

**Title 16, Dental Board of California
DEPARTMENT OF CONSUMER AFFAIRS**

INITIAL STATEMENT OF REASONS

Hearing Date: No Hearing Has Been Scheduled

Subject Matter of the Proposed Regulations: Minimum Standards for Infection Control

Sections Affected: California Code of Regulations, Title 16, Division 10, Section 1005

Background and Statement of the Problem:

The Dental Board of California (Board) licenses and regulates approximately 104,000 dental professionals pursuant to the provisions of the Dental Practice Act (“Act” – Bus. & Prof. Code, §§ 1600 and following), including dentists, registered dental assistants (RDAs), registered dental assistants in extended functions (RDAEFs), dental sedation assistants (DSAs), and orthodontic assistants (OAs). The Board also sets the duties and functions of unlicensed dental assistants and establishes standards for the issuance of permits to administer anesthesia and sedation. In carrying out this complex work, the Board's highest priority is the protection of the public.

BPC section 1614 authorizes the Board, in accordance with the Administrative Procedure Act (APA) (Government Code section 11400 et seq.), to adopt, amend, or repeal rules and regulations concerning the administration and enforcement of the Act. Business and Professions Code (BPC) section 1680, subdivision (ad), makes it unprofessional conduct, and therefore a ground for discipline to, without good cause, knowingly fail to protect patients by failing to follow infection control guidelines of this Board.

BPC section 1680(ad) further requires the Board to review infection control guidelines (Guidelines), if necessary, on an annual basis. Proposed changes to the Guidelines must also be reviewed by the Dental Hygiene Board of California (DHBC) by law. Section 1680, subdivision (ad), requires the DHBC to submit any recommended changes to the Guidelines to the Board for review “to establish a consensus.” According to existing Board regulations, licensees are specifically required to comply with the Board’s Guidelines, enforce them in their facilities, and maintain a written infection control protocol that is available to all dental healthcare personnel (DHCP).

The Board has adopted its Guidelines at California Code of Regulations (hereinafter “CCR”), title 16, section 1005, which were last revised 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 updates in the Centers for Disease Control's (CDC) "Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008" 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. Although Cal/OSHA's regulation has not been revised since 2009, the CDC's healthcare facilities guidelines were last updated in June 2024 (see Underlying Data from the CDC). Further, the CDC has also released other publications since 2011 that relate to infection prevention practices in dental settings, and there have been changes in California law and dentistry practice that should also be considered.

Beginning on April 15, 2024, the Board's and DHBC's working groups met to discuss possible updates to the Guidelines and further develop specific recommendations for discussion and possible action at Dental Assisting Council (Council), DHBC, and Dental Board meetings. These working groups met several times over a one-year period to consider possible updates and to draft proposed language for consideration by both Boards that included clarifying language and suggested amendments to reflect current minimum standards for infection control. Public board, Council and committee meetings to receive input on the two working group's joint recommendations were held by the DHBC in November 2024 and this Board in February 2025.

After consideration of prior public comments on this issue, the final proposed language recommended by the two working groups was considered and approved by the Dental Board at its May 14, 2025, Board meeting. Board staff submitted the proposed text to the DHBC for review and consensus. At its meeting on July 19, 2025, the DHBC approved the Dental Board's approved proposed language, and thereby reached consensus with the Board.

The proposed language contains updated Guidelines recommended by the Board's and the DHBC's subject matter experts and approved by both Boards. 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 (PPE), other potentially infectious materials (OPIM) and dental healthcare personnel (DHCP), as specified. In addition, the list of subjects covered by "standard precautions" would be updated to include hand hygiene "protocols and hand care," use of personal protective equipment, procedures for patient care items, safe handling and disposal of contaminated medical waste, respiratory hygiene or cough etiquette, and use of disinfectant agents in accordance with this section.

Amendments would also specify that standard precautions shall be used for care of

all patients regardless of “the procedure performed or the health history of the patient.”

(2) New definitions in subsection (a) 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, as specified.

(3) 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 at the treatment facility and reviewed and updated at least “annually” by the employer or employer-designated representative responsible for infection control compliance, and as needed to maintain compliance with CCR section 1005. 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 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), chin-length face shields and face visors, chemical and puncture-resistant utility gloves and chemical-resistant PPE, reusable protective eyewear, face shields and visors, 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,” “rash” or “weeping dermatitis” 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. The proposal also specifies chemical and puncture-resistant utility gloves shall be cleaned and disinfected or sterilized.

(E) updated standard precautions and protocols for cleaning, sterilizing and disinfecting items or surfaces, including use of EPA-registered products, the prescribed order for standard precautions for disinfection and sterilization, requirements for cleaning critical and semi-critical instruments if sterilized package is compromised (e.g., wet, torn or punctured), requirements for cleaning and disinfecting 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 to ensure all minimum standards for infection control are in one location.

(G) revised requirements for facilities (renamed more precisely “Treatment Facilities”) that includes requirements for non-critical items or clinical contact surfaces to be “physically 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 water lines shall be monitored or tested routinely in accordance with manufacturer’s instructions.

(H) the addition of new requirements for laboratory equipment cleaning (including handpieces, polishing (rag) wheels, grinding wheels, and laboratory burs, used to polish, trim, or adjust contaminated appliances and intraoral prosthetic devices), 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 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 specified.

(3) The addition of a new training requirement in subsection (c) for all dental healthcare personnel (DHCP) who are employers of other DHCP 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 specified in subsection (b)(2). 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 of California 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 and establishing a “consensus” since it does not appear to be necessary. BPC section 1680(ad) already requires the two Boards to review the Guidelines on an annual basis “if necessary” and to review the Guidelines to establish a “consensus.”

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

Anticipated Benefits of the Regulations

Updates to the Board’s Guidelines for infection control establish the minimum infection prevention and control standards required of all dental healthcare personnel (DHCP) covered by this proposal to protect the health and safety of patients, staff, and the broader community. It ensures alignment with, and enforcement of, current evidence-based practices and supports statewide consistency in the delivery of safe dental care.

The proposal helps safeguard public health by ensuring that all DHCP adhere to up-to-date infection prevention and control practices to help ensure currency of scientific knowledge, preparation for emerging infectious threats, and use of advancements in dental technology including compliance with:

- Standard precautions
- Protocols for cleaning, sterilization, and disinfection of instruments and devices
- Requirements for clinical surface cleaning and disinfection
- Dental unit waterline quality and maintenance standards
- Personal protective equipment (PPE) use requirements
- Hand hygiene protocols and hand care standards
- Respiratory hygiene/cough etiquette measures

- Staff training and documentation of compliance requirements

Updating and enforcing infection control standards strengthens patient and worker safety, reduces the risk of bloodborne infectious diseases, promotes consistency in safeguards across dental practices, and enhances public trust in the state's dental care system.

Specific Purpose of, and Factual Basis/Rationale for each adoption, amendment or repeal

The Board proposes to:

Amend Section 1005 Relating to Minimum Standards for Infection Control.

Renumbering and re-ordering paragraphs within CCR section 1005(a)

Purpose and Rationale: Currently, subsection (a) contains a list of definitions and terms used within this subsection listed in the following order:

- (1) Standard precautions
- (2) Critical items
- (3) Semi-critical items
- (4) Non-critical items
- (5) Low-level disinfection
- (6) Intermediate-level disinfection
- (7) High-level disinfection
- (8) Germicide
- (9) Sterilization
- (10) Cleaning
- (11) Personal Protective Equipment (PPE)
- (12) Other Potentially Infectious Materials (OPIM)
- (13) Dental Healthcare Personnel (DHCP)

The Board proposes to re-order this list of definitions based on what it believes is the order of importance from a clinical perspective and not alphabetically. 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. Existing definitions proposed to be added or repealed are discussed further below.

As a result of the renumbering and proposed additional changes, the definitions would include the following and follow this order in subsection (a):

- (1) Standard precautions
- (2) Personal Protective Equipment (PPE)
- (3) Other Potentially Infectious Materials (OPIM)
- (4) Instrument/Device Classifications (with subparagraph numbering added as (A), (B) and (C) for existing “Critical items”, “Semi-critical items”, and “Non-critical items” definitions proposed to be listed under this new heading)
- (5) Disinfect or disinfection
- (6) Disinfection classifications
- (7) Cal/EPA-registered
- (8) Sterilization
- (9) Cleaning
- (10) Dental Healthcare Personnel (DHCP)
- (11) “Contaminated medical waste”

Amend CCR section 1005(a)(1)

Purpose: This subsection sets forth the definition of the term “Standard precautions” and would be amended, as follows:

(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.

Rationale: As noted above, the Board proposes to partially repeal the existing standard precautions definition in the first sentence and to add the above-noted language that more accurately describes and provides greater notice of what a standard precaution means for the purposes of this section. This section sets forth protocols and procedures established for use in any dental healthcare setting and the Board has therefore amended it to conform to that purpose. The amended text more clearly specifies that the defined “standard precautions” apply to all patients treated in any setting in which “dental” healthcare is delivered to ensure all patients and personnel receive protection from infectious diseases, and to ensure consistent precautions are utilized in the provision of dental healthcare. In the Board’s experience, these amendments are necessary to avoid possible confusion

regarding whether these precautions are applicable in any setting in which dental healthcare is delivered.

The amendments would also repeal a reference to “use of gloves, gown, mask, eye protection or face shield, depending on the anticipated exposure,” as the Board believes a more comprehensive list is necessary to capture all subject matter requirements proposed by the amendments to this section. The amended text provides a more comprehensive general definition with an expanded list that would include all topics covered by this section including use of personal protective equipment, procedures for patient care items, safe handling and disposal of contaminated medical waste, respiratory hygiene or cough etiquette, and use of disinfectant agents. Punctuation changes would be made to add commas between phrases to accommodate the additions and deletions of the proposed text referenced above.

The amended text also repeals the reference to “their diagnoses or personal infectious status” and adds “the procedure performed or the health history of the patient” to more clearly align with the intent that standard precautions apply to all patients with no risk assessment needed. This revision also avoids any possible confusion about when standard precautions would be used for the care of the patient in a more practical way, i.e., used for care of all patients regardless of the procedure performed or the health history of the patient.

Amend CCR sections 1005(a)(2), (a)(3) and (a)(4) (renumbered as (a)(4)(A), (a)(4)(B), and (a)(4)(C), and addition of new introductory paragraph (a)(4)

Purpose: In accordance with the paragraph renumbering noted above, the existing paragraphs at CCR sections 1005(a)(2), (a)(3) and (a)(4) would be renumbered as (a)(4)(A), (a)(4)(B), and (a)(4)(C) and a new introductory paragraph (a)(4) would be added entitled “Instrument/device classifications” and would provide a definition that would specify that these classifications include categories used to identify patient care items (“items” – a shorthand reference for ease of use) 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. This proposal would also amend existing definitions for critical, semi-critical and critical items 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.

Rationale: Existing regulations in these subsections follow the CDC’s classification system for patient-care items based on infection transmission risk as follows: Critical (highest risk, penetrates tissue/bone, requires sterilization), Semi-critical (touches mucous membranes, requires high-level disinfection/sterilization), and Non-critical (contacts skin, requires low-level disinfection) (see Underlying Data and the following: (1) CDC’s Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008 (Last Update: June 2024), and (2) “Summary of Infection Prevention Practices in Dental Settings -- Basic Expectations for Safe Care”, October 2016 – hereinafter referred to as “CDC’s Guidelines for Dental Settings”).

However, there is currently no general explanation in the regulations for what these terms mean and why they are used. To address this issue consistent with the CDC’s Guidelines, the Board proposes to add a definition that explains that these classifications include categories used to identify patient care items (“items” – a short-hand reference for ease of use) 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. This ensures greater notice and guidance to users regarding what these classifications mean, what types of dental instruments and devices they apply to, and what the associated level of sterilization or disinfection is required for safe practice consistent with CDC recommendations.

The amended text also would feature a clear breakdown of each classification into newly numbered paragraphs under subsection (a)(4) to help identify the kinds of instruments or devices being used as critical, semi-critical, or non-critical and would update the language used in these classification for the following reasons:

(A) “Critical items”: The Board proposes to repeal the existing regulation definition that states: “confer a high risk for infection if they are contaminated with any microorganism.”

While this definition is technically accurate, the Board proposes to amend it to define critical items to mean “carry the highest risk of transmitting infection” to emphasize the highest degree of risk associated with these items since they directly contact or penetrate soft tissue or bone. Consequently, any contamination of an instrument, device or other item can cause immediate, life-threatening infections, such as bloodstream infections or sepsis. This interpretation is also similar to the CDC’s Guidelines for Dental Settings, which describe critical items as having the “greatest risk of transmitting infection.” (See p. 12.)

Existing regulations for this section also use the term “Other items used to penetrate soft tissue or bone,” without any further explanation of what that might mean. To address this ambiguity, the Board proposes to add the following examples of the instruments that would qualify as they do penetrate soft tissue or bone: “such as such as surgical instruments, periodontal instruments, hygiene scalers, and burs.”

(B) “Semi-critical items”: The Board proposes to repeal part of the existing regulation definition that states that semi-critical items include 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).” While this definition is technically accurate, the Board proposes to amend it to define semi-critical items to more closely align with every day dental practice and that would more comprehensively include all items that “come into contact” with oral tissue (in general), blood, or OPIM without penetration. To further provide notice of the types of items that would qualify as a “semi-critical”, the Board adds commonly recognized items in dental practice that “come into contact” with a patient’s oral tissues, blood or OPIM: “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.”

(C) “Non-critical items”: The Board proposes to add a parenthetical for greater understanding and ease of use that includes a new short-form reference for “clinical contact surfaces.” This is necessary for consistency in interpretation since the terms “clinical contact surfaces” and “surface” are used throughout this regulation when referring to infection control practices for these types of surfaces (described in this paragraph and commonly understood in the regulated community as high-touch areas that come in contact with soil, debris, OPIM and intact skin during patient care). For greater understanding and consistency with CDC Guidelines, the Board also proposes to also add a parenthetical to further define “soil” as “(e.g., organic and inorganic material).” (See, CDC’s Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008 (Last Update: June 2024), p. 10.)

For greater notice of the types of items that qualify as “semi-critical” in the dental setting using terms commonly understood in the regulated community, the Board proposes to

add “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.”

Adopt CCR section 1005(a)(5)

Purpose: This subsection sets forth the definition for the terms “Disinfect” or “disinfection,” which means the use of a chemical solution to reduce or lower the number of microorganisms on inanimate objects using a Cal/EPA-registered product.

Rationale: Existing regulations do not define the terms “disinfect” or “disinfection” as the terms are used in this section. The adopted text would resolve that ambiguity by adopting a definition that specifies what is commonly understood as a disinfectant in a dental setting and consistent with existing California regulatory requirements. By adding the process of using a “chemical solution” to this definition, the Board incorporates the method of disinfection commonly used in dental facilities to achieve the objective of reducing or lowering the number of microorganisms on inanimate objects. The addition of the use of a Cal/EPA-registered product is necessary to comply with California law. Disinfectants intended for sale or use in California must be registered with the California Department of Pesticide Regulation (DPR), which is part of the Cal EPA (Food & Agr. Code, §§ 12993, 12753 and 12754.5.) The definition is also consistent with existing and proposed regulations in this section that mandate use of Cal/EPA-registered disinfectants to be considered compliant with the Board’s infection control standards.

Adopt CCR section 1005(a)(6) and Amend Existing subsections (a)(5), (a)(6), and (a)(7) to (a)(6)(A), (a)(6)(B), and (a)(6)(C)

Purpose: This subsection sets forth the definition of the term “Disinfection classifications,” which specifies that the defined “Disinfection classifications” are categories used to determine the effectiveness of a disinfectant agent to inactivate mycobacterium during surface disinfection procedure. Existing paragraphs

Rationale: Existing regulations do not specify the purpose of the “low-level”, “intermediate-level” and “high-level” disinfection categories. The amended text would address that omission and provide greater notice of the intent and purpose of this section by adding an introductory sentence (new subsection (a)(6)) that explains that these categories are used to determine the effectiveness of a disinfectant agent to inactivate mycobacterium during surface disinfection procedure.

The amended text now features a clear breakdown of each classification into newly lettered subparagraphs in subsection (a)(6) that clarify (A) Low-level disinfection, (B) Intermediate-

level disinfection, and (C) High-level disinfection. The words “kill”, “kills” or “killed” has been changed to “inactivate”, “inactivates” or “inactivated” throughout this section to provide a more scientific and precise description for non-spore-forming pathogens. The term “inactivate” more accurately describes the process of rendering mycobacterium unable to reproduce or cause infection, which may involve mechanisms other than immediate cellular death (see Underlying Data from CDC’s Guidelines for Environmental Infection Control in Health-Care Facilities (2003), updated July 2019, which uses the term “inactivate” throughout.). The term is also consistent with the introductory sentence added as a new subsection (a)(6), which uses the term “inactivate.” The word “some” in subsection (A) is deleted as duplicative since the introductory phrase already includes the word “some,” which applies to the words “bacteria, viruses, and fungi.”

“High-level disinfection” in subsection (a)(6)(C) would be amended to repeal the existing definition and replace it with a definition that the Board believes more accurately describes the disinfection process and consistent with CDC guidance that states, The process of high-level disinfection, an appropriate standard of treatment for heat-sensitive, semi-critical medical instruments (e.g., flexible, fiberoptic endoscopes), inactivates all vegetative bacteria, mycobacteria, viruses, fungi, and some bacterial spores.” (See Underlying Data, p. 87 of CDC’s Guidelines for Environmental Infection Control in Health-Care Facilities (2003), updated July 2019.)

Adopt CCR section 1005(a)(7)

Purpose: This subsection has been adopted to set forth a definition for the term “Cal/EPA-registered” to mean a product registered by the U.S. Environmental Protection Agency (EPA) and the California Department of Pesticide Regulation for sale and use in California as a pesticide.

Rationale: This definition is necessary to make the Board’s regulation consistent with existing California law. In California, pesticide registration is governed by both state law and regulations that mandate federal approval as a prerequisite for most products. As noted above in the rationale for subsection (a)(5), disinfectants intended for sale or use in California must be registered with the California Department of Pesticide Regulation (DPR), which is part of the Cal EPA (Food & Agr. Code, §§ 12993, 12753 and 12754.5.) Further, under California Code of Regulations, title 3, section 6170, applicants must submit all data provided to the U.S. EPA to the California Department of Pesticide Regulation (DPR) and proof of federal approval for the label, if any, as part of registering with the DPR. This definition therefore provides advance notice and specificity regarding what the Board means by “Cal/EPA-registered” consistent with state law.

Repeal CCR section (a)(8)

Purpose and Rationale: The Board proposes to repeal the current definition for “germicide” in this subsection. According to CDC Guidelines, germicides include both antiseptics (for living tissue) and disinfectants (for inanimate objects) (See CDC’s Glossary in the Guideline for Disinfection and Sterilization in Healthcare Facilities (2008), last update June 2024.) While germicides kill germs, the term “disinfectant” specifically refers to EPA-registered chemical agents used on inanimate objects. Since “germicides” are a form of disinfectant and the term “disinfectant” is the term most commonly used by in this context, the Board proposes to eliminate this term and its definition in this subsection as unnecessary. The use of disinfectants and their associated requirements for disinfection by category are already covered in this section.

Amend CCR section 1005(a)(9) and renumber as (a)(8)

Purpose: This subsection sets forth the definition for the term “Sterilization” and would be amended to remove the words “render a product free of all forms of viable microorganisms,” and replace it with “eliminate all forms of microbial life using acceptable methods of sterilization set forth in this section.” This subsection would also be renumbered to accommodate the changes made by removing existing subsection (a)(8) and for better organization.

Rationale: CDC guidelines describe sterilization to mean the use of a physical or chemical procedure **to destroy all microbial life**, including large numbers of highly-resistant bacterial endospores.” (Emphasis added. See Underlying Data, Glossary of CDC’s Guidelines for Environmental Infection Control in Health-Care Facilities (2003), last updated July 2019.) The Board believes these revisions are necessary to more accurately describe what sterilization process means in this context, and which is defined similarly in CDC guidelines noted above.

Existing text also does not completely address what “validated process” means in this context. The amended rephrasing provides better notice and clarity of meaning to the reader by tying the “validated process” to “acceptable methods of sterilization set forth in this section” (see subsections (b)(8)(C) and (D) – which cover acceptable sterilization methods depending on the type of item).

Amend CCR section 1005(a)(10) and renumber as (a)(9)

Purpose: This subsection would also be renumbered to accommodate the changes made by removing existing subsection (a)(8) and for better organization. This existing subsection sets forth the definition for the term “Cleaning,” and would be amended to remove a parenthetical definition for “visible soil” (e.g. organic and inorganic material), add the term “blood” to the list of items requiring removal, and add a new requirement that prior to the use of a sterilization device or disinfectant for surface disinfection, one of two applicable

methods listed in newly proposed subparagraphs (A) and (B) would need to be used. Subparagraphs (A) and (B) would include the following:

(A) Cleaning of clinical contact surfaces and non-critical items means 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 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.

Rationale: The amended text would remove the parenthetical since the Board believes that the removal of any visible soil of any type should be mandated for greater public protection. The addition of "blood" to the list of items that would require removal from objects and surfaces is added to provide greater notice of the most encountered items in the dental health care setting that necessitate removal to prevent infection. A comma is added after "soil" for proper punctuation and to correct an inadvertent error in the existing sentence.

In addition, the amended text now features a clear breakdown of each of the two cleaning methods required in a dental setting into newly lettered subparagraphs "(A)" cleaning of clinical contact surfaces and "(B)" cleaning of semi-critical or critical items, and which would specify required methods of cleaning prior to the use of a sterilization device or disinfectant for surface disinfection. As CDC Guidelines state:

"Cleaning is the necessary **first step** of any sterilization or disinfection process. Cleaning is a form of decontamination that renders the environmental surface safe to handle or use by removing organic matter, salts, and visible soils, all of which interfere with microbial inactivation. The physical action of scrubbing with detergents and surfactants and rinsing with water removes large numbers of microorganisms from surfaces. **If the surface is not cleaned before the terminal reprocessing procedures are started, the success of the sterilization or disinfection process is compromised.**" (Emphasis added. See, Underlying Data from the CDC's Guidelines for Environmental Infection Control in Health-Care Facilities (2003) Last update: July 2019, pgs. 86-87).

As a result, these amendments are an important additional level of infection control for public protection and are needed to provide instruction on how to meet the Board's cleaning standards for affected objects and surfaces as set forth in subparagraphs (A) and (B).

Specifically, subparagraph (A) requires that clinical contact surfaces and non-critical items must be cleaned thoroughly by scrubbing with water and a detergent or by applying a surface disinfectant, either of which is registered with Cal/EPA as a disinfectant to clean surfaces or items in accordance with the manufacturer's instructions. In the Board's experience, this procedure is essential to remove inorganic or organic material, such as blood or saliva, which can interfere with disinfectant effectiveness, and to ensure proper microbial reduction. Using only Cal/EPA registered disinfectants to clean (either a detergent that claims to kill bacteria or viruses on its label or a surface disinfectant, both of which are required to register with Cal/EPA) guarantees compliance with state regulations as noted above and provides assurance that products have been tested for safety and efficacy. Also, in the Board's experience, ensuring the disinfectant is used according to manufacturer's instructions is the minimum standard needed to ensure that the disinfectant is used correctly and safely for the protection of the public. Adhering to these requirements helps prevent cross-contamination and supports infection control standards in dental treatment facilities.

Subparagraph (B) would require cleaning for semi-critical or critical items to include 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 and would further specify what "acceptable mechanical cleaning devices" would include. As noted in the rationale above for subparagraph (A), cleaning is the foundation of infection prevention. If visible soil, debris, blood and OPIM remain, sterilization can fail, leading to cross-contamination and serious infections. Semi-critical and critical items (e.g., surgical instruments, periodontal instruments) come into contact with soft tissue or bone, so they pose a high risk of infection. Visible soil, blood, and organic debris must be physically removed before sterilization or high-level disinfection because these contaminants can shield microorganisms from the sterilizing agent.

As noted above, the CDC recommends mechanical cleaning or manual scrubbing as the first step in cleaning to ensure that sterilization or disinfection processes are validated and effective. Long-handled brushes allow safe manual cleaning while minimizing staff exposure to sharps and contaminants. FDA-approved mechanical cleaning devices (e.g., ultrasonic cleaners, automated washers approved under the authority conferred by the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 301 et. seq.)) ensure consistent, thorough cleaning and reduce human error. Requiring the use of detergents or enzymatic products ensures consistency in cleaning, since these products are specifically formulated to break

down proteins, fats, and other organic matter that prevent residue buildup that could compromise sterilization and damage instruments.

Specifying that acceptable mechanical cleaning devices must include ultrasonic cleaners that use enzymatic products or detergents, which effectively remove debris from complex instrument surfaces, or devices manufactured specifically for washing and mechanically drying dental instruments, cassettes, and devices prior to preparing for sterilization is necessary to ensure consistent cleaning and safe practice. These methods ensure thorough removal of organic material, reduce the risk of cross-contamination and sharps injuries, and guarantee instruments are completely clean and dry before sterilization, which is essential for compliance with infection control standards and patient or personnel safety. Finally, in the Board's experience, ensuring that cleaning devices are used according to the manufacturers' instructions for the device or item type and quantity to be cleaned is the minimum standard needed to ensure that the equipment used is operated safely and effectively for the protection of the public.

Amend CCR section 1005(a)(11), renumbered to (a)(2)

Purpose: This subsection sets forth the definition for the term "Personal Protective Equipment" (PPE) and would be amended to add two commas to correct punctuation in this paragraph, strike "body fluids" and "OPIM" and replace them with the phrase "other potentially infectious materials." As noted in the rationale above for the section "Renumbering and re-ordering paragraphs within CCR section 1005(a)", this paragraph would be renumbered from (a)(11) to (a)(2) to reflect the importance of this concept from a practice perspective.

Rationale: As amended, the text would feature the newly added words "other potentially infectious materials" to replace "body fluids" as this term is covered by the broader, more comprehensive term "other potentially infectious materials." A definition is provided in existing CCR section 1005(a)(12)(proposed to be renumbered to (a)(3)) for "Other Potentially Infectious Materials" that includes body fluids and that subsection also uses the acronym "(OPIM)." However, since this is the first time that the term would be listed in this regulatory section, the Board proposes to strike the acronym "OPIM" in paragraph (a)(2) to avoid confusion for users, leaving the OPIM acronym to appear for the first time in (a)(3) so that the meaning is readily apparent.

Amend CCR section 1005(a)(12), renumbered to (a)(3)

Purpose and Rationale: This subsection sets forth the definition for the term "Other Potentially Infections Materials" (OPIM) and would be amended to remove the word "one" as unnecessarily redundant since the sentence already states that OPIM means "any" of the following listed items in this subsection. As noted in the rationale above for the section

“Renumbering and re-ordering paragraphs within CCR section 1005(a)”, this paragraph would be renumbered from (a)(12) to (a)(3) to reflect the importance of this concept from a practice perspective.

Amend CCR section 1005(a)(13), renumbered to (a)(10)

Purpose: This subsection sets forth the definition for the term “Dental Healthcare Personnel” (DHCP) and would be amended to repeal the term “dental healthcare setting” and replace it with “treatment facility”, and to repeal “body substances” and replace it with “blood and OPIM,”.

Rationale: The amended text would more precisely describe the setting where dental healthcare personnel (DHCP) work and use the defined terms “blood and OPIM” to resolve any ambiguity regarding what “body substances” are considered infectious and that DHCP might be occupationally exposed to. Using the defined term of “OPIM” as set forth in CCR section 1005(a)(3) also helps with consistency in the text.

Adopt CCR section 1005(a)(11)

Purpose: The adopted text specifies that the defined “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.

Rationale: Proposed regulations refer to “contaminated medical waste” without specifying what that means. The primary purpose is to distinguish between items that genuinely pose a risk of disease transmission and those that do not, even if they were used in a dental healthcare setting. Section 117690 of the California Health and Safety Code defines “medical waste” under California’s Medical Waste Management Act. It specifically covers waste generating in health care facilities including biohazardous, pathology, pharmaceutical, or trace chemotherapy waste, sharps, and other waste generated during diagnosis, treatment, immunization, or research. This helps ensure proper identification, handling, and disposal of materials that pose an infection risk, such as items contaminated with blood or body fluids. Items listed in Health and Safety Code section 117700 are specifically excluded because they do not present an infectious hazard. Key exclusions defined in Section 117700 include: food waste and common solid waste (e.g., paper towels, products, and articles without blood or bodily fluids), preventing unnecessary operational burdens while maintaining safety and regulatory consistency. This added text ensures proper notice of waste handling requirements by way of definition and provides consistency of interpretation in specifying regulated waste handling requirements under California law.

Amend CCR section 1005(b)

Purpose and Rationale: This section has been amended to add the words “all applicable” before the words “infection control” and “applicable” before the words about minimum standard precautions. This is necessary to avoid possible confusion since not every dental setting encounters the various issues outlined in this regulatory section. For example, not all DHCP are employers (see subsection (b)(2)). The Board also proposes to add the word “standard” before “precautions” for consistency in terminology throughout this section and to conform with how these infection control standards are referred to generally by the CDC in its publications (see Underlying Data).

The amended text would also include the words “in the treatment facility” to more precisely describe the setting where DHCP work and for consistency in the text for this section (see proposed amendments to subsection (b)(10)).

Amend CCR section 1005(b)(1)

Purpose and Rationale: This section has been amended to repeal “practiced” and add the word “used.” This change is necessary for better readability and to avoid user confusion when these standards are expected to be “used” in every applicable case.

Amend CCR section 1005(b)(2)

Purpose: This section has been amended strike references to a “written protocol” required to be developed, maintained and periodically updated, as specified, and to strike the requirement that the protocol shall be made available to all DHCP at the dental office. Instead, the Board would specify that the infection control plan detailing the protocols and procedures 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.

Rationale: Existing regulations require a “written protocol” but do not specify the minimum requirements for the content of that protocol or on what basis the protocol would need to be updated to be considered compliant with the Board’s minimum standard precautions. To address these issues, the Board proposes to require a written 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. These requirements also ensure currency of knowledge among DHCP in all of the Board’s minimum standards for infection control.

An infection control plan that is developed, maintained, and regularly updated is essential to protect patients and personnel by preventing the spread of infections. It ensures compliance with the Board's regulatory standards and reduces the risk of transmission of bloodborne infectious diseases by providing clear, consistent protocols and procedures for DHCP. Regular updates allow the plan to incorporate regulatory changes and new evidence-based practices to respond to emerging threats like pandemics or resistant organisms. By standardizing procedures and promoting accountability ("in accordance with the Board's requirements in this section), the plan would support patient safety, staff training, and emergency preparedness, making it a critical component of public protection.

The requirements for a written infection control plan to be readily available to all Dental Health Care Personnel (DHCP) and reviewed and updated at least annually are necessary because it ensures that every staff member has immediate access to clear, standardized protocols for preventing infection, and promoting consistency and safety in patient care and worker safety. In the Board's experience, regular reviews and updates by the employer or employer-designated representative are critical to maintain compliance with the Board's current regulations and allow them address emerging infectious threats. This process reinforces accountability, supports staff training, and ensures the facility remains prepared for Board inspections and public health emergencies, ultimately safeguarding both patients and dental healthcare workers.

Amend CCR section 1005(b)(3)

Purpose: This section has been amended to repeal the words "dental office" and to specify that a copy of this regulation shall be conspicuously posted in each "treatment facility and included in the written infection control plan described in paragraph (2)."

Rationale: Existing regulations already require conspicuous posting of a copy of this regulation in each dental office greater notice and awareness of regulatory requirements for DHCP. This section would be amended to repeal "dental office" and replace it with "treatment facility" for consistency in the text proposed to be amended in subsection (b). Also requiring a copy of this regulation to be included in the written plan (as noted above in paragraph (2)) ensures DHCP can easily access and follow the requirements. This dual approach promotes transparency, reinforces regulatory standards, and helps maintain a safe environment for both patients and staff by having a well-informed regulated community.

Amend CCR section 1005(b)(4) and renumber introductory phrase to (4) and existing subsection (4) to (4)(A)

Purpose: This subsection sets forth the minimum standards for Personal Protective Equipment (PPE – an acronym added for ease of reference) and would be amended to

remove punctuation “.” and add “(4)” before the words “Personal Protective Equipment (PPE)”. This introductory paragraph would precede new renumbered and additional paragraphs set forth in (B)-(F) (further discussed below) for greater comprehension of related subject matter. Existing subsection (4) would become (4)(A) for better organization. The new subsection (b)(4)(A) would include the following amendments:

(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 ~~germicide~~ disinfectant agents, or OPIM. For 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).

Rationale: This subsection has been amended to specify in new subparagraph (A) that all DHCP shall wear “single-use, disposable” surgical facemasks to avoid any ambiguity regarding whether reusable facemasks might meet the Board’s standards during patient treatment and stress rather that such masks must be single use, disposable masks to meet standards “during patient treatment.” This requirement is necessary to specify that DHCP wear single-use, disposable surgical facemasks during patient treatment because they are a critical component of Standard Precautions designed to prevent the transmission of infectious agents. Masks protect the mucous membranes of the nose and mouth from exposure to blood, saliva, respiratory secretions, and other potentially infectious materials (OPIM) that can be generated during dental procedures through splashes, sprays, or aerosols. They also help reduce the risk of cross-contamination between patients and staff. This practice aligns with CDC guidelines for infection control in dental settings and is essential for ensuring patient and provider safety. (See Underlying Data, CDC’s “Guidelines for Infection Control in Dental Health-Care Settings — 2003,” dated December 19, 2003.)

This proposal would also amend this paragraph by deleting the word “germicide” and replacing it with “disinfectant.” As noted above in the rationale for repeal of existing CCR section (a)(8), the Board believes that the word “disinfectant” is the more accurate term.

Finally, proposed amendments to this paragraph would add a new definition for “protective eyewear,” consistent with what the Board believes is the minimum standard for eye protection in the dental setting, which 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 – to ensure accuracy in identifying compliant safety glasses – see Underlying Data). In the

Board's experience, this standard ensures the eyewear provides adequate protection against hazards commonly encountered in dental settings. Dental procedures often involve high-speed instruments that can generate flying particles, debris, and fragments. ANSI Z87.1-certified eyewear is tested for impact resistance, reducing the risk of eye injuries to DHCP. Further, dental treatment often includes exposure to saliva, blood, and chemical splashes, as well as aerosols that can carry infectious agents. Side shields prevent these materials from entering around the edges of the glasses for the protection of DHCP. Providing certified protective equipment minimizes the risk of workplace injuries, supports infection control, and protects both DHCP and patients and is recognized by federal OSHA regulations as a method of meeting eye protection requirements. (See 29 CFR § 1910.133(b)(1) requiring employers to provide eye protection when the employee is exposed to eye or face hazards from flying particles and mandating that eye and face protection comply with consensus standards set by the American National Standards Institute (ANSI) Z87.1.)

Add new subparagraph (B) to CCR section 1005(b)(4) and amend existing text

Purpose: Subparagraph (B) would be added to this subsection for greater understanding of PPE standards and existing language amended to add the requirement that 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. The Board also proposes to repeal this existing sentence in this paragraph: "Chemical-resistant utility gloves and appropriate, task specific PPE shall be worn when handling hazardous chemicals." The Board would also add to this paragraph the word "surgical face" in front of "masks" for consistency in terminology throughout this section and add that that such masks shall be changed and disposed "when leaving laboratories or areas of patient care activities."

Rationale: For the reasons noted above in subparagraph (A), a new, single use, disposable surgical facemask shall be used for each patient, and to reduce transmission risk, the Board adds the requirement that the facemask shall be used for each patient at the beginning of their treatment session. Requiring mask replacement any time it becomes moist or soiled is necessary for infection prevention and to maintain the mask's function. Surgical facemasks in dental settings must be replaced whenever they become moist or soiled because moisture and contamination significantly reduce the mask's filtration ability, allow more particles to pass through, and can promote microbial growth, making the mask no longer an effective barrier. In addition, splatter and aerosols generated during dental procedures can contaminate the mask surface, increasing the risk of cross-contamination.

The Board removes the sentence relating to requirements for "chemical resistant utility gloves and appropriate, task specific PPE" as more accurate requirements are being added to this PPE to explain what "task specific" requirements the Board intends to cover and the

glove requirements are covered more thoroughly in proposed amendments to CCR section 1005(b)(4)(D) and (b)(6).

The Board also adds the requirement that surgical facemasks shall be changed and disposed “when leaving laboratories or areas of patient care activities” because once a mask has been used in a clinical or laboratory environment, it may be contaminated with aerosols, droplets, or microorganisms. Wearing that same mask into clean, non-clinical areas increases the risk of carrying contaminants out of the patient-care zone, potentially spreading pathogens to administrative areas, staff break rooms, or other personnel. Removing and discarding the mask when exiting these areas prevents cross-contamination. CDC guidance also recommends removal of all PPE (including facemasks) before leaving the work area (See Underlying Data, CDC’s Guidelines for Dental Settings and CDC’s “Dental Infection Prevention and Control – Standard Precautions” dated May 15, 2024).

Add new subparagraph (C) to CCR section 1005(b)(4) and amend existing text

Purpose: This subsection would add a new subparagraph (C) and amend existing text to specify that 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. Further amendments would add the phrase “when leaving laboratories or areas of patient care activities” to the existing requirement that after each patient treatment, face shields and protective eyewear shall be cleaned, disinfected, or disposed.

Rationale: The Board specifies that chin-length face shields and face visors are acceptable replacements for protective eyewear in dental settings—when worn with a surgical facemask—because they meet CDC’s requirements for eye protection by fully covering the front and sides of the eyes, provide an effective barrier against splatter and aerosols generated during dental procedures, and offer broader coverage than goggles by also protecting parts of the face and the mask itself. (See Underlying Data, CDC’s Guidelines for Infection Control in Dental Health-Care Settings (2003), dated December 19, 2003.)

However, since face shields and face visors do not provide respiratory protection, the Board specifies that they are only acceptable in combination with a surgical mask, not as a standalone device. For the same reasons noted above for similar amendments in subparagraph (B) above, the Board adds the requirement that face shields and protective eyewear shall be disposed “when leaving laboratories or areas of patient care activities.”

Add new subparagraph (D) to CCR section 1005(b)(4)

Purpose: Subparagraph (D) would be added to specify that 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).

Rationale: The Board would add this requirement because regular exam gloves and standard PPE cannot protect against chemical burns, skin irritation, or puncture injuries during instrument cleaning and disinfection. Utility gloves prevent sharps injuries, and chemical-resistant PPE blocks harmful disinfectants and sterilants from contacting skin and eyes of DHCP.

In addition, adopting these standards ensures compliance with state and federal laws and guidelines for employee protection in this setting. The Occupational Safety and Health Administration (OSHA)'s Hazard Communication Standard (29 CFR 1910.1200) and the PPE Standard (29 CFR 1910.132) require employers to ensure workers wear PPE appropriate to the hazards identified in each chemical's Safety Data Sheet. In particular, OSHA requires manufacturers to specify the PPE needed for each chemical and requires employers to ensure workers are trained to use that PPE as part of their overall hazard-protection responsibilities (see 29 CFR 1910.1200(g)(1), (2), 29 CFR 1910.1200(h)(3)(iii)).

Additionally, CDC's Guidelines for Infection Control in Dental Health-Care Settings (See Underlying Data, dated December 19, 2003) recommend that dental staff use heavy-duty utility gloves and appropriate protective equipment for instrument processing and chemical handling, ensuring safety and compliance with federal infection-control and workplace-safety requirements.

Finally, Title 8, California Code of Regulations section 5193 (Cal/OSHA Bloodborne Pathogens Standard) further requires employers to provide PPE that is appropriate, readily accessible, and resistant to the hazards encountered, including utility gloves, gowns, aprons, and face and eye protection. Adding these glove requirements ensures consistency with these requirements, proper protection for DHCP and full compliance with federal and California occupational safety laws.

Add new subparagraph (E) to CCR section 1005(b)(4)

Purpose: Subparagraph (E) would be added to specify that reusable protective eyewear, face shields, and visors shall be washed with soap and water, or if visibly soiled, cleaned and disinfected between patients.

Rationale: This requirement is necessary because these items are frequently contaminated with saliva, blood, aerosols, and splatter during dental procedures and can transmit microorganisms if not properly cleaned and disinfected. CDC's Guidelines for Infection

Control in Dental Health-Care Settings (See Underlying Data, MMWR 2003) explicitly state that “reusable protective eyewear should be cleaned and disinfected between patients” and that visible soil must be removed before disinfection to ensure effectiveness. By specifying these steps, dental facilities ensure consistent compliance with CDC guidance, reduce the risk of transmitting infectious agents, and maintain safe practices for both patients and DHCP.

Add new subparagraph (F) to CCR section 1005(b)(4) and amend existing text

Purpose: Subparagraph (F) would be amended to strike the words “germicides” and “germicidal” and replace those terms with the word “disinfectants” or “disinfectant” and add the word “when” for greater understanding of the timing of when these standards would apply in the first sentence related to the wearing of protective attire. The proposed amendments would add requirements that all DHCP shall wear reusable or disposable protective attire “during patient treatment,” and “or” (to accommodate the addition of this phrase). The Board would remove the word “must” and replace it with a stronger regulatory directive of “shall” to avoid confusion and for consistency of terminology in this section. The Board would remove the requirement for changing attire “if they should become moist or visibly soiled” and add the requirement that protective attire shall be changed “immediately” if the attire becomes soiled with blood or OPIM.

Rationale: As noted above, the term “germicide” is proposed to be repealed since it would be replaced by the more accurate term “disinfectant.” Wearing protective attire during patient treatment in a dental office is essential because it serves as a physical barrier that protects DHCP from exposure to blood, saliva, respiratory droplets, and other potentially infectious materials generated during routine dental procedures. Dental environments produce significant aerosols and splatter, and protective attire—such as gowns, lab coats, and jackets—prevents these contaminants from contacting the clinician’s skin or street clothes, reducing the risk of transmitting pathogens like hepatitis B, hepatitis C, HIV, and airborne or droplet-borne infections. This practice aligns with CDC guidelines for infection control in dental settings to wear protective clothing during patient care and is essential for ensuring patient and DHCP safety. (See Underlying Data, CDC’s “Dental Infection Prevention and Control – Standard Precautions” dated May 15, 2024.)

The Board proposes to repeal existing text related to changing attire when it becomes “moist or visibly soiled” to more accurately describe when attire should be changed in a dental facility. This is important because once contaminated, attire can no longer serve as a safe barrier and instead becomes a source of exposure and cross-infection. When blood or OPIM saturate or soil a gown, jacket, or lab coat, microorganisms can penetrate the fabric or transfer to the wearer’s skin, underlying clothing, or other surfaces, increasing the risk of transmitting pathogens such as HBV, HCV, or HIV. Contaminated attire can also spread infectious material to instruments, equipment, or other patients if it is not removed

promptly. This standard also maintains consistency with existing federal recommendations and state regulations. While CDC's Standard Precautions require that protective clothing be removed "as soon as feasible" when it becomes contaminated, Cal/OSHA (California Code of Regulations, title 8, section 5193) mandates immediate removal of any garment penetrated by blood or OPIM. In the Board's experience, immediately changing soiled attire maintains the minimum necessary infection-control barriers and protects both dental personnel and patients.

Amend CCR Section 1005(b)(6) (renumbered to (b)(5)) and addition of paragraphs (A) and (B)

Purpose: Changes to this subsection would strike (6) and to add (5) to the existing title "Hand Hygiene" for greater organization and the title "Hand Hygiene" would be amended to better reflect content to "Hand Hygiene Protocols and Hand Care". The addition of subparagraphs (A) and (B) to existing paragraphs as well as grammatical or punctuation changes were made to account for the addition of new text within this section and would also increase comprehension by grouping related concepts together.

Amendments to introductory paragraph, renumbered as (A)

Existing introductory sentences in this subsection relate to protocols for handwashing and use of alcohol-based hand rubs. Subparagraph (A) would be amended to more clearly specify how 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. The proposal would also specify requirements for an "alcohol-based" hand rub (hyphen added for consistency in terminology in this section), which would be an alcohol concentration between 60-95%. The proposal would add requirements that an alcohol-based hand rub shall be used according to the manufacturer's instructions, add a requirement that hands shall be "completely dry" (repealing existing terms "thoroughly dried") and would repeal the term "bacterial" and replace it with "microbial."

Subparagraph (B) would be amended to add "and" as a grammatical connector and to specify DHCP shall refrain "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.

Rationale: The amendments to these standards better prevent the spread of infectious disease based upon updated CDC guidance (see Underlying Data from the CDC's "Clean Hands – About Handwashing" dated February 16, 2024). With respect to washing hands with soap and water (which would mean covering all surfaces of hands and fingers), these proposed amendments to the existing paragraph (now referred to as (A)) provides more specificity as to the meaning of "thoroughly wash" to the reader. The 20-second duration

ensures enough mechanical action to scrub all hand surfaces, including fingertips and thumbs, which are common sites for missed contamination. In the Board's experience, handwashing in this manner reduces the risk of transmitting infections between patients, prevents contamination of dental instruments and surfaces, and protects both staff and patients in the clinical environment.

Further amendments to proposed paragraph (A)

According to CDC Guidelines, alcohol concentrations in hand sanitizers of 60–95% are most effective for infection control in healthcare and dental settings (see Underlying Data, “Guideline for Hand Hygiene in Health-Care Settings Recommendations of the Healthcare Infection Control Practices Advisory Committee and the HICPAC/SHEA/APIC/IDSA Hand Hygiene Task Force” dated October 25, 2002). Alcohol concentrations between 60% and 95% are recommended because this range provides the most effective antimicrobial activity. Alcohol requires water to penetrate microbial cell walls and denature proteins efficiently; solutions below 60% are not reliably germicidal, while concentrations above 95% act too quickly to fully penetrate organisms. The 60–95% range rapidly kills a broad spectrum of bacteria, enveloped viruses, and fungi while remaining safe for frequent use on skin.

In the Board's experience, ensuring that an alcohol-based hand rub is used according to the manufacturers' instructions is the minimum standard needed to ensure that the hand rub is used safely and effectively for the protection of the public. The Board would remove the reference to “thoroughly dried” and replace it with “completely dry” as it relates to the existing requirement of drying hands before donning gloves to provide greater specificity as to the Board's requirements and ensure greater compliance with the dry hand requirement. This is important because wet hands are more likely to transfer microorganisms and can compromise glove integrity. Finally, the word “bacterial” would be deleted and replaced with “microbial” for greater accuracy in referring to the process of reproduction of an infectious agent.

Proposed amendments to paragraph (B)

Purpose: To consolidate the existing prohibitions against handling patient care equipment (currently in subsection (b)(7) and proposed to be repealed and moved to this paragraph) when specified hand conditions exist. This proposal would also provide more detailed examples of such conditions (such as the presence of lesions, rash, or weeping dermatitis).

Rationale: Existing guidelines and CDC guidance recommend excluding healthcare workers with weeping dermatitis and exudative lesions of the hands from direct contact with patient-care equipment (see Underlying Data, CDC “Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008” (Last Update: June 2024) and Guidelines for

Infection Control in Dental Health-Care Settings (MMWR 2003)). These amendments are necessary to provide more specific guidance and notice to DHCP as to when to refrain from handling equipment and what types of conditions qualify for the limitations on handling patient-care equipment and providing direct patient care. DHCP must refrain from providing direct patient care or handling patient care equipment when they have lesions, rashes, or weeping dermatitis because these skin conditions compromise the skin's protective barrier and greatly increase the risk of transmitting or acquiring infections. Broken or inflamed skin can shed large numbers of microorganisms, and moist or weeping dermatitis can contaminate gloves, instruments, and clinical surfaces, creating a direct pathway for cross-infection. At the same time, damaged skin makes the DHCP more susceptible to opportunistic infection from patient materials or contaminated equipment.

Repeal CCR section 1005(b)(7)

Purpose and Rationale: This proposal would repeal the existing requirement that “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” as unnecessary. The Board proposes to move these requirements to a new subsection, which are more accurately and thoroughly addressed in proposed amendments to CCR section 1005(b)(5)(B) as noted above. By adopting the above amendments, the Board proposes to remove the existing requirement to refrain from care “until the condition resolves,” as it creates ambiguity for DHCP as to what “resolves” means. The more specific standard that provides greater notice to DHCP is proposed in existing paragraph (5)(B) above which requires a DHCP to refrain from providing direct patient care when specified conditions “are present.”

Amend CCR Section 1005(b)(8) (renumbered to (b)(6)) and addition of paragraphs (A)-(E)

Purpose: This subsection sets forth the minimum standards for gloves, which would be updated to add new requirements as specified below and the paragraph number (6) to the “Gloves” title. The addition of subparagraphs (A)-(E) to existing paragraphs and adding of punctuation within this subsection would increase comprehension by grouping related concepts together consistent with correction of punctuation or grammar (occurring because of the addition of new items to this subsection).

Amendments to subparagraph (A) (renumbered from (8))

Purpose: This proposal would amend this paragraph to add “ination” at the end of exam for consistency in terminology for this subsection and add the words “DHCP” after the words “shall be worn by DHCP to resolve potential ambiguity regarding who would be required to wear medical examination gloves. This subsection would also be amended to add that

medical examination gloves are disposable, synthetic single-use only items. The proposal would also require gloves to be replaced when torn or punctured, upon completion of dental treatment, and before leaving laboratories or areas of patient care activities.

Rationale: To avoid confusion, the Board provides a definition in this section for “medical examination gloves” consistent with federal law and CDC guidelines, which includes “disposable, synthetic single-use only items.” The U.S. Food and Drug Administration (FDA) identifies patient-examination gloves under 21 CFR 880.6250 as disposable devices. Consistent with federal requirements, the Centers for Disease Control and Prevention (CDC) also states that gloves are single use, must not be reused and must be discarded after each use as part of Standard Precautions (see Underlying Data, CDC “Dental Infection Prevention and Control – Standard Precautions” dated May 15, 2024). Only single-use gloves are compliant since reuse, washing, or decontamination of medical examination gloves compromise glove integrity and increase the risk of cross-contamination, infection transmission, and noncompliance with federal infection control standards.

Existing CDC guidelines recommend removing gloves after each patient, after touching contaminated surfaces, and when torn or punctured. (See Underlying Data, CDC Guidelines for Infection Control in Dental Health-Care Settings (2003), dated December 19, 2003.) In addition, to adding these requirements more specifically, the Board proposes adding requirements for greater infection control protection practices for the public that would require gloves to be replaced upon completion of dental treatment and before leaving laboratories or areas of patient care activities.

Further, a glove that is torn or punctured can no longer act as a barrier to bloodborne pathogens, saliva, chemicals, or microorganisms, immediately increasing the risk of exposure. At the end of a dental treatment, gloves are contaminated with oral fluids and surface microbes; keeping them on would allow transfer of these contaminants to charts, equipment, doorknobs, or other patients. Similarly, gloves must be removed before leaving laboratories or patient care areas because wearing contaminated gloves in other areas could spread pathogens to public spaces and environmental surfaces. Replacing gloves at these specific points is a core element of standard precautions, ensuring effective contamination control and preventing cross-transmission of infectious agents.

Addition of subparagraph (B)

Purpose: Subparagraph (B) would be added to specify that chemical and puncture-resistant utility gloves shall be available at the point of use and worn by DHCP for cleaning, sterilization, and disinfectant procedures. Chemical and puncture-resistant utility gloves shall be cleaned and disinfected or sterilized in accordance with the manufacturer’s instructions. Disposable utility gloves shall be disposed of after each use.

Rationale: These requirements are necessary because the cleaning, sterilization, and disinfectant procedures expose DHCP to hazardous chemicals, sharps, and contaminated instruments that can easily puncture or degrade standard examination gloves. Chemical and puncture-resistant utility gloves provide a higher level of protection against disinfectants, sterilants, and sharp instruments, reducing the risk of chemical burns, injuries, and exposure to infectious materials. Keeping them at the point of use ensures they are consistently used at the exact moments when risks are highest and in compliance with federal and state worker safety laws and regulations (see above rationale for CCR section 1005(b)(4)(D) above for further explanation). Chemical and puncture-resistant gloves must be cleaned and disinfected or sterilized in accordance with manufacturer instructions to maintain their integrity and prevent cross-contamination between tasks. When utility gloves are designed to be disposable, they must be discarded after each use because reuse would compromise their protective properties and violate infection-control standards for the protection of the public including workers as mandated by federal and state law. Overall, these requirements ensure the safety of dental personnel, prevent occupational injuries, and maintain effective infection-control practices throughout the mandating these minimum standards for reprocessing, cleaning or disposal of gloves in accordance with this paragraph.

Amendment of existing paragraph (renumbered as subparagraph (C))

Purpose and Rationale: Subparagraph (C) has been amended to remove references to “heavy duty” utility gloves and replace it with “chemical and puncture-resistant” gloves for consistency in interpretation and terminology used in subparagraph (B) discussed above. The Board also proposes to add the requirement that utility gloves shall be cleaned and sterilized in accordance with the manufacturer’s instructions after each use. This ensures that gloves are cleaned and sterilized safely and effectively for the protection of the public.

Amendment of existing paragraph (renumbered as subparagraph (D))

Purpose and rationale: Subparagraph (D) would be amended to add more circumstances under which gloves shall be discarded and update terminology in this subsection. This would include removing the word “must” and replacing it with “shall” for consistency in terminology in this section. Since the Board would be adding more criteria to this subparagraph, the Board proposes to add “under any of the following circumstances” for greater notice to the reader. Additional subparagraph numbering within this paragraph would be added as (i), (ii), and (iii) for greater notice and to emphasize these concepts. Existing requirements for discarding all types of gloves would be amended to resolve ambiguity and provide greater notice of these requirements:

(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.

Since medical examination gloves are used for dental treatment, lab work and patient care (not utility gloves, which are used when cleaning or disinfecting items or surfaces), the words “when using medical examination gloves” is proposed to be added to the relevant subparagraphs above to avoid possible confusion.

Amendment of existing paragraph (renumbered as subparagraph (E))

Purpose and Rationale: Subparagraph (E) would be amended to specify all DHCP shall perform hand hygiene “protocols and hand care” procedures specified in paragraph (5) for consistency in terminology and interpretation across this section. In addition, the Board proposes to add the term “medical examination” before gloves in this paragraph for consistency in terminology in this section. Finally, the Board proposes to add the requirement that medical examination gloves shall not be reused. This change is necessary for consistency with CDC guidelines, which state that these gloves cannot be reused and for other similar amendments regarding single-use medical examination gloves in this section. (See Underlying Data, CDC’s “Dental Infection Prevention and Control – Standard Precautions,” dated May 15, 2024.)

Amend to add (7) to “Needle and Sharps Safety title and renumber existing paragraph (9) to subparagraph (A) and add a new subparagraph (B)

Purpose and Rationale: This section sets forth the minimum standards for needle and sharps safety. This section has been renumbered to be CCR Section 1005(b)(7) in accordance with the Board’s proposed renumbering of this section. The subsection has also been divided into two subparagraphs (A) and (B) for better organization, readability and grouping of related subjects.

Amend CCR Section 1005(b)(10)-(17) (renumbered to (b)(8)) and addition of paragraphs (A)-(I) and subparagraphs (I)(i) and (ii))

Purpose and rationale: Existing subsections (b)(10)-(17) would be renumbered as paragraphs (A)-(I)(i) and (ii) under the existing title “Sterilization and Disinfection:” for greater organization, grouping of related concepts and readability. These paragraphs would also be updated to add new requirements as specified below. Changes to grammar and punctuation would be needed to accommodate revisions to the text.

Amendments to subsection (b)(10) (renumbered to (A)) – Use of Cleaning and Disinfecting Products

Purpose and Rationale: This subsection would be amended in subparagraph (A) to strike (10) replace it with (A) for the reasons noted above. In addition, a reference to “germicides must” would be struck and replaced with “all products used to clean or disinfect items or surfaces shall be” used in accordance with intended use and label instructions. This change is necessary for consistency with terminology and interpretation of these standards in other subsections. As previously noted, “germicides” are a form of disinfectant and the term “disinfectant” is the term most commonly used by DHCP in this context, therefore the Board proposes to eliminate this term in this subsection as unnecessary. Since products are also used to clean as well as disinfect, the Board adds the words products use to “clean or disinfect” are proposed to be added.

The required use of disinfectants and cleaning requirements are already covered in other parts of this section, but they do not describe their compliant use in accordance with any specified standards. This proposal would specify that the use of these products shall be in accordance with intended use and label instructions to give practical guidance necessary to ensure the safe and effective use of these products for greater prevention control practices for the protection of the public.

Amendments to subsection (b)(11) (renumbered to (B)) — Standard Precautions Performance for Disinfection and Sterilization

Purpose: This subsection would be amended in subparagraph (B) to strike (11) and replace it with (B) for the reasons noted above. Subparagraph (B) would also be amended to specify standard precautions for disinfection and sterilization that shall be performed in a specific order, as follows:

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

(ii) second, ~~Cleaning 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.

Rationale: The Board proposes to repeal as unnecessary language in this subsection that requires “cleaning must precede” any disinfection or sterilization and requirements that “products used to clean items or surfaces prior to disinfection procedures shall be used according to label instructions. These requirements will be more thoroughly and accurately covered in this subsection in proposed subparagraphs (ii) and (ii) and in subsection (b)(8)(A) noted above. To ensure consistency in interpretation of the requirements in this section the Board proposes adding the changes noted above in subparagraphs (i) and (ii) and (iii).

In the Board’s experience, the other foregoing changes are necessary because standard precautions only work effectively if the above-noted prescribed sequence and requirements are followed. The effectiveness of all of these steps (standard precautions for hand hygiene and hand care (in accordance with paragraph (b)(5)), cleaning of items or surfaces prior to any disinfection or sterilization process, and use of disinfection and sterilization standards as required by this section) depends on the successful completion of the previous ones and adherence to prescribed protocols (cross-referenced within the above-noted sections for ease of reference). Performing steps out of order jeopardizes patient safety and compliance. Adherence to this prescribed sequence and these standards cross-referenced in this section is therefore necessary to meet validated cleaning or disinfection standards or achieve microbial inactivation for items or surfaces, to prevent environmental recontamination, to protect personnel from chemicals, and to ensure compliance with federal infection-control guidelines, including Standard Precautions and device processing and reprocessing requirements (see Underlying Data, CDC “Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008” Update: June 2024).

The Board adds the requirement of using hand hygiene protocols and hand care in accordance with paragraph (5) (where the protocols are located in this section) in subparagraph (i) as the first step in this process because following these hand hygiene protocols removes pathogens picked up from patient contact, gloves, instruments, or the environment, ensuring DHCP do not unintentionally spread bacteria or viruses on to clean surfaces or equipment. This protects both patients and staff and aligns with CDC and Cal-OSHA infection control requirements for maintaining a safe clinical environment. (See Cal. Code Regs., tit. 8, § 5193(d)(3)(I); CDC “Guideline for Hand Hygiene in Health-Care Settings” dated October 25, 2002.)

The Board proposes to retain the existing requirement in subparagraph (ii) that cleaning must precede any disinfection or sterilization process but rephrases the existing sentence to more comprehensively cover and give greater notice of the cleaning process by adding “items or surfaces” and using the active voice (stating “clean items or surfaces prior to any disinfection or sterilization process”). This preserves the CDC’s foundational guidance, based on the Spaulding classification, to remove debris or materials (e.g., blood, saliva, bioburden) prior to any disinfection or sterilization since these materials can adversely

affect disinfectants and impede sterilant contact, rendering processes ineffective and risking cross-contamination if items are reintroduced on to clean surfaces or items (see Underlying Data, CDC “Guideline for Disinfection and Sterilization in Healthcare Facilities (2008)” last update June 2024).

The Board would add a requirement to use disinfection or sterilization standards required by this section as the third step for performance of standard precautions in subparagraph (iii). This is necessary because they are a core part of standard precautions, which are designed to prevent the transmission of infectious diseases in any dental healthcare setting—regardless of a patient’s health history. Dental procedures routinely involve exposure to blood, saliva, and aerosols, which can carry bacteria, viruses, and other pathogens. By complying with the Board’s sterilization and disinfection requirements, DHCP ensure that instruments, devices, and clinical surfaces are consistently rendered safe for use, reducing the risk of cross-contamination between patients and protecting both patients and dental personnel.

Finally, the last sentence of subparagraph (iii) is necessary because dental facilities generate high-risk contamination from blood, saliva, and aerosols, and only Cal/EPA registered products are legally verified to inactivate the pathogens commonly encountered in these environments. Using the correct, registered disinfectant ensures compliance with California regulations (as noted above in the rationale for the definition of “Cal/EPA registered”), supports CDC-established standards for preventing cross-contamination and disease transmission, protects both patients and staff, and helps avoid regulatory violations. (See Underlying Data, CDC “Best Practices for Environmental Infection Prevention and Control” dated May 15, 2024.)

Amendments to subsection (b)(12) (renumbered to (C)) -- Critical Instruments

Purpose: Existing subsection (b)(12) would be renumbered to subparagraph (C) for the reasons noted above. Subparagraph (C) would also be amended to repeal the words “discarded or,” and add commas for grammatical reasons to the first sentence of this paragraph. The Board would also add the word “treatment” before “facility” in this subparagraph for consistency in terminology throughout this proposal. Subparagraph (C) would also be amended to state that, if stored, sterilized packaging is compromised (e.g., wet, torn, or punctured defined for easier notice to the user), the instruments shall be recleaned, packaged in new wrap, and sterilized again before use.

Rationale: Since critical instruments (defined in subsection (a)(4) to include “surgical instruments, periodontal instruments, hygiene scalers, and burs) are not normally “discarded” in practice in the Board’s experience, the words “discarded or” are proposed to be removed from the first sentence.

The Board proposes to add the requirement that if sterilized packaging that is compromised (as specified), the instruments shall be recleaned, packaged in new wrap and sterilized again before use because any breach in the packaging immediately invalidates sterility and creates a risk of cross-contamination in a dental healthcare setting. Sterile wraps and pouches are designed to act as a microbial barrier; when they become wet, torn, or punctured, they can allow bacteria, viruses, fungi, or debris from the environment to enter and contaminate the instruments. Since sterility cannot be visually confirmed and cannot be assumed once packaging integrity is compromised, the only safe and CDC-recommended action is to fully reprocess the instruments to ensure they are safe for patient use. (See Underlying Data, CDC “Guideline for Disinfection and Sterilization in Healthcare Facilities (2008)” last update June 2024.)

Amendments to subsection (b)(13) (renumbered to (D)) -- Semi-Critical Instruments

Purpose and Rationale: Existing subsection (b)(13) would be renumbered to subparagraph (D) for the reasons noted above. Subparagraph (D) would also be amended to add a comma after “wrapped” in the first sentence and a hyphen to the word “high level” for grammatical reasons. The Board would also add the word “treatment” before “facility” in this subparagraph for consistency in terminology throughout this proposal. Subparagraph (D) also would be amended to specify 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. The Board proposes to add the requirement that if sterilized packaging that is compromised (as specified), the instruments shall be recleaned, packaged in new wrap and sterilized again for the reasons noted above in the rationale for this same change to the last sentence of subparagraph (D).

Amendments to subsection (b)(14) (renumbered to (E)) – Non-critical surfaces and Patient Care Items

Purpose: Existing subsection (b)(14) would be renumbered to subparagraph (E) for the reasons noted above. Subparagraph (E) would also be amended to specify non-critical surfaces and patient care items shall be cleaned and disinfected “after every use” and remove the name “California Environmental Protection Agency” and strike the parentheses around “Cal/EPA” as unnecessary since the shortform reference “Cal/EPA” is being defined to include this information in proposed amendments to CCR section 1005(a)(7)). The Board proposes to also add the words “spray or wipe” after the words “Cal/EPA-registered hospital disinfectant (low-level disinfectant)” and remove the words “labeled effective against HBV and HIV.”

Rationale: The adoption of the clean and disinfect “after every use” requirement is necessary because surfaces and patient care items frequently become contaminated during dental procedures and can easily serve as sources of indirect disease transmission.

Cleaning and disinfecting after every use removes organic material and inactivates some bacteria, viruses and fungi, which helps prevent cross-contamination between patients, protecting staff, and maintaining compliance with the Board's minimum standards consistent with CDC guidelines. (See Underlying Data, CDC "Guideline for Disinfection and Sterilization in Healthcare Facilities (2008)" last update June 2024.) Since these low-level disinfectants commonly are manufactured as sprays or wipes, the Board adds "sprays or wipes" for greater notice and consistency with this practice.

Finally, the Board proposes to remove references to "labeled effective against HBV and HIV" as no longer necessary since Cal/EPA, through the Department of Pesticide Regulation (DPR), only requires that disinfectants used in healthcare settings be registered in California and meet the federal EPA requirements for "hospital disinfectant" classification since California does not have its own classification system for hospital disinfectants (See Food & Agr. Code, §§ 12753 and 12811 and California Code of Regulations, title 3, § 6145 and 7 U.S.C. §136a and the federal EPA guidelines for efficacy below.)

According to the federal EPA, the performance testing required for hospital-grade registration is based on efficacy against benchmark organisms, including: *Staphylococcus aureus*, *Pseudomonas aeruginosa*, and *Salmonella enterica* (see Underlying Data hospital "hospital/healthcare disinfectant" testing requirements at U.S. Environmental Protection Agency "Product Performance Test Guidelines, OCSP 810.2200: Disinfectants for Use on Environmental Surfaces Guidance for Efficacy Testing" dated February 2018). Because these organisms are more resistant to disinfectants than enveloped viruses like HIV and HBV, a product that meets the hospital-grade standard is presumed effective against HIV and HBV even without specific label claims. Therefore, Cal/EPA does not currently require HIV or HBV kill-claims on the product label. This is consistent with CDC guidance that considers hospital disinfectants effective against standard test organisms as adequate for managing contamination involving bloodborne pathogens, including HIV and HBV. (See Underlying Data, CDC "Guideline for Disinfection and Sterilization in Healthcare Facilities (2008)" last update June 2024.) Since Cal/EPA no longer requires this labeling requirement and there would be no way to comply with this standard, the Board proposes to repeal this requirement as obsolete.

Amendments to subsection (b)(15) (renumbered to (F)) – Sterilizing rotary components includes "motor"

Purpose: Existing subsection (b)(15) would be renumbered to subparagraph (F) for the reasons noted above and to correct punctuation. Subparagraph (F) would also be amended to add commas for grammatical reasons and the words rotary components, "including the motor" and would therefore apply the existing requirements in this paragraph to package, label, and heat-sterilize the motor in a manner consistent with the same sterilization practices as a semi-critical item.

Rationale: The requirement to include motors in sterilization practices is necessary because these devices become contaminated internally through backflow of saliva, blood, and microorganisms during use, and only heat sterilization can reliably eliminate pathogens within their internal components. Packaging maintains sterility after processing, labeling ensures traceability and compliance with sterilization monitoring requirements, and together these steps prevent recontamination and cross-infection between patients, consistent with CDC guidelines that direct all dental handpieces, and their attachments must be heat-sterilized between patients in accordance with standard precautions. (See Underlying Data, “Summary of Infection Prevention Practices in Dental Settings Basic Expectations for Safe Care,” dated October 2016.)

Amendments to subsection (b)(16) (renumbered to (G)) – Defining Single Use Items

Purpose and Rationale: Existing subsection (b)(16) would be renumbered to subparagraph (G) for the reasons noted above and to add punctuation where required. Subparagraph (G) would also be amended to add “critical, semi-critical, and non-critical” before the words disposable to more accurately cover, and give notice of, the types of items listed in this paragraph that are commonly considered “single use” and “disposable”. In addition, the Board proposes to add to the existing enumerated list for single-use disposable items, “scalpel blades,” which are typically classified as critical items in dental healthcare settings because they penetrate soft tissue and bone, posing the highest risk of transmitting infection. Such items are typically considered a single use, disposable item and are being added to this list for greater notice to the user.

Amendments to subsection (b)(17) (renumbered to (H)) – Confirmation of test results for proper functioning of the sterilization cycle

Purpose and Rationale: Existing subsection (b)(17) would be renumbered to subparagraph (H) for the reasons noted above. Subparagraph (H) would be amended to specify 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.” Existing regulations does not specify how test results will be verified. These requirements are necessary because dental healthcare individuals are typically trained (using manufacturer’s instructions) and qualified to accurately interpret sterilization test results and ensure that the sterilizer is functioning properly. Spore tests are the most reliable method for verifying that heat sterilization has successfully destroyed highly resistant microorganisms, and incorrect interpretation can lead to the continued use of a malfunctioning sterilizer, creating a serious risk of cross-infection. Having results reviewed by competent personnel or an independent laboratory ensures accuracy, documentation, and timely response to failures, supporting compliance with CDC recommendations and maintaining patient safety and

regulatory accountability. (See Underlying Data, CDC “Best Practices for Sterilization Monitoring in Dental Settings” dated May 15, 2024.)

Add new subsection (b)(l)(i) and (b)(l)(ii) – Add requirements for chemical indicators

Purpose: Subparagraph (l) would be added to specify:

(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.

Rationale: The adoption of this new paragraph is necessary for better organization of related subject matter. The adoption of subparagraph (i) is necessary to ensure the minimum standards for sterilization are met. Since chemical indicators provide immediate, package-specific confirmation that the sterilizing agent has actually reached the instruments inside. Internal indicators verify penetration of steam, heat, or chemical vapor into the center of the package, something external indicators alone cannot confirm. If an internal indicator is not visible, an external indicator is required to show that the package has been processed at all, preventing accidental use of unsterilized or improperly processed items. Together, these indicators ensure that sterilization conditions were met for each individual package, allow early detection of sterilizer malfunction or packaging errors, and support CDC-recommended best practices for preventing cross-infection and maintaining sterility assurance. (See Underlying Data, CDC “Best Practices for Sterilization Monitoring in Dental Settings” dated May 15, 2024.)

The adoption of subparagraph (ii) is necessary to require immediate inspection of the chemical indicator after removing packages from the sterilizer because this is the only point in the sterilization workflow where DHCP can verify, package-by-package, that the sterilizing agent actually penetrated the wrap and reached the instruments inside. Chemical indicators are designed to give instant visual confirmation that critical sterilization parameters—such as temperature, steam exposure, or chemical vapor penetration—were achieved for that specific package. If the indicator does not change appropriately, it signals that the instruments may not have been exposed to adequate sterilizing conditions due to incorrect loading, equipment malfunction, or packaging error. Reprocessing the instruments (recleaning, repackaging, and sterilizing again) is necessary because sterility cannot be assumed in the absence of a properly functioning indicator. This requirement helps prevent the use of potentially non-sterile instruments on patients, supports early detection of

sterilizer problems, and aligns with CDC best practices for ensuring sterility assurance and preventing cross-infection in dental treatment facilities. (See Underlying Data, CDC “Best Practices for Sterilization Monitoring in Dental Settings” dated May 15, 2024.)

Amend CCR section 1005(b)(18) (renumbered as (b)(9)) and add new subparagraph numbering (A)-(C)

Purpose: This section sets forth the minimum standards for irrigation. This subsection would be renumbered from (b)(18) to (b)(9) (moved before the title “Irrigation”) and add new subparagraph numbering (A)-(C) for better organization within this subsection. The Board would also amend this subsection by adding a new subparagraph (B) to specify that when performing procedures on exposed dental pulp, water or other irrigation solutions shall be sterile or contain disinfecting or antibacterial properties. The word “shall” was added in place of “must” for consistency in terminology throughout this section and better readability in subparagraph (C), which currently specifies how sterile coolants/irrigants shall be delivered using a sterile delivery system.

Rationale: The amendments to these standards better prevent the spread of infectious disease based upon updated CDC guidance and provide more notice to the reader. These requirements related to procedures on exposed dental pulp are necessary to place all minimum requirements for infection control in one location for the convenience of the regulated community, to provide better notice to users of this compliance standard and for consistency with BPC section 1680(ag) (which makes it unprofessional conduct to use water, or other methods used for irrigation, that are not sterile or that do not contain recognized disinfecting or antibacterial properties when performing dental procedures on exposed dental pulp).

The public policy behind BPC section 1680(ag) is that pulp is a directly exposed tissue, and introducing non-sterile water can introduce bacteria or other microorganisms deep into the tooth where the body cannot easily clear them. This can cause pulp infection, postoperative inflammation, or treatment failure. Dental unit waterlines often harbor biofilm and microorganisms, even when maintained properly, so they are not suitable for contact with exposed pulp. Using sterile or antimicrobial irrigation solutions ensures that the environment is as aseptic as possible, prevents contamination during procedures like pulp exposures or pulp therapy, and aligns with CDC recommendations that sterile solutions be used when water contacts normally sterile tissues. This requirement protects patient safety, supports standard precautions, and reduces the risk of introducing pathogens into the tooth’s internal structures. (See Underlying Data, CDC “Best Practices for Dental Unit Water Quality” dated May 15, 2024.)

Amend CCR section 1005(b)(19)-(b)(22) (renumbered as (b)(10) and add new subparagraphs (A)-(E))

Purpose and Rationale: These subsections would be renumbered from (b)(19)-(b)(22) to (b)(10) (moved before the changed title “Treatment Facilities”) and add new subparagraph numbering (A)-(E) for better organization within this subsection.

Amendments to CCR section 1005(b)(19), renumbered to subparagraph (A)

Purpose: Subparagraph (A) would be amended to specify, “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.”

Rationale: The Board adds the term “clinical contact” before “surfaces” for consistent interpretation and use of terminology throughout this section (see subsection (a)(4)(C)). The repeal of “are” and addition of “or” is necessary to notify and more accurately specify those circumstances when use of disposable impervious barriers are required. Since “protected” is susceptible to multiple interpretations, the Board uses the more accurate term “physically covered” to ensure compliance with CDC guidelines. (See Underlying Data, CDC “Guidelines for Infection Control in Dental Health-Care Settings 2003, dated December 19, 2003.)

When non-critical items or a surface cannot be reliably cleaned and disinfected, including due to manufacturing design, they become a potential source of cross-contamination between patients. Using single-use, impermeable barriers approved by the FDA (pursuant to the Federal Food, Drug and Cosmetic Act as a “medical device”) and designed by the manufacturer for that purpose ensures use of validated products that prevent contaminants from penetrating to the surface. Further, use of such products allows for complete removal of all contamination after each patient simply by discarding the barrier. This protects patients and staff, maintains compliance with CDC infection-control principles, and ensures that even difficult-to-clean items or clinical contact surfaces are safely managed under standard precautions in the dental treatment facility.

Amendments to CCR section 1005(b)(20) renumbered to subparagraph (B)

Purpose: Subparagraph (B) would be amended as follows:

~~(20)(B)~~ (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.

Rationale: The Board proposes to remove the name “California Environmental Protection Agency” and strike the parentheses around “Cal/EPA” as unnecessary since the shortform reference “Cal/EPA” is being defined to include this information in proposed amendments to CCR section 1005(a)(7), and would add a hyphen between Cal/EPA and registered consistent with the definition in subsection (a)(7). The Board would also repeal the reference to “germicide” and replace it with disinfectant for consistency in terminology throughout this section.

The Board adds the requirement to use an intermediate-level disinfectant if visibly contaminated with blood because blood can carry higher concentrations of pathogens like HBV, HCV, and HIV, which low-level disinfectants may not reliably inactivate. Intermediate-level products are formulated to kill these more resilient microorganisms, reducing the risk of cross-contamination on high-touch dental surfaces. This approach aligns with CDC best practices, which treat visible blood as a higher-risk exposure that requires stronger disinfection. (See Underlying Data, CDC “Best Practices for Environmental Infection Prevention and Control” dated May 15, 2024.)

Addition of new paragraph number (C) before existing paragraph related to cleaning housekeeping surfaces and amendments to the existing paragraph

Purpose: Subparagraph (C) numbering would be added to this existing paragraph under CCR section 1005(b)(20) (renumbered to (b)(10) under this proposal) and would otherwise be amended as follows:

“(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 (MSDS) handling and storage instructions.”

Rationale: To ensure consistency in terminology and the new definition in subsection (a)(7), the Board adds a hyphen between “Cal/EPA” and “registered.” The Board proposes to strike the word “material” before “safety data sheet” and the “M” inside the acronym “MSDS” for consistency with updated terminology used by the Occupational Safety and Health Administration (OSHA). OSHA formally adopted this change from “material safety data sheet” to “safety data sheet” in its 2012 revision of the Hazard Communication Standard (29 CFR 1910.1200 et seq.).

Amendments to CCR section 1005(b)(21) renumbered to subparagraph (D)

Purpose: Subsection (b)(21) would be renumbered to subparagraph (D) for the reasons noted above regarding renumbering changes. Subparagraph (D) would be amended to specify, “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~~after each patient for a minimum of twenty (20) seconds. Dental unit water lines shall be monitored or tested routinely in accordance with manufacturer's instructions.”

Rationale: These requirements are necessary to ensure compliance with the most recent CDC guidance for dental unit water quality and to ensure the most effective methods of ensuring water quality are followed in every case, which include flushing water (not purging air) and flushing that occurs “after” each patient for clearer notice. Further, without referencing manufacturer instructions, facilities might monitor or test too infrequently, use the wrong method, or miss required maintenance steps—resulting in unsafe water, biofilm overgrowth, and patient risk. Tying the requirement to manufacturer instructions ensures the safety protocol is evidence-based, device-specific, enforceable, and consistent with CDC’s approach to testing (See Underlying Data, CDC “Best Practices for Dental Unit Water Quality” dated May 15, 2024.)

Amend CCR section 1005(b)(22) relating to “Contaminated solid waste” disposal requirements

Purpose and Rationale: This paragraph has been renumbered to be CCR section 1005(b)(10)(E) for better organization within this subsection.

Amend CCR section 1005(b)(23)-(b)(24) (renumbered as (b)(11) and add new subparagraph numbering (A)-(D))

Purpose and Rationale: These subsections would be renumbered from (b)(23)-(b)(24) to (b)(11) (moved before the title “Lab Areas”) and add new subparagraph numbering (A)-(D) for better organization within this subsection.

Amendments to CCR section 1005(b)(23), 1st paragraph renumbered to subparagraph (A)

Purpose and Rationale: This proposal would add the word “disposable” before “rag wheel” for greater notice of this requirement and a comma for grammatical reasons. This is necessary because rag wheels absorb contaminants and cannot be safely reused unless fully sterilized, or a new, disposable rag-wheel is used for each patient to prevent cross-infection. The word “Devices” is proposed to be repealed as this concept is already covered in proposed amendments to subparagraph (B) below.

Amendments to CCR section 1005(b)(23), 2nd paragraph renumbered to subparagraph (B)

Rationale: This paragraph would be renumbered to (B) and further amended in subparagraph (B) to specify that, “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).”

Rationale: These requirements are necessary to update existing standards to more accurately describe the instruments (currently referred to as “devices”) and standard precautions expected to be taken to ensure infection control under these circumstances. Cross-referencing to the applicable sterilization practices and disposal requirements in this section ensures consistency in interpretation and implementation of the Board’s minimum standards.

In the Board’s experience, laboratory items, including handpieces, polishing (rag) wheels, grinding wheels, and laboratory burs contact materials that have been in a patient’s mouth, which means they may be contaminated with saliva, blood, and microorganisms. Dental prostheses and appliances—such as dentures, partials, night guards, aligners, bite splints—can carry pathogens on their surfaces and porous areas. When a DHCP polishes or adjusts them, the equipment used becomes contaminated by direct contact, aerosols, and debris.

Many lab items are porous or have complex surfaces, making them difficult to disinfect through surface wiping alone. That means only heat sterilization (or single-use disposable items) can reliably eliminate microbial contamination. CDC infection control guidelines treat any instrument that contacts mucous membranes or contaminated intraoral devices as semi-critical, meaning they require cleaning, disinfection, proper packaging or wrapping and heat sterilization between uses unless the item cannot tolerate heat (in which case it must be disposable). (See Underlying Data, CDC “Guidelines for Infection Control in Dental Health-Care Settings (2003)” dated December 19, 2003.) These amendments ensure the Board’s standards align with these guidelines and, in the Board’s experience, current standards for infection control in the regulated community.

Adopt new subparagraph (C) in CCR section 1005(b)(11)

Purpose and Rationale: This proposal would adopt new subparagraph (C) to specify that, “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).”

This is necessary to ensure adequate notice of this requirement consistent with CDC guidelines and, in the Board's experience, current standards for infection control in the regulated community.

Storing laboratory equipment in the same manner as semi-critical items is necessary because once these tools have been sterilized, they must remain sterile until their next use to prevent cross-contamination. As noted in the rationale for subparagraph (B) above, equipment used on contaminated appliances and prosthetic devices is exposed to saliva, blood, and microorganisms, so it must be processed to the same standard as semi-critical instruments. If the equipment is then stored in an unprotected environment, it can be recontaminated by dust, aerosols, or handling, making the sterilization useless. Proper storage -- such as keeping items wrapped or packaged as noted in subparagraph (G) of subsection (b)(8) -- maintains the integrity of sterilization and ensures the equipment remains safe for use on the next patient.

Amendments to CCR section 1005(b)(24), renumbered to subparagraph (D)

Purpose: This subsection would be renumbered for subparagraph (D) for the reasons noted above and would be further amended in subparagraph (D) to specify that, "All intraoral items such as impressions, bite registrations, and prosthetic and orthodontic appliances shall be cleaned and disinfected with 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."

Rationale: The amendments to add the word "and" to correct grammar since the words "prosthetic and orthodontic" both apply to appliances and to provide greater notice and specificity regarding these types of items. The Board proposes to add a reference to "Cal/EPA-registered" before intermediate-level disinfectant to ensure consistency with state law regarding use of pesticides in California as discussed above in the rationale for the addition of "Cal/EPA-registered" in proposed amendments to CCR section 1005(a)(7).

Finally, the Board would add the words "and after" to specify requirements for cleaning and disinfecting must occur with the Cal-EPA-registered disinfectant specified above after manipulation in the laboratory and before placement in the patient's mouth. This requirement is necessary for minimum infection control precautions because these devices can carry saliva, blood, and microorganisms from the oral cavity. When an appliance is handled in a lab or clinic, it can contaminate surfaces, equipment, and personnel, creating a risk of spreading pathogens between patients or to staff. Cleaning and disinfecting it after laboratory manipulation ensures that any contaminants introduced during trimming, polishing, or handling are removed before the device is placed back into the patient's mouth. Cleaning and using a Cal/EPA-registered intermediate-level disinfectant ensures

reliable elimination of a broad spectrum of pathogens, preventing cross-infection and maintaining patient and staff safety.

Adopt CCR section 1005(b)(12) and title Respiratory Hygiene/Cough Etiquette

Purpose: This section sets forth the minimum standards for respiratory hygiene/cough etiquette and includes new subparagraphs (A)-(E) for better organization and readability. This section has been amended to conform with updated CDC guidelines. This proposal would add a new subsection title “Respiratory Hygiene/Cough Etiquette” for better notice and organization within this section and add the following introductory sentence before proposed subparagraphs (A)-(E):

“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.”

Rationale: This proposal is necessary to give notice of the Board’s public policy rationales for requiring this new standard precaution and set new respiratory hygiene and cough etiquette standards consistent with CDC guidelines. (See Underlying Data, CDC’s “Dental Infection Prevention and Control – Standard Precautions,” dated May 15, 2024; and CDC’s “Summary of Infection Prevention Practices in Dental Settings: Basic Expectations for Safe Care,” dated October 2016.) As noted above, these measures would be mandated to be implemented to contain respiratory secretions and to prevent droplet and fomites transmission of respiratory pathogens (the spread of pathogens via contaminated inanimate objects (fomites) like doorknobs, phones, or surfaces).

These measures are necessary because pathogens like influenza, RSV, adenovirus, parainfluenza, and SARS-CoV-2 (COVID-19) can survive on surfaces, spread through close contact, and infect people before symptoms appear. Controlling respiratory secretions and such transmissions with patient instructions, providing tissues and receptacles, using hand hygiene protocols, using masks and barriers, and maintaining distance between patients as provided further in subparagraphs (A)-(E) reduce the likelihood that respiratory viruses will spread in the treatment facility, especially during seasonal outbreaks when community transmission is high. These measures protect vulnerable patients, maintain a safe working environment for staff, and prevent associated infections.

Adopt new subparagraph (A): Sign posting requirement

Purpose: This proposal would require the following:

(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 receptacles; and, (iii) wash hands with soap and water or use alcohol-based hand rub after coughing or sneezing.

Rationale: These requirements are necessary implement CDC guidance on this issue and because posting prominent 12-point type font signs, the Board's experience, ensures signs as specified above are visible at entrances and reception/registration desks; this provides immediate, accessible instructions that help prevent the spread of respiratory pathogens the moment people enter the treatment facility.

Many respiratory viruses—such as influenza, RSV, adenovirus, parainfluenza, and SARS-CoV-2—spread through droplets and contaminated surfaces, and individuals may be contagious even before symptoms appear. By directing patients to cover their coughs and sneezes, dispose of tissues properly, and wash hands with soap and water or use an alcohol-based hand rub after coughing or sneezing, the signs promote behaviors that reduce the release of infectious droplets and limit surface contamination. Making the signage prominent and easy to read ensures that everyone entering the dental practice receives the same clear guidance, which helps protect other patients, staff, and the clinical environment, especially during seasonal outbreaks when the risk of transmission is high.

Pursuant to the Executive Officer's delegation by the Board to make non-substantive changes, a typographical correction was made in the above-referenced new subparagraph (A) for the word "receptacles" which was errantly spelled "receptables" in the prior version of the proposed text.

Adopt new subparagraph (B): Provide tissues and no-touch receptacles

Purpose: This proposal would adopt a new subparagraph (B) to specify: "Provide tissues and no-touch receptacles (e.g. foot-pedal operated lid or open plastic-lined waste basket) for disposal of tissues."

Rationale: This requirement is necessary to align with the above-noted CDC guidance on standard precautions for this issue and because it helps prevent the spread of respiratory pathogens by allowing patients to cover their coughs or sneezes and dispose of used tissues without contaminating their hands or surrounding surfaces. When receptacles can be used without hand contact, it reduces the chance that patients will spread germs to

doorknobs, countertops, pens, forms, or treatment areas. Supplying tissues encourages proper cough etiquette, and the no-touch disposal method helps keep the environment cleaner and safer for both patients and dental staff.

Adopt new subparagraph (C): Soap, warm running water and paper towels or alcohol-based rub available

Purpose: This proposal would adopt a new subparagraph (C) to specify: “Have soap, warm running water, and paper towels, or alcohol-based hand rub available for use in or immediately adjacent to waiting areas.”

Rationale: This requirement is necessary to align with the above-noted CDC guidance on standard precautions for this issue and because hand hygiene (washing with soap or water or using alcohol-based hand rub) is one of the most effective ways to prevent the spread of respiratory viruses. When people cough, sneeze, blow their nose, or touch contaminated surfaces, their hands can carry pathogens like influenza, RSV, adenovirus, parainfluenza, and SARS-CoV-2. If hand-cleaning supplies are not easily accessible, patients may touch door handles, pens, countertops, or clipboards with contaminated hands, increasing the risk of spreading infection to others in the dental office. By placing hand-hygiene resources directly where patients wait and check in, the practice encourages immediate cleaning after coughing or sneezing, reduces contamination of shared surfaces, and helps protect both patients and staff.

Adopt new subparagraph (D): Offer masks to coughing or sneezing patients

Purpose: This proposal would adopt a new subparagraph (D) in this subsection and adopt the following requirement: “Offer masks to coughing or sneezing patients or other persons when they enter the treatment facility.”

Rationale: This requirement is necessary to align with the above-noted CDC guidance on standard precautions for this issue and because masks help reduce the release of respiratory droplets that can carry viruses such as influenza, RSV, adenovirus, parainfluenza, and SARS-CoV-2. When symptomatic individuals wear a mask, it limits how far their respiratory droplets can travel and reduces contamination of surfaces and the air in waiting areas and clinical spaces. This simple measure helps protect other patients, vulnerable individuals, and staff from respiratory infections, especially during times of increased community spread, while maintaining a safer clinical environment overall.

Adopt new subparagraph (E): Providing distance between patients who cough or sneeze

Purpose: This proposal would adopt a new subparagraph (E) in this subsection that would specify: “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.”

Rationale: This requirement is necessary to align with the above-noted CDC guidance on standard precautions for this issue and because increasing physical space helps reduce the spread of respiratory droplets that can transmit viruses such as influenza, RSV, adenovirus, parainfluenza, and SARS-CoV-2. These pathogens spread easily when people with respiratory symptoms are near others, especially in indoor dental treatment facilities where patients may be medically vulnerable. Distancing symptomatic individuals limits the amount of respiratory droplets that can reach other patients, decreases contamination of shared surfaces, and reduces the overall risk of transmission in the facility. Separating symptomatic patients when possible is a form of source control, helping maintain a safer environment for both patients and staff.

Adopt new CCR section 1005(c), (c)(1)(A) and (B), and (c)(2) regarding DHCP employer offered training

Purpose: Existing subsection (c) would be repealed (as explained more fully below in the “Repeal existing CCR section 1005(c)” below) and replaced with a new subsection that sets forth the requirement that 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 shall be provided at no cost to the personnel during working hours in accordance with a list of specified criteria in paragraphs (1) and (2) of this subsection.

Rationale: Existing regulations require a written protocol to be developed, maintained and periodically updated as specified in existing subsection (b)(2) and a copy of this regulation posted in each dental office in existing subsection (b)(3). As noted above in the amendments to subsection (b)(2), this protocol would be replaced with a written infection control plan for the reasons set forth above. This proposal would specify that DHCP employers provide DHCP personnel with training on the minimum standards required by this section and their written infection control plan.

Existing Cal/OSHA requirements at California Code of Regulations, title 8, section 5193 mandate that 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. The training is required to be provided: 1. at the time of initial assignment to tasks where occupational exposure may take place; and, 2. at least annually thereafter. (Cal. Code. Regs., tit. 8, § 5193(g)(2)(A) and (B).)

Consistent with these existing Cal/OSH requirements that mandate employees who have exposure be trained at no cost during working hours, the Board proposes to require DHCP

employers to provide training on the Board's minimum standards (which are already required to be complied with and enforced by DHCP generally at subsection (b)) and their infection control plan at no cost to the personnel and during working hours in accordance with paragraphs (1) and (2).

These requirements are necessary because proper training ensures that every DHCP member understands the procedures required to prevent the spread of infectious diseases and to maintain a safe clinical environment. Infection control regulations are detailed and can only be implemented effectively if staff know what is required, how to perform each step correctly, and why the procedures matter. Consistent training promotes uniform practices among all personnel, reduces the risk of errors or lapses that could lead to cross-contamination, and ensures compliance with the Board's standards. It also protects patients, protects staff, and reduces the employer's risk of regulatory violations or preventable exposures. In short, training is essential to translate the written infection control rules into consistent, safe daily practice. These requirements also ensure consistency in requirements for worker safety and fair labor practices under California law.

Adopt paragraph (1) and subparagraphs (A) and (B) re: content of employer-offered training program

Purpose and Rationale: The Board proposes to adopt an introductory sentence that provides that "the training program shall be provided as follows" for greater notice regarding these requirements and organization of the related material is this subsection. The paragraph would precede the more specific requirements outline in paragraphs (A) and (B).

Paragraph (A) would specify that such training on the Board's minimum standards and the employer's infection control plan would occur "prior to assignment to tasks where OPIM exposure may take place." Paragraph (B) would require the specified training program to be provided within one year of the date of the DHCP's previous training thereafter.

As noted above in the rationale above for adoption of proposed subsection (c), these changes are necessary to ensure training of DHCP personnel consistent with employer requirements for DHCP employee training prior to exposure that is required by Cal/OSHA, but specific to this Board's minimum standards in infection control and the employer's related infection control plan. Training is essential before DHCP perform any task involving potential exposure to other infectious materials because it ensures they understand how infections spread, how to use protective equipment correctly, how to handle sharps and contaminated instruments safely, and how to follow the Board's minimum requirements for infection control. Without this preparation, employees are at higher risk of contracting or transmitting pathogens, causing cross-contamination, or violating the Board's standards. Compliance training protects the worker, the patient, and the entire dental practice by reducing preventable exposure incidents and ensuring everyone follows consistent,

evidence-based safety procedures. Annual retraining within one-year of the date of the DHCP's previous training ensures currency of knowledge in the Board's infection control requirements and the employer's infection control plan for the protection of the public.

Adopt paragraph (2) re: requirements for additional training to DHCP

Purpose: Paragraph (2) would be adopted to specify, "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."

Rationale: When the Dental Board updates its minimum infection-control standards, or when an office updates its own written infection control plan, previous procedures may no longer be compliant. Without timely training, staff may unknowingly continue outdated practices that increase the risk of exposure incidents, cross-contamination, or disease transmission. The Board's regulations require employers to train personnel prior to or by the effective date of any change so that the treatment facility and its staff remain compliant with state law and maintain currency of knowledge in the Board's minimum infection control standards for the protection of the public. Failure to train staff can result in citations and fines or discipline (see BPC section 1680(ad)), or liability if an exposure occurs.

Limiting the training to the actual changes in the Board's infection control standards or the written infection control plan avoids unnecessary repetition, reduces the burden on employers and staff, and ensures that time and resources are spent on the information that truly affects safety and compliance. This approach keeps the DHCP current with new regulations, technologies, or procedures without forcing them to relearn material they already understand and use in practice, while still ensuring that every employee can safely and correctly implement the updated standards or plan in daily practice. This balances the need to ensure currency of knowledge and notice to staff of changes to practice standards while ensuring a more focused, effective training opportunity for employers (see also Cal. Code Regs., tit. 8, § 5193(g)(2)(C) which uses a similar updated training approach).

Repeal existing CCR section 1005(c)

Purpose: Subdivision (c), which states that the Board and DHBC shall review this regulation annually and establish consensus, would be repealed.

Rationale: 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 is not necessary in the Board's experience with this regulation, which has not been

amended since 2011. BPC section 1680(ad) already requires the two Boards to review the Guidelines on an annual basis “if necessary” and to establish a consensus.

Repeal footnote regarding Cal/EPA Contacts

Purpose and Rationale: A footnote at the bottom of the regulation for Cal/EPA contacts (Website and telephone number) would be repealed under this proposal as obsolete and unnecessary. Those references are no longer accurate or provide any useful information regarding Cal/EPA contacts. Further, most consumers are currently aware of and know how to find Cal/EPA contact information online using common internet browsers.

Underlying Data

Documents relied upon:

1. U.S. Department of Health and Human Services Centers for Disease Control and Prevention (CDC), “Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008”, Update: June 2024
2. “Guidelines for Environmental Infection Control in Health-Care Facilities”, Recommendations of CDC and the Healthcare Infection Control Practices Advisory Committee (HICPAC), U.S. Department of Health and Human Services Centers for Disease Control and Prevention (CDC) 2003, (Updated: July 2019)
3. CDC’s “Summary of Infection Prevention Practices in Dental Settings: Basic Expectations for Safe Care,” dated October 2016.
4. CDC “Guideline for Hand Hygiene in Health-Care Settings Recommendations of the Healthcare Infection Control Practices Advisory Committee and the HICPAC/SHEA/APIC/IDSA Hand Hygiene Task Force” dated October 25, 2002
5. U.S. Environmental Protection Agency “Product Performance Test Guidelines, OCSPP 810.2200: Disinfectants for Use on Environmental Surfaces Guidance for Efficacy Testing” dated February 2018
6. Dental Hygiene Board’s (DHBC) Legislative and Regulatory Committee’s November 15, 2024, Committee Meeting: Agenda, Meeting Minutes and Relevant Meeting Materials
7. DHBC’s November 16, 2024, Board Meeting Agenda and Meeting Minutes
8. Dental Board of California’s Dental Assisting Council’s (Council) February 6, 2025, Council Meeting Agenda, Meeting Minutes and Relevant Meeting Materials that include:
 - A. Council memo dated January 16, 2025 to Members of the Dental Assisting Council entitled “**Agenda Item 8.b.:** Discussion and Possible Action to Initiate a

- Rulemaking to Amend California Code of Regulations (CCR), Title 16, Section 1005 Regarding Minimum Standards for Infection Control”
 - B. Proposed Regulatory Language for amendments to CCR Section 1005 dated 11/5/24
 - C. Proposed Regulatory Language for amendments to CCR Section 1005 dated 2/6/25
 - D. California Code of Regulations, title 8, section 5193
 - E. Centers for Disease Control’s (CDC) “About Handwashing,” dated February 16, 2024
 - F. CDC’s “Best Practices for Environmental Infection Prevention and Control,” dated May 15, 2024
 - G. CDC’s “Best Practices for Sterilization Monitoring in Dental Settings,” dated May 15, 2024
 - H. CDC’s “Dental Infection Prevention and Control – Standard Precautions,” dated May 15, 2024
9. Dental Board of California’s (Board) February 6-7, 2025, Board Meeting Agenda, Minutes and Relevant Meeting Materials that include:
- A. Board memo dated January 16, 2025 to Members of the Dental Board of California entitled “**Agenda Item 11.b.:** Discussion and Possible Action to Initiate a Rulemaking to Amend California Code of Regulations (CCR), Title 16, Section 1005 Regarding Minimum Standards for Infection Control”
 - B. Proposed Regulatory Language for amendments to CCR Section 1005 dated 11/5/24
 - C. Proposed Regulatory Language for amendments to CCR Section 1005 dated 2/6/25
 - D. California Code of Regulations, title 8, section 5193
 - E. Centers for Disease Control’s (CDC) “About Handwashing,” dated February 16, 2024
 - F. CDC’s “Best Practices for Environmental Infection Prevention and Control,” dated May 15, 2024
 - G. CDC’s “Best Practices for Sterilization Monitoring in Dental Settings,” dated May 15, 2024
 - H. CDC’s “Dental Infection Prevention and Control – Standard Precautions,” dated May 15, 2024

10. Council's May 14, 2025, Council Meeting Agenda, Meeting Minutes and Relevant Meeting Materials that include:
- A. Council memo dated April 28, 2025 to Members of the Dental Assisting Council entitled "**Agenda Item 12.b.**: Discussion and Possible Action to Recommend Initiation of a Rulemaking to Amend California Code of Regulations (CCR), Title 16, Section 1005 Regarding Minimum Standards for Infection Control"
 - B. Proposed Regulatory Text to Amend CCR, Title 16, Section 1005 Approved by DHBC and dated 11/5/24
 - C. Proposed Regulatory Text to Amend CCR, Title 16, Section 1005, dated 5/14/25
 - D. Letter to Board from the California Dental Assisting Alliance, dated February 7, 2025 RE: Dental Assisting Alliance comments on Section 1005 – Minimum Standards of Infection Control
 - E. Email from Leslie Canham, CDA, RDA, CDIPC, CSP dated February 11, 2025, RE: Input Requested with personal contact information redacted and with the following attachments:
 - (1) Screenshot from the Association for Dental Safety (ADS)'s website showing hyperlinks and information regarding Dental Unit Waterlines (DUWL): overview and resources
 - (2) Screenshot from the ADS' website showing hyperlinks to factsheets and information from the Food and Drug Administration, American Dental Association, ADS and Related Articles.
 - (3) Excerpt from 2003 CDC Guidelines for Infection Control, entitled "Strategies To Improve Dental Unit Water Quality"
 - (4) Excerpt from 2003 CDC Guidelines for Infection Control, entitled "Maintenance and Monitoring of Dental Unit Water"
 - (5) Excerpt from document entitled "SYNOPSIS OF PROPOSED ADOPTIONS OF THE GEORGIA BOARD OF DENTISTRY RULE 150-8-.05 DENTAL UNIT WATER QUALITY."
 - (6) Journal of Dental Infection Control and Safety, Vol. 1, Issue 1, DENTAL UNIT WATER QUALITY: ORGANIZATION FOR SAFETY, ASEPSIS AND PREVENTION WHITE PAPER AND RECOMMENDATIONS–2018, the Organization for Safety, Asepsis and Prevention (OSAP).
 - (7) Sheet entitled "DENTAL UNIT WATERLINE INFECTION CONTROL: A GUIDE TO DENTAL WATER INFECTION CONTROL FROM ADA"

- F. Email from Amy Knepshield Condrin, MPH, Senior Consultant
OSHA Review, Inc. Re: Urgent: Dental Board of California Contact to Submit
Feedback on Proposed Infection Control Language, dated March 1, 2025,
with attachment from CDC's Morbidity and Mortality Weekly Report entitled
"Guidelines for Infection Control in Dental Health-Care Settings — 2003,"
dated December 19, 2003
 - G. Email from Amy Knepshield Condrin, MPH, Senior Consultant
OSHA Review, Inc. Re: Urgent: Dental Board of California Contact to Submit
Feedback on Proposed Infection Control Language, dated March 2, 2025
 - H. 16 CCR 1005 Summary of Stakeholder Comments with the Board's Working
Group's Responses and Other Recommendations
11. Board's May 14-15, 2025, Board Meeting Agenda, Minutes and Relevant Meeting
Materials that include:
- A. Board memo dated April 28, 2025 to Members of the Dental Board of
California entitled "**Agenda Item 10.b.**: Discussion and Possible Action to
Initiate a Rulemaking to Amend California Code of Regulations (CCR),
Title 16, Section 1005 Regarding Minimum Standards for Infection
Control"
 - B. Proposed Regulatory Text to Amend CCR, Title 16, Section 1005
Approved by DHBC and dated 11/5/24
 - C. Proposed Regulatory Text to Amend CCR, Title 16, Section 1005, dated
5/14/25
 - D. Letter to Board from the California Dental Assisting Alliance, dated
February 7, 2025 RE: Dental Assisting Alliance comments on Section
1005 – Minimum Standards of Infection Control
 - E. Email from Leslie Canham, CDA, RDA, CDIPC, CSP dated February 11,
2025, RE: Input Requested with personal contact information redacted
and with the following attachments:
 - (1) Screenshot from the Association for Dental Safety (ADS)'s website
showing hyperlinks and information regarding Dental Unit Waterlines
(DUWL): overview and resources
 - (2) Screenshot from the ADS' website showing hyperlinks to factsheets and
information from the Food and Drug Administration, American Dental
Association, ADS and Related Articles.
 - (3) Excerpt from 2003 CDC Guidelines for Infection Control, entitled
"Strategies To Improve Dental Unit Water Quality"
 - (4) Excerpt from 2003 CDC Guidelines for Infection Control, entitled
"Maintenance and Monitoring of Dental Unit Water"

- (5) Excerpt from document entitled “SYNOPSIS OF PROPOSED ADOPTIONS OF THE GEORGIA BOARD OF DENTISTRY RULE 150-8-.05 DENTAL UNIT WATER QUALITY.”
- (6) Journal of Dental Infection Control and Safety, Vol. 1, Issue 1, DENTAL UNIT WATER QUALITY: ORGANIZATION FOR SAFETY, ASEPSIS AND PREVENTION WHITE PAPER AND RECOMMENDATIONS–2018, the Organization for Safety, Asepsis and Prevention (OSAP).
- (7) Page entitled “DENTAL UNIT WATERLINE INFECTION CONTROL: A GUIDE TO DENTAL WATER INFECTION CONTROL FROM ADA”
- F. Email from Amy Knepshield Condryn, MPH, Senior Consultant OSHA Review, Inc. Re: Urgent: Dental Board of California Contact to Submit Feedback on Proposed Infection Control Language, dated March 1, 2025, with attachment from CDC’s Morbidity and Mortality Weekly Report entitled “Guidelines for Infection Control in Dental Health-Care Settings — 2003,” dated December 19, 2003
- G. Email from Amy Knepshield Condryn, MPH, Senior Consultant OSHA Review, Inc. Re: Urgent: Dental Board of California Contact to Submit Feedback on Proposed Infection Control Language, dated March 2, 2025
- H. 16 CCR 1005 Summary of Stakeholder Comments with the Board’s Working Group’s Responses and Other Recommendations

12. DHBC’s July 19, 2025 Board meeting Agenda, Minutes and Relevant Meeting Materials

Business Impact:

The Board has made the initial determination that the proposed regulations will not have a significant statewide adverse economic impact directly affecting businesses including the ability of California businesses to compete with businesses in other states.

This initial determination is based on the following facts or other evidence:

The proposal consolidates and updates existing minimum standards applicable to all dental healthcare personnel in a treatment facility consistent with current dentistry practice. It would also include a new requirement to have a written infection control plan and for employers to provide training on that plan at no cost to their employees during working hours; a copy of this regulation would need to be included in the plan.

Existing Board regulations already require employers to post the Board’s infection control regulation and have a written protocol developed, maintained and periodically updated for proper instrument processing, operator cleanliness and management of injuries; the

protocol must be made available to all personnel at the dental office. Existing Cal/OSHA regulations also already require dental healthcare personnel employers to provide training to their employees on the employer's exposure control plan at no cost to their employees during working hours. As a result, licensees are anticipated to comply with these provisions within normal business operations.

The regulations establish equipment and supply guidelines with estimated costs per item as follows:

CCR Section	Equipment Type	Volume	Cost*	Cost Per Unit*
1005(a)(6)(A)	Disinfectant cleaner (Cal/EPA-registered low-level)	4 gallons	\$120 – \$200	\$30 – \$50
1005(a)(6)(B)	Disinfectant cleaner (Cal/EPA-registered intermediate-level)	4 gallons	\$140 – \$240	\$35 – \$60
1005(a)(6)(C)	Disinfectant cleaner (Cal/EPA-registered high-level)	4 gallons	\$200 – \$350	\$50 – \$87.50
1005(b)(4)(A)	Safety glasses with side shields (ANSI/ISEA Z87.1-2020)	24 pairs (case)	\$180 – \$300	\$7.50 – \$12.50
1005(b)(4)(B)	Single-use disposable surgical facemask	2,000 (40 boxes x 50)	\$300 – \$450	\$0.15 – \$0.23
1005(b)(4)(C)	Chin-length face shield or face visor	240 (case)	\$350 – \$600	\$1.45 – \$2.50
1005(b)(4)(D)	Chemical and puncture-resistant utility gloves	36 pairs (12 packs x 3)	\$210 – \$300	\$5.80 – \$8.30
1005(b)(4)(F)	Protective attire gowns (reusable per Cal/OSHA)	12 (case)	\$240 – \$360	\$20 – \$30
1005(b)(4)(F)	Protective attire gowns (disposable)	500 (case)	\$350 – \$600	\$0.70 – \$1.20
1005(b)(5)(A)	Hand soap	4 gallons	\$100 – \$160	\$25 – \$40
1005(b)(5)(A)	Alcohol-based hand rub (60-95% concentration)	12 x 1,200 ml (case)	\$300 – \$350	\$25 – \$29.17
1005(b)(6)(A)	Medical examination gloves (disposable)	10,000 (50 boxes x 200)	\$450 – \$700	\$0.05 – \$0.07
1005(b)(8)(I)	Sterilization package with chemical indicator	2,000 (10 boxes x 200)	\$90 – \$150	\$0.05 – \$0.08

*Estimated Cost

The Board notes it does not have a total cost impact estimate because most licensees are already in compliance with the proposed standards. Additionally, the rate of consumption for licensees is unknown. As a result, any incremental cost impact cannot be determined at this time. However, licensees are anticipated to comply with the proposed regulations within normal business operations.

Economic Impact Assessment:

The Board has determined that this regulatory proposal will have the following effects:

- It will not result in the creation of new jobs or elimination of jobs within the State of California because the costs of complying with the revised regulations are minimal compared to the revenue businesses generate by providing dental services.
- It will not result in the creation of new businesses or elimination of existing businesses within the State of California because the costs of complying with the revised regulations are minor compared to the revenue businesses generate by providing dental services.

- It will not affect the expansion of businesses currently doing business within the State of California because the proposed regulations because the costs of complying with the revised regulations are minor compared to the revenue businesses generate by providing dental services.
- This regulatory proposal will benefit the health and welfare of California residents because updates to the Board's Guidelines for infection control establish the minimum infection prevention and control standards required of all dental healthcare personnel (DHCP) covered by this proposal to protect the health and safety of patients, staff, and the broader community. It ensures alignment with, and enforcement of, current evidence-based practices and supports statewide consistency in the delivery of safe dental care.

The proposal helps safeguard public health by ensuring that all DHCP adhere to up-to-date infection prevention and control practices to help ensure currency of scientific knowledge, preparation for emerging infectious threats, and use of advancements in dental technology including compliance with:

- Standard precautions
- Protocols for cleaning, sterilization, and disinfection
- Requirements for clinical surface cleaning and disinfection
- Dental unit waterline quality and maintenance standards
- Personal protective equipment (PPE) use requirements
- Hand hygiene protocols and hand care standards
- Respiratory hygiene/cough etiquette measures
- Staff training and documentation of compliance requirements

Updating and enforcing infection control standards strengthens patient safety, reduces the risk of bloodborne infectious diseases, promotes consistency in safeguards across dental practices, and enhances public trust in the state's dental care system.

- This regulatory proposal benefits worker safety because the regulatory proposal updates the minimum required standards for cleaning, sterilization, PPE use, and injury management, incorporating current scientific evidence, reducing exposure to infectious materials, standardizing handling of sharps and other instruments, and ensuring all staff are trained and following consistent, up-to-date safety practices.

- This regulatory proposal does not affect the state's environment. The proposal impacts the minimum infection control standards required to be used by all dental health care personnel in all dental treatment facilities; however, those safety standards should not impact the state's environment.

Specific Technologies or Equipment:

This regulation mandates the use of specific technologies or equipment. Such mandates or prescriptive standards are required for the following reasons. To help to ensure greater public safety using the most effective safeguards, the regulation will require specific protective equipment and cleaning supplies as follows:

CCR Section	Equipment Type
1005(a)(6)(A)	Disinfectant cleaner (Cal/EPA-registered low-level)
1005(a)(6)(B)	Disinfectant cleaner (Cal/EPA-registered intermediate-level)
1005(a)(6)(C)	Disinfectant cleaner (Cal/EPA-registered high-level)
1005(b)(4)(A)	Safety glasses with side shields (ANSI/ISEA Z87.1-2020)
1005(b)(4)(B)	Single-use disposable surgical facemask
1005(b)(4)(C)	Chin-length face shield or face visor
1005(b)(4)(D)	Chemical and puncture-resistant utility gloves
1005(b)(4)(F)	Protective attire gowns (reusable per Cal/OSHA)
1005(b)(4)(F)	Protective attire gowns (disposable)
1005(b)(5)(A)	Hand soap
1005(b)(5)(A)	Alcohol-based hand rub (60-95% concentration)
1005(b)(6)(A)	Medical examination gloves (disposable)
1005(b)(8)(I)	Sterilization package with chemical indicator

Consideration of Alternatives:

No reasonable alternative to the regulatory proposal would be either more effective in carrying out the purpose for which the action is proposed or would be as effective or less burdensome to affected private persons and equally effective in achieving the purposes of the regulation in a manner that ensures full compliance with the law being implemented or made specific.

No such alternatives have been proposed, however, the Board welcomes comments from the public.

Description of reasonable alternatives to the regulation that would lessen any adverse impact on small business:

No such alternatives have been proposed, however, the Board welcomes comments from the public.