges) to measure radiation exposure during clinics and labs in which radiographs are taken.

11. Medical Emergency Protocol for 0_2 Administration

    a. Oxygen is to be administered with the use of sterile mask and ambu bag.
    b. Pocket masks are available, if needed, in the medical emergency crash cart.
    c. These devices minimize the risk for exchange of body fluids during resuscitation procedures.

12. Mercury hygiene

    a. Students will immediately notify faculty and will not attempt to clean up spilled Mercury.
    b. Faculty will immediately evacuate the area.
    c. Faculty will immediately call the Office of Safety and Security (ext. 4710) and/or Facility Services (ext. 4600).
    d. Faculty may contain the spill with cat litter or by using the Mercury Spill Kit.

IV. PERSONAL PROTECTIVE EQUIPMENT

Personal Protection: Routine use of barrier devices such as gloves, masks, and protective eyewear significantly reduces the possibilities for blood and salivary exposure between patients and dental health care workers. **Blood, saliva, and gingival fluids from all dental patients must be considered infectious.**

A. Nitrile Examination Gloves.

All individuals will wear disposable gloves whenever there is contact with blood, saliva, or mucous membranes. Gloves must NOT be washed or otherwise reused. Gloves must be changed between patients. Gloves must be removed and hands washed before leaving the clinical area. Alcohol hand rub must be used between glove changes.

B. Masks and Eyewear.

Masks should be changed after every 30 minutes of wear or if they become wet. Disposable masks and protective eyewear with side shields will be worn during all clinic procedures. A new disposable mask is to be worn for each patient treatment session. When not in use, the **mask** should not be placed on the forehead or around the neck.

Protective eyewear should be given to the patient for use during the clinic session. Both sets of eyewear should be cleaned between uses, being certain not to handle them with unprotected hands until they have been decontaminated. Eyewear cannot be heat sterilized. Clean with soap and water, disinfect for 10 minutes (store). Rinse with water and dry before giving to a patient.

C. Clinic Attire.

All DHCW will routinely wear appropriate attire to prevent skin exposure and soiling of street clothes when contact with blood or saliva is anticipated. **FLUID-IMPERVIOUS JACKETS MUST NOT BE WORN OUTSIDE THE CLINIC.** Attire must be changed daily, or more often if visibly soiled.

D. Utility Gloves.

Nitrile utility gloves should be worn for all cleaning and disinfection of contaminated instruments, dental units, and environmental surfaces. Utility gloves have an increased resistance to instrument punctures and chemicals. After use, while wearing gloves, wash with soap and water, spray each glove with Birex SE III, remove gloves – allow 10 minutes to dry and place under the sink.

V. HOUSEKEEPING

A. Environmental Surface and Equipment Cleaning and Disinfection

1. Many blood- and saliva-borne disease-causing microorganisms such as hepatitis B virus and Mycobacterium tuberculosis can remain viable for many hours- even days - when transferred from an infected person to clothes and to environmental surfaces within dental operatories and other clinical areas. Since subsequent contact with these contaminated surfaces can expose others to such microbes and may result in disease transmission, adequate measures must be used in each clinical area to control possible transmission from contaminated surfaces.

2. A practical and effective method for routinely managing operatory surface contamination between patients is to use disposable blood/saliva impermeable barriers, such as plastic film and aluminum foil, to shield surfaces from direct and indirect exposure. Removal of blood, saliva and microbes is accomplished by routinely changing surface covers between patients. Time-consuming cleaning and disinfection procedures between patients can then be minimized.

3. Thorough cleaning and proper disinfection between patients is necessary for those uncovered operatory surfaces that are routinely touched and become contaminated during patient treatment.

4. Only chemical disinfectants that are OSHA approved or EPA-registered, hospital-level mycobacterial agents capable of killing both lipophilic and hydrophilic virus at use dilution are considered acceptable agents for environmental surface disinfection. Use of any chemical killing-agent not so approved is unacceptable.

B. Preparing for the Patient:

1. COVID daily screening clearance, and obtain proper masks as directed by faculty.

2. Enter the lab and change into clinic shoes. Store street shoes on top of shoe box, not inside.

3. Perform hand-washing protocol.

4. Each clinician will replenish unit water bottle as needed (use distilled water and tablet).

5. On the bracket table, turn the "master switch" on (towards 1).

6. Adjust clinician chair to correct height. Place barrier on hand lever under seat.

7. Flush the air water syringe for 2 minutes at the beginning of the day and then for 30 seconds between patients. It should also be flushed for 2 minutes at the end of treatment.

   If an ultrasonic scaler is to be used, flush the waterline for at least 2 minutes at the beginning and end of treatment.

   ***Rationale:** It has been shown that blood, saliva, and gingival fluid of patients can be aspirated into the handpiece or waterline. Therefore, flushing the unit's water reservoir between patients and before starting the day is mandatory.

8. Put on nitrile utility gloves if you need to disinfect the operatory, otherwise go to handwashing.

9. Spray the disinfecting solution on the cabinet top, folding table, clinician chair and any part of the patient chair and unit **WHICH DOES NOT GET COVERED WITH A BARRIER.** Let stand for 10 minutes. (The front surface of the light should NOT be sprayed directly; apply water to a soft towel and wipe the front light surface to clean.)

10. Remove and discard gloves. Wash hands, as per guideline, with medical grade antibacterial soap. (Soap needs to be used only for this initial washing, or if hands are visibly soiled. Otherwise, the alcohol rub should be used.)

8. Go to the dispensary and collect the items needed, possibly: (**Ungloved Hands**)

items are usually prepared in a wax bag
mask
sponge wipe or sterile gauze with ortho band
bib
saliva ejector
dappen dish
cotton-tip applicator for disclosing
tongue blade (for Vaseline, or topical anesthetic not individual dose)
2 bracket table covers (1 for counter, 1 for unit tray)
sterile gauze packet – place on counter tray cover
sterile instruments – cassette pouch – place on counter
handpiece/ - only if treatment planned – barrier tray cover
patient drinking cup

Gather barriers:

Chair cover/headrest (no ultrasonic planned)
light handle/dominant hand side only unless left-handed clinician or faculty
air/water syringe
saliva ejector cover
handpiece
ultra-sonic scaler — only if Tx planned, otherwise SA will assist set up
curing wand
pen (black)
red/blue pencil
clip board and clips (Do not need barrier if it can be disinfected.)

9. Place barriers over (applicable) equipment.

10. Place barriers over items which may become contaminated but do not have a specific barrier:

For example: light switch, hand controls for chair, bracket tray handle, bracket table handle and clipboard

Note: Do **not** put barriers on clinician chair, therefore, do not touch chair upon sitting or standing.

11. Tape waxed bag to bracket table (use this to discard items such as used gauze to keep bracket tray clean).

12. Set up all non-sterile items to be used during patient treatment.

A. Place on countertop (with sink)

Patient chart (most recent radiographs go onto viewbox) (keep in folder holder to the left).
Evaluation form (with carbon) on clipboard
Previous evaluation forms on same patient.
1 box of exam gloves
Chairside Instructor (patient education book)
Glasses, clinician and patient.
Box of tissues (should be in each unit)

B. Place on cart shelf: Forms to be used, possibly

oral exam
perio assessment
dental charting
Plastic "forms barrier" (plastic page protector)
wrapped pen and pencil
wrapped red/blue pencil

C. Prepare a small tray with the items needed for OHI to place on countertop:

typodont
demo toothbrush
tape/floss dispenser
dappen dish
disclosing solution bottle
mirror with stand (with barriers)

14. Place patient drinking cup next to holder, and upside down. Once patient is seated, fill with ½ oz. antimicrobial rinse. **DO NOT DILUTE**. Repeat before ultrasonic or polish.

15. **Put on exam gloves**.

16. Attach saliva ejector tips, air/water syringe tip, sterilized handpieces if treatment planned, otherwise ask SA. Place appropriate barrier. Place empty sterilizer bag over handpiece.

17. Remove cassette from pouch. Sharpen with sterile stone if needed.

18. Place sterile items on bracket tray. A length of neatly coiled floss/tape should be dispensed. Cover the items on the bracket table with the patient bib. Place napkin chain atop. Do not throw out sterilization pouch if you do not open in front of the patient.

Note: Non-sterile items do not go onto the bracket table (such as gauze envelope, floss dispenser, etc.).

19. Radiology Services: See Radiology section

C. Patient Treatment

1. Seat patient. Complete appropriate patient forms as per appointment sequence guidelines. Clinician and patient should use pen and clipboard that do not have barriers.

2. Place bib on patient. Instruct the patient to rinse with mouthrinse for 30 seconds.

3. Handwashing is done first thing before set up. Alcohol rub if hands are not soiled. Once gloved, touch only the patient and barrier-covered areas/items, or areas that have been cleaned and disinfected.

4. Recordkeeping (charting, oral exam)
The patient chart should always be placed on the cabinet (by sink), and it should not be handled by gloved hands. When charting or performing the oral exam, place the chart form on the black table/cart. Use the covered pen or pencil. Do not touch the form with contaminated gloves. Use plastic cover sheet as a barrier while documenting forms. Gloved hand should contact cover sheet only and not the form. Move the barrier down or up the page as needed while performing documentation.

5. OHI:

   Place OHI demo tray on cart or black table. Prepare bracket table by putting all instruments, except a mouth mirror, into the cassette and close it to make room on the bracket table. Place dappen dish with disclosing solution and the standing mirror with a barrier on the base on to the bracket table. Remove patient toothbrush from the container and place it on the bracket table. Recycle package (do not put package on bracket tray! CA will pick up package for recycling.) Do not contaminate demo items such as typodont, toothbrush, floss dispenser.

6. Low Speed Evacuation System

   Use the saliva ejector to manage saliva pooling and as an aid for rinsing during treatment. Cover tubing with protective barrier.

7. High Speed Evacuation System

   The use of high speed evacuation is recommended during any procedure which could cause splatter (to reduce droplets) or during treatment procedures such as sealants. It may be used with an assistant. Cover tubing with protective barrier.

8. Air/water syringe.

   The air/water syringe is very helpful. Drying teeth with air is important for assessment and during treatment services. Water may be helpful for rinsing blood or materials such as etch from the clinical field. The air/water syringe may produce splatter; the use of the water or air separately reduces splatter.

   Prior to OE check, make sure this has been flushed for 2 minutes and is working.

   Do not push syringe through plastic barrier while assembling. Cover tubing with protective barrier.

9. If an instrument becomes bloody, dip the working end into dappen dish/medicine cup with hydrogen peroxide during the treatment phase.

10. Dropped instruments

    An instrument that is dropped will not be picked up and reused (place in the operatory sink). If the instrument is essential for the procedure, a sterilized replacement instrument must be obtained. (Ask Clinical Assistant for assistance.)

11. Patient Toothbrushes: The patient uses the toothbrush for skill training during OHI. The patient's toothbrush may remain on the bracket table until the end of the appointment. The clinician may use the patient's toothbrush as an aid to polishing.

    At the end of the appointment after patient education:
    - Rinse patient toothbrush
    - Dip in undiluted Listerine, gently shake excess
    - Dry
    - After the appointment, place in closed Ziploc bag marked with patient name (in Sharpie)
    - Store in assigned clinic drawer, use at subsequent appointments.
    - Give patient toothbrush and baggie at last appointment.

12. Disposable items

Disposable items should be discarded at the end of the appointment.

13. Storage of Sterilized Items

All pouches must have a date and student name (in pencil) and indicating tape placed before going into the "To Be Sterilized" drawer. The shelf life of correctly packed sterilized instruments is approximately 1 to 2 months as long as the packaging remains intact. Do not store instruments for intraoral use unwrapped. There must be evidence on the wrapping, such as color indicator, that the correct temperature was achieved in the sterilization cycle and a biological monitor strip in the pouch. Instruments must be repackaged and resterilized if there is any sign of damage to the wrapping.

D. Clean-up After Patient Treatment

1. Remove gloves and use alcohol rub immediately.

2. Escort the patient to the waiting room.

3. Put on utility gloves, masks, and glasses before starting the clean up. Use these whenever working with contaminated instruments and chemicals.

4. Discard irrigating cannulas, broken instruments or any other disposable sharp items into Sharps container in the dispensary.

5. Remove contaminated instruments, accessories, handpieces, ultrasonic scalers and prepare them for sterilization. See section titled "Instrument Sterilization". Place cassettes into ultrasonic cleaner before cleaning unit. Time for 10 minutes.

6. Disinfect all patient-contaminated items to be transported to the laboratory, such as impressions, bite registrations, etc. See section titled "Laboratory Procedures".

7. Clean patient eyeglasses with soap and water. Spray, let stand for 10 minutes, wipe, then put away. Rinse with water and dry before giving to the next patient.

8. Remove all contaminated barriers and waste into headrest/chair cover including contents of the wax bag with the exception of blood soaked guaze which must be placed in the biohazard bag in the dispensary.

   Remove all barriers and disposables from unit and discard into head rest or chair cover; close securely. Place this into large waste containers located in the storage room or the laboratory. (Do not use the waste receptacles in the dispensary - they are too small.)

   Note: Large waste containers are decontaminated weekly or sooner if visibly soiled. See section titled "Sterilizing Assistant".

9. Clean the **Cuspidor**

   a. Remove the trap. Clean and rinse thoroughly (Remove all disclosing residue and debris.) in unit sink. Spray with Cavicide. Let sit for 10 minutes. Rinse. Do not discard. Disposable traps may be discarded if stained.
   b. Clean bowl (under rim also). Spray with Birex SE III, wipe the surface, re-spray with disinfectant. Let stand 10 minutes.
   c. Re-assemble cuspidor.

10. **Note:** Evacuation system cleaner is run through the (slow speed suction) saliva ejector every week. See section titled "Sterilizing Assistant".

11. If high speed evacuation used: Suck through at least 4 cups of water. Do not put any fluids through the evacuation system with colored tape, this is for the Nitrous Oxide Scavenging System.
Note: Evacuation system cleaner is run through the high-speed suction every week. See section titled "Sterilizing Assistant".

12. Disinfect chair, unit, waste container and cabinet area, plastic sheet "forms barrier", and any other possibly contaminated items with the recommended disinfectant <u>if it was contaminated and not covered by a barrier.</u> Spray, let stand for 10 minutes, wipe.

    a. Spray the solution onto the surface to be cleaned.
    b. Let stand for 10 minutes.
    c. Wipe with a paper towel.
    d. Disinfectant wipes may be used instead of Birex SE III but NOT in combination with.

    Note: Any area covered by a barrier <u>should be</u> re-covered without cleaning and disinfecting, if the barrier was not punctured or broken.

13. Clean eyeglasses (clinician's) with detergent and water. (Spray with disinfectant if visibly soiled. Wait ten minutes and wipe.) Rinse with water and dry before next patient to remove chemicals.

14. With utility gloves on, wash with soap and water and spray outside of gloves with Cavicide, remove gloves and let sit for 10 minutes on the sink to dry and put away. **<u>Perform hand wash with soap before leaving the clinic.</u>**

15. Exit the clinic area and remove the lab coat turning inside out and placing it into a red bag for laundering. Go to the lab and change from clinic shoes to street shoes, placing clinic shoes into boxes under the counter. NO CLINIC SHOES should be worn home. Use hand sanitizer after removing clinic shoes.

E. Instrument Sterilization

All contaminated reusable instruments, including handpieces that can be sterilized in heat-sterilizing devices, must be thoroughly cleaned and heat sterilized before use in the treatment of another patient. The use of chemicals as a substitute for heat sterilization of these items is unacceptable.

Currently, all reusable items that cannot be heat-sterilized are disposable. (However, if there is an item that needs to be chemically sterilized, it should be immersed in a chemical which is EPA registered or OSHA approved as a dental instrument sterilant. Manufacturer's instructions specified for sporicidal activity are followed. Monitoring the efficacy of the solution is done regularly with appropriate test strips.

1. Preparation of instruments for sterilizing (Use utility gloves when handling instrument cassette.)

    a. Students must wear PPE when working in Dispensary.
    b. Instruments should be clean prior to placing into the cassette. Place instrument cassettes into ultra-sonic cleaner. Put lid in place. Vibrate for 10 minutes. Rinse with water. Gently shake cassette and place in draining rack to air dry. When dry, bag cassette. Label with name and date (in pencil).

c. If necessary to quick dry, place instrument cassette in alcohol bath after removal from ultrasonic and water rinse. Place on drying rack, dry excess with paper towels. Bag and label as in b. above.

d. Handpiece: **DO NOT** put any part of the handpiece into the Ultrasonic.

Motor (College issued)

1. Remove debris with gauze.
2. Remove gasket - put in cup where motors are stored.
3. Bag motor in paper-backed sterilization pouch and label date.
4. Do **NOT** oil Titan motor; **DO** oil Benco motor (see instructions). Occasionally oil NSK motor.
5. Sterilize

Shank (for adaptor)

1. Wipe exterior with alcohol, remove all external debris.
2. Place 1 drop of oil in hole at top (near gear).
3. Place in pouch and label date.
4. Sterilize.

Angle (College issued)

1. Remove all debris (nondisposable)
2. Disassemble angle; unscrew knurled ring and separate into three (3) parts. Put l drop of Titan lubricant in areas indicated in instruction booklet
3. Place in pouch, marked with name and date.
4. Sterilize.

NOTE: DON'T FORCE ANYTHING ON THE HANDPIECE. IF IN DOUBT, GIVE IT TO AN INSTRUCTOR.

Disposable Prophy Angles are for single use. Prophy cups and brushes are for single use only. Dispose of after the final check.

e. **Packaging for Sterilization**

Any supplies to be sterilized are placed into a sterilizing pouch or cassette. The type of wrap to use depends on the size and shape of the item(s) to be sterilized. A piece of indicator tape (which shows a color change after going through a properly heated sterilizing cycle) must be placed on the wrap.

1. Instrument cassette. Each clinician has at least two (2) of these cassettes, in which her/his personal instruments and supplies are sterilized.

2. Clear sterilization tubing. Items are placed into the tubing and the ends are sealed with indicator tape.

3. Label with name and date in pencil.

4. Internal indicators will be placed in the pouches.

2. Sterilization

a. Hydrogen Peroxide Solution (Sporox) is rarely used because almost all items are disposable or autoclavable. Items which cannot withstand high temperature of heat sterilizers are put into a sterilant solution for 6 hours.

Wearing clean examination gloves, mask and glasses, remove from sterilant solution, rinse with water, then dry. Place into clear plastic Ziploc bag. Put away.

b. Operation of Sterilizers: See directions on the following pages.

c. Sterilizer Monitoring

1. Methods used:

1. Digital readout of each batch observed.

2. Spore Test Biological Monitoring System USED WEEKLY. (See Sterilizing Assistant Duties)

3. Observe and document in Sterilization Log and Spore Test Log daily/weekly.

ATTC No. 7953

Organism: *Geobacillus stearothermophilus*

Instructions for Use

IMS-1373 IMS-1373H IMS-1374 IMS-1375 IMS-1376 IMS-1377

SporeCheck® self-contained biological indicators are inoculated with viable Geobacillus stearothermophilus bacterial spores and are intended for monitoring the efficacy of saturated steam sterilization processes operating at 121°C and 132°C gravity displacement, 132°C flash gravity displacement and 121°C–134°C prevacuum cycles. SporeCheck self-contained biological indicators are also appropriate for use in monitoring the efficacy of saturated steam prevacuum sterilization processes operating at 135°C for 3 minutes exposure time.

Due to varying sterilizer come-up times, it is recommended to extend the cycle time from 3 minutes to 4 minutes in order to achieve consistent kill when testing the gravity steam process at 270°F (132°C) in Flash Cycles.

Sporecheck biological indicators (BIs) meet performance parameters of the US Pharmacopia and AAMI/ISO 11138. Culture media is tryptic soy broth validated for growth promotion capabilities per USP guidelines. Media growth promotion has been validated for extended steam cycles operating at 132°C for 20 minutes exposure time.

Monitoring Frequency:
Per AAMI, ADA and CDC recommendations, steam sterilizers should be biologically tested at least weekly, preferably daily and with every load that contains an implant.

Instruction for Use
1. Note the sterilizer number, load number and processing date on the BI vial label.
2. Place the BI vial inside an instrument tray, peel pouch or AAMI challenge pack, whichever is representative of the load being processed.
3. Test the most challenging area in the sterilizer (i.e. the bottom shelf near the door, over the drain of a large sterilizer or in the middle shelf of a small sterilizer).
4. Process the load according to the sterilizer manufacturer's instructions.
5. Retrieve the BI vial and confirm the chemical indicator printed on the label has turned **brown**. If label has not turned brown, re-run the sterilization cycle with a new BI vial.
   (Caution: After processing, the BI vial is hot and under pressure. Always allow it to cool for ten minutes before crushing. Failure to do so could cause the glass ampule inside the BI vial to burst which may result in injury. For this reason, safety glasses should be worn when handling and crushing a processed BI vial.)

Activation and Incubation
1. Activate the processed BI vial within 8 hours of processing by crushing the inner glass media tube using either the vial crusher built into the incubator or one provided by Hu-Friedy Mfg.
2. Incubate at 55°-60°C for 24 hours checking for spore growth (visual color change from purple to yellow) at regular intervals (i.e. 3, 5 and 8 hours). Growth of surviving spores has been documented in as little as 2.5 hours.

Use of Controls
1. As a Control, an unprocessed BI vial (from the same lot) should be gently crushed using a vial crusher and incubated each time the sterilizer is tested. Positive results (color change from purple to yellow) are expected and should be recorded. If the control BI vial doesn't change color, rerun the test.
2. If you are testing more than one sterilizer at a time, only one unprocessed BI vial is needed as a control.

Test Results
1. Record negative (no growth) results after full incubation (24 hours) in a Sterilizer Record Notebook (IMS-1375). No color change in the purple media after processing indicates proper sterilization.
2. Any positive result (indicated by a purple to yellow color change), should be recorded and reported immediately to a supervisor. The sterilizer should be taken out of service until the issue is resolved.

Refer to CDC guidelines for further instruction, www.cdc.gov

Sterilization Tips
1. Always run a warm up cycle prior to processing loads.
2. Do not overload the sterilizer as it can cause a sterilization failure.
3. Run cycles that are specified by the sterilizer or instrument manufacturer-whichever is longer.
4. Allow packaged loads to dry completely before handling to avoid recontamination.

Special Note: 55°-60°C Dry Block Incubator (IMS-1374), SporeCheck In-Office Test (IMS-1373) and Sterilizer Record Notebook (IMS-1375) are available for first time users in the form of a Starter Kit (IMS-1376).

CERTIFICATION

Purity: No evidence of contamination using standard plate count techniques.

Disposal: Autoclave BI vials at 121°C for 30 minutes or longer and dispose of as normal waste.

Lot No. 6410
Exp. Date: 01/2015

Population[1]: 1.9 x 10^5, Performance Characteristics:

PROCESS	TEMPERATURE	D-VALUE	SURVIVES (+)[4]	KILLED (-)[4]
Steam (Saturated)	250°F (121.1 ± 0.5°C)	1.6[2]	5.3 minutes	14.8 minutes
Steam (Saturated)	270°F (132.2 ± 0.5°C)	0.73[2]	2.4 minutes	6.7 minutes
Steam (Saturated)	273.2°F (134 ± 0.5°C)	0.66[3]	2.2 minutes	6.1 minutes
Steam (Saturated)	275°F (135 ± 0.5°C)	0.62[3]	2.1 minutes	5.7 minutes

1. After a preliminary heat treatment of 95-100°C for 15 min.
2. Determined at the time of manufacture using fraction negative procedures (e.g. Stumbo Murphy Cochran) in an AAMI/ISO compliant test vessel. The D-value is reproducible only under the exact conditions under which it was determined. Users may not necessarily obtain the same results. The manufacturers D-value cannot be duplicated in a healthcare facility.
3. Emperically derived data.
4. Calculated using USP, AAMI and ISO survival and kill time formulas.

DEPARTMENT OF DENTAL HYGIENE R. 2/18

STERILIZER MONITORING (Autoclave)

1. Processing one "batch" = 1 cycle.
2. Record the # of cycles run for each sterilizer each day.
3. Rotate the sterilizers used.
4. A spore test is done weekly. See log book, calendar.

DATE	SA NAME	STERILIZER 1			STERILIZER 2		
		# of Cycles	Spore Test ( )	Weekly/Monthly Maintenance	# of Cycles	Spore Test ( )	Weekly/Monthly Maintenance

SUNY ORANGE
DEPARTMENT OF DENTAL HYGIENE

WATERLINE MAINTENANCE PROTOCOL

The CDC issued a Health Alert Network (HAN) Health Advisory regarding nontuberculous *Mycobacteria* infections associated with contaminated dental unit waterlines and the need for dental health care personnel (DHCP) to follow established recommendations to ensure the safety of their patients. Dental unit waterlines promote bacterial growth and development of biofilm; thus, all dental unit waterlines must be treated regularly with chemical germicides. Untreated dental units cannot reliably produce water that meets drinking water standards (which is fewer than 500 CFU/mL of water of heterotrophic water bacteria).

https://emergency.cdc.gov/han/2022/han00478.asp

Recommendations for Dental Facilities

- Ensure that the dental facility has an infection prevention plan that includes policies and standard operating procedures dedicated to maintaining and monitoring water quality.
- Provide staff training on how to properly maintain and monitor dental water quality. Training should be based on the manufacturer's instructions for use of the products and devices used in the dental facility, provided for all new hires, and provided when new equipment is purchased and then at least annually.
- Document all maintenance records, and monitoring results. Accurate record keeping is an important component of a dental infection prevention program, ensures proper protocols have been met, and establishes accountability. Records should be maintained according to state and federal requirements.

https://www.cdc.gov/oralhealth/infectioncontrol/faqs/dental-unit-water-quality.html

The Health Advisory contains recommendations and a list of resources for DHCP to visit to learn more information. Some key recommendations include:

- Dental professionals should establish written standard operating procedures to guide dental personnel in performing infection control procedures for dental unit waterlines.
- Implement the use of equipment and procedures such as separate reservoirs, chemical treatment protocols, use of filtration systems, and sterile water delivery systems.
- For units using separate water reservoirs, purge the dental unit waterlines each night and whenever units are out of service to prevent stagnant water from settling within the waterlines.
- Discharge water and air lines for a minimum of 20–30 seconds after each patient to physically flush out patient material that might have entered the dental water system during treatment.
- Monitor waterlines for damage or visible contamination and replace if needed or as directed by the manufacturer.
- Be alert to signs that may indicate biofilm formation including musty odor, cloudiness or particulates in the water, and clogging of lines.

https://www.fda.gov/medical-devices/dental-devices/dental-unit-waterlines

As such the protocol for the SUNY Orange Dental Hygiene Clinic will be as follows:

- Unit water bottles will be emptied at the end of each day
- Unit water bottles will be filled with distilled water at the beginning of each day and a water treatment tablet will be added to the water bottle
- Each week the suction lines (according to the SA duties sheets) will be ran with suction line cleaner and documented in the log book
- Quarterly the water lines will be "shocked" with a chemical germicide and documented in the log book
- Quarterly the water lines will be tested and sent out to an independent monitoring facility. The returned report will be stored in the Clinical Coordinators office.
- The water and air lines will be discharged for a minimum of 20–30 seconds after each patient to physically flush out patient material that might have entered the dental water system during treatment in multi patient clinics.
- No patient will be allowed to place their closed mouth onto suction during treatment.
- The air water syringe and ultrasonic will be flushed for two minutes at the beginning of the day.

WATERLINE MAINTENANCE LOG

DATE	NAME	TREATMENT- WEEKLY SUCTION	SHOCK – 90 DAYS	TEST - QUARTERLY

F. Laboratory Procedures

1. Extracted teeth used in Maxillofacial Anatomy Lab

   a. Instructional materials utilized to study tooth morphology include extracted human teeth. Because the specimens present a potential source of infection to students and faculty, the teeth will be sterilized or disinfected according to the following guidelines.

      1. Anyone processing nonsterile extracted teeth should wear gloves, masks, eye glasses, and fluid impervious lab coats.
      2. Extracted teeth should be collected in wide-mouthed plastic jars containing 10% bleach solutions.
      3. Spread teeth on several layers of paper towels to sort and dry.
      4. Place teeth without amalgam restorations in clear plastic autoclave bags. (Do not attempt to remove tissue or deposits from teeth at this time.) Autoclave for 40 minutes (121^0, 15 lab. Psi)
      5. Teeth with amalgam restorations will not be used at this time.
      6. Upon following the accepted process, teeth may be safely handled with ungloved hands.

   b. See CDC Resource: Infection Control, FAQ Extracted Teeth, 2013.

2. Extracted Teeth used in Instrumentation Labs

   Advanced instrumentation workshops (including but not limited to ultra-sonic scalers) using human extracted teeth will use PPE including gloves to simulate standard precautions for clinical procedures.

2. Bio-Materials

a. Gloves, masks, eyeglasses and lab coats or plastic aprons are to be worn for the following procedures (exceptions noted):

1. pouring models
2. trimming models (omit gloves)
3. custom tray construction (omit gloves)
4. bite registration

b. After Alginate Impressions and Bite Registration are taken...Spray with disinfectant and place in a baggie for 10 minutes. Rinse well, dry and pour casts.

After you separate the impression from the cast, spray the cast with Birex SE III. Let stand for 10 minutes, rinse well, dry, and then trim.

Store S/M casts in labeled plastic bin trays till dry. After they are dried, label heel of cast with patient's name and date. Secure rubber band with Bite Registration between casts and place in Ziploc Baggie.

c. If the laboratory lathe is to be used on anything coming into direct patient contact, clean pumice, a disposable tray and a sterile rag wheel must be used.

3. Radiology

a. Prepare the x-ray operatory according to standard protocol for preparing the unit. See section titled "Preparing for the Patient".

b. Use barriers for extension arm and tubehead, chair headrest, machine controls, and door knob (outer door knob only).

c. All supplies and film should be set up prior to starting the exposures.

1. Sterile film holders, cotton rolls, rubber bands and cushions should be placed on a tray with tray cover and put in the x-ray operatory.

2. <u>Digital Imaging</u>:
Use barriers for computer mouse, keypad, and sensors/wires.
Place barriered sensors on tray with other supplies.

d. The clinician must wear all PPE when exposing radiographs on a patient.

e. When all exposures are complete:

1. Put on utility gloves.

2. **Carefully** remove all plastic wrap and discard properly.

3. Discard all other disposables into trash receptacle.

4. Clean and spray disinfectant on all contaminated surfaces which were not covered with barriers. (**NOTE:** Do not spray control panel.)

5. Remove gloves – disinfect as directed.

4. Pain Management in Dentistry

See Infection Control Guidelines and Safety Protocols for DNT 110.

VI. INFORMATION AND TRAINING

A. Initial Training

1. Students:

The first 2 weekly lectures (2 hours each) of the first year course entitled "Preventive Oral Health Services I" is devoted to disease transmission and control. Principles and practice of exposure control are immediately implemented in the first clinic session, and are observed and evaluated in every clinic session of the 2 year program.

2. Dental Hygiene faculty:

Incoming new department faculty are trained prior to working in clinic.

B. Changes in the infection control protocol are communicated to the faculty and students immediately.

1. **Written**: a memo is sent to all faculty and students explaining any change.

2. **Verbal:** the memo is discussed and questions addressed

a. monthly faculty department meetings
b. weekly student classes

C. Annual training takes place each September, and involves

1. Review and discussion of the protocols.
2. Written exams.
3. Viewing of the Training Materials.

D. Training Materials

1. Copy of the "Guidelines For Management of Occupational Exposures to HIV - Recommendations for PEP" (2013).

2. Copy of the O.C.C.C. Infection Control Plan, and the departmental protocol which is specific to the dental field.

3. Lecture

a. epidemiology and symptoms of bloodborne diseases
b. modes of transmission of bloodborne pathogens
c. recognizing exposure activities
d. uses and limitations of personal protective equipment, barrier techniques and work practices.

ORANGE COUNTY COMMUNITY COLLEGE
Department of Dental Hygiene

Protocol for Post-Exposure Prophylaxis (PEP)

Following is the protocol for PEP as set forth by the Orange County Community College's Wellness Center regarding faculty or student exposure to Blood-borne Pathogens in the Dental Hygiene Clinic.

Immediately following the incident (after having cleaned the wound), the student must inform a faculty member. If the student decides to follow-through with the process, both the student and the faculty member should approach the patient (the "source" individual) and inform them of the incident. Explain the PEP procedure to them. If they agree to be tested, both the patient and the student will go to the Wellness Center (call first! x4870). If they do not agree, then the student will go alone. After 4 P.M. on a Friday, they will have to go to Orange Regional *Medical Center's* Emergency Room. Remember to file an incident report within 24 hours of the incident.

US PUBLIC HEALTH SERVICE GUIDELINE

Updated US Public Health Service Guidelines for the Management of Occupational Exposures to Human Immunodeficiency Virus and Recommendations for Postexposure Prophylaxis

David T. Kuhar, MD;[1] David K. Henderson, MD;[2] Kimberly A. Struble, PharmD;[3] Walid Heneine, PhD;[4] Vasavi Thomas, RPh, MPH;[4] Laura W. Cheever, MD, ScM;[5] Ahmed Gomaa, MD, ScD, MSPH;[6] Adelisa L. Panlilio, MD;[1] for the US Public Health Service Working Group

This report updates US Public Health Service recommendations for the management of healthcare personnel (HCP) who experience occupational exposure to blood and/or other body fluids that might contain human immunodeficiency virus (HIV). Although the principles of exposure management remain unchanged, recommended HIV postexposure prophylaxis (PEP) regimens and the duration of HIV follow-up testing for exposed personnel have been updated. This report emphasizes the importance of primary prevention strategies, the prompt reporting and management of occupational exposures, adherence to recommended HIV PEP regimens when indicated for an exposure, expert consultation in management of exposures, follow-up of exposed HCP to improve adherence to PEP, and careful monitoring for adverse events related to treatment, as well as for virologic, immunologic, and serologic signs of infection. To ensure timely postexposure management and administration of HIV PEP, clinicians should consider occupational exposures as urgent medical concerns, and institutions should take steps to ensure that staff are aware of both the importance of and the institutional mechanisms available for reporting and seeking care for such exposures. The following is a summary of recommendations: (1) PEP is recommended when occupational exposures to HIV occur; (2) the HIV status of the exposure source patient should be determined, if possible, to guide need for HIV PEP; (3) PEP medication regimens should be started as soon as possible after occupational exposure to HIV, and they should be continued for a 4-week duration; (4) new recommendation—PEP medication regimens should contain 3 (or more) antiretroviral drugs (listed in Appendix A) for all occupational exposures to HIV; (5) expert consultation is recommended for any occupational exposures to HIV and at a minimum for situations described in Box 1; (6) close follow-up for exposed personnel (Box 2) should be provided that includes counseling, baseline and follow-up HIV testing, and monitoring for drug toxicity; follow-up appointments should begin within 72 hours of an HIV exposure; and (7) new recommendation—if a newer fourth-generation combination HIV p24 antigen–HIV antibody test is utilized for follow-up HIV testing of exposed HCP, HIV testing may be concluded 4 months after exposure (Box 2); if a newer testing platform is not available, follow-up HIV testing is typically concluded 6 months after an HIV exposure.

Infect Control Hosp Epidemiol 2013;34(9):875-892

Preventing exposures to blood and body fluids (ie, primary prevention) is the most important strategy for preventing occupationally acquired human immunodeficiency virus (HIV) infection. Both individual healthcare providers and the institutions that employ them should work to ensure adherence to the principles of Standard Precautions,[1] including ensuring access to and consistent use of appropriate work practices, work practice controls, and personal protective equipment. For instances in which an occupational exposure has occurred, appropriate postexposure management is an important element of workplace safety. This document provides updated recommendations concerning the management of occupational exposures to HIV.

The use of antiretrovirals as postexposure prophylaxis (PEP) for occupational exposures to HIV was first considered in guidelines issued by the Centers for Disease Control and Prevention (CDC) in 1990.[2] In 1996, the first US Public Health Service (PHS) recommendations advocating the use of PEP after occupational exposure to HIV were published; these recommendations have been updated 3 times.[3-6] Since

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 0899-823X/2013/3409-0001. DOI: 10.1086/672271

Box 1: Situations for Which Expert Consultation for Human Immunodeficiency Virus (HIV) Postexposure Prophylaxis (PEP) Is Recommended

Delayed (ie, later than 72 hours) exposure report
- Interval after which benefits from PEP are undefined

Unknown source (eg, needle in sharps disposal container or laundry)
- Use of PEP to be decided on a case-by-case basis
- Consider severity of exposure and epidemiologic likelihood of HIV exposure
- Do not test needles or other sharp instruments for HIV

Known or suspected pregnancy in the exposed person
- Provision of PEP should not be delayed while awaiting expert consultation

Breast-feeding in the exposed person
- Provision of PEP should not be delayed while awaiting expert consultation

Known or suspected resistance of the source virus to antiretroviral agents
- If source person's virus is known or suspected to be resistant to 1 or more of the drugs considered for PEP, selection of drugs to which the source person's virus is unlikely to be resistant is recommended
- Do not delay initiation of PEP while awaiting any results of resistance testing of the source person's virus

Toxicity of the initial PEP regimen
- Symptoms (eg, gastrointestinal symptoms and others) are often manageable without changing PEP regimen by prescribing antimotility or antiemetic agents
- Counseling and support for management of side effects is very important, as symptoms are often exacerbated by anxiety

Serious medical illness in the exposed person
- Significant underlying illness (eg, renal disease) or an exposed provider already taking multiple medications may increase the risk of drug toxicity and drug-drug interactions

Expert consultation can be made with local experts or by calling the National Clinicians' Post-Exposure Prophylaxis Hotline (PEPline) at 888-448-4911.

Box 2: Follow-Up of Healthcare Personnel (HCP) Exposed to Known or Suspected Human Immunodeficiency Virus (HIV)–Positive Sources

Counseling (at the time of exposure and at follow-up appointments). Exposed HCP should be advised to use precautions (eg, use of barrier contraception and avoidance of blood or tissue donations, pregnancy, and, if possible, breast-feeding) to prevent secondary transmission, especially during the first 6–12 weeks after exposure.

For exposures for which postexposure prophylaxis (PEP) is prescribed, HCP should be informed regarding the following:
- Possible drug toxicities (eg, rash and hypersensitivity reactions that could imitate acute HIV seroconversion and the need for monitoring)
- Possible drug interactions
- The need for adherence to PEP regimens

Early reevaluation after exposure. Regardless of whether a healthcare provider is taking PEP, reevaluation of exposed HCP within 72 hours after exposure is strongly recommended, as additional information about the exposure or source person may be available.

Follow-up testing and appointments. Follow-up testing at a minimum should include the following:
- HIV testing at baseline and at 6 weeks, 12 weeks, and 6 months after exposure; alternatively, if the clinician is certain that a fourth-generation combination HIV p24 antigen–HIV antibody test is being utilized, then HIV testing could be performed at baseline, 6 weeks after exposure, and 4 months after exposure
- Complete blood counts and renal and hepatic function tests (at baseline and 2 weeks after exposure; further testing may be indicated if abnormalities are detected)

HIV testing results should preferably be given to the exposed healthcare provider at face-to-face appointments.

Oral Health

Infection Prevention & Control in Dental Settings

Current COVID-19 Interim Guidance

Find the most up-to-date information about infection prevention and control practices on CDC's COVID-19 page, including CDC's Infection Control Guidance for Healthcare Professionals about Coronavirus (COVID-19), which is applicable to all U.S. settings where healthcare is delivered, including dental settings. For more information, see CDC Updates COVID-19 Infection Prevention and Control Guidance.

CDC develops evidence-based recommendations to guide infection prevention and control practices in all settings in which dental treatment is provided.

This site includes guidelines and recommendations, frequently asked questions, resources to support the evaluation of and adherence to guidelines, and a glossary of terms.

COVID-19 Status Update

CDC Updates COVID-19 Infection Prevention and Control Guidance

Frequently Asked Questions (FAQS)

Frequently asked questions on important infection prevention topics.

Reprocessing Dental Handpieces

CDC Statement to update current guidelines.

Selected References

References and resources in infection prevention and control by topic area.

Summary of Infection Prevention Practices in Dental Settings

Published guidelines and summaries of recommendations.

CDC DentalCheck Mobile Application

Checklist to assess facility practices and ensure they meet the minimum expectations for safe care.

CDC Training Courses for Infection Prevention and Control in Dental Settings

Training materials and other resources to increase the knowledge, skills, and ability of dental health care personnel.

Screening and Evaluating Safer Dental Devices

Information and sample forms to assist dental health care personnel in screening and evaluating devices for clinical acceptability.

Glossary

Definitions of terms used in infection control.

Page last reviewed: September 13, 2021

Appendix II

"How to Handwash" Poster

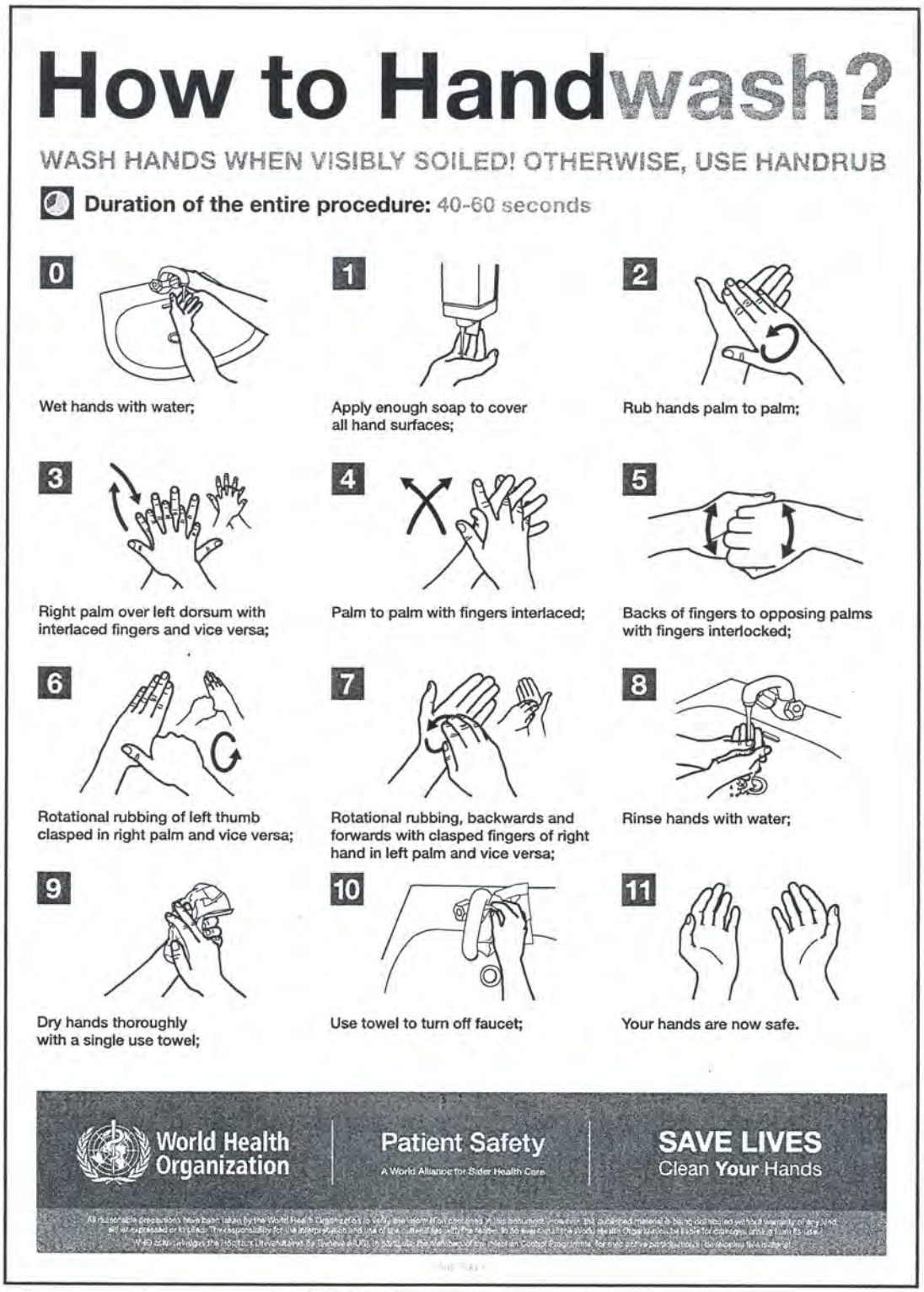

Image source: World Health Organization (WHO)

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ORANGE COUNTY COMMUNITY COLLEGE
Department of Dental Hygiene

Clinical Guidelines – Sustainability

Our goal is to maintain a cost-effective, earth-friendly approach to infection control and to limit refuse, if at all possible.

- If it can be sprayed with disinfectant, it no longer needs to be wrapped in plastic.
- Full day clinics: Allow cassettes to be "air" dried on the dish drainer between AM and PM clinics. SA assigned to the afternoon will put them in pouches.
- If there is time at the end of the day to air dry, please do; but if you must use isopropyl alcohol to dry cassettes before bagging, use as little as possible. (Do not use lots of C-fold towels to dry cassettes, it is defeating the purpose. It is possible to dry multiple cassettes with 2 C-fold towels.)
- Only dispense materials you know you will use. Do not contaminate wax bag set ups. Remove mask, gauze, bib etc. before discarding contaminated gauze etc.
- Operator/Clinician Stools: Students should adjust the seat backs prior to clinic so that it is not necessary to barrier that lever. Barrier the up/down lever only.
- Light On/Off Switch: Be careful to only barrier the switch not the surrounding light area. Do not pull off the spare bulb holder compartment between the back of the light and the switch.
- Plastic garmer clamps cotton roll holders (purple) may be bagged (small pouches) and placed on the middle shelf of the autoclave.
- Clinicians should prepare 1 water bottle for the unit. SA may prepare second bottle if needed.

"Every year we make enough plastic film to shrink-wrap the State of Texas"

Orange County Community College
Dental Hygiene Department

On-Campus Protocol for COVID 19- Pandemic

The students, faculty, and staff of the Department of Dental Hygiene will follow the college-wide protocols for on-campus instruction but will also be accountable for the departmental protocols that are part of the curriculum and clinical infection control policy outlined in the Clinic Manual. The infection control protocol is an action plan that guides the clinical decision making of all students and faculty as a standard of care for the clinical setting. A COVID-19 addendum to the Infection Control protocol will be in effect with regular updates as more is discovered and topical research published.

COVID-19 Pandemic Addendum to the Infection Control Protocol
Classrooms - follow college wide plan
Clinics and labs - Follow infection control protocol or lab instructions to mitigate transmission of the coronavirus.

General directions

- Wash hands when you come into the clinic and leave the clinic (before and after eating, using the restroom, and if you need to touch your face, if you have no access to antiseptic hand rub)
- Wear a mask and face covering at all times.
- Recognize new symptoms; take temperature at home. Answer the CampusClear app and the program QR2 survey each day before entering the college.
- Maintain 6 ft. separation from each other as best you can. BE AWARE in all situations -Social Distancing at all times, not limited to our clinic area, inside or outside!
- Recognize when there are too many people for the location and wait patiently to enter, including the locker room. Recognize that there are people waiting to also access the space and efficiently take care of your business. Do not dawdle.
- AVOID sharing your typodont, pens, utensils, etc. All individuals should carry a pen for sign in activities and avoid sharing a pen
- Use hand sanitizer often when hand washing is not possible after sneezing, coughing, or touching your eyes or any mucous membrane.
- Use a barrier if appropriate when turning or opening doors, etc.

Screenings/Attendance Students, Faculty, and Staff

- All students and employees of the college will participate in daily health surveys, use the CampusClear app, and obtain clearance to come to campus.
- The department QR code survey will also be used whenever a student has a lab, class meeting or clinic on campus since this process may be used for attendance.
- If there is a problem with any software, we will take attendance manually and screen students as recommended procedures by the industry.

Clinical and Laboratory Protocol during the Pandemic

- Clinical instruction and instrumentation skills will only be done on manikins until the facility has been renovated for aerosol mitigation, adequate PPE can be obtained, and all are trained in new standards.
- No aerosol generating procedures (AGP) will be performed in any lab or clinic at this time. Any AGP performed in the clinic will require and assistant using High Volume Evacuation (HVE)
- AGP can only be performed on manikins at this time.

- Initial Preprocedural rinses will be antimicrobial before oral examination and a rinse specific to the coronavirus before use of any AGP (rinses with alcohol such as Essential oils (Listerine) and Chlorhexidine Gluconate (Peridex) will be used unless it is contraindicated based on the patient Medical History.
- Disinfect all counters, units, stools, x-ray equipment, computers (mice) at the end of all labs and clinics using spray, wipe, spray 10-minute disinfectant on all surfaces that did not have a barrier placed. Disinfectant wipes should only be used on those items that should be wiped down but not drenched (example near the dental unit light, to clean an area that had a barrier if visibly soiled.
- Follow the Respiratory Health Plan.
- Proper PPE will be required for any human patient interaction and will be determined by procedures.
- Level 3 ASTM Face masks with a Face shield and goggles or eyewear, a fluid impervious gown and clinic shoes will be standard. Head and feet coverings will be required for AGP such as using ultrasonic scalers or hand piece polishing.
- Ideally, students should not take the clinic shoes home and should keep them in the locker, use hand sanitizer after putting on your shoes or taking them off if you need to touch the shoes.

DNT Office/Waiting Room Disinfection Schedule

Every day a DNT will disinfect the office and waiting room to include door knobs, phones, and computers (no directly sprayed), before lunch and at the end of the day.