

## **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 or 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.) Videotapes
    - 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 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 Health Service (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 by Health Services.
  - 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.

**NOTE: 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 O<sub>2</sub> 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.

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.

##### 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. Nitrile gloves have an increased resistance to instrument punctures. Wash with soap and spray disinfectant after use 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. Each clinician will replenish unit water bottle as needed (use distilled water and tablet).
2. On the bracket table, turn the “master switch” on (towards 1).
3. Adjust clinician chair to correct height.
4. 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.

5. Put on nitrile examination gloves.
6. 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.)
7. Using a wet (water) towel, wipe the disinfecting solution from the sprayed areas.
8. 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.)

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

sponge wipe or sterile gauze with ortho band  
bracket table cover  
bib  
saliva ejector  
cotton-tip applicator  
tongue blade (for Vaseline, or topical anesthetic)  
sterile gauze  
sterile instruments  
handpiece  
patient drinking cup  
barriers:  
    chair  
    air/water syringe  
    saliva ejector  
    handpiece  
    ultra-sonic scaler  
    curing wand  
    pen (black)  
    red/blue pencil  
    light handles  
    hosing  
    front edge of bracket table  
    clip board and clips

10. Place barriers over (applicable) equipment.
11. Place plastic or aluminum foil barriers over items which may become contaminated but do not have a specific barrier:

For example:   .bracket table handle  
                  .clipboard

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

12. Tape waxed bag to bracket table. Used gauze, floss, cotton-tip applicators should go into this bag, not onto the bracket table.
13. Set up all non-sterile items to be used during patient treatment.

A. Place on countertop (by sink)

Patient chart (most recent radiographs go onto viewbox).  
Evaluation form (with carbon).  
Past evaluation forms on same patient.  
Unwrapped black pen.  
Mask  
Gloves  
Chairside Instructor.  
Glasses, clinician and patient.  
Box of tissues.

B. Place on small table: Forms to be used, possibly

oral exam  
perio assessment  
dental charting  
Plastic “forms barrier”  
wrapped pen  
wrapped red/blue pencil

C. Prepare a barriered small tray with the items needed for OHI:

typodont  
toothbrush (in the box)  
tape/floss  
dappen dish  
disclosing solution  
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.**

15. **Put on exam gloves.**

16. Attach saliva ejector tips, air/water syringe tip, sterilized handpieces. Place empty sterilizer bag over handpiece.

17. Place sterile items on bracket tray. A length of neatly coiled floss/tape may go on also. Cover the items on the bracket table with the patient bib. Place napkin chain atop.

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

18. 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 non-barriered pen and clipboard.

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

3. Wash hands and wrists (as per these guidelines), and glove. Short scrub or alcohol rub if hand washing was done before set-up. 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. Use the barriered pen or pencil. Do not touch the form with contaminated gloves. Use plastic cover sheet as a barrier while documenting form. 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 tray on 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 mouth mirror with barriered base on bracket table. Remove toothbrush from the container and place it on the bracket table.

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.

Make sure it works prior to OE check.

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 of 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.

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 clinic drawer
- Give patient toothbrush and baggie at last appointment.

12. Disposable items

Disposable items should be discarded immediately after use.

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. 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 before starting the clean up.
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.
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. Rinse, dry, put away.
8. Remove waxed bag from bracket table (make sure there are no tongue blades or other objects which could puncture a bag - cotton tip applicators must be broken into 2 pieces). Discard into chair cover. Place any blood soaked gauze or blue sponges in separate waxed bag and place in biohazard bag kept in the dispensary.

Remove all barriers and disposables from unit and discard into 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 disinfectant. Let sit for 10 minutes. Rinse. Do not discard.
- b. Clean bowl (under rim also). Spray with disinfectant, wipe the surface, re-spray with disinfectant. Let stand 10 minutes.
- c. Re-assemble cuspidor.

10. **Note:** Evacuation system cleaner is run through the saliva ejector every week. See section titled “Sterilizing Assistant”.
11. High speed evacuation: Suck through at least 4 cups of water.  
**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”, (typodont, OHI mirror, floss dispensers) and any other possibly contaminated items with the recommended disinfectant if it was not covered by a barrier. A “spray, wipe, spray, wipe” technique is to be used:

- a. Spray the solution onto the surface to be cleaned.
- b. Wipe clean with a paper towel.
- c. Re-spray the solution onto the surface and allow it to remain for 10 minutes.
- d. Wipe with a damp (water) towel.
- e. Disinfectant wipes may also be used.

**Note:** Any area covered by a barrier should be 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. Spray and wipe.)
14. Remove utility gloves. (Spray outside of gloves with disinfecting solution. Let sit for 10 minutes, rinse, dry, put away.) Perform hand wash with soap before leaving the clinic.

#### 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.

All reusable items that cannot be heat-sterilized are 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. Place instrument cassettes into ultra-sonic cleaner. Put lid in place. Vibrate for 10 minutes. Carefully check instruments for any remaining debris or blood. Re-vibrate if necessary. Rinse with water. Gently shake cassette and place in draining rack to 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. Bag and label as in b. above.
- d. Handpiece: **DO NOT** put any part of the handpiece into the Ultrasonic.

**Motor**

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).
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**

1. Remove all debris.
2. Disassemble angle; unscrew knurled ring and separate into three (3) parts. Put 1 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 Prophylaxis Angles are for single use. Prophylaxis cups and brushes are for single use only. Dispose of after use.**

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 most 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)



## 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 CD.

### 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.

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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

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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.

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