

**INFECTION CONTROL PLAN
LSUHSC SCHOOL OF DENTISTRY
1100 Florida Avenue
New Orleans, Louisiana 70119**

PURPOSE

Dental Health Care Workers (DHCW) potentially can be exposed to a number of pathogens, both bloodborne and airborne. These pathogens are transmitted by direct contact with blood or oral fluids; by indirect contact with contaminated instruments or environmental surfaces; and by conjunctival or mucosal contact or by inhalation of aerosol. This Infection Control Plan establishes policies and procedures for delivery of dental care at LSUHSC School of Dentistry that prevents disease transmission from patient to DHCW, DHCW to patient, and patient to patient.

All School of Dentistry personnel with occupational exposure to pathogens are required to comply with the guidelines in this plan. Everyone is encouraged to submit suggestions or observations to improve the safe delivery of dental care.

The Infection Control Committee is responsible for implementation of the Infection Control Plan. The Plan is reviewed annually by the committee which seeks input from all clinical personnel regarding improvements and new technologies to reduce risk of exposure to infectious agents.

The Infection Control Plan is available on the school's website and will be available in clinic dispensaries.

References:

Occupational Safety and Health Administration Regulations. 29 CFR Bloodborne Pathogens. – 1910.1030

Centers for Disease Control and Prevention. Guidelines for Infection Control in Dental Health-Care Settings – 2003. MMWR2003;52(No.RR-17)

Summary of Infection Prevention Practices in Dental Settings: Basic Expectations for Safe Care, CDC, March 2016

Interim Infection Prevention and Control Guidance for Dental Settings During the COVID-19 Response: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/dental-settings.html#EquipmentConsiderations>

EXPOSURE DETERMINATION

Job classifications with occupational exposure

Clinical Faculty – Dental and Hygiene Schools
Basic Science Faculty – Gross Anatomy
Dental Prosthetic Laboratory School Faculty
Dental Assistant
Dental Radiology Technician
Central Sterilization Assistant
Prosthetic Laboratory Technicians
Students – Dental, Hygiene, Prosthetic Laboratory, Dental Assisting

Tasks and procedures with occupational exposure

Exposure of dental radiographs
All clinical dental procedures – Adult and Pediatric
 Examination
 Prophylaxis, scaling and root planning
 Restorative procedures including operative and prosthodontics
 Removable prosthodontics
 Endodontics
 Periodontal surgery
 Oral and maxillofacial surgery
 Orthodontics
Packaging and sterilization of dental instruments
 Transport of contaminated instruments to Central Sterilization Room
 Cleaning and disinfection of instruments
 Packaging of instruments for sterilization

COMPLIANCE POLICIES AND PROCEDURES

TRAINING

All employees are trained on infection control procedures, rationale and policies at time of employment.

All employees receive infection control and bloodborne pathogens training annually.

All students are trained on infection control procedures early in the first year of their program and annually.

In accordance with OSHA 1910.1030, training will include:

1910.1030(g)(2)(vii)(A)

An accessible copy of the regulatory text of this (Bloodborne Pathogens) standard and an explanation of its contents;

1910.1030(g)(2)(vii)(B)

A general explanation of the epidemiology and symptoms of bloodborne diseases;

1910.1030(g)(2)(vii)(C)

An explanation of the modes of transmission of bloodborne pathogens;

1910.1030(g)(2)(vii)(D)

An explanation of the employer's Infection Control Plan and the means by which the employee can obtain a copy of the written plan;

1910.1030(g)(2)(vii)(E)

An explanation of the appropriate methods for recognizing tasks and other activities that may involve exposure to blood and other potentially infectious materials;

1910.1030(g)(2)(vii)(F)

An explanation of the use and limitations of methods that will prevent or reduce exposure including appropriate engineering controls, work practices, and personal protective equipment;

1910.1030(g)(2)(vii)(G)

Information on the types, proper use, location, removal, handling, decontamination and disposal of personal protective equipment;

1910.1030(g)(2)(vii)(H)

An explanation of the basis for selection of personal protective equipment;

1910.1030(g)(2)(vii)(I)

Information on the hepatitis B vaccine, including information on its efficacy, safety, method of administration, the benefits of being vaccinated, and that the vaccine and vaccination will be offered free of charge;

1910.1030(g)(2)(vii)(J)

Information on the appropriate actions to take and persons to contact in an emergency involving blood or other potentially infectious materials;

1910.1030(g)(2)(vii)(K)

An explanation of the procedure to follow if an exposure incident occurs, including the method of reporting the incident and the medical follow-up that will be made available;

1910.1030(g)(2)(vii)(L)

Information on the post-exposure evaluation and follow-up that the employer is required to provide for the employee following an exposure incident;

1910.1030(g)(2)(vii)(M)

An explanation of the signs and labels and/or color coding required by paragraph (g)(1); and **1910.1030(g)(2)(vii)(N)**

An opportunity for interactive questions and answers with the person conducting the training session.

As a result of the COVID-19 pandemic, added section: *Enforcement Discretion for Respiratory Protection* ([29 CFR 1910.134](#))

In light of the [Presidential Memorandum](#) on making general use respirators available for healthcare workers during the COVID-19 pandemic, OSHA has issued temporary enforcement guidance:

- Required annual fit-testing (paragraph (f)(2))
- Selection of respirators (paragraph (d)); and/or the equivalent respiratory protection provisions of other health standards
- Recording and Reporting Occupational Injuries and Illness ([29 CFR 1904](#))

STANDARD PRECAUTIONS/TRANSMISSION PRECAUTIONS

Standard Precautions apply to all patients. They integrate and expand Universal Precautions to include organisms spread by blood and the following:

- Body fluids, secretions, and excretions except sweat, whether or not they contain blood
- Non-intact (broken) skin
- Mucous membranes

TRANSMISSION-BASED PRECAUTIONS

Standard Precautions are sometimes referred to as the first tier of precautions because when patients present with documented or suspected infection with highly transmissible pathogens, additional measures, or a second tier of precautions, are necessary to prevent the potential spread of these diseases. In other words, when the routes of transmission cannot be completely interrupted with Standard Precautions alone, it is necessary to use Transmission Based Precautions.

There are three categories of Transmission Based Precautions that mirror the modes of disease transmission:

- *Airborne Precautions*
- *Droplet Precautions*
- *Contact Precautions*

More than one Transmission Based Precaution category may apply because some diseases are spread by multiple routes of transmission. It is important to note that when used alone or in combination, Transmission Based Precautions are always used in addition to Standard Precautions.

Contact Precautions are intended to prevent transmission of infectious agents spread by direct or indirect contact with the patient or the patient's environment.

- examples of diseases/conditions requiring contact precautions: Clostridium difficile, Herpes simplex, H1N1 influenza*, Methicillin-resistant Staphylococcus aureus (MRSA), Severe acute respiratory syndrome (SARS)*, Smallpox*, and Varicella Zoster (chicken pox)*

Droplet Precautions are used to prevent transmission of pathogens spread through close respiratory or mucous membrane contact with respiratory secretions. Person-to-person transmission can occur when an infected person coughs, sneezes, or talks and generates large particle droplets (> 5 µm). Spatter of blood and saliva are frequently generated during dental treatment and if these materials from an infected patient contact unprotected broken skin or mucous membranes, disease transmission may occur. Generally, special ventilation requirements are not needed to prevent droplet transmission because these pathogens do not remain infectious over long distances in a health care facility.

- examples of diseases/conditions requiring droplet precautions: Seasonal Influenza, H1N1 influenza*, Mumps, Rubella, Pertussis, and Severe acute respiratory syndrome (SARS)*

Airborne Precautions involves smaller particles (< 5µm) called droplet nuclei or aerosols. Transmission occurs when these particles, which can remain suspended in the air for long periods of time, are inhaled by dental health care personnel or patients. Exposure to aerosols containing microorganisms from patient's blood or saliva may occur when using rotary instruments including dental handpieces or ultrasonic scalers. Airborne Precautions are used to prevent transmission of infectious agents that remain infectious over long distances when suspended in the air.

- Examples of Diseases/Conditions Requiring Airborne Precautions: H1N1 influenza*, Measles, Severe acute respiratory syndrome (SARS)*, Smallpox*, Tuberculosis (confirmed pulmonary or laryngeal), and Varicella Zoster (chicken pox)*

PERSONAL PROTECTIVE EQUIPMENT (PPE)

PPE are designed to protect the skin and mucous membranes of the eyes, nose and mouth from blood or other potentially infectious material (OPIM). Spray and aerosol from handpieces and air-water syringe, patient's cough, and other activities in the operatory are possible sources of pathogens. PPE required includes:

N99/N95 mask: During **aerosol-generating procedures conducted on patients assumed to be non-contagious**, the N99/N95 respirator offers a higher level of protection and are used for all aerosol-producing dental procedures

Surgical mask: covers both mouth and nose that protects patient from microorganisms generated by the wearer and the DHCW during non-aerosol. Mask should be changed if wet or visibly soiled and between patients. LSUSD has no facility or NIOSH certified masks for treating active tuberculosis patients.

For suspected TB patient protocol see Appendix A.

Protective eyewear: Goggles or a face shield are worn for all clinical procedures. Protective eyewear is required for the patient to protect their eyes from debris. Eyewear is cleaned and disinfected between patients.

Long-sleeve disposable gowns: worn for all clinical procedures. Gowns are changed as soon as possible if torn or visibly soiled and between patients. Gowns are removed before leaving treatment areas and are not worn into waiting areas, lounges or between buildings.

Single use, powder free gloves: worn for all clinical procedures. Patient examination gloves may be worn for non-surgical clinical procedures. Sterile surgical gloves are worn for periodontal surgery and oral surgery procedures. Hands are washed before putting on and after removing gloves.

Gowns, gloves and masks are removed before leaving treatment areas, simulation and technique laboratories.

Central Sterilization Room (CSR) personnel use nitrile utility gloves when cleaning and disinfecting contaminated instruments. Nitrile gloves are used when cleaning with disinfectant solutions as latex gloves do not adequately protect the user. Gowns, gloves and masks are removed before leaving CSR.

Non-latex gloves, both nitrile and vinyl are available for providers or patients with latex allergy or sensitivity. For more information on latex allergy see Appendix B.

ADMINISTRATIVE CONTROLS

Key CDC Administrative Recommendations For Dental Settings:

LSUSD maintains infection prevention and occupational health programs and provides supplies necessary for adherence to Standard Precautions (e.g., hand hygiene products, safer devices to reduce percutaneous injuries, personal protective equipment).

The infection control program is coordinated by the Chairman of the Infection Control Committee and the committee members under the charge of the Associate Dean of Clinical Affairs.

LSUSD has written infection prevention policies and procedures appropriate for the services provided by the facility and based upon evidence-based guidelines, regulations, or standards. These infection prevention policies and procedures are reassessed annually.

The facility meets challenges of emerging infections by modifying protocols for each disease outbreak, and works with LSU Health to provide the most effective means to address each challenge.

The facility has a system for early detection and management of potentially infectious persons at initial points of patient encounter.

Periodic monitoring of the clinic facilities are regularly scheduled and carried out by the Infection Control Committee; a checklist (Appendix J) is used to inspect the clinic areas and violations (student, staff, and faculty) are reported to the Infection Control Committee to determine what action to take.

DHCP receive education on the importance of infection prevention measures to contain respiratory secretions to prevent the spread of respiratory pathogens when examining and caring for patients with signs and symptoms of a respiratory infection.

ENGINEERING CONTROLS

Puncture proof, properly labeled sharps containers are used to prevent injury to both clinical staff and housekeeping staff.

WORK-PRACTICE CONTROLS

All burs are removed from handpieces and discarded before removing the handpiece from the dental unit to prevent percutaneous injury.

Tissue retraction for anesthetic injection, incision and suturing is done with an instrument and not with a finger.

All sharps, including but not limited to disposable needles, anesthetic carpules, burs, disposable scalpel blades broken instruments are disposed of in properly labeled, puncture-resistant sharps containers located in each operatory.

Recapping needles is done using a one-hand scoop method or a recapping device. Personnel do not use a two-hand recapping technique or bend or break needles before disposal. Needles are recapped before removing from aspirating syringe, and uncapped needles are not passed.

Surface decontamination: Surfaces in the dental operatory are considered either contact surfaces or housekeeping surfaces. Housekeeping surfaces (floors, walls, and sinks) are not considered risks for disease transmission and can be cleaned with detergent and water or hospital disinfectant/detergent as part of routine housekeeping.

Contact surfaces in the operatory include:

- Light handles
- Switches
- Radiographic equipment
- Computers
- Reusable containers
- Drawer handles
- Mobile cabinet tops
- Counter tops

Barrier protection is used whenever possible to cover contact surfaces. Barriers include plastic wrap, bags, adhesive wrap and other moisture impervious materials. All instruments/cassettes are placed in autoclave bags and sterilized. Computers, books and items not used to treat the patient are kept clear of the sterile and/or contaminated areas.

If contact surfaces cannot be barrier-protected or if they become contaminated inadvertently, they must be disinfected following manufacturer's directions with an EPA registered hospital disinfectant. All surfaces are cleaned and disinfected at the end of the day. Note: computer keyboards cannot be disinfected and clinicians must use barriers or remove gloves before using clinic computers.

Contaminated Instruments: At the completion of treatment, instruments are placed in the cassette and waste is properly disposed of. Treatment gown and gloves are removed from the inside out and place in the biohazard bag. The cassette is wrapped in the blue wrap with the outside of the wrap now being considered clean and the inside of the wrap contaminated. The wrapped cassette is delivered to the window bare-handed while avoiding holding the wrapped cassette against your body.

Contaminated instruments are transported from dispensaries to the central sterilization room using properly labeled, covered mobile carts.

STERILIZATION AND DISINFECTION OF PATIENT-CARE DEVICES

CDC Recommendations for Sterilization and Disinfection of Patient-Care Devices for Dental Settings:

Reusable dental Instruments and equipment are cleaned and reprocessed according to manufacturer's instructions. If the manufacturer does not provide such instructions, the device may not be suitable for multi-patient use.

Manufacturer instructions for reprocessing reusable dental instruments/equipment are readily available in or near the reprocessing area.

Reprocessing of dental equipment is done by an appropriately trained dental worker, who wears appropriate PPE when handling and reprocessing contaminated patient equipment.

Mechanical, chemical, and biological monitors are used according to manufacturer instructions to ensure the effectiveness of the sterilization process

Sterilization records are maintained in accordance with state and local regulations.

Additional Recommendations: Although the following items are not included as key recommendations, they are included in Appendix E as relevant recommendations for sterilization and disinfection released by CDC since 2003:

- Label sterilized items with the sterilizer used and date of sterilization.

- Ensure routine maintenance for sterilization equipment is performed according to manufacturer instructions and maintenance records are available.

Eating, drinking, smoking, applying cosmetics or lip balm and handling contact lenses are prohibited in clinics, laboratories and central sterilization rooms.

No food or drinks is kept in refrigerators, freezers, shelves, cabinets or on counter tops where and potentially infectious material may be present.

Dental unit waterlines are treated to control biofilm and reduce microbacterial count in operatory aerosol and spatter. See Appendix D.

HAND HYGIENE

Hand hygiene is the single most critical measure for reducing the risk of transmitting organisms to patients and DHCW and is especially important during the COVID-19 pandemic, according to the CDC.

Use ABHR with 60-95% alcohol or wash hands with soap and water for at least 20 seconds. If hands are visibly soiled, use soap and water before returning to ABHR.

All involved in patient care will adhere to the following protocols:

Wash hands with soap and water for at least 15 seconds before and after beginning donning gloves for clinical procedures and,

Wash hands with soap and water or (if hands are not visibly soiled) use an alcohol-based antiseptic hand rub, rubbing hands until the agent is dry, whenever removing and re-donning gloves.

Before surgical procedures, personnel will perform a surgical hand scrub with antimicrobial soap for 2-6 minutes (or with plain soap followed by alcohol-based surgical hand-scrub with persistent activity).

Petroleum base hand lotions can weaken latex gloves and increase their permeability and should not be used until the end of the workday.

Fingernails should be short enough to allow thorough cleaning underneath and to prevent glove tears. Artificial nails harbor gram-negative organisms and have been implicated in fungal and bacteriological infection outbreaks in hospital ICUs and are not allowed.

Jewelry should not interfere with glove use. If rings may cause tears or cause the person to have to wear an improper glove size, they must be removed. Removal of jewelry is recommended.

INFECTION CONTROL PLAN REVIEW

The LSUHSC School of Dentistry Infection Control Plan is reviewed annually by the Infection Control Committee. In addition to a periodic review of the school's infection control program, the committee will also discuss the following:

- Technology changes to eliminate or reduce exposure to blood borne pathogens, including staff suggestions
- Consideration and implementation of appropriate commercial safer medical devices
- Input from non-managerial employees responsible for direct patient care

APPENDICIES

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APPENDIX A

DEFINITIONS

Blood means human blood, human blood components, and products made from human blood.

Bloodborne Pathogens means pathogenic microorganisms that are present in human blood and can cause disease in humans. These pathogens include, but are not limited to, hepatitis B virus (HBV) and human immunodeficiency virus (HIV).

Contaminated means the presence or the reasonably anticipated presence of blood or other potentially infectious materials on an item or surface.

Contaminated Laundry means laundry that has been soiled with blood or other potentially infectious materials or may contain sharps.

Contaminated Sharps means any contaminated object that can penetrate the skin including, but not limited to, needles, scalpels, broken glass, broken capillary tubes, and exposed ends of dental wires.

Decontamination means the use of physical or chemical means to remove, inactivate, or destroy bloodborne pathogens on a surface or item to the point where they are no longer capable of transmitting infectious particles and the surface or item is rendered safe for handling, use, or disposal.

Engineering Controls means controls (e.g., sharps disposal containers, self-sheathing needles, safer medical devices, such as sharps with engineered sharps injury protections and needleless systems) that isolate or remove the bloodborne pathogens hazard from the workplace.

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

Handwashing Facilities means a facility providing an adequate supply of running potable water, soap and single use towels or hot air drying machines.

Licensed Healthcare Professional is a person whose legally permitted scope of practice allows him or her to independently perform the activities required by paragraph (f) Hepatitis B Vaccination and Post-exposure Evaluation and Follow-up.

HBV means hepatitis B virus.

HIV means human immunodeficiency virus.

Occupational Exposure means reasonably anticipated skin, eye, mucous membrane, or parenteral contact with blood or other potentially infectious materials that may result from the performance of an employee's duties.

Other Potentially Infectious Materials means (1) The following human body fluids: semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, saliva in dental procedures, any body fluid that is visibly contaminated with blood, and all body fluids in situations where it is difficult or impossible to differentiate between body fluids; (2) Any unfixed tissue or organ (other than intact skin) from a human (living or dead); and (3) HIV-containing cell or tissue cultures, organ cultures, and HIV- or HBV-containing culture medium or other solutions; and blood, organs, or other tissues from experimental animals infected with HIV or HBV.

Parenteral means piercing mucous membranes or the skin barrier through such events as needlesticks, human bites, cuts, and abrasions.

Personal Protective Equipment is specialized clothing or equipment worn by an employee for protection against a hazard. General work clothes (e.g., uniforms, pants, shirts or blouses) not intended to function as protection against a hazard are not considered to be personal protective equipment.

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

Research Laboratory means a laboratory producing or using research-laboratory-scale amounts of HIV or HBV. Research laboratories may produce high concentrations of HIV or HBV but not in the volume found in production facilities.

Sars-CoV2 virus or severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) is the name of the new virus that causes the disease **COVID-19**

Sharps with engineered sharps injury protections means a non-needle sharp or a needle device used for withdrawing body fluids, accessing a vein or artery, or administering medications or other fluids, with a built-in safety feature or mechanism that effectively reduces the risk of an exposure incident.

Source Individual means any individual, living or dead, whose blood or other potentially infectious materials may be a source of occupational exposure to the employee. Examples include, but are not limited to, hospital and clinic patients; clients in institutions for the developmentally disabled; trauma victims; clients of drug and alcohol treatment facilities;

residents of hospices and nursing homes; human remains; and individuals who donate or sell blood or blood components.

Standard Precautions is the use of personal protective equipment (PPE) to prevent exposure to both bloodborne and airborne pathogens.

Sterilize means the use of a physical or chemical procedure to destroy all microbial life including highly resistant bacterial endospores.

Universal Precautions is an approach to infection control. According to the concept of Universal Precautions, all human blood and certain human body fluids are treated as if known to be infectious for HIV, HBV, and other bloodborne pathogens.

Work Practice Controls means controls that reduce the likelihood of exposure by altering the manner in which a task is performed (e.g., prohibiting recapping of needles by a two-handed technique).

APPENDIX B

PROTOCOL FOR TRIAGE OF SUSPECTED ACTIVE TUBERCULOSIS PATIENTS

Background: *M. tuberculosis* is the bacterium that causes tuberculosis. It is an airborne infection. The bacteria are carried by droplet nuclei generated when an infected person coughs, sneezes or talks. These droplet nuclei can stay suspended in the air for hours. Infection occurs when a susceptible person inhales the droplets. 90% of people infected with *M. tuberculosis* will not develop active disease, 5% will develop active TB in 1-2 years and 5% will develop active TB later in life.

Symptoms of active TB include productive cough, night sweats, fatigue, malaise, fever and unexplained weight loss. Latent TB is asymptomatic and is diagnosed by tuberculin skin test.

There was a tremendous resurgence of TB in the United States from 1985-1992. The “annual TB rate steadily decreased during 1993--2005; however, the decline has recently decelerated, raising concerns that the progress toward eliminating TB is slowing.” In 2003, 71 new active TB cases were reported to the CDC for New Orleans.

Surgical masks do not provide protection for the Dental Health Care Worker against *m. tuberculosis*. The CDC recommends patients suspected of active TB be treated in facilities that can provide airborne infection isolation. LSUHSC School of Dentistry clinics **do not** have this capability.

PROTOCOL FOR TRIAGE AND TREATMENT

A thorough health history and review of symptoms is performed for every patient.

For a patient with medical history or symptoms suggesting possible active TB:

- The patient should not remain in the clinic longer than necessary to assess their dental condition and refer for medical evaluation.
- The patient should wear a surgical mask when not being examined and should be instructed to cover their mouth and nose when coughing or sneezing.
- If emergency care is needed, the patient must be seen in a facility that provides airborne infection isolation.
- Elective treatment will not be provided until active TB has been ruled out by medical examination.
- Any DHCW with symptoms suggesting active TB will not be allowed in clinic until infection has been ruled out.

APPENDIX C

LATEX ALLERGY AND SENSITIVITY

Centers for Disease Control and Prevention. **Guidelines for Infection Control in Dental Health-Care Settings – 2003**. MMWR2003; 52(No.RR-17) p19-20.

Taking thorough health histories for both patients and DHCP, followed by avoidance of contact with potential allergens, can minimize the possibility of adverse reactions. Certain common predisposing conditions for latex allergy include previous history of allergies, a history of spina bifida, urogenital anomalies, or allergies to avocados, kiwis, nuts, or bananas.

The following protocols/precautions are considered to ensure safe treatment for patients who have possible or documented latex allergy:

- Awareness that latent allergens in the ambient air can cause respiratory or anaphylactic symptoms among persons with latex hypersensitivity. Patients with latex allergy should be scheduled when possible for the first appointment of the day to minimize their inadvertent exposure to airborne latex particles.
- Communication with other DHCP regarding patients with latex allergy (e.g., by oral instructions, written protocols, and posted signage) to prevent them from bringing latex-containing materials into the treatment area.
- Frequently cleaning all working areas contaminated with latex powder or dust.
- Having emergency treatment kits with latex-free products available at all times.

If latex-related complications occur during or after a procedure, manage the reaction and seek emergency assistance as indicated. Follow current medical emergency response recommendations for management of anaphylaxis (32).

Occupationally related contact dermatitis can develop from frequent and repeated use of hand hygiene products, exposure to chemicals, and glove use. Contact dermatitis is classified as either irritant or allergic. Irritant contact dermatitis is common, nonallergic, and develops as dry, itchy, irritated areas on the skin around the area of contact. By comparison, allergic contact dermatitis (type IV hypersensitivity) can result from exposure to accelerators and other chemicals used in the manufacture of rubber gloves (e.g., natural rubber latex, nitrile, and neoprene), as well as from other chemicals found in the dental practice setting (e.g., methacrylates and glutaraldehyde). Allergic contact dermatitis often manifests as a rash beginning hours after contact and, similar to irritant dermatitis, is usually confined to the area of contact.

Latex allergy (type I hypersensitivity to latex proteins) can be a more serious systemic allergic reaction, usually beginning within minutes of exposure but sometimes occurring hours later and producing varied symptoms. More common reactions include runny nose, sneezing, itchy eyes, scratchy throat, hives, and itchy burning skin sensations. More severe symptoms include asthma marked by difficult breathing, coughing spells, and wheezing; cardiovascular and gastrointestinal ailments; and in rare cases, anaphylaxis and death (32,225). The American Dental Association

(ADA) began investigating the prevalence of type I latex hypersensitivity among DHCP at the ADA annual meeting in 1994. In 1994 and 1995, approximately 2,000 dentists, hygienists, and assistants volunteered for skin-prick testing. Data demonstrated that 6.2% of those tested were positive for type I latex hypersensitivity (226). Data from the subsequent 5 years of this ongoing cross-sectional study indicated a decline in prevalence from 8.5% to 4.3% (227). This downward trend is similar to that reported by other studies and might be related to use of latex gloves with lower allergen content (228--230).

Natural rubber latex proteins responsible for latex allergy are attached to glove powder. When powdered latex gloves are worn, more latex protein reaches the skin. In addition, when powdered latex gloves are donned or removed, latex protein/powder particles become aerosolized and can be inhaled, contacting mucous membranes (231). As a result, allergic patients and DHCP can experience cutaneous, respiratory, and conjunctival symptoms related to latex protein exposure. DHCP can become sensitized to latex protein with repeated exposure (232--236). Work areas where only powder-free, low-allergen latex gloves are used demonstrate low or undetectable amounts of latex allergy-causing proteins (237--239) and fewer symptoms among HCP related to natural rubber latex allergy. Because of the role of glove powder in exposure to latex protein, NIOSH recommends that if latex gloves are chosen, HCP should be provided with reduced protein, powder-free gloves (32). Nonlatex (e.g., nitrile or vinyl) powder-free and low-protein gloves are also available (31,240). Although rare, potentially life-threatening anaphylactic reactions to latex can occur; dental practices should be appropriately equipped and have procedures in place to respond to such emergencies.

DHCP and dental patients with latex allergy should not have direct contact with latex-containing materials and should be in a latex-safe environment with all latex-containing products removed from their vicinity (31). Dental patients with histories of latex allergy can be at risk from dental products (e.g., prophylaxis cups, rubber dams, orthodontic elastics, and medication vials) (241). Any latex-containing devices that cannot be removed from the treatment environment should be adequately covered or isolated. Persons might also be allergic to chemicals used in the manufacture of natural rubber latex and synthetic rubber gloves as well as metals, plastics, or other materials used in dental care

APPENDIX D

DENTAL UNIT WATERLINE TREATMENT PROTOCOL

Background: Narrow-bore dental unit waterlines (duwl) become colonized with microorganisms if not treated to prevent colonization. Colonization is in the form of a biofilm on the internal surfaces of the tubing. The biofilm can be likened to dental plaque, a complex colony of different microorganisms in a polysaccharide slime layer. This biofilm reservoir concentrates the microbial load in duwl water delivered in patient care. Microbial counts of $\geq 10^6$ CFU/ml have been found in untreated duwls. In contrast, the American Public Health Association and American Water Works Association have established ≤ 500 CFU/ml as the standard for drinking water.

While no significant risk from duwls has been established, disease outbreaks have been associated with a grocery store mist machine, whirlpool spas, and potable water supplies (Legionnaires disease). 2 cases of *Pseudomonas aeruginosa* infection in immunocompromised patients potentially are linked to duwl contamination.

CDC recommends that duwl water be maintained at least ≤ 500 CFU/ml, the U.S. standard for drinking water. All of the dental units utilize individual water reservoirs facilitating maintenance of a high quality of water delivered for patient care.

DUWL TREATMENT PROTOCOL

Wash hands with soap and water and put on exam gloves as the pick-up tube and bottle opening can become contaminated with improper handling. Avoid touching the bottle top or pick-up tube.

Turn the water bottle to the left until it can be removed. Empty any remaining water.

Sterisil Dental Water Treatment Straws are engineered to produce a shock treatment after initial connection and treatment of dental water. Bottle is filled with water from tap which is automatically treated as it runs through the straw. Straws are replaced once per year (based on straw capacity and replacement schedule).

Align the full bottle with the water unit cap making sure the pick-up tube extends straight down into the bottle.

Screw the bottle onto the unit until secure.

Operate the air-water syringes and handpiece lines to clear air from the water lines.

WATERLINE TESTING

DUWL water will be tested on a regular basis using an independent testing facility and results will be reported to the Infection Control Committee.

Any unit that tests above ≤ 500 CFU/ml will be shocked with Sterilex Ultra and then retested.

APPENDIX E
STERILE PROCESSING
STANDARD OPERATING PROCEDURES

Purpose

- This Standard Operating Procedures (SOP) manual prescribes the policies, responsibilities, and methods for the sterilization process at LSUSD. It covers processing, sterilization, handling, and storage of instruments before, during, and after sterilization.
- The objective is to achieve assurance of sterility and delivery of sterile supplies to user areas of the facilities.

Responsibilities

- Supervisors of the sterilization process will ensure that all personnel performing the sterilization process will have:
 - (1) Documented competency training
 - (2) Orientation to the work space
 - (3) On-the-job training
 - (4) Active participation in continuing education or in-service programs

Receiving Area

- Access to the processing area is limited to the CSR supervisor and designated central service workers only.
- All other personnel are prohibited from entering this area.
- Instruments will be transported in covered carts labeled with the biohazard symbol from the clinic floor to the instrument processing area.
- Instrument cassettes will be placed directly into the washer-disinfector units and cleaned following manufacturers directions.
- Basket/cassette will be removed from the ultrasonic unit and thoroughly rinsed under running water and transferred to the processing area.
- No eating or drinking in this area

Personal Protective Equipment (PPE)

- Wear puncture- and chemical-resistant heavy duty gloves for instrument cleaning and decontamination procedures.
- Wear protective rubber apron, lab coat or other soak-proof clothing.

- Eye/face protection: Wear a full face shield with crown and chin protection that wraps around the face to the point of the ear or a combination of ANSI approved splash goggles and face shield.

(Note: Per NIOSH, “disposable face shields made of light weight films that are attached to a surgical mask or fit loosely around the face should not be relied upon as optimal protection.”)

Cleaning

- Since a diminished bioburden increases the assurance that an item will be sterilized, thorough cleaning procedures are essential during the presterilization processing.
- Cleaning procedures will be carried out in a designated area. This area will have a physical barrier separating it from all other areas of the department.
- There must be a designated area to perform this function

Hand pieces

- Hand pieces will be scrubbed and wiped while wearing personal protective equipment (PPE).
- High-speed: Wipe down thoroughly with isopropyl alcohol, paying special attention to the fiber optic areas.
- Low-speed: Attachments will be wiped down with isopropyl alcohol, taken apart, lubed and run.

Processing

- Wear utility gloves and inspect instruments for cleanliness and damage. Any instruments that are not clean will be returned to the ultrasonic cleaner and run for an additional 15 minutes. Worn or damaged instruments will be replaced.
- Sort all instruments according to sets or packs.
- All sets/packs not in cassettes will be placed on a tray suitable for sterilization.
- Place all expendable items such as 2x2 gauze, cotton rolls, cotton pellets, aluminum foil, and needles on the tray.
- Inspect bur blocks and replace missing burs.
- Wrap all packs and cassettes in a double layer of blue paper wrap. Close the pack with a process monitor (striped tape).
- Place other critical items to be sterilized in a peel pack with a dosage indicator.

Labeling Sterile Packs

- Label ALL packs with:
 - I.D. number of the sterilizer
 - Date: Day, Month, Year
 - The load cycle the package was run in the sterilizer.
- Write on the tape and opening portion of the peel packs only, never on the blue paper or body of the peel pack.

Event-Related Sterilization

- Event-related and not time-related
- A storage practice that recognizes that a package and its contents remain sterile until some event (e.g., the packaging becomes wet or torn) causes the items to become contaminated.
- A package is considered un-sterile if the wrapper is torn, punctured, wet or moist (wet appearance or wet and then dried), opened, mishandled or damaged in any other way.
- Packaged or wrapped items are not sterile if the tape is broken.
- Peel pack pouches are not sterile if they are not sealed correctly or if they are excessively wrinkled.
- Items with an external chemical indicator, that has not changed, are not sterile.
- Closed container systems that do not have locks, filters, external indicators, or lids that do not fit properly are not sterile.
- Items in plastic dust protectors, which are unsealed, are not sterile.
- If the package has not been handled and stored properly, it is not sterile.
- Store sterile items and dental supplies in a covered or closed cabinet, if possible. Every effort must be made to protect sterile items from environmental elements such as moisture and dust.

Sterilization

- Arrange packs loosely in the autoclave
- Ensure enough space between sets to facilitate transfer of steam throughout the sterilizer
- All sterilization will be performed by using medical sterilization equipment cleared by the FDA.

- All sterilization times, temperatures, and other operation parameters recommended by the manufacturer of the equipment will be used, as well as instructions for correct containers, wraps, and chemical, and biological indicators.

Sterilization Monitoring

- Monitor each load with mechanical indicators
- Time
- Temperature
- Pressure
- All sterilization peel packs come with an internal TTP indicator. If the internal indicator is not visible from the outside, then use an external indicator.
- Inspect indicator after sterilization and at time of use.
- Do not use instrument packs if chemical or mechanical monitoring indicate inadequate processing

Biological Monitoring

Steam Sterilizers

- Perform biological testing weekly with the initial load on Monday. Place the test in the center of the sterilizer.
- Standard sterilization time
- 5 minutes-sterilization
- 20 minutes-dry
- Standard Temperature
- 270-275 Degrees Fahrenheit
- Interpretation
 - Compare test to control
 - Read and record results at both 3 and 24 hours.
- Spore test every load if sterilizing implantable devices
- Do not use flash sterilization for reasons of convenience or to save time

Positive Biological Indicator Recall

- In the event a biological indicator is read to be positive, immediately notify the Chairman of the Infection Control Committee (Dr Garbee) and repair (Mike Boutte) and secure the sterilizer.
- In the event any instrument may have already been used, notify the Assistant Dean of Clinical Affairs.
- Make appropriate log entry and complete a Risk Management Screen.
- Resterilize all packs since the last negative test.

APPENDIX F

PROSTHETIC LABORATORY PROCEDURES

The student or resident will remove mask, gloves and clinic gown before leaving the clinic area. Any student attempting to deliver a case to the prosthetic lab in clinical attire will be refused service and their name will be reported to the Infection Control Committee.

All impressions, appliances, dentures, records, and anything else that will be turned in for processing will be disinfected prior to leaving the clinic area.

All items will be delivered to the lab bare handed and labeled “disinfected” or be delivered in a cup containing disinfectant or, in the case of impressions, in a headrest cover sprayed with disinfectant.

Impressions will be gently rinsed with water to remove saliva prior to disinfection. If necessary, stone powder and a sable brush can be used to remove blood and debris. The impressions will then be placed in a headrest cover and sprayed with mid-level disinfectant. The appliance will remain in the disinfectant for 10 minutes then gently rinsed with water.

Newly fabricated crowns and bridges will be placed in a cup and covered with mid-level disinfectant for 10 minutes by the clock.

Old, grossly contaminated appliances will be placed in a headrest cover and sprayed with mid-level disinfectant. The appliance will remain in the disinfectant for 10 minutes then rinsed and placed in a clean headrest cover. The appliance will be delivered to the lab in the headrest cover for further cleaning by ultrasonic or scrubbing as determined by lab personnel.

APPENDIX G

CDC RECOMMENDATIONS FOR SAFE INJECTION PRACTICES IN DENTAL SETTINGS

Where Applicable (E.G. Oral Surgery, Periodontics, Out Patient Clinic, Etc.)

- Prepare injections using aseptic technique in a clean area.
- Disinfect the rubber septum on a medication vial with alcohol before piercing.
- Do not use needles or syringes for more than one patient (this includes manufactured prefilled syringes and other devices such as insulin pens).
- Medication containers (single and multi-dose vials, ampules and bags) are entered with a new needle and syringe, even when obtaining additional doses for the same patient.
- Use single-dose vials for parenteral medications when possible.
- Do not use single-dose (single-use) medication vials, ampules, and bags or bottles of intravenous solution for more than one patient.
- Do not combine the leftover contents of single-use vials for later use.
- The following apply if multidose vials are used:
 - Dedicate multidose vials to a single patient whenever possible.
 - If multidose vials will be used for more than one patient, they should be restricted to a centralized medication area and should not enter the immediate patient treatment area (e.g., dental operatory) to prevent inadvertent contamination.
 - If a multidose vial enters the immediate patient treatment area, it should be dedicated for single-patient use and discarded immediately after use.
 - Date multidose vials when first opened and discard within 28 days, unless the manufacturer specifies a shorter or longer date for that opened vial.

APPENDIX H
INSTRUCTIONS FOR MANDATORY TESTS AND IMMUNIZATIONS
Bring this and the purple health form to your physician for completion

COPIES OF ORIGINAL LABS MUST ACCOMPANY PURPLE HEALTH FORM

- #1 Varicella IgG (CPT code 86787, LabCorp 096206, Quest 4439)
If titer shows no immunity you must complete 2 varivax injections unless there is a health reason not to be vaccinated as indicated by your physician. A history of chicken pox is **NOT** sufficient.
- #2 VDRL or RPR (CPT code 86592, LabCorp 006072, Quest 36126)
If your titer is positive, you must prove that you have been treated for syphilis.
- #3 Measles (Rubeola) IgG (CPT code 86765, LabCorp 096560, Quest 964)
- #4 Mumps IgG (CPT code 86735, LabCorp 096552, Quest 8624)
- #5 Rubella IgG (CPT code 86762, LabCorp 006197, Quest 802)
OR (1 MMR vaccination after you are at least 12 months old, and a second immunization no sooner than 28 days after the first) unless there is a health reason not to be vaccinated as documented by your physician.
- a. Documentation of MMR series (2 injections) no titer is required.
 - b. To prove immunity by titer all three tests must be drawn.
 - c. If titers show you are not immune you must receive 2 MMR's.
- #6 Tetanus
Documented tetanus booster or Tdap within the 10-year period before you register (e.g., if you register in 2018, you must have had a tetanus vaccination anytime between the years 2009 and your registration date in 2018).
- #7 Hepatitis B
Document Hepatitis B vaccination(s), 3 shot series. The second shot is given no earlier than 30 days after the first. The final shot is given no earlier than 6 months after the first (or at least 5 months from the 2nd shot).
- a. Proving immunity by titer, HepB surface antibody (CPT code 86706, LabCorp 006395, Quest 34000). (Note: if you have not received all injections, you are not likely to be immune, so the titer would be a waste of money and it is **NOT** required).
 - b. You may not have enough time to complete the series before you register. You **MUST** have the 1st injection **BEFORE** registration day. Please keep on schedule to provide the best chance for immunity.
 - c. You must complete the series while at school or you **WILL BE BLOCKED** at future registrations.

#8 TB skin test

You must document that you have not been exposed to tuberculosis (i.e. TB Results are negative).

- All results should be reported in terms of the observed millimeters of induration (e.g. -0- mm induration).
- You will need a chest X-Ray only if your TB skin test was positive.
- You MAY document post-exposure prophylaxis if you wish. We will include this with your student health record.
- This test is required annually and can be received at the dental school.

****DENTAL SCHOOL SUPPLEMENT****

This is only required for Doctor of Dental Surgery and Dental Hygiene students and Dental Residents/Fellows. This is not required for Dental Lab Tech students.

Hepatitis B IgM-anti-HBc (core) (CPT code 86705, LabCorp 016881, Quest 4848)

Hepatitis B HbsAg (surface antigen) (CPT code 87340, LabCorp 006510, Quest 498)

Hepatitis C EIA for anti HCV (CPT code 86803, LabCorp 143991, Quest 8472)

HIV (HIV1-Ab) (CPT code 86701, LabCorp 083824, Quest 6449)

All of these tests are mandatory to show that you are not a Hepatitis B carrier or have Hepatitis C or HIV.

**APPENDIX I
EXPOSURE PROTOCOL AND INJURY REPORT**

Quick reference

EMPLOYEE/STAFF

First Aid- wash with soap and water DO NOT USE BLEACH OR SQUEEZE

1. Review and answer questions in the exposure packet. Ask the patient to sign the consent for obtaining the quick HIV test. Please review each page and follow the directions. The completed packet is to be sent to Campus RN.
2. Perform **quick HIV test**. (The individual test and instructions are located in the Central Sterilization area in BR and in each instrument dispensary on the second, third and fourth floors in NO. Allow 20 minutes for blood test result. **Perform the test ASAP** since the recommendation is to start medication within 2 hours for a positive test result. **It is required that blood be drawn from the student and the source for all exposure injuries.**
 - For a **positive quick test** result, the employee must go to Concentra to have blood work drawn immediately and to see if medication is indicated.
 - For a **negative test result**, the employee should go the same day for the blood work.
 - Contact Campus RN for permission to sign Employer’s Authorization for Examination or Treatment and make a copy. Give the original to the employee to take to Concentra.
 - Send a copy of the incident report and the Treatment Authorization form to Campus RN.
 - Send the source to Labcorp or Campus RN to have the blood drawn. Room 4312K, office phone 504-941-8393, cell 504-289-5915, Fax 504-941-8394. The bill will be paid by LSUSD.

<p>Concentra Medical Center for employee M-F 8-5 318 Baronne Street 70112 Phone 561-1051</p> <p>1600 Williams Blvd Kenner 70062 Phone 468-1506</p> <p>4015 Jefferson Hwy 70121 Phone 837-6447</p> <p>3235 Perkins Rd, BR. 70808 Phone 225-387-3030</p>	<p>Labcorp, New Orleans/ Campus RN for source 1716 St. Charles Ave. 70130. Phone 525-8033 Mon-Fri 8-5pm Lunch 12-1</p> <p>4330 Loveland St., Ste C Metairie, La 70006 Phone 455-5268 Mon-Fri 7:30-4:30pm Lunch 12-1</p> <p>7525 Picardy Baton Rouge, La. Phone 225-766-9489 Mon-Fri 8-5pm Lunch 12-1</p>
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Students/Residents

STOP PROCEDURE AND RINSE THE AREA WITH SOAP AND WATER. DO NOT USE BLEACH OR SQUEEZE THE AREA.

- ✚ Review and answer the questions in the exposure packet. These can be found in the dispensaries on the second, third and fourth floors and Central Sterilization in BR. Consents must be signed by both the student and the patient. Student /Faculty please review each page and follow the directions for filling out the forms. Return the completed packet to Campus RN.
- ✚ Quick HIV test. (The individual test and instructions are located in the CSR in BR and in each instrument dispensary on the second, third and fourth floors. in NO. The quick test is the only step that is urgent. It takes 20 minutes for the blood test results. It is important to perform the test quickly because it is recommended that medication be started within 2 hours if the test result is positive.
 - For a **positive HIV quick** test, contact Dr. Lauren A. Davis, Student Health Director, 504-525-4839; after-hours/holidays 504-412-1366. She will advise the student on the best post exposure treatment options.
 - For a **negative HIV quick** test- it is no longer considered an emergency situation.
- ✚ **Blood work** needs to be drawn from student and source either by Campus RN or by Labcorp. Give the student the lab request forms to bring to Labcorp.

Locations:

Labcorp, New Orleans

1716 St. Charles Ave.

Distance 3.81 mi. from school

NO, LA 70130

525-8033

Mon-Fri 8-5pm

Lunch 12-1

Or

4330 Loveland St. Ste C

Distance 5.78 mi. from school

Metairie, La 70006

455-5268

7:30-12 1-4:30

Labcorp, Baton Rouge

7525 Picardy

Distance 5 mi. from school

Baton Rouge, La.

225-769-2897

Mon-Fri 8-5pm

Lunch 12-1

- The patient and student should be instructed by faculty/supervising staff to return to the dental school the following day to have Campus RN draw the

blood work if she is not available at the time of the incident. Alternatively, the student and source can go to Labcorp. To have blood drawn; the lab orders necessary are found in the packet. The school will be billed for the cost of the source blood work.

- Faculty/supervising staff will fill out the names on the lab forms and give to the student to bring to the lab.

 If the patient refuses to be tested, the consent form needs to be filled out with the proper selection and signed by the patient (this form is in the packet). The student can see Campus RN or go to Labcorp to have his/her blood drawn. If the student refuses to go, a paper must be signed for refusing. The lab results will be faxed to Campus RN.

- Counseling and follow up will be done by LSUHSC Student Health.
- Student fills out LSUHSC employer injury/incident report (form is in the packet) within 24 hours and sends the completed packet to Campus RN via campus mail, box 145 or room 4312K

The student must provide a copy of his/her UnitedHealth Care insurance card and driver's license.

Campus RN

Dr. Lauren A. Davis' office: 525-4839; after hours/holidays: 504-412-1366

POST EXPOSURE CHECK LIST

	<i>STUDENT EXPOSURE</i>		<i>EMPLOYEE EXPOSURE</i>	
1	<input type="checkbox"/>	<i>Notify faculty and Student Health RN</i>	<input type="checkbox"/>	<i>Notify faculty and Student Health RN</i>
2	<input type="checkbox"/>	<i>Student Exposure packet and quick HIV test obtained from the dispensary</i>	<input type="checkbox"/>	<i>Employee Exposure packet and quick HIV test obtained from the dispensary</i>
3	<input type="checkbox"/>	<i>Student and Patient Source consents signed prior to OraQuick HIV test</i>	<input type="checkbox"/>	<i>Patient Source consent to be signed prior to performing OraQuick HIV test</i>
4	<input type="checkbox"/>	<i>Have Patient or student sign refusal if indicated</i>	<input type="checkbox"/>	<i>Have Patient Source sign the refusal if indicated and Employee if refuses blood testing</i>
5	<input type="checkbox"/>	<i>Immediately do OraQuick HIV test on Patient Source. Results of tests in 20 min Neg <input type="checkbox"/> Pos <input type="checkbox"/> If Neg. skip to step 8; if Pos, proceed to 6 and 7.</i>	<input type="checkbox"/>	<i>Immediately do Quick HIV test on Patient Source. Results of tests in 20 min Neg <input type="checkbox"/> Pos <input type="checkbox"/> If Neg. skip to step 8; if Pos, proceed to 6 and 7.</i>
6	<input type="checkbox"/>	<i>Positive results – Immediately have blood drawn from student and patient source by Student Health RN or Labcorp.</i>	<input type="checkbox"/>	<i>Positive results – Notify Concentra for Employee Exposure. Send employee to Concentra to have blood drawn.</i>
7	<input type="checkbox"/>	<i>Positive results -- Notify Dr. Davis and/or LSUHSC Comprehensive Medicine, MD to determine if PEP (Post Exposure Prophylaxis) is recommended; 504-525-4839; after hours/holidays 504-412-1366.</i>	<input type="checkbox"/>	<i>Positive results – Patient source blood to be drawn immediately by Student Health RN or Labcorp.</i>
8	<input type="checkbox"/>	<i>Negative results – Blood to be drawn from patient (HIV, Hep C, Hep B) and from student (baseline) by Student Health RN or Labcorp. (May be done up to a week from exposure)</i>	<input type="checkbox"/>	<i>Negative results – Blood to be drawn from patient (HIV, Hep C, Hep B) (baseline) by Student Health RN or Labcorp. Patient can return within a week to have blood drawn. Employee can go to Concentra within a week to have the baseline blood work drawn.</i>
9	<input type="checkbox"/>	<i>Student should never drive a patient to Labcorp but patient can follow student or employee.</i>	<input type="checkbox"/>	<i>Employee should never drive a patient to Lab Corp but patient can follow employee.</i>
10	<input type="checkbox"/>	<i>Fill out all forms and send packet to Student Health RN</i>	<input type="checkbox"/>	<i>Employee must fill out an incident report and bring a copy along with the completed Concentra Authorization for treatment form.</i>

In the interest of the health and safety of employees, students and patients, all exposures to blood and/or bodily fluids must be reported immediately. Time is critical with exposure.

OFFICE OF WORKER'S
 COMPENSATION
 POST OFFICE BOX 94040
 BATON ROUGE, LA 70804-9040
 (225) 342-7565

**EMPLOYER REPORT
 OF
 INJURY / ILLNESS
 LDOL-WC-1007**

Employee Social Security Number
Employer UI Account Number
Employer Federal ID Number
Location Code

**This report is completed by the Employer for each injury/illness identified by them or their employee as occupational.
 A copy is to be provided to the employee and the insurer immediately. Forms for cases resulting in more than 7 days
 of
 disability or death are to be sent to the OWCA by the 10th day after the incident or as requested by the OWCA.**

PURPOSE OF REPORT: (Check all that apply)

- More than 7 days of disability
- Injury resulted in death
- Amputation or disfigurement

- Possible dispute
- Lump Sum Compromise/Settlement
- Other

Medical Only
 (no copy needed by OWCA)

1. Date of Report MM/DD/YY	2. Date / time of injury: MM/DD/YY Time AM <input type="checkbox"/> PM <input type="checkbox"/>	3. Normal Starting Time Day of Accident: AM <input type="checkbox"/> PM <input type="checkbox"/>	4. If Back to Work Give Date MM/DD/YY	5. At same Wage? <input type="checkbox"/> Yes <input type="checkbox"/> No	DO NOT WRITE IN THIS COLUMN
6. If Fatal injury, Give Date of Death: MM/DD/YY	7. Date Employer Knew of injury: MM/DD/YY	8. Date Disability began: MM/DD/YY	9. Last Full Day Paid MM/DD/YY	Date Received	
10. Employee Name: First Middle Last			11. <input type="checkbox"/> Male <input type="checkbox"/> Female	12. Employee Phone # () -	S.I.C.
13. Address and Zip Code				14. Parish of Injury	State-Parish
15. Date of Hire	16. Age at illness/injury	17. Occupation		18. Dept./Division Employed:	Occupation
19. Place of Injury-Employer's Premises ? <input type="checkbox"/> Yes <input type="checkbox"/> No		20. If No, indicate Location-Street, City, Parish and State			Nature
21. What work activity was the employee doing when the incident occurred ? (Give weight, size and shape of material or equipment involved. Tell what he was doing with them. Indicate if correct procedures were followed.)					Part of Body
					Source
					Event
					NCC:
22. What caused the incident to happen? (Describe fully the events which resulted in injury or disease. Tell what happened and how it happened. Name any objects or substances involved and tell how they were involved. Give full details on all factors which led to or contributed to this injury or illness.)					
23. Part of body injured and Nature of Injury or Illness(ex. left leg: multiple fractures)				24. If Occ. Disease- Give Date Diagnosed	

25. Physician and Address		street	city	state	zip	26. If Hospitalized, give name & address of facility	
27. Employer's Name						28. Person Completing This Report – Please print	
29. Employer's Address		street	city	state	zip	30. Employer's Telephone Number () -	
31. Employer's Mailing Address – If Different From Above			city	state	zip	32. Nature of Business – Type of Mfg., Trade, Construction, Service, etc.	
33. Wage Information		Employee was paid <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other				The average weekly wage was \$	per week.
34. Verification of Employer Knowledge of this Report.						OFFICE OF RISK MANAGEMENT P.O. Box 91106 Baton Rouge, LA 70821-9106 Phone No. (225) 219-0168	
Name:		Title:		Date:			
DA 1973 R 8/98							

OFFICE OF RISK MANAGEMENT COPY

EMPLOYER CERTIFICATE OF COMPLIANCE

You must submit this Certification to your workers' compensation insurer. Failure to submit this Certification as required may result in your being penalized by a fine of \$500, payable to your insurer.

You must secure workers' compensation for your employees through insurance or by becoming an authorized self-insured. If you fail to provide security for workers' compensation, you must pay an additional 50% in weekly benefits to your injured workers.

If you willfully fail to provide security for workers' compensation, then you are subject to a fine of up to \$ 10,000, imprisonment with or without hard labor for not more than 1 year, or both. If you have been previously fined and again fail to provide security for workers' compensation, then you are subject to additional penalties, including a court order to cease and desist from continuing further business operations.

You must not collect, demand, request, or accept any amount from any employee to pay or reimburse for the workers' compensation insurance premium. If you violate this provision, you may be punished with a fine of not more than \$500, or imprisoned with or without hard labor for not more than one year, or both.

It is unlawful for you to willfully make, or to assist or counsel someone else to make, a false statement or representation in order to obtain or to defeat workers' compensation benefits. If you violate this provision, you may be fined up to \$10,000, imprisoned with or without hard labor for up to 10 years, or both depending on the amount of benefits unlawfully obtained or defeated. In addition to these criminal penalties, you may be assessed a civil penalty of up to \$5,000.

EMPLOYER CERTIFICATION

I certify that I can read the English language, that I have read this entire document and understand its contents, and that I understand I am held responsible for this information. I certify my compliance with the Louisiana Workers' Compensation Act.

Preparer Name (PRINT)

Signature

Date

Company Name

Company Address

() -

Phone Number

Insurance Policy Number

- -

Employee Name

Employee Social Security Number

Source Risk Assessment Questionnaire

Name: _____

DOB: _____ Date: _____

QUESTION	YES	NO
Have you ever tested positive for HIV?		
Have you ever tested positive for Hepatitis B or Hepatitis C?		
Have you ever had a sexually transmitted disease?		
Did you receive a blood transfusion or blood products between 1978 and 1985?		
Have you ever used needles to inject street drugs?		
Have you ever shared needles to inject street drugs?		
Have you had sex with another person with HIV or Aids?		
Are you a male who has had sex with male partners?		
Have you had sex with a person who injects street drugs?		
Have you ever traded sex for money, drugs, food or housing?		
Have you had unprotected sex (of and kind) within the last 10 years with someone other than your spouse?		
Have you ever been sexually assaulted?		
Have you had occupational exposure to blood or body fluids such as a needle stick within the last 10 years?		
Do you have a sex partner with any of the above risks for HIV?		
Are you pregnant?		
Comments:		

Patient Signature: _____ Reviewed by: _____

Date: _____

POST EXPOSURE PROPHYLAXIS TREATMENT REGIMENS

Post exposure prophylaxis is maximally effective when given within the first two hours post exposure. It is critically important not to delay the institution of post exposure prophylaxis when it is indicated.		
Exposure Category	Source Category	Recommendation
1	1	PEP may not be warranted. Exposure type does not pose a known risk for HIV Transmission. Whether the risk for drug toxicity outweighs the benefit of PEP should be decided by the exposed health care worker and treating clinician.
1	2	Consider basic regimen. Exposure type poses a negligible risk for HIV transmission. A high HIV titer in the source may justify consideration of PEP. Whether the risk for drug toxicity outweighs the benefit of PEP should be decided by the exposed health care worker and treating clinician.
2	1	Recommend basic regimen. Most HIV exposures are in this category: no increased risk for HIV transmission has been observed but use of PEP is appropriate.
2	2	Recommend expanded regimen. Exposure type represents an increased risk of HIV transmission risk.
3	1 or 2	Recommend expanded regimen. Exposure type represents an increased HIV transmission risk.
2 or 3	Unknown	Consider PEP basic regimen, if the source or, in the case of an unknown source, the setting where the exposure occurred suggests a possible risk for HIV exposure and the exposure codes is a 2 or 3.

You can give the exposure info to Dr. McLean and she can determine the code.

Codes

EC1 Small (e.g., few drops, short duration)

EC2 Large (e.g., several drops, major blood splash and/or longer duration (i.e., several minutes or more))

EC2 Less Severe (e.g., solid needles, superficial scratch)

EC3 More Severe (e.g., large-bore hollow needle, deep puncture, visible blood on device, or needle used in source patient's artery or vein)

General Health System-Post Exposure Evaluation

Date: _____

Employee information

Name _____

Address _____

Home Phone _____

SS# _____

Work Area _____

Work Phone _____

Hep B Vaccine _____

Body area involved _____

Type/Brand device involved _____

Employee baseline labs:

HIV, Hep B, Hep C,

Source information

Name _____

medical record# _____

Risk Factors _____

HIV quick test results _____

Follow up Lab_ No Follow up lab indicated_____

2 week Lab test	Date drawn	Results
6 week Lab test	Date drawn	Results
3 month Lab test	Date drawn	Results
6 month Lab test	Date drawn	Results
12 month Lab test	Date drawn	Results

- Using the algorithm in packet determine the PEP recommendation, if any. Please record any recommendations, treatment or counseling below.

First aid/treatment _____

Follow up /
Counseling _____

**POST EXPOSURE EVALUATION STUDENT
CONSENT**

Name: _____

Date:

(print your name)

Consent for Bloodborne Pathogen testing

I agree to have my blood drawn for Hepatitis B, HIV, and Hepatitis C. The results will indicate the present status of my blood. These tests results are in no way related to the present incident, and are used as a baseline for future testing.

Signature: _____

Receiving blood test results via telephone

I wish to receive the results of my blood tests via telephone. In order to do so, I have been instructed to contact the Student Health Department during normal business hours at 504-941-8175. I will be asked to supply both my social security number and date of birth for verification.

Signature: _____

Receiving blood test results in person

I wish to receive the results of my blood tests in person. In order to do so, I have been instructed to report to the Student Health Department during normal business hours. I should allow at least one business day to return for my results.

Signature: _____

Declination for Bloodborne Pathogen testing

I do not wish to have my blood drawn at this time for testing.

Signature: _____

POST EXPOSURE EVALUATION SOURCE CONSENT

Name: _____

Date:

(print your name)

Consent for Bloodborne Pathogen testing

I agree to have my blood drawn for Hepatitis B, HIV, and Hepatitis C. The results will indicate the present status of my blood. These tests results are in no way related to the present incident, and are used as a baseline for future testing.

Signature: _____

Receiving blood test results via telephone

I wish to receive the results of my blood tests via telephone. In order to do so, I have been instructed to contact the Student Health Department during normal business hours at 504-941-8175. I will be asked to supply both my social security number and date of birth for verification.

Signature: _____

Receiving blood test results in person

I wish to receive the results of my blood tests in person. In order to do so, I have been instructed to report to the Student Health Department during normal business hours. I should allow at least one business day to return for my results.

Signature: _____

Declination for Bloodborne Pathogen testing

I do not wish to have my blood drawn at this time for testing.

Signature: _____

Important information

Name: _____ Your CDC HIV algorithm code is: _____

Relative risk for HIV infection in the CDC recommendation for PEP below. If the HIV risk is significant, PEP is recommended.

CDC recommendation for PEP: Yes No (circle)

The CDC estimates that the average risk of HIV transmission after a percutaneous exposure to HIV-infected blood is approximately 0.3% and 0.09% after a mucous membrane exposure. The risk for transmission is estimated to be less than the risk for mucous membrane exposure.

More information about CDC studies can be found at www.cdc.gov. Use the search function to find specific articles.

PEP will include at least 2 drugs for 4 weeks. We prescribe Raltegravir (Isentress; RAL) 400mg PO twice daily, plus Truvada, (Tenofovir DF 300mg + emtricitabine 200 mg) 1 PO once daily.

PEP is most effective when begun 24-48 hours after exposure, but best when taken within 2 hours. Fill your prescription immediately.

Significant GI symptoms (e.g. nausea/vomiting/diarrhea) are common side effects. Call Student Health if you have side effects that are worrisome.

ALL 4 WEEKS OF TREATMENT ARE REQUIRED FOR PROPHYLAXIS.

Seroconversion usually occurs during the first 6-12 weeks after the exposure, so multiple testing is required.

Blood Monitoring Schedule

INITIAL DRAW:

On Exposed Person

HIV – Antibody Test #083904

Anti HBsAb –Test #006395

HCV RNA-Test #550100

On Patient

Rapid 4th generation HIV
and/or HIV Ab

HepB Surface Ag

HCV RNA

- If PEP: Follow up with healthcare provider within 72 hours
- If PEP: Recheck kidney and liver functions in 2 weeks.
- Treatment duration is 28 days

HIV Post-Exposure:

- If 4th generation combination HIV p24 ag/ab testing being used, follow up lab testing as follows:
 - **At 6 weeks: HIV antibody**
 - **At 16 weeks: HIV antibody (is sufficient)**
- If 4th generation combination HIV p24 ag/ab testing not available, perform HIV antibody testing for at least 6 months as follows:
 - **At 6 weeks: HIV antibody**
 - **At 3 months: HIV antibody**
 - **At 6 months: HIV antibody**
 - **At 1 year: HIV Antibody (recommended if source patient was co-infected with Hepatitis C)**

HCV Post-Exposure:

- **At 3 weeks: HCV RNA test**
If negative, no further testing needed

PEP Meds -- Isentress 400 mg twice daily and Truvada once daily for 28 days

Pregnant Women: Combivir and Kaletra

It is YOUR responsibility to come for testing.

Call Student Health Nurse (504-941-8175) to have your blood drawn.

24 hour Needlestick Hotline

(888) 448-4911

**Established by the CDC and
manned by the physicians of San
Francisco General Hospital**

Available for consultation

FREE!

(This form is NOT for use in reporting a claim. The claim reporting form can be found at: www.iaorm.com)

**OFFICE OF RISK MANAGEMENT
UNIT OF RISK ANALYSIS AND LOSS PREVENTION
STUDENT ACCIDENT REPORTING FORM
General Liability claims – For Agency Use Only**

**KEEP COMPLETED FORMS ON FILE AT THE LOCATION
WHERE INCIDENT/ACCIDENT OCCURRED**

(PLEASE TYPE OR PRINT)

1. AGENCY NAME and LOCATION CODE

2. DATE and TIME of ACCIDENT

3. VISTOR/CLIENT NAME

4. VISTOR/CLIENT
ADDRESS

5. CLAIMANT'S TELEPHONE#

6. DETAIL DESCRIPTION OF HOW INCIDENT/ACCIDENT OCCURRED:

7. DID THE EMPLOYEE ASK THE STUDENT IF HE/SHE WAS INJURED? ____Y ____N

8. DID THE CLAIMANT VERBALLY EXPRESS AN INJURY TO ANY PART OF HIS/HER BODY? ____Y
____N

9. IF THE CLAIMANT EXPRESSED AN INJURY, WHAT PART OF HIS/HER BODY DID THEY STATE WAS INJURED?

PLEASE BE SPECIFIC (IE. RIGHT FOREARM, LEFT WRIST, LOWER RIGHT ABDOMEN)

10. IF THE CLAIMANT EXPRESSED INJURY, WAS MEDICAL CARE OFFERED? ____Y ____N

11. DID THE CLAIMANT ACCEPT OR DECLINE MEDICAL CARE? ____ACCEPT ____DECLINE

12. WERE THERE WITNESS (ES)? __Y ____N

13. WITNESS'S NAME, ADDRESS and TELEPHONE# (use additional sheet if needed)

14. WITNESS STATEMENTS ATTACHED ____Y ____N

15. DETAIL DESCRIPTION OF ACCIDENT LOCATION

IS THIS LOCATION IN A STATE-OWNED OR LEASED BUILDING

**This form is prepared for internal use only and is prepared
in anticipation of litigation.**

Visitor/Client Post Incident/Accident Analysis (DA3000)

(This form is NOT for use in reporting a claim. The claim reporting form can be found at: www.iaorm.com)

16. DID THE PERSON CONDUCTING THE INVESTIGATION OBSERVE ANYTHING THAT WAS DIFFERENT THAN THE STUDENT/WITNESS'S ACCOUNT ____Y ____N IF YES, WHAT

17. CHECK THE APPROPRIATE ENVIRONMENTAL CONDITION THAT IS APPLICABLE TO THE ACCIDENT: RAINING SUNNY CLOUDY FOGGY COLD HOT LIGHTING WIND OTHER CONDITION _____ WEATHER NOT A FACTOR

18. CHECK THE APPROPRIATE BOX (S) THAT PERTAINS TO THE ACCIDENT: LIQUID ON FLOOR TYPE OF LIQUID _____ STAIRS PARKING LOT GARAGE SIDEWALK ELEVATORS GRATING SPONSORED ACTIVITY DORMITORY WAITING ROOM WALKWAYS RAILINGS FURNITURE FLOORING - DESCRIBE THE TYPE OF FLOOR AND TYPE OF WAX _____ EQUIPMENT (SPECIFY TYPE) _____
 OTHER CONDITION _____

19. IF THE ACCIDENT INVOLVED ITEMS THAT CAN BE RETAINED (i.e. furniture, muffler, exam table), THE CLAIMS

UNIT REQUIRES THAT THE ITEM BE TAGGED WITH THE DATE OF ACCIDENT AND NAME OF THE STUDENT. IF THE ITEM IS BROKEN OR DAMAGED, IT MUST BE PLACED IN A SECURED AREA AFTER BEING TAGGED. THE TAG CANNOT BE REMOVED OR THE BROKE/DAMAGE ITEM CANNOT BE SURPLUS/DISCARDED UNTIL NOTIFIED BY THE CLAIMS UNIT. IF APPLICABLE, WAS THIS DONE? Y____N____

20. WAS THE CLAIMANT AUTHORIZED TO BE IN THIS AREA ____Y ____N

21. DID ANY EMPLOYEE OBSERVE ANYTHING BEFORE/AFTER THAT IS RELEVANT TO THE ACCIDENT ____Y ____N; IF YES, WAS A STATEMENT OBTAINED AND ATTACHED ____Y ____N

22. DID THE SUPERVISOR OR AGENCY SAFETY OFFICE RECEIVE A REPORT OF ANY OBSERVED CONDITIONS?
____Y ____N

23. WERE PICTURES TAKEN AND ARE THEY ATTACHED? ____Y ____N

24. NAME AND POSITION OF EMPLOYEES FILLING OUT THIS REPORT

PLEASE DATE

KEEP COMPLETED FORMS ON FILE AT THE LOCATION WHERE INCIDENT/ACCIDENT OCCURRED

**This form is prepared for internal use only and is prepared
in anticipation of litigation.**

Table J. Infection Control Monitoring Criteria and Report

LSUSD Infection Control Monitoring Criteria

Infraction
<p>Cubicle Set-up (4 points for any infraction in category)</p> <ul style="list-style-type: none"> • No safety glasses for patient • No cover on light handles • No cover on chair (head rest) • No bracket tray plastic sleeve • No sleeve on water/ air syringe • No sleeve on high evacuation • No sleeve on saliva ejector • No sleeve/cover on computer keyboard
<p>PPE: (4 points for any infraction in category)</p> <ul style="list-style-type: none"> • No safety glasses including side shields(clinic) • No safety glasses including side shields (lab) • No safety glasses including side shields (patient) • Face mask needed to be removed • Gloves needed to be removed • Leaving clinic area without removing PPE. • Inadequate barriers for x-ray chair and unit. • No patient bib • Inappropriate footwear • Long hair in treatment field
<p>Cubicle Tear Down (4 points for any infraction in category)</p> <ul style="list-style-type: none"> • Instruments left in cubicle • Failure to properly clean equipment or cubicle after patient care. • Debris left on dental chair, cubicle surfaces or floor • Failure to remove hardened material from instrument • Inappropriate disposal of hazardous waste
<p>Sharps Safety (4 points for any infraction in category)</p> <ul style="list-style-type: none"> • Attempting to clean sharp instrument by hand • Syringe not capped. • Bur in Headpiece not covered • Inappropriate disposal of sharps
<p>General/Professionalism (2 points for any infraction in category)</p> <ul style="list-style-type: none"> • Bunsen burner near computer equipment or PPE gown • Eating or drinking on the clinic floor • Children in cubicle with patient • Appearance guidelines violation (dress code) • Exposed jewelry, large earrings, Pierced nose, lip, eyebrow, and tongue with jewelry • Seasonal decorations on the clinic floor/ in the cubicles or clinic area.

LSUSD Infection Control Monitoring Report

Examiner: _____ **Date:** _____

Violator	Violations Points for each infraction					Total
Name of Violator and Clinic Area	Cubicle Set-up - 4 pts	Cubicle Tear-Down - 4 pts	PPE: 4 pts	Sharps Safety 4 pts.	General/ Professionalism 2 pts.	

Comments:

APPENDIX K

PROTOCOL FOR POTENTIAL COVID-19 PATIENTS

Background: SARS-CoV-2, the virus that causes COVID-19, is an airborne infection thought to be spread primarily through respiratory droplets when an infected person coughs, sneezes, or talks. These droplet nuclei can stay suspended in the air for hours. Infection occurs when a susceptible person inhales the droplets. Airborne transmission from person-to-person over long distances is unlikely. However, COVID-19 is a new disease, and we are still learning about how it spreads and the severity of illness it causes. The virus has been shown to persist in aerosols for hours, and on some surfaces for days under laboratory conditions. COVID-19 may be spread by people who are not showing symptoms.

Risk: The practice of dentistry involves the use of rotary dental and surgical instruments, such as handpieces or ultrasonic scalers and air-water syringes. These instruments create a visible spray that can contain particle droplets of water, saliva, blood, microorganisms, and other debris. Surgical masks protect mucous membranes of the mouth and nose from droplet spatter, but they do not provide complete protection against inhalation of airborne infectious agents. There are currently no data available to assess the risk of SARS-CoV-2 transmission during dental practice. To date in the United States, clusters of healthcare personnel who have tested positive for COVID-19 have been identified in hospital settings and long-term care facilities, but no clusters have yet been reported in dental settings or among DHCP.

Symptoms:

People with COVID-19 have had a wide range of symptoms reported – ranging from mild symptoms to severe illness. Symptoms may appear **2-14 days after exposure to the virus**. People with these symptoms may have COVID-19:

- Fever or chills
- Cough
- Shortness of breath or difficulty breathing
- Fatigue
- Muscle or body aches
- Headache
- New loss of taste or smell
- Sore throat
- Congestion or runny nose
- Nausea or vomiting
- Diarrhea

This list does not include all possible symptoms. CDC will continue to update this list as we learn more about COVID-19.

Older adults and people who have severe underlying medical conditions like heart or lung disease or diabetes seem to be at higher risk for developing more serious complications from COVID-19 illness.

PROTOCOL FOR TRIAGE AND TREATMENT

Patient Management

All patients are contacted prior to dental treatment; patients are telephone screened for symptoms consistent with COVID-19. If the patient reports symptoms of COVID-19, treatment is delayed until the patient has recovered

The patient's dental condition is assessed it is determine whether the patient needs to be seen in the dental setting.

Patients are asked to limit the number of visitors accompanying the patient to the dental appointment to only those people who are necessary.

Advise patients that they, and anyone accompanying them to the appointment, will be requested to wear a face covering when entering the facility and will undergo screening for fever and symptoms consistent with COVID-19.

Upon arrival temperatures are taken and patients and visitors are systematically assessed; they are asked about the presence of fever or other symptoms consistent with COVID-19.

Patients and visitors are asked to don their own face covering, or a surgical mask is provided if the patient doesn't have their own.

If the patient is afebrile (temperature < 100.4°F)* and otherwise without symptoms consistent with COVID-19, the patient is admitted for dental care.

Patients are asked to re-don their face covering at the completion of their clinical dental care when they leave the treatment area.

Even when DHCP screen patients for respiratory infections, inadvertent treatment of a dental patient who is later confirmed to have COVID-19 may occur. To address this, patients are asked to inform the dental clinic if they develop symptoms or are diagnosed with COVID-19 within 14 days following the dental appointment.

Facility Considerations

- Steps taken to ensure patients and staff adhere to respiratory hygiene and cough etiquette, as well as hand hygiene, and all patients follow triage procedures throughout the duration of the visit.
 - Visual alerts (e.g., signs, posters) are posted at the entrance and in strategic places (e.g., waiting areas, elevators, break rooms) to provide

instructions (in appropriate languages) about hand hygiene and respiratory hygiene and cough etiquette. Instructions should include wearing a cloth face covering or facemask for source control, and how and when to perform hand hygiene.

- Alcohol-based hand rub (ABHR) with 60– 95% alcohol, tissues, and no-touch receptacles for disposal, are available at healthcare facility entrances, waiting rooms, and patient check-ins.
- Install physical barriers (e.g., glass or plastic windows) at reception areas to limit close contact between triage personnel and potentially infectious patients.
- Place chairs in the waiting room at least six feet apart.
- Remove toys, magazines, and other frequently touched objects that cannot be regularly cleaned or disinfected from waiting areas.
- The number of persons waiting in the waiting room are minimized.
 - Patients may opt to wait in a personal vehicle or outside the dental facility where they can be contacted by mobile phone when it is their turn for dental care.
 - Due to reduced chairs used in clinic, overlapping dental appointments are reduced.
- Patient placement
 - To prevent the spread of pathogens patient cubicles are reduced and spread out so that no adjacent cubicles are used (side-to-side, head-to-foot)
 - At least 6 feet of space between patient chairs.
- Patient volume
 - The maximum number of patients who can safely receive care at the same time in the dental facility are determined by:
 - the number of dental chairs, the layout of the clinic Bays, and the time needed to clean and disinfect patient operatories*.

**To allow time for droplets to sufficiently fall from the air after a dental procedure, DHCP should wait at least 15 minutes after the completion of dental treatment and departure of the patient to begin the room cleaning and disinfection process.³*

Hygiene

*Ensure DHCP practice strict adherence to **hand hygiene**, including*

- Before and after all patient contact, contact with potentially infectious material, and before putting on and after removing personal protective equipment (PPE), including gloves. Hand hygiene after removing PPE is particularly important to remove any pathogens that might have been transferred to bare hands during the removal process.

Universal Source Control

As part of source control efforts, DHCP should wear a facemask **at all times** while they are in the dental setting.

- Cloth face coverings are worn in non-clinical areas until notified that this isn't necessary.
- Some DHCP whose job duties do not require PPE (such as clerical personnel) may continue to wear their cloth face covering for source control while in the dental setting.
- Other DHCP (such as dentists, dental hygienists, dental assistants) may wear their cloth face covering when they are not engaged in direct patient care activities, and then switch to a respirator or a surgical mask when PPE is required.
- DHCP should remove their respirator or surgical mask and put on their cloth face covering when leaving the facility at the end of their shift.
- DHCP should also be instructed that if they must touch or adjust their mask or cloth face covering, they should perform hand hygiene immediately before and after.
- Use ABHR with 60-95% alcohol or wash hands with soap and water for at least 20 seconds. If hands are visibly soiled, use soap and water before returning to ABHR.

Because facemasks and cloth face coverings can become saturated with respiratory secretions, DHCP should take steps to prevent self-contamination:

- DHCP should change facemasks and coverings if they become soiled, damp, or hard to breathe through.
- Cloth face coverings should be laundered daily and when soiled.
- DHCP should perform hand hygiene immediately before and after any contact with the facemask or cloth face covering.

All DHCP should wear a surgical mask, eye protection (goggles, protective eyewear with solid side shields, or a full-face shield), and a gown or protective clothing during procedures likely to generate splashing or spattering of blood or other body fluids.

Precautions during aerosol-generating procedures conducted on patients assumed to be non-contagious:

Students, faculty and staff wear the school provided N99 respirator with goggles or a full-face shield.

Pre-procedural rinse should be used prior to any aerosol-generating procedure. At this time, the ADA and CDC are only recommending peroxide to destroy the virus. Colgate Proxyl is the rinse used at the dental school.

To clean and disinfect the dental operatory after a patient **without suspected or confirmed COVID-19**, wait 15 minutes after completion of clinical care and exit of each patient to begin to clean and disinfect room surfaces. This time will allow for droplets to sufficiently fall from the air after a dental procedure, and then be disinfected properly.

- Routine cleaning and disinfection procedures (e.g., using cleaners and water to clean surfaces **before** applying an Environmental Protection Agency-registered, hospital-grade disinfectant to frequently touched surfaces or objects for appropriate contact times as indicated on the product's label) are appropriate for SARS-CoV-2 in healthcare settings, including those patient-care areas in which aerosol-generating procedures are performed.

CONSIDERATIONS FOR ADDITIONAL PRECAUTIONS OR STRATEGIES FOR TREATING PATIENTS WITH SUSPECTED OR CONFIRMED COVID-19

- If a patient arriving at the dental school is suspected or confirmed to have COVID-19, defer dental treatment and take the following actions:
 - If the patient is not already wearing a mask, give the patient a mask to cover his or her nose and mouth.
 - If the patient is not acutely sick, send the patient home, and instruct the patient to call their primary care provider.
 - If the patient is acutely sick (for example, has trouble breathing), refer the patient to a medical facility, or call 911 as needed and inform them that the patient may have COVID-19.