

DENTAL HYGIENE PROGRAM CLINIC INFECTION CONTROL PROTOCOL

Grounded in OSAP, CDC, OSHA, and ADA Guidelines

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Section 1: Purpose and Scope

This Infection Control Protocol establishes mandatory standards for the prevention and control of infectious disease transmission within the Dental Hygiene Program clinic. These standards apply to all individuals who enter the clinical environment, including enrolled students, faculty supervisors, staff, patients, and clinical observers.

This protocol is grounded in the most current evidence-based guidelines from the Organization for Safety, Asepsis and Prevention (OSAP), the Centers for Disease Control and Prevention (CDC), the Occupational Safety and Health Administration (OSHA), and the American Dental Association (ADA). Compliance with this document is mandatory and is enforced as a condition of continued clinical participation.

The Program Chair or designee is responsible for annual review and revision of this document and for ensuring faculty, staff, and students receive appropriate training prior to clinical participation.

Section 2: Regulatory Authority and Source Documents

This protocol is derived from and must remain consistent with the following primary sources:

- **CDC Guidelines for Infection Control in Dental Health-Care Settings (2003, updated guidance 2016)**
 - Kohn WG, Collins AS, Cleveland JL, et al. Guidelines for Infection Control in Dental Health-Care Settings — 2003. MMWR Recomm Rep. 2003;52(RR-17):1-61.
- **OSAP: From Policy to Practice — OSAP’s Infection Prevention and Exposure Control Manual for the Dental Team (current edition)**
- **OSHA Bloodborne Pathogens Standard — 29 CFR 1910.1030**
- **OSHA Hazard Communication Standard — 29 CFR 1910.1200**
- **ADA Infection Control in Dentistry Guidelines**
- **CODA Accreditation Standards for Dental Hygiene Education Programs (Section 2-17, 2-18)**
- **EPA-registered disinfectant labeling requirements for dental surface disinfectants**
- **ANSI/AAMI ST79 — Comprehensive Guide to Steam Sterilization and Sterility Assurance in Healthcare Facilities**
- **State Dental Board Infection Control Regulations (applicable jurisdiction)**

Section 3: Definitions

Term	Definition
Standard Precautions	A set of infection prevention practices applied to all patients regardless of suspected or confirmed diagnosis, including hand hygiene, PPE, safe injection practices, respiratory hygiene, and environmental controls (CDC, 2016).

Critical Instruments	Instruments that penetrate soft tissue or bone (e.g., scalers, curettes, extraction forceps). Must be heat sterilized between each use (Spaulding Classification).
Semi-Critical Instruments	Instruments that contact mucous membranes but do not penetrate tissue (e.g., mouth mirrors, condensers, impression trays). Must receive at minimum high-level disinfection; heat sterilization is preferred.
Non-Critical Surfaces/Items	Items that contact only intact skin. Require low- to intermediate-level disinfection (e.g., blood pressure cuffs, light handles).
Regulated Medical Waste (RMW)	Waste that poses a risk of infection, including blood-soaked materials, sharps, and extracted teeth. Must be handled and disposed of per OSHA and state regulations.
Biofilm	A structured community of microorganisms that adhere to surfaces within dental unit waterlines, reducing water quality and posing an infection risk.
Sterilization	A process that destroys all forms of microbial life, including bacterial spores (e.g., autoclaving at 134°C for 3 minutes or 121°C for 15 minutes).
High-Level Disinfection (HLD)	Elimination of all microorganisms except high levels of bacterial spores. Achieved with EPA-approved chemical sterilants.
Intermediate-Level Disinfection	Inactivation of vegetative bacteria, most fungi, Mycobacterium tuberculosis, and most viruses. Does not kill bacterial spores.
PPE	Personal Protective Equipment. Includes gloves, masks, protective eyewear, and protective clothing required in the dental clinical setting.

Section 4: Standard Precautions

Standard Precautions are the foundation of infection control in all dental healthcare settings. They assume that blood, all body fluids, secretions, excretions (except sweat), non-intact skin, and mucous membranes may contain transmissible infectious agents (CDC, 2016).

All students, faculty, and staff must adhere to Standard Precautions for every patient encounter, without exception, regardless of patient-reported medical history or diagnosis.

Core Elements of Standard Precautions in the Dental Clinic:

- Hand hygiene before and after every patient contact and after glove removal
- Appropriate use of personal protective equipment (PPE) for all clinical procedures
- Safe injection practices — never recap needles with two hands; use a one-handed scoop technique or a mechanical recapping device
- Respiratory hygiene and cough etiquette — for both patients and providers
- Patient placement — isolate patients with known communicable illness when clinically appropriate
- Proper handling and disposal of sharps and regulated medical waste
- Safe handling of patient care equipment — clean and disinfect or sterilize as appropriate
- Environmental control — routine cleaning and disinfection of clinical surfaces
- Textiles and laundry — handle contaminated linens minimally and with appropriate PPE

Section 5: Hand Hygiene

Hand hygiene is the single most important measure to prevent the spread of infection in dental healthcare settings (CDC, 2016; WHO, 2009). All clinical personnel must perform hand hygiene as outlined below.

5.1 Indications for Hand Hygiene

- Before and after each patient contact
- Before donning and immediately after removing gloves
- After contact with blood, body fluids, secretions, or excretions
- After contact with contaminated instruments, surfaces, or equipment
- Before handling sterile instruments or medications
- Before eating, drinking, or handling contact lenses
- After using the restroom

5.2 Technique

Routine Hand Wash (non-surgical)

- Use soap (antimicrobial or plain) and water
- Wet hands, apply soap, lather for at least 15 seconds covering all surfaces
- Rinse thoroughly under running water; dry with a single-use paper towel
- Use the paper towel to turn off the faucet to avoid recontamination

Surgical Hand Antisepsis

- Perform before all surgical procedures using an antimicrobial surgical hand scrub OR an approved alcohol-based hand rub with persistent activity
- Follow manufacturer's instructions for duration and technique
- Remove all jewelry including rings, bracelets, and watches prior to scrubbing

Alcohol-Based Hand Rub (ABHR)

- Use when hands are not visibly soiled
- Apply to all surfaces of the hands and rub until completely dry (approximately 20–30 seconds)
- ABHR is not appropriate if hands are visibly soiled with blood or other organic material — use soap and water

5.3 Hand Hygiene Products

- Antimicrobial soap (e.g., chlorhexidine gluconate or triclosan-based) is required at all clinical sinks
- ABHR with at least 60% alcohol concentration must be available at point of care
- Lotions that are compatible with gloves are permitted to prevent skin breakdown; petroleum-based products are prohibited as they degrade latex gloves

5.4 Artificial Nails and Jewelry

Per CDC guidelines, artificial nails, nail enhancements, and rings or bracelets are NOT permitted in the clinical environment. Natural nails must be kept short (no longer than 1/4 inch past the fingertip) and free of chipped nail polish. These restrictions apply to all students, faculty, and staff during clinical activities.

Section 6: Personal Protective Equipment (PPE)

PPE creates a physical barrier between the clinician and potentially infectious materials. Selection of appropriate PPE is determined by the nature of the procedure and anticipated exposure risk (OSHA 29 CFR 1910.1030; CDC, 2016).

6.1 Gloves

- Medical-grade examination gloves (latex or non-latex nitrile) are required for all patient care
- Sterile surgeon's gloves are required for invasive surgical procedures
- Utility gloves (heavy rubber/nitrile) must be worn for instrument processing, surface disinfection, and handling of regulated medical waste
- Gloves must be changed between patients; donning a new pair over a soiled pair is prohibited
- Double gloving is required when treating patients known to be HBV, HCV, or HIV positive, or per faculty instruction
- Gloves with visible holes, tears, or compromise must be immediately changed
- Hands must be washed before donning and after removing gloves

6.2 Masks

- A surgical/procedure mask (ASTM Level 2 or Level 3) is required for all aerosol-generating procedures
- ASTM Level 3 masks provide the highest fluid resistance and are required for procedures generating significant blood spray or spatter
- N95 respirators are required when treating patients with known or suspected airborne diseases (e.g., active pulmonary tuberculosis), per OSHA and CDC respiratory protection standards
- Masks must be worn throughout the patient encounter and changed when wet or visibly soiled, and between patients
- Masks must not be worn around the neck or stored in a pocket for reuse between patients

6.3 Protective Eyewear

- Side-shield protective glasses or goggles are required for all aerosol-generating procedures and potential spatter exposure
- Face shields may be used as an adjunct to a mask but do not replace protective eyewear alone
- Prescription glasses without side shields do not satisfy this requirement
- Eyewear must be cleaned and disinfected between patient uses
- Patient protective eyewear must also be provided for every appointment

6.4 Protective Clothing

- A clean clinic gown or jacket with long sleeves must be worn during all patient care activities
- Clinic attire must not be worn outside of the clinical environment and must be changed if visibly soiled with blood or body fluids
- Contaminated clinic apparel should be laundered in the facility's approved manner or in a separate load with hot water and detergent
- Closed-toe shoes covering the entire foot are required in all clinical areas

Section 7: Respiratory Hygiene and Cough Etiquette

All persons in the clinical environment — including patients, students, faculty, staff, and visitors — must observe respiratory hygiene and cough etiquette to minimize the risk of transmission of respiratory pathogens (CDC, 2016).

- Cover mouth and nose with a tissue or elbow when coughing or sneezing
- Dispose of tissues promptly in a designated waste receptacle
- Perform hand hygiene immediately after respiratory contact
- Surgical masks should be offered to patients presenting with signs of respiratory illness
- Symptomatic patients presenting with active respiratory illness should be rescheduled unless treatment is urgently necessary; faculty must be notified for a risk-benefit determination
- Students and faculty exhibiting signs of active respiratory illness must inform the Program Chair and may be required to refrain from patient contact

Section 8: Sharps Safety and Injury Prevention

Needlestick and sharps injuries represent the most significant occupational exposure risk in dental healthcare settings. OSHA requires implementation of engineering controls, work practice controls, and administrative controls to minimize sharps injuries (29 CFR 1910.1030).

8.1 Engineering Controls

- Safety-engineered syringes and needles with passive or active safety features are required for all injections
- Sharps disposal containers (puncture-resistant, leak-proof, labeled) must be located at or near the point of use
- Containers must be replaced when three-quarters full — never overfilled

8.2 Work Practice Controls

- Two-handed recapping of used needles is PROHIBITED
- The one-handed scoop technique or a mechanical needle recapping device must be used when recapping is necessary
- Needles must not be bent, broken, or removed from syringes by hand
- Scalpel blades must be removed using a hemostat or mechanical blade remover — never by hand
- Sharps must be passed between clinician and assistant using an instrument exchange tray or container — never hand-to-hand
- All sharps must be immediately disposed of in an approved sharps container after use

8.3 Post-Exposure Protocol (See Section 14)

Any sharps injury or mucous membrane exposure to blood or body fluids must be treated as a medical emergency. Refer immediately to Section 14 of this document for the complete Exposure Incident Protocol.

Section 9: Instrument Processing — Sterilization and Disinfection

All reusable instruments must undergo appropriate reprocessing based on their Spaulding Classification prior to use on another patient. The Spaulding Classification system is the accepted framework for determining appropriate instrument processing levels (CDC, 2016).

9.1 Spaulding Classification Summary

Category	Examples	Required Processing
Critical	Scalers, curettes, explorer, forceps, needles, burs	Heat sterilization (autoclave, dry heat) — mandatory
Semi-Critical	Mouth mirror, condenser, impression tray, high-volume evacuator tip	Heat sterilization preferred; high-level disinfection if heat-sensitive
Non-Critical	Blood pressure cuff, pulse oximeter, light handle (with barrier)	Low- to intermediate-level disinfection

9.2 Instrument Processing Steps

Instrument processing must follow a strict linear workflow to prevent cross-contamination between dirty and clean/sterile areas. All instrument processing areas must be clearly designated and physically or functionally separated.

Step 1 — Transport

- Contaminated instruments must be transported from the operatory to the processing area in a closed, rigid, leak-proof container
- Never carry loose contaminated instruments by hand

Step 2 — Sorting and Pre-Cleaning

- Utility gloves, mask, protective eyewear, and clinic jacket must be worn during all instrument processing
- Sort instruments to separate sharps from non-sharps to reduce injury risk
- Instruments should be pre-soaked in an enzymatic solution or immediately processed to prevent drying of organic material

Step 3 — Cleaning

- Mechanical cleaning is preferred: ultrasonic cleaner or instrument washer/disinfector
- Hand scrubbing of contaminated instruments is discouraged due to injury risk; if required, use a long-handled brush and puncture-resistant utility gloves
- Ultrasonic cleaning solution must be changed daily and the unit cleaned per manufacturer instructions
- Rinse instruments thoroughly after cleaning to remove enzymatic and cleaning residue

Step 4 — Drying and Inspection

- Instruments must be thoroughly dried before packaging or placement in sterilizer to prevent instrument damage and ensure sterilization efficacy
- Inspect instruments for cleanliness, corrosion, and functionality; discard or repair damaged instruments

Step 5 — Packaging

- Package instruments in pouches or wraps compatible with the sterilization method
- Label each pouch with: date of sterilization, sterilizer number, cycle number, and lot/load number
- Do not overpack pouches; instruments should be positioned to allow steam or sterilant contact on all surfaces
- Include a Class 5 chemical integrator or internal chemical indicator in each pouch

Step 6 — Sterilization

- Steam autoclave (gravity or pre-vacuum) is the preferred method for heat-tolerant critical and semi-critical instruments
- Follow manufacturer's instructions and ANSI/AAMI ST79 guidelines for cycle times, temperatures, and load configurations
- Common steam sterilization parameters: 132–134°C for 3–4 minutes (pre-vacuum/dynamic air removal) or 121°C for 15–30 minutes (gravity displacement)
- Dry heat or chemical vapor sterilization may be used per manufacturer instructions and instrument compatibility

Step 7 — Monitoring

- Mechanical monitoring: review temperature, pressure, and time gauges for every cycle and document
- Chemical monitoring: use external chemical indicators on every pouch; use internal Class 5 integrators in each pouch or package
- Biological monitoring (spore testing): perform at least weekly using *Geobacillus stearothermophilus* spore strips for steam sterilizers; document all results
- If a biological indicator (BI) test fails: remove sterilizer from service immediately, notify the Program Chair, quarantine all items processed since the last negative BI, re-sterilize quarantined items after the sterilizer is repaired and a negative BI is confirmed

Step 8 — Storage

- Store sterile packages in a clean, dry, enclosed area away from moisture, traffic, and contamination sources
- Event-related sterility: packaged instruments remain sterile indefinitely if the package is intact and dry; damaged or compromised packaging requires re-processing
- Maintain a first-in, first-out (FIFO) system for instrument inventory

Section 10: Surface Disinfection and Environmental Controls

Clinical contact surfaces must be managed with either protective barriers or surface disinfection to prevent cross-contamination between patients (CDC, 2016; OSAP).

10.1 Barrier Protection

- Plastic barriers (wrap, tubing covers, headrest covers) may be used to protect clinical contact surfaces and must be removed and replaced between each patient while still gloved
- Barriers are particularly recommended for: light handles, chair controls, air/water syringe handles, HVE handles, radiograph equipment controls, computer keyboards/mouse in operatories

10.2 Surface Disinfection

- If barriers are not used, surfaces must be cleaned and disinfected between every patient
- Use an EPA-registered hospital-grade intermediate-level disinfectant that is tuberculocidal and active against non-lipid viruses
- The spray-wipe-spray (or wipe-discard-wipe) two-step method must be used:
 - First application: clean the surface — remove gross contamination
 - Second application: disinfect — allow the product to remain wet for the manufacturer's specified contact time (typically 1–3 minutes)
- Allow surfaces to air dry completely before placing new barriers or seating next patient

10.3 Disinfectant Product Requirements

- Must be EPA-registered for use as a hospital disinfectant
- Must carry tuberculocidal claim
- Must be labeled effective against HBV and HIV (or equivalent surrogate viruses)
- Products must be used per manufacturer dilution and contact time instructions
- Disinfectant wipes must remain wet on the surface for the required contact time — a single wipe pass does not constitute adequate disinfection

10.4 Housekeeping Surfaces

- Floors, walls, and non-contact surfaces require less rigorous disinfection than clinical contact surfaces
- Clean with detergent and water or an EPA-registered disinfectant per routine schedule
- Spills of blood or body fluids must be cleaned immediately using appropriate PPE, a disinfectant solution, and single-use absorbent material
- Blood spill cleanup materials must be disposed of as regulated medical waste

Section 11: Dental Unit Waterlines (DUWL)

Dental unit waterline biofilm poses a recognized infection control risk. The CDC and OSAP recommend that all water used in routine, non-surgical dental treatment should meet drinking water standards — no more than 500 colony-forming units (CFU) per milliliter of heterotrophic bacteria (CDC, 2016).

11.1 Daily Protocols

- Flush all waterlines (handpiece, air/water syringe, ultrasonic scaler) for a minimum of 20–30 seconds at the beginning of the day before patient care begins
- Flush handpieces and air/water syringes for 20–30 seconds between patients
- Run handpiece at the end of the day to discharge retained water

11.2 Waterline Treatment

- A chemical treatment system or self-contained water system with EPA-registered chemical tablets/solutions must be used per the manufacturer's recommended protocol and concentration
- Maintain documentation of waterline treatment products used, concentrations, and application schedule

11.3 Waterline Testing

- Water quality testing must be performed at minimum quarterly using an OSAP-recommended commercial testing kit or by sending samples to an accredited laboratory
- Testing results must be documented and reviewed by the Program Chair
- If results exceed 500 CFU/mL, the affected unit must be removed from patient use, the waterlines shocked per manufacturer instructions, retested, and not returned to service until compliant results are confirmed
- Surgical procedures requiring irrigation require sterile water or sterile saline — never standard dental unit water

Section 12: Aerosol and Splash Management

Dental procedures routinely generate aerosols and spatter containing blood, saliva, and microorganisms. The CDC, OSAP, and ADEA recognize aerosol management as a core competency for dental hygiene clinicians (CDC Safe Care Modules; ADEA Competencies for Entry into the Dental Hygiene Profession).

12.1 Engineering Controls

- High-Volume Evacuator (HVE): Use HVE during all aerosol-generating procedures (ultrasonic/sonic scaling, air polishing, air/water syringe use). The HVE must be positioned within 6–15 mm of the oral site of instrumentation
- Saliva ejectors may be used as a low-volume supplement but do not replace the HVE requirement
- Rubber dam isolation must be used when appropriate for restorative procedures; its use for other procedures should be considered when clinically indicated
- Extraoral vacuum systems (HEPA-filtered air purifiers with appropriate air exchange rates) in the operatory are strongly recommended as adjunctive engineering controls

12.2 Pre-Procedural Antimicrobial Mouth Rinse

- Patients should be provided a pre-procedural antimicrobial rinse prior to all aerosol-generating procedures to reduce the microbial load of oral aerosols
- Accepted agents include: 0.12% chlorhexidine gluconate, essential oil mouthrinse, or cetylpyridinium chloride (CPC)-based rinse
- Rinse for 30–60 seconds and expectorate prior to beginning treatment

12.3 Operatory Turnover After Aerosol-Generating Procedures

- Allow adequate settling time (minimum 15 minutes where possible) before beginning environmental decontamination after heavy aerosol-generating procedures
- Perform full surface disinfection per Section 10 protocol
- Change all barriers and all PPE prior to seating the next patient

Section 13: Waste Management and Regulated Medical Waste

All waste generated in the dental clinic must be managed in compliance with OSHA regulations (29 CFR 1910.1030), EPA guidelines, and applicable state regulations. The Program Chair is responsible for ensuring compliance and for designating a waste management coordinator.

13.1 Categories of Waste

Waste Type	Examples	Disposal Method
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Sharps (RMW)	Needles, scalpel blades, burs, endodontic files, broken instruments	Puncture-resistant sharps container; licensed medical waste hauler
Contaminated Solid Waste (RMW)	Blood-soaked gauze, gloves, masks with visible blood	Biohazard bags; medical waste disposal
Non-Regulated Solid Waste	Lightly soiled paper towels, packaging materials	Regular trash
Extracted Teeth (Non-Amalgam)	Natural teeth without amalgam restorations	Sharps container or biohazard bag; medical waste disposal
Extracted Teeth (With Amalgam)	Teeth containing amalgam restorations	Separate container; must be sent to amalgam recycler — do NOT autoclave
Amalgam Waste	Scrap amalgam, chair-side traps, separator waste	ISO 11143-compliant amalgam separator; licensed recycler
Lead Foil (Film Packets)	Radiograph film lead backing	Lead recycler — do NOT place in regular trash
Fixer Solution	Radiographic fixer (contains silver)	Silver reclamation or licensed hazardous waste disposal
Disinfectant Solutions	Expired or spent surface disinfectants	Per SDS/manufacturer instructions; contact facilities management

13.2 Biohazard Labeling

- All containers for regulated medical waste must display the universal biohazard symbol and the word BIOHAZARD
- Biohazard bags must be red or orange-red and impervious to leakage
- Sharps containers must be labeled, closeable, puncture-resistant, leak-proof on sides and bottom, and red or labeled with the biohazard symbol

13.3 Amalgam Waste Management

Per EPA Dental Effluent Guidelines (40 CFR Part 441, effective 2020), all dental facilities that place or remove amalgam must use ISO 11143-compliant amalgam separators and follow best management practices for amalgam waste. This includes:

- No amalgam scrap, teeth containing amalgam, or amalgam-contaminated materials may be placed in regular trash or flushed into the sanitary sewer
- Chair-side traps must be cleaned and the collected material sent to an amalgam recycler
- Amalgam separator maintenance and waste disposal must be documented

Section 14: Exposure Incident Protocol

An exposure incident is defined as any specific eye, mouth, other mucous membrane, non-intact skin, or parenteral contact with blood or other potentially infectious materials (OPIMs) that results from the performance of an employee's or student's duties (OSHA 29 CFR 1910.1030).

All exposure incidents must be treated urgently. The following protocol must be followed immediately and without delay.

Step 1 — Immediate First Aid (Within Seconds)

- Needlestick or cut: Immediately remove gloves and wash the wound thoroughly with soap and running water for a minimum of 15 minutes. Do NOT squeeze or press the wound to induce bleeding — gently allow water to flush the area
- Mucous membrane splash (eye, nose, mouth): Immediately irrigate the affected area with water or sterile saline for a minimum of 15 minutes. Use the nearest eyewash station if available
- Skin exposure: Wash the affected area with soap and water

Step 2 — Immediate Notification (Within Minutes)

- Notify the supervising faculty member immediately
- Faculty must notify the Program Chair or designee immediately
- Do NOT continue patient care until evaluated by a supervisor

Step 3 — Documentation

- Complete the institution's Exposure Incident Report form
- Document: date and time of exposure, route of exposure, circumstances, source patient identity (if known and with consent), type and volume of material, PPE in use at the time
- The report must be filed with the institution's Human Resources/Student Health Office per college policy

Step 4 — Medical Evaluation

- The exposed individual must be referred immediately to the designated healthcare provider or emergency department for post-exposure evaluation
- Medical evaluation must include: testing of source patient (with consent) for HIV, HBV, and HCV; evaluation for post-exposure prophylaxis (PEP) for HIV (must be initiated within 72 hours for maximum efficacy); baseline blood draw from the exposed individual with consent
- The exposed individual has the right to decline testing, but this must be documented

Step 5 — Confidentiality

- All exposure incident information is strictly confidential and protected under OSHA regulations and HIPAA

- The Program Chair may be informed on a need-to-know basis for corrective action and safety program improvement
- No identifying information about the source patient or exposed individual may be disclosed to unauthorized parties

Step 6 — Follow-Up

- Follow-up testing and medical evaluation must be conducted per the evaluating healthcare provider's recommendations
- The Program Chair must conduct a root-cause review of the incident to identify corrective actions and prevent recurrence
- OSHA 300 log entry may be required per institutional reporting obligations

Section 15: Student and Faculty Health Requirements

Maintaining clinician health and immunization status is a fundamental component of infection control in dental education. Requirements are grounded in CDC immunization recommendations for healthcare personnel and CODA accreditation standards.

15.1 Required Immunizations (Prior to Clinical Participation)

Vaccine	Requirement	Documentation
Hepatitis B (HBV)	3-dose series with post-vaccination titer showing immunity (anti-HBs ≥ 10 mIU/mL). Non-responders must be evaluated by a physician and may require additional doses or exemption documentation.	Titer result required
MMR (Measles, Mumps, Rubella)	2-dose series or serological evidence of immunity	Records or titer
Varicella (Chickenpox)	2-dose series or serological immunity or documented prior disease	Records or titer
Tdap (Tetanus, Diphtheria, Pertussis)	One dose Tdap; Td booster every 10 years	Immunization record
Annual Influenza	Required annually prior to each fall clinical semester	Immunization record
COVID-19	Per current institutional and public health guidance	Per college policy
Tuberculosis (TB) Screening	Annual TB skin test (TST/PPD) or IGRA blood test required; positive reactors must submit chest X-ray clearance	Annual documentation

15.2 Illness and Clinical Exclusion Policy

- Students or faculty with active respiratory illness (fever, productive cough, suspected influenza), conjunctivitis, open skin lesions, or other potentially transmissible conditions must not participate in direct patient care
- Notification to the Program Chair is required prior to any clinical absence due to illness

- Return to clinical activities following illness requires medical clearance when applicable
- Students on antibiotics for a confirmed contagious condition must remain excluded from clinic until non-contagious, per healthcare provider guidance

Section 16: Patient Screening and Medical History Review

Thorough patient screening is an essential component of infection control in the dental clinic. Although Standard Precautions must be applied universally regardless of patient history, the medical history informs clinical decision-making regarding patient management and treatment modifications.

16.1 Medical History Protocol

- A complete, updated medical history must be obtained and reviewed at each appointment
- The student clinician and supervising faculty must review the medical history together prior to beginning patient care
- Any change in health status since the previous appointment must be documented in the patient record
- The patient must verbally confirm review and sign the medical history form at each appointment

16.2 Screening Questions Relevant to Infection Control

- Current medications (including anticoagulants, immunosuppressants, bisphosphonates)
- Known communicable disease diagnoses (HIV, HBV, HCV, active tuberculosis, herpes, etc.) — note: presence of communicable disease does NOT permit refusal of treatment; Standard Precautions apply universally
- Recent hospitalization or surgery
- Current respiratory illness, cough, or fever
- Immunocompromised status
- History of antibiotic prophylaxis requirements

16.3 Patients with Known Communicable Diseases

Patients with known communicable diseases must be treated with the same level of respect and access to care as all other patients. Standard Precautions eliminate the need for specialized protocols beyond those already in place. The Program Chair or faculty supervisor should be consulted for any cases requiring additional clinical judgment regarding risk management or treatment sequencing.

Section 17: Clinic Infection Control Compliance Checklist

This checklist is adapted from the CDC Dental Infection Prevention Checklist (available via the CDC DentalCheck App: https://www.cdc.gov/dental-infection-control/hcp/cdc_dentalcheck/index.html) and must be used for regular clinic compliance monitoring. The Program Chair or designee must conduct a formal review no less than once per semester. Student self-assessment is expected at the beginning of each clinic session.

HAND HYGIENE		
Task	Frequency	Responsible Party
Antimicrobial soap available at all clinical sinks	Daily	Faculty/Staff

ABHR (≥60% alcohol) available at point of care	Daily	Faculty/Staff
Students perform hand hygiene before/after each patient	Each patient	Student/Faculty
No artificial nails or jewelry observed in clinic	Each session	Faculty
PERSONAL PROTECTIVE EQUIPMENT		
Task	Frequency	Responsible Party
ASTM Level 2 or 3 masks available and used for aerosol procedures	Each session	Student/Faculty
Appropriate gloves used and changed between patients	Each patient	Student/Faculty
Protective eyewear worn and disinfected between patients	Each patient	Student/Faculty
Patient protective eyewear provided at each appointment	Each patient	Student
Clinical attire not worn outside the clinical environment	Each session	Student/Faculty
INSTRUMENT PROCESSING		
Task	Frequency	Responsible Party
Contaminated instruments transported in closed containers	Each session	Student
Ultrasonic cleaner solution changed	Daily	Staff/Student
Sterilization pouches dated, labeled, and include chemical indicator	Each load	Student
Sterilization cycle parameters documented (temp, time, pressure)	Each load	Student/Faculty
Biological indicator (spore test) performed and documented	Weekly	Program Chair/Designee
Sterile packages inspected before use for integrity	Before each use	Student
SURFACE DISINFECTION & BARRIERS		
Task	Frequency	Responsible Party
Barriers placed on all appropriate surfaces before patient seating	Each patient	Student
Barriers removed and replaced between patients while gloved	Each patient	Student
Two-step spray-wipe-spray disinfection performed on non-barrier surfaces	Each patient	Student
Contact time for disinfectant product observed and not wiped dry prematurely	Each patient	Student/Faculty
Operatory disinfected at end of each clinic session	Each session	Student
DENTAL UNIT WATERLINES		
Task	Frequency	Responsible Party

Waterlines flushed 20–30 seconds at start of day	Daily	Student/Faculty
Handpieces and air/water syringes flushed 20–30 seconds between patients	Each patient	Student
Waterline treatment system maintained per manufacturer protocol	Per schedule	Staff/Faculty
Water quality testing performed and documented	Quarterly	Program Chair
SHARPS SAFETY		
Task	Frequency	Responsible Party
Sharps containers located at point of use in each operatory	Each session	Faculty/Staff
Safety-engineered syringes/needles in use	Each session	Student/Faculty
No two-handed recapping of needles observed	Each session	Faculty
Sharps containers not overfilled (no more than 3/4 full)	Each session	Faculty/Staff
WASTE MANAGEMENT		
Task	Frequency	Responsible Party
Biohazard containers properly labeled and available	Each session	Faculty/Staff
Amalgam separator functioning and documented	Monthly	Program Chair/Designee
Regulated medical waste disposed of per institutional policy	As generated	Student/Staff
STUDENT & FACULTY HEALTH		
Task	Frequency	Responsible Party
All immunization records current and on file	Annual/Semester	Program Chair
TB screening current for all students and faculty	Annual	Program Chair
Ill students/faculty excluded from patient contact	As needed	Program Chair/Faculty
TRAINING & DOCUMENTATION		
Task	Frequency	Responsible Party
Annual infection control training completed and documented for all students/faculty/staff	Annual	Program Chair
Exposure incident log current	As needed	Program Chair
OSHA Bloodborne Pathogens training completed for new students at program entry	Program entry	Program Chair
CDC Safe Care Modules completed (cdc.gov/oralhealth/infectioncontrol)	Annual	Program Chair

Section 18: References and Authoritative Resources

This protocol is grounded in the following peer-reviewed guidelines, regulatory standards, and professional organization resources. Faculty, students, and staff are encouraged to access these primary sources for self-directed learning and professional development.

Federal Regulatory Standards

- U.S. Department of Labor, Occupational Safety and Health Administration. Bloodborne Pathogens Standard. 29 CFR 1910.1030. <https://www.osha.gov/bloodborne-pathogens>
- U.S. Department of Labor, Occupational Safety and Health Administration. Hazard Communication Standard. 29 CFR 1910.1200.
- U.S. Environmental Protection Agency. Dental Effluent Guidelines. 40 CFR Part 441. Effective July 14, 2017; compliance required by 2020.

CDC Guidelines and Training Resources

- Kohn WG, Collins AS, Cleveland JL, et al. Guidelines for Infection Control in Dental Health-Care Settings — 2003. *MMWR Recomm Rep.* 2003;52(RR-17):1–61.
- Centers for Disease Control and Prevention. Summary of Infection Prevention Practices in Dental Settings: Basic Expectations for Safe Care. Atlanta, GA: US Department of Health and Human Services; 2016.
- CDC Basic Expectations for Safe Care Training Modules (online, free CME/CEU credit available):
 - <https://www.cdc.gov/oralhealth/infectioncontrol/safe-care-modules.htm>
- CDC Best Practices in Dental Infection Prevention and Control — FAQs for Dental Healthcare Personnel:
 - <https://www.cdc.gov/dental-infection-control/hcp/dental-ipc-faqs/index.html>
- CDC DentalCheck App — Mobile Infection Prevention Checklist Tool for Dental Settings:
 - <https://www.cdc.gov/dental-infection-control/hcp/cdcdentalcheck/index.html>

Professional Organization Guidelines

- Organization for Safety, Asepsis and Prevention (OSAP). From Policy to Practice: OSAP's Infection Prevention and Exposure Control Manual for the Dental Team. Current Edition. <https://www.osap.org>
- American Dental Association (ADA). Infection Control in Dentistry. <https://www.ada.org/resources/practice/dental-standards/guidelines-for-infection-control>
- American Dental Education Association (ADEA). Competencies for Entry into the Dental Hygiene Profession. *J Dent Educ.* 2017;81(7):1–5. <https://www.adea.org>
- ADEA Policy Statement on Infection Control in Dental Education Programs. American Dental Education Association.

Sterilization and Instrument Processing Standards

- Association for the Advancement of Medical Instrumentation (AAMI). ANSI/AAMI ST79: Comprehensive Guide to Steam Sterilization and Sterility Assurance in Health Care Facilities. Current Edition. Arlington, VA: AAMI.
- Spaulding EH. Chemical disinfection of medical and surgical materials. In: Lawrence C, Block SS, eds. Disinfection, Sterilization, and Preservation. Philadelphia, PA: Lea & Febiger; 1968:517–531. [Original source of the Spaulding Classification System]

Dental Unit Waterline Standards

- OSAP. Dental Unit Waterlines: Biofilm, Treatment, and Concerns. <https://www.osap.org>
- American Dental Association. Statement on Dental Unit Waterlines. <https://www.ada.org>

Accreditation Standards

- Commission on Dental Accreditation (CODA). Accreditation Standards for Dental Hygiene Education Programs. Standards 2-17 and 2-18. Chicago, IL: American Dental Association; Current Edition. <https://www.ada.org/coda>

Immunization Guidelines

- Centers for Disease Control and Prevention. Immunization of Health-Care Personnel: Recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR Recomm Rep. 2011;60(RR-7):1–45.

World Health Organization

- World Health Organization. WHO Guidelines on Hand Hygiene in Health Care. Geneva: WHO Press; 2009. <https://www.who.int/publications/i/item/9789241597906>

END OF DOCUMENT

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Next scheduled review: April 2027 | All previous versions superseded