CALIFORNIA DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY • GAVIN NEWSOM, GOVERNOR

DENTAL BOARD OF CALIFORNIA
2005 Evergreen St., Suite 1550, Sacramento, CA 95815
P (916) 263-2300 | F (916) 263-2140 | www.dbc.ca.gov

DENTAL BOARD OF CALIFORNIA
DENTAL ASSISTING COUNCIL

NOTICE OF MEETING
February 6, 2025

Council Members
De'Andra Epps-Robbins, RDA, Chair
Jeri Fowler, RDAEF, OA, Vice Chair
Jessica Gerlach, RDA, OA
Cara Miyasaki, RDA, RDHEF, MS
Rosalinda Olague, RDA, PhD(c)
Carie Smith, RDAEF, OA

Action may be taken on any item listed on the agenda.

The Dental Assisting Council (Council) of the Dental Board of California (Board) will meet in person in accordance with Government Code section 11122.5, subdivision (a), at 8:30 a.m., on Thursday, February 6, 2025, at:

Department of Consumer Affairs
1625 N. Market Blvd., Hearing Room #102
Sacramento, CA 95834

This meeting also will be held via WebEx Events for public participation. Instructions to connect to the meeting can be found HERE.

Click Here to Join Meeting
Experiencing issues joining the meeting?

Copy and paste the link text below into an internet browser:
https://dca-meetings.webex.com/dca-meetings/j.php?MTID=mcc77ccaaf5d3619bd2a1d3a4951534c6

Event number: 2482 053 0545
Event password: DBC26 (32226 from phones)

Due to potential technical difficulties, please consider submitting written comments by January 28, 2025, to dentalboard@dca.ca.gov for consideration.

AGENDA

1. Call to Order/Roll Call/Establishment of a Quorum

2. Public Comment on Items Not on the Agenda **[4]**
   Note: The Council may not discuss or take action on any matter raised during this Public Comment section, except to decide whether to place the matter on the agenda of a future meeting. (Government Code Sections 11125 and 11125.7(a).)

3. Discussion and Possible Action on November 7, 2024 Meeting Minutes **[5-11]**

4. Assistant Executive Officer Report **[12]**
   a. Strategic Planning Process

5. Update on Dental Assisting Examination Statistics **[13-14]**
   a. Registered Dental Assistant General Written and Law and Ethics Examinations
   b. Registered Dental Assistant in Extended Functions General Written Examination
   c. Orthodontic Assistant Written Examination
   d. Dental Sedation Assistant Written Examination

6. Update on Dental Assisting Licensing Statistics **[15-25]**
   a. Registered Dental Assistant License
   b. Registered Dental Assistant in Extended Functions License
   c. Orthodontic Assistant Permit
   d. Dental Sedation Assistant Permit
   e. Abandoned Dental Assisting Applications

7. Update on Registered Dental Assistant and Registered Dental Assistant in Extended Functions Educational Programs and Courses Application Approvals **[26-29]**

8. Update, Discussion, and Possible Recommendations to the Board on Proposed Regulations
   a. Status Update on Pending Regulations **[30]**
      i. Update on Plans for the Dental Assisting Regulations Working Group
   b. Discussion and Possible Recommendation to Initiate a Rulemaking to Amend California Code of Regulations, Title 16, Section 1005 Regarding Minimum Standards for Infection Control **[31-112]**

9. Update, Discussion, and Possible Recommendation to the Board on Proposed Legislation
   a. Legislation of Interest **[113]**
   b. Discussion and Possible Recommendation on Legislative Proposal to Amend Business and Professions Code (BPC) Sections 1725, 1750, and 1753.52 and Repeal BPC Sections 1754.5 and 1755 Regarding Dental Assisting Courses **[114-129]**

10. Adjournment

Information regarding the meeting is available by contacting the Board at (916) 263-2300 or (877) 729-7789, email: DentalBoard@dca.ca.gov, or send a written request to the Dental Board of California, 2005 Evergreen Street, Suite 1550, Sacramento, CA 95815. This agenda can be found on the Dental Board of California website at dbc.ca.gov. The time and order of agenda items are subject to change at the discretion of the Council Chair and may be taken out of order. In accordance with the Bagley-Keene Open Meeting Act, all meetings of the Council are open to the public.

The meeting will be webcast, provided there are no unforeseen technical difficulties or limitations. To view the webcast, please visit **thedcapage.wordpress.com/webcasts/**. The meeting will not be cancelled if webcast is not available. Meeting adjournment may not be webcast if it is the only item that occurs after a closed session. Members of the public may, but are not obligated to, provide their names or personal information as a condition of observing or participating in the meeting. (Government Code section 11124.)

Government Code section 11125.7 provides the opportunity for the public to address each agenda item during discussion or consideration by the Council prior to the Council taking any action on said item. Members of the public will be provided appropriate opportunities to comment on any issue before the Council, but the Council Chair may, at their discretion, apportion available time among those who wish to speak. Individuals may appear before the Council to discuss items not on the agenda; however, the Council can neither discuss nor take official action on these items at the time of the same meeting (Government Code sections 11125, 11125.7(a)).

This meeting is being held in person and via teleconference through WebEx Events for public participation. The meeting location is accessible to the physically disabled. A person who needs disability-related accommodations or modifications to participate in the meeting may make a request by contacting Christy Bell, Assistant Executive Officer, at Dental Board of California, 2005 Evergreen Street, Suite 1550, Sacramento, CA 95815, or by phone at (916) 263-2300. Providing your request at least five (5) business days prior to the meeting will help ensure availability of the requested accommodations. TDD Line: (877) 729-7789

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MEMORANDUM

DATE	January 13, 2025
TO	Members of the Dental Assisting Council
FROM	Mirela Taran, Administrative Analyst Dental Board of California
SUBJECT	**Agenda Item 2.:** Public Comment on Items Not on the Agenda

Notes

DENTAL BOARD OF CALIFORNIA
DENTAL ASSISTING COUNCIL
MEETING MINUTES
November 7, 2024

Pursuant to Government Code section 11122.5, subdivision (a), the Dental Assisting Council (Council) of the Dental Board of California (Board) met in-person with additional public participation available by teleconference/WebEx Events on Thursday, November 7, 2024, with the following location available for Council and public member participation:

Department of Consumer Affairs
2005 Evergreen Street, Hearing Room #1150
Sacramento, CA 95815

Members Present:
Cara Miyasaki, RDA, RDHEF, MS, Chair
Jeri Fowler, RDAEF, OA, Vice Chair
De'Andra Epps-Robbins, RDA
Jessica Gerlach, RDA, OA
Rosalinda Olague, RDA, BA
Joanne Pacheco, RDH, MAOB
Carie Smith, RDAEF, OA

Staff Present:
Tracy A. Montez, Ph.D., Executive Officer
Ryan Blonien, Enforcement Chief (North)
Paige Ragali, Chief of Administration and Compliance
Tina Vallery, Chief of License and Program Compliance and Dental Assisting
Victor Libet, License and Program Compliance Unit Manager
Jessica Olney, Anesthesia Unit Manager
Wilbert Rumbaoa, Administrative Services Unit Manager
Brant Nelson, Legislative and Regulatory Specialist
Kelly Silva, Investigator
Mirela Taran, Administrative Analyst
Bryce Penney, Television Specialist, Office of Public Affairs, Department of Consumer Affairs (DCA)
Trisha St. Clair, Facilitator and Strategic Planner, SOLID, DCA
Tara Welch, Board Counsel, Attorney IV, Legal Affairs Division, DCA

Agenda Item 1: Call to Order/Roll Call/Establishment of a Quorum
Council Chair, Ms. Cara Miyasaki, called the meeting to order at 8:37 a.m.; seven members of the Council were present, and a quorum was established.

Agenda Item 2: Public Comment on Items Not on the Agenda
There were no public comments made on this item.

Agenda Item 3: Discussion and Possible Action on August 15, 2024 Meeting Minutes
Motion/Second/Call the Question (M/S/C) (Fowler/Pacheco) to approve the August 15, 2024 Meeting Minutes.

Chair Miyasaki requested public comment before the Council acted on the motion. There were no public comments made on the motion.

Chair Miyasaki called for the vote on the motion. Ms. Mirela Taran took a roll call vote on the motion.

Ayes: Epps-Robbins, Fowler, Gerlach, Miyasaki, Olague, Pacheco, Smith.
Nays: None.
Abstentions: None.
Absent: None.
Recusals: None.

The motion passed and the Minutes were approved.

Agenda Item 4: Executive Officer Report
Dr. Tracy Montez reported that the Board has about a 5% vacancy rate. As she shared at prior Board meetings, she noted that the vacancy rate fluctuates but believed this is probably the lowest that the Board has been as of recent years. Additionally, she shared that Board staff met with the Bureau for Private and Post-Secondary Education (BPPE) to get clarification on a board item, which turned into an interesting conversation. She disclosed that it was an example of how collaboration with DCA [boards] can be very helpful to the Board. Dr. Montez disclosed that the Board's November 2024 Board newsletter has been distributed and posted to the Board's webpage and encouraged the public to review it. She conveyed that along with Board President Dr. Alan Felsenfeld, she will be attending the November 15, 2024 Dental Hygiene Board of California (DHBC) meeting. Furthermore, she disclosed that this is Council Member Joanne Pacheco's last Council meeting as she is terming out. She expressed that Council Member Pacheco has been with the Board and Council for quite some time and has been extremely valuable.

Council Member Pacheco thanked the Council and the Board for partnering with dental auxiliaries and respecting their abilities to partner in public protection in rendering patient care. She noted that it has been an honor to serve the Council as well as the Board in several positions.

Chair Miyasaki, on behalf of the Council, thanked Council Member Pacheco for her participation in the Council and appreciates her input and participation.

Chair Miyasaki requested public comment on this item. The Council received public comment.

Shari Becker, representing the Alliance, extended their thanks to Council Member Pacheco for her service over the years and gratefulness for her participation.

Agenda Item 5: Update on Dental Assisting Examination Statistics
Tina Vallery provided the report, which is available in the meeting materials.

Chair Miyasaki requested public comment on this item. There were no public comments made on this item.

Agenda Item 6: Update on Dental Assisting Licensing Statistics
Ms. Vallery provided the report, which is available in the meeting materials.

Chair Miyasaki requested public comment on this item. There were no public comments made on this item.

Agenda Item 7: Update on Registered Dental Assistant and Registered Dental Assistant in Extended Functions Educational Programs and Courses Application Approvals
Victor Libet provided the report, which is available in the meeting materials. Mr. Libet mentioned that the Board currently has two site visits scheduled, which include a Registered Dental Assistant in Extended Functions (RDAEF) site visit in November and a Registered Dental Assistant (RDA) site visit in December.

Chair Miyasaki requested public comment on this item. The Council received public comment.

Ms. Becker, representing the Alliance, for clarification purposes asked if the reevaluations will be for all programs or if they are random audits.

Agenda Item 7.a.: Overview of Educational Program and Course Re-evaluations
Ms. Vallery provided the report, which is available in the meeting materials.

Council Member Pacheco asked if some of these courses are taught online. Ms. Vallery responded that for the pit and fissure sealants courses, there is only the allowance for didactic to be taught online while laboratory and clinical components have to be done in person. Therefore, there is no provider that offers it a hundred percent online or at least there should not be.

Council Member Pacheco asked whether Board staff would be reviewing curriculum online. Ms. Vallery responded that when the programs do the reevaluation, they have to submit all of the information that they would if they were applying for the first time. Therefore, part of that would be a curriculum review.

Council Member Pacheco asked whether Board staff would have a link to go online and see all the curriculum. Ms. Vallery responded that the program/course provider would have to submit the information in writing.

Chair Miyasaki asked what is the next course that will be evaluated. Ms. Vallery responded that her inclination is probably coronal polishing, but she had not determined that yet.

Dr. Montez conveyed that Ms. Vallery's unit will be tackling this strategically, given that they are also part of the sunset bill changes. She added that as the dental assisting division has quite a bit on its plate, one can probably guess it may start with the smaller courses moving forward to the larger programs.

Chair Miyasaki asked if the course is part of a program, like an RDA program, whether that is under scrutiny for the evaluation or are these evaluations only for standalone courses. Ms. Vallery responded that currently, Board staff are merely reevaluating standalone pit and fissure sealants courses, and that was part of the request for information. She believes that there was some misunderstanding about which ones the Board were asking about, and so it was strictly not related to any RDA programs, just ones that are offered as standalone.

Chair Miyasaki asked whether they will be reevaluated every seven years. Ms. Vallery replied that is the goal, and now with the License and Program Compliance Unit, Board staff is making huge strides to try to get this on a schedule.

Chair Miyasaki requested public comment on this item. There were no public comments made on this item.

Agenda Item 8: Update and Discussion on the Analysis of Registered Dental Assistant General Written and Law and Ethics Examinations Preparation vs. Pass Rate Statistics
Dr. Montez provided the report, which is available in the meeting materials.

Dr. Montez noted that after we get through January 1st, implementing some of the significant changes for sunset, Board staff will continue moving on with the various areas that the Access to Care Committee has asked us to look at.

Chair Miyasaki requested public comment on this item. There were no public comments made on this item.

Agenda Item 9.: Update, Discussion, and Possible Recommendation on the Table of Permitted Dental Auxiliary Duties Delegable by Supervising Dentist as Required by California Code of Regulations (CCR), Title 16, Section 1068
Ms. Vallery provided the report, which is available in the meeting materials.

Dr. Montez communicated that as Board staff have begun to implement Senate Bill (SB) 1453 [(Ashby, Chapter 483, Statutes of 2024)], Board staff have noticed some areas that need clarification. There are some areas in the table of permitted duties where the boxes for both general and direct supervision are checked, and that is something that will need to be clarified in a future legislative proposal. As for now, where both of the supervision boxes are checked, it will ultimately come down to the decision of the supervising dentist. Dr. Montez reiterated the goal at this meeting is to look at this table and see if there is something that perhaps was missed in terms of SB 1453, but it is not an opportunity to discuss what changes should be made in terms of how the bill was written.

Chair Miyasaki noted that for the RDA, they can do the allowable duties of an Orthodontic Assistant (OA) or a Dental Sedation Assistant (DSA) as long as it is checked that it is direct and they must take a course. Chair Miyasaki asked if they would still be allowed to do those duties if they do not take the exam. Ms. Vallery responded that they would have to take the course and apply for the permit.

(M/S/C) (Olague/Pacheco) to recommend to the Board that it approve the Table of Permitted Dental Auxiliary Duties Delegable by Supervising Dentist as Required by California Code of Regulations, Title 16, Section 1068.

Chair Miyasaki requested public comment before the Council acted on the motion. The Council received public comment.

Melodi Randolph, representing the Alliance, encouraged Board staff to do the cleanup as quickly as possible because there is going to be a lot of confusion with some of the things that are on here that need to be cleaned up. Ms. Randolph noted that they would be happy to help in that process.

Dr. Montez encouraged the stakeholder groups to send her any initial feedback they are willing to share as it helps Board staff get a jump on any cleanup and also to determine the significance of it, as any cleanup likely will require a law change but not necessarily so.

Chair Miyasaki called for the vote on the motion. Ms. Taran took a roll call vote on the motion.

Ayes: Epps-Robbins, Fowler, Gerlach, Miyasaki, Olague, Pacheco, Smith.
Nays: None.
Abstentions: None.
Absent: None.
Recusals: None.

The motion passed.

Agenda Item 10: Update, Discussion, and Possible Recommendations to the Board on Proposed Regulations
Agenda Item 10.a.: Status Update on Pending Regulations
Brant Nelson provided the report, which is available in the meeting materials.

Chair Miyasaki requested public comment on this item. There were no public comments made on this item.

Agenda Item 10.b.: Discussion and Possible Recommendation to Initiate a Rulemaking to Amend CCR, Title 16, Section 1005 Regarding Minimum Standards for Infection Control
Mr. Nelson provided the report, which is available in the meeting materials.

Dr. Montez verbalized this is an example of the working group's hard work on this, and Board staff is looking forward to bringing this to the Board and the Council in February of 2025.

Chair Miyasaki requested public comment on this item. There were no public comments made on this item.

Agenda Item 11: Update, Discussion, and Possible Recommendation to the Board on Proposed Legislation
Agenda Item 11.a.: Legislation of Interest
Mr. Nelson provided the report, which is available in the meeting materials.

Chair Miyasaki requested public comment on this item. There were no public comments made on this item.

Agenda Item 11.b.: Legislative Proposal to Amend BPC Section 1725 Regarding Dental Auxiliary Course and Educational Program Fees
Dr. Montez stated this agenda item is being tabled for the meeting as the legislative proposal could be revised. She noted that Board staff had a meeting with BPPE and learned some very valuable information they think will be helpful for the future of the Board and its education programs and courses.

Chair Miyasaki requested public comment on this item. There were no public comments made on this item.

Agenda Item 12: Election of 2025 Council Chair and Vice Chair
Dr. Montez facilitated the election. She opened the floor for nominations for the position of Council Chair. Dr. Montez stated that Council Member De'Andra Epps-Robbins was nominated for appointment as the 2025 Council Chair; Council Member Epps-Robbins accepted the nomination. There were no other nominations for Council Chair.

(M/S/C) (Fowler/Olague) to elect Epps-Robbins as the 2025 Council Chair.

Dr. Montez requested public comment before the Council acted on the motion. There were no public comments made on the motion.

Dr. Montez called for the vote on the motion. Ms. Taran took a roll call vote on the motion.

Ayes: Epps-Robbins, Fowler, Gerlach, Miyasaki, Olague, Pacheco, Smith.
Nays: None.
Abstentions: None.
Absent: None.
Recusals: None.

The motion passed. Council Member Epps-Robbins was elected as 2025 Council Chair.

Dr. Montez opened the floor for nominations for the position of Council Vice Chair. Dr. Montez stated that Council Member Fowler was nominated for appointment as the 2025 Vice Chair; Council Member Fowler accepted the nomination. There were no other nominations.

(M/S/C) (Olague/Pacheco) to appoint Council Member Fowler as the 2025 Council Vice Chair.

Dr. Montez requested public comment before the Council acted on the motion. There were no public comments made on the motion.

Dr. Montez called for the vote on the motion. Ms. Taran took a roll call vote on the motion.

Ayes: Epps-Robbins, Fowler, Gerlach, Miyasaki, Olague, Pacheco, Smith.
Nays: None.
Abstentions: None.
Absent: None.
Recusals: None.

The motion passed. Council Member Fowler was elected as 2025 Council Vice Chair.

Dr. Montez noted the Chair and Vice Chair terms begin on January 1, 2025.

Agenda Item 13: Adjournment
Chair Miyasaki adjourned the meeting at 9:30 a.m.

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MEMORANDUM

DATE	January 13, 2025
TO	Members of the Dental Assisting Council
FROM	Mirela Taran, Administrative Analyst Dental Board of California
SUBJECT	**Agenda Item 4.:** Assistant Executive Officer Report

Background

Christy Bell will provide an update on Board activities, including upcoming strategic planning.

Action Requested

No action required.

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MEMORANDUM

DATE	January 7, 2025
TO	Members of the Dental Assisting Council
FROM	Taylor Williams, Dental Assisting Program Manager Dental Board of California
SUBJECT	**Agenda Item 5.:** Update on Dental Assisting Examination Statistics

Background

The following table provides the examination statistics for candidates who attempted dental assisting examinations in fiscal years (FY) 2021–22, 2022–23, 2023–24, and 2024–25 through December 31, 2024.

License Type		RDA	OA	DSA	RDAEF		
		Written	Written	Written	Clinical	Practical	Written
FY 2024/25	Total 1st Time Candidates Tested	1,300	109	3	N/A	N/A	93
	1st Time Candidates Pass	1,077	95	3	N/A	N/A	79
	1st Time Candidates Pass %	82%	87%	100%	N/A	N/A	85%
	1st Time Candidates Fail	223	14	0	N/A	N/A	14
	1st Time Candidates Fail %	18%	13%	N/A	N/A	N/A	15%
	Total Repeat Candidates Tested	413	47	N/A	N/A	N/A	31
	Repeat Candidates Pass	182	22	N/A	N/A	N/A	17
	Repeat Candidates Pass %	44%	47%	N/A	N/A	N/A	55%
	Repeat Candidates Fail	231	25	N/A	N/A	N/A	14
	Repeat Candidates Fail %	56%	53%	N/A	N/A	N/A	45%
	Total Candidates Tested	**1,713**	**156**	**3**	**N/A**	**N/A**	**124**
	Total Candidates Passed	**1,259**	**117**	**3**	**N/A**	**N/A**	**96**
	Total Candidates Pass %	**73%**	**75%**	**100%**	**N/A**	**N/A**	**77%**
	Total Candidates Failed	**454**	**39**	**N/A**	**N/A**	**N/A**	**28**
	Total Candidates Failed %	**27%**	**25%**	**N/A**	**N/A**	**N/A**	**23%**
FY 2023/24	Total 1st Time Candidates Tested	2,466	171	8	N/A	N/A	213
	1st Time Candidates Pass	1,973	123	7	N/A	N/A	176
	1st Time Candidates Pass %	80%	72%	87.5%	N/A	N/A	83%
	1st Time Candidates Fail	493	48	1	N/A	N/A	37
	1st Time Candidates Fail %	20%	28%	12.5%	N/A	N/A	17%
	Total Repeat Candidates Tested	1,065	150	1	N/A	N/A	107
	Repeat Candidates Pass	504	47	1	N/A	N/A	46
	Repeat Candidates Pass %	47%	31%	100%	N/A	N/A	43%

	Repeat Candidates Fail	561	103	0	N/A	N/A	61
	Repeat Candidates Fail %	53%	69%	0	N/A	N/A	57%
	Total Candidates Tested	**3,531**	**321**	**9**	**N/A**	**N/A**	**320**
	Total Candidates Passed	**2,477**	**170**	**8**	**N/A**	**N/A**	**222**
	Total Candidates Pass %	**70%**	**53%**	**89%**	**N/A**	**N/A**	**69%**
	Total Candidates Failed	**1,054**	**151**	**1**	**N/A**	**N/A**	**98**
	Total Candidates Failed %	**30%**	**47%**	**11%**	**N/A**	**N/A**	**31%**
FY 2022/23	Total 1st Time Candidates Tested	2,107	255	8	N/A	N/A	194
	1st Time Candidates Pass	1,644	189	7	N/A	N/A	155
	1st Time Candidates Pass %	78%	74%	88%	N/A	N/A	80%
	1st Time Candidates Fail	463	66	1	N/A	N/A	39
	1st Time Candidates Fail %	22%	26%	12%	N/A	N/A	20%
	Total Repeat Candidates Tested	814	100	3	N/A	N/A	130
	Repeat Candidates Pass	361	54	3	N/A	N/A	52
	Repeat Candidates Pass %	44%	54%	100%	N/A	N/A	40%
	Repeat Candidates Fail	453	46	0	N/A	N/A	78
	Repeat Candidates Fail %	56%	46%	N/A	N/A	N/A	60%
	Total Candidates Tested	**2,921**	**355**	**11**	**N/A**	**N/A**	**324**
	Total Candidates Passed	**2,005**	**243**	**10**	**N/A**	**N/A**	**207**
	Total Candidates Pass %	**69%**	**68%**	**91%**	**N/A**	**N/A**	**64%**
	Total Candidates Failed	**916**	**112**	**1**	**N/A**	**N/A**	**117**
	Total Candidates Fail %	**31%**	**32%**	**9%**	**N/A**	**N/A**	**36%**
FY 2021/22	Total 1st Time Candidates Tested	1,556	137	5	54	58	160
	1st Time Candidates Pass	1,077	102	4	37	46	111
	1st Time Candidates Pass %	69%	74%	80%	69%	79%	69%
	1st Time Candidates Fail	479	35	1	17	12	49
	1st Time Candidates Fail %	31%	26%	20%	31%	21%	31%
	Total Repeat Candidates Tested	1,001	130	1	14	19	108
	Repeat Candidates Pass	411	66	1	9	12	43
	Repeat Candidates Pass %	41%	51%	100%	64%	63%	40%
	Repeat Candidates Fail	590	64	N/A	5	7	65
	Repeat Candidates Fail %	59%	49%	N/A	36%	37%	60%
	Total Candidates Tested	**2,557**	**267**	**6**	**68**	**77**	**268**
	Total Candidates Passed	**1,488**	**168**	**5**	**46**	**58**	**154**
	Total Candidates Pass %	**58%**	**63%**	**80%**	**68%**	**75%**	**57%**
	Total Candidates Failed	**1,069**	**99**	**1**	**22**	**19**	**114**
	Total Candidates Fail %	**42%**	**37%**	**20%**	**32%**	**25%**	**43%**

The Office of Professional Examination Services (OPES) monitors the passing rates for the dental assistant examinations. OPES works with subject matter experts (i.e., actively practicing licensees who are in good standing) to build a bank of quality questions that adhere to professional guidelines and technical standards for use on occupational licensing examinations.

Action Requested

Informational only. No action required.

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MEMORANDUM

DATE	January 7, 2025
TO	Members of the Dental Assisting Council
FROM	Taylor Williams, Dental Assisting Program Manager Dental Board of California
SUBJECT	**Agenda Item 6.:** Update on Dental Assisting Licensing Statistics

Dental Assistant License Application Statistics

The following tables provide monthly dental assistant license application statistics for fiscal years 2021–2022, 2022–2023, 2023–2024, and 2024–2025.

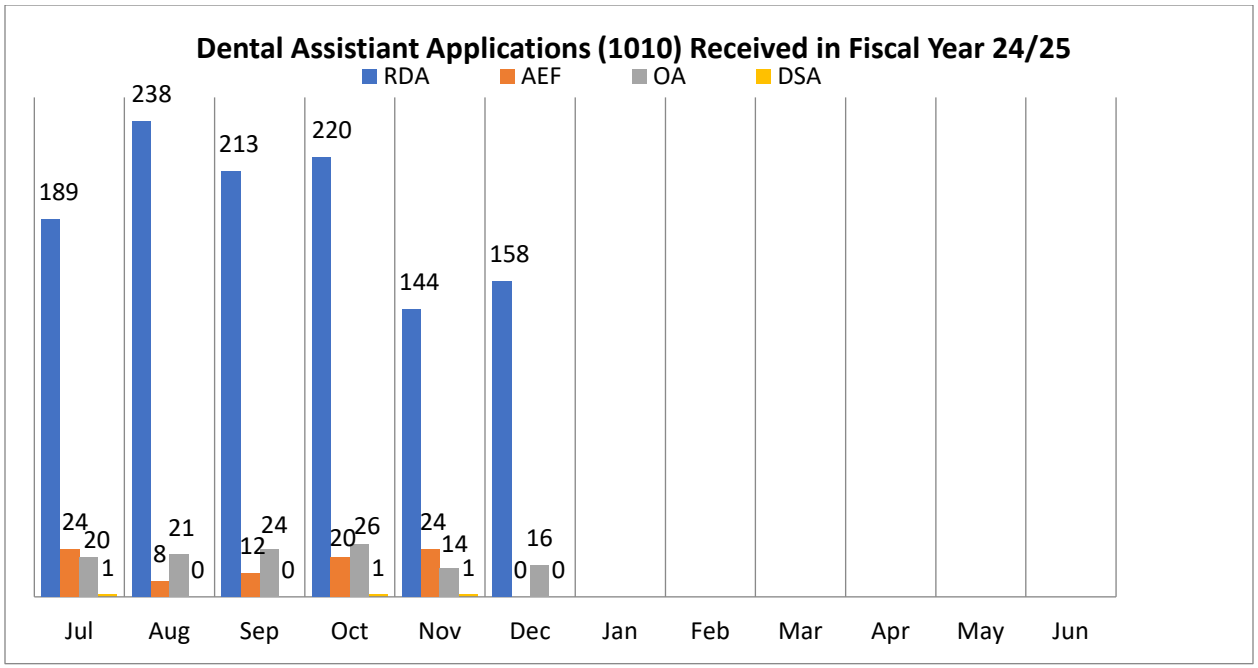
Dental Assistant Applications (1010) Received by Month													
	July	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Totals**
RDA 21-22	212	220	246	256	176	174	172	159	222	199	278	331	**2,645**
RDA 22-23	265	213	138	184	156	100	187	155	190	272	281	183	**2,324**
RDA 23-24	329	277	224	251	190	165	118	203	200	171	291	246	**2,665**
RDA 24-25	189	238	213	220	144	158							**1,162**
RDAEF 21-22	4	7	27	14	21	13	9	9	5	42	10	29	**190**
RDAEF 22-23	4	14	11	24	10	8	4	10	20	29	31	40	**205**
RDAEF 23-24	16	15	4	25	1	5	23	16	24	37	10	25	**201**
RDAEF 24-25	24	8	12	20	24	0							**88**
OA 21-22	14	24	26	25	30	28	18	14	25	26	22	20	**272**
OA 22-23	16	28	23	16	18	8	27	19	19	25	17	13	**228**
OA 23-24	19	21	19	13	26	29	12	18	27	23	24	17	**248**
OA 24-25	20	21	24	26	14	16							**121**
DSA 21-22	0	0	1	5	0	2	0	1	2	6	1	0	**18**
DSA 22-23	0	4	3	8	0	1	0	0	1	3	1	0	**21**
DSA 23-24	1	1	0	4	0	0	1	0	0	1	2	1	**11**
DSA 24-25	1	0	0	1	1	0							**3**
Dental Assistant Applications (1010) Approved by Month													
	Jul	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Totals**
RDA 21-22	225	273	225	209	176	108	71	118	114	139	118	121	**1,897**
RDA 22-23	129	271	846	378	480	338	180	140	286	252	247	284	**3,831**
RDA 23-24	171	332	232	407	152	203	130	251	270	210	227	326	**2,911**
RDA 24-25	179	296	281	340	169	177							**1,442**

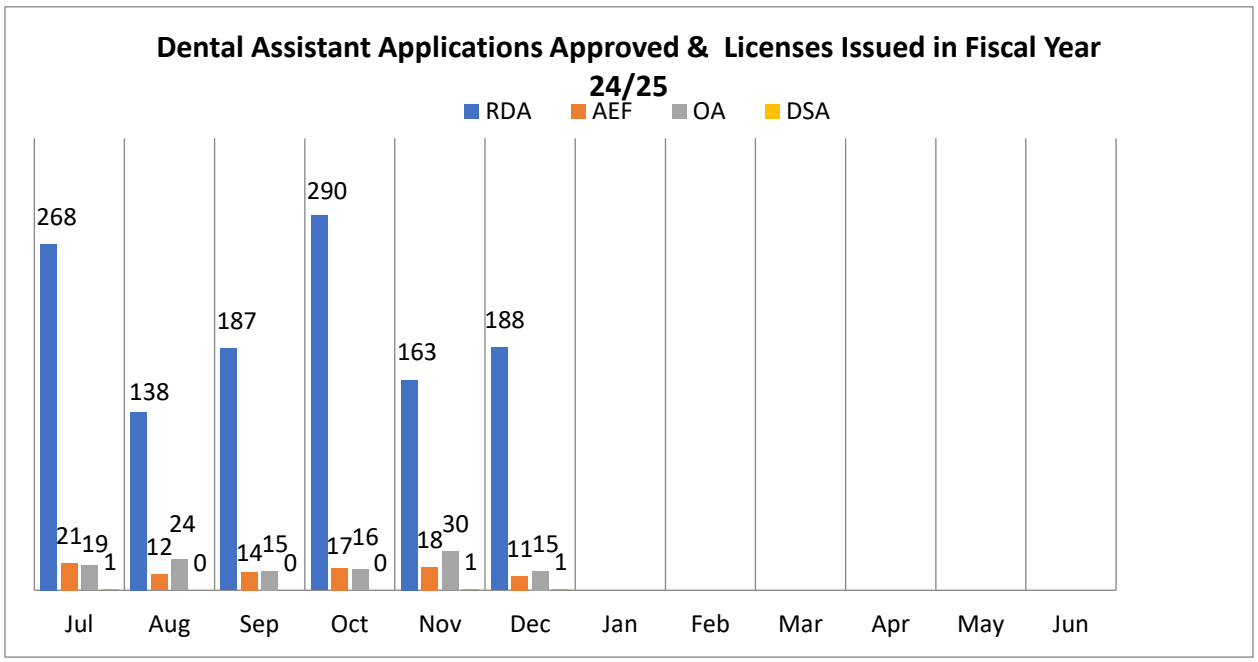
Dental Assistant Applications (1010) Approved by Month – Cont'd													
	Jul	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Totals**
RDAEF 21-22	18	1	4	22	25	12	3	11	9	7	24	35	**171**
RDAEF 22-23	25	20	0	21	18	10	17	4	32	26	20	33	**226**
RDAEF 23-24	12	18	6	33	8	3	8	22	12	33	26	16	**197**
RDAEF 24-25	15	20	10	18	14	16							**93**
OA 21-22	20	18	13	6	23	12	10	10	7	13	11	14	**157**
OA 22-23	22	22	36	56	26	19	20	15	35	23	19	13	**306**
OA 23-24	3	8	12	29	12	23	17	18	27	17	24	23	**213**
OA 24-25	15	18	19	41	13	9							**115**
DSA 21-22	2	0	0	0	0	0	0	1	2	0	1	0	**6**
DSA 22-23	2	1	0	2	1	4	1	2	0	0	1	3	**17**
DSA 23-24	0	0	1	4	1	1	0	0	0	0	0	1	**8**
DSA 24-25	0	0	1	0	1	1							**3**
Dental Assistant Applications (1010) Abandoned by Month													
	Jul	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Totals**
RDA 21-22	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
RDA 22-23	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
RDA 23-24	49	221	2	4	204	19	0	10	36	7	41	9	**602**
RDA 24-25	16	9	31	39	15	6							**116**
RDAEF 21-22	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
RDAEF 22-23	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
RDAEF 23-24	8	0	0	0	0	2	0	3	0	0	1	0	**14**
RDAEF 24-25	0	0	1	1	0	0							**2**
OA 21-22	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
OA 22-23	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
OA 23-24	27	0	0	0	20	2	0	2	4	1	2	1	**59**
OA 24-25	1	1	2	1	0	1							**6**
DSA 21-22	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
DSA 22-23	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
DSA 23-24	3	0	0	0	0	9	0	0	0	0	0	0	**12**
DSA 24-25	0	0	0	1	1	0							**2**
Dental Assistant Applications (1020) Approved and Licenses Issued by Month													
	Jul	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Totals**
RDA 21-22	244	151	126	149	155	181	79	97	99	97	121	100	**1,599**
RDA 22-23	115	126	117	248	221	222	153	165	221	136	166	159	**2,049**
RDA 23-24	215	173	259	281	209	196	219	186	139	188	207	231	**2,503**
RDA 24-25	268	138	187	290	163	188							**1,234**
RDAEF 21-22	0	46	1	1	0	0	262	0	2	6	7	4	**329**
RDAEF 22-23	39	20	19	8	14	24	11	8	25	21	18	30	**237**
RDAEF 23-24	15	14	25	27	18	12	8	6	19	20	34	22	**220**
RDAEF 24-25	24	8	12	17	18	11							**90**

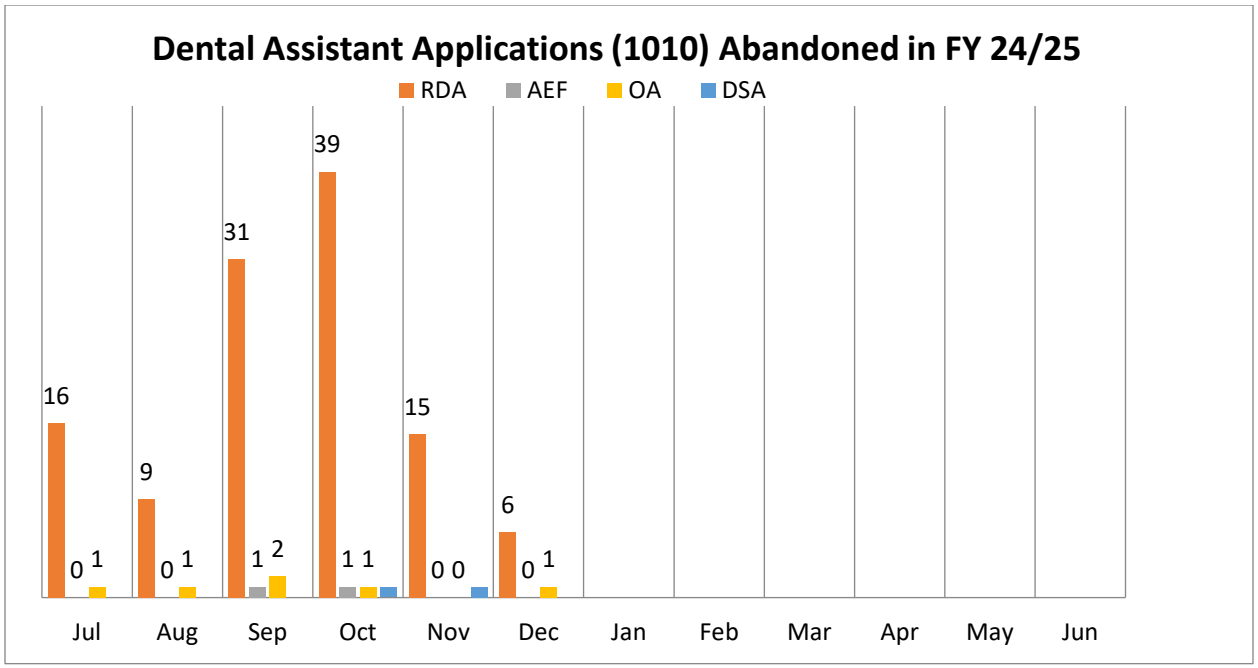
Dental Assistant Applications (1020) Approved and Licenses Issued by Month – Cont'd													
	Jul	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Totals**
OA 21-22	10	17	2	0	32	19	22	13	15	17	11	11	**169**
OA 22-23	18	20	12	30	28	34	19	16	24	21	20	25	**267**
OA 23-24	15	8	6	4	26	12	17	11	18	16	17	19	**169**
OA 24-25	19	24	15	16	30	15							**119**
DSA 21-22	0	0	0	0	0	2	0	0	0	2	0	1	**5**
DSA 22-23	0	1	1	0	0	2	0	2	0	0	1	3	**10**
DSA 23-24	1	0	0	1	0	2	1	2	2	0	0	0	**9**
DSA 24-25	1	0	0	0	1	1							**3**
Dental Assistant Applications (1020) Denied by Month													
	Jul	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Totals**
RDA 21-22	1	0	0	0	0	1	0	0	0	0	4	0	**6**
RDA 22-23	2	1	0	0	0	2	0	2	0	0	5	2	**14**
RDA 23-24	0	1	3	3	0	1	2	2	0	1	0	0	**13**
RDA 24-25	1	0	0	0	1	0							**2**
RDAEF 21-22	0	0	0	0	0	0	0	0	0	0	0	0	**0**
RDAEF 22-23	0	0	0	0	0	0	0	0	0	0	0	0	**0**
RDAEF 23-24	0	0	0	0	0	0	0	0	0	0	0	0	**0**
RDAEF 24-25	0	0	0	0	0	0							**0**
OA 21-22	0	0	0	0	0	0	0	0	0	0	0	0	**0**
OA 22-23	0	0	0	0	0	0	0	0	0	0	0	0	**0**
OA 23-24	0	0	0	0	1	0	0	0	0	0	0	0	**1**
OA 24-25	0	0	0	0	0	0							**0**
DSA 21-22	0	0	0	0	0	0	0	0	0	0	0	0	**0**
DSA 22-23	0	0	0	0	0	0	0	0	0	0	0	0	**0**
DSA 23-24	0	0	0	0	0	0	0	0	0	0	0	0	**0**
DSA 24-25	0	0	0	0	0	0							**0**
Dental Assistant Applications (1020) Abandoned by Month													
	Jul	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Totals**
RDA 21-22	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
RDA 22-23	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
RDA 23-24	676	70	20	60	81	36	28	30	31	36	21	15	**1,104**
RDA 24-25	38	21	91	68	37	34							**289**
RDAEF 21-22	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
RDAEF 22-23	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
RDAEF 23-24	6	0	0	0	0	0	0	0	0	0	1	3	**10**
RDAEF 24-25	1	0	1	0	0	0							**2**
OA 21-22	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
OA 22-23	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
OA 23-24	15	8	4	1	3	2	4	2	1	1	0	0	**41**
OA 24-25	4	0	3	5	4	3							**19**

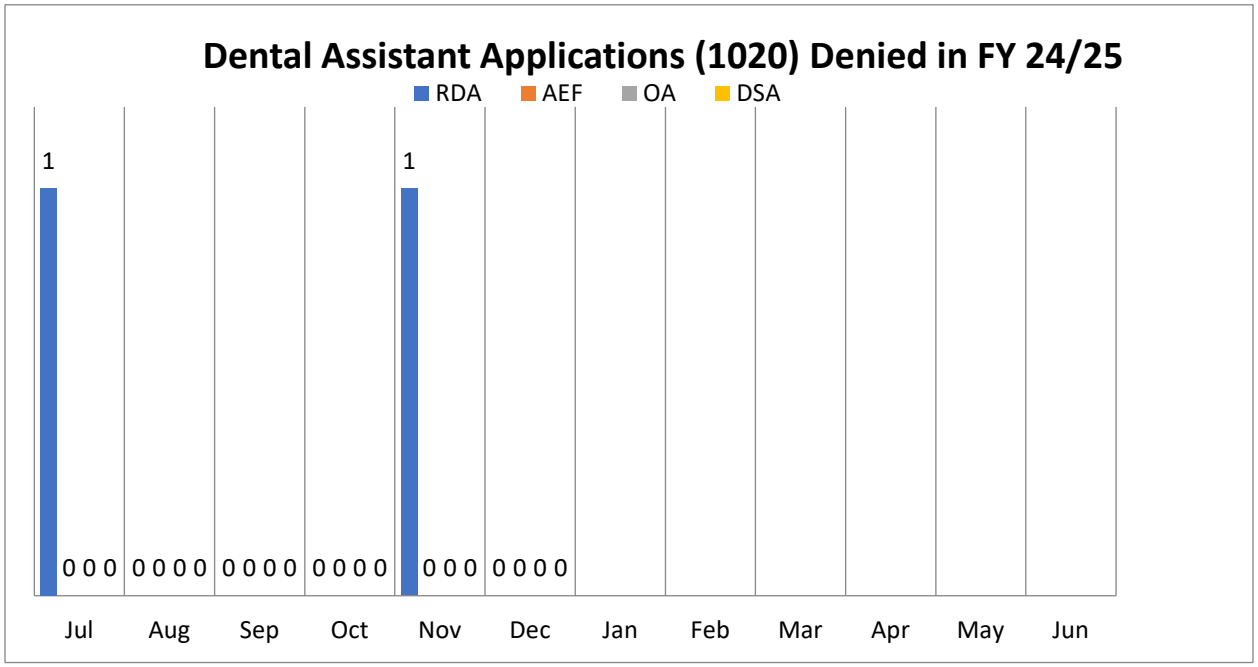
Dental Assistant Applications (1020) Abandoned by Month – Cont'd													
	Jul	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Totals**
DSA 21-22	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
DSA 22-23	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
DSA 23-24	0	0	0	0	0	0	0	0	0	1	0	0	**1**
DSA 24-25	0	0	0	0	0	0							**0**

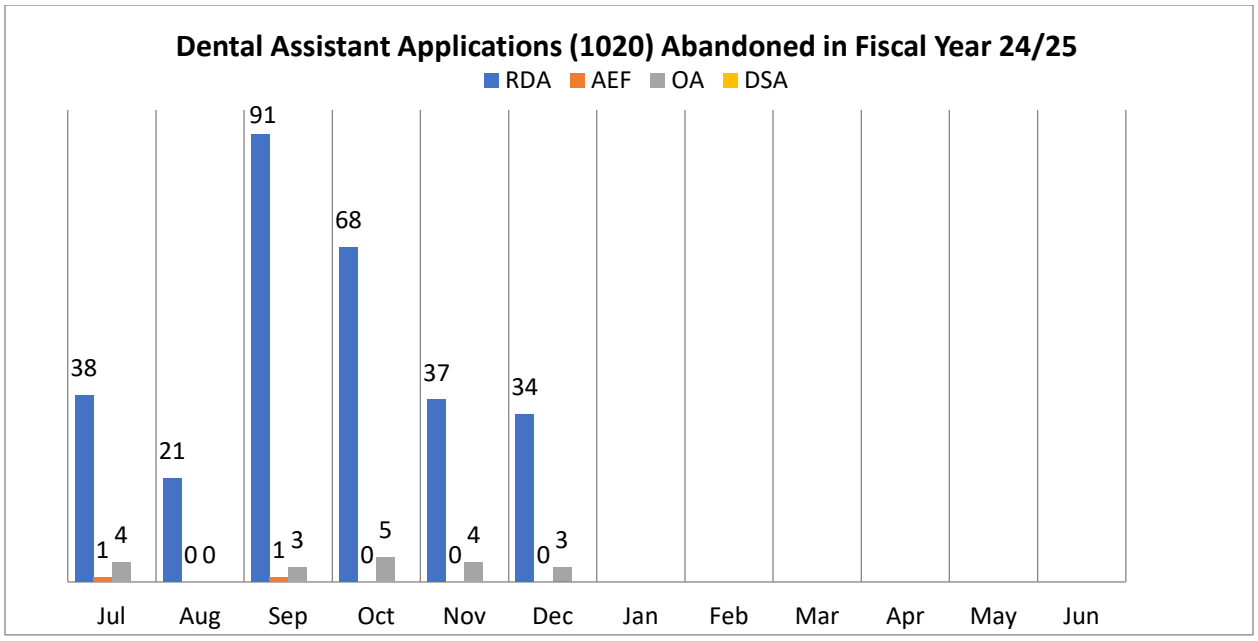
Application Definitions	
Received	Application received in paper format or electronically through BreEZe system.
Approved	Application for eligibility of licensure processed with required documentation and examination eligibility issued.
License Issued	Final application including examination results approved and license issued.
Abandoned (1010)	An applicant who fails to complete application requirements within one year after being notified by the Board of deficiencies.
Abandoned (1020)	Pursuant to CCR, title 16, section 1004, an application is considered abandoned if: 1) The applicant fails to submit the application, examination, or reexamination fee within 180 days after notification by the Board that such fee is due and unpaid. 2) The applicant fails to take the licensing examination within two years after the date their application was received by the Board. 3) … [A]fter failing the examination, [the applicant] fails to take a reexamination within two years after the date the applicant was notified of such failure.
Denied	The Board denies an application on the grounds that the applicant has been convicted of a crime or has been subject to formal discipline; in accordance with Business and Professions Code, Division 1.5, Chapter 2, Denial of Licenses.

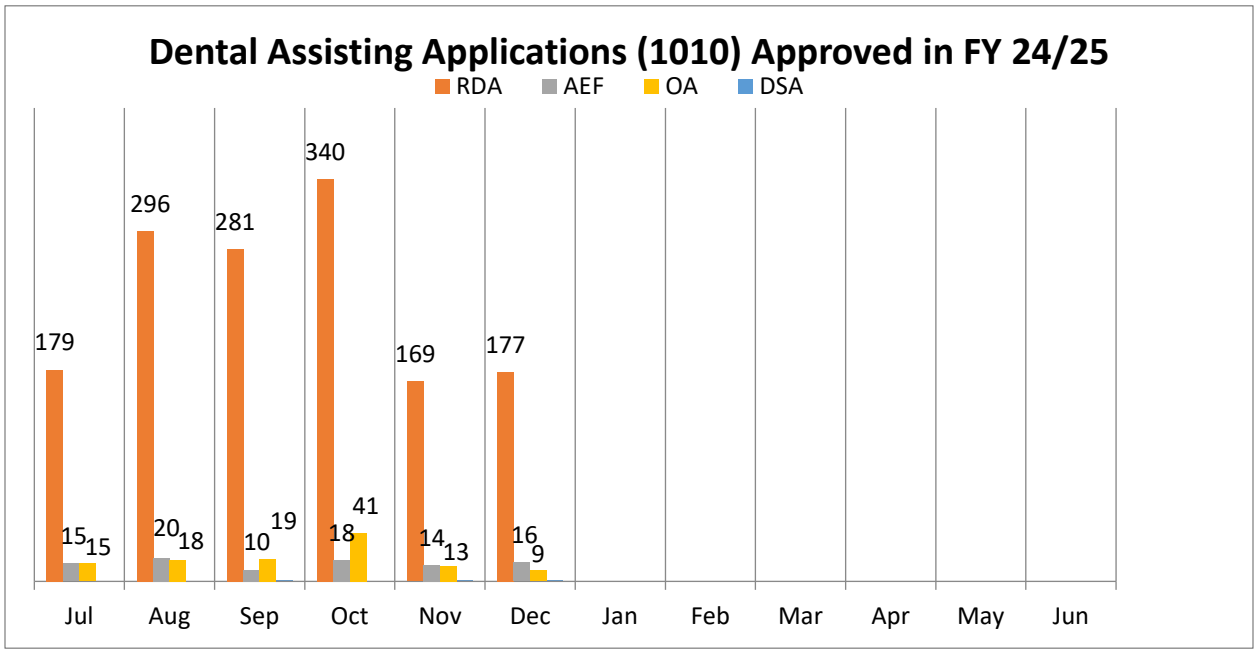

Dental Assistiant Applications (1010) Received in Fiscal Year 24/25
RDA
AEF
OA
DSA
189
24
20
1
238
8
21
0
213
12
24
0
220
20
26
1
144
24
14
1
158
0
16
0
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun


Dental Assistant Applications Approved & Licenses Issued in Fiscal Year 24/25
RDA
AEF
OA
DSA
268
21
19
1
138
12
24
0
187
14
15
0
290
17
16
0
163
18
30
1
188
11
15
1
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun


Dental Assistant Applications (1010) Abandoned in FY 24/25
RDA
AEF
OA
DSA
16
0
1
9
0
1
31
1
2
39
1
1
15
0
0
6
0
1
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun


Dental Assistant Applications (1020) Denied in FY 24/25
RDA
AEF
OA
DSA
1
0 0 0
0 0 0 0
0 0 0 0
0 0 0 0
1
0 0 0
0 0 0 0
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun


Dental Assistant Applications (1020) Abandoned in Fiscal Year 24/25
RDA
AEF
OA
DSA
38
1
4
21
0
0
91
1
3
68
0
5
37
0
4
34
0
3
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun


Dental Assisting Applications (1010) Approved in FY 24/25
RDA
AEF
OA
DSA
179
15
15
296
20
18
281
10
19
340
18
41
169
14
13
177
16
9
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun

Dental Assistant License Status Statistics

The following table provides dental assistant license and permit status statistics for fiscal years 2021–22, 2022–23, 2023–24, and 2024–25. Cancelled licenses indicates number of licenses/permits cancelled to date.

License Type	License Status	FY 2021–22	FY 2022–23	FY 2023–24	FY 2024–25
Registered Dental Assistant	Active	28,902	28,437	28,711	28,875
	Inactive	3,991	3,790	3,611	3,473
	Delinquent	12,992	13,543	13,696	13,847
	Cancelled	51,512	53,712	55,903	56,973
License Type	**License Status**	**FY 2021–22**	**FY 2022–23**	**FY 2023–24**	**FY 2024–25**
Registered Dental Assistant in Extended Functions	Active	1,756	1,950	2,082	2,148
	Inactive	75	77	78	81
	Delinquent	298	305	352	359
	Cancelled	420	462	494	512
License Type	**License Status**	**FY 2021–22**	**FY 2022–23**	**FY 2023–24**	**FY 2024–25**
Orthodontic Assistant	Active	1,407	1,602	1,678	1,757
	Inactive	44	46	50	46
	Delinquent	286	333	399	410
	Cancelled	27	51	78	105
License Type	**License Status**	**FY 2021–22**	**FY 2022–23**	**FY 2023–24**	**FY 2024–25**
Dental Sedation Assistant	Active	38	45	52	55
	Inactive	2	4	4	3
	Delinquent	16	17	12	13
	Cancelled	7	9	15	15

License Status Definitions	
Active	An individual who has an active status and has completed all renewal requirements.
Inactive	An individual who has an inactive status and has paid the renewal fees, but who cannot perform the duties of the license unless the license is re-activated. Continuing education units are not required for inactive license renewal.
Delinquent	An individual who does not comply with renewal requirements. This status remains until renewal requirements are met.
Cancelled	An individual who fails to comply with renewal requirements by a set deadline.

The following table provides statistics on population, current and active Registered Dental Assistant (RDA) licenses by county, and population per RDA license by county for fiscal years 2021–22, 2022–23, 2023–24, and 2024–2025. These statistics represent the licensee's address of record and not necessarily the licensee's workplace address.

County	RDA 22-23	Pop. 22-23	Pop. per RDA 22-23	DDS 22-23	RDA to DDS Ratio 22-23	RDA 23-24	Pop. 23-24	Pop. per RDA 23-24	DDS 23-24	RDA to DDS Ratio 23-24	RDA 24-25	Pop. 24-25	Pop. per RDA 24-25	DDS 24-25	RDA to DDS Ratio 24-25
Alameda	1,221	1,651,979	1,352	1,485	0:1	1,106	1,636,194	1,479	1,472	0:1	1,116	1,641,869	1,471	1,480	0:1
Alpine	0	1,200	0	0	0	0	1,184	0	0	0	0	1,179	0	0	0
Amador	78	40,297	516	21	2:1	52	39,837	766	23	2:1	52	39,611	761	25	2:1
Butte	291	201,608	692	124	2:1	271	205,592	758	118	2:1	271	205,928	759	114	2:1
Calaveras	69	45,049	652	21	2:1	59	44,890	760	21	2:1	60	44,842	747	17	2:1
Colusa	28	21,807	778	6	4:1	28	21,771	777	4	4:1	27	21,743	805	3	4:1
Contra Costa	1320	1,156,555	876	1,103	1:1	1222	1,147,653	939	1,092	1:1	1,218	1,146,626	941	1,096	1:1
Del Norte	30	27,218	907	11	2:1	28	26,599	949	11	2:1	29	26,345	908	14	2:1
El Dorado	257	190,465	741	152	1:1	202	189,006	935	148	1:1	189	188,583	997	148	1:1
Fresno	962	1,011,273	1,051	620	1:1	891	1,011,499	1,135	625	1:1	888	1,017,431	1,145	637	1:1
Glenn	46	28,750	625	7	7:1	50	28,636	572	7	7:1	48	28,736	598	8	7:1
Humboldt	162	135,168	834	63	2:1	161	134,047	832	66	2:1	167	133,100	797	68	2:1
Imperial	102	179,329	1,758	39	2:1	90	179,476	1,994	40	2:1	95	182,881	1,925	42	2:1
Inyo	8	18,978	2,372	5	1:1	7	18,896	2,699	7	1:1	7	18,856	2,693	7	1:1
Kern	734	909,813	1,239	341	1:1	624	907,476	1,454	350	1:1	641	910,300	1,420	353	1:1
Kings	157	152,023	968	61	2:1	155	151,018	974	58	2:1	161	152,627	947	56	2:1
Lake	112	67,407	601	39	1:1	84	66,800	795	37	1:1	86	67,001	779	39	1:1
Lassen	40	30,274	756	22	1:1	35	28,275	807	18	1:1	35	28,197	805	18	1:1
Los Angeles	5099	9,861,224	1,933	8,416	0:1	4505	9,761,210	2,166	8,464	0:1	4,499	9,824,091	2,183	8,458	0:1
Madera	144	157,396	1,093	44	3:1	155	158,148	1,020	47	3:1	150	159,328	1,062	56	3:1
Marin	183	257,135	1,405	290	0:1	172	252,959	1,470	279	0:1	170	252,844	1,487	270	0:1
Mariposa	11	17,045	1,549	7	1:1	9	16,935	1,881	6	1:1	6	16,966	2,827	6	1:1
Mendocino	112	89,999	803	49	1:1	94	89,164	948	45	1:1	89	89,476	1,005	48	1:1

County	RDA 22-23	Pop. 22-23	Pop. per RDA 22-23	DDS 22-23	RDA to DDS Ratio 22-23	RDA 23-24	Pop. 23-24	Pop. per RDA 23-24	DDS 23-24	RDA to DDS Ratio 23-24	RDA 24-25	Pop. 24-25	Pop. per RDA 24-25	DDS 24-25	RDA to DDS Ratio 24-25
Merced	264	284,338	1,077	92	2:1	233	285,337	1,224	98	2:1	242	287,303	1,187	96	2:1
Modoc	3	8,690	2,896	3	0:1	3	8,527	2,842	5	0:1	4	8,484	2,121	5	0:1
Mono	5	13,379	2,675	5	1:1	5	13,156	2,631	5	1:1	5	12,861	2,572	3	1:1
Monterey	436	433,716	994	248	1:1	370	430,368	1,163	244	1:1	369	437,614	1,185	252	1:1
Napa	141	136,179	965	110	1:1	130	134,637	1,035	106	1:1	129	135,029	1,046	105	1:1
Nevada	100	101,242	1,012	72	1:1	84	100,720	1,199	69	1:1	86	100,177	1,164	66	1:1
Orange	1814	3,162,245	1,743	4,073	0:1	1632	3,137,164	1,922	4,183	0:1	1634	3,150,835	1,928	4,218	0:1
Placer	534	409,025	765	472	0:1	469	410,305	874	482	0:1	474	412,844	870	481	0:1
Plumas	18	18,942	1,052	13	1:1	14	18,996	1,356	13	1:1	13	18,841	1,449	12	1:1
Riverside	2171	2,435,525	1,121	1,142	1:1	2019	2,439,234	1,208	1,163	1:1	1982	2,442,378	1,232	1,182	1:1
Sacramento	1887	1,576,618	835	1,176	1:1	1590	1,572,453	988	1,207	1:1	1570	1,578,938	1,005	1,204	1:1
San Benito	118	65,479	554	23	4:1	98	65,666	670	26	4:1	96	65,853	685	28	4:1
San Bernardino	1688	2,187,665	1,296	1,398	1:1	1530	2,182,056	1,426	1,403	1:1	1561	2,181,433	1,397	1,447	1:1
San Diego	2808	3,287,306	1,170	2,820	0:1	2537	3,269,755	1,288	2,853	0:1	2523	3,291,101	1,304	2,857	0:1
San Francisco	452	842,754	1,864	1,151	0:1	424	831,703	1,961	1,127	0:1	422	843,071	1,997	1,128	0:1
San Joaquin	873	784,298	898	376	1:1	793	786,145	991	393	1:1	783	791,408	1,010	390	1:1
San Luis Obispo	248	280,721	1,131	210	1:1	207	278,348	1,344	217	1:1	206	278,469	1,351	217	1:1
San Mateo	572	744,662	1,301	843	0:1	533	737,644	1,383	829	0:1	540	741,565	1,373	831	0:1
Santa Barbara	399	445,164	1,115	307	1:1	355	440,557	1,241	312	1:1	343	443,623	1,293	314	1:1
Santa Clara	1662	1,894,783	1,140	2,289	0:1	1517	1,886,079	1,243	2,283	0:1	1515	1,903,198	1,256	2,273	0:1
Santa Cruz	225	266,564	1,184	168	1:1	196	262,051	1,336	171	1:1	197	262,572	1,332	170	1:1
Shasta	203	180,531	889	100	1:1	164	179,436	1,094	109	1:1	164	179,195	1,092	112	1:1
Sierra	2	3,229	1,614	0	0:1	2	3,193	1,596	0	0:1	1	3,171	3,171	0	0:1
Siskiyou	28	43,830	1,565	23	1:1	21	43,548	2,073	23	1:1	20	43,409	2,170	23	1:1
Solano	623	447,241	717	279	2:1	562	443,749	789	277	2:1	563	446,426	792	275	2:1
Sonoma	675	482,404	714	382	1:1	607	478,174	787	374	1:1	618	478,152	773	386	1:1

County	RDA 22-23	Pop. 22-23	Pop. per RDA 22-23	DDS 22-23	RDA to DDS Ratio 22-23	RDA 23-24	Pop. 23-24	Pop. per RDA 23-24	DDS 23-24	RDA to DDS Ratio 23-24	RDA 24-25	Pop. 24-25	Pop. per RDA 24-25	DDS 24-25	RDA to DDS Ratio 24-25
Stanislaus	665	549,466	826	274	2:1	577	545,939	946	277	2:1	559	548,744	981	283	2:1
Sutter	143	99,145	693	51	2:1	120	98,952	824	49	2:1	122	100,110	820	52	2:1
Tehama	95	65,052	684	31	2:1	75	64,271	856	28	2:1	84	64,308	765	29	2:1
Trinity	5	16,023	3,204	3	1:1	5	15,939	3,187	2	1:1	6	15,915	2,652	3	1:1
Tulare	491	475,014	967	217	2:1	474	475,064	1,002	218	2:1	487	478,918	983	221	2:1
Tuolumne	81	55,291	682	47	1:1	77	54,590	708	45	1:1	78	54,407	697	44	1:1
Ventura	590	833,652	1,412	627	0:1	512	825,653	1,612	634	0:1	523	823,863	1,575	633	0:1
Yolo	210	221,165	1,053	122	1:1	187	220,880	1,181	125	1:1	189	221,666	1,172	122	1:1
Yuba	104	82,275	791	7	13:1	97	82,677	852	10	13:1	93	83,721	900	10	13:1
TOTAL	**31,499**	**39,185,605**	**66,100**	**32,080**	**N/A**	**28,219**	**38,940,231**	**72,942**	**32,298**	**N/A**	**28,205**	**39,128,162**	**74,362**	**32,435**	**N/A**

*Population data obtained from Department of Finance, Demographic Research Unit.
**Ratios are rounded to the nearest whole number.

Counties with the Highest Population per RDA:	Sierra County (1:3,171)	Counties with the Lowest Population per RDA:	Alpine County (No RDAs)
	Mariposa County (1:2,827)		Glenn County (1:598)
	Inyo County (1:2,693)		San Benito County (1:685)
	Trinity County (1:2,653)		Tuolumne County (1:697)
	Mono County (1:2,573)		Calaveras County (1:747)

Action Requested
Informational only. No action required.

CALIFORNIA DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY • GAVIN NEWSOM, GOVERNOR

DENTAL BOARD OF CALIFORNIA
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MEMORANDUM

DATE	January 8, 2025
TO	Members of the Dental Assisting Council
FROM	Victor Libet, Manager of License and Program Compliance Unit Dental Board of California (Board)
SUBJECT	**Agenda Item 7.:** Update on Registered Dental Assistant and Registered Dental Assistant in Extended Functions Educational Programs and Courses Application Approvals

Background

The following table provides dental assisting (DA) educational programs and courses application statistics for fiscal years 2021–22, 2022–23, 2023–24 and 2024–2025 through December 31, 2024.

RDA and RDAEF Educational Program and Course Applications Approved				
Program/Course	2021–22	2022–23	2023–24	2024–25
RDA Program	1	0	0	0
RDAEF Program	0	0	0	0
RDAEF-ITR	0	0	0	0
Radiation Safety	9	11	5	5
Coronal Polishing	9	9	3	4
Pit & Fissure Sealant	9	5	3	1
Ultrasonic Scaling	7	0	2	0
Infection Control	11	4	4	2
DSA Permit	13	3	0	1
OA Permit	9	19	6	3
Total Applications Approved	**68**	**51**	**23**	**16**
RDA and RDAEF Educational Program and Course Applications Denied				
Program/Course	2021–22	2022–23	2023–24	2024–25
RDA Program	1	0	1	0
RDAEF Program	0	0	1	0
RDAEF-ITR	0	0	0	0
Radiation Safety	3	0	7	4
Coronal Polishing	0	0	4	2
Pit & Fissure Sealant	1	0	0	2
Ultrasonic Scaling	1	0	1	1
Infection Control	3	1	16	6

DSA Permit	1	1	1	0
OA Permit	0	0	2	4
Total Applications Denied	**10**	**2**	**33**	**19**

RDA and RDAEF Educational Program and Course Applications Deficient				
Program/Course	2021-22	2022-23	2023-24	2024-25
RDA Program	0	0	1	0
RDAEF Program	0	0	0	0
RDAEF-ITR	0	0	0	0
Radiation Safety	0	0	2	0
Coronal Polishing	0	0	3	2
Pit & Fissure Sealant	0	0	2	2
Ultrasonic Scaling	0	0	1	1
Infection Control	0	0	3	0
DSA Permit	1	0	0	1
OA Permit	1	1	2	1
Total Applications Deficient	**2**	**1**	**14**	**7**

RDA and RDAEF Educational Program and Course Applications Pending				
Program/Course	2021-22	2022-23	2023-24	2024-25
RDA Program	0	0	0	1
RDAEF Program	0	1	0	1
RDAEF-ITR	0	0	0	0
Radiation Safety	6	0	6	2
Coronal Polishing	4	0	3	1
Pit & Fissure Sealant	2	0	3	3
Ultrasonic Scaling	0	0	1	0
Infection Control	3	0	4	2
DSA Permit	0	0	0	0
OA Permit	6	0	3	1
Total Applications Pending	**21**	**1**	**20**	**11**

Application Definitions	
Approved	Application for Board approval of educational program/course processed with required documentation, and approval number issued.
Denied	The Board denies an application on the grounds that the application lacks documentation that the educational program/course complies with the requirements of the California Code of Regulations.
Deficient	Application for Board approval of educational program/course processed with submitted documentation, and additional documentation requested from applicant. For completed fiscal years, this is a snapshot of the number of deficient applications on June 30. For the current fiscal year, this is a snapshot of the number of deficient applications on December 31, 2024. Status changes weekly.
Pending	Board staff and/or contracted subject matter expert is reviewing an application for Board approval of an educational program/course with submitted documentation.

The following table provides the number of Registered Dental Assistant (RDA) and RDA in Extended Functions (RDAEF) program site visits conducted in fiscal years 2021–22, 2022–23, 2023–24, and 2024–25 through December 31, 2024.

RDA and RDAEF Educational Program Site Visits					
	RDA Programs		RDAEF Programs		Grand Total
	Provisional	Full	Provisional	Full	
2021–22	1	0	0	0	1
2022–23	0	0	0	0	0
2023–24	1	0	0	0	1
2024–25	1	0	1	0	2

The following table provides approved programs and courses by name and type of program for fiscal year 2024–25, through December 31, 2024.

Programs and Courses by Name and Type Approved in Q1 2024–25											
Provider	**Approval Date**	**RDA**	**RDAEF**	**RDAEF ITR**	**RS**	**CP**	**PF**	**US**	**IC**	**DSA**	**OA**
Triumph University	7/1/24					X					
Triumph University	7/1/24				X						
OceanPointe Dental Assisting Academy - La Crescenta	7/16/24								X		
West Coast Grins	7/26/24										X
Triumph University	7/29/24						X				
Aviara Academy	7/29/24				X						
Chaffey Community College	7/29/24				X						
OceanPointe Dental Assisting Academy - La Crescenta	10/9/24				X						
OceanPointe Dental Assisting Academy - Merced	10/21/24				X						
OceanPointe Dental Assisting Academy - Merced	10/21/24								X		
North West College - Anaheim	10/24/24					X					
North West College - West Covina	10/24/24					X					
Sheila T. Luwiharto DDS, MS, PC	11/19/24					X					
Rolling Hills Dental Clinic	12/10/24										X
Capital Pediatric Dentistry	12/19/24									X	
Citrus College	12/31/24										X
PROGRAM/COURSE TOTALS		**0**	**0**	**0**	**5**	**4**	**1**	**0**	**2**	**1**	**3**

TOTAL APPROVALS = 16

The following table provides the total number of approved DA educational programs and courses in active status as of December 31, 2024.

Table 4
Total Approved DA Educational Programs and Courses in Active Status

RDA Program	RDAEF Program	RDAEF-ITR	Radiation Safety	Coronal Polishing	Pit & Fissure Sealant	Ultrasonic Scaling	Infection Control	DSA Permit	OA Permit
82	10	3	194	134	111	46	170	49	205

Action Requested

Informational only. No action required.

CALIFORNIA DEPARTMENT OF CONSUMER AFFAIRS

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MEMORANDUM

DATE	January 10, 2025
TO	Members of the Dental Assisting Council
FROM	Brant Nelson, Legislative and Regulatory Specialist Dental Board of California
SUBJECT	**Agenda Item 8.a:** Status Update on Pending Regulations

Background

There are currently no pending regulations.

Action Requested

This item is informational only. No action is requested.

CALIFORNIA DEPARTMENT OF CONSUMER AFFAIRS

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MEMORANDUM

DATE	January 16, 2025
TO	Members of the Dental Assisting Council
FROM	Brant Nelson, Legislative and Regulatory Specialist Dental Board of California
SUBJECT	**Agenda Item 8.b.:** Discussion and Possible Recommendation to Initiate a Rulemaking to Amend California Code of Regulations, Title 16, Section 1005 Regarding Minimum Standards for Infection Control

Background

Business and Professions Code (BPC) section 1680(ad) requires the Dental Board of California (Board) to review infection control guidelines (Guidelines), if necessary, on an annual basis. Proposed changes to the Guidelines must be reviewed by the Dental Hygiene Board of California (DBC) by law. Section 1680 requires the DHBC to submit any recommended changes to the infection control guidelines to the Board for review "to establish a consensus." The Board has adopted its Guidelines at CCR section 1005.

The Board last revised CCR section 1005 in 2011. At that time, the purpose for amending the regulation was to revise the Board's existing infection control regulations to conform with recent changes in the Centers for Disease Control (CDC) "Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008" (hereinafter "CDC guidelines") and incorporate revisions made to regulations of the California Division of Occupational Safety and Health ("Cal/OSHA") at California Code of Regulations, title 8, section 5193 (see **Attachment 3**). Although Cal/OSHA's regulation has not been revised since 2009, the CDC guidelines were last updated in June 2024 and are available online here: https://www.cdc.gov/infection-control/media/pdfs/guideline-disinfection-h.pdf).

At the February 9, 2024 Board meeting, the Board President appointed Dental Assisting Council (Council) Chair Cara Miyasaki and former Board Vice President Joanne Pacheco to serve as the Board's working group to review CCR section 1005 and develop recommendations to update the existing regulatory language. Over the course of many months, beginning on April 15, 2024, the working group met to discuss possible updates to the Guidelines and further develop specific recommendations for discussion

and possible action at future Council, DHBC and Board meetings. In addition to the CDC guidelines, the reference materials in Attachments 3 through 7 were consulted in the development of the proposal. Once agreement was reached on a draft proposal, the proposed regulatory language was provided to the DHBC's subject matter experts: Adina A. Pineschi-Petty, DDS, and DHBC Board Member Michael Long, RDHAP for review. The two groups of experts then consulted on possible further revisions to the proposal in the development of an agreed-upon final draft. Agreements were reached and a final draft of proposed regulatory amendments to the existing Guidelines was finalized in November 2024 as set forth in **Attachment 1**.

To begin the process of establishing a "consensus" on the Guidelines, **Attachment 1** was brought to the DHBC's Legislation and Regulatory Committee on November 15, 2024 for review and action, and thereafter brought to the DHBC at its November 16, 2024 Board meeting. However, at these DHBC meetings, the California Dental Association (CDA) raised concerns about two issues in the proposed regulatory amendments:

> (1) additional training being proposed on the "written infection control plan" training for dental healthcare personnel (DHCP) employers to provide to other affected DHCP (see subsection (c), page 11 of Attachment 1) as "duplicative" of Cal/OSHA and other state-mandated trainings, and,
>
> (2) the requirement that safety glasses include "top and side shields" (see subsection (b)(4)(A) on p. 5 of Attachment 1). The CDA expressed concerns about meeting the "top shield" requirement, and such eyewear not being readily available to all dental personnel. After hearing from the Board's Executive Officer, who advocated for approval of the proposed regulatory language, the DHBC voted to approve **Attachment 1** as recommended by the working groups.

Following the November 15-16, 2024, DHBC meetings, Board staff requested input from the Board's and DHBC's subject matter experts regarding CDA's concerns about the "top shields" requirement for protective eyewear. Subject matter expert Joanne Pacheco indicated that shielding on all sides gives the best protection but agreed that clinicians may find it difficult to meet the ANSI/ISEA Z87.1-2020 industry standard with a top shield; Cara Miyaski concurred in that assessment. DHBC subject matter experts Dr. Petty and Michael Long recommended removal of the "top shields" requirement as well. Mr. Long indicated that the Cal/OSHA and the CDC guidelines both describe eye protection devices as glasses with "solid side shields" and that that there is no reference to a minimum standard requiring the inclusion of a top shield. Given this, Mr. Long recommended removing the reference to "top shields" and aligning the Guidelines with the established standards from OSHA and the CDC in the proposed text.

Discussion and Recommendations

Overview of Proposed Changes

The current proposal at **Attachment 1** contains updated Guidelines recommended by the Board's and the DHBC's subject matter experts. These updated Guidelines would include the following amendments to CCR section 1005:

(1) revised definitions in subsection (a) for standard precautions, critical items, semi-critical items, non-critical items, low-level disinfection, intermediate-level disinfection, high-level disinfection, sterilization, cleaning, personal protective equipment, and dental healthcare personnel (DHCP). New definitions for "Instrument/device classifications," "Disinfect" or "Disinfection", "Disinfection Classifications", "Cal/EPA registered" and "Contaminated medical waste" would be added to resolve potential ambiguities in new or existing language. The term and definition for "germicide" is proposed to be repealed since it would be replaced by the more accurate term "disinfectant" throughout this proposal.

(2) updated minimum infection control standard precautions in subsection (b), including:

(A) removal of requirements for a "written protocol" that is "periodically updated" and the addition of a new requirement for a "written infection control plan" as specified that is readily available to all DHCP and updated "annually" by the employer or employer-designated representative responsible for infection control compliance. A copy of CCR section 1005 must be included in the written infection control plan.

(B) revised requirements for using surgical facemasks, protective eyewear (safety glasses), chin-length face shields and face visors, chemical and puncture-resistant utility gloves and chemical-resistant PPE and protective attire.

(C) revised requirements for hand hygiene protocols and hand care, including hand washing, the use of alcohol-based hand rubs, and prohibitions on providing direct patient care and handling equipment if hand conditions such as "lesions" or a "rash" exist.

(D) revised requirements for wearing medical examination gloves, and chemical and puncture-resistant utility gloves, and the circumstances when gloves must be discarded. The proposal would add further specificity regarding when to perform hand hygiene protocols and hand care procedures and further specifies the prohibitions on reusing medical examination gloves.

(E) updated standard precautions and protocols for cleaning and disinfecting items or surfaces, including use of EPA-registered products, the prescribed order for cleaning and disinfection, requirements for cleaning compromised (wet, torn or punctured) sterilized packaging and non-critical surfaces and patient care items, new standards for confirming results and the proper functioning of the sterilization cycle of all sterilization devices, and new requirements for the use and inspection of a chemical indicator inside every sterilization package.

(F) the addition of new requirements for using sterile water or other irrigation solutions containing disinfecting or antibacterial properties when performing procedures on exposed dental pulp.

(G) revised requirements for facilities (renamed more precisely “Treatment Facilities”) that includes requirements for non-critical items or clinical contact surfaces to be covered with disposable impervious barriers “approved by the FDA and designed by the manufacturer for that purpose,” the use of an intermediate level disinfectant on clinical contact surfaces if physically contaminated with blood, and the addition of a requirement that dental unit lines and devices be flushed “after the final patient of the day”.

(H) the addition of new requirements for laboratory equipment cleaning including requirements for heat sterilization or disposal (for single use items), storage requirements, and requirements for cleaning and disinfection of “intraoral items” before “and after” manipulation in the laboratory and before placement in the patient’s mouth.

(I) the addition of new “respiratory hygiene/cough etiquette” requirements to contain respiratory secretions to prevent droplet and fomite transmission of respiratory pathogens during seasonal outbreaks of infections, including influenza, RSV, adenovirus, parainfluenza virus, or SARS-CoV-2 (COVID-19) virus.

(3) The addition of a new training requirement in subsection (c) for all dental healthcare personnel (DHCP) employers to provide their DHCP with a training program on the minimum standards required by this section and their written infection control plan specified in subsection (b).

The training program shall be provided at no cost and during working hours as follows: (A) prior to assignment to tasks where OPIM exposure may take place, and, (B) within one year of the date of the DHCP's previous training thereafter. Additional training would be required prior to or by the effective date of any change to the minimum standards in this section or to the written infection control plan. The

additional training may be limited to addressing the changes in the standards required by this section or the written infection control plan.

(4) The repeal of the requirement for the Board and the Dental Hygiene Committee to review this regulation annually. This would not prevent the Board or the DHBC from meeting annually, but rather remove the policy statement mandating annual reviews since it does not appear to be necessary. BPC section 1680 already requires the two Boards to review the Guidelines on an annual basis "if necessary."

(5) A footnote at the bottom of the regulation would be removed as those references are no longer accurate or provide any useful information regarding Cal/EPA contacts.

Proposed Additional Revisions

Board staff do not recommend removing the proposed training requirement in subsection (c) as requested by CDA. While this proposal may have some overlap with the Cal/OSHA bloodborne pathogens training set forth in **Attachment 3**, the Board's proposed training requirement would be unique to this Board's Guidelines and is therefore not duplicative. Training provides assurances that personnel are knowledgeable about the Board's Guidelines and their treatment facility's' individualized infection control plans.

However, Board staff do recommend revising the proposed regulatory language to make further changes to this proposal to remove the "top shields" reference from the safety glasses requirement as requested by CDA. The revision would strike the words "top and" from subsection (b)(4)(A), as follows:

> ~~(4)~~(A) All DHCP shall wear single-use, disposable surgical facemasks in combination with either chin length plastic face shields or protective eyewear during patient treatment or whenever there is potential for aerosol spray, splashing, or spattering of the following: droplet nuclei, blood, chemical or ~~germicidal~~disinfectant agents, or OPIM. For the purposes of this section, "protective eyewear" includes safety glasses with ~~top and~~ side shields bearing evidence of compliance with American National Standard for Occupational and Education Personal Eye and Face Protection Devices ANSI/ISEA Z87.1-2020 (the "Z87" marking).

A final draft with that recommended change is included for the Council's review at **Attachment 2.** Considering the subject matter experts' recommendations, Board staff recommends that the Council consider recommending to the Board approval of the text as set forth in **Attachment 2**.

Action Requested

The Council members should review the proposed regulatory text and consider whether they would support the staff's recommendation to adopt **Attachment 2** or if there are suggested changes to the proposed text. After review, the staff requests that the Council consider one of the following motions:

Option 1 (if the Council agrees with the staff recommendation and has no changes)
I move to recommend the Board approve the proposed regulatory text in **Attachment 2**, and request that staff provide **Attachment 2** to the Dental Hygiene Board of California for their review and reconsideration of their prior action on this item, and to obtain a consensus with this Board on the Guidelines. Upon receiving notice that the Dental Hygiene Board of California has approved **Attachment 2** and thereby reached consensus with this Board, the Council recommends the Board further direct staff to submit the text to the Director of the Department of Consumer Affairs and the Business, Consumer Services and Housing Agency for review. If no adverse comments are received, authorize the Executive Officer to take all steps necessary to initiate the rulemaking process, make any non-substantive changes to the text and the package, and set the matter for a hearing if requested. If after the 45-day public comment period, no adverse comments are received, and no public hearing is requested, authorize the Executive Officer to take all steps necessary to complete the rulemaking, and adopt the proposed regulations as noticed for CCR, title 16, section 1005.

Option 2 (The Council has suggested changes for the proposed regulatory text in **Attachment 2**.)

I move to recommend the Board approve the proposed regulatory text in **Attachment 2** with the following changes (Describe the proposed changes to the proposed text here), and request that staff provide **Attachment 2** as amended to the Dental Hygiene Board of California for their review and reconsideration of their prior action on this item, and to obtain a consensus with this Board on the Guidelines. Upon receiving notice that the Dental Hygiene Board of California has approved **Attachment 2** as amended and thereby reached consensus with this Board, the Council recommends the Board further direct staff to submit the text to the Director of the Department of Consumer Affairs and the Business, Consumer Services and Housing Agency for review. If no adverse comments are received, authorize the Executive Officer to take all steps necessary to initiate the rulemaking process, make any non-substantive changes to the text and the package, and set the matter for a hearing if requested. If after the 45-day public comment period, no adverse comments are received, and no public hearing is requested, authorize the Executive Officer to take all steps necessary to complete the rulemaking, and adopt the proposed regulations as noticed for CCR, title 16, section 1005.

Attachments:

1. Proposed Regulatory Language for amendments to CCR Section 1005 dated 11/5/24
2. Proposed Regulatory Language for amendments to CCR Section 1005 dated 2/6/25
3. California Code of Regulations, title 8, section 5193
4. CDC's "About Handwashing," dated February 16, 2024
5. CDC's "Best Practices for Environmental Infection Prevention and Control," dated May 15, 2024
6. CDC's "Best Practices for Sterilization Monitoring in Dental Settings," dated May 15, 2024
7. CDC's "Dental Infection Prevention and Control – Standard Precautions," dated May 15, 2024

DENTAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

PROPOSED REGULATORY LANGUAGE

Proposed amendments to the regulatory language are shown in single underline for new text and single ~~strikethrough~~ for deleted text. Where the Board proposes to re-number existing paragraphs to a new paragraph within this section, the Board has ~~struck through~~ the existing number of the paragraph and underlined the new proposed paragraph number to show the proposed re-ordering of paragraphs within this section.

Amend Section 1005 of Division 10 of Title 16 of the California Code of Regulations to read as follows:

§ 1005. Minimum Standards for Infection Control.

(a) Definitions of terms used in this section:

(1) "Standard precautions" are ~~a group of infection prevention practices that apply to all patients, regardless of suspected or confirmed infection status,~~ infection prevention protocols and procedures established for use in any setting in which dental healthcare is delivered. These include: hand hygiene protocols and hand care, ~~use of gloves, gown, mask, eye protection, or face shield, depending on the anticipated exposure,~~ use of personal protective equipment, procedures for patient care items, ~~and~~ safe handling of sharps~~.~~, safe handling and disposal of contaminated medical waste, respiratory hygiene or cough etiquette, and use of disinfectant agents in accordance with this section. Standard precautions shall be used for care of all patients regardless of ~~their diagnoses or personal infectious status.~~ the procedure performed or the health history of the patient.

(4) "Instrument/device classifications" are categories used to identify patient care items ("items") as critical, semi-critical, or non-critical depending on the potential risk for infection associated with their intended use and their required level of sterilization or disinfection for safe practice, as follows:

~~(2)~~(A) "Critical items" ~~confer a high risk for infection if they are contaminated with any microorganism.~~ carry the highest risk of transmitting infection. These include all instruments, devices, and other items used to penetrate soft tissue or bone~~.~~, such as surgical instruments, periodontal instruments, hygiene scalers, and burs.

~~(3)~~ (B) "Semi-critical items" are instruments, devices, and other items that ~~are not used to penetrate soft tissue or bone, but contact oral mucous membranes, non-~~

~~intact skin or other potentially infectious materials (OPIM).~~ come into contact with oral tissue, blood, or OPIM without penetration, such as those items used for intraoral examination, and dental procedures including dental mouth mirrors, amalgam condensers, reusable dental impression trays, and orthodontic pliers with plastic parts.

~~(4)~~ (C) "Non-critical items" are instruments, devices, equipment, and surfaces ("clinical contact surfaces") that come in contact with soil (e.g., organic and inorganic material), debris, blood, OPIM and intact skin, but not oral mucous membranes, and are utilized extraorally or are indirectly contaminated with debris, blood, or OPIM during clinical procedures, such as dental X-ray machines, assistant cart attachments, dental material delivery systems, patient safety eyewear, plastic dental syringes, and countertops.

(5) "Disinfect" or "Disinfection" means the use of a chemical solution to reduce or lower the number of microorganisms on inanimate objects using a Cal/EPA-registered product.

(6) "Disinfection classifications" are categories used to determine the effectiveness of a disinfectant agent to inactivate mycobacterium during surface disinfection procedures and are as follows:

~~(5)~~ (A) "Low-level disinfection" is the least effective disinfection process. It kills some bacteria, some viruses and fungi, but does not kill bacterial spores or mycobacterium tuberculosis var bovis, a laboratory test organism used to classify the strength of disinfectant chemicals.

~~(6)~~ (B) "Intermediate-level disinfection" kills mycobacterium tuberculosis var bovis indicating that many human pathogens are also killed. This process does not necessarily kill spores.

~~(7)~~ (C) "High-level disinfection" ~~kills some, but not necessarily all bacterial spores. This process kills mycobacterium tuberculosis var bovis, bacteria, fungi, and viruses.~~ inactivates all vegetative bacteria, mycobacteria, viruses, fungi, and some bacterial spores.

(7) "Cal/EPA-registered" means a product registered by the U.S. Environmental Protection Agency (EPA) and the California Environmental Protection Agency (Cal EPA) that has demonstrated bactericidal, fungicidal, and virucidal activity. The product used shall include a label from the manufacturer that indicates the level of disinfection (low, intermediate, or high) and both the EPA registration number and the California Department of Pesticide Regulation (Cal DPR) registration number.

~~(8) "Germicide" is a chemical agent that can be used to disinfect items and surfaces based on the level of contamination.~~

~~(9)~~(8) "Sterilization" is a ~~validated process used to render a product free of all forms of viable microorganisms.~~ mechanical process used to eliminate all forms of microbial life using acceptable methods of sterilization set forth in this section with a device approved by the U.S. Food and Drug Administration (FDA) for sterilization.

~~(10)~~(9) "Cleaning" is the removal of visible soil ~~(e.g., organic and inorganic material),~~ debris, blood, and OPIM from objects and surfaces and shall be accomplished manually or mechanically using water with detergents or enzymatic products~~.~~ prior to the use of a sterilization device or disinfectant for surface disinfection, using one of the following applicable methods:

(A) Cleaning of clinical contact surfaces and non-critical items means hand scrubbing using water and a detergent, or a surface disinfectant, either of which is registered with Cal/EPA as a disinfectant to clean surfaces or items according to manufacturer's instructions.

(B) Cleaning of semi-critical or critical items means hand scrubbing with a long-handled brush or using an FDA-approved mechanical device to remove visible soil from contaminated items using detergents or enzymatic products. Acceptable mechanical cleaning devices shall include ultrasonic cleaners using enzymatic products or detergents that require manual drying, or devices manufactured specifically for washing and mechanical drying of dental instruments, cassettes, and devices prior to preparing for sterilization. All mechanical cleaning devices shall be used in accordance with the manufacturer's instructions for the device or item type and quantity being cleaned.

~~(11)~~(2) "Personal Protective Equipment" (PPE) is specialized clothing or equipment worn or used for protection against a hazard. PPE items may include, but are not limited to, gloves, masks, respiratory devices, protective eyewear, and protective attire which are intended to prevent exposure to blood, ~~body fluids, OPIM~~other potentially infectious materials, and chemicals used for infection control. General work attire such as uniforms, scrubs, pants, and shirts, are not considered to be PPE.

~~(12)~~(3) "Other Potentially Infectious Materials" (OPIM) means any ~~one~~ of the following:

(A) Human body fluids such as saliva in dental procedures and 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.

(B) Any unfixed tissue or organ (other than intact skin) from a human (living or dead).

(C) Any of the following, if known or reasonably likely to contain or be infected with human immunodeficiency virus (HIV), hepatitis B virus (HBV), or hepatitis C virus (HCV):

1. Cell, tissue, or organ cultures from humans or experimental animals;

2. Blood, organs, or other tissues from experimental animals; or

3. Culture medium or other solutions.

~~(13)~~(10) "Dental Healthcare Personnel" (DHCP)~~,~~ are all paid and non-paid personnel in the ~~dental healthcare setting~~ treatment facility who might be occupationally exposed to infectious materials, including ~~body substances~~blood, OPIM, and contaminated supplies, equipment, environmental surfaces, water, or air. DHCP includes dentists, dental hygienists, dental assistants, dental laboratory technicians (in-office and commercial), students and trainees, contractual personnel, and other persons not directly involved in patient care but potentially exposed to infectious agents (e.g., administrative, clerical, housekeeping, maintenance, or volunteer personnel).

(11) "Contaminated medical waste" shall include "medical waste" as defined in Section 117690 of the Health and Safety Code occurring in the dental healthcare setting and shall not include those applicable items set forth in Section 117700 of the Health and Safety Code.

(b) All DHCP shall comply with all applicable infection control standard precautions and enforce the following applicable minimum standard precautions in the treatment facility to protect patients and DHCP and to minimize the transmission of pathogens in health care settings as mandated by the California Division of Occupational Safety and Health (Cal/OSHA).

(1) Standard precautions shall be ~~practiced~~used in the care of all patients.

(2) A written ~~protocol shall be developed, maintained, and periodically updated for proper instrument processing, operatory cleanliness, and management of injuries. The protocol shall be made available to all DHCP at the dental office.~~ infection control plan detailing the protocols and procedures that shall be developed, maintained, and periodically updated for all standard precautions in accordance with the requirements of this section. The written infection control plan shall be made readily available to all DHCP at the treatment facility and reviewed and updated at least annually by the DHCP employer or employer-designated representative

responsible for infection control compliance, and as needed to maintain compliance with this section.

(3) A copy of this regulation shall be conspicuously posted in each ~~dental office.~~ treatment facility and included in the written infection control plan described in paragraph (2).

(4) Personal Protective Equipment~~:~~ (PPE):

~~(4)~~(A) All DHCP shall wear single-use, disposable surgical facemasks in combination with either chin length plastic face shields or protective eyewear during patient treatment or whenever there is potential for aerosol spray, splashing, or spattering of the following: droplet nuclei, blood, chemical or ~~germicidal~~disinfectant agents, or OPIM. For the purposes of this section, "protective eyewear" includes safety glasses with top and side shields bearing evidence of compliance with American National Standard for Occupational and Education Personal Eye and Face Protection Devices ANSI/ISEA Z87.1-2020 (the "Z87" marking).

(B) A new, single-use, disposable surgical facemask shall be used for each patient at the beginning of their treatment session. Surgical facemask replacement shall occur at any point during a procedure where the mask becomes moist or soiled. ~~Chemical-resistant utility gloves and appropriate, task specific PPE shall be worn when handling hazardous chemicals.~~ After each patient treatment, surgical facemasks shall be changed and disposed when leaving laboratories or areas of patient care activities.

(C) Chin-length face shields and face visors are acceptable replacements for protective eyewear when worn in combination with a surgical facemask. Face shields and face visors shall not be used as a replacement for a surgical facemask. After each patient treatment, face shields and protective eyewear shall be cleaned, disinfected, or disposed when leaving laboratories or areas of patient care activities.

(D) Chemical and puncture-resistant utility gloves and chemical-resistant PPE shall be worn when handling hazardous chemicals and shall be worn in accordance with paragraph (6).

(E) Reusable protective eyewear, face shields and visors shall be washed with soap and water, or if visibly soiled, cleaned and disinfected between patients.

~~(5)~~(F) Protective attire shall be worn for disinfection, sterilization, and housekeeping procedures involving the use of ~~germicides~~ disinfectants or when handling contaminated items. All DHCP shall wear reusable or disposable

protective attire during patient treatment, or whenever there is a potential for aerosol spray, splashing, or spattering of blood, OPIM, or chemicals and ~~germicidal~~ disinfectant agents. Protective attire ~~must~~shall be changed daily, or ~~between patients~~immediately if they should become moist or visibly soiled. All PPE used during patient care shall be removed when leaving laboratories or areas of patient care activities. Reusable gowns shall be laundered in accordance with Cal/OSHA Bloodborne Pathogens Standards (Title 8, Cal. Code Regs., section 5193).

(5) Hand Hygiene~~:~~ Protocols and Hand Care:

~~(6)~~(A) All DHCP shall thoroughly wash their hands with soap and water (covering all surfaces of hands and fingers) for no less than 20 seconds at the start and end of each workday. DHCP shall wash contaminated or visibly soiled hands with soap and water and put on new gloves before treating each patient. If hands are not visibly soiled or contaminated, an alcohol-~~-~~based hand rub, with an alcohol concentration between 60-95%, may be used as an alternative to soap and water. An alcohol-based hand rub shall be used according to the manufacturer's instructions. Hands shall be ~~thoroughly dried~~completely dry before donning gloves in order to prevent promotion of ~~bacterial~~ microbial growth and washed again immediately after glove removal.

(B) A DHCP shall refrain from providing direct patient care and from handling patient care equipment if hand conditions such as the presence of lesions, rash, or weeping dermatitis are present that may render DHCP or patients more susceptible to opportunistic infection or exposure.

~~(7) All DHCP who have exudative lesions or weeping dermatitis of the hand shall refrain from all direct patient care and from handling patient care equipment until the condition resolves~~.

(6) Gloves:

~~(8)~~(A) Medical examination gloves shall be worn by DHCP whenever there is contact with mucous membranes, blood, OPIM, and during all pre-clinical, clinical, post-clinical, and laboratory procedures. Medical examination gloves are disposable, synthetic single-use only items. Gloves shall be replaced when torn or punctured, upon completion of dental treatment, and before leaving laboratories or areas of patient care activities.

(B) Chemical and puncture-resistant utility gloves shall be available at the point of use and worn by DHCP for clinical care break-down (setting up or breaking down a treatment room), cleaning, and disinfectant procedures. Chemical and

puncture-resistant utility gloves shall be cleaned and sterilized in accordance with the manufacturer's instructions after each use.

(C) When processing contaminated sharp instruments, needles, and devices, DHCP shall wear ~~heavy-duty~~chemical and puncture-resistant utility gloves ~~to prevent puncture wounds~~. Utility gloves shall be cleaned and sterilized in accordance with the manufacturer's instructions after each use.

(D) Gloves ~~must~~shall be discarded under any of the following circumstances:

(i) when torn or punctured~~,~~;

(ii) upon completion of dental treatment when using medical examination gloves;~~,~~ and,

(iii) before leaving laboratories or areas of patient care activities when using medical examination gloves.

(E) All DHCP shall perform hand hygiene protocols and hand care procedures specified in paragraph (5) before donning gloves and after removing and discarding medical examination gloves. Medical examination ~~G~~gloves shall not be washed before or after use, or reused.

(7) Needle and Sharps Safety:

~~(9)~~(A) Needles shall be recapped only by using the scoop technique or a protective device. Needles shall not be bent or broken for the purpose of disposal.

(B) Disposable needles, syringes, scalpel blades, or other sharp items and instruments shall be placed into sharps containers for disposal as close as possible to the point of use according to all applicable local, state, and federal regulations.

(8) Sterilization and Disinfection:

~~(10)~~(A) All ~~germicides must~~ products used to clean or disinfect items or surfaces shall be used in accordance with intended use and label instructions.

~~(11)~~(B) Standard precautions for disinfection and sterilization shall be performed in the following order:

(i) first, use appropriate hand hygiene protocols and hand care in accordance with paragraph (5);

(ii) second, ~~C~~clean~~ing must precede~~ items or surfaces prior to any disinfection or sterilization process; and,

(iii) third, use the disinfection or sterilization standards required by this section. ~~Products used to clean items or surfaces prior to disinfection procedures shall be used according to all label instructions~~ Disinfection procedures shall include use of a Cal/EPA-registered product with an applicable disinfection classification in accordance with paragraph (6) of subsection (a) to disinfect items.

~~(12)~~(C) Critical instruments, items, and devices shall be ~~discarded or~~ pre-cleaned, packaged or wrapped, and sterilized immediately after each use. Methods of sterilization shall include steam under pressure (autoclaving), chemical vapor, and dry heat. If a critical item is heat-sensitive, it shall, at minimum, be processed with high-level disinfection and packaged or wrapped upon completion of the disinfection process. These instruments, items, and devices~~,~~ shall remain sealed and stored in a manner so as to prevent contamination, and shall be labeled with the date of sterilization and the specific sterilizer used if more than one sterilizer is utilized in the treatment facility. If stored, sterilized packaging is compromised (e.g., wet, torn, or punctured), the instruments shall be recleaned, packaged in new wrap, and sterilized again before use.

~~(13)~~(D) Semi-critical instruments, items, and devices shall be pre-cleaned, packaged or wrapped, and sterilized immediately after each use. Methods of sterilization include steam under pressure (autoclaving), chemical vapor and dry heat. If a semi-critical item is heat sensitive, it shall, at minimum, be processed with high level disinfection and packaged or wrapped upon completion of the disinfection process. These packages or containers shall remain sealed and shall be stored in a manner so as to prevent contamination, and shall be labeled with the date of sterilization and the specific sterilizer used if more than one sterilizer is utilized in the treatment facility. If stored, sterilized packaging is compromised (e.g., wet, torn, or punctured), the instruments shall be recleaned, packaged in new wrap, and sterilized again before use.

~~(14)~~(E) Non-critical surfaces and patient care items shall be cleaned and disinfected after every use with a ~~California Environmental Protection Agency (~~Cal/EPA~~)~~-registered hospital disinfectant (low-level disinfectant) spray or wipe ~~labeled effective against HBV and HIV~~. When the item is visibly contaminated with blood or OPIM, a Cal/EPA-registered hospital intermediate-level disinfectant with a tuberculocidal claim shall be used.

~~(15)~~(F) All high-speed dental hand pieces, low-speed hand pieces, rotary components, and dental unit attachments such as reusable air/water syringe tips and ultrasonic scaler tips, shall be packaged, labeled, and heat-sterilized in a manner consistent with the same sterilization practices as a semi-critical item.

~~(16)~~(G) Single use critical, semi-critical, and non-critical disposable items such as scalpel blades, prophylaxis angles, prophylaxis cups and brushes, tips for high-speed evacuators, saliva ejectors, air/water syringe tips, and gloves shall be used for one patient only and discarded.

~~(17)~~(H) Proper functioning of the sterilization cycle of all sterilization devices shall be verified at least weekly through the use of a biological indicator (such as a spore test) with results confirmed by either authorized DHCP or an independent laboratory. Test results shall be documented and maintained for 12 months.

(I)(i) A chemical indicator shall be used inside every sterilization package to verify that the sterilizing agent has penetrated the package and reached the instruments inside. If the internal chemical indicator is not visible from the outside of the package, an external chemical indicator shall also be used.

(ii) The chemical indicator shall be inspected immediately when removing packages from the sterilizer; if the chemical indicator did not register that the sterilizing agent has penetrated the package, the instruments shall be repackaged and sterilized again.

(9) Irrigation:

~~(18)~~(A) Sterile coolants/irrigants shall be used for surgical procedures involving soft tissue or bone.

(B) When performing procedures on exposed dental pulp, water or other irrigation solutions shall be sterile or contain disinfecting or antibacterial properties.

(C) Sterile coolants/irrigants ~~must~~shall be delivered using a sterile delivery system.

(10) Treatment Facilities:

~~(19)~~(A) If non-critical items or clinical contact surfaces likely to be contaminated ~~are~~ or manufactured in a manner preventing cleaning and disinfection, they shall be ~~protected~~physically covered with disposable impervious barriers approved by the FDA and designed by the manufacturer for that purpose. Disposable barriers shall be changed when visibly soiled or damaged and between patients.

~~(20)~~(B) Clean and disinfect all clinical contact surfaces that are not protected by impervious barriers using a ~~California Environmental Protection Agency~~ ~~(~~Cal/EPA~~)~~ ~~-~~-registered, hospital grade low- to intermediate-level ~~germicide~~disinfectant after each patient. The low-level disinfectants used shall be labeled effective against HBV and HIV. Use an intermediate-level disinfectant if visibly contaminated with blood. Use disinfectants in accordance with the manufacturer's instructions.

(C) Clean all housekeeping surfaces (e.g. floors, walls, sinks) with a detergent and water or a Cal/EPA-registered, hospital grade disinfectant. Products used to clean items or surfaces prior to disinfection procedures shall be clearly labeled, and DHCP shall follow all ~~material~~ safety data sheet (~~M~~SDS) handling and storage instructions.

~~(21)~~(D) Dental unit water lines shall be anti-retractive. At the beginning of each workday, dental unit lines and devices shall be ~~purged with air or~~ flushed with water for at least two (2) minutes prior to attaching handpieces, scalers, air water syringe tips, or other devices. The dental unit lines and devices shall be flushed between each patient and after the final patient of the day for a minimum of twenty (20) seconds.

~~(22)~~(E) Contaminated solid waste shall be disposed of according to applicable local, state, and federal environmental standards.

(11) Lab Areas:

~~(23)~~(A) Splash shields and equipment guards shall be used on dental laboratory lathes. Fresh pumice and a sterilized or new, disposable rag-wheel shall be used for each patient. ~~Devices~~

(B) Laboratory equipment, including handpieces, polishing (rag) wheels, grinding wheels, and laboratory burs, used to polish, trim, or adjust contaminated appliances and ~~intraoral~~ prosthetic devices shall be cleaned, disinfected ~~or sterilized~~, properly packaged or wrapped, and heat-sterilized in a manner consistent with the same sterilization practices as a semi-critical item as specified in subparagraph (D) of paragraph (8), or if a single-use item, disposed of in accordance with subparagraph (G) of paragraph (8).

(C) Laboratory equipment shall be stored in a manner consistent with the same storage practices as a semi-critical item as specified in subparagraph (D) of paragraph (8).

~~(24)~~(D) All intraoral items such as impressions, bite registrations, and prosthetic and orthodontic appliances shall be cleaned and disinfected with ~~a~~an Cal/EPA-registered intermediate-level disinfectant before and after manipulation in the laboratory and before placement in the patient's mouth. Such items shall be thoroughly rinsed prior to placement in the patient's mouth.

(12) Respiratory Hygiene/Cough Etiquette: Measures shall be implemented to contain respiratory secretions and to prevent droplet and fomites transmission of respiratory pathogens, especially during seasonal outbreaks of viral respiratory infections such as influenza, RSV, adenovirus, parainfluenza virus, or SARS-CoV-2 (COVID-19) virus, as follows.

(A) Prominently posting at least one sign at every point of entrance and reception or registration desk of the treatment facility, accessible to public view, in which case the signs shall be in at least 12-point type font. The signs shall contain instructions to patients who cough or sneeze at the treatment facility to do at least all of the following: (i) cover their mouths or noses when coughing or sneezing; (ii) use and dispose of tissues in waste receptables; and, (iii) wash hands with soap and water or use alcohol hand rub after coughing or sneezing.

(B) Provide tissues and no-touch receptacles (e.g. foot-pedal operated lid or open plastic-lined waste basket) for disposal of tissues.

(C) Have soap, warm running water, and paper towels, or alcohol hand rub available for use in or immediately adjacent to waiting areas.

(D) Offer masks to coughing or sneezing patients or other persons when they enter the treatment facility.

(E) Provide distance between patients who cough or sneeze in common waiting areas. If available, facilities shall place these patients in a separate area while waiting for care.

(c) DHCP who are employers of other DHCP shall provide those personnel with a training program on the minimum standards required by this section and the infection control plan specified in paragraph (2) of subsection (b). Such training program shall be provided at no cost to the DHCP and during working hours in accordance with all of the following.

(1) The training program shall be provided as follows:

(A) Prior to assignment to tasks where OPIM exposure may take place; and,

(B) Within one year of the date of the DHCP's previous training thereafter.

(2) DHCP employers shall provide additional training prior to or by the effective date of any change to the minimum standards in this section or to the written infection control plan specified in paragraph (2) of subsection (b). The additional training may be limited to addressing the changes in the standards required by this section or the written infection control plan.

~~(c) The Dental Board of California and Dental Hygiene Committee of California shall review this regulation annually and establish a consensus.~~

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~~[1] Cal/EPA contacts: WEBSITE www.cdpr.ca.gov or Main Information Center (916) 324-0419.~~

Note: Authority cited: Section 1614, Business and Professions Code. Reference: Section 1680, Business and Professions Code.

DENTAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

PROPOSED REGULATORY LANGUAGE

Proposed amendments to the regulatory language are shown in single underline for new text and single ~~strikethrough~~ for deleted text. Where the Board proposes to re-number existing paragraphs to a new paragraph within this section, the Board has ~~struck through~~ the existing number of the paragraph and underlined the new proposed paragraph number to show the proposed re-ordering of paragraphs within this section.

Amend Section 1005 of Division 10 of Title 16 of the California Code of Regulations to read as follows:

§ 1005. Minimum Standards for Infection Control.

(a) Definitions of terms used in this section:

(1) "Standard precautions" are ~~a group of infection prevention practices that apply to all patients, regardless of suspected or confirmed infection status,~~ infection prevention protocols and procedures established for use in any setting in which dental healthcare is delivered. These include: hand hygiene protocols and hand care, ~~use of gloves, gown, mask, eye protection, or face shield, depending on the anticipated exposure,~~ use of personal protective equipment, procedures for patient care items, ~~and~~ safe handling of sharps~~.~~, safe handling and disposal of contaminated medical waste, respiratory hygiene or cough etiquette, and use of disinfectant agents in accordance with this section. Standard precautions shall be used for care of all patients regardless of ~~their diagnoses or personal infectious status.~~ the procedure performed or the health history of the patient.

(4) "Instrument/device classifications" are categories used to identify patient care items ("items") as critical, semi-critical, or non-critical depending on the potential risk for infection associated with their intended use and their required level of sterilization or disinfection for safe practice, as follows:

~~(2)~~(A) "Critical items" ~~confer a high risk for infection if they are contaminated with any microorganism.~~ carry the highest risk of transmitting infection. These include all instruments, devices, and other items used to penetrate soft tissue or bone~~.~~, such as surgical instruments, periodontal instruments, hygiene scalers, and burs.

~~(3)~~ (B) "Semi-critical items" are instruments, devices, and other items that ~~are not used to penetrate soft tissue or bone, but contact oral mucous membranes, non-~~

~~intact skin or other potentially infectious materials (OPIM).~~ come into contact with oral tissue, blood, or OPIM without penetration, such as those items used for intraoral examination, and dental procedures including dental mouth mirrors, amalgam condensers, reusable dental impression trays, and orthodontic pliers with plastic parts.

~~(4)~~ (C) "Non-critical items" are instruments, devices, equipment, and surfaces ("clinical contact surfaces") that come in contact with soil (e.g., organic and inorganic material), debris, blood, OPIM and intact skin, but not oral mucous membranes, and are utilized extraorally or are indirectly contaminated with debris, blood, or OPIM during clinical procedures, such as dental X-ray machines, assistant cart attachments, dental material delivery systems, patient safety eyewear, plastic dental syringes, and countertops.

(5) "Disinfect" or "Disinfection" means the use of a chemical solution to reduce or lower the number of microorganisms on inanimate objects using a Cal/EPA-registered product.

(6) "Disinfection classifications" are categories used to determine the effectiveness of a disinfectant agent to inactivate mycobacterium during surface disinfection procedures and are as follows:

~~(5)~~ (A) "Low-level disinfection" is the least effective disinfection process. It kills some bacteria, some viruses and fungi, but does not kill bacterial spores or mycobacterium tuberculosis var bovis, a laboratory test organism used to classify the strength of disinfectant chemicals.

~~(6)~~ (B) "Intermediate-level disinfection" kills mycobacterium tuberculosis var bovis indicating that many human pathogens are also killed. This process does not necessarily kill spores.

~~(7)~~ (C) "High-level disinfection" ~~kills some, but not necessarily all bacterial spores. This process kills mycobacterium tuberculosis var bovis, bacteria, fungi, and viruses.~~ inactivates all vegetative bacteria, mycobacteria, viruses, fungi, and some bacterial spores.

(7) "Cal/EPA-registered" means a product registered by the U.S. Environmental Protection Agency (EPA) and the California Environmental Protection Agency (Cal EPA) that has demonstrated bactericidal, fungicidal, and virucidal activity. The product used shall include a label from the manufacturer that indicates the level of disinfection (low, intermediate, or high) and both the EPA registration number and the California Department of Pesticide Regulation (Cal DPR) registration number.

~~(8) "Germicide" is a chemical agent that can be used to disinfect items and surfaces based on the level of contamination.~~

~~(9)~~(8) "Sterilization" is a ~~validated process used to render a product free of all forms of viable microorganisms.~~ mechanical process used to eliminate all forms of microbial life using acceptable methods of sterilization set forth in this section with a device approved by the U.S. Food and Drug Administration (FDA) for sterilization.

~~(10)~~(9) "Cleaning" is the removal of visible soil ~~(e.g., organic and inorganic material),~~ debris, blood, and OPIM from objects and surfaces and shall be accomplished manually or mechanically using water with detergents or enzymatic products~~.~~ prior to the use of a sterilization device or disinfectant for surface disinfection, using one of the following applicable methods:

(A) Cleaning of clinical contact surfaces and non-critical items means hand scrubbing using water and a detergent, or a surface disinfectant, either of which is registered with Cal/EPA as a disinfectant to clean surfaces or items according to manufacturer's instructions.

(B) Cleaning of semi-critical or critical items means hand scrubbing with a long-handled brush or using an FDA-approved mechanical device to remove visible soil from contaminated items using detergents or enzymatic products. Acceptable mechanical cleaning devices shall include ultrasonic cleaners using enzymatic products or detergents that require manual drying, or devices manufactured specifically for washing and mechanical drying of dental instruments, cassettes, and devices prior to preparing for sterilization. All mechanical cleaning devices shall be used in accordance with the manufacturer's instructions for the device or item type and quantity being cleaned.

~~(11)~~(2) "Personal Protective Equipment" (PPE) is specialized clothing or equipment worn or used for protection against a hazard. PPE items may include, but are not limited to, gloves, masks, respiratory devices, protective eyewear, and protective attire which are intended to prevent exposure to blood, ~~body fluids, OPIM~~other potentially infectious materials, and chemicals used for infection control. General work attire such as uniforms, scrubs, pants, and shirts, are not considered to be PPE.

~~(12)~~(3) "Other Potentially Infectious Materials" (OPIM) means any ~~one~~ of the following:

(A) Human body fluids such as saliva in dental procedures and 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.

(B) Any unfixed tissue or organ (other than intact skin) from a human (living or dead).

(C) Any of the following, if known or reasonably likely to contain or be infected with human immunodeficiency virus (HIV), hepatitis B virus (HBV), or hepatitis C virus (HCV):

1. Cell, tissue, or organ cultures from humans or experimental animals;

2. Blood, organs, or other tissues from experimental animals; or

3. Culture medium or other solutions.

~~(13)~~(10) "Dental Healthcare Personnel" (DHCP)~~,~~ are all paid and non-paid personnel in the ~~dental healthcare setting~~ treatment facility who might be occupationally exposed to infectious materials, including ~~body substances~~blood, OPIM, and contaminated supplies, equipment, environmental surfaces, water, or air. DHCP includes dentists, dental hygienists, dental assistants, dental laboratory technicians (in-office and commercial), students and trainees, contractual personnel, and other persons not directly involved in patient care but potentially exposed to infectious agents (e.g., administrative, clerical, housekeeping, maintenance, or volunteer personnel).

(11) "Contaminated medical waste" shall include "medical waste" as defined in Section 117690 of the Health and Safety Code occurring in the dental healthcare setting and shall not include those applicable items set forth in Section 117700 of the Health and Safety Code.

(b) All DHCP shall comply with all applicable infection control standard precautions and enforce the following applicable minimum standard precautions in the treatment facility to protect patients and DHCP and to minimize the transmission of pathogens in health care settings as mandated by the California Division of Occupational Safety and Health (Cal/OSHA).

(1) Standard precautions shall be ~~practiced~~used in the care of all patients.

(2) A written ~~protocol shall be developed, maintained, and periodically updated for proper instrument processing, operatory cleanliness, and management of injuries. The protocol shall be made available to all DHCP at the dental office.~~ infection control plan detailing the protocols and procedures that shall be developed, maintained, and periodically updated for all standard precautions in accordance with the requirements of this section. The written infection control plan shall be made readily available to all DHCP at the treatment facility and reviewed and updated at least annually by the DHCP employer or employer-designated representative

responsible for infection control compliance, and as needed to maintain compliance with this section.

(3) A copy of this regulation shall be conspicuously posted in each ~~dental office.~~ treatment facility and included in the written infection control plan described in paragraph (2).

(4) Personal Protective Equipment~~:~~ (PPE):

~~(4)~~(A) All DHCP shall wear single-use, disposable surgical facemasks in combination with either chin length plastic face shields or protective eyewear during patient treatment or whenever there is potential for aerosol spray, splashing, or spattering of the following: droplet nuclei, blood, chemical or ~~germicidal~~disinfectant agents, or OPIM. For the purposes of this section, "protective eyewear" includes safety glasses with side shields bearing evidence of compliance with American National Standard for Occupational and Education Personal Eye and Face Protection Devices ANSI/ISEA Z87.1-2020 (the "Z87" marking).

(B) A new, single-use, disposable surgical facemask shall be used for each patient at the beginning of their treatment session. Surgical facemask replacement shall occur at any point during a procedure where the mask becomes moist or soiled. ~~Chemical-resistant utility gloves and appropriate, task specific PPE shall be worn when handling hazardous chemicals.~~ After each patient treatment, surgical facemasks shall be changed and disposed when leaving laboratories or areas of patient care activities.

(C) Chin-length face shields and face visors are acceptable replacements for protective eyewear when worn in combination with a surgical facemask. Face shields and face visors shall not be used as a replacement for a surgical facemask. After each patient treatment, face shields and protective eyewear shall be cleaned, disinfected, or disposed when leaving laboratories or areas of patient care activities.

(D) Chemical and puncture-resistant utility gloves and chemical-resistant PPE shall be worn when handling hazardous chemicals and shall be worn in accordance with paragraph (6).

(E) Reusable protective eyewear, face shields and visors shall be washed with soap and water, or if visibly soiled, cleaned and disinfected between patients.

~~(5)~~(F) Protective attire shall be worn for disinfection, sterilization, and housekeeping procedures involving the use of ~~germicides~~ disinfectants or when handling contaminated items. All DHCP shall wear reusable or disposable

protective attire during patient treatment, or whenever there is a potential for aerosol spray, splashing, or spattering of blood, OPIM, or chemicals and ~~germicidal~~ disinfectant agents. Protective attire ~~must~~shall be changed daily, or ~~between patients~~immediately if they should become moist or visibly soiled. All PPE used during patient care shall be removed when leaving laboratories or areas of patient care activities. Reusable gowns shall be laundered in accordance with Cal/OSHA Bloodborne Pathogens Standards (Title 8, Cal. Code Regs., section 5193).

(5) Hand Hygiene~~:~~ Protocols and Hand Care:

~~(6)~~(A) All DHCP shall thoroughly wash their hands with soap and water (covering all surfaces of hands and fingers) for no less than 20 seconds at the start and end of each workday. DHCP shall wash contaminated or visibly soiled hands with soap and water and put on new gloves before treating each patient. If hands are not visibly soiled or contaminated, an alcohol-~~-~~based hand rub, with an alcohol concentration between 60-95%, may be used as an alternative to soap and water. An alcohol-based hand rub shall be used according to the manufacturer's instructions. Hands shall be ~~thoroughly dried~~completely dry before donning gloves in order to prevent promotion of ~~bacterial~~ microbial growth and washed again immediately after glove removal.

(B) A DHCP shall refrain from providing direct patient care and from handling patient care equipment if hand conditions such as the presence of lesions, rash, or weeping dermatitis are present that may render DHCP or patients more susceptible to opportunistic infection or exposure.

~~(7) All DHCP who have exudative lesions or weeping dermatitis of the hand shall refrain from all direct patient care and from handling patient care equipment until the condition resolves~~.

(6) Gloves:

~~(8)~~(A) Medical examination gloves shall be worn by DHCP whenever there is contact with mucous membranes, blood, OPIM, and during all pre-clinical, clinical, post-clinical, and laboratory procedures. Medical examination gloves are disposable, synthetic single-use only items. Gloves shall be replaced when torn or punctured, upon completion of dental treatment, and before leaving laboratories or areas of patient care activities.

(B) Chemical and puncture-resistant utility gloves shall be available at the point of use and worn by DHCP for clinical care break-down (setting up or breaking down a treatment room), cleaning, and disinfectant procedures. Chemical and

puncture-resistant utility gloves shall be cleaned and sterilized in accordance with the manufacturer's instructions after each use.

(C) When processing contaminated sharp instruments, needles, and devices, DHCP shall wear ~~heavy-duty~~chemical and puncture-resistant utility gloves ~~to prevent puncture wounds~~. Utility gloves shall be cleaned and sterilized in accordance with the manufacturer's instructions after each use.

(D) Gloves ~~must~~shall be discarded under any of the following circumstances:

(i) when torn or punctured~~,~~;

(ii) upon completion of dental treatment when using medical examination gloves;~~,~~ and,

(iii) before leaving laboratories or areas of patient care activities when using medical examination gloves.

(E) All DHCP shall perform hand hygiene protocols and hand care procedures specified in paragraph (5) before donning gloves and after removing and discarding medical examination gloves. Medical examination ~~G~~gloves shall not be washed before or after use, or reused.

(7) Needle and Sharps Safety:

~~(9)~~(A) Needles shall be recapped only by using the scoop technique or a protective device. Needles shall not be bent or broken for the purpose of disposal.

(B) Disposable needles, syringes, scalpel blades, or other sharp items and instruments shall be placed into sharps containers for disposal as close as possible to the point of use according to all applicable local, state, and federal regulations.

(8) Sterilization and Disinfection:

~~(10)~~(A) All ~~germicides must~~ products used to clean or disinfect items or surfaces shall be used in accordance with intended use and label instructions.

~~(11)~~(B) Standard precautions for disinfection and sterilization shall be performed in the following order:

(i) first, use appropriate hand hygiene protocols and hand care in accordance with paragraph (5);

(ii) second, ~~C~~clean~~ing must precede~~ items or surfaces prior to any disinfection or sterilization process; and,

(iii) third, use the disinfection or sterilization standards required by this section. ~~Products used to clean items or surfaces prior to disinfection procedures shall be used according to all label instructions~~ Disinfection procedures shall include use of a Cal/EPA-registered product with an applicable disinfection classification in accordance with paragraph (6) of subsection (a) to disinfect items.

~~(12)~~(C) Critical instruments, items, and devices shall be ~~discarded or~~ pre-cleaned, packaged or wrapped, and sterilized immediately after each use. Methods of sterilization shall include steam under pressure (autoclaving), chemical vapor, and dry heat. If a critical item is heat-sensitive, it shall, at minimum, be processed with high-level disinfection and packaged or wrapped upon completion of the disinfection process. These instruments, items, and devices~~,~~ shall remain sealed and stored in a manner so as to prevent contamination, and shall be labeled with the date of sterilization and the specific sterilizer used if more than one sterilizer is utilized in the treatment facility. If stored, sterilized packaging is compromised (e.g., wet, torn, or punctured), the instruments shall be recleaned, packaged in new wrap, and sterilized again before use.

~~(13)~~(D) Semi-critical instruments, items, and devices shall be pre-cleaned, packaged or wrapped, and sterilized immediately after each use. Methods of sterilization include steam under pressure (autoclaving), chemical vapor and dry heat. If a semi-critical item is heat sensitive, it shall, at minimum, be processed with high level disinfection and packaged or wrapped upon completion of the disinfection process. These packages or containers shall remain sealed and shall be stored in a manner so as to prevent contamination, and shall be labeled with the date of sterilization and the specific sterilizer used if more than one sterilizer is utilized in the treatment facility. If stored, sterilized packaging is compromised (e.g., wet, torn, or punctured), the instruments shall be recleaned, packaged in new wrap, and sterilized again before use.

~~(14)~~(E) Non-critical surfaces and patient care items shall be cleaned and disinfected after every use with a ~~California Environmental Protection Agency (~~Cal/EPA~~)~~-registered hospital disinfectant (low-level disinfectant) spray or wipe ~~labeled effective against HBV and HIV~~. When the item is visibly contaminated with blood or OPIM, a Cal/EPA-registered hospital intermediate-level disinfectant with a tuberculocidal claim shall be used.

~~(15)~~(F) All high-speed dental hand pieces, low-speed hand pieces, rotary components, and dental unit attachments such as reusable air/water syringe tips and ultrasonic scaler tips, shall be packaged, labeled, and heat-sterilized in a manner consistent with the same sterilization practices as a semi-critical item.

~~(16)~~(G) Single use critical, semi-critical, and non-critical disposable items such as scalpel blades, prophylaxis angles, prophylaxis cups and brushes, tips for high-speed evacuators, saliva ejectors, air/water syringe tips, and gloves shall be used for one patient only and discarded.

~~(17)~~(H) Proper functioning of the sterilization cycle of all sterilization devices shall be verified at least weekly through the use of a biological indicator (such as a spore test) with results confirmed by either authorized DHCP or an independent laboratory. Test results shall be documented and maintained for 12 months.

(I)(i) A chemical indicator shall be used inside every sterilization package to verify that the sterilizing agent has penetrated the package and reached the instruments inside. If the internal chemical indicator is not visible from the outside of the package, an external chemical indicator shall also be used.

(ii) The chemical indicator shall be inspected immediately when removing packages from the sterilizer; if the chemical indicator did not register that the sterilizing agent has penetrated the package, the instruments shall be repackaged and sterilized again.

(9) Irrigation:

~~(18)~~(A) Sterile coolants/irrigants shall be used for surgical procedures involving soft tissue or bone.

(B) When performing procedures on exposed dental pulp, water or other irrigation solutions shall be sterile or contain disinfecting or antibacterial properties.

(C) Sterile coolants/irrigants ~~must~~shall be delivered using a sterile delivery system.

(10) Treatment Facilities:

~~(19)~~(A) If non-critical items or clinical contact surfaces likely to be contaminated ~~are~~ or manufactured in a manner preventing cleaning and disinfection, they shall be ~~protected~~physically covered with disposable impervious barriers approved by the FDA and designed by the manufacturer for that purpose. Disposable barriers shall be changed when visibly soiled or damaged and between patients.

~~(20)~~(B) Clean and disinfect all clinical contact surfaces that are not protected by impervious barriers using a ~~California Environmental Protection Agency~~ ~~(~~Cal/EPA~~)~~ ~~-~~-registered, hospital grade low- to intermediate-level ~~germicide~~disinfectant after each patient. The low-level disinfectants used shall be labeled effective against HBV and HIV. Use an intermediate-level disinfectant if visibly contaminated with blood. Use disinfectants in accordance with the manufacturer's instructions.

(C) Clean all housekeeping surfaces (e.g. floors, walls, sinks) with a detergent and water or a Cal/EPA~~-~~-registered, hospital grade disinfectant. Products used to clean items or surfaces prior to disinfection procedures shall be clearly labeled, and DHCP shall follow all ~~material~~ safety data sheet (~~M~~SDS) handling and storage instructions.

~~(21)~~(D) Dental unit water lines shall be anti-retractive. At the beginning of each workday, dental unit lines and devices shall be ~~purged with air or~~ flushed with water for at least two (2) minutes prior to attaching handpieces, scalers, air water syringe tips, or other devices. The dental unit lines and devices shall be flushed between each patient and after the final patient of the day for a minimum of twenty (20) seconds.

~~(22)~~(E) Contaminated solid waste shall be disposed of according to applicable local, state, and federal environmental standards.

(11) Lab Areas:

~~(23)~~(A) Splash shields and equipment guards shall be used on dental laboratory lathes. Fresh pumice and a sterilized or new, disposable rag-wheel shall be used for each patient. ~~Devices~~

(B) Laboratory equipment, including handpieces, polishing (rag) wheels, grinding wheels, and laboratory burs, used to polish, trim, or adjust contaminated appliances and ~~intraoral~~ prosthetic devices shall be cleaned, disinfected ~~or sterilized~~, properly packaged or wrapped, and heat-sterilized in a manner consistent with the same sterilization practices as a semi-critical item as specified in subparagraph (D) of paragraph (8), or if a single-use item, disposed of in accordance with subparagraph (G) of paragraph (8).

(C) Laboratory equipment shall be stored in a manner consistent with the same storage practices as a semi-critical item as specified in subparagraph (D) of paragraph (8).

~~(24)~~(D) All intraoral items such as impressions, bite registrations, and prosthetic and orthodontic appliances shall be cleaned and disinfected with ~~a~~an Cal/EPA-registered intermediate-level disinfectant before and after manipulation in the laboratory and before placement in the patient's mouth. Such items shall be thoroughly rinsed prior to placement in the patient's mouth.

(12) Respiratory Hygiene/Cough Etiquette: Measures shall be implemented to contain respiratory secretions and to prevent droplet and fomites transmission of respiratory pathogens, especially during seasonal outbreaks of viral respiratory infections such as influenza, RSV, adenovirus, parainfluenza virus, or SARS-CoV-2 (COVID-19) virus, as follows.

(A) Prominently posting at least one sign at every point of entrance and reception or registration desk of the treatment facility, accessible to public view, in which case the signs shall be in at least 12-point type font. The signs shall contain instructions to patients who cough or sneeze at the treatment facility to do at least all of the following: (i) cover their mouths or noses when coughing or sneezing; (ii) use and dispose of tissues in waste receptables; and, (iii) wash hands with soap and water or use alcohol hand rub after coughing or sneezing.

(B) Provide tissues and no-touch receptacles (e.g. foot-pedal operated lid or open plastic-lined waste basket) for disposal of tissues.

(C) Have soap, warm running water, and paper towels, or alcohol hand rub available for use in or immediately adjacent to waiting areas.

(D) Offer masks to coughing or sneezing patients or other persons when they enter the treatment facility.

(E) Provide distance between patients who cough or sneeze in common waiting areas. If available, facilities shall place these patients in a separate area while waiting for care.

(c) DHCP who are employers of other DHCP shall provide those personnel with a training program on the minimum standards required by this section and the infection control plan specified in paragraph (2) of subsection (b). Such training program shall be provided at no cost to the DHCP and during working hours in accordance with all of the following.

(1) The training program shall be provided as follows:

(A) Prior to assignment to tasks where OPIM exposure may take place; and,

(B) Within one year of the date of the DHCP's previous training thereafter.

(2) DHCP employers shall provide additional training prior to or by the effective date of any change to the minimum standards in this section or to the written infection control plan specified in paragraph (2) of subsection (b). The additional training may be limited to addressing the changes in the standards required by this section or the written infection control plan.

~~(c) The Dental Board of California and Dental Hygiene Committee of California shall review this regulation annually and establish a consensus.~~

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[1] ~~Cal/EPA contacts: WEBSITE www.cdpr.ca.gov or Main Information Center (916) 324-0419.~~

Note: Authority cited: Section 1614, Business and Professions Code. Reference: Section 1680, Business and Professions Code.

Barclays California Code of Regulations
Title 8. Industrial Relations
Division 1. Department of Industrial Relations
Chapter 4. Division of Industrial Safety
Subchapter 7. General Industry Safety Orders
Group 16. Control of Hazardous Substances
Article 109. Hazardous Substances and Processes

8 CCR § 5193

§ 5193. Bloodborne Pathogens.

Currentness

(a) Scope and Application. This section applies to all occupational exposure to blood or other potentially infectious materials as defined by subsection (b) of this section.

EXCEPTION: This regulation does not apply to the construction industry.

(b) Definitions. For purposes of this section, the following shall apply:

"Biological Cabinet" means a device enclosed except for necessary exhaust purposes on three sides and top and bottom, designed to draw air inward by means of mechanical ventilation, operated with insertion of only the hands and arms of the user, and in which virulent pathogens are used. Biological cabinets are classified as:

(1) Class I: A ventilated cabinet for personnel protection with an unrecirculated inward airflow away from the operator and high-efficiency particulate air (HEPA) filtered exhaust air for environmental protection.

(2) Class II: A ventilated cabinet for personnel, product, and environmental protection having an open front with inward airflow for personnel protection, HEPA filtered laminar airflow for product protection, and HEPA filtered exhaust air for environmental protection.

(3) Class III: A total enclosed, ventilated cabinet of gas-tight construction. Operations in the cabinet are conducted through attached protective gloves.

"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), hepatitis C virus (HCV) and human immunodeficiency virus (HIV).

“Chief” means the Chief of the Division of Occupational Safety and Health of the California Department of Industrial Relations or designated representative.

“Clinical Laboratory” means a workplace where diagnostic or other screening procedures are performed on blood or other potentially infectious materials.

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

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

“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. Decontamination includes procedures regulated by Health and Safety Code Section 118275.

“Engineering Controls” means controls (e.g., sharps disposal containers, needlelesss systems and sharps with engineered sharps injury protection) that isolate or remove the bloodborne pathogens hazard from the workplace.

“Engineered Sharps Injury Protection” means either:

(1) A physical attribute built into a needle device used for withdrawing body fluids, accessing a vein or artery, or administering medications or other fluids, which effectively reduces the risk of an exposure incident by a mechanism such as barrier creation, blunting, encapsulation, withdrawal or other effective mechanisms; or

(2) A physical attribute built into any other type of needle device, or into a non-needle sharp, which effectively reduces the risk of an exposure incident.

“Exposure Incident” means a specific eye, mouth, other mucous membrane, non-intact skin, or parenteral contact with blood or other potentially infectious materials that results 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.

“HBV” means hepatitis B virus.

“HCV” means hepatitis C virus.

“HIV” means human immunodeficiency virus.

“Licensed Healthcare Professional” is a person whose licensed scope of practice includes an activity which this section requires to be performed by a licensed healthcare professional.

“Needle” or “Needle Device” means a needle of any type, including, but not limited to, solid and hollow-bore needles.

“Needleless System” means a device that does not utilize needles for:

(1) The withdrawal of body fluids after initial venous or arterial access is established;

(2) The administration of medication or fluids; and

(3) Any other procedure involving the potential for an exposure incident.

“NIOSH” means the Director of the National Institute for Occupational Safety and Health, U.S. Department of Health and Human Services, or designated representative.

“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.

“One-Hand Technique” means a procedure wherein the needle of a reusable syringe is capped in a sterile manner during use. The technique employed shall require the use of only the hand holding the syringe so that the free hand is not exposed to the uncapped needle.

“OPIM” means other potentially infectious materials.

“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 other body fluid that is visibly contaminated with blood such as saliva or vomitus, and all body fluids in situations where it is difficult or impossible to differentiate between body fluids such as emergency response;

(2) Any unfixed tissue or organ (other than intact skin) from a human (living or dead); and

(3) Any of the following, if known or reasonably likely to contain or be infected with HIV, HBV, or HCV:

(A) Cell, tissue, or organ cultures from humans or experimental animals;

(B) Blood, organs, or other tissues from experimental animals; or

(C) Culture medium or other solutions.

“Parenteral Contact” 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 or used 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.

“Production Facility” means a facility engaged in industrial-scale, large-volume or high concentration production of HIV, HBV or HCV.

“Regulated Waste” means waste that is any of the following:

(1) Liquid or semi-liquid blood or OPIM;

(2) Contaminated items that:

(A) Contain liquid or semi-liquid blood, or are caked with dried blood or OPIM; and

(B) Are capable of releasing these materials when handled or compressed.

(3) Contaminated sharps.

(4) Pathological and microbiological wastes containing blood or OPIM.

(5) Regulated Waste includes “medical waste” regulated by Health and Safety Code Sections 117600 through 118360.

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

“Sharp” means any object used or encountered in the industries covered by subsection (a) that can be reasonably anticipated to penetrate the skin or any other part of the body, and to result in an exposure incident, including, but not limited to, needle devices, scalpels, lancets, broken glass, broken capillary tubes, exposed ends of dental wires and dental knives, drills and burs.

“Sharps Injury” means any injury caused by a sharp, including, but not limited to, cuts, abrasions, or needlesticks.

“Sharps Injury Log” means a written or electronic record satisfying the requirements of subsection (c)(2).

“Source Individual” means any individual, living or dead, whose blood or OPIM may be a source of occupational exposure to the employee. Examples include, but are not limited to, hospital and clinical 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.

“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, HCV, and other bloodborne pathogens.

“Work Practice Controls” means controls that reduce the likelihood of exposure by defining the manner in which a task is performed (e.g., prohibiting recapping of needles by a two-handed technique and use of patient-handling techniques).

(c) Exposure Response, Prevention and Control.

(1) Exposure Control Plan.

(A) Each employer having an employee(s) with occupational exposure as defined by subsection (b) of this section shall establish, implement and maintain an effective Exposure Control Plan which is designed to eliminate or minimize employee exposure and which is also consistent with Section 3203.

(B) The Exposure Control Plan shall be in writing and shall contain at least the following elements:

1. The exposure determination required by subsection (c)(3);

2. The schedule and method of implementation for each of the applicable subsections: (d) Methods of Compliance, (e) HIV, HBV and HCV Research Laboratories and Production Facilities, (f) Hepatitis B Vaccination and Post-exposure Evaluation and Follow-up, (g) Communication of Hazards to Employees, and (h) Recordkeeping, of this standard;

3. The procedure for the evaluation of circumstances surrounding exposure incidents as required by subsection (f)(3)(A).

4. An effective procedure for gathering the information required by the Sharps Injury Log.

5. An effective procedure for periodic determination of the frequency of use of the types and brands of sharps involved in the exposure incidents documented on the Sharps Injury Log;

NOTE: Frequency of use may be approximated by any reasonable and effective method.

6. An effective procedure for identifying currently available engineering controls, and selecting such controls, where appropriate, for the procedures performed by employees in their respective work areas or departments;

7. An effective procedure for documenting patient safety determinations made pursuant to Exception 2. of subsection (d)(3)(A); and

8. An effective procedure for obtaining the active involvement of employees in reviewing and updating the exposure control plan with respect to the procedures performed by employees in their respective work areas or departments.

(C) Each employer shall ensure that a copy of the Exposure Control Plan is accessible to employees in accordance with Section 3204(e).

(D) The Exposure Control Plan shall be reviewed and updated at least annually and whenever necessary as follows:

1. To reflect new or modified tasks and procedures which affect occupational exposure;

2.a. To reflect changes in technology that eliminate or reduce exposure to bloodborne pathogens; and

b. To document consideration and implementation of appropriate commercially available needleless systems and needle devices and sharps with engineered sharps injury protection;

3. To include new or revised employee positions with occupational exposure;

4. To review and evaluate the exposure incidents which occurred since the previous update; and

5. To review and respond to information indicating that the Exposure Control Plan is deficient in any area.

(E) Employees responsible for direct patient care. In addition to complying with subsections (c)(1)(B)6. and (c)(1)(B)8., the employer shall solicit input from non-managerial employees responsible for direct patient care who are potentially exposed to injuries from contaminated sharps in the identification, evaluation, and selection of effective engineering and work practice controls, and shall document the solicitation in the Exposure Control Plan.

(F) The Exposure Control Plan shall be made available to the Chief or NIOSH or their respective designee upon request for examination and copying.

(2) Sharps Injury Log.

The employer shall establish and maintain a Sharps Injury Log, which is a record of each exposure incident involving a sharp. The information recorded shall include the following information, if known or reasonably available:

(A) Date and time of the exposure incident;

(B) Type and brand of sharp involved in the exposure incident;

(C) A description of the exposure incident which shall include:

1. Job classification of the exposed employee;

2. Department or work area where the exposure incident occurred;

3. The procedure that the exposed employee was performing at the time of the incident;

4. How the incident occurred;

5. The body part involved in the exposure incident;

6. If the sharp had engineered sharps injury protection, whether the protective mechanism was activated, and whether the injury occurred before the protective mechanism was activated, during activation of the mechanism or after activation of the mechanism, if applicable;

7. If the sharp had no engineered sharps injury protection, the injured employee's opinion as to whether and how such a mechanism could have prevented the injury; and

8. The employee's opinion about whether any engineering, administrative or work practice control could have prevented the injury.

(D) Each exposure incident shall be recorded on the Sharps Injury Log within 14 working days of the date the incident is reported to the employer.

(E) The information in the Sharps Injury Log shall be recorded and maintained in such a manner as to protect the confidentiality of the injured employee.

(3) Exposure Determination.

(A) Each employer who has an employee(s) with occupational exposure as defined by subsection (b) of this section shall prepare an exposure determination. This exposure determination shall contain the following:

1. A list of all job classifications in which all employees in those job classifications have occupational exposure;

2. A list of job classifications in which some employees have occupational exposure; and

3. A list of all tasks and procedures or groups of closely related task and procedures in which occupational exposure occurs and that are performed by employees in job classifications listed in accordance with the provisions of subsection (c)(3)(A)2. of this standard.

(B) This exposure determination shall be made without regard to the use of personal protective equipment.

(d) Methods of Compliance.

(1) General. Universal precautions shall be observed to prevent contact with blood or OPIM. Under circumstances in which differentiation between body fluid types is difficult or impossible, all body fluids shall be considered potentially infectious materials.

(2) Engineering and Work Practice Controls--General Requirements.

(A) Engineering and work practice controls shall be used to eliminate or minimize employee exposure.

(B) Engineering controls shall be examined and maintained or replaced on a regular schedule to ensure their effectiveness.

(C) Work practice controls shall be evaluated and updated on a regular schedule to ensure their effectiveness.

(D) All procedures involving blood or OPIM shall be performed in such a manner as to minimize splashing, spraying, spattering, and generation of droplets of these substances.

(3) Engineering and Work Practice Controls--Specific Requirements.

(A) Needleless Systems, Needle Devices and non-Needle Sharps.

1. Needleless Systems. Needleless systems shall be used for:

a. Withdrawal of body fluids after initial venous or arterial access is established;

b. Administration of medications or fluids; and

c. Any other procedure involving the potential for an exposure incident for which a needleless system is available as an alternative to the use of needle devices.

2. Needle Devices. If needleless systems are not used, needles with engineered sharps injury protection shall be used for:

a. Withdrawal of body fluids;

b. Accessing a vein or artery;

c. Administration of medications or fluids; and

d. Any other procedure involving the potential for an exposure incident for which a needle device with engineered sharps injury protection is available.

3. Non-Needle Sharps. If sharps other than needle devices are used, these items shall include engineered sharps injury protection.

4. Exceptions. The following exceptions apply to the engineering controls required by subsections (d)(3)(A)1.-3.:

a. Market Availability. The engineering control is not required if it is not available in the marketplace.

b. Patient Safety. The engineering control is not required if a licensed healthcare professional directly involved in a patient's care determines, in the reasonable exercise of clinical judgement, that use of the engineering control will jeopardize the patient's safety or the success of a medical, dental or nursing procedure involving the patient. The determination shall be documented according to the procedure required by (c)(1)(B)7.

c. Safety Performance. The engineering control is not required if the employer can demonstrate by means of objective product evaluation criteria that the engineering control is not more effective in preventing exposure incidents than the alternative used by the employer.

d. Availability of Safety Performance Information. The engineering control is not required if the employer can demonstrate that reasonably specific and reliable information is not available on the safety performance of the engineering control for the employer's procedures, and that the employer is actively determining by means of objective product evaluation criteria whether use of the engineering control will reduce the risk of exposure incidents occurring in the employer's workplace.

(B) Prohibited Practices.

1. Shearing or breaking of contaminated needles and other contaminated sharps is prohibited.

2. Contaminated sharps shall not be bent, recapped, or removed from devices.

EXCEPTION: Contaminated sharps may be bent, recapped or removed from devices if:

a. The employer can demonstrate that no alternative is feasible or that such action is required by a specific medical or dental procedure; and

b. The procedure is performed using a mechanical device or a one-handed technique.

3. Sharps that are contaminated with blood or OPIM shall not be stored or processed in a manner that requires employees to reach by hand into the containers where these sharps have been placed.

4. Disposable sharps shall not be reused.

5. Broken Glassware. Broken glassware which may be contaminated shall not be picked up directly with the hands. It shall be cleaned up using mechanical means, such as a brush and dust pan, tongs, or forceps.

6. The contents of sharps containers shall not be accessed unless properly reprocessed or decontaminated.

7. Sharps containers shall not be opened, emptied, or cleaned manually or in any other manner which would expose employees to the risk of sharps injury.

8. Mouth pipetting/suctioning of blood or OPIM is prohibited.

9. Eating, drinking, smoking, applying cosmetics or lip balm, and handling contact lenses are prohibited in work areas where there is a reasonable likelihood of occupational exposure.

10. Food and drink shall not be kept in refrigerators, freezers, shelves, cabinets or on countertops or benchtops where blood or OPIM are present.

(C) Requirements for Handling Contaminated Sharps.

1. All procedures involving the use of sharps in connection with patient care, such as withdrawing body fluids, accessing a vein or artery, or administering vaccines, medications or fluids, shall be performed using effective patient-handling techniques and other methods designed to minimize the risk of a sharps injury.

2. Immediately or as soon as possible after use, contaminated sharps shall be placed in containers meeting the requirements of subsection (d)(3)(D) as applicable.

3. At all time during the use of sharps, containers for contaminated sharps shall be:

a. Easily accessible to personnel and located as close as is feasible to the immediate area where sharps are used or can be reasonably anticipated to be found (e.g., laundries);

b. Maintained upright throughout use, where feasible; and

c. Replaced as necessary to avoid overfilling.

(D) Sharps Containers for Contaminated Sharps.

1. All sharps containers for contaminated sharps shall be:

a. Rigid;

b. Puncture resistant;

c. Leakproof on the sides and bottom;

d. Portable, if portability is necessary to ensure easy access by the user as required by subsection (d)(3)(C)3.a.; and

e. Labeled in accordance with subsection (g)(1)(A)(2).

2. If discarded sharps are not to be reused, the sharps container shall also be closeable and sealable so that when sealed, the container is leak resistant and incapable of being reopened without great difficulty.

(E) Regulated Waste.

1. General.

Handling, storage, treatment and disposal of all regulated waste shall be in accordance with Health and Safety Code Chapter 6.1, Sections 117600 through 118360, and other applicable regulations of the United States, the State, and political subdivisions of the State.

2. Disposal of Sharps Containers.

When any container of contaminated sharps is moved from the area of use for the purpose of disposal, the container shall be:

a. Closed immediately prior to removal or replacement to prevent spillage or protrusion of contents during handling, storage, transport, or shipping; and

b. Placed in a secondary container if leakage is possible. The second container shall be:

i. Closable;

ii. Constructed to contain all contents and prevent leakage dur8ing handling, storage, transport, or shipping; and

iii. Labeled according to subsection (g)(1)(A) of this section.

3. Disposal of Other Regulated Waste. Regulated waste not consisting of sharps shall be disposed of in containers which are:

a. Closable;

b. Constructed to contain all contents and prevent leakage during handling, storage, transport, or shipping;

c. Labeled and color-coded in accordance with subsection (g)(1)(A) of this section; and

d. Closed prior to removal to prevent spillage or protrusion of contents during handling, storage, transport, or shipping.

4. Outside Contamination. If outside contamination of a container of regulated waste occurs, it shall be placed in a second container. The second container shall be:

a. Closable.

b. Constructed to contain all contents and prevent leakage of fluids during handling, storage, transport or shipping;

c. Labeled and color-coded in accordance with subsection (g)(1)(A) of this section; and

d. Closed prior to removal to prevent spillage or protrusion of contents during handling, storage, transport, or

shipping.

(F) Handling Specimens of Blood or OPIM.

Specimens of blood or OPIM shall be placed in a container which prevents leakage during collection, handling, processing, storage, transport, or shipping.

1. The container for storage, transport, or shipping shall be labeled or color-coded according to subsection (g)(1)(A), and closed prior to being stored, transported, or shipped. When a ffacility utilizes Universal Precautions in the handling of all specimens, the labeling/color-coding of specimens is not necessary provided containers are recognizable as containing specimens. This exemption only applies while such specimens/containers remain within the facility. Labeling or color-coding in accordance with subsection (g)(1)(A) is required when such specimens/containers leave the facility.

2. If outside contamination of the primary container occurs, the primary container shall be placed within a second container which prevents leakage during collection, handling, processing, storage, transport, or shipping and is labeled or color-coded to the requirements of this standard.

3. If the specimen could puncture the primary container, the primary container shall be placed within a secondary container which is puncture-resistant in addition to the above characteristics.

(G) Servicing or Shipping Contaminated Equipment.

Equipment which may become contaminated with blood or OPIM shall be examined prior to servicing or shipping and shall be decontaminated as necessary, unless the employer can demonstrate that decontamination of such equipment or portions of such equipment is not feasible or will interfere with a manufacturer’s ability to evaluate failure of the device.

1. A readily observable label in accordance with subsection (g)(1)(A)8. shall be attached to the equipment stating which portions remain contaminated.

2. Information concerning all remaining contamination shall be conveyed to all affected employees, the servicing representative, and/or the manufacturer, as appropriate, prior to handling, servicing, or shipping so that appropriate precautions will be taken.

(H) Cleaning and Decontamination of the Worksite.

1. General Requirements.

a. Employers shall ensure that the worksite is maintained in a clean and sanitary condition.

b. Employers shall determine and implement appropriate written methods and schedules for cleaning and decontamination of the worksite.

c. The method of cleaning or decontamination used shall be effective and shall be appropriate for the:

i. Location within the facility;

ii. Type of surface or equipment to be treated;

iii. Type of soil or contamination present; and

iv. Tasks or procedures being performed in the area.

d. All equipment and environmental and work surfaces shall be cleaned and decontaminated after contact with blood or OPIM no later than at the end of the shift. Cleaning and decontamination of equipment and work surfaces is required more often as specified below.

2. Specific Requirements.

a. Contaminated Work Surfaces. Contaminated work surfaces shall be cleaned and decontaminated with an appropriate disinfectant immediately or as soon as feasible when:

i. Surfaces become overtly contaminated;

ii. There is a spill of blood or OPIM;

iii. Procedures are completed; and

iv. At the end of the work shift if the surface may have become contaminated since the last cleaning.

b. Receptacles. All bins, pails, cans, and similar receptacles intended for reuse which have a reasonable likelihood for becoming contaminated with blood or OPIM shall be inspected and decontaminated on a regularly scheduled basis and cleaned and decontaminated immediately or as soon as feasible upon visible contamination.

c. Protective Coverings. Protective coverings, such as plastic wrap, aluminum foil, or imperviously-backed absorbent paper used to cover equipment and environmental surfaces, shall be removed and replaced as soon as feasible when they become overtly contaminated or at the end of the workshift if they may have become contaminated during the shift.

(I) Hygiene.

1. Employers shall provide handwashing facilities which are readily accessible to employees.

2. When provision of handwashing facilities is not feasible, the employer shall provide either an appropriate antiseptic hand cleanser in conjunction with clean cloth/paper towels or antiseptic towelettes. When antiseptic hand cleansers or towelettes are used, hands shall be washed with soap and running water as soon as feasible.

3. Employers shall ensure that employees wash their hands immediately or as soon as feasible after removal of gloves or other personal protective equipment.

4. Employers shall ensure that employees wash hands and any other skin with soap and water, or flush mucous membranes with water immediately or as soon as feasible following contact of such body areas with blood or OPIM.

(J) Laundry.

1. Contaminated laundry shall be handled as little as possible with a minimum of agitation.

a. Contaminated laundry shall be bagged or containerized at the location where it was used and shall not be sorted or rinsed in the location of use.

b. Contaminated laundry shall be placed and transported in bags or containers labeled or color-coded in accordance with subsection (g)(1)(A) of this standard. When a facility utilizes Universal Precautions in the handling of all soiled laundry, alternative labeling or color-coding is sufficient if it permits all employees to recognize the containers as requiring compliance with Universal Precautions.

c. Whenever contaminated laundry is wet and presents a reasonable likelihood of soaking through or leakage from the bag or container, the laundry shall be placed and transported in bags or containers which prevent soak-through and/or leakage of fluids to the exterior.

2. The employer shall ensure that employees who have contact with contaminated laundry wear protective gloves and other appropriate personal protective equipment.

3. When a facility ships contaminated laundry off-site to a second facility which does not utilize Universal Precautions in the handling of all laundry, the facility generating the contaminated laundry must place such laundry in bags or containers which are labeled or color-coded in accordance with subsection (g)(1)(A).

(4) Personal Protective Equipment.

(A) Provision. Where occupational exposure remains after institution of engineering and work practice controls, the employer shall provide, at no cost to the employee, appropriate personal protective equipment such as, but not limited to, gloves, gowns, laboratory coats, face shields or masks and eye protection, and mouthpieces, resuscitation bags, pocket masks, or other ventilation devices. Personal protective equipment will be considered “appropriate” only if it does not permit blood or OPIM to pass through to or reach the employee’s work clothes, street clothes, undergarments, skin, eyes, mouth, or other mucous membranes under normal conditions of use and for the duration of time which the protective equipment will be used.

NOTE: For fire fighters, these requirements are in addition to those specified in Sections 3401-3411, and are intended to be consistent with those requirements.

(B) Use. The employer shall ensure that the employee uses appropriate personal protective equipment unless the employer shows that the employee temporarily and briefly declined to use personal protective equipment when, under rare and extraordinary circumstances, it was the employee’s professional judgment that in the specific instance its use would have prevented the delivery of health care or public safety services or would have posed an increased hazard to the safety of the worker or co-worker. When the employee makes this judgment, the circumstances shall be investigated and documented in order to determine whether changes can be instituted to prevent such occurences in the future. The employer shall encourage employees to report all such instances without fear of reprisal in accordance with Section 3203.

(C) Accessibility. The employer shall ensure that appropriate personal protective equipment in the appropriate sizes is

readily accessible at the worksite or is issued to employees. Hypoallergenic gloves, glove liners, powderless gloves, or other similar alternatives shall be readily accessible to those employees who are allergic to the gloves normally provided.

(D) Cleaning, Laundering, and Disposal. The employer shall clean, launder, and dispose of personal protective equipment required by subsections (d) and (e) of this standard, at no cost to the employee.

(E) Repair and Replacement. The employer shall repair or replace personal protective equipment as needed to maintain its effectiveness, at no cost to the employee.

(F) Removal.

1. If a garment(s) is penetrated by blood or OPIM, the garment(s) shall be removed immediately or as soon as feasible.

2. All personal protective equipment shall be removed prior to leaving the work area.

3. When personal protective equipment is removed it shall be placed in an appropriately designated area or container for storage, washing, decontamination or disposal.

(G) Gloves. Gloves shall be worn when it can be reasonably anticipated that the employee may have hand contact with blood, OPIM, mucous membranes, and non-intact skin; when performing vascular access procedures except as specified in subsection (d)(4)(G)4.; and when handling or touching contaminated items or surfaces. These requirements are in addition to the provisions of Section 3384.

1. Disposable (single use) gloves such as surgical or examination gloves, shall be replaced as soon as practical when contaminated or as soon as feasible if they are torn, punctured, or when their ability to function as a barrier is compromised.

2. Disposable (single use) gloves shall not be washed or decontaminated for re-use.

3. Utility gloves may be decontaminated for re-use if the integrity of the glove is not compromised. However, they must be discarded if they are cracked, peeling, torn, punctured, or exhibit other signs of deterioration or when their ability to function as a barrier is compromised.

4. If an employer in a volunteer blood donation center judges that routine gloving for all phlebotomies is not necessary then the employer shall:

a. Periodically reevaluate this policy;

b. Make gloves available to all employees who wish to use them for phlebotomy;

c. Not discourage the use of gloves for phlebotomy; and

d. Require that gloves be used for phlebotomy in the following circumstances:

i. When the employee has cuts, scratches, or other breaks in his or her skin;

ii. When the employee judges that hand contamination with blood may occur, for example, when performing phlebotomy on an uncooperative source individual; and

iii. When the employee is receiving training in phlebotomy.

(H) Masks, Eye Protection, Face Shields, and Respirators.

1. Masks in combination with eye protection devices, such as goggles or glasses with solid side shields, or chin-length face shields, shall be worn whenever splashes, spray, spatter, or droplets of blood or OPIM may be generated and eye, nose, or mouth contamination can be reasonably anticipated. These requirements are in addition to the provisions of Section 3382.

2. Where respiratory protection is used, the provisions of Sections 5144 and 5147 are required as applicable.

NOTE: Surgical masks are not respirators.

(I) Gowns, Aprons, and Other Protective Body Clothing.

1. Appropriate protective clothing such as, but not limited to, gowns, aprons, lab coats, clinic jackets, or similar outer garments shall be worn in occupational exposure situations. The type and characteristics will depend upon the task and degree of exposure anticipated. These requirements are in addition to the provisions of Section 3383.

2. Surgical caps or hoods and/or shoe covers or boots shall be worn in instances when gross contamination can reasonably be anticipated (e.g., autopsies, orthopaedic surgery). These requirements are in addition to the provisions of Section 3383.

(e) HIV, HBV and HCV Research Laboratories and Production Facilities.

(1) General.

This subsection applies in addition to the other requirements of this section to research laboratories and production facilities engaged in the culture, production, concentration, experimentation, and manipulation of HIV, HBV and HCV.

EXCEPTION: This subsection does not apply to clinical or diagnostic laboratories engaged solely in the analysis of blood, tissues, or organs.

(2) Research laboratories and production facilities shall meet the following criteria:

(A) Standard Microbiological Practices. All regulated waste shall either be incinerated or decontaminated by a method such as autoclaving known to effectively destroy bloodborne pathogens. Such methods are further specified in Health and Safety Code Section 118215.

(B) Special Practices.

1. Laboratory doors shall be kept closed when work involving HIV, HBV or HCV is in progress.

2. Contaminated materials that are to be decontaminated at a site away from the work area shall be placed in a durable, leakproof, labeled or color-coded container that is closed before being removed from the work area.

3. Access to the work area shall be limited to authorized persons. Written policies and procedures shall be established whereby only persons who have been advised of the potential biohazard, who meet any specific entry requirements, and who comply with all entry and exit procedures shall be allowed to enter the work areas and animal rooms.

4. When OPIM or infected animals are present in the work area or containment module, a hazard warning sign incorporating the universal biohazard symbol shall be posted on all access doors. The hazard warning sign shall comply with subsection (g)(1)(B) of this standard.

5. All activities involving OPIM shall be conducted in biological safety cabinets or other physical-containment devices within the containment module. No work with these OPIM shall be conducted on the open bench.

6. Laboratory coats, gowns, smocks, uniforms, or other appropriate protective clothing shall be used in the work area and animal rooms. Protective clothing shall not be worn outside of the work area and shall be decontaminated before being laundered.

7. Special care shall be taken to avoid skin contact with OPIM. Gloves shall be worn when handling infected animals and when making hand contact with OPIM is unavoidable.

8. Before disposal, all waste from work areas and from animal rooms shall either be incinerated or decontaminated by a method such as autoclaving known to effectively destroy bloodborne pathogens.

9. Vacuum lines shall be protected with liquid disinfectant traps and HEPA filters or filters of equivalent or superior efficiency and which are checked routinely and maintained or replaced as necessary.

10. Hypodermic needles and syringes shall be used only for parenteral injection and aspiration of fluids from laboratory animals and diaphragm bottles. Only needle-locking syringes or disposable syringe-needle units (i.e., the needle is integral to the syringe) shall be used for the injection or aspiration of OPIM. Extreme caution shall be used when handling needles and syringes. A needle shall not be bent, sheared, replaced in the sheath or guard, or removed from the syringe following use. The needle and syringe shall be promptly placed in a puncture-resistant container and autoclaved or decontaminated before reuse or disposal.

11. All spills shall be immediately contained and cleaned up by appropriate professional staff or others properly trained and equipped to work with potentially concentrated infectious materials.

12. A spill or accident that results in an exposure incident shall be immediately reported to the laboratory director or other responsible person.

13. Written biosafety procedures shall be prepared and adopted into the Exposure Control Plan of subsection (c)(1). Personnel shall be advised of potential hazards, shall be required to read instructions on practices and procedures, and shall be required to follow them.

(C) Containment Equipment.

1. Certified biological safety cabinets (Class I, II, or III) or other appropriate combinations of personal protection or physical containment devices, such as special protective clothing, respirators, centrifuge safety cups, sealed centrifuge rotors, and containment caging for animals, shall be used for all activities with OPIM that pose a threat of exposure to droplets, splashes, spills, or aerosols.

2. Biological safety cabinets shall be certified by the employer that they meet manufacturers' specifications when installed, whenever they are moved and at least annually.

(3) HIV, HBV and HCV research laboratories shall meet the following criteria:

(A) Each laboratory shall contain a facility for hand washing and an eye wash facility which is readily available within the work area.

(B) An autoclave for decontamination of regulated waste shall be available.

NOTE: Treatment of medical waste should meet the requirements of Health and Safety Code Section 118215.

(4) HIV, HBV and HCV production facilities shall meet the following criteria:

(A) The work areas shall be separated from areas that are open to unrestricted traffic flow within the building. Passage through two sets of doors shall be the basic requirement for entry into the work area from access corridors or other contiguous areas. Physical separation of the high-containment work area from access corridors or other areas or activities may also be provided by a double-doored clothes-change room (showers may be included), airlock, or other access facility that requires passing through two sets of doors before entering the work area.

(B) The surfaces of doors, walls, floors and ceilings in the work area shall be water resistant so that they can be easily cleaned. Penetrations in these surfaces shall be sealed or capable of being sealed to facilitate decontamination.

(C) Each work area shall contain a sink for washing hands and a readily available eye wash facility. The sink shall be foot, elbow, or automatically operated and shall be located near the exit door of the work area.

(D) Access doors to the work area or containment module shall be self-closing.

(E) An autoclave for decontamination of regulated waste shall be available within or as near as possible to the work area.

NOTE: Treatment of medical waste should meet the requirements of Health and Safety Code Section 118215.

(F) A ducted exhaust-air ventilation system shall be provided. This system shall create directional airflow that draws air into the work area through the entry area. The exhaust air shall not be recirculated to any other area of the building, shall be discharged to the outside, and shall be dispersed away from occupied areas and air intakes. The proper direction of the airflow shall be verified (i.e., into the work area). The ventilation system shall conform to the requirements of Article 107.

(5) Training Requirements.

Training requirements for employees in HIV, HBV and HCV research laboratories and HIV, HBV and HCV production facilities are specified in subsection (g)(2) and they shall receive in addition the following initial training:

(A) The employer shall assure that employees demonstrate proficiency in standard microbiological practices and techniques and in the practices and operations specific to the facility before being allowed to work with HIV, HBV or HCV.

(B) The employer shall assure that employees have prior experience in the handling of human pathogens or tissue cultures before working with HIV, HBV or HCV.

(C) The employer shall provide a training program to employees who have no prior experience in handling human pathogens. Initial work activities shall not include the handling of infectious agents. A progression of work activities shall be assigned as techniques are learned and proficiency is developed. The employer shall assure that employees participate in work activities involving infectious agents only after proficiency has been demonstrated.

(f) Hepatitis B Vaccination and Bloodborne Pathogen Post-exposure Evaluation and Follow-up.

(1) General.

(A) The employer shall make available the hepatitis B vaccine and vaccination series to all employees who have occupational exposure, and post-exposure evaluation and follow-up for bloodborne pathogens exposure to all employees who have had an exposure incident. When an employer is also acting as the evaluating health care professional, the employer shall advise an employee following an exposure incident that the employee may refuse to consent to

post-exposure evaluation and follow-up from the employer-healthcare professional. When consent is refused, the employer shall make immediately available to exposed employees a confidential medical evaluation and follow-up from a healthcare professional other than the exposed employee's employer.

EXCEPTION: Designated first aid providers who have occupational exposure are not required to be offered pre-exposure hepatitis B vaccine if the following conditions exist:

1. The primary job assignment of such designated first aid providers is not the rendering of first aid.

a. Any first aid rendered by such persons is rendered only as a collateral duty responding solely to injuries resulting from workplace incidents, generally at the location where the incident occurred.

b. This exception does not apply to designated first aid providers who render assistance on a regular basis, for example, at a first aid station, clinic, dispensary, or other location where injured employees routinely go for such assistance, and emergency or public safety personnel who are expected to render first aid in the course of their work.

2. The employer's Exposure Control Plan, subsection (c)(1), shall specifically address the provision of hepatitis B vaccine to all unvaccinated first aid providers who have rendered assistance in any situation involving the presence of blood or OPIM (regardless of whether an actual exposure incident, as defined by subsection (b), occurred) and the provision of appropriate post-exposure evaluation, prophylaxis and follow-ups for those employees who experience an exposure incident as defined in subsection (b), including:

a. Provisions for a reporting procedure that ensures that all first aid incidents involving the presence of blood or OPIM shall be reported to the employer before the end of work shift during which the first aid incident occurred.

i. The report must include the names of all first aid providers who rendered assistance, regardless of whether personal protective equipment was used and must describe the first aid incident, including time and date.

A. The description must include a determination of whether or not, in addition to the presence of blood or OPIM, an exposure incident, as defined in subsection (b), occurred.

B. This determination is necessary in order to ensure that the proper post-exposure evaluation, prophylaxis and follow-up procedures required by subsection (f)(3) are made available immediately if there has been an exposure incident, as defined in subsection (b).

ii. The report shall be recorded on a list of such first aid incidents. It shall be readily available to all employees and shall be provided to the Chief upon request.

b. Provision for the bloodborne pathogens training program, required by subsection (g)(2), for designated first aiders to include the specifics of the reporting requirements of subsection (f)(3) and of this exception.

c. Provision for the full hepatitis B vaccination series to be made available as soon as possible, but in no event later than 24 hours, to all unvaccinated first aid providers who have rendered assistance in any situation involving the presence of blood or OPIM regardless of whether or not a specific exposure incident, as defined by subsection (b), has occurred.

3. The employer must implement a procedure to ensure that all of the provisions of subsection 2. of this exception are complied with if pre-exposure hepatitis B vaccine is not to be offered to employees meeting the conditions of subsection 1. of this exception.

(B) The employer shall ensure that all medical evaluations and procedures, including the hepatitis B vaccine and vaccination series and post-exposure evaluation and follow-up, including prophylaxis, are:

1. Made available at no cost to the employee;

2. Made available to the employee at a reasonable time and place;

3. Performed by or under the supervision of a licensed physician or by or under the supervision of another licensed healthcare professional; and

4. Provided according to recommendations of the U.S. Public Health Service current at the time these evaluations and procedures take place, except as specified by this subsection (f).

(C) The employer shall ensure that all laboratory tests are conducted by an accredited laboratory at no cost to the employee.

(2) Hepatitis B Vaccination.

(A) Hepatitis B vaccination shall be made available after the employee has received the training required in subsection (g)(2)(G)9. and within 10 working days of initial assignment to all employees who have occupational exposure unless the employee has previously received the complete hepatitis B vaccination series, antibody testing has revealed that the employee is immune, or the vaccine is contraindicated for medical reasons.

(B) The employer shall not make participation in a prescreening program a prerequisite for receiving hepatitis B vaccination.

(C) If the employee initially declines hepatitis B vaccination but at a later date while still covered under the standard decides to accept the vaccination, the employer shall make available hepatitis B vaccination at that time.

(D) The employer shall assure that employees who decline to accept hepatitis B vaccination offered by the employer sign the statement in Appendix A.

(E) If a routine booster dose(s) of hepatitis B vaccine is recommended by the U.S. Public Health Service at a future date, such booster dose(s) shall be made available in accordance with section (f)(1)(B).

(3) Post-exposure Evaluation and Follow-up. Following a report of an exposure incident, the employer shall make immediately available to the exposed employee a confidential medical evaluation and follow-up, including at least the following elements:

(A) The employer shall document the route(s) of exposure, and the circumstances under which the exposure incident occurred;

(B) The employer shall identify and document the source individual, unless the employer can establish that identification is infeasible or prohibited by state or local law;

1. The source individual's blood shall be tested as soon as feasible and after consent is obtained in order to determine HBV, HCV and HIV infectivity. If consent is not obtained, the employer shall establish that legally required consent cannot be obtained. When the source individual's consent is not required by law, the source individual's blood, if available, shall be tested and the results documented.

2. When the source individual is already known to be infected with HBV, HCV or HIV, testing for the source individual's known HBV, HCV or HIV status need not be repeated.

3. Results of the source individual's testing shall be made available to the exposed employee, and the employee shall be informed of applicable laws and regulations concerning disclosure of the identity and infectious status of the source individual.

(C) The employer shall provide for collection and testing of the employee's blood for HBV, HCV and HIV serological status;

1. The exposed employee's blood shall be collected as soon as feasible and tested after consent is obtained.

2. If the employee consents to baseline blood collection, but does not give consent at that time for HIV serologic testing, the sample shall be preserved for at least 90 days. If, within 90 days of the exposure incident, the employee elects to have the baseline sample tested, such testing shall be done as soon as feasible.

3. Additional collection and testing shall be made available as recommended by the U.S. Public Health Service.

(D) The employer shall provide for post-exposure prophylaxis, when medically indicated, as recommended by the U.S. Public Health Service;

(E) The employer shall provide for counseling and evaluation of reported illnesses.

(4) Information Provided to the Healthcare Professional.

(A) The employer shall ensure that the healthcare professional responsible for the employee's hepatitis B vaccination is provided a copy of this regulation.

(B) The employer shall ensure that the healthcare professional evaluating an employee after an exposure incident is provided the following information:

1. A copy of this regulation;

2. A description of the exposed employee's duties as they relate to the exposure incident;

3. Documentation of the route(s) of exposure and circumstances under which exposure occurred, as required by subsection (f)(3)(A);

4. Results of the source individual's blood testing, if available; and

5. All medical records relevant to the appropriate treatment of the employee including vaccination status which are the employer's responsibility to maintain, as required by subsection (h)(1)(B)2.

(5) Healthcare Professional's Written Opinion.

The employer shall obtain and provide the employee with a copy of the evaluating healthcare professional's written opinion within 15 days of the completion of the evaluation.

(A) The healthcare professional's written opinion for hepatitis B vaccination shall be limited to whether hepatitis B vaccination is indicated for an employee, and if the employee has received such vaccination.

(B) The healthcare professional's written opinion for post-exposure evaluation and follow-up shall be limited to the following information:

1. That the employee has been informed of the results of the evaluation; and

2. That the employee has been told about any medical conditions resulting from exposure to blood or OPIM which require further evaluation or treatment.

(C) All other findings or diagnoses shall remain confidential and shall not be included in the written report.

(6) Medical Recordkeeping.

Medical records required by this standard shall be maintained in accordance with subsection (h)(1) of this section.

(g) Communication of Hazards to Employees.

(1) Labels and Signs.

(A) Labels.

1. Warning labels shall be affixed to containers of regulated waste, refrigerators and freezers containing blood or OPIM; and other containers used to store, transport or ship blood or OPIM, except as provided in subsection (g)(1)(A)5., 6. and 7.

NOTE: Other labeling provisions, such as Health and Safety Code Sections 118275 through 118320 may be applicable.

2. Labels required by this section shall include either the following legend as required by Section 3341:

Or in the case of regulated waste the legend:

BIOHAZARDOUS WASTE or SHARPS WASTE

as described in Health and Safety Code Sections 118275 through 118320.

3. These labels shall be fluorescent orange or orange-red or predominantly so, with lettering and symbols in a contrasting color.

4. Labels required by subsection (g)(1)(A) shall either be an integral part of the container or shall be affixed as close as feasible to the container by string, wire, adhesive, or other method that prevents their loss or unintentional removal.

5. Red bags or red containers may be substituted for labels except for sharp containers or regulated waste red bags. Bags used to contain regulated waste shall be color-coded red and shall be labeled in accordance with subsection (g)(1)(A)2. Labels on red bags or red containers do not need to be color-coded in accordance with subsection (g)(1)(A)3.

6. Containers of blood, blood components, or blood products that are labeled as to their contents and have been released for transfusion or other clinical use are exempted from the labeling requirements of subsection (g).

7. Individual containers of blood or OPIM that are placed in a labeled container during storage, transport, shipment or disposal are exempted from the labeling requirement.

8. Labels required for contaminated equipment shall be in accordance with this subsection and shall also state which portions of the equipment remain contaminated.

9. Regulated waste that has been decontaminated need not be labeled or color-coded.

(B) Signs.

1. The employer shall post signs at the entrance to work areas specified in subsection (e), HIV, HBV and HCV Research Laboratory and Production Facilities, which shall bear the following legend:

(Name of the Infectious Agent)

(Special requirements for entering the area)

(Name, telephone number of the laboratory director or other responsible person.)

2. These signs shall be fluorescent orange-red or predominantly so, with lettering and symbols in a contrasting color, and meet the requirements of Section 3340.

(2) Information and Training.

(A) Employers shall ensure that all employees with occupational exposure participate in a training program which must be provided at no cost to the employee and during working hours.

(B) Training shall be provided as follows:

1. At the time of initial assignment to tasks where occupational exposure may take place;

2. At least annually thereafter.

(C) For employees who have received training on bloodborne pathogens in the year preceding the effective date of the standard, only training with respect to the provisions of the standard which were not included need be provided.

(D) Annual training for all employees shall be provided within one year of their previous training.

(E) Employers shall provide additional training when changes, such as introduction of new engineering, administrative or work practice controls, modification of tasks or procedures or institution of new tasks or procedures, affect the employee's occupational exposure. The additional training may be limited to addressing the new exposures created.

(F) Material appropriate in content and vocabulary to educational level, literacy, and language of employees shall be used.

(G) The training program shall contain at a minimum the following elements:

1. Copy and Explanation of Standard. An accessible copy of the regulatory text of this standard and an explanation of its contents;

2. Epidemiology and Symptoms. A general explanation of the epidemiology and symptoms of bloodborne diseases;

3. Modes of Transmission. An explanation of the modes of transmission of bloodborne pathogens;

4. Employer's Exposure Control Plan. An explanation of the employer's exposure control plan and the means by which the employee can obtain a copy of the written plan;

5. Risk Identification. An explanation of the appropriate methods for recognizing tasks and other activities that may involve exposure to blood and OPIM;

6. Methods of Compliance. An explanation of the use and limitations of methods that will prevent or reduce exposure including appropriate engineering controls, administrative or work practice controls and personal protective equipment;

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

8. Personal Protective Equipment. An explanation of the basis for selection of personal protective equipment;

9. Hepatitis B Vaccination. 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;

10. Emergency. Information on the appropriate actions to take and persons to contact in an emergency involving blood or OPIM;

11. Exposure Incident. An explanation of the procedure to follow if an exposure incident occurs, including the method of reporting the incident, the medical follow-up that will be made available and the procedure for recording the incident on the Sharps Injury Log;

12. Post-Exposure Evaluation and Follow-Up. Information on the post-exposure evaluation and follow-up that the employer is required to provide for the employee following an exposure incident;

13. Signs and Labels. An explanation of the signs and labels and/or color coding required by subsection (g)(1); and

14. Interactive Questions and Answers. An opportunity for interactive questions and answers with the person conducting the training session.

NOTE: Additional training is required for employees of HIV, HBV, and HCV Research Laboratories and Production Facilities, as described in subsection (e)(5).

(H) The person conducting the training shall be knowledgeable in the subject matter covered by the elements contained in the training program as it relates to the workplace that the training will address.

(h) Recordkeeping.

(1) Medical Records.

(A) The employer shall establish and maintain an accurate record for each employee with occupational exposure, in accordance with Section 3204.

(B) This record shall include:

1. The name and social security number of the employee;

2. A copy of the employee's hepatitis B vaccination status including the dates of all the hepatitis B vaccinations and any medical records relative to the employee's ability to receive vaccination as required by subsection (f)(2);

3. A copy of all results of examinations, medical testing, and follow-up procedures as required by subsection (f)(3);

4. The employer's copy of the healthcare professional's written opinion as required by subsection (f)(5); and

5. A copy of the information provided to the healthcare professional as required by subsections (f)(4)(B)2., 3. and 4.

(C) Confidentiality. The employer shall ensure that employee medical records required by subsection (h)(1) are:

1. Kept confidential; and

2. Not disclosed or reported without the employee's express written consent to any person within or outside the workplace except as required by this section or as may be required by law.

(D) The employer shall maintain the records required by subsection (h)(1) for at least the duration of employment plus 30 years in accordance with Section 3204.

(2) Training Records.

(A) Training records shall include the following information:

1. The dates of the training sessions;

2. The contents or a summary of the training sessions;

3. The names and qualifications of persons conducting the training; and

4. The names and job titles of all persons attending the training sessions.

(B) Training records shall be maintained for 3 years from the date on which the training occurred.

(3) Sharps Injury Log.

The Sharps Injury Log shall be maintained 5 years from the date the exposure incident occurred.

(4) Availability.

(A) The employer shall ensure that all records required to be maintained by this section shall be made available upon request to the Chief and NIOSH for examination and copying.

(B) Employee training records required by this subsection shall be provided upon request for examination and copying to employees, to employee representatives, to the Chief, and to NIOSH.

(C) Employee medical records required by this subsection shall be provided upon request for examination and copying to the subject employee, to anyone having written consent of the subject employee, to the Chief, and to NIOSH in accordance with Section 3204.

(D) The Sharps Injury Log required by subsection (c)(2) shall be provided upon request for examination and copying to employees, to employee representatives, to the Chief, to the Department of Health Services, and to NIOSH.

(5) Transfer of Records.

(A) The employer shall comply with the requirements involving transfer of records set forth in Section 3204.

(B) If the employer ceases to do business and there is no successor employer to receive and retain the records for the prescribed period, the employer shall notify NIOSH, at least three months prior to their disposal and transmit them to the NIOSH, if required by the NIOSH to do so, within that three month period.

(i) Appendix.

Appendix A to this section is incorporated as a part of this section and the provision is mandatory.

Appendix A. Hepatitis B Vaccine Declination

(MANDATORY)

The employer shall assure that employees who decline to accept hepatitis B vaccination offered by the employer sign the following statement as required by subsection (f)(2)(D):

I understand that due to my occupational exposure to blood or OPIM I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to myself. However, I decline hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or OPIM and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.

Credits

NOTE: Authority cited: Sections 142.3 and 144.7, Labor Code. Reference: Sections 142.3 and 144.7, Labor Code; Sections 117600 through 118360, Health and Safety Code.

HISTORY

1. New section filed 12-9-92; operative 1-11-93 (Register 92, No. 50).

2. Editorial correction of printing errors in subsections (c)(1)(A) and (d)(2)(C) (Register 93, No. 32).

3. Amendment of subsections (g)(1)(A)2. and (g)(1)(B)2. filed 2-5-97; operative 3-7-97 (Register 97, No. 6).

4. Amendment filed 1-22-99 as an emergency; effective 1-22-99 (Register 99, No. 4). The emergency regulation filed 1-22-99 shall remain in effect until the nonemergency regulation becomes operative or until August 1, 1999, whichever first occurs pursuant to Labor Code section 144.7(a).

5. Permanent adoption of 1-22-99 amendments, including further amendments, filed 7-30-99 pursuant to Labor Code section 144.7(a); operative 7-30-99 pursuant to Government Code section 11343.4(d) (Register 99, No. 31).

6. Repealer of subsection (c)(1)(D)2., new subsections (c)(1)(D)2.a.-b. and (c)(1)(E), subsection relettering, amendment of subsection (c)(2), new subsections (c)(2)(D)-(E) and amendment of subsections (d)(3)(B)2.Exception, (d)(3)(E)3.b., (d)(3)(H)1.b. and (d)(3)(H)2.a. filed 8-3-2001; operative 8-3-2001. Submitted to OAL for printing only. Exempt from OAL review pursuant to Labor Code section 142.3 (Register 2001, No. 31).

7. Change without regulatory effect providing more legible illustrations for biohazard symbols filed 3-2-2009 pursuant to section 100, title 1, California Code of Regulations (Register 2009, No. 10).

8. Editorial correction of subsection (g)(2)(E) (Register 2015, No. 37).

This database is current through 12/27/24 Register 2024, No. 52.

Cal. Admin. Code tit. 8, § 5193, 8 CA ADC § 5

FEBRUARY 16, 2024

About Handwashing

KEY POINTS

- Many diseases and conditions are spread by not washing hands with soap and clean, running water.
- Handwashing with soap is one of the best ways to stay healthy.
- If soap and water are not readily available, use a hand sanitizer with at least 60% alcohol to clean your hands.

Why it's important

Washing hands can keep you healthy and prevent the spread of respiratory and diarrheal infections. Germs can spread from person to person or from surfaces to people when you:

- Touch your eyes, nose, and mouth with unwashed hands
- Prepare or eat food and drinks with unwashed hands
- Touch surfaces or objects that have germs on them
- Blow your nose, cough, or sneeze into hands and then touch other people's hands or common objects

Key times to wash hands

You can help yourself and your loved ones stay healthy by washing your hands often, especially during these key times when you are likely to get and spread germs:

- Before, during, and after preparing food
- Before and after eating food
- Before and after caring for someone at home who is sick with vomiting or diarrhea
- Before and after treating a cut or wound
- After using the toilet
- After changing diapers or cleaning up a child who has used the toilet
- After blowing your nose, coughing, or sneezing
- After touching an animal, animal feed, or animal waste
- After handling pet food or pet treats
- After touching garbage

How it works

Washing your hands is easy, and it's one of the most effective ways to prevent the spread of germs. Follow these five steps every time.

1. **Wet** your hands with clean, running water (warm or cold), turn off the tap, and apply soap.
2. **Lather** your hands by rubbing them together with the soap. Lather the backs of your hands, between your fingers, and under your nails.

3. **Scrub** your hands **for at least 20 seconds**. Need a timer? Hum the "Happy Birthday" song from beginning to end twice.

4. **Rinse** your hands well under clean, running water.

5. **Dry** your hands using a clean towel or an air dryer.

Use hand sanitizer when you can't use soap and water

Washing hands with soap and water is the best way to get rid of germs in most situations. If soap and water are not readily available, you can use an alcohol-based hand sanitizer that contains at least 60% alcohol. You can tell if the sanitizer contains at least 60% alcohol by looking at the product label.

Keep Reading:
Hand Sanitizer Facts

What you can do

CDC has health promotion materials to encourage kids and adults to make handwashing part of their everyday lives.

- Share social media graphics and messages.
- Print stickers and place clings on bathroom mirrors.
- Promote handwashing on or around Global Handwashing Day, celebrated each year on October 15.
- Distribute fact sheets to share information about hand hygiene for specific audiences.

Resources

- Frequent Questions About Hand Hygiene
- Hand Hygiene in Healthcare Settings
- The *Life is Better with Clean Hands* Campaign

SOURCES

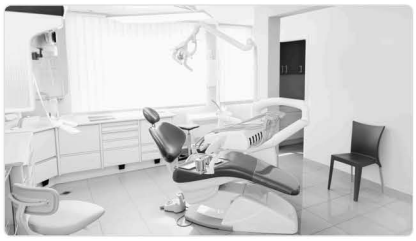
CONTENT SOURCE:
National Center for Emerging and Zoonotic Infectious Diseases (NCEZID)

MAY 15, 2024

Best Practices for Environmental Infection Prevention and Control

KEY POINTS

In the dental operatory, environmental surfaces can become contaminated through touch, splash, or droplets generated during patient care.



Why it matters

Certain surfaces, especially ones touched frequently—such as light handles, unit switches, and drawer knobs—can serve as reservoirs of microbial contamination. This may cause cross-contamination that can expose dental health care personnel or patients to disease.

Recommendations

Full recommendations on cleaning and disinfecting environmental surfaces can be found on pages 25–28 in CDC's *Guidelines for Infection Control in Dental Health-Care Settings—2003* and in the *Summary of Infection Prevention Practices in Dental Settings: Basic Expectations for Safe Care*.

Types of decontamination

Cleaning removes debris and organic contamination from surfaces. Cleaning is the necessary first step of any disinfection process. If a surface is not cleaned first, the disinfection process can be compromised.

Disinfection eliminates many or all disease-causing microorganisms on an object. However, it does not remove bacterial spores.

Sterilization eliminates all disease-causing microorganisms, as well as bacterial spores. This is typically done by heat (steam autoclave, dry heat, and unsaturated chemical vapor) or liquid chemical sterilants. Sterilization is used for patient care items.

Choosing the right product

The choice of specific cleaning or disinfecting agents is largely a matter of judgment, guided by product label claims and instructions and government regulations.

Choosing the correct product depends on the consideration of multiple factors, including the degree of microbial killing required; the nature and composition of the surface, item, or device to be treated; and the cost, safety, and ease of use.

A single product might not satisfy all disinfection requirements in a given dental facility.

Low-level disinfectants are Environmental Protection Agency (EPA)-registered **without** a **tuberculocidal claim**. The label may instead provide a hepatitis B virus (HBV) or HIV label claim. Low-level disinfection kills most vegetative bacteria, some viruses, and some fungi, but cannot be relied on to kill mycobacteria or bacterial spores.

Intermediate-level disinfectants are registered with the US EPA and have a **tuberculocidal claim.** Intermediate-level disinfection kills bacteria, most viruses and most fungi, but does not reliably kill bacterial spores.

High-level disinfectants, such as glutaraldehyde, are used as chemical sterilants. Because of their toxic nature, high level disinfectants **should never be used** on environmental surfaces.

What personal protective equipment (PPE) should be used when cleaning the dental operatory?

Because of the risks associated with exposure to chemical disinfectants and contaminated surfaces, dental health care personnel (DHCP) should wear appropriate PPE to prevent exposure to infectious agents or chemicals. PPE can include gloves, gowns, masks, and eye protection. Chemical- and puncture-resistant utility gloves offer more protection than patient examination gloves when using hazardous chemicals.

DHCP should follow manufacturer instructions and review the manufacturer Safety Data Sheet (formerly called Material Safety Data Sheet) regarding correct procedures for handling or working with hazardous chemicals.

Clinical contact surfaces

Clinical contact surfaces, such as light handles, bracket trays, switches on dental units, and computer equipment, are likely be contaminated by direct spray or spatter generated during dental procedures. They can also be contaminated by contact with contaminated gloved hands.

Ideally, clinical contact surfaces, especially those that are hard to clean, should be **barrier protected** with a Food and Drug Administration (FDA)-approved surface barrier. This barrier should be changed between each patient.

After removing the barrier, **examine the surface** to make sure it did not become soiled. If it is contaminated, the surface needs to be cleaned and disinfected before the next patient.

If surface barriers cannot be used, clean and then disinfect the surface with an EPA-registered, low-level hospital disinfectant that is effective against HIV and HBV.

If the surface is visibly contaminated with blood or other potentially infectious material, clean and then disinfect the surface with an **EPA-registered, intermediate-level hospital** disinfectant with a tuberculocidal claim.

Housekeeping surfaces

Housekeeping surfaces, such as floors, walls, and sinks, do not come into contact with patients or devices used in dental procedures. These surfaces have a limited risk of disease transmission and can be decontaminated with less rigorous methods than those used on dental patient-care items and clinical contact surfaces.

Housekeeping surface can be cleaned with soap and water or cleaned and disinfected if visibly contaminated with blood.

Reusable mops and cloths should be cleaned after use and allowed to dry before reuse. Alternatively, use single-use disposable options.

Prepare fresh cleaning and disinfecting solutions daily and according to the manufacturer's recommendations.

Disposing of medical waste

The majority of soiled items in dental offices are **general medical waste**. Examples include used gloves, masks, gowns, and lightly soiled gauze or cotton rolls. Non-regulated medical waste can be disposed of with ordinary waste.

Some waste—such as gauze soaked in blood, extracted teeth, and used needles—carries a substantial risk of causing infection during handling and disposal and is **regulated medical waste**. This type of waste requires special storage, handling, neutralization, and disposal strategies.

Regulated medical waste that does not have any sharp items can be contained in a single leak-resistant biohazard bag.

Sharp items, like scalpel blades, needles, or syringes, should be placed in puncture-resistant containers with a biohazard label (e.g., a sharps container).

Any facility generating regulated medical waste should have a plan for its management that complies with federal, state, and local regulations.

Dental health care facilities should dispose of medical waste regularly so that it does not accumulate.

Amalgam

Never include extracted teeth with amalgam in waste that will be treated with heat or incineration for final disposal.

Frequently asked questions

Who regulates disinfectants?

EPA regulates low- and intermediate-level disinfectants that are used on environmental surfaces (clinical contact surfaces and housekeeping). FDA regulates liquid chemical sterilants/high-level disinfectants (e.g., glutaraldehyde, hydrogen peroxide, and peracetic acid) used on heat-sensitive semicritical patient care devices.

Does CDC recommend a specific environmental surface disinfectant?

CDC does not test, evaluate, or otherwise recommend specific chemical germicides. The CDC dental guidelines provide overall guidance for dental health care personnel to choose from among general classes of products based on infection prevention and control principles. This guidance recommends appropriate application of liquid chemical disinfectants registered with the EPA for use in dental health care settings.

The EPA maintains a list of selected EPA-registered disinfectants.

Since tuberculosis is not transmitted by contaminated environmental surfaces, why is it important to select a disinfectant with tuberculocidal claim?

The ability to kill *Mycobacterium tuberculosis* is used as a benchmark to measure how well a disinfectant can kill germs. Mycobacteria have among the highest levels of resistance of all microorganisms. Therefore, any germicide with a tuberculocidal claim is considered capable of inactivating a broad spectrum of pathogens, including less resistant organisms such as bloodborne pathogens (e.g., hepatitis B and C viruses, HIV). The use of such products on environmental surfaces plays no role in preventing the spread of tuberculosis (which is airborne).

SOURCES

CONTENT SOURCE:
National Center for Chronic Disease Prevention and Health Promotion; Division of Oral Health

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MAY 15, 2024

Best Practices for Sterilization Monitoring in Dental Settings

KEY POINTS

- Sterilization monitoring is the process of using indicators to provide feedback on the effectiveness of instrument sterilization.
- Sterilization monitoring and equipment maintenance records are important components of a dental infection prevention program.

Why it matters

Sterilization monitoring is a critical step in ensuring that instruments and devices are safe to use on another patient.

Dental health care personnel should use a combination of mechanical, chemical, and biological monitoring to check whether a sterilizer reached the conditions necessary to achieve sterilization.

Recommendations

CDC provides recommendations for sterilization monitoring in the Guideline for Disinfection and Sterilization in Healthcare Facilities (2008) as well as on page 24–25 of the *Guidelines for Infection Control in Dental Health-Care Settings (2003)* and in the *Summary of Infection Prevention in Dental Settings: Basic Expectations for Safe Care*.

Mechanical monitoring

Mechanical monitoring involves checking the sterilizer gauges, computer displays, or printouts, and documenting in your sterilization records that pressure, temperature, and exposure time have reached the levels recommended by the sterilizer manufacturer. Since these parameters can be observed during the sterilization cycle, this might be the first indication of a problem. Mechanical monitoring should be conducted for every sterilizer load.

Do not use instrument packages if the mechanical monitoring indicates that the sterilizer did not reach the required temperature, time, or pressure to render the items sterile.

Chemical monitoring

Chemical monitoring uses sensitive chemicals that change color when exposed to high temperatures or combinations of time and temperature.

A chemical indicator should be used inside **every package** to verify that the sterilizing agent has penetrated the package and reached the instruments inside. If the internal chemical indicator is not visible from the outside of the package, an external indicator should also be used.

Inspect the chemical indicator **immediately when removing packages** from the sterilizer; if the appropriate color change did not occur, **do not use the instruments**.

Biological monitoring

Biological monitoring, also called a spore test, assesses the sterilization process directly by killing known highly resistant microorganisms. Because the spores used in biologic indicators are more resistant than the common microbial contaminants found on patient-care equipment, a negative spore test indicates that other potential microorganisms in the load have been killed.

A spore test should be used **at least weekly** to monitor sterilizers, and should use a matching control (i.e., biological indicator and control from same lot number). Follow the manufacturer's directions for how to place the biological indicator in the sterilizer.

A spore test should also be used for **every load** with an implantable device. Ideally, implantable items should not be used until they test negative.

Sterilization records

Sterilization monitoring records are an important component of a dental infection prevention program. Maintaining accurate records ensures cycle parameters have been met and establishes accountability. In addition, if there is a problem with a sterilizer (e.g., unchanged chemical indicator, positive spore test), documentation helps to determine if an instrument recall is necessary.

Maintain your sterilization monitoring records (mechanical, chemical, and biological) long enough to comply with state and local regulations.

Sterilization failures

What causes a sterilization failure?

Mechanical, chemical, or biological monitoring failures can be caused by a number of issues, including but not limited to:

- Improper cleaning of instruments.
- Incorrect operation of the sterilizer.
- Improper loading or overloading of the sterilizer.
- Improper packaging.
- Improper packaging material selected for the method of sterilization.

Keep Reading:
Factors Affecting the Efficacy of Disinfection and Sterilization

What should I do if there's a positive spore test?

If the mechanical (e.g., time, temperature, pressure) and chemical (internal or external) indicators suggest that the sterilizer is functioning properly, a single positive spore test result probably does not indicate sterilizer malfunction.

- First, **remove the sterilizer from service** and review the sterilization operating procedures to determine potential reasons for the failed test.
- **Recall and quarantine** any implantable items and do not use them until they are shown to be sterile.
- Items other than implantable items do not necessarily need to be recalled.
- **Repeat the spore test immediately** using the same cycle that produced the positive spore test.
- If the result of the repeat spore test is negative and operating procedures were correct, then the sterilizer can be returned to service.

If the repeat spore test result **is positive**, remove the sterilizer from service and **do not use until it** has been inspected or repaired and re-challenged with spore tests in three consecutive fully loaded chamber sterilization cycles.

When possible, items from suspect loads dating back to the last negative spore test should be **recalled, rewrapped, and re-sterilized.**

See Table 12 of the Guideline for Disinfection and Sterilization in Healthcare Facilities (2008) for the suggested protocol to manage a positive biological indicator in a steam sterilizer.

Infection Control Breaches

If patient care items are not properly reprocessed, this could represent an infection control breach.
Visit CDC's Steps for Evaluating an Infection Control Breach for more information on what to do in this situation.

Frequently asked questions

Do I have to perform a spore test if I don't use my sterilizer on a full time basis?

CDC does not provide a separate recommendation for sterilizers that are used on a part-time basis. CDC recommends that dental health care personnel monitor sterilizers at least weekly by using a biological indicator with a matching control (i.e., biological indicator and control from same lot number).

SOURCES

CONTENT SOURCE:
National Center for Chronic Disease Prevention and Health Promotion; Division of Oral Health

SOURCES

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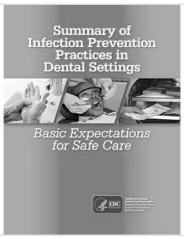
MAY 15, 2024

Standard Precautions

WHAT TO KNOW

Standard Precautions are designed to both protect dental health care personnel (DHCP) and prevent DHCP from spreading infections among patients.



Background

Standard Precautions are the minimum infection prevention practices that apply to all patient care, regardless of suspected or confirmed infection status of the patient, in any setting where health care is delivered. Standard Precautions include:

1. Hand hygiene.
2. Use of personal protective equipment (e.g., gloves, masks, eyewear).
3. Respiratory hygiene/cough etiquette.
4. Sharps safety (engineering and work practice controls).
5. Safe injection practices (i.e., aseptic technique for parenteral medications).
6. Sterile instruments and devices.
7. Clean and disinfected environmental surfaces.

Each element of Standard Precautions is described in the following sections. Education and training are critical elements of Standard Precautions, because they help DHCP make appropriate decisions and comply with recommended practices.

When Standard Precautions alone cannot prevent transmission, they are supplemented with Transmission-Based Precautions. This second tier of infection prevention is used when patients have diseases that can spread through contact, droplet or airborne routes (e.g., skin contact, sneezing, coughing), and are always used in addition to Standard Precautions. Dental settings are not typically designed to carry out all of the Transmission-Based Precautions (e.g., Airborne Precautions for patients with suspected tuberculosis, measles, or chickenpox) that are recommended for hospital and other ambulatory care settings. Patients, however, do not usually seek routine dental outpatient care when acutely ill with diseases requiring Transmission-Based Precautions.

Nonetheless, DHCP should develop and carry out systems for early detection and management of potentially infectious patients at initial points of entry to the dental setting. To the extent possible, this includes rescheduling non-urgent dental care until the patient is no longer infectious or referral to a dental setting with appropriate infection prevention precautions when urgent dental treatment is needed.

Hand hygiene

Hand hygiene is the most important measure to prevent the spread of infections among patients and DHCP. Education and training programs should thoroughly address indications and techniques for hand hygiene practices before performing routine and oral surgical procedures.

For routine dental examinations and nonsurgical procedures, use water and plain soap (hand washing), or antimicrobial soap (hand antisepsis) specific for health care settings, or use an alcohol-based hand rub. Although alcohol-based hand rubs are effective for hand hygiene in health care settings, soap and water should be used when hands are visibly soiled (e.g., dirt, blood, body fluids). For surgical procedures, [A] perform a surgical hand scrub before putting on sterile surgeon's gloves. For all types of hand hygiene products, follow the product manufacturer's label

for instructions. Complete guidance on how and when hand hygiene should be performed, including recommendations regarding surgical hand antisepsis and artificial nails, can be found in the Guideline for Hand Hygiene in Healthcare Settings.

Key Recommendations for HAND HYGIENE in Dental Settings

1. Perform Hand Hygiene:
    a. When hands are visibly soiled.
    b. After barehanded touching of instruments, equipment, materials, and other objects likely to be contaminated by blood, saliva, or respiratory secretions.
    c. Before and after treating each patient.
    d. Before putting on gloves and again immediately after removing gloves.
2. Use soap and water when hands are visibly soiled (e.g., blood, body fluids); otherwise, an alcohol-based hand rub may be used.

Personal protective equipment

Personal protective equipment (PPE) refers to wearable equipment that is designed to protect DHCP from exposure to or contact with infectious agents. PPE that is appropriate for various types of patient interactions and effectively covers personal clothing and skin likely to be soiled with blood, saliva, or other potentially infectious materials (OPIM) should be available. These include gloves, face masks, protective eye wear, face shields, and protective clothing (e.g., reusable or disposable gown, jacket, laboratory coat). Examples of appropriate use of PPE for adherence to Standard Precautions include:

- Use of gloves in situations involving possible contact with blood or body fluids, mucous membranes, non-intact skin (e.g., exposed skin that is chapped, abraded, or with dermatitis) or OPIM.
- Use of protective clothing to protect skin and clothing during procedures or activities where contact with blood or body fluids is anticipated.
- Use of mouth, nose, and eye protection during procedures that are likely to generate splashes or sprays of blood or other body fluids.

DHCP should be trained to select and put on appropriate PPE and remove PPE so that the chance for skin or clothing contamination is reduced. Hand hygiene is always the final step after removing and disposing of PPE. Training should also stress preventing further spread of contamination while wearing PPE by:

- Keeping hands away from face.
- Limiting surfaces touched.
- Removing PPE when leaving work areas.
- Performing hand hygiene.

The application of Standard Precautions and guidance on appropriate selection and an example of putting on and removal of personal protective equipment is described in detail in the 2007 Guideline for Isolation Precautions.

Keep Reading:
Best Practices for Personal Protective Equipment

Key Recommendations for PERSONAL PROTECTIVE EQUIPMENT (PPE) in Dental Settings

1. Provide sufficient and appropriate PPE and ensure it is accessible to DHCP.
2. Educate all DHCP on proper selection and use of PPE.
3. Wear gloves whenever there is potential for contact with blood, body fluids, mucous membranes, non-intact skin, or contaminated equipment.
    a. Do not wear the same pair of gloves for the care of more than one patient.
    b. Do not wash gloves. Gloves cannot be reused.
    c. Perform hand hygiene immediately after removing gloves.
4. Wear protective clothing that covers skin and personal clothing during procedures or activities where contact with blood, saliva, or OPIM is anticipated.
5. Wear mouth, nose, and eye protection during procedures that are likely to generate splashes or spattering of blood or other body fluids.

6. Remove PPE before leaving the work area.

Respiratory hygiene/cough etiquette

Respiratory hygiene/cough etiquette infection prevention measures are designed to limit the transmission of respiratory pathogens spread by droplet or airborne routes. The strategies target primarily patients and individuals accompanying patients to the dental setting who might have undiagnosed transmissible respiratory infections, but also apply to anyone (including DHCP) with signs of illness including cough, congestion, runny nose, or increased production of respiratory secretions.

DHCP should be educated on preventing the spread of respiratory pathogens when in contact with symptomatic persons. Respiratory hygiene/cough etiquette measures were added to Standard Precautions in 2007. Additional information related to respiratory hygiene/cough etiquette can be found in the 2007 Guideline for Isolation Precautions. Recommendations for preventing the spread of influenza are available at: Infection Control in Health Care Facilities | CDC.

Key Recommendations for RESPIRATORY HYGIENE/COUGH ETIQUETTE in Dental Settings

1. Implement measures to contain respiratory secretions in patients and accompanying individuals who have signs and symptoms of a respiratory infection, beginning at point of entry to the facility and continuing throughout the visit.
    a. Post signs at entrances with instructions to patients with symptoms of respiratory infection to (1) cover their mouths/noses when coughing or sneezing; (2) use and dispose of tissues; and (3) perform hand hygiene after hands have been in contact with respiratory secretions.
    b. Provide tissues and no-touch receptacles for disposal of tissues.
    c. Provide resources for performing hand hygiene in or near waiting areas.
    d. Offer masks to coughing patients and other symptomatic persons when they enter the dental setting.
    e. Provide space and encourage persons with symptoms of respiratory infections to sit as far away from others as possible. If available, facilities may wish to place these patients in a separate area while waiting for care.
2. Educate DHCP 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.

Sharps safety

Most percutaneous injuries (e.g., needlestick, cut with a sharp object) among DHCP involve burs, needles, and other sharp instruments. Implementation of the OSHA Bloodborne Pathogens Standard has helped to protect DHCP from blood exposure and sharps injuries. However, sharps injuries continue to occur and pose the risk of bloodborne pathogen transmission to DHCP and patients. Most exposures in dentistry are preventable; therefore, each dental practice should have policies and procedures available addressing sharps safety. DHCP should be aware of the risk of injury whenever sharps are exposed. When using or working around sharp devices, DHCP should take precautions while using sharps, during cleanup, and during disposal.

Engineering and work-practice controls are the primary methods to reduce exposures to blood and OPIM from sharp instruments and needles. Whenever possible, engineering controls should be used as the primary method to reduce exposures to bloodborne pathogens. Engineering controls remove or isolate a hazard in the workplace and are frequently technology based (e.g., self-sheathing anesthetic needles, safety scalpels, and needleless IV ports). Employers should involve those DHCP who are directly responsible for patient care (e.g., dentists, hygienists, dental assistants) in identifying, evaluating, and selecting devices with engineered safety features at least annually and as they become available. Other examples of engineering controls include sharps containers and needle recapping devices.

When engineering controls are not available or appropriate, work-practice controls should be used. Work-practice controls are behavior-based and are intended to reduce the risk of blood exposure by changing the way DHCP perform tasks, such as using a one-handed scoop technique for recapping needles between uses and before disposal. Other work-practice controls include not bending or breaking needles before disposal, not passing a syringe with an unsheathed needle by hand, removing burs before disassembling the handpiece from the dental unit, and using instruments in place of fingers for tissue retraction or palpation during suturing and administration of anesthesia.

All used disposable syringes and needles, scalpel blades, and other sharp items should be placed in appropriate puncture-resistant containers located close to the area where they are used. Sharps containers should be disposed of according to state and local regulated medical waste rules.

For more information about sharps safety, see the *Guidelines for Infection Control in Dental Health-Care Settings—2003*, the CDC Workbook for Designing, Implementing, and Evaluating a Sharps Injury Prevention Program, and the CDC Sample Screening PDF and Device Evaluation Forms PDF for Dentistry.

Key Recommendations for SHARPS SAFETY in Dental Settings

1. Consider sharp items (e.g., needles, scalers, burs, lab knives, and wires) that are contaminated with patient blood and saliva as potentially infective and establish engineering controls and work practices to prevent injuries.

2. Do not recap used needles by using both hands or any other technique that involves directing the point of a needle toward any part of the body.
3. Use either a one-handed scoop technique or a mechanical device designed for holding the needle cap when recapping needles (e.g., between multiple injections and before removing from a non-disposable aspirating syringe).
4. Place used disposable syringes and needles, scalpel blades, and other sharp items in appropriate puncture-resistant containers located as close as possible to the area where the items are used.

Safe injection practices

Safe injection practices are intended to prevent transmission of infectious diseases between one patient and another, or between a patient and DHCP during preparation and administration of parenteral (e.g., intravenous or intramuscular injection) medications. Safe injection practices are a set of measures DHCP should follow to perform injections in the safest possible manner for the protection of patients. DHCP most frequently handle parenteral medications when administering local anesthesia, during which needles and cartridges containing local anesthetics are used for one patient only and the dental cartridge syringe is cleaned and heat sterilized between patients. Other safe practices described here primarily apply to use of parenteral medications combined with fluid infusion systems, such as for patients undergoing conscious sedation. Unsafe practices that have led to patient harm include (1) use of a single syringe—with or without the same needle—to administer medication to multiple patients, (2) reinsertion of a used syringe—with or without the same needle—into a medication vial or solution container (e.g., saline bag) to obtain additional medication for a single patient and then using that vial or solution container for subsequent patients, and (3) preparation of medications in close proximity to contaminated supplies or equipment.

Safe injection practices were covered in the Special Considerations section (Aseptic Technique for Parenteral Medications) of the 2003 CDC dental guidelines. However, because of reports of transmission of infectious diseases by inappropriate handling of injectable medications, CDC now considers safe injection practices to be a formal element of Standard Precautions. Complete guidance on safe injection practices can be found in the 2007 Guideline for Isolation Precautions. Additional materials, including a list of frequently asked questions from providers and a patient notification toolkit, are also available.

Keep Reading:
Best Practices for Safe Injections

Key Recommendations for SAFE INJECTION PRACTICES in Dental Settings

1. Prepare injections using aseptic technique [B] in a clean area.
2. Disinfect the rubber septum on a medication vial with alcohol before piercing.
3. Do not use needles or syringes [C] for more than one patient (this includes manufactured prefilled syringes and other devices such as insulin pens).
4. Medication containers (single and multidose vials, ampules, and bags) are entered with a new needle and new syringe, even when obtaining additional doses for the same patient.
5. Use single-dose vials for parenteral medications when possible.
6. Do not use single-dose (single-use) medication vials, ampules, and bags or bottles of intravenous solution for more than one patient.
7. Do not combine the leftover contents of single-use vials for later use.
8. The following apply if multidose vials are used:
    a. Dedicate multidose vials to a single patient whenever possible.
    b. 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.
    c. If a multidose vial enters the immediate patient treatment area, it should be dedicated for single-patient use and discarded immediately after use.
    d. Date multidose vials when first opened and discard within 28 days, unless the manufacturer specifies a shorter or longer date for that opened vial.
9. Do not use fluid infusion or administration sets (e.g., IV bags, tubings, connections) for more than one patient.

SOURCES

CONTENT SOURCE:

FOOTNOTES

A. Definition from 2003 CDC Dental Guidelines—Oral surgical procedures involve the incision, excision, or reflection of tissue that exposes the normally sterile areas of the oral cavity. Examples include biopsy, periodontal surgery, apical surgery, implant surgery, and surgical extractions of teeth (e.g., removal of erupted or nonerupted tooth requiring elevation of mucoperiosteal flap, removal of bone or section of tooth, and suturing if needed).

B. A technique that prevents or reduces the spread of microorganisms from one site to another, such as from patient to DHCP, from patient to operatory surfaces, or from one operatory surface to another.

C. A Note about Administering Local Dental Anesthesia: When using a dental cartridge syringe to administer local anesthesia, do not use the needle or anesthetic cartridge for more than one patient. Ensure that the dental cartridge syringe is appropriately cleaned and heat sterilized before use on another patient.

SOURCES

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CALIFORNIA DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY • GAVIN NEWSOM, GOVERNOR

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MEMORANDUM

DATE	January 10, 2025
TO	Members of the Dental Assisting Council
FROM	Brant Nelson, Legislative and Regulatory Specialist Dental Board of California
SUBJECT	**Agenda Item 9.a.:** Legislation of Interest

Background

The Dental Board of California (Board) tracks bills that impact the Board, the Department of Consumer Affairs (DCA), including other DCA licensing boards. For any such bill, this memorandum will include information regarding each bill's status, location, date of introduction, date of last amendment, and a summary. The bills will be listed in numerical order, with the Assembly Bills (AB XXX) first, followed by the Senate Bills (SB XXX).

The Governor called a special session of the Legislature, which began on December 2, 2024. Special sessions of the legislature are focused on specific purposes outlined in the Proclamation convening that session, and legislation for other purposes cannot be considered in that special session. The focus of this special session was to protect California values, including fundamental civil rights, reproductive freedom, climate action, immigrant families, and more.

The California Legislature began its 2024-2025 regular session on January 6, 2025. As of this writing, the Assembly has introduced 133 bills, and the Senate has introduced 19 bills. Board staff have reviewed these bills and found that, at this time, none have an impact that requires the Board's consideration. Staff will continue to monitor new legislation and amendments to existing legislation for potential impacts on the Board and its stakeholders.

Additional information on any bills can be located at the following:
https://leginfo.legislature.ca.gov/
https://www.senate.ca.gov/
https://www.assembly.ca.gov/

Action Requested

No action requested.

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MEMORANDUM

DATE	January 13, 2025
TO	Members of the Dental Assisting Council
FROM	Infection Control Working Group: Cara Miyasaki, RDA, RDHEF, MS
SUBJECT	**Agenda Item 9.b.:** Discussion and Possible Recommendation on Legislative Proposal to Amend Business and Professions Code (BPC) Sections 1725, 1750, and 1753.52 and Repeal BPC Sections 1754.5 and 1755 Regarding Dental Assisting Courses

This memorandum discusses concerns and a legislative proposal regarding the new unlicensed dental assistant infection control course (Business and Professions Code (BPC), §§ 1750 and 1755), radiation safety course (BPC, § 1754.5), and interim therapeutic restoration and radiographic decisionmaking course (BPC, § 1753.52) requirements established under law that became operative on January 1, 2025, under Senate Bill (SB) 1453 (Ashby, Chapter 483, Statutes of 2024), the Board's Sunset bill.

Background

At the November 7-8, 2024 Dental Board of California (Board) meeting, a memorandum was presented discussing concerns regarding the new unlicensed dental assistant infection control course requirements established under BPC section 1755 that became operative on January 1, 2025, under SB 1453 (Ashby, Chapter 483, Statutes of 2024), the Board's Sunset bill. (*See* Nov. 7-8, 2024 Meeting Memo, Agenda Item 27.e.) The Board did not take action on this item but acknowledged the Executive Officer's intent to work with Board staff and stakeholders to resolve concerns.

The matter was referred to the Council for review, and the Council appointed the two-person Infection Control working group comprised of Council Chair Cara Miyasaki and Council Member Joanne Pacheco to work on the issues. Due to Board member composition amendments made to BPC section 1601.1 by SB 1453, the Board no longer has a Registered Dental Hygienist position on the Board or Council, and Ms. Pacheco's member term has ended.

Discussion

The Working Group held meetings with Board staff to understand the issues, and it was determined that the implementation issues that exist with the new infection control course also exist with the new radiation safety course. The Working Group reached out to the California Dental Association (CDA), the California Dental Assisting Alliance (CDAA), and The FADE Institute, Inc. and held a meeting on December 9, 2024, with CDA and CDAA representatives to discuss the issues and propose solutions (FADE did not attend).

The main issues discussed during the December 9, 2024 stakeholder meeting included the lack of in-person laboratory or preclinical instruction requirements for the infection control course and the need to make infection control courses accessible to rural areas, especially at the start of dental assisting employment, and the lack of Board approval procedure and laboratory and preclinical instruction requirements in the radiation safety course statute, clinical oversight concerns, and extramural dental facility access issues.

Following the stakeholder meeting, Board staff identified additional concerns with the larger issue of Board approval of dental assisting programs and courses, including the Board's inability to timely review dental assisting programs and courses to ensure compliance with regulatory requirements and student and, ultimately, consumer protection, as well as providing for recent and future advancements in the delivery of electronic instruction. Notably, the Board's draft regulatory proposal to amend the existing dental assisting educational programs and courses regulations currently is on hold pending staff and regulatory counsel review.

Board staff has received numerous inquiries regarding implementation of the new infection control and radiation safety courses, as well as dental office employment of dental assistants who have not yet completed these courses prior to performing dental assisting duties on patients. Given the complex issues regarding the numerous dental assisting program and course requirements and Board approval thereof, as well as the implementation issues with the new infection control and radiation safety courses, the Working Group believes the most critical issues need to be addressed immediately while work continues how best to revise the dental assisting educational program and course requirements going forward. The legislative proposal, described further below, is intended to resolve the critical issues pending further Board and stakeholder discussion on how to address the other issues.

In addition, Board staff note that the new interim therapeutic restoration and radiographic decisionmaking course established in BPC section 1753.52 refers to an application fee in regulation, which does not currently exist. As such, Board staff proposed establishing the new interim therapeutic restoration and radiographic

decisionmaking course application fee in statute, BPC section 1725, and making a conforming amendment to BPC section 1753.52.

Recommendation

The Working Group recommends the following legislative proposal to resolve the immediate issues with the infection control and radiation safety courses and establish the application fee for the new interim therapeutic restoration and radiographic decisionmaking course.

The proposal would achieve the following:

1. Amend BPC section 1725 to add new subdivision (l) to establish the application fee for the new interim therapeutic restoration and radiographic decisionmaking course. All other course application fees established in regulation are set at $300 (*see* Cal. Code Regs, tit. 16, § 1022, subs. (p)-(v)). Since processing the application for Board approval of the new interim therapeutic restoration and radiographic decisionmaking course requires the same staff effort as other dental assisting courses, the new course application fee would be set at the same amount as the existing courses.

2. Amend BPC section 1750, subdivision (c), to change the new requirement for dental assistants to complete a Board-approved eight-hour course in infection control prior to performing any basic supportive dental procedures involving potential exposure to blood, saliva, or other potentially infection materials. To accommodate employers seeking to hire new dental assistants who cannot complete the infection control course prior to hiring, the amendment would allow the dental assistant to complete the course within 60 days of hiring. Notably, the prior requirement was to complete the course within one of year of employment.

3. Amend BPC section 1753.52, subdivision (a)(2), to reflect the interim therapeutic restoration and radiographic decisionmaking course application fee in BPC section 1725, subdivision (l), proposed above, rather than in regulation.

4. Repeal BPC sections 1754.5 (radiation safety course) and 1755 (infection control course) to resolve the infection control and radiation safety course implementation issues described above and continue to rely on Board approval of courses under existing regulations until a broader plan is formed to address the issues with Board review of dental assisting educational programs and courses.

Action Requested

The Working Group requests the Council review the information presented in this memorandum and the attached legislative proposal for recommendation to the Board.

Suggested Motions

Option 1 (support the proposed recommendation): Move to approve the recommendation for submission to the Board the legislative proposal to amend BPC sections 1725, 1750, and 1753.52, and repeal BPC sections 1754.5 and 1755 regarding dental assisting courses.

Option 2 (support the proposed recommendation as revised during this meeting): Move to approve the recommendation for submission to the Board the legislative proposal to amend BPC sections 1725, 1750, and 1753.52, and repeal BPC sections 1754.5 and 1755 regarding dental assisting courses, as revised during this meeting [insert specific revisions].

Option 3 (no action): If the Council does not wish to act on the recommendation, no motion is needed.

Attachment: Legislative Proposal to Amend Sections 1725, 1750, and 1753.52 and Repeal Sections 1754.5 and 1755 of the Business and Professions Code Relating to Dental Assisting Courses

DENTAL BOARD OF CALIFORNIA

LEGISLATIVE PROPOSAL TO AMEND SECTIONS 1725, 1750, AND 1753.52 AND REPEAL SECTIONS 1754.5 AND 1755 OF THE BUSINESS AND PROFESSIONS CODE RELATING TO DENTAL ASSISTING COURSES

Proposed amendments are indicated in underline for new text and ~~strikethrough~~ for deleted text.

Amend Section 1725 of Article 6 of Chapter 4 of Division 2 of the Business and Professions Code as follows:

1725. The amount of the fees prescribed by this chapter that relate to the licensing and permitting of dental assistants shall be established by regulation and subject to the following limitations:

(a) The application fee for an original license shall not exceed two hundred dollars ($200).

(b) The fee for examination for licensure as a registered dental assistant shall not exceed the actual cost of the examination.

(c) The fee for application and for the issuance of an orthodontic assistant permit or a dental sedation assistant permit shall not exceed two hundred dollars ($200).

(d) The fee for the written examination for an orthodontic assistant permit or a dental sedation assistant permit shall not exceed the actual cost of the examination.

(e) The fee for the Registered Dental Assistant Combined Written and Law and Ethics Examination for a registered dental assistant shall not exceed the actual cost of the examination.

(f) The fee for examination for licensure as a registered dental assistant in extended functions shall not exceed the actual cost of the examination.

(g) The biennial renewal fee for a registered dental assistant license, registered dental assistant in extended functions license, dental sedation assistant permit, or orthodontic assistant permit shall not exceed two hundred dollars ($200).

(h) The delinquency fee shall be 50 percent of the renewal fee for the license or permit in effect on the date of the renewal of the license or permit.

(i) The fee for issuance of a duplicate registration, license, permit, or certificate to replace one that is lost or destroyed, or in the event of a name change, shall not exceed one hundred dollars ($100).

(j) The fee for each curriculum review and site evaluation for educational programs for registered dental assistants that are not accredited by a board-approved agency, or the Chancellor's office of the California Community Colleges shall not exceed seven thousand five hundred dollars ($7,500).

(k) The fee for review of each approval application or reevaluation for a course that is not accredited by a board-approved agency or the Chancellor's office of the California Community Colleges shall not exceed two thousand dollars ($2,000).

(l) The fee for review of each approval application or reevaluation for a course provided pursuant to Section 1753.52 that is not accredited by a board-approved agency or the Chancellor's office of the California Community Colleges shall be three hundred dollars ($300).

(~~l~~m) Fees collected pursuant to this section shall be deposited in the State Dentistry Fund.

Amend Section 1750 of Article 7 of Chapter 4 of Division 2 of the Business and Professions Code as follows:

1750. (a) A dental assistant is an individual who, without a license, may perform basic supportive dental procedures, as authorized by Section 1750.1 and by regulations adopted by the board, under the supervision of a licensed dentist. "Basic supportive dental procedures" are those procedures that have technically elementary characteristics, are completely reversible, and are unlikely to precipitate potentially hazardous conditions for the patient being treated.

(b) The supervising licensed dentist shall be directly responsible for determining the competency of the dental assistant to perform the basic supportive dental procedures, as authorized by Section 1750.1.

(c) The employer of a dental assistant shall be responsible for ensuring that the dental assistant has successfully completed a board-approved eight-hour course in infection control within 60 days from the date of first employment at the dental office~~prior to performing any basic supportive dental procedures involving potential exposure to blood, saliva, or other potentially infectious materials~~.

(d) The employer shall maintain evidence for the length of the employment for the dental assistant at the supervising dentist's treatment facility to verify the dental assistant has met and maintained all certification requirements as dictated by statute and regulation.

(e) The employer shall inform the dental assistant of the educational requirements described in subdivision (f) to maintain employment as an unlicensed dental assistant.

(f) The employer of a dental assistant shall be responsible for ensuring that the dental assistant who has been employed continuously or on an intermittent basis by that employer for one year from the date of first employment provides evidence to the

employer that the dental assistant has already successfully completed, or successfully completes, all of the following within one year of the first date of employment:

(1) A board-approved two-hour course in the Dental Practice Act.

(2) Current certification in basic life support issued by the American Red Cross, the American Heart Association, the American Safety and Health Institute, the American Dental Association's Continuing Education Recognition Program, or the Academy of General Dentistry's Program Approval for Continuing Education, in accordance with both of the following:

(A) The dental assistant shall be responsible for maintaining current certification in basic life support to perform duties involving patients.

(B) The employer of a dental assistant shall be responsible for ensuring that the dental assistant maintains certification in basic life support.

(3) To perform radiographic procedures, a dental assistant shall complete a board-approved course in radiation safety. The original or a copy of the current, valid certificate issued by a board-approved radiation safety course provider shall be publicly displayed at the treatment facility where the dental assistant performs dental services.

(4) To perform coronal polishing prior to licensure as a registered dental assistant, an unlicensed dental assistant shall complete a board-approved coronal polishing course and obtain a certificate of completion. Prior to taking the coronal polishing course, the dental assistant shall provide evidence to the course provider of having completed a board-approved eight-hour course in infection control and a current, valid certification in basic life support.

(A) Coronal polishing performed pursuant to this paragraph shall be performed under the direct supervision and pursuant to the order, control, and full professional responsibility of a licensed dentist, who shall, at minimum, evaluate each patient after coronal polishing procedures are performed by the dental assistant.

(B) The original or a copy of the current, valid certificate issued by a board-approved coronal polishing course provider shall be publicly displayed at the treatment facility where the dental assistant performs dental services.

Amend Section 1753.52 of Article 7 of Chapter 4 of Division 2 of the Business and Professions Code as follows:

1753.52. (a) On or after January 1, 2026, a provider of a course for instruction in interim therapeutic restorations and radiographic decisionmaking for a registered dental

assistant in extended functions shall apply for board approval to offer the course and submit all of the following to the board:

(1) An application prescribed by the board that shall specify the name of the course or educational program administrator or director, the name of the course provider, the name of the course, and the location where the course will be offered.

(2) The application fee prescribed ~~by regulation~~in Section 1725.

(3) A detailed course curriculum evidencing that the course is sufficient in length for the students to develop competency in placement of protective restorations, but shall be, at a minimum, 16 hours in length and include all of the following:

(A) Four hours of didactic training, which may take place in an in-person or online environment, and shall include:

(i) Review of pulpal anatomy.

(ii) Theory of adhesive restorative materials used in the placement of adhesive protective restorations, including mechanisms of bonding to tooth structure, handling characteristics of the materials, preparation of the tooth prior to material placement, and placement techniques.

(iii) Criteria used in clinical dentistry pertaining to the use and placement of adhesive protective restorations, which shall include:

(I) Patient factors, as follows:

(ia) According to the American Society of Anesthesiologists Physical Status Classification, the patient is Class III or less.

(ib) The patient is cooperative enough to have the interim therapeutic restoration placed without the need for special protocols, including sedation or physical support.

(ic) The patient, or responsible party, has provided consent for the interim therapeutic restoration procedure.

(id) The patient reports that the tooth is asymptomatic, or if there is mild sensitivity that stops within a few seconds of the removal of the offending stimulus.

(II) Tooth factors, as follows:

(ia) The lesion is accessible without the need for creating access using a dental handpiece.

(ib) The margins of the lesion are accessible so that clean, noninvolved margins can be obtained around the entire periphery of the lesion with the use of hand instrumentation.

(ic) The depth of the lesion is more than two millimeters from the pulp on radiographic examination or is judged by the supervising licensed dentist to be a shallow lesion such that the treatment does not endanger the pulp or require the use of local anesthetic.

(id) The tooth is restorable and does not have other significant pathology.

(iv) The protocols to deal with adverse outcomes used in the placement of adhesive protective restorations, including mechanisms of bonding to tooth structure, handling characteristics of the materials, preparation of the tooth prior to material placement, and placement techniques.

(v) Criteria for evaluating successful completion of adhesive protective restorations, including, but not limited to, restorative material not in hyper occlusion, no marginal voids, and minimal excess material.

(vi) Protocols for adverse outcomes after interim therapeutic restoration placement, including, but not limited to, exposed pulp, tooth fracture, gingival tissue injury, high occlusion, open margins, tooth sensitivity, rough surface, complications, or unsuccessful completion of adhesive protective restorations, including situations requiring immediate referral to a dentist.

(vii) Protocols for followup of adhesive protective restorations, including, but not limited to, at least two followup examinations of the interim therapeutic restoration within a 12-month period.

(B) Four hours of laboratory training, which shall be held at a physical facility, and include placement of 10 adhesive protective restorations where students demonstrate competency in this technique on typodont teeth.

(C) Eight hours of clinical training, which shall be held at a physical facility, and include experiences where students demonstrate, at minimum, placement of five interim therapeutic restorations under direct supervision of faculty.

(4) A detailed course curriculum evidencing that the course is sufficient in length for the students to develop competency in making decisions about which radiographs to expose to facilitate diagnosis and treatment planning by a dentist, but shall be, at a minimum, four hours in length and include all of the following:

(A) Didactic instruction, including all of the following:

(i) The concept of managing caries and individualizing treatment based on a caries risk assessment.

(ii) Guidelines for radiographic decisionmaking, including, but not limited to, both of the following concepts:

(I) The American Dental Association's Dental Radiographic Examinations: Recommendations for Patient Selection and Limiting Radiation Exposure (Revised 2012).

(II) The American Academy of Pediatric Dentistry's Guidelines on Prescribing Dental Radiographs.

(iii) The guidelines developed by Pacific Center for Special Care at the University of the Pacific Arthur A. Dugoni School of Dentistry (Pacific) for use in training for Health and Workforce Pilot Project No. 172, including both of the following:

(I) Instruction on specific decisionmaking guidelines that incorporate information about the patient's health, radiographic history, time span since previous radiographs were taken, and availability of previous radiographs.

(II) Instruction pertaining to the general condition of the mouth, including the extent of dental restorations present and visible signs of abnormalities, including broken teeth, dark areas, holes in teeth, demineralization, visible carious lesions, and remineralization.

(B) Laboratory training that includes case-based examination with various clinical situations where trainees make decisions about which radiographs to expose and demonstrate competency to faculty based on these case studies.

(C) Simulated clinical experiences consisting of a review of various clinical cases with instructor-led discussion about radiographic decisionmaking in these clinical situations.

(5) Evidence of student access to adequate equipment and facilities to satisfy the educational requirements as specified in this section.

(6) Evidence that the physical facilities required under this section have all of the following:

(A) A patient clinic area, laboratory, and radiology area.

(B) Access to equipment necessary to develop dental assisting skills in radiographic decisionmaking.

(C) Infection control equipment as required by the board.

(7) Evidence that the physical facilities and equipment are maintained and replaced in a manner designed to provide students with a course that will meet the educational objectives set forth in this section.

(8) Evidence that all students have access to all of the following:

(A) A hazardous waste management plan for the disposal of needles, cartridges, medical waste, and storage of oxygen and nitrous oxide tanks.

(B) A clinic hazard communication plan.

(C) A copy of the course's bloodborne and infectious diseases exposure control plan, which shall include emergency needlestick information.

(9) Written clinical and laboratory protocols to ensure adequate asepsis, infection and hazard control, and disposal of hazardous wastes, which shall comply with the board's regulations and other federal, state, and local requirements. The course provider shall provide such protocols to all students, faculty, and appropriate staff to assure compliance with such protocols. Adequate space shall be provided for preparing and sterilizing all armamentaria.

(10) Evidence that the course is established at the postsecondary educational level.

(b) The course content may be incorporated into a current registered dental assistant in extended functions program.

(c) For course enrollment, the course provider shall ensure submission by the student of satisfactory evidence of both of the following requirements:

(1) A current, active license as a registered dental assistant in extended functions issued on or after January 1, 2010.

(2) A current certification in basic life support from American Red Cross, American Heart Association, American Safety and Health Institute, American Dental Association's Continuing Education Recognition Program, or Academy of General Dentistry's Program Approval for Continuing Education.

(d) The program or course director shall do both of the following:

(1) Ensure all faculty involved in clinical evaluation of students maintain currency in evaluation protocols for interim therapeutic restoration placement and radiographic decisionmaking.

(2) Ensure that all faculty responsible for clinical evaluation have completed a one-hour methodology course in clinical evaluation for interim therapeutic restoration placement and radiographic decisionmaking before instruction.

(e) Satisfactory completion of a course in interim therapeutic restoration and radiographic decisionmaking is determined using criteria-referenced completion standards, where the instructor determines when the trainee has achieved competency based on these standards, but trainees take varying amounts of time to achieve competency. Any student who does not achieve competency in this duty in the specified period of instruction may receive additional training and evaluation. In cases where, in the judgment of the faculty, students are not making adequate progress, they shall be discontinued from the program.

(f) Each student shall pass a written examination which reflects the entire curriculum content.

(g) Each student shall pass a simulated clinical examination in which the student successfully completes the application of three of the five interim therapeutic restoration placements required for clinical instruction under faculty supervision.

(h) Each approved course shall be subject to board review at any time for compliance with the requirements under this section. The board may withdraw approval at any time that it determines that the course does not meet the requirements set forth in this section.

(i) The program or course director shall be responsible for notifying the board in writing of any changes to the course content, physical facilities, and faculty within 10 days of such changes.

(j) The board may adopt regulations to implement this section.

Repeal Section 1754.5 of Article 7 of Chapter 4 of Division 2 of the Business and Professions Code as follows:

~~**1754.5.** (a) A radiation safety course shall have the primary purpose of providing theory, laboratory, and clinical application in radiographic techniques. The board shall approve only those courses that adhere to the minimum requirements of this section.~~

~~(b) A radiation safety course provider applying for initial board approval shall submit a completed application for course approval, on a form provided by the board, accompanied by the applicable fee. The board may approve or deny approval after it evaluates all components of the course.~~

~~(c) Continuation of approval will be contingent upon continued compliance with Sections 1070 and 1070.1 of Title 16 of the California Code of Regulations and all requirements set forth in this section. The board may withdraw approval at any time that it determines that the course does not meet the requirements set forth in this subdivision.~~

~~(d) Providers shall make adequate provisions for appropriate supervision, operation, and facilities when used for laboratory and preclinical instruction.~~

(e) A course in radiation safety shall be of sufficient duration for the student to achieve minimum competence, but in no event less than 32 hours, including at least 8 hours of didactic instruction, at least 12 hours of laboratory instruction, and at least 12 hours of supervised clinical instruction.

(f) A course shall establish specific instructional objectives. The theoretical aspects of the course shall provide the content necessary for students to make safe and ethical judgments regarding radiation safety.

(g) Objective evaluation criteria shall be used for measuring student progress. Students shall be provided with specific performance objectives and the evaluation criteria that will be used for all evaluation and testing procedures.

(h) Areas of didactic instruction shall include, at a minimum, all of the following:

(1) Radiation physics and biology.

(2) Radiation protection and safety.

(3) Recognition of normal intraoral and extraoral anatomical landmarks.

(4) Radiograph exposure and processing techniques.

(5) Radiograph mounting or sequencing, and viewing, including anatomical landmarks of the oral cavity.

(6) Intraoral techniques including holding devices and image receptors.

(7) Proper use of patient protection devices and personal protective equipment for operator use.

(8) Identification and correction of faulty radiographs.

(9) Introduction to contemporary equipment and devices including the use of computerized digital radiography and extraoral imaging that may include panographs or cone-beam imaging.

(10) Techniques and exposure guidelines for a variety of patients including, but not limited to, adult, pediatric, edentulous, partially edentulous, endodontic, and patients with special needs.

(11) Radiographic record management.

(i) For the student to achieve minimum competence in the application of dental radiographic techniques and radiation safety, all the following shall be met by a board-approved course:

(1) Successful completion of laboratory experiences consisting of at least two bitewing radiographic series and two full mouth intraoral radiographic series using an

~~x-ray training mannequin designed for radiographic exposures utilizing any dental radiographic image receptor or device deemed appropriate by the course director.~~

~~(2) Successful completion of clinical experiences consisting of at least three full-mouth intraoral radiographic series using any dental radiographic image receptor or device deemed appropriate by the course director or supervising dentist.~~

~~(j) All clinical radiographs shall be made using diagnostic criteria established by the course of instruction and shall in no event exceed three reexposures per series.~~

~~(k) Before the student's performance of procedures on patients, the student shall provide evidence to the radiation safety course provider of having completed a board-approved eight-hour course in infection control and current, valid certification in basic life support.~~

~~(l) Completion of student and instructor written evaluations of each radiographic series identifying errors, causes of error, correction of errors, and, if applicable, the number of reexposures necessary for successful completion of a series to clinical competency.~~

~~(m) The student shall successfully complete a comprehensive written exam prior to the completion of the course. The exam shall include questions specific to items addressed in Article 4 (commencing with Section 30305) of Group 3 of Subchapter 4 of Chapter 5 of Division 1 of Title 17 of the California Code of Regulations relative to the special requirements for the use of x-ray in the healing arts.~~

~~(n) Extramural dental facilities may be utilized by a course for the purposes of clinical experiences. Clinical oversight shall be performed under the general supervision of a licensed dentist who shall authorize the student to perform, at minimum, three radiographic series. Didactic and laboratory instruction shall be provided only by course faculty or instructional staff prior to clinical performances.~~

~~(o) Programs and courses using extramural dental faculties for dental radiographic clinical experiences shall provide to the board, upon request or renewal of provider status, copies of all contracts of affiliation and documentation demonstrating compliance with board regulations.~~

~~(p) Upon successful completion of the course, students shall receive a certificate of completion as defined in subdivision (e) of Section 1741.~~

~~(q) The board may adopt regulations to implement this section.~~

Repeal Section 1755 of Article 7 of Chapter 4 of Division 2 of the Business and Professions Code as follows:

1755. (a) A course in infection control is one that has as its main purpose providing theory and clinical application in infection control practices and principles where the protection of the public is its primary focus.

(b) An unlicensed dental assistant not enrolled in a board-approved program for registered dental assisting or an alternative dental assisting program as defined in subdivision (a) of Section 1741, shall complete one of the following infection control certification courses:

(1) A board-approved eight-hour course, with six hours being didactic instruction and two hours being laboratory instruction.

(2) A board-approved eight-hour course, with six hours of didactic instruction and at least two hours of laboratory instruction using video or a series of video training tools, all of which may be delivered using asynchronous, synchronous, or online learning mechanisms or a combination thereof.

(c) A course shall establish specific instructional objectives. Instruction shall provide the content necessary for students to make safe and ethical judgments regarding infection control and asepsis.

(d) Objective evaluation criteria shall be used for measuring student progress. Students shall be provided with specific performance objectives and the evaluation criteria that will be used for didactic testing.

(e) Didactic instruction shall include, at a minimum, all of the following as they relate to Cal/OSHA regulations, as set forth in Sections 300 to 344.85, inclusive, of Title 8 of the California Code of Regulations, and the board's Minimum Standards for Infection Control, as set forth in Section 1005 of Title 16 of the California Code of Regulations:

(1) Basic dental science and microbiology as they relate to infection control in dentistry.

(2) Legal and ethical aspects of infection control procedures.

(3) Terms and protocols specified in Section 1005 of Title 16 of the California Code of Regulations regarding the minimum standards for infection control.

(4) Principles of modes of disease transmission and prevention.

(5) Principles, techniques, and protocols of hand hygiene, personal protective equipment, surface barriers and disinfection, sterilization, sanitation, and hazardous chemicals associated with infection control.

(6) Principles and protocols of sterilizer monitoring and the proper loading, unloading, storage, and transportation of instruments to work area.

(7) Principles and protocols associated with sharps management.

~~(8) Principles and protocols of infection control for laboratory areas.~~

~~(9) Principles and protocols of waterline maintenance.~~

~~(10) Principles and protocols of regulated and nonregulated waste management.~~

~~(11) Principles and protocols related to injury and illness prevention, hazard communication, general office safety, exposure control, postexposure requirements, and monitoring systems for radiation safety and sterilization systems.~~

~~(f) Upon successful completion of the course, students shall receive a certificate of completion as defined in subdivision (e) of Section 1741.~~

~~(g) The board may adopt regulations to implement this section.~~