Helping the Infection Control Coordinator Build a Framework for the Safest Dental Visit™

OSAP continues to support The Safest Dental Visit™, an educational program based on authoritative best practices and supported by behavioral change tools including Infection Control in Practice. This year Infection Control in Practice will provide the infection control coordinator with a framework to establish a high quality infection control program and maintain the Safest Dental Visit™. This guide can be used as a tool to spark discussion during a morning team huddle, at a staff meeting or within an educational presentation.

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TEAM HUDDLE: The Plan for Establishing a High Quality Infection Control Program - Building a Framework for the Safest Dental Visit™

Assess your Current Infection Control Program

Persons desiring to become an infection control coordinator (ICC) may need to propose such a position to their employer. The infection control coordinator needs to take ownership of the coordinator responsibilities, assess the current status of the infection control program, set some measurable goals for the coming year and develop a plan to achieve those goals, and will also need to evaluate the effectiveness of the program. This issue of ICIP will concentrate on evaluation/assessment of the infection control program.

LEARNING OBJECTIVES

After reading this publication, the reader should be able to:

• describe the importance of evaluating the infection control program.
• describe how to evaluate the infection control program.
• describe why direct observation is better than interviewing when evaluating the infection control program.
The Incident

Dr. Gem’s 10-year-old general dentistry practice was getting overwhelmed with patients since his associate DDS retired and went into full-time teaching. So Dr. G offered the associate’s position to a Dr. Vennes who just completed a General Practice Residency program.

In the course of considering the position Dr. V asked Dr. G if the office was up-to-date with infection control procedures, rules, and regulations. Dr. G said, “I believe so, but I’ll have my main assistant (Thelma) conduct an official evaluation and report the results to us.” Thelma interviewed the rest of the clinical staff, which included two hygienists and two more assistants, and read the Bloodborne Pathogens (BBP) and Hazard Communication (HazCom) Standards and the Centers for Disease Control and Prevention (CDC) 2003 infection control guidelines.

She reported that all of the staff said that the operatory barriers were placed and removed after each patient; the digital x-ray sensors were covered for each patient; non-barrier-protected operatory surfaces and supply containers were being spray disinfected after each patient; and lab cases were being disinfected before being sent out.

Thelma also stated that everyone said they were wearing fresh gloves and masks with attached eye shields for each patient along with their disposable gowns; they were wearing gloves, mask, eyewear and gowns for operatory clean-up and instrument processing; they were faithfully using the alcohol hand-rub; they were carefully recapping all needles and using sharps containers that were picked up about every 10 days; all the instruments in their cassettes were ultrasonically cleaned, rinsed, and put in pouches with the multi-parameter chemical indicators when sterilized; before sterilization the packages were dated, initialed, sterilized, and placed in closed wall cabinets; the steam sterilizers were spore tested every week with results documented; and the chemical tablet was being used in the water reservoirs at all the units.

She also reported that the exposure control plan was updated three months ago, the post-exposure system was in place, the safety data sheets were in order; the eyewash unit was in place; the annual Occupational Safety and Health Administration (OSHA) training was scheduled for next month and the training records were current. All of the staff said that their immunizations and medical records were current.

Dr. V accepted the position and was pleased with Thelma’s report; however, after he began work he noticed some things that were a bit disturbing. He observed one of the assistants dismissing a patient and while still wearing her exam gloves, proceeded to remove and replace the light handle and headrest barriers.

On another day the same assistant while still wearing her exam gloves was cleaning up some blood spots on the bracket table but did not clean the surface before spray disinfecting. Dr. V then read the label on the low-level disinfectant being used, and it indicated to clean first then disinfect. After confronting the assistant, she said she would, in the future, clean the bracket tray surfaces with the sterilant/high-level disinfectant they use on plastic instruments.
ulations and CDC recommendations and didn’t recall any violations. She also said that no one indicated any violations during the interviews.

Consequences and Regulations, Recommendations and Prevention

Thelma’s evaluation report “sounded” fairly good, but the results were based on interviews with the staff. The staff said that surface barriers were replaced with each patient, which is great. However, this statement did not show that the procedure used to replace them was wrong since contaminated gloves were used to place the fresh barriers. Direct observation would have detected this breach. Also the routine use of an alcohol hand-rub is good, but direct observation may have detected the inappropriate use of the rub on soiled hands. Wearing and changing all disposable personal protective equipment (PPE) with each patient is indeed good, but at least in one instance gloves were put on first (instead of last) which brings unnecessary contamination to the patient’s mouth. Direct observation would have detected this breach, as well as wearing exam gloves instead of heavy duty utility gloves during operating clean-up.

Carefully recapping needles is not the same as the use of engineered safety devices/needles, but utilization of the one-handed scoop method or a needle recapper does reduce the risk of a sharps injury. Direct observation of the hygienist recapping a needle would have detected the dangerous two-handed procedure. Actually watching the assistant processing contaminated instruments also would have detected the handling of wet packs rather than letting them dry in the sterilizer to prevent wicking.

Cleaning a surface before disinfection reduces the bioburden on the surface, giving the disinfectant a better chance to work. Also, surfaces contaminated with blood need to be cleaned and disinfected with an intermediate-level not a low-level disinfectant. Sterilant/high-level disinfectants are not to be used on environmental surfaces. Direct observation would have revealed the label of the wrong disinfectant being used and the absence of precleaning.

Meaningful evaluation of actual performance of a procedure is based on direct observation of the employees. Interviews can be fraught with hesitations to admit errors, lapses in memory, and incomplete questioning to detect problems. Using checklists helps identify all the procedures, rules, and recommendations to be evaluated. Also the check marks provide documentation that an area was considered in the evaluation.

It is assumed that the first step in building a framework for the Safest Dental Visit™ has been completed. This first step was to take ownership of the ICC role. This was summarized in the February 2016 issue of Infection Control in Practice (Vol.15, No 1, page 3-4). The Second Step in The Annual Plan to Build a Framework for the Safest Dental Visit™ is to assess the current infection control program; and to identify issues that need correction.

ASSESS YOUR CURRENT INFECTION CONTROL PROGRAM

What to Evaluate

Evaluations of the current status of the facility’s infection control and safety program are a key role for the ICC and should be done periodically (e.g., every six months) and when changes occur in staffing, facilities, equipment, regulations, recommendations, or procedures.

Evaluation must be based on some standard. Infection control and safety can be based on standard operating procedures (SOP) designed to comply with 1) OSHA’s BBP and HazCom Standards and 2) infection control guidelines for dental settings from the CDC.

Review the CDC’s recommendations for infection control program evaluation by revisiting the December 2015 issue of Infection Control in Practice (Vol 14, No 6). The “Success Strategies” chart on pages 3 and 4 of that issue lists specific tools to assist with program evaluation and gives the following examples of what to evaluate and how to evaluate.

• Immunization of the office staff
• Occupational exposure to infectious materials
• Post-exposure management and follow-up
• Hand hygiene procedures
• Use of personal protective equipment
• Monitoring the sterilization process
• Evaluation of safety devices
• Microbial quality of dental unit water

continued on page 4
MEASURABLE STRATEGIES FOR THE INFECTION CONTROL COORDINATOR
The Annual Plan to Build a Framework for the Safest Dental Visit™

EVALUATE YOUR CURRENT INFECTION CONTROL PROGRAM  continued from page 3

Evaluation is the process of gathering information about the merit or worth of a program or the performance of procedures for the purpose of making decisions about it’s Effectiveness, Compliance, and Program Improvement.

Evaluate for Effectiveness
Infection control procedures involve killing or removing microbes or preventing contact with microbes. Thus, to measure the true effectiveness of a procedure one needs to measure the result (i.e., the killing, removal, presence/absence of microbes). This can be determined for some procedures. For example, measuring the death of bacterial spores determines the effectiveness of the sterilization process. Also, analyzing the presence of bacteria in dental unit water determines the effectiveness of water treatment systems. On the other hand, it's not easy to determine the true infection control effectiveness of such procedures as surface disinfection, handwashing, use of an alcohol hand-rub, the appropriate use of personnel protective equipment, or use of environmental surface covers. These evaluations would require microbiological recovery procedures not easily performed on site. So if the effectiveness of a procedure cannot be determined by assessing a result, then it can be evaluated by directly observing the routine correct performance of the procedure based on an approved/accepted standard operating procedure.

Evaluate for Compliance
Dental infection control and safety compliance mainly relates to the OSHA BBP and HazCom Standards and the CDC guidelines. Checklists lend themselves nicely to this type of evaluation. Such lists for asepsis before, during, and after patient treatment have been published. Also, the CDC will soon publish “Summary of infection prevention practices in dental settings: basic expectations for safe care.” This summary guide for all dental healthcare settings will be based on the 2003 guidelines but will contain some new recommendations as well as a very useful infection prevention checklist that can be used to evaluate compliance.

Evaluate for Program Improvement
A key aspect of evaluation is to identify any issues that need attention. To ensure everyone is involved in the process, use the team huddle or other staff meeting to go over the evaluation, identify the issues, and set priorities for program improvement. To assist in this effort OSAP members can download OSAP’s 12-Month Planning Guide to Establish a High Quality Infection Control and Safety Program. See the Product Spotlight on page 6 for more information.

EVALUATE YOUR PROGRESS BASED ON THE PLAN  Check Yes or No in each box to indicate if the item has been completed.

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* If no, describe how to achieve: ____________________________
What’s Wrong With This Picture?
Can you identify the breach(s) in infection prevention and safety procedures in this photo taken during a treatment procedure? Check your answer below.

Answer: The dentist’s eyewear does not have protective side shields. The patient has not been given protective eye wear. The front of the dentist’s gown is open and does not provide protection to the neck and clothing. The dental assistants are not wearing any protective outerwear/overgowns. The handpiece and suction tubing are not barrier protected and it is hoped they have been cleaned and disinfected between patients.

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TEAM HUDDLE DISCUSSION GUIDE

1. Do you have an infection control coordinator in your facility?
2. How are you progressing on evaluating your infection control program?
3. What infection control issues need to be addressed?

Product Spotlight

Have you accessed OSAP’s 12-Month Planning Guide to Establish a High Quality Infection Control and Safety Program?

This planning guide lists the key steps to establish a high quality infection control and safety program in the dental care setting. The planner is customized by filling in the name of the practice, the targeted months for task completion, and allows space to fill in the task leader and actual month of task completion. It also includes excerpted charts and checklists from prior issues of Infection Control in Practice and provides active links to sources of information about regulatory standards and guidelines and tools to evaluate your infection control program.

Login to www.osap.org and go to the ‘Knowledge Center’, select ‘Members Only Tools’ and select ‘Publications’ to download your 12-month planning guide today.

Glossary

Wicking: The drawing through of microbes or other particles through material that is wet.

Links to Resources

KEY TAKEAWAYS

1. The CDC recommends that every dental facility should have an infection control coordinator.

2. Use checklists and direct observations to evaluate your current infection control program and make decisions about effectiveness, compliance, and program improvement.

QUESTIONS FOR ONLINE QUIZ

1. What is usually the best way to evaluate the performance of a procedure?
   a. Interview others in the office about how the person performs the procedure
   b. Have the person performing the procedure verbally describe how it is done
   c. Have the person performing the procedure write out how it is done
   d. Directly observe the person performing the procedure

2. The drawing through of microbes or other particles through material that is wet is called:
   a. retroaction.
   b. suck-back.
   c. wicking.
   d. ebbing.

3. Why should gloves be put on last when donning PPE?
   a. It avoids unnecessary contamination of the gloves before entering the patient’s mouth
   b. It prevents contaminating the other PPE with any material present on the gloves
   c. It is easier to don the other PPE with bare rather than gloved hands
   d. It eliminates the need to perform hand hygiene

4. What should be done before using an alcohol hand-rub?
   a. Decontaminate the hands with an antiseptic
   b. Make sure the hands are not dirty
   c. Put on powder-free gloves
   d. Wet the hands with water

5. What is the least important when evaluating your infection control program?
   a. Estimating patient satisfaction with their dental treatment
   b. Identifying areas for program improvement
   c. Assessing compliance with regulations
   d. Measuring program effectiveness

6. What is the importance of cleaning a surface before disinfecting that surface?
   a. It eliminates the need to wipe the surface after spraying the disinfectant
   b. It reduces the disinfectant contact time by two-thirds
   c. It can give the disinfectant a better chance to work
   d. It allows the use of half as much disinfectant

7. What type of gloves should be worn for operatory clean-up and instrument handling?
   a. Powder-free latex exam gloves
   b. Low-protein latex exam gloves
   c. Powdered latex exam gloves
   d. Heavy-duty utility latex gloves

8. What type of disinfectant should be used on an environmental surface contaminated with blood?
   a. Low-level disinfectant
   b. Intermediate-level disinfectant
   c. Sterilant/high-level disinfectant
   d. Liquid sterilant

9. The true infection control effectiveness can be easily evaluated in the office for what infection control procedure?
   a. Use of an alcohol hand-rub
   b. Heat sterilization
   c. Surface disinfection
   d. Handwashing

10. Which method should be avoided when recapping a used anesthetic needle?
    a. Hold the cap tightly between the thumb and the index finger
    b. Hold the cap with cotton pliers
    c. Use a stationary cap holder
    d. Use a scoop technique

GET YOUR CE CREDIT ONLINE

Follow the instructions below to purchase and complete the quiz to receive 1 hour of CE credit.

**Step 1:** Go to http://bit.ly/OSAPICIPAPRIL2016 and purchase the CE exam through the OSAP Store. OSAP members, 1 CE credit $15. Non-members, 1 CE credit $20.

**Step 2:** OSAP will send you a purchase confirmation email and a separate email with the link to the online CE exam. Click on that link to access the exam.

**Step 3:** Complete the online exam. You have 2 attempts to pass with 7 out of 10 correct answers. When finished, you can print out or download your CE record of completion for your records. Your record of completion will also be emailed to you.

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TEAM HUDDLE HIGHLIGHTS

1. Are you building a framework for the Safest Dental Visit™?
2. Who is the designated infection control coordinator (ICC) in your facility?
3. How would you go about evaluating your infection control program?

Read on!