



FLORIDA
STATE COLLEGE

at Jacksonville™

Infection Control Manual
2015

Infection Control Committee

History

Review Committee December 1999 - 2003	Review Committee February 2004
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Review Committee June, 2005	Review Committee August, 2006
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Terminology

The following terms are defined in order that the reader will have a clear understanding of the information and acronyms being presented.

1. ADA - American Dental Association
2. ADAA –American Dental Assistant Association
3. ADHA - American Dental Hygiene Association
4. Antiseptics - are agents applied to living tissue to remove disease causing microorganisms.
5. Asepsis - a condition in which living pathogenic microorganisms are absent, whereas sepsis is the condition of having disease causing organisms present. Complete Asepsis is not possible in the dental office.
6. Blood-Borne Pathogens - Pathogenic organisms that are present in human blood and can cause disease in humans.
7. CDC - The Center for Disease Control, an agency of the federal government.
8. Critical Surfaces - those that actually enter the mouth and have direct contact with blood, or saliva.

Non-critical Surfaces - those that are present in the dental environment but are unlikely to be contaminated by oral pathogens, or touched during treatment.

Semi-critical Surfaces - those that have frequent contact with aerosols or are touched by the patient or the contaminated hands of the dental operator.
9. Cross-Contamination - the transmission of a pathogen from one person to another or from an inanimate surface to an individual.
10. Disinfection - any process, chemical or physical, by means of which pathogenic agents can be destroyed. It is the destruction of most microorganisms, but not necessarily all.
11. Disinfectants - are agents applied to inanimate objects in order to reduce the microorganisms to a safe level.
12. DHCP – Dental Health Care Personnel. This term refers to all paid and unpaid personnel in dental health care who could experience occupational exposure to infectious materials, including body substances and contaminated supplies, equipment,

environmental surfaces, water or air. DHCP includes dentists, dental hygienists, dental assistants, dental laboratory technicians (in-office and commercial), students and trainees, contract personnel, and other people not directly involved in patient care but who could be exposed to infectious agents (such as administrative, clerical, housekeeping, maintenance or volunteer personnel.)

13. FSCJ Dental Clinic – refers to both dental hygiene and assisting clinics
14. FDA - The Food and Drug Administration, a branch of the Federal Government.
15. HAV - Hepatitis A Virus. This virus is transmitted primarily through contaminated food and water through the fecal-oral route. This was previously called infectious hepatitis.
16. HBV - Hepatitis B Virus. This virus is capable of being transmitted through multiple body fluids. This was previously called serum hepatitis.
17. HCV – Hepatitis C Virus. This virus is transmitted primarily through blood.
18. HDV – Hepatitis D, also referred to as Delta Hepatitis is a co-infection of Hepatitis B. A person can have HBV without HDV, but they cannot have HDV without HBV.
19. HIV - Human Immunodeficiency Virus. The term "HIV" is currently used in place of other names previously given to the virus that causes AIDS.
20. HRS - The Department of Health and Rehabilitative Services, which is the State of Florida's Health Department. (The Duval County Health Department is called "Health Welfare & Bio-environmental Services).
21. MMWR - The Morbidity and Mortality Weekly Report. A publication of the U.S. Center for Disease Control
22. MQA – Medical Quality Assurance. An agency of the State of Florida that regulates 37 professions including Dentistry. The Florida Board of Dentistry, (BOD) , specifically regulates the practice of licensed dentists and hygienists.
23. OPIM – Other potentially infectious material.
24. OSHA - The Occupational Safety and Health Administration, a branch of the U.S. Department of Labor
25. Parenteral - denoting any medication route other than the alimentary canal, such as intravenous, subcutaneous, or mucosal.
26. Personal Protective Equipment - specialized clothing or equipment worn by health worker for protection against a hazard. (Uniforms are NOT considered a PPE though gowns are)

27. Sanitization - the process by which the number of organisms on inanimate objects is reduced to a safe levels. It does not imply freedom from microorganisms, and generally refers to "cleaning".
28. Standard Precautions (Universal Precautions is the older term) - is a method of infection control in which all human blood and certain body fluids are treated as if known to be infectious for bloodborne pathogens. Standard precautions must be used in all patient encounters. Universal precautions traditionally referred to blood, whereas standard precautions expanded the concept to include additional body fluids. In dentistry, the terms are usually synonymous.
29. Sterilization - the process by which all forms of microbial life, including bacteria spores and viruses, are destroyed by physical or chemical agents.

Introduction

Goal of the Infection Control Manual

The goal of this manual is to establish policy that will ensure the safety of FSCJ Dental Program students and health care personnel and comply with state and federal guidelines for infection control.

Rationale for Manual

The dental office environment places the dentist, dental hygienist, and dental assistant at risk of contracting many infectious diseases during the working day, some of which are extremely dangerous.

Precautions to guard against transmission of disease from the patient to the practitioner, and from the practitioner to the patient, and patient-to-patient, must be taken. These precautions include (1) cleaning or reducing the number of pathogens that are present to a safe amount, (2) protecting the health worker through use of barriers and equipment between the pathogen and the person, and (3) vaccination against specific organisms that may be present in the dental office environment.

Infectious diseases which may be transmitted through a dental practice include: AIDS or HIV infection, Hepatitis B, Hepatitis C, Hepatitis D, Herpes infection, and various respiratory diseases. Confirmed transmission of HBV and HIV in Dentistry is documented, although the risk is considered to be very small.

The occupational risk of infection after exposure has been shown to be:

Risk of getting Hepatitis B is 6 - 30%, according to the CDC

Risk of getting Hepatitis C is 1.8% (rare)

Risk of getting HIV is 0.3% for percutaneous incidents and 0.09% for abraded skin or mucous membrane exposure.

Since June 2000 – 56 health care workers have documented seroconversion from an exposure.

Reference: ACCESS, ADHA, Feb 2003, "Management of Post-exposure Prophylaxis."

History of Documents Regulating Infection Control in Dentistry

1992 The OSHA Bloodborne Pathogen Standard: Occupational Safety and Health Administration (OSHA) developed the first written standard (rules) for protection of the worker against occupational exposure to bloodborne diseases in 1986 and published the final rules in 1991. The standard identified the employers' responsibility and mandated certain practices in the workplace. It is known as The OSHA Bloodborne Pathogen Standard and became effective in March, 1992. Noncompliance can result in fines of up to ten thousand dollars.

1993 Recommended Infection Control Practices for Dentistry: After OSHA published its Standards, the CDC published Recommended Infection Control Practices for Dentistry, 1993.

Many dental licensing boards, including Florida, adopted CDC’s recommendations as the standard for dental practice. The Florida BOD infection control standards can be found in the Division of Medical Quality Assurance, Board of Dentistry, Rule 64B5, Chapter 64B5-25 “Sterilization and Disinfection Procedures.”

2001 Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HBV, HCV, and HIV and recommendations for Post-exposure Prophylaxis: This 40 page document was published in the MMWR in June 2001. The primary purpose was to provide an update on recommendations for the management of health-care personnel who have exposure to blood that might contain hepatitis B virus, hepatitis C virus, or human immunodeficiency virus.

2003 Guidelines for Infection Control in Dental Health-Care Settings: In 2003, with the emergence of new technologies and new issues, the CDC published a new set of recommendations that are relevant to dentistry. The new guidelines are published in a 67-page document titled Guidelines for Infection Control in Dental Health-Care Settings –2003. The new guidelines are much longer than the 1993 version, include a broad range of topics and include major updates.

This FSCJ Dental Infection Control Manual reflects the most recent infection control standards available. This manual is written in an outline format with topic headings corresponding to the American Dental Association’s “Special Report” document* that summarizes the CDC 2003 guidelines. Per the CDC, there have been no significant changes to the standards that would warrant a revision or update to the 2003 guidelines.

*Reference: “Special Report”, Kohn, WG., Harte, JA., Malvitz, DM, Collins, AS, Cleveland, JL, Edlund, KJ, Journal of the American Dental Association, Volume 135, January 2004. pgs. 33-47.

I. Personnel Health Elements of an Infection Control Program

A. General Recommendations

1. This written manual is for all health care personnel in FSCJ Dental Programs. The policy, procedures, and guidelines apply to students, faculty, staff and all personnel.
2. The qualified individuals at FSCJ for overseeing enforcement includes the Dental Program Manager, the Dental Programs Faculty, the North Campus Safety Committee, the North Campus Security Officers, the North Campus Administrators, and the FSCJ Risk Management team.

B. Education and Training

1. New Employees

New employees who work in the clinic setting, such as adjunct professors, full-time professors, staff and student assistants hired in the dental programs must receive training immediately after hiring regarding exposure to potentially infectious agents. A copy of this manual must be provided to each new employee. The FSCJ Instructional Program Manager will discuss the infection control plan with each new employee and dental programs will provide annual infection control training.

It is the responsibility of the dental programs faculty in each dental program to monitor, maintain, and assure compliance of the sterilization and infection control procedures set forth in this manual. There can be no exceptions to these policies.

A 30-day period will be allowed for all those engaged in patient care to become familiar with and comply with these regulations. Failure to comply will result in loss of clinic privileges.

Required annual training including OSHA's Bloodborne Pathogens Standard will be provided to all individuals involved in patient care by a department representative. The representative receives annual training through FSCJ's Safety Department.

2. New Students

Applicants are notified of the risk of exposure associated with a dental career in the program application packet. Newly accepted applicants to the dental hygiene and dental assisting program are informed at an orientation session of the risk of exposure to bloodborne pathogens. For dental hygiene students, this occurs approximately two months prior to the start date of classes; for assisting students, orientation occurs two weeks before class. At this time, the required vaccinations and health certificates are reviewed with the student.

New dental hygiene and dental assisting students must receive initial training regarding exposure to potentially infectious agents immediately upon entering the program. This

must occur during the first two or three weeks of the start of classes and continue throughout the educational process. Students will receive training in specific procedures for infection control and the prevention of disease transmission in core dental hygiene and dental assisting courses.

Evaluation documents used in teaching and training will assure competency in all procedures. Continued patient care privileges will be contingent upon compliance.

C. Immunization for Students

1. Required Vaccinations and Tests

Students accepted in the dental hygiene and dental assisting programs must complete a health certificate prior to treatment of patients. The certificate must be signed by a physician who acknowledges the following immunizations and tests have been administered:

- TB Test (Mantoux tuberculin test) current within 3 months of entering program
- Measles, Mumps, Rubella (MMR)
- Varicella (Chickenpox)
- Diphtheria – Tetanus
- Influenza vaccine is recommended (though not required)
- Hepatitis B Vaccine

With knowledge of the increased risk of infection of Hepatitis B, it is required that each student receive the vaccination for HBV during or, preferably, before the first term of the freshman year. Dental Hygiene and Dental Assisting students must sign a document prior to admission indicating they have been informed of the requirement and they must either accept or decline to have the vaccine administered. Prior to vaccination, the individual should be tested for the presence of antibody. If the individual does not already have protection, the vaccine should be administered. If sufficient antibody level is already present, vaccination is not necessary.

One to two months after completion of the 3-dose series, a post-vaccination antibody test (anti-HBs) must be performed to determine if the vaccine was successful. Once immunity is confirmed, the booster vaccines are not recommended.

2. Referral to Agency for Vaccinations

The Duval County Health Department administers the hepatitis vaccine at a reasonable cost. A series of three injections, over a 6 month period is required. Phone 630-3243 for an appointment and current fees. The Duval County Health Unit is located at 515 West 6th Street in Jacksonville. The vaccines are also available in private physician's offices and primary health centers. Costs may vary.

D. Exposure Prevention and Post-exposure Management

1. Management and Medical Follow-up

Definition of Bloodborne Exposure: A bloodborne exposure means having blood, blood contaminated saliva, or a blood contaminated instrument from one individual (source person) come into contact with broken skin or mucous membranes of the eyes or mouth, of a second individual (injured person). The most common example of exposures in FSCJ dental programs occurs when the operator accidentally pierces the skin with a contaminated instrument in clinic or in a private dental practice utilized as an externship site. This can occur either during treatment or following treatment on a patient. Most exposures have been documented as occurring while cleaning the treatment area if the student does not follow proper procedures and does not wear heavy-duty gloves to protect the fingers and hands.

An exposure is:

- a percutaneous injury (needlestick or cut with a contaminated sharp instrument)
- a mucous membrane exposure (eyes, mouth, etc)
- a non-intact skin surface exposure (chapped skin, abrasion, dermatitis)

With:

- blood
- body fluids containing blood - like saliva
- other body fluids that are potentially infectious are semen, vaginal secretions, which are implicated in sexual transmission but not with dental healthcare workers

a. Policies and Procedures for Reporting, Evaluating, and Counseling Bloodborne Exposures:

Immediately stop, inform the patient of what occurred if the incident occurs during patient treatment. Remove examination gloves and wash the wound with soap and water. Immediately after washing notify the clinical instructor. If the exposure is significant and the risk to HIV is high, the student must go to a health agency within TWO HOURS for testing and counseling.

An antiseptic such as Neosporin or Polysporin ointment, located in the first aid kit, can be applied to the injury but it is not required. Chlorohexidine gluconate (Peridex), if available, may also be used as an antiseptic. A bandage can be applied, if needed.

Treatment on the patient should be postponed until another appointment if possible.

Note: If a second student continues treatment on the patient, the contaminated instrument must be removed from the treatment field for re-sterilization.

Documents for Reporting Incident	
Student Information	Source Individual (patient)
<p>Form 1 is completed by the student with the instructor's assistance. Forms 1 is confidential and is kept on file in the program office. The incident is recorded in the "Log of Exposure Incidents" which is located in the Dental Program Office.</p> <p>FSCJ's School Activities form, which is the Notification of Injury for insurance purposes, must also be completed. The Notification of Injury form can be downloaded using the link at this web site:</p> <p>http://docjeff.net/Dental_Courses/Home.html or through Artemis, College, Risk Management, Documents and Forms, Student Injury, School Activities Notification of Injury form or, if employee, First Report of Injury form</p> <p>The North Campus Security Office should be notified of the injury. Copies of the "School Activities" insurance form can be obtained online. It is the student's responsibility to return the completed form to the Security Office.</p> <p>Note: The students' medical insurance is the primary insurance carrier and the school insurance is the secondary insurance carrier; therefore, students must file insurance with their primary provider first. FSCJ's school insurance will pay the remainder that is not covered or is denied from the primary provider. Uninsured students will be covered by the College.</p>	<p>Form 2 – The Source Individual form is completed by the instructor. The source patient should be informed of the incident and interviewed by the instructor to collect information that will help determine the risk factor involved. The instructor should ask the patient if they will consent to a blood test.</p> <p>If consent is given the source patient should be tested for HBsAg, anti-HCV, and HIV antibody.</p> <p>FSCJ is financially responsible for the patient's blood test. Note: If the source patient is not present for collecting information, the program director should phone the source patient and collect the information.</p>

b. Mechanism for Referral - Blood Testing of the Student and Patient

Proper follow-up of the dental hygiene and assisting student includes blood testing and counseling as soon as possible (within two hours of exposure). The recommended facility must have a trained health professional with expertise in the selection of and use of current post-exposure prophylactics.

Blood testing and counseling of the student is necessary for two reasons:

- To establish the student's baseline serological data for HIV and HBV status.
- To determine if prophylactic pharmaceuticals are recommended. For example, in some cases of high risk to HIV, an antiviral chemotherapeutic agent may be given within 1 to 2 hours after exposure. It is less effective if taken 24 hours post-exposure. The decision whether to take the pharmaceutical agent is done by the physician and student at the medical facility, on a case-by-case basis, based on exposure risk. For exposures with negligible risk, post-exposure prophylaxis is not recommended.

U.S. Department of Health and Human Services, CDC "Update: Provisional Public Health Service Recommendations for Chemoprophylaxis after occupational exposure to HIV". June 7, 1996, Volume 45, Number 22, pages 468-472

Raphael J. Landovitz, M.D., and Judith S. Currier, M.D.; *"Post-exposure Prophylaxis for HIV Infection"*; New England Journal of Medicine; Volume 361:1768-1775; Number 18; 29 Oct 2009.

Blood testing of the patient is recommended the same day if possible in order to determine if the patient has a communicable bloodborne disease such as Hepatitis B, Hepatitis C or HIV. FSCJ is responsible for paying for the patient's blood test. The patient's test results are sent to the agency that does the testing. The results are released to the student if the patient gives permission for releasing the report.

If the student and/or patient consents to blood testing, the dental program manager or the clinical instructor must contact the FSCJ Risk Management Office, at 632-3166 or 632-3127.

A copy of the "Source Information Form" is sent to the medical facility by the Risk Management Office. (See page 12 for sample document.)

b. Mechanism for Referral (continued)

Health Facilities for Students* (if approved by Risk Management Office) and for Source Patient in Exposure Incident

1st
Choice

Care Spot
22032 Dunn Ave.
Jacksonville, FL
Phone: 757-2008
Hours: 8:00 am-8:00 pm (7 days per week)

After
Hours

Baptist Medical Center
Emergency Center
800 Prudential Drive
Jacksonville, FL 32207
Phone: 202-2046 Open 24 hours a day

* If a student has their own health insurance and they have a personal physician they are to go to that personal physician for testing.

Important Note:

Students are urged to use any of the Care Spot facilities, if at all possible, unless their primary insurance does not cover treatment rendered there.

Note:

The students' medical insurance is the primary insurance carrier and the school insurance is the secondary insurance carrier; therefore, students must file insurance with their primary provider first. FSCJ's insurance will pay the remainder that is not covered or is denied from the primary provider. Uninsured students will be covered by the College.

Form 2
FSCJ Exposure Incident Report
 (To be completed by Source Individual)

Name of exposed student/ employee _____

Date _____

I, _____ understand that a student or employee of Florida State College had an incident during the delivery of routine dental care, which involved an exposure of this student or employee to my blood/body fluid. I also understand that this exposure may place the individual at risk of contracting any bloodborne pathogens that may currently be present in my body fluids. I therefore provide the following information with respect to my health status.

- | | | |
|-----|----|--|
| YES | NO | Do you have any reason to believe you have been exposed to hepatitis within the last six months? |
| YES | NO | Have you been diagnosed as having or been treated for a sexually transmitted disease? |
| YES | NO | Have you injected or been injected with a prescription (insulin or tranquilizer, etc) or a mood altering drug? |
| YES | NO | Are you infected with HIV (the virus which causes AIDS)? |
| YES | NO | Does your lifestyle put you at risk of contracting AIDS? |
| YES | NO | Have you been hospitalized within the last year? |
| YES | NO | Have you been under a physician's care for any condition during the last year? |
| YES | NO | Have you had surgery during the last year? |
| YES | NO | Have you ever had a blood transfusion? |

To the best of my knowledge, I have answered the above questions honestly.

 Signature Date

Please check and sign only one statement below...

- I hereby consent to any serological test that is deemed necessary including HIV testing at no expense to me. Further, I consent to have the results of the tests released to the Dental Program manager so that appropriate care can be provided to the student.

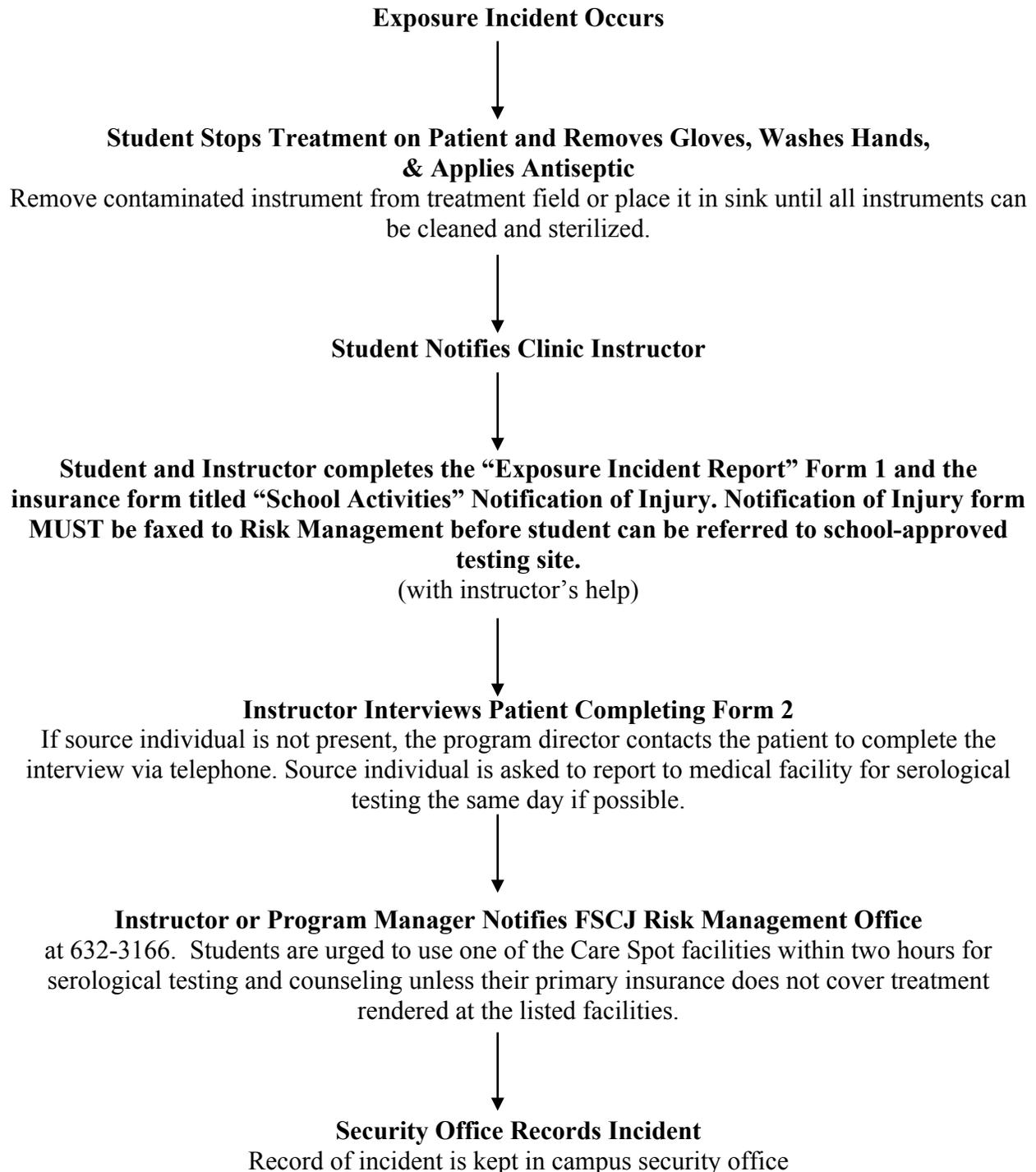
 Signature Date

- I hereby consent to any serological test deemed necessary EXCEPT HIV at no expense to me. Further, I consent to have the results of the tests released to the Dental Program manager so that appropriate care can be provided to the student.

 Signature Date

- I refuse any and all serological testing.

SUMMARY OF PROTOCOL FOR BLOODBORNE EXPOSURE



c. Preventing and Managing Exposure to Tuberculosis

Students and faculty providing care to dental hygiene patients may be exposed to persons with infectious Tuberculosis. Tuberculosis has re-emerged as a disease threat since the late 1980's and early 1990's. Even though the number of cases has declined since 1993, TB is still considered a public health concern.

TB is an airborne disease, spread by an infectious person's droplet nuclei through coughing, sneezing, speaking, laughing, or singing. Adequate ventilation is an important measure to prevent transmission. Only people with active disease are contagious. People who have been treated with appropriate drugs for at least two weeks usually are not infectious. (New York State Dental Journal, Lassiter, T.E. & Panagakos, F.S., "Tuberculosis", November 2003.)

The FSCJ Dental Clinic is an open bay environment with no provision for isolation and special ventilation. Therefore patients with active or suspected tuberculosis will not be treated.

The Mantoux Tuberculin skin test is required for all students current within three months of entering the dental hygiene program. If the skin test is positive, a report of chest x-ray must be submitted to the program manager indicating the student is negative for tuberculosis. Any student or clinical faculty with a persistent cough, weight loss, night sweats, fatigue, bloody sputum, anorexia, or fever, must be evaluated promptly. They must not return to school unless infectious tuberculosis has been excluded.

E. Medical Conditions, Work-related Illness and Work Restrictions

1. There are times when medical conditions or illness indicate that a student, faculty or employee should be excluded from clinical work. The authority on implementing policies regarding work restrictions and exclusion is the Dental Program Manager who is under direction from the Dean of Health Programs and the Campus President.
2. The table on the next two pages (pg 16-17) has been adopted as FSCJ policy for excluding students, faculty, or employees from clinical work. This table was published by the Center for Disease Control and Prevention and is located in the MMWR, December 19, 2003, Volume 52, No. RR-17, pg 8-9. Any individual who is excluded from clinical work is encouraged to seek appropriate treatment and curative care.
3. If contact dermatitis occurs the student must be evaluated by a clinical instructor to determine the cause of the dermatitis and to determine if the dermatitis has made the student more susceptible to infections and if they should be excluded from clinical work. The ultimate decision for exclusion from clinic is with the Instructional Program Manager.

TABLE 1. Suggested work restrictions for health-care personnel infected with or exposed to major infectious diseases in health-care settings, in the absence of state and local regulations*

Disease/problem	Work restriction	Duration
Conjunctivitis	Restrict from patient contact and contact with patient's environment.	Until discharge ceases
Cytomegalovirus infection	No restriction	
Diarrheal disease		
Acute stage (diarrhea with other symptoms)	Restrict from patient contact, contact with patient's environment, and food-handling.	Until symptoms resolve
Convalescent stage, <i>Salmonella</i> species	Restrict from care of patients at high risk.	Until symptoms resolve; consult with local and state health authorities regarding need for negative stool cultures
Enteroviral infection	Restrict from care of infants, neonates, and immunocompromised patients and their environments.	Until symptoms resolve
Hepatitis A	Restrict from patient contact, contact with patient's environment, and food-handling.	Until 7 days after onset of jaundice
Hepatitis B		
Personnel with acute or chronic hepatitis B surface antigenemia who do not perform exposure-prone procedures	No restriction [†] ; refer to state regulations. Standard precautions should always be followed.	
Personnel with acute or chronic hepatitis B e antigenemia who perform exposure-prone procedures	Do not perform exposure-prone invasive procedures until counsel from a review panel has been sought; panel should review and recommend procedures that personnel can perform, taking into account specific procedures as well as skill and technique. Standard precautions should always be observed. Refer to state and local regulations or recommendations.	Until hepatitis B e antigen is negative
Hepatitis C	No restrictions on professional activity. [†] HCV-positive health-care personnel should follow aseptic technique and standard precautions.	
Herpes simplex		
Genital	No restriction	
Hands (herpetic whitlow)	Restrict from patient contact and contact with patient's environment.	Until lesions heal
Orofacial	Evaluate need to restrict from care of patients at high risk.	
Human immunodeficiency virus; personnel who perform exposure-prone procedures	Do not perform exposure-prone invasive procedures until counsel from an expert review panel has been sought; panel should review and recommend procedures that personnel can perform, taking into account specific procedures as well as skill and technique. Standard precautions should always be observed. Refer to state and local regulations or recommendations.	
Measles		
Active	Exclude from duty	Until 7 days after the rash appears
Postexposure (susceptible personnel)	Exclude from duty	From fifth day after first exposure through twenty-first day after last exposure, or 4 days after rash appears
Meningococcal infection	Exclude from duty	Until 24 hours after start of effective therapy
Mumps		
Active	Exclude from duty	Until 9 days after onset of parotitis
Postexposure (susceptible personnel)	Exclude from duty	From twelfth day after first exposure through twenty-sixth day after last exposure, or until 9 days after onset of parotitis

Source: Adapted from Bolyard EA, Hospital Infection Control Practices Advisory Committee. Guidelines for infection control in health care personnel, 1998. *Am J Infect Control* 1998;26:289-354.

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

[†] Unless epidemiologically linked to transmission of infection.

[§] Those susceptible to varicella and who are at increased risk of complications of varicella (e.g., neonates and immunocompromised persons of any age).

[¶] Patients at high risk as defined by ACIP for complications of influenza.

TABLE 1. (Continued) Suggested work restrictions for health-care personnel infected with or exposed to major infectious diseases in health-care settings, in the absence of state and local regulations*

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

Source: Adapted from Bolyard EA, Hospital Infection Control Practices Advisory Committee. Guidelines for infection control in health care personnel, 1998. *Am J Infect Control* 1998;26:289-354.

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

† Unless epidemiologically linked to transmission of infection.

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

¶ Patients at high risk as defined by ACIP for complications of influenza.

E. Medical Conditions, Work-related Illness and Work Restrictions (continued)

4. The policy of FSCJ Dental Programs is to move as rapidly as possible toward a latex-free environment. Students are required to wear latex-free examination gloves, either nitrile or vinyl. Other products which were traditionally made of latex, such as rubber polishing cups and dental dam material, are purchased as latex-free items whenever possible. However, any skin reaction on the hands where skin integrity is broken must be reported to an instructor to determine if clinical work is safe for the student. Any suspected latex allergy must be evaluated and diagnosed by a qualified health care professional to determine its specific cause and treatment as well as work restrictions. The student will not be penalized for absence related to latex sensitivity or allergy.

Students are educated in preclinical courses on the signs and symptoms of adverse reactions to latex. There are three distinct types of reactions that persons with sensitivity to latex can experience: (1) irritant contact dermatitis, (2) allergic contact dermatitis (delayed hypersensitivity) and (3) latex allergy.

Three Types of Reactions to Latex		
Irritant Contact Dermatitis	Allergic Contact Dermatitis	Latex Allergy
Dry irritated areas on skin, usually the hands.	Rash develops 24 to 48 hours after contact	Exposures to even very low levels can trigger allergic reaction.
Horizontal cracks on skin	Oozing skin blisters that spread away from the area of skin touched by the latex	Reaction can occur within minutes of exposure or hours later.
Note: Not a true allergy	Red raised palpable areas in the form of bumps, sores.	Mild reactions: skin redness, hives, itching.
	Delayed hypersensitivity	Facial swelling, rhinitis, generalized urticaria. Severe Reactions: runny nose, wheezing, itchy eyes, scratchy throat, asthma, difficulty breathing. Rare: Anaphylactic Shock

Reference: The Preventive Angle, Caren Barnes and Gwen Hlava, "Latex Allergies: Protection for Healthcare Workers and Patients", Volume 2, Issue 1. (www.youngdental.com)

F. Maintenance of Records of Exposure Incidents

1. Student admission documents, health certificates and occupational exposure incidents are confidential information and are maintained by the department. Records for students and faculty are stored in a locked file cabinet in the department office.

2. FSCJ is in compliance with local laws and with ADA accreditation guidelines for medical record keeping and confidentiality.

II. Preventing Transmission of Bloodborne Pathogens

A. HBV Vaccination

1. The vaccine series is required for all students entering the program. The vaccine series is made available to all full-time faculty employed who have not previously been vaccinated for HBV. New students are made aware of the immunization requirement months prior to entering the Dental Hygiene Program. Each student must sign an HBV Vaccination document, which is kept on file in the department.
2. FSCJ follows the CDC recommendations for HBV vaccinations, serologic testing, follow-up and booster dosing.
3. Students must have a blood test for anti-HBsAg one to two months after completion of the three-dose vaccination series.
4. If there is no antibody response, students must complete a second 3-dose series.
5. Retest for anti-HBsAg at completion of the second series is required.
6. FSCJ recommends counsel to non-responders to the vaccination who are HbsAg negative concerning their susceptibility. The appropriate counselor must also provide education regarding risks of HBV transmission.
7. If a student or employee declines vaccination, they must sign the declination form that is kept on file in the department.

B. Preventing Exposures to Blood and Other Potentially Infectious Material

1. General Recommendations
 - a. Use standard precautions (universal precautions) for all patient encounters.
 - b. Contaminated sharps must be stored in the designated sharps container at the point of origin in the clinic or close to where they were used. Items to be placed in the sharps containers include, but are not limited to injection needles and anesthetic cartridges (emptied of any solution).
 - c. Students must wear protective heavy duty nitrile gloves for clean-up of dental area. Any item that is blood or saliva contaminated must be disposed of in the appropriate red bag designated for biohazardous materials. All policies and

procedures to prevent exposure to blood must be followed. Students are monitored during all patient encounters and observed periodically throughout their education to enforce good practice procedures.

2. Engineering Controls

a. Safety devices used in the clinic must be identified, evaluated and considered on an annual basis. Clinical faculty participates in the evaluation during scheduled faculty meetings each term. Sales representatives are encouraged to provide samples of new products for evaluation. Adjunct faculty is encouraged to attend dental seminars and conventions where new infection control practices are discussed. Full-time faculty is provided an opportunity for professional development to participate in such activities.

b. All Sharps Containers must be clearly placed in the clinics close to the area they are used.

c. Recapping of needles must never be done with the needle pointed toward any part of the body. The two handed recapping technique should never be used.

d. Recapping of needles must be done with the one-hand scoop technique performed by the operator that gives the injection. The other acceptable recapping technique is the heavy stainless steel needle cap holder device or blue rubber device located in the clinics.

III. Hand Hygiene

A. General Considerations

1. Hand hygiene is taught during the first week of clinic when the student enters the dental hygiene program. Dental assisting students receive similar instruction during the DEA0725 Introduction to Dental Assisting class that is held during the fall term. Students and faculty must use the “Initial Scrub” technique at the start of the day allowing 2 to 3 minutes for this first handwashing. Following the initial scrub the students and faculty must use the “short standard scrub” technique of three short latherings and three rinses in 30 seconds. (Reference: Wilkins, Clinical Practice of the Dental Hygienist, 11th Edition, pg. 66-67.) The approved antimicrobial soap located at each sink must be used for handwashing. No substitute is allowed without faculty approval.

2. Handwashing must be performed at the beginning of the day, after touching contaminated objects bare-handed, before and after de-gloving, and whenever hands are visibly soiled.

3. Soap containers must be placed at each sink and clearly marked as to their contents. The soap containers should be used until empty and should not be refilled unless the old

container can be rinsed, washed and dried before refilling. Do not add soap to a partially-empty container at the sink.

4. Antiseptic alcohol-based hand rub dispensers are available in the clinics.

B. Special Considerations for Hand Hygiene and Glove Usage

1. It is recommended that all students and faculty use hand lotion at the end of the day in order to prevent dryness and chapping of the hands.

2. Fingernails must be kept clean, trimmed, smooth, and well groomed. Fingernails cannot extend beyond the pad of the finger. An orangewood stick (cuticle stick) is recommended for cleaning under the nail when washing hands at the beginning of the day. The orangewood stick can be rinsed and autoclaved for re-use.

3. Artificial nails are not allowed in clinic.

4. Jewelry cannot be worn on the fingernails and rings cannot be worn for patient treatment. FSCJ policy states that only a plain wedding band can be worn under examination gloves. A watch with a plain band can be worn but should be removed for the initial hand scrub of the day.

IV. Personal Protective Equipment (PPE)

Personal protective barriers for the dental hygiene and assisting students include gloves, masks, protective eyewear or face shield, and disposable gowns.

A. Masks, Protective Eyewear, Face Shields

1. Students must wear a surgical mask and eye protection with solid side shields or a face shield to protect mucous membranes of the eyes, nose and mouth during procedures likely to generate splashing or spattering of blood or other body fluids. A face shield may be worn in place of safety glasses, but it does not eliminate the need for the surgical mask.

Change masks between patients, or during patient treatment if the mask becomes contaminated with moisture or visibly soiled.

Face shields should be cleaned with soap and water and disinfected between patients or if visibly soiled during treatment.

B. Protective Clothing

Students must wear a disposable gown over regulation uniform or scrub.

Change disposable gown if visibly soiled or contaminated by blood or other potentially infectious materials.

Gowns are to be worn during patient treatment. Upon leaving the operatory, the gown should be removed. Gowns should be folded, placed inside a plastic wrap and left in the cabinet until returning to the treatment area.

C. Gloves

When dental hygiene students leave the patient to request an instructor's assistance, gloves must be removed (or overgloves worn) before touching the sign-up sheet. Hands must be washed and fresh gloves used when returning to treatment area.

1. Wear examination gloves when the potential exists for contacting blood, saliva, or other potentially infectious material.
2. Wear a new pair of examination gloves for each patient, remove them promptly after use, and wash hands immediately to avoid transfer of microorganisms to other patients or environmental surfaces.
3. Remove gloves that are torn, cut or punctured immediately and wash hands before re-gloving.
4. Do not wash patient examination gloves before use.
5. Ensure that appropriate gloves in the correct size are readily accessible.
6. Use appropriate gloves (e.g., puncture-and-chemical-resistant utility gloves) when cleaning instruments and performing housekeeping tasks involving contact with blood or "Other Potentially Infectious Materials" (OPIM).
7. Consult with glove manufacturers if questions arise regarding the chemical compatibility of glove material and dental materials used.

Contact Dermatitis and Latex Hypersensitivity

General Recommendations

1. Educate dental hygiene and assisting students and faculty regarding the signs, symptoms and diagnoses of skin reactions associated with frequent hand hygiene and glove use
2. Screen all patients for latex allergy (e.g., take health history and refer for medical consultation when latex allergy is suspected).
3. FSCJ Dental Programs provides a latex-safe environment for patients, students and staff with latex allergy.

V. Sterilization and Disinfection of Patient-Care Items

A. General Recommendations

1. Use only FDA-approved medical devices for sterilization and follow the manufacturer's instructions for correct use.
2. Clean and heat sterilize critical dental instruments before each use.
3. Clean and heat sterilize semi-critical items before each use.
4. Allow packages to dry in the sterilizer before they are handled to avoid contamination.
5. Use of heat-stable semi-critical alternatives is encouraged.
6. FSCJ reprocesses heat-sensitive critical and semi-critical instruments by using ProCide-D Plus, [glutaraldehyde] solution for a minimum of 10 hours at 24°C. Follow manufacturer's instructions for use of chemical sterilants/high-level disinfectants.
7. Single-use disposable instruments are acceptable alternative provided they are used only one and disposed of correctly.
8. Do not use glutaraldehyde solutions for environmental surface disinfection or as holding solutions.
9. Ensure that non-critical patient-care items are barrier-protected or cleaned or, if visible soiled, cleaned and disinfected after each use with an EPA-registered hospital disinfectant with an HIV, HBV effectiveness claim (low-level disinfectant) or tuberculocidal claim (intermediate-level disinfectant), (i.e., intermediate level if visibly contaminated with blood or OPIM).
10. Inform students and staff of all OSHA guidelines for exposure to chemical agents used for disinfection and sterilization. Identify areas and tasks that have potential for exposure.
 - a. Laboratory Classes
 - b. Expanded Duties Lab



Receiving window for dirty instruments



Instruments are cleaned in the ultrasonic cleaners



Instrument packaging station



Large heat sterilizer for heat-resistant instruments



Small heat sterilizer for heat-resistant instruments



Small heat sterilizer for heat-resistant instruments in Dental Assisting Clinic

B. Instrument Processing/Recirculation Area

1. The instrument processing/recirculation area is located in the larger dental clinic and is divided into specific areas to represent the steps in instrument processing.

a. Receiving

Soiled instruments and cassettes are placed in the window designated as “Receiving and Cleaning.”

b. Cleaning

Instruments are cleaned utilizing an ultrasonic cleaner to minimize contact with contaminated instruments.

c. Packaging

Instruments/items are wrapped/ bagged and labeled using appropriate materials for heat sterilization. An internal chemical indicator should be placed in every package. In addition, an external chemical indicator (e.g., chemical indicator tape) should be used when the internal indicator cannot be seen from outside the package. Heat sensitive items are placed in labeled high level disinfectant/sterilant containers.

d. Sterilization

Instruments are sterilized in either the large or small heat sterilizer. Marked containers are available for packages waiting to be sterilized.

e. Storage

Dry packaged instruments are stored in individual student lockers in the instrument locker room. Miscellaneous instruments/ items are stored in labeled containers in the processing area, separate from the contaminated and preparation sections. This is a clean, dry environment designed to maintain the integrity of the package.

f. Quality Assurance

Quality assurance in the instrument recirculation process is monitored and maintained by:

1. Only designated/assigned individuals are permitted in the processing area during scheduled clinic sessions. This is done to minimize handling of contaminated instruments and to maintain the correct flow in the sterilization process.
2. Process/biologic monitoring is used in the packaging section.
3. All students/faculty are trained in the instrument recirculation process.

4. All students/faculty are trained in recordkeeping in the instrument recirculation process.

5. All students/faculty are trained in the processing area equipment cleaning and maintenance.

2. The large regulated (biohazardous) waste receptacle designated with the international biohazardous symbol is located in the processing area. The permit (see arrow below) approving FSCJ Dental Programs as a generator of regulated waste is also located in the processing area.



3. Ultrasonic cleaning solutions, intermediate level disinfectants and high level disinfectant/sterilants, instrument packaging materials, and process/biologic monitoring materials are readily available in the processing area.

4. Proper personal protective equipment must be worn by individuals working in the processing area.

VII. Environmental Infection Control

General Recommendations

- Follow the manufacturers' instructions for correct use of cleaning and EPA-registered hospital disinfecting products.
- Do not use liquid sterilants/high-level disinfectants for disinfection of environmental (clinical contact or housekeeping) surfaces. DO NOT use glutaraldehyde, which is a product that is found in the clinic sterilization room and is used for other purposes.
- Use PPE, as appropriate, when cleaning and disinfecting environmental surfaces. Such equipment might include gloves (puncture and chemical resistant utility), protective clothing (disposable gown), and protective eyewear/ nitrile gloves and mask.
- A face shield can be worn instead of protective eyeglasses.

Clinical Contact Surfaces

- Use surface barriers to protect clinical contact surfaces, particularly those that are difficult to clean (e.g., switches on dental chairs) and change surface barriers between patients.
- Clean and disinfect clinical contact surfaces that are not barrier protected, by using an EPA-registered hospital disinfectant with an intermediate level (i.e., tuberculocidal claim) after each patient. Use an intermediate level disinfectant if visibly contaminated with blood.
- Birex is the product presently being used in the FSCJ clinic.

Housekeeping Surfaces

- Clean housekeeping surfaces (e.g., sinks) with a chlorine-containing scouring powder and water or an EPA-registered hospital disinfectant/detergent on a daily basis.

Regulated Medical Waste

- Blood and saliva-contaminated items are disposed of in the trash container marked “Biohazardous” that contains a red bag. Examples of these items are: operator’s gloves, gauze, cotton swabs, cotton rolls, patient napkins and patient wipes or facial tissues, barriers if visibly soiled and x-ray packets.
- All other items are disposed of in the container with a bag liner of a color other than red. Examples of these items are: operator gowns, paper towels, plastic barriers and face masks unless visibly soiled with blood, paper cups, paper boxes, autoclave wrap and autoclave bags.
- Place sharp items (e.g., needles and empty anesthetic carpules) in the designated red sharps container, which is located at the point of origin.
- The student is responsible for tying up the red and non-red liner bags at the end of the day, while wearing heavy-duty utility gloves.
- The red bags are tied and placed in the large waste receptacle in the sterilization room.
- The non-red bags are tied and placed in the designated container.
- After emptying, new bags are placed in the appropriate containers.



VIII. Dental Unit Water Lines, Biofilm and Water Quality

General Recommendations

- Use water that meets EPA regulatory standard for drinking water for routine dental treatment output water.
- At the present time, all of the clinic dental units have self-contained water systems that require special care for water line care and maintenance per the manufacturer’s instructions.
- Ultrasonic devices require a two-minute flush before placement of the insert.
- Discharge water and air for a minimum of 20-30 seconds after each patient, from any device that enters the patient’s mouth (e.g., handpieces, ultrasonic scalers and air/water syringes).

IX. Special Considerations

Dental Instruments

- Before sterilization, items must be thoroughly cleaned. Organic debris (i.e. saliva, plaque and blood) if left to remain on instruments, can prevent or hinder sterilization. As stated by the ADA, “all practical methods of sterilization or disinfection can be over challenged by soiled or heavily contaminated materials”. This statement indicates the importance of proper cleaning of instruments and other items before sterilization.
- The best method for this is the ultrasonic cleaner. It is safer than manually scrubbing instruments, more efficient and more effective. It also reduces the risk of direct contact with pathogenic microorganisms.
- The most advanced technology for this process involves the use of a cassette tray which holds a complete set of instruments and can be carried from chairside to ultrasonic cleaner to autoclave to storage.
- Instruments that have been processed through the ultrasonic cleaner must be thoroughly rinsed with water in order to remove the detergent cleaning solution. If this step is not completed the instruments will become stained and spotted during the subsequent sterilization process.
- During cleaning of instruments, the operator must wear heavy utility gloves. Examination gloves should not be worn during this process. Utility gloves may be disinfected for re-use if the integrity of the glove is not compromised.
- Do not advise patients to close their lips tightly around the tip of the saliva ejector to evacuate oral fluids.
- Slow speed handpieces must be cleaned and sterilized. Handpieces are not placed in the ultrasonic cleaner.
- The ultrasonic equipment must be drained, cleaned and disinfected in the middle and at the end of the day for re-use.

B. Dental Radiology

- Wear gloves when exposing radiographs and handling contaminated film packets.
- Use heat-tolerant sterilizable or disposable intraoral devices whenever possible (e.g., film holding and positioning devices). Clean and heat-sterilize heat tolerant devices between patients.
- Transport and handle exposed radiographs in an aseptic manner to prevent contamination of developing equipment.

C. Aseptic Technique for Parenteral Medications

- These procedures are not done in this program.

D. Pre-procedural Mouthrinses

- A pre-procedural antimicrobial mouthrinse is performed on each patient prior to starting intraoral procedures.

E. Handling of Extracted Teeth

- Extracted teeth that are to be used for educational purposes are to be cleaned and placed in a leak-proof plastic container, labeled with a biohazard symbol and immersed in a 10% solution of bleach water (sodium hypochlorite) for transport to the educational institution.
- Before use, teeth should be heat sterilized or placed into a solution of gluteraldehyde if amalgam is present.

Program Evaluation

There is to be an annual review of all aspects of infection control policies and procedures conducted annually (usually in January).