COMPLIANCE TRAINING PARTNERS®

Supplemental Information

Table 1. Suggest work restrictions for healthcare personnel infested with or exposed to major infectious diseases in healthcare 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
	No restriction	
virus infection 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, Salmonella species	Restrict from care of patients at high risk.	Until symptoms resolve; consult with local & state health authorities regarding need for negative stool cultures
Entero viral 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-handing.	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
Oral facial	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 Committee on Immunization Practices (ACIP). † Unless epidemiologically linked to transmission of infection.§1998;26:289–354.
*Modified from recommendations of the Advisory Com

Table 1. (Continued) Suggest work restrictions for healthcare personnel infested with or exposed to major infectious diseases in healthcare 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	Until 5 days after start of effective antibiotic therapy
Postexposure (symptomatic personnel)	Exclude from duty	
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
Staphylococcus aureus 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
Post-exposure (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 immuno-suppressed 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 febril	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.

Appendix B
Immunizations Strongly Recommended for Health-Care Personnel (HCP)

Vaccine	Dose schedule	Indications	Major precautions and contraindications	Special considerations
Hepatitis B recombinant vaccine*	Three-dose schedule administered intramuscularly (IM) in the deltoid; 0,1,6 - second dose administered 1 month after first dose; third dose administered 4 months after second. Booster doses are not necessary for persons who have developed adequate antibodies to hepatitis B surface antigen (anti-HBs).	Health-care personnel (HCP) at risk for exposure to blood and body fluids.	History of anaphylactic reaction to common baker's yeast. Pregnancy is not a contraindication.	No therapeutic or adverse effects on hepatitis B virus (HBV)-infected persons; cost-effectiveness of prevaccination screening for susceptibility to HBV depends on costs of vaccination and antibody testing and prevalence of immunity in the group of potential vaccinees; health-care personnel who have ongoing contact with patients or blood should be tested 1–2 months after completing the vaccination series to determine serologic response. If vaccination does not induce adequate anti-HBs (>10 mIU/mL), a second vaccine series should be administered.
Influenza vaccine (inactivated)	Annual single-dose vaccination IM with current vaccine.	HCP who have contact with patients at high risk or who work in chronic-care facilities; HCP aged >50 years or who have high-risk medical conditions.	History of anaphylactic hypersensitivity to eggs or to other components of the vaccine.	Recommended for women who will be in the second or third trimesters of pregnancy during the influenza season and women in any stage of pregnancy who have chronic medical conditions that are associated with an increased risk of influenza.§
Measles live- virus vaccine	One dose administered subcutaneously (SC); second dose >4 weeks later.	HCP who were born during or after 1957 without documentation of 1) receipt of 2 doses of live vaccine on or after their first birthday, 2) physician-diagnosed measles, or 3) laboratory evidence of immunity. Vaccine should also be considered for all HCP who have no proof of immunity, including those born before 1957.	Pregnancy; immunocompromised† state (including human immunodeficiency virus [HIV]-infected persons with severe immunosuppression); history of anaphylactic reactions after gelatin ingestion or receipt of neomycin; or recent receipt of antibody-containing blood products.	Measles, mumps, rubella (MMR) is the recommended vaccine, if recipients are also likely to be susceptible to rubella or mumps; persons vaccinated during 1963–1967 with 1) measles killed-virus vaccine alone, 2) killed-virus vaccine followed by live-virus vaccine, or 3) a vaccine of unknown type, should be revaccinated with two doses of live-virus measles vaccine.
Mumps live-virus vaccine	One dose SC; no booster.	HCP believed susceptible can be vaccinated; adults born before 1957 can be considered immune.	Pregnancy; immunocompromised† state; history of anaphylactic reaction after gelatin ingestion or receipt of neomycin.	MMR is the recommended vaccine.
Rubella live-virus vaccine	One dose SC; no booster.	HCP, both male and female, who lack documentation of receipt of live vaccine on or after their first birthday, or lack of laboratory evidence of immunity can be vaccinated. Adults born before 1957 can be considered immune, except women of childbearing age.	Pregnancy; immunocompromised† state; history of anaphylactic reaction after receipt of neomycin.	Women pregnant when vaccinated or who become pregnant within 4 weeks of vaccination should be counseled regarding theoretic risks to the fetus; however, the risk of rubella vaccine-associated malformations among these women is negligible. MMR is the recommended vaccine.
Varicella-zoster live-virus vaccine	Two 0.5 mL doses SC 4–8 weeks apart if aged >13 years.	HCP without reliable history of varicella or laboratory evidence of varicella immunity.	Pregnancy; immunocompromised† state; history of anaphylactic reaction after receipt of neomycin or gelatin; recent receipt of antibody-containing blood products; salicylate use should be avoided for 6 weeks after vaccination.	Because 71%–93% of U.S.-born persons without a history of varicella are immune, serologic testing before vaccination might be cost-effective.

Sources: 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.
CDC. Immunization of health-care workers: recommendations of the Advisory Committee on Immunization Practices (ACIP) and the Hospital Infection Control Practices Advisory Committee (HICPAC). MMWR 1997;46(No. RR-18).
CDC. Prevention and control of influenza: recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR 2003;52:1-34.
CDC. Using live, attenuated influenza vaccine for prevention and control of influenza: supplemental recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR 2003;52(No. RR-13).

* A federal standard issued in December 1991 under the Occupational Safety and Health Act mandates that hepatitis B vaccine be made available at the employer's expense to all HCP occupationally exposed to blood or other potentially infectious materials. The Occupational Safety and Health Administration requires that employers make available hepatitis B vaccinations, evaluations, and follow-up procedures in accordance with current CDC recommendations.

† Persons immunocompromised because of immune deficiencies, HIV infection, leukemia, lymphoma, generalized malignancy; or persons receiving immunosuppressive therapy with corticosteroids, alkylating drugs, antimetabolites; or persons receiving radiation.

§ Vaccination of pregnant women after the first trimester might be preferred to avoid coincidental association with spontaneous abortions, which are most common during the first trimester. However, no adverse fetal effects have been associated with influenza vaccination.

¶ A live attenuated influenza vaccine (LAIV) is FDA-approved for healthy persons aged 5-49 years. Because of the possibility of transmission of vaccine viruses from recipients of LAIV to other persons and in the absence of data on the risk of illness and among immunocompromised persons infected with LAIV viruses, the inactivated influenza vaccine is preferred for HCP who have close contact with immunocompromised persons.

Active Shooter Supplemental Information

There are several things a healthcare facility can do to ensure safety for their employees. Practices will want to ensure the following:

1. **Organizational Preparedness**

    a. Emergency Action Plan

    Preparing an emergency action plan helps employees know and understand proper procedures. A successful plan should include:

    - How to report emergencies to authorities
    - Evacuation polices and escape procedures
    - Contact information for area hospitals and individual who perform specific tasks during emergencies

    b. Training Exercises

    - Develop training exercises that simulate active shooter situations
    - Contact local law enforcement and emergency response agencies for their assistance
    - Training includes the following
        - Recognizing the sound of gunfire
        - When to dial 911
        - What to do when law enforcement arrives
        - Understanding a "survival mindset"

        *see training exercise

    c. Preventative Measures

    - Cultivate a respectful environment in the workplace
    - Watch for signs of workplace violence and take necessary corrective actions

    d. Organizational Responsibilities

    - Perform background checks for all new employees
    - Implement a workplace violence reporting system
    - Provide resources

    e. Warning Signs

    - Before an incident, active shooters usually exhibit traits of potentially violent behavior over an extended period of time
    - Know the warning signs and train employees
    - Report signs of potentially violent behavior to a manager

- Common traits that may be indicative of potentially violent behavior:
    - Resistance to policy or procedural changes
    - Increased mood swings
    - Unprovoked outbursts of rage or anger
    - Increased talk of personal, financial or domestic issues
    - Increased absences
    - Talk of suicide or preparing for death
- Shooter Statistics
    - Usually associated with the location of the incident
    - May be current employees or friends or relations of employees

2. **Active Shooter Response**

a. What to Expect

- Active shooter incidents are rarely prolonged
    - Many are over in a matter of minutes
    - Often end before law enforcement can arrive
    - End when the active shooter stops shooting and flee or take their own lives

b. Evacuation

- First plan is to evacuate
- Have an escape route in mind
- Evacuate regardless of whether others agree to follow
- Leave your belongings behind
- If possible, help others to escape
- Prevent individuals from entering an area where the shooter might be
- Keep your hands visible
- Do not move wounded individuals
- Call 911 when you are safe

c. Hiding

- If you are not able to evacuate, find a safe place to hide
- A safe hiding place should:
    - Be out of view from the shooter
    - Provide protection if shots are fired in your direction
    - Allow safe access to possible evacuation routes
- If the shooter approaches your hiding place
    - Lock and barricade the door, if possible
    - Set any mobile devices to silent and turn off any other sources of noise
    - Hide behind a large item
    - Stay quiet

d. If Unable to Evacuate or Hide
    - Keep call
    - Dial 911 to notify police of the shooter's location

e. The Last Resort

    - Attempting to incapacitate an active shooter is strictly a last resort. Never attempt to confront a shooter unless your life is in immediate danger and there are not safe evacuation routes or hiding places
    - Strategies recommended:
        - Acting as aggressively as possible against him/her
        - Throwing items and improvising weapons
        - Yelling
        - Committing to your actions

f. When Law Enforcement Arrives

    - Police officers may be outfitted with tactical equipment and high-powered firearms
    - Officers will proceed directly to the shooter's last known location and will not stop to tend to wounded individuals
    - If you encounter police officers:
        - Officers may shout or push individuals to make sure they are out of harm's way.
        - Keep calm and obey orders
        - Put down any items you may be carrying and raise your hands and spread your fingers
        - Do not make any sudden or quick movements in the direction of the officers
        - Avoid screaming, yelling or pointing
        - Continue in the direction from which the officers are coming from and do not ask them for help

3. **Post-Incident Actions**

a. Immediate Response

    - Take a count of personnel to determine if anyone is missing and/or wounded.
    - Contact families of those involved
    - Implement plans to provide counseling or psychological care for employees

b. Analyzing the Incident

    - Thoroughly document the incident
    - Document response activities
    - Identify successful actions and procedures that took place
    - Identify areas where stronger preventative measures or more training is required
    - Evaluate the existing emergency action plan's effectiveness. Make recommendations for improvement as needed

Active Shooter and Workplace Violence Training Exercises

The scenario below looks at the incident from the perspective of first responders and the private sector owner/operators. As the scenario develops, the reader should identify actions relevant to their company and position within the company. The scenarios only look at the incident and do not take into consideration recovery, business continuity planning, or after-event considerations.

Dental Office

Date: Friday, February 19

Time: 11:00am EST

A member of your dental team, who has been with your company for eight years, has just had his employment terminated. As he is escorted out of the building by security, he tells them they will regret treating him like this.

- Who should be informed of this behavior?
- What concerns might you have?
- What actions would you consider taking, if any, at this stage?

Date: Monday, April 5 Time: 9:15 am EST A popping sound is heard within the building. An employee runs into your office shouting that there is a man firing a gun in the waiting area.

- What actions should you take?
- How are you communicating with employees? Who is communicating?
- Who is in charge of the situation?

Update:

You decide to shelter in place in an office and secure the immediate area.

The popping noises seems to be close. There is yelling and screaming outside your door.

- What actions are taken to secure the area?
- Who is responsible for contacting law enforcement?
    - What information do you relay to them?
- What are you telling your employees?

Update: A woman knocks frantically on your door pleading to be let in.

- What action will you take to ensure your office remains secure?
    - What will you do about the woman outside your door?
- What additional concerns do you have at this time?

Update: You hear someone attempting to open the door, then several loud shots. After a few minutes of silence, it appears that the shooter may have moved on.

- What are your immediate concerns at this time?
- What do you tell coworkers sheltering in place with you?

Update: For nearly an hour there is no sound from outside your door. Employees are receiving calls from family members who have learned of the active shooter in your building. Emergency personnel can be seen outside. Several employees express interest in leaving.

- Who is responsible for deciding when it is safe to leave the secure area?
- How will family members be contacted?

Update: Law enforcement personnel arrive outside your office door and direct you to evacuate the building.

- How do you prepare your employees for the disturbing scenes they may encounter as they evacuate?
- Who is responsible for communicating with law enforcement?
- What concerns do you have leaving your office unsecure?

Update: Upon evacuation, your employees are cornered by news reporters asking about the experience. Some employees do not have their car or house keys and are concerned about getting home.

- Who is responsible for communicating with news media? o What information will you give them?
    - Can you control who else the media approaches? If not, what can you do?
- How will your employees get home? o Will you request access back into the building? Who would go in?

Update: The building is designated a crime scene and is closed for a week.

- Who initiates business continuity plans?
- What else needs to be considered?
- How is information disseminated to employees?

Update: Date: Monday, April 12 You can get back into the building and resume normal business operations. Several employees ask for more time to emotionally recover from the event.

- Are you able to continue normal business operations using fewer staff?
- How will you accommodate individuals who have been emotionally traumatized by the event?
- What resources will you make available to all staff?
- How will you communicate your company's resilience to concerned clients? Additional considerations:
- Upon arriving on scene, law enforcement officials will remove the threat before treating victims and evacuating survivors. It is important to be patient and stay in the secure area until you are instructed to evacuate
- Because some employees may not feel comfortable returning to work right away, be prepared to work with a dispersed or smaller work force following an active shooter event.
- Ensure mental health professionals are available for employees.

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OSHA COMPLIANCE

AUDIT CHECKLIST

Y	N	TRAINING
☐	☐	Are employees provided annual training on all applicable OSHA regulations including Hazard Communications, Bloodborne Pathogens, and TB?
☐	☐	Are new employees provided training before performing duties?
☐	☐	Are training records kept for a minimum of 3 years?
☐	☐	Are all safety practices and procedures updated annually?

		HAZARD COMMUNICATION
☐	☐	Is a written hazard communication program customized, reviewed, updated annually and accessible to all employees?
☐	☐	Are SDS Sheets on file?
☐	☐	Has a chemical inventory list containing all hazardous materials been created?
☐	☐	Are all hazardous products labeled properly?
☐	☐	Do all employees understand the emergency spill procedures?
☐	☐	Is there a spill kit available?
☐	☐	Have employees been trained on use of the eyewash station?
☐	☐	Is the eyewash station labeled and functioning properly?

		BLOODBORNE PATHOGENS
☐	☐	Are waste containers in operatory or treatment room labeled with a biohazard label?
☐	☐	Are waste containers covered or have a drop through opening?
☐	☐	Are employees offered the Hepatitis B vaccination free and within 10 days of task assignment?
☐	☐	Does a written exposure control plan exist and is it accessible to all employees?
☐	☐	Is the plan reviewed and updated at least annually?
☐	☐	Is all food and drink kept out of clinical and laboratory areas?
☐	☐	Is handwashing performed before and after treating patients?
☐	☐	Are all CDC Infection Control Guidelines for infection control being followed?

		GENERAL HOUSEKEEPING, STORAGE, WALKING SURFACES, MEANS OF EGRESS
☐	☐	Are all areas of the office clean, uncluttered, and sanitary?
☐	☐	Are all passageways and aisles marked and free from obstruction?
☐	☐	Are lighted or glow in the dark exit signs in place?
☐	☐	Are there at least 2 means of egress (exits)?
☐	☐	Does the office have proper ventilation and air quality control (HVAC fan on during working hours, filters changed regularly)?
☐	☐	Are electrical and medical gas closets free from stored items?

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ELECTRICAL

- ☐ ☐ Are all the electrical devices properly grounded (3 prong plug)?
- ☐ ☐ Are all electrical outlets in kitchens, bathrooms, labs and areas near water on a GFI circuit?
- ☐ ☐ Have you checked that extension cords are not in use?
- ☐ ☐ Are all cords and plugs free of visible wear?

MEDICAL EMERGENCIES, SAFETY & FIRST AID

- ☐ ☐ Is at least one person on each shift trained in First Aid and Cardiopulmonary Resuscitation?
- ☐ ☐ Do all staff members know the proper post exposure procedure?
- ☐ ☐ Is the eyewash station being inspected and tested weekly?
- ☐ ☐ Are monthly inspections of the facility being conducted, including the first aid kit and fire extinguisher?
- ☐ ☐ Is there an eyewash station within 25 feet or 10 seconds of hazardous chemicals?
- ☐ ☐ Is a fire extinguisher available?
- ☐ ☐ Have employees been trained on proper use of the fire extinguisher?
- ☐ ☐ Do stairs have a handrail with adequate headroom and lighting?

GRINDING EQUIPMENT & COMPRESSED GASES

- ☐ ☐ Is grinding equipment in good and safe condition with guards and shields?
- ☐ ☐ Are the gas cylinders (nitrous oxide/oxygen) properly chained or cabled to a wall?
- ☐ ☐ Are gas cylinders properly labeled?
- ☐ ☐ Are employees trained on compressed gas safety?

EMPLOYEE FILES / RECORD KEEPING

- ☐ ☐ Do employee files contain medical reports of workplace accidents or injuries?
- ☐ ☐ Do employee files contain vaccination history?
- ☐ ☐ Do employee files contain hepatitis B vaccination record or declination form?
- ☐ ☐ Are medical records maintained for the duration of employment plus 30 years?

PERSONAL PROTECTIVE EQUIPMENT (PPE)

- ☐ ☐ Is proper personal protective equipment provided and maintained by the employer?
- ☐ ☐ Are gloves and masks changed after each patient?
- ☐ ☐ Are employees trained to put on and remove PPE?
- ☐ ☐ Are protective eyewear/shields worn?
- ☐ ☐ Are long sleeve lab coats and/or gowns worn and changed when visibly soiled and at the end of the day?
- ☐ ☐ Are nitrile or synthetic gloves provided to those who have sensitivity to latex?
- ☐ ☐ Is handwashing performed before and after gloving?
- ☐ ☐ During laser procedures, is laser protective eyewear available and used?
- ☐ ☐ During bonding/light curing procedures, are protective glasses or shields used?

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POSTERS AND SIGNS PROPERLY DISPLAYED

- ☐ ☐ Is the Federal Minimum Wage poster displayed?
- ☐ ☐ Is the OSHA 3165 poster displayed?
- ☐ ☐ Is the Equal Opportunity Employer poster displayed?
- ☐ ☐ Is the Family Medical Leave Act poster displayed (50 or more employees)?
- ☐ ☐ Is the Uniformed Service Employment and Reemployment Rights Act poster displayed?
- ☐ ☐ Is the Employee Polygraph Protection Act poster displayed?
- ☐ ☐ Is there an emergency evacuation plan?
- ☐ ☐ Are all state specific posters displayed where required?
- ☐ ☐ Is a housekeeping schedule posted?

LAUNDRY

- ☐ ☐ Is soiled laundry placed in marked bags or containers labeled with the biohazard symbol?
- ☐ ☐ Is protective clothing either laundered in-house or by a professional service?

SHARPS

- ☐ ☐ Is there a sharps log available for documenting exposure incidents?
- ☐ ☐ Are sharps containers readily accessible in the area of use?
- ☐ ☐ Are filled containers transported by a biohazardous waste hauler?
- ☐ ☐ Are employees using a singled handed needle recapping technique or a needle recapping device?
- ☐ ☐ Are filled sharps containers picked up at the time interval mandated by your state?
- ☐ ☐ Are reusable contaminated sharps transported in a closed leak-proof container?

NON-SHARP REGULATED WASTE

- ☐ ☐ Is saturated gauze, cotton and other absorbent waste placed in a red bag?
- ☐ ☐ Is human tissue placed in a red bag?
- ☐ ☐ Is regulated waste placed in closable, leak proof, biohazard labeled containers for pick up?

MONITORING

- ☐ ☐ Are exposed employees wearing radiation dosimeters as required?
- ☐ ☐ If nitrous oxide is used, are nitrous monitors used quarterly as recommended?

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DETAILED INFECTION CONTROL CHECKLIST

Y	N	PERSONAL PROTECTIVE EQUIPMENT

Masks, Protective Eyewear and Face Shields

- ☐ ☐ Do employees wear surgical masks during procedures likely to generate splashes or sprays of blood or saliva?
- ☐ ☐ Do employees wear eye protection with solid side shields or a face shield during procedures that are likely to generate splashes or sprays of blood or saliva?
- ☐ ☐ Do employees change masks between patients and during patient treatment if the mask becomes wet or visibly contaminated?
- ☐ ☐ Is PPE removed before leaving the work area?
- ☐ ☐ Is hand hygiene performed immediately after removal of PPE?

Gloves

- ☐ ☐ Do employees wear gloves for potential contact with blood, body fluids, mucous membranes, non-intact skin or contaminated equipment?
- ☐ ☐ Do employees change gloves between patients?
- ☐ ☐ Do employees wear puncture and chemical-resistant utility gloves when cleaning instruments and performing housekeeping tasks involving blood or OPIM (other potentially infectious materials)?
- ☐ ☐ Do employees remove gloves that are torn, cut or punctured and perform hand hygiene before putting on new gloves?

Protective Clothing

- ☐ ☐ Do employees wear protective clothing (e.g. reusable or disposable gown, lab coat, or uniform) that is long sleeved and covers personal clothing as well as skin (e.g. forearms) likely to be soiled with blood, saliva or OPIM?
- ☐ ☐ Do employees change protective clothing if visibly soiled and immediately or as soon as possible if penetrated by blood or OPIM?

RESPIRATORY HYGIENE/COUGH ETIQUETTE

- ☐ ☐ Are signs posted at entrances with instructions to patients with symptoms of respiratory infection?
- ☐ ☐ Are tissue and no-touch receptables for disposal of tissue available?
- ☐ ☐ Are resources available to perform hand hygiene in waiting areas?
- ☐ ☐ Are face masks available for coughing patients and other symptomatic individuals who enter the office?
- ☐ ☐ Are all employees educated on recognition of signs, symptoms and transmission of TB?
- ☐ ☐ Is a written TB infection control plan available to all employees?
- ☐ ☐ Has baseline TB testing (TST) been performed on all employees who may have contact with possible TB active patients?

HAND HYGIENE

- ☐ ☐ Is hand hygiene performed when hands are visibly soiled; before and after each patient; before and after gloving; and whenever touching contaminated surfaces?
- ☐ ☐ Is a surgical scrub performed before putting on sterile surgical gloves, which must be used in all surgical procedures (e.g. biopsy, periodontal surgery, apical surgery, implant surgery, and surgical extractions)?

SHARPS SAFETY

- ☐ ☐ Are engineering controls used to prevent injuries (e.g. needle re-capping device, scalpel blade remover)?
- ☐ ☐ Are work practice controls used to prevent injuries (e.g. one-handed scoop technique, not breaking or bending needles)?
- ☐ ☐ Do employees use either one-handed scoop technique or a mechanical device designed for holding the needle cap when re-capping needles?
- ☐ ☐ Are sharps disposed of in a puncture resistant sharps container located as close as possible to the area in which items are used?
- ☐ ☐ Are reusable contaminated sharps transported in a closed leak-proof container?

SAFE INJECTION PRACTICES

- ☐ ☐ Are injections prepared using an aseptic technique, in a clean area free from contaminants or contact with blood, body fluids or contaminated equipment?
- ☐ ☐ Are needles and syringes used for only one patient?
- ☐ ☐ Is the dental cartridge syringe appropriately cleaned and heat sterilized before use on another patient?
- ☐ ☐ Is the rubber septum on a medication vial disinfected with alcohol before piercing?
- ☐ ☐ Are medication containers (single and multi-dose vials, ampules and bags) entered with a new needle and a new syringe?
- ☐ ☐ Are single-dose vials, ampules and bags or bottle of intravenous solutions used for only one patient?
- ☐ ☐ Leftover contents of single-dose vials, ampules and bags of intravenous solutions are not combined for later use.

When using multi-dose medication vials:

- ☐ ☐ Are multi-dose vials dedicated to individual patients whenever possible?
- ☐ ☐ Are multi-dose vials which are used for more than one patient kept in a centralized medication area?
- ☐ ☐ Are multi-dose vials dated when first opened and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the opened vial?
- ☐ ☐ Are fluid infusion and administration sets (i.e. IV bags, tubing and connections) used for one patient only?

INSTRUMENT STERILIZATION AND DISINFECTION OF PATIENT-CARE ITEMS

- ☐☐ Is the instrument processing area separated into 4 sections: A) Receiving, cleaning and decontamination, B) Preparation/packaging, C) Sterilization and D) Storage?
- ☐☐ Are reusable critical and semi-critical dental items and devices cleaned and heat sterilized according to the manufacturer's instructions before using on patients (e.g. high speed handpieces, low speed motors and handpiece components, endodontic instruments, air-water syringe tips)?
- ☐☐ Are single-use devices discarded after one use and never used for more than one patient?
- ☐☐ Are work practice controls that minimize contact with sharp instruments used and appropriate PPE worn if manual cleaning is necessary (e.g. puncture resistant utility gloves)?
- ☐☐ Are items thoroughly cleaned and visually inspected for residual contamination before sterilization?
- ☐☐ Is an enzymatic cleaner or detergent used for pre-cleaning and discarded according to the manufacturer's instructions?
- ☐☐ Are instruments appropriately packaged for sterilization after pre-cleaning?
- ☐☐ Is a chemical indicator used internally and externally on all sterilization packaging?
- ☐☐ Are FDA-cleared medical devices designed for sterilization (autoclaves and dry heat sterilizers) used according to the manufacturer's instructions?
- ☐☐ Is a biological indicator used at least weekly and with every load containing implantable devices?
- ☐☐ Are sterile packages labeled, at a minimum, with the sterilizer used and the date of sterilization?
- ☐☐ Are sterilization records maintained (i.e. mechanical, chemical and biological) in compliance with state and local regulations?
- ☐☐ Are sterile packages inspected for integrity and, are compromised packages reprocessed before use?
- ☐☐ After sterilization, are dental devices and instruments stored in such a manner that sterility is not compromised?
- ☐☐ Are reusable, heat sensitive, semi-critical items that cannot be replaced by heat stable or disposable high level disinfected according to the manufacturer's instructions?
- ☐☐ Are X-ray sensors heat sterilized between patients and covered with a FDA cleared barrier? If this is not done they are cleaned and disinfected between patients with an EPA registered intermediate-level disinfectant, then covered with and FDA cleared barrier.
- ☐☐ Are X-ray sensor holding or positioning devices heat sterilized or high-level disinfected between patients?

ENVIRONMENTAL INFECTION CONTROL

- ☐ ☐ Are clinical contact surfaces either barrier covered or cleaned and disinfected after each patient, using an EPA registered intermediate level disinfectant?
- ☐ ☐ Are cleaners and disinfectants used according to manufacturer's instructions?
- ☐ ☐ Is regulated medical waste handled and disposed of according to local, state and federal regulations?
- ☐ ☐ Are burs, polishing points, rag wheels, etc., sterilized or disinfected between patients or disposable replacements used?
- ☐ ☐ Is PPE used when handling items in the dental laboratory?
- ☐ ☐ Are contaminated items (e.g. bites, impressions, models) disinfected using an EPA registered intermediate level disinfectant?
- ☐ ☐ Are laboratory cases disinfected, and labeled as such, before being sent out?

HOUSEKEEPING SURFACES

- ☐ ☐ Are walls, sinks and floors routinely cleaned with detergent and water or an EPA registered disinfectant/detergent?
- ☐ ☐ Are mops and cloths cleaned after use and allowed to dry?
- ☐ ☐ Are fresh cleaning and disinfecting solutions prepared daily?

DENTAL UNIT WATER QUALITY

- ☐ ☐ Dental unit waterline treatment products/devices are used to ensure that water meets EPA regulatory standards for drinking water (<500 CFU/ml of heterotrophic water bacteria)?
- ☐ ☐ Is sterile saline or sterile water used as a coolant/irrigant when preforming surgical procedures?
- ☐ ☐ Is dental unit water tested quarterly, as recommended, to ensure that it is below 500 CFU of heterotrophic water bacteria?

TRAINING

- ☐ ☐ Is training conducted at least annually for all employees and immediately for new employees?
- ☐ ☐ Has someone in the office been designated to be in charge of infection control?