

**DENTAL PROGRAM PROCEDURES**

**SCHEDULE OF DENTAL SERVICES**

**DENTAL CLINICAL GUIDELINES**

**And**

**CLINICAL EVALUATION CRITERIA**

**Approved**

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## INTRODUCTION

This manual describes a comprehensive schedule of oral health services available in dental clinics and programs which provide care under the direction of \_\_\_\_\_. Also described are the system-wide dental program procedures, dental clinical guidelines, and clinical evaluation criteria for all dental programs functioning under this authority. The described professional services have been defined using the standard procedure codes and nomenclature elaborated by the American Dental Association for reimbursement purposes in dental insurance programs.

The following schedule of services have been designed to meet federal and state requirements of all agencies providing reimbursement for the provision of dental services to the population groups which are served by our organization. In instances where the requirements of the funding agency are different than those enclosed herein, it is incumbent upon the medical and dental directors of the affected clinic to comply with the requirements of that funding agency which shall supersede the following schedule of services provided that the quality of care is not compromised.

The following schedule of services has been written to comply with an administrative interpretation of requirements of law and regulations described in the **Health Centers Consolidation Act of 1996** and the **Code of Federal Regulations, 51c Grants for Community Health Services, revised 1996** as well as Health and Human Services (DHHS) priorities as described in the draft publication entitled **Bureau Of Primary Health Care Oral Health Policy And Program Expectations For Community And Migrant Health Centers (1997)**.

The services detailed herein, while primarily focuses on clinics which have an onsite dental program also address the dental responsibilities of non-dental personnel in medical clinics which does not have an on-site dental program. The individual clinic medical director (or dental director when one exists) is responsible for developing a primary oral health care plan which addresses the needs of the community based upon financial feasibility. The dental program should be determined based upon projected revenues, other resources and grant support.

The quality of dental care provided by the dental programs of \_\_\_\_\_ shall be an integral requirement of that care and, as such, shall be subject to continual monitoring and review. The Quality Assurance/Continuous Quality Improvement (QA/CQI) program shall include the following:

1. A quality workforce - will insure that a high quality of dental personnel provide dental services through the recruitment and selection effort (Human Resources Department) and credentialing process (The Quality Improvement/Professional Affairs Committee).
2. A high standard of professional care - will insure that a high quality of professional care is provided through a carefully structured, active peer review of each dentist's activities through regularly scheduled, rotating chart audits. The audits will focus upon appropriateness of care, comprehensiveness of care, and continuity of care.
3. A high standard of service delivery - will insure that patients are satisfied with each clinics accessibility and patient care through regular patient satisfaction surveys.
4. A continuing Performance Improvement of health status outcomes - will insure that each clinic is provided a mechanism to record, review, and improve certain quantifiable and identifiable health outcomes consistent with the health care plan adopted by this

organization. Clinics will utilize these measures to help eliminate the disparities experienced by vulnerable and underserved populations.

The Health Centers Consolidation Act of 1996 requires that federally funded health centers provide preventive dental services and pediatric dental screening to determine need for care and emergency services. The scope of each clinic's dental services will, therefore, have as its base these services. Additional primary oral health care services may be included where an on-site dental program exists.

Clinic sites which do not have an on-site dental program must make arrangements with other dental providers to provide access to required services for their service population. At a minimum these clinic sites should provide the minimum preventive dental health education services and track referrals to appropriate oral health care providers in the community or in a contiguous population area for preventive and emergency services.

Clinic sites having an on-site dental facility are to adopt the following schedule of dental services, thereby providing the community a comprehensive dental care program. Individual sites unable to comply with this organizational requirement must be able to justify why services and/or populations are excluded from the scope of practice, if the scope of services is limited and/or less than comprehensive.

**The scope of services for primary oral health care programs is comprised of the following services and activities:**

LEVEL I SERVICES - Acute Emergency Dental Services (Required):

Services which eliminate acute infection, control bleeding, relieve pain, and treat injuries to the maxillofacial and intraoral regions.

Activities: Diagnosis, Pulp Therapy, Tooth Extraction, Palliative or Temporary restorations and fillings, periodontal therapy, and prescription of medications.

LEVEL II SERVICES - Prevention and Diagnosis (Required):

Services that protect individuals and communities against disease agents by placing barriers between an agent and host and/or limiting the impact of a disease once an agent and host have interacted so that a patient/community can be restored to health. Risk assessment should occur for children, in particular, in migrant camps, homeless shelters, and community schools where at-risk children attend.

Activities: Professional oral health assessment, dental sealants, professional applied topical fluorides, and supplement prescriptions where necessary, oral prophylaxis, and patient/community education on self maintenance and disease prevention, and pediatric dental screening to assess need.

LEVEL III SERVICES - Treatment of Dental Disease/Early Intervention Services:

Basic dental services which maintain and restore oral health function:

Activities: Restorative services which include dental fillings and single unit crowns; periodontal maintenance services; such as periodontal scaling, non-surgical periodontal therapy; space maintenance procedures to prevent orthodontic complications for patients 3-13; endodontic therapy to prevent tooth loss; and simple, interceptive orthodontic treatment provided to prevent severe, avoidable malocclusion for patients 6-12.

#### LEVEL IV SERVICES - Rehabilitative Services (optional):

Provision of low cost solutions to replace dentition that would allow patients to obtain employment, education, or enhance self esteem. Patients share in costs of these services to a greater extent than in any of the other categories within the scope of care.

Activities: Fabrication of removable prosthetics; such as dentures and partial dentures, single or multiple unit fixed prosthetics, elective oral surgery, and other specialty services.

The clinical guidelines and evaluation criteria detailed in the following document; while specific in many instances have been designed to allow Dental Directors and Clinic Administrators adequate latitude to develop a dental plan which is effective, based upon the needs of their community. We would anticipate that this latitude coupled with the wide diversity in community size and age of the target patient populations, will allow for significantly divergent provider production profiles. These protocols do, however, require that all dental programs meet or exceed the accepted therapeutics and guidelines of the American Dental Association as well as other relevant program regulations of contracting agencies

The aforementioned levels of care are prioritized. The lower levels of care include services which are: 1) the most frequently needed, 2) the least costly to provide in terms of manpower or dollars, and 3) those which produce the greatest long-term benefit to oral health in the community. The provision of emergency care has been considered mandatory and thus, it forms the first level of services. After Level I, those services which prevent oral disease have been given greater priority than those intended to contain a disease process or to correct the damage caused by the consequences of disease.

The schedule of services and clinical guidelines are intended to provide direction for: dentists employed by \_\_\_\_\_, dentists contracting dental services to \_\_\_\_\_, administrators of dental programs and third party administrators. Local administrators and unit dental directors may use the schedule of services as a guide to develop a dental care delivery system sensitive to the needs and desires of the community while maintaining assurances that the most cost-effective services are provided. The guidelines should prove useful in all dental clinic programs.

It should be noted that while the prioritized levels of care address the identification of those services which will provide the greatest good to the greatest number in a community, administrators and dental directors must consider the benefit to the financial viability of their program which may be obtained through the inclusion of Level IV services. Level IV services, while elective in nature; require a greater degree of cost sharing by the patient, thereby serving to support the financial integrity of the program.

#### **HOURS OF OPERATION**

Dental clinics operated by \_\_\_\_\_ shall endeavor to maintain regular clinic hours of operation which shall best meet the needs of the community being served.

It shall be the intent of all dental clinics to provide dental services to the majority of the health centers population. Clinics, therefore, should strive to provide services which will allow members of their patient population to access services with minimal impact upon the personal obligations of patients/ employment. Clinics are encouraged to block time for emergency care during early mornings and/or evenings.

All dental clinics should provide mechanisms for patient care outside of regular clinic hours, specifically after hours and week-end emergency care. These mechanisms may include arrangements with other community

providers, arrangements with on-call medical clinic staff, or arrangements with local hospital emergency room facilities. The health center population must be able to receive emergency relief of pain and/or infection after hours and on week-ends, and it is the responsibility of the clinic dental director and the clinic administrator to provide access to such care.

## **PATIENT SCHEDULING/PATIENT FLOW**

Dental clinics should maintain adequate flexibility in their appointment scheduling systems to allow for evaluation of emergency problems, walk-in patients, patients with special problems, and new patients. It being understood that should demand for care exceed a clinics capability to provide such care, measures to place limitations on the availability and nature of that care may be necessary and appropriate. Limitations or exclusions of care must take into consideration the clinics various contractual commitments, the clinic size, staffing, and financial resources. System dental directors and clinic administrators are encouraged to consult with the Corporate Dental Director and Corporate Officers prior to curtailing or limiting dental services.

In order that dental clinics operate at maximum efficiency it is recommended that there be at least two operatories per dentist and one operatory per hygienist. Clinics should attempt to provide a minimum of 1.5 FTE chairside dental assistants per dentist.

Clinics should endeavor to facilitate patient flow by employing such measures as:

1. Closely following a printed daily schedule placed in each treatment room for easy access by all dental and dental assisting personnel.
2. Allowing office manager/dental secretary complete appointment book control.
3. Maintaining a well-trained chairside assisting staff, certified to provide all expanded functions allowed by the states Dental Practice Act.
4. Maintaining dental equipment to prevent down time of a portion of the clinic.
5. Maintaining an adequate supply of sterile instruments and supplies.
6. Adequate cross-training of staff to allow for unexpected absences of critical staff.
7. Insuring that auxiliary staff are trained to minimize the efforts of the dentist by adequately preparing patient and treatment rooms, i.e. all instruments required for initiating care are at hand, lipstick removed, napkin placed operatory fully equipped with sterile handpiece, etc.

## **PATIENT RECORDS**

In clinics where the dental clinic is in close approximation to the medical records room, where office design is appropriate, and where a combined medical-dental record will not compromise the accessibility of the dental record, a combined record will allow physicians, dentists and behavioral health care workers to have an optimum knowledge of the entirety of the health services being provided the patient by providers.

Dental clinic design and placement within the facility and record accessibility problems may, however, preclude a combined record. Each facility, therefore, should determine if a combined record is feasible.

The dental record should contain:

1. Patient registration sheet, signed by patient (including treatment consent statement).
2. Copy of patients insurance or Medicaid card
3. Medical History

4. Dental Examination
5. Progress Notes sheets added as required
6. X-ray envelope

The patient chart, when opened, should display the Medical History Form on the left and the Dental Examination Form on the right. The dentist should be able to view the opened chart to these two pages during treatment reducing the need to touch the chart after having gloved for patient care.

A full page Dental Examination form upon which a new patient existing dental conditions is charted with a blue pencil, is overlaid with a 2 sheet exam form upon which needed care is charted in red. The 2 sheet overlay should also display the treatment plan which is to be filled out at the exam appointment with approximate time intervals required between appointments.

The 2 sheet overlay should also display any drug allergies or medical conditions which might require the dentist or hygienist to provide special consideration to that patient before or during patient care (such notations should be replicated at the top of each sheet of the progress notes as well).

Specific requirements of Patient Dental Records are detailed in the Dental Guidelines and Evaluation Criteria (see Sec. I.A.).

### **PATIENT DATA SYSTEMS**

All patient registration data is entered in the \_\_\_\_\_ Patient Data Base. This information is accessible from all outpatient clinics sites of the organization and does not include patient medical, dental or behavioral health records. This material is maintained in the AS400 computer data base at Central Office.

Patients' individual health care charts are maintained at each clinic site utilizing strict principles of confidentiality.

\_\_\_\_\_ staff (including janitorial personnel) are required to attend an in-service orientation on confidentiality. Under no circumstances is information in either the patient registration data or patient health care records to be shared with any persons other than staff who require access to this data for the delivery of said health care.

A separate data grouping may be kept for patient recall information. This data may be kept apart from the dental patient record, but may include information only pertaining to patient number, patient name, address, telephone number, names of parents or guardians, and dates of anticipated recall appointments. This file should not contain health care information.

Individuals desiring copies of patient records or x-rays should be provided to them. Patients should expect a reasonable period of time for the processing of these copies. Under no circumstances may any staff member give or lend the original copies of patient records or x-rays to patients, patient's parents, guardians or insurance companies.

See Administrative Policies and Procedures:

Procedures for Release of Patient Medical Records to Third Parties, and  
Policy III A (Retention of Records)

## **PATIENT TRACKING/CLINIC PRODUCTIVITY MEASURES**

Clinic productivity and dental clinic staff productivity may be evaluated by any number of methods.

Patient encounters, which have historically been the basic productivity measure, will continue to be monitored. Provider encounter rates, while subject to valid criticism due to the great variety of procedures which an encounter may represent, will continue to be monitored due to the value inherent in any measure which has been recorded for a significant period of time. Indeed, the practice of calculating and distributing to dentists their average number of encounters/8 hr day is valuable for it allows dentists to compare their encounter productivity with that of their colleagues.

Other measures, including those which are associated with Relative Value Units, will also be utilized (Appendix A). These values will more closely evaluate the efficient use of a provider's time for they determine the number of ten minute measures of time a provider expends providing patient care for a specific procedure.

Another set of productivity measures which cannot be ignored are the financial activity reports. It is crucial that dental clinics generate adequate income to maintain their financial viability. Dental directors must recognize and accept the administrative responsibility of their programs, and will track provider productivity in a growing number of ways to assure that the amount of service is at a level to ensure adequate cash flow to meet daily operations, assure access to care, and maximize benefits for the patient population.

## **QUALITY ASSURANCE INDICATORS**

\_\_\_\_\_ strives to maintain the highest quality of dental care possible by insuring a high quality workforce through a careful recruitment and selection effort by the Human Resources Department and a stringent credentialing and privileging process by the Quality Improvement / Professional Affairs Committee.

Quality clinical care will be assured through an active, carefully structured Peer Review Program. This program, which focuses upon appropriateness of care, comprehensiveness of care, and continuity of care is based on regularly scheduled chart audits. Dentists within the organization utilize the attached chart audit standards and audit document (Appendix B) to regularly evaluate the performance of their colleagues. The results of the audits are provided to the dentist evaluated and to the clinic administrator to formulate methods of improving upon any weaknesses in the care provided by the dental program which were identified by the chart audit.

Other Evaluation Criteria (Sec. IV) directly related to the Dental Clinical Guidelines may be included in specific Peer Review Audits or in the Performance Improvement Program in a given audit year. The evaluation criteria in this section will be utilized when specific patient complaints arise or concerns occur within the organization which relate to the quality of clinical care being provided by a given dental provider or clinic. Dental Directors and/or corporate officers may direct that one or more of the Clinical Guidelines Evaluation Criteria be selected as Performance Improvement indicators to evaluate any one or all system dental clinics as described in the following paragraph.

The third evaluation instrument, to be referred to as the Performance Improvement Program, requires regular reporting of suspected problem or high risk area quantifiers, and shall be monitored to evaluate specific dental health outcomes. These quantifiers may be, but are not limited to, the Evaluation Criteria of the Dental Clinical Guidelines (Sec. IV). The reporting of these identified quantifiers of care will continue until the system Dental Directors or corporate officers determine that the assessment of these outcomes are no longer of high priority.

Clinic Dental Directors will be responsible for reporting the data required for this Performance Improvement activity. Reporting may be as often as monthly, the reporting document will be on a Performance Improvement form. These activities will follow a Plan, do, check and act format.

Quality of service delivery is a very important aspect of our clinics care. We regularly attempt to evaluate our patients' satisfaction with the manner in which we deliver that care through patient satisfaction surveys. The results of these surveys are evaluated by the dental directors and the clinic administrators to identify methods of improving the way in which we deliver dental care.

It is of primary importance to \_\_\_\_\_ to determine that the efforts of our dental programs staff and the monetary expenditures of our dental clinic systems are improving the dental health of our communities. Toward that end is endeavoring to create certain outcomes based on statistical measures which can help make those determinations. These measures are included in the Health Plan Document and may be evaluated through Performance Improvement; Peer Review, and Clinical Care Guidelines Evaluation Criteria programs

Quality will always be an issue of key consideration with \_\_\_\_\_. As such, our efforts to track quality will always be evolving. The measures we utilize today will be improved upon as our programs develop better ways to document and report their activities.

## **EMERGENCY CARE**

### **AND**

## **REFERRALS TO/FROM OTHER DENTAL PROVIDERS**

### **EMERGENCY REFERRALS FROM OTHER OFFICES TO CLINICS:**

Dental clinics should block appropriate units of time for patients needing emergency care and for emergency referrals from other practitioners. Dental clinics will make every effort to help patients requiring emergency care or who are referred for dental emergencies from other offices in one of the following ways:

1. Will see the patient for immediate treatment or
2. After an examination will prescribe appropriate medications to relieve the pain and/or infection until an appointment can be scheduled, or
3. Refer patient to the medical clinic for medical evaluation and needed prescriptions until the dental clinic can schedule an appointment for required care, or
4. Refer the patient to another dental office, or
5. Refer the patient to the nearest hospital emergency room.

### **REFERRALS FROM DENTAL CLINICS TO OTHER PROVIDERS:**

Dental facilities may deem it necessary to refer a patient to another office if:

1. Neither the dental clinic nor the medical clinic are able to attend to the patients problem or
2. The dental clinic examines the patient and determines that the patient would be better served seeking care from a specialist, or another provider better trained to treat the patients problem.

When a dental facility refers a patient to another office it will do the following:

The dentist or a dental staff member shall telephone the dentist to whom the patient is to be referred confirming the availability of an appointment within a reasonable period of time.

1. The dental facility will note the referral in the patient's chart, if applicable, and log the referral, noting the day and time of the appointment, next to the patient's name and telephone number.
2. If considered an emergency, the dental facility will telephone the dentist's office where the referral was arranged, after the appointed time, to confirm the arrival of the patient. In the event that the patient did not keep the referral appointment the patient shall be telephoned to re-establish the needed appointment with the dentist's office.
3. If the referral is not an emergency, the dentist may elect to simply confirm the referral at the next patient visit to the clinic, re-referring the patient if necessary.

### **Risk Management**

In recent years there has been a frightening increase in the number of malpractice claims brought against dentists. This trend has had a profound impact on several aspects of dentistry: the costs of malpractice insurance are increasing, leading to an increase in cost to patients, and dentists are concerned that they must constantly practice defensively. This increasing influence of litigation on dentistry has resulted in an effort by the profession to reduce the risk of legal liability by more closely examining several issues, including treatment, improved documentation, and better dentist-patient relationships. Reviewing all aspects of dental practice to provide the best possible patient care and to reduce unnecessary legal liability is termed *risk management*.

Although there is no substitute for sound clinical practice, many lawsuits are related directly to miscommunication and misunderstanding between the dentist and patient, not to treatment problems. This section reviews concepts of liability and risk management and discusses methods of risk reduction.

### **RISK REDUCTION**

The foundation for all dental practice should be based on sound clinical procedures. However, properly addressing other aspects of patient care may significantly reduce potential legal liability. These aspects include dentist-patient communication, patient information, informed consent, proper documentation, and appropriate management of complications.

#### **Patient information**

One method of improving the dentist-patient relationship is to provide patients with as much information as possible on any specific problems that the patient may have their relationship to overall health, and methods of managing them. Well-informed patients generally have a much better understanding of specific problems and more realistic expectations about treatment outcomes. Efforts by dental practitioners to provide information to patients generally improve patient rapport.

Patients value and expect a discussion with their dentist about their care. Brochures and various other types of informational packages are often very helpful in providing patients with both general and specific information about general dental and oral surgical care. Patients who need oral surgical, periodontic or endodontic care will benefit from information on the nature of their problem, recommended treatment and alternatives, expectations,

and possible complications. This information should have a well-organized format that is easily understood and is written in layman's language. When a dentist has a specific discussion with a patient or gives a patient an informational package, it should be documented in the patients chart.

## **Informed consent**

Dentists (and their parent organization) can be sued not only for negligence in dental treatment but also for failing to inform patients properly about the treatment to be rendered, alternatives, and possible complications of that treatment.

The current concepts of informed consent are based as much on providing the patient the necessary information as on actually obtaining a consent or signature for a procedure. In addition to fulfilling the legal obligations, there are several benefits of obtaining the proper informed consent from patients (see App. D). First, well-informed patients who understand the nature of the problem and have realistic expectations are less likely to sue. Second, a properly presented and documented informed consent often prevents unmeritorious claims based on misunderstanding or unrealistic expectations of the patient. Finally, obtaining informed consent offers the dentist the opportunity to develop better rapport with the patient by demonstrating greater personal interest in the patients understanding of the problem and anticipated treatment.

Initially, informed consent was to inform patients that bodily harm or death may result from a procedure. It did not require discussion of minor, unlikely complications that seldom occur and infrequently result in ill effects. However, many states have currently adopted the concept of *α* material risk, which requires dentists to discuss *all* aspects material to the patients decision to undergo treatment, even if it is not customary in the profession to provide such information. A risk is material when a reasonable person is likely to attach significance to it assessing whether to have the proposed therapy.

Informed consent actually consists of three phases:

1. Discussion
2. Written consent and
3. Documentation in the patients chart.

A frank, oral discussion of the appropriate issues should take place between the dentist and patient. If the patient is a minor, a parent or legal guardian must be present. In addition, at least one witness must be present during this discussion. This can be an auxiliary person from the dental office, the patients spouse (or an interested participant) or both, if possible. The witness's signature on the informed consent document not only verifies the patient's signature but also verifies that the information was actually presented to the patient. It is therefore necessary that the witness be present during the discussion. The discussion should include information about 1) the specific problem; 2) proposed treatment; 3) anticipated common side effects; 4) possible complications and frequency of occurrence; 5) anesthesia; 6) treatment alternatives; and 7) uncertainties about final outcome, including a statement that the treatment has no absolute guarantees or warranties. \_\_\_\_\_ has developed informed consent documents in English and in Spanish. They are to be used prior to any oral surgery or endodontic procedure. This information must be presented so that the patient has no difficulty understanding it. It is also necessary that this information be presented by the dentist and not delegated to a dental assistant or other auxiliary personnel. At the conclusion of the discussion the patient must be given an opportunity to ask any remaining questions.

After the discussion, the written informed consent must be signed by the patient, the dentist, and a witness (dental assistant). The written consent should include each of the items presented in the discussion, described in easily

understandable terms. It must also be documented that the patient can read and speak English; if not; the oral presentation and written consent should be given in the patients language. A person who speaks but does not read a language provided on the consent forms shall receive the discussion in their language by a member of the dental staff or a family member of friend. These situations, being far from ideal, must be extremely well documented. The patient, the interpreter, and a staff member should all sign the English document, indicating that a foreign language translation was performed providing the name of the translator. To ensure that the patient understands each specific aspect of the written consent form, each paragraph should be individually initialed. At the conclusion of the discussion, the informed consent document should be signed by the patient, the dentist, the translator (if one was required), and at least one witness. In the case of a minor the informed consent should be signed by both the patient and parent or legal guardian.

The third and final phase of the informed consent procedure is to document in the patients chart that an informed consent was obtained. This documentation should include a note stating that the discussion took place. The written consent form should be included in the chart.

There are three special situations in which an informed consent may deviate from these guidelines:

1. A patient may specifically ask not to be informed of all aspects of the treatment and complications (this must be specifically documented in the chart).
2. It may be harmful in some cases to provide all of the appropriate information to the patient. This is termed *the therapeutic privilege* for not obtaining a complete informed consent. It is somewhat controversial and would rarely apply to routine dental or oral surgical procedures.
3. A complete informed consent may not be necessary in an emergency, when the need to proceed with treatment is so urgent that unnecessary delays to obtain an informed consent may result in further harm to the patient. It should be noted that while many dental conditions may seem urgent in the eyes of the dentist, the reality is that most can be stabilized without an invasive procedure, allowing the patient time to confer with family members or even seek a second opinion.

The Quality Improvement/ Professional Affairs Committee of \_\_\_\_\_ have approved the Informed Consent forms attached in Appendix B. These forms are to be utilized for all oral surgery and endodontics. Compliance with this requirement is important enough to be included in our peer review chart review document.

## Records and documentation

Adequate documentation of the diagnosis and treatment is one of the most important aspects of patient care. In addition to the obvious patient care issues, the patient record frequently forms the basis for and contains the information directly related to litigation. The following is information that *must* be included in the chart:

1. Current medical history (valid for one year- after which new history to be completed)
2. Current medications
3. Allergies
4. Clinical and radiographic findings (e.g.: caries, periapical abscess, pericoronitis, etc. (All emergency/urgent care must follow SOAP format, i.e.: subjective findings, objective findings, assessment of problem, proposed treatment)
5. Recommended treatment (may be on treatment plan section of exam sheet)
6. Therapy instituted
7. Recommended follow-up care

Other information often overlooked that should also be included in every chart is the following:

1. All prescriptions or refills should be replicated in patients progress notes as written or as dictated to pharmacy over the telephone. Notation should include:
  - a. Drugs generic name
  - b. Strength of medication prescribed
  - c. Number of pills/ccs of syrup prescribed
  - d. Dosage prescribed
  - e. Duration of medication period
2. Medications or drugs utilized during treatment (specify: drug name, strength, amount)
3. All messages or other discussions related specifically to patient
4. Any consultations obtained
5. Appointments recommended (may be in treatment plan)
6. Post-op instructions and orders given
7. Missed or canceled appointments
8. Informed consent

Corrections should be made by drawing a single line through any information to be deleted and the correct information inserted above. The single-line deletion should be initialed. No portion of the chart should be discarded, erased, or altered in any fashion.

All entries into dental progress notes which describe dental treatment provided under the authority of a dentist (including hygienists procedures) must be signed by the dentist. The first signature on each page by a given dentist must be the signature which is on file with the administrative offices of the clinic and should include the dentists' professional degree (i.e. DDS, DMD, etc). Additional signatures on that page by that dentist may be the dentist's initials (also on file). Clerical staff who record no-shows and cancellations in the dental chart must sign their full signature after recording such an entry.

## **Complications**

In spite of the best efforts in diagnosis, treatment planning, and technique, the outcome of a procedure(s) is sometimes less than desirable. A poor result does not necessarily suggest that a practitioner is guilty of negligence or other wrongdoing. However, when complications occur, it is mandatory that the dentist immediately begin to address the problem in an appropriate manner.

In most instances the dentist should frankly discuss the problem with the patient. When possible, the dentist should avoid admitting guilt or liability. Examples of such situations are loss or failure to recover a root tip, perforation of the maxillary sinus, damage to adjacent teeth, inadvertent fracture of surrounding bone, separated endodontic file, etc. In these instances the dentist should clearly outline proposed management of the problem including specific instructions to the patient, further treatment that may be necessary, and referral to an oral surgeon, endodontist, periodontist, etc. when appropriate.

In some instances a poor outcome is more clearly related to practitioner error, such as the extraction of the wrong tooth. It is again necessary to present the problem frankly and honestly. However, it is generally best to consider all treatment options that may still produce reasonable results, even after extraction of the wrong tooth. In many such instances a referral to a specialist (in this case an orthodontist) should occur before removing any further teeth to see if an orthodontic solution to the lost tooth may be an appropriate action to avoid an adverse outcome. If serious endodontic problems arise an endodontic referral would be advisable. If the problem occurs on a child

patient the parents should be notified immediately. The dentist must assume the responsibility of relating the problem to the parent(s), recommending solutions which may best remedy the problem.

It is very important that the malpractice carrier for be notified of any *potential* litigation. And clearly if a patient threatens to discuss the problem with an attorney the malpractice carrier must be notified. It is also important that the dentist refrain from entering into any arguments with the patient or the patient's representative, and should not admit liability or negligence. Finally, it is imperative that the record accurately reflect the details of the occurrence. No additions, deletions, or changes of any sort should be made in the patient's record at a later date. Records must not be misplaced or destroyed according to records retention policies.

## **Patient Abandonment**

Having accepted a patient for care and initiated treatment, the dentist is obligated to provide care until the treatment is terminated. There is an obligation of community health centers to continue to treat patients even after others would have given up. There are virtually no situations when termination of a patients care is justified. In those instances when it is determined, however, that the patient's problem would be better resolved in another setting, it is appropriate to refer the patient to that resource.

If a situation should arise in which the dentist believes the dentist-patient relationship between that dentist and a patient should be terminated, the clinic dental director must follow certain steps before discontinuing treatment to avoid being accused of patient abandonment. They are:

1. Approval to terminate care must be obtained from:
  - a. The Corporate Dental Director or the Corporate Medical Director and
  - b. The Clinic Administrator, after which
2. A letter must be sent to the patient, indicating the intent to withdraw from the case and the unwillingness to provide further treatment -
  - a. The letter must explicitly include the reasons for the decision to discontinue treatment, and
  - b. The letter should be sent by certified mail to ensure that the patient does in fact receive it.
3. The dentist must continue to remain available for treatment of emergency problems until the patient has had adequate time to seek treatment from another dentist.
4. The dentist must offer to forward copies of all pertinent records that affect patient care.

## **Summary**

In addition to providing the best technical care, the dentist must address several other aspects of patient care to minimize unnecessary legal liability. The dentist should develop the best possible rapport with patients through improved communication, providing any information that may improve their understanding of treatment. Adequate documentation of all aspects of patient care is also necessary.

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## **SCHEDULE OF DENTAL SERVICES**

### **LEVEL I DENTAL SERVICES**

#### **ACUTE EMERGENCY DENTAL CARE (REQUIRED)**

Emergency dental services are those necessary for the relief of acute oral conditions. Emergency Dental care services include all necessary laboratory and preoperative work including examinations, radiographs, and appropriate anesthesia (local, general, sedative) for optimal management of the emergency. Emergency dental services shall include but are not limited to the following:

1. Control of oral and maxillofacial bleeding in any condition when loss of blood will jeopardize the patients well-being. Treatment may consist of any professionally accepted procedure deemed necessary.
2. Relief of life-threatening respiratory difficulty and improvement of the airway (respiratory system) from any oral and maxillofacial condition. Treatment may consist of any professionally accepted procedure deemed necessary.
3. Relief of severe pain accompanying any oral or maxillofacial condition affecting the nervous system limited to immediate palliative treatment, but including extractions where professionally indicated.
4. Immediate and palliative procedures for:
  - a) Fractures, subluxations, and avulsions of teeth
  - b) Fractures of jaw and other facial bones (reduction and fixation only),
  - c) Temporomandibular joint subluxations, and
  - d) Soft tissue injuries
5. Initial treatment for acute infections.

Emergency dental conditions are determined to be such by the dentist and not by the patient. It must be recognized, however, that a patient's perception of the severity of their condition must be considered seriously. A broken denture, a lost anterior crown, a vague pain and even a chipped tooth are often considered to be calamitous conditions to some even though the implications to their general health are insignificant. Every effort must be made to place the severity of the condition into perspective for the patient should it be determined that immediate treatment is not required.

### **SCHEDULE OF LEVEL I SERVICES ACUTE EMERGENCY CARE (REQUIRED)**

#### **CLINICAL ORAL EXAMINATIONS**

00140 Limited Oral Evaluation - Limited to problem area, not an assessment of routine dental needs.

#### **RADIOGRAPHS**

00220-00330 Any and all radiographs deemed necessary to evaluate the condition presented.

#### **TESTS AND LABORATORY EXAMINATIONS**

00460 Pulp vitality tests (per episode)

#### **RESTORATIVE (TEMPORARY)**

02970 Temporary Restoration of Fractured Tooth

(Repair may be effectuated using any restorative agent accepted by the ADA Council on Dental Therapeutics, including, but not limited to IRM, Zinc Phosphate Cement, Zinc Oxide/Eugenol, Composite Resin, Alloy, Pre-formed Stainless Steel, Aluminum or Resin Crowns.)

#### PERIODONTICS (UNSCHEDULED)

04920 Unscheduled Dressing Change (by other than treating dentist)

#### REMOVABLE PROSTHODONTICS

05410 05422; 05510 05660

(i.e. any and all denture repairs and adjustments necessary to eliminate pain)

Also any denture repairs or revisions deemed cosmetically urgent by the dentist.

#### FIXED PROSTHODONTICS

06930 06980

(i.e. any repair or recementation necessary to maintain adequate position of abutment teeth or deemed cosmetically urgent by the dentist).

#### EXTRACTIONS

07110 Extraction single tooth, simple (primary or permanent tooth)

07120 Each additional tooth (at same appointment)

07210 Extraction of erupted (or partially erupted) tooth - requiring a tissue flap and removal of bone and/or sectioning of tooth.

07270 Tooth reimplantation and stabilization of accidental avulsed or displaced tooth or alveolus.

#### SURGICAL INCISIONS

07510 Incision and drainage of abscess - (intraoral).

07520 Incision and drainage of abscess - (extraoral).

#### TREATMENT OF SIMPLE FRACTURES

07610 Open reduction fractured maxilla, teeth immobilized (if present)

07620 Closed reduction fractured maxilla, teeth immobilized (if present)

07630 Open reduction mandibular fracture, teeth immobilized (if present)

07640 Closed reduction mandibular fracture, teeth immobilized (if present)

07670 Alveolus-stabilization of teeth, opens reduction splinting

#### MANAGEMENT OF TEMPOROMANDIBULAR JOINT DISLOCATION OR DYSFUNCTIONS

07820 Closed reduction of dislocation

09940 Occlusal guard (to relieve acute symptoms)

#### REPAIR OF TRAUMATIC WOUNDS

07910 Suture of recent small wounds up to 5cm

07911 Complicated suturing up to 5cm

07912 Complicated suturing greater than 5cm

#### SURGICAL INCISION

07971 Excision of pericoronal gingiva (with suturing if necessary)

#### ADJUNCTIVE LEVEL I SERVICES

- 09110 Palliative treatment of dental pain, minor emergency procedures  
EXAMPLES: Trauma to a tooth, sinus pain mimicking toothache, periodontal abscess, acute necrotizing ulcerative gingivitis, re-open non-vital tooth to relieve symptoms, other.
- 09210 Local anesthesia (not in conjunction with other dental procedures)
- 09910 Application of desensitizing agents
- 09930 Treat unusual complications to surgery
- 09940 Occlusal guard (to relieve acute symptoms)

## **SCHEDULE OF LEVEL II SERVICES PREVENTION AND DIAGNOSIS (REQUIRED)**

Prevention and Diagnostic services include those services intended to prevent the onset of the dental disease process. Prevention and Diagnostic care may be directed at an individual or a community.

### PROPHYLAXIS (AND FLUORIDE APPLICATION)

- 01110 Adult Prophylaxis (once/6mos)
- 01120 Child Prophylaxis (once/6mos if calculus present)
- 01201 Prophylaxis and Fluoride (Child)-(selected patients w/ significant caries activity)
- 01203 Fluoride (child) w/o Prophylaxis
- 01204 Fluoride (adult) w/o Prophylaxis
- 01205 Prophylaxis and Fluoride (Adult)

### OTHER PREVENTIVE SERVICES

- 01330 Oral Health Education
- 01351 Occlusal Sealant Application (per tooth).

### PERIODONTIC SERVICES

- 04910 Periodontal maintenance procedures following active therapy. Includes education, prophylaxis, scaling and polishing as needed.

### MISCELLANEOUS SERVICES

- 09941 Athletic Mouthguard

## **SCHEDULE OF LEVEL III SERVICES TREATMENT OF DISEASE/EARLY INTERVENTION SERVICES**

Treatment of dental disease through the early intervention includes those services deemed necessary to control the early stages of disease. These services are not complicated in nature and usually more than one procedure can be accomplished in an appointment.

### DIAGNOSTIC

#### CLINICAL ORAL EXAMINATIONS

- 00120 Periodic Dental Examination - An evaluation performed to determine any change in patients dental or medical health status since previous comprehensive or periodic examination.

- 00140 Limited Oral Evaluation (Problem Focused) - An evaluation or re-evaluation limited to a specific oral health problems. *Typically, patients present with specific problem: emergencies, trauma, acute infections, etc.*
- 00150 Comprehensive Oral Evaluation - Thorough evaluation/recording of hard and soft tissues. *Typically, would include evaluation of patients medical history and a general health assessment. It should include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, occlusal relationships, periodontal conditions, hard and soft tissue anomalies, etc.*

## RADIOGRAPHS

- 00210-00340 Any and all radiographs determined to be necessary by the attending dentist with following limitations:

Full mouth radiographs and/or panoramic radiograph - once/3 years

Supplemental Bitewings - once/6 mos

## PREVENTIVE

### SPACE MAINTAINERS (passive appliances)

- 01510-01525 Includes unilateral and bilateral fixed and removable appliances. Note: some programs reimburse only for fixed appliances. Refer to programs schedule of benefits.

## RESTORATIVE

High copper silver alloy, composite resin, stainless steel crowns, cast crowns and porcelain fused to metal crowns and bridgework are the restorative materials of choice. Some programs may specify those materials allowable under their reimbursement schedules. Attending dentists are given the responsibility of determining the materials to be used in any given restoration based upon the specific physical and cosmetic requirements of that restoration. Only materials approved by the American Dental Associations Council on Dental Therapeutics may be used in any dental facility functioning under the authority of \_\_\_\_\_.

It is recommended that primary, posterior teeth having multiple surfaces of carious involvement be restored with stainless steel crowns.

The restoration of primary anterior teeth (incisors) should be attempted in early stages. When caries has involved multiple surfaces of these teeth the decision not to restore them may be valid, owing to the inconsequential implications of the early loss of these teeth and to the trauma which their restoration requires. The decision to place steel crowns on anterior primary teeth shall, therefore, be left to each, individual clinic dental director.

## AMALGAM RESTORATIONS

- 02110-02161 Amalgam restorations, primary and secondary dentition

## COMPOSITE RESIN RESTORATIONS

- 02330-02387 Composite restorations, primary and secondary dentition, anterior and posterior teeth. The attending dentist is given the responsibility of determining the appropriate use of composite restorations

## STAINLESS STEEL CROWNS

02930 Stainless Steel Crown (primary tooth)

02931 Stainless Steel Crown (permanent tooth) - to be placed with understanding that it is provisional until a cast crown is feasible

## OTHER RESTORATIVE PROCEDURES

02940 Sedative filling

02950 Crown build-up

02951 Pin Retention per Tooth

02954 Post and Core + Crown, Prefabricated

02960 Labial Composite Veneer - Chairside

02962 Labial Porcelain Veneer - Laboratory

02970 Temporary Crown/Fractured Tooth

## ENDODONTICS

### PULPOTOMY

03220 Therapeutic pulpotomy or pulpectomy, primary teeth only

### ROOT CANAL THERAPY

It is recommended that except for emergency care, endodontic services not be provided for second or third molars unless retaining the tooth is critical to the placement of a fixed bridge or removable partial denture.

It is recommended that root canal therapy not be completed until all other needed operative, preventive and periodontal services have been completed.

All materials utilized in the sealing of root canals must be approved by the ADA Council on Dental Therapeutics.

03310 - 03330 Root Canal Therapy, permanent teeth (excludes final restoration)

03351 - 03353 Apexification - initial, interim and final visits

## PERIODONTICS

### GINGIVAL SURGERY/CURETTAGE

04210 Gingivectomy/Plasty per Quadrant

04220 Gingival Curettage per Quadrant

04341 Periodontal Scaling/Root Planing/Quadrant

## PROSTHODONTICS

### DENTURE RELINING

05850 Tissue Conditioning - upper denture, per treatment series

05851 Tissue Conditioning - lower denture, per treatment series

## ORAL SURGERY

### EXODONTIA

07130 Root Removal, Exposed Roots (per tooth)

07220 Removal of Impacted Tooth - Soft Tissue (requires mucoperiosteal flap elevation)  
07230 Removal of Impacted Tooth - Partial Bony Imp.  
07240 Removal of Impacted Tooth - Complete Bony  
07250 Surgical Removal of Residual Roots/Tooth

#### **SURGICAL EXCISION**

07260 Closure Oroantral Fistula  
07280 Surgical Exposure Impacted Tooth for Orthodontic Purposes  
07281 Surgical Exposure Impacted Tooth to Aid Eruption

07310 Alveoloplasty w/ Extractions/Quadrant  
07320 Alveoloplasty w/o Extractions/Quadrant  
07470 Removal Exostosis- Maxilla or Mandible

#### **SURGICAL INCISIONS (CONTINUED)**

07585 Biopsy of Oral (hard) Tissue  
07586 Biopsy of Oral (soft) Tissue  
07430 Excision of benign tumor-lesion diameter up to 1.25cm  
07431 Excision of benign tumor-lesion diameter over 1.25cm  
07960 Frenulectomy-Separate Procedures  
07970 Excise Hyperplastic Tissue

### **SCHEDULE OF LEVEL IV SERVICES REHABILITATIVE SERVICES (OPTIONAL)**

Rehabilitative services includes high quality reasonably priced solutions which replace missing teeth. These services include the fabrication of removable partial dentures, full dentures and single or multiple unit fixed prosthetics. Also included are elective oral surgery, orthodontics and other specialty services

#### **CAST RESTORATIVE**

02510-02810 Includes cast inlays and crowns of base metals, low noble metals and high noble metals. It also includes Porcelain fused to metal crowns. encourages the use of the least expensive material which will not significantly compromise the life of the restoration. Base metal, therefore, is recommended for most restorations. Due to the high cost of providing laboratory fabricated restorations, patients will be expected to share costs to a greater extent than in restorations not requiring costly laboratory procedures.

#### **REMOVABLE PROSTHODONTICS**

05110 Complete Upper Dentures  
05120 Complete Lower Dentures  
05130 Immediate Upper Full Denture (extractions not included)  
05140 Immediate Lower Full Denture (extractions not included)  
05211 Upper Partial-Acrylic (including clasps and rests)  
05212 Lower Partial-Acrylic (including clasps and rests)  
05213 Upper Partial - Chrome Steel/Acrylic  
05214 Lower Partial - Chrome Steel/Acrylic

## DENTURE REPAIRS

05410-05660 Denture repairs, adjustments, revisions included in Level I (please see)

## DENTURE REBASES AND RELINES

05710 Rebase Complete Upper Dentures

05711 Rebase Complete Lower Dentures

05720 Rebase Partial Upper Dentures

05721 Rebase Partial Lower Denture

05730 Reline Complete Upper Denture (chairside)

05731 Reline Complete Lower Denture (chairside)

05740 Reline Upper Partial (chairside)

05741 Reline Lower Partial (chairside)

05750 Reline Upper Full Dentures (Lab)

05751 Reline Lower Full Dentures (Lab)

05760 Reline Upper Partial (Lab)

05761 Reline Lower Partial (Lab)

05820 Provisional Removable Partial Dentures w/o Cast Clasps, Upper

05821 Provisional Removable Partial Dentures w/o Cast Clasps Lower

## MISCELLANEOUS DENTURE SERVICES

05860 Overdenture-Complete

05851 Overdenture-Partial

## FIXED BRIDGE PROSTHODONTICS

06210-06792 Fixed ridge prosthodontics include bridge retainers and pontics of base metals, low noble metals and high noble metals. It also includes porcelain fused to metal retainers and pontics. Encourages the use of the least expensive material which will not significantly compromise the life of the restoration. Base metal, therefore, is recommended for most restorations. Due to the high cost of providing laboratory fabricated restorations, patients will be expected to share costs to a greater extent than in restorations not requiring costly laboratory procedures.

## MISCELLANEOUS FIXED PROSTHODONTIC SERVICES

06930 Recement Bridge (a level I service)

06970 Cast Post/Core used with Bridge Retainer

06972 Prefab. Post/Core w/ Bridge Retainer (a level II service)

06973 Core Build-up for Retainer, (including pins)

## ORTHODONTICS

08210 Removable Habit Appliance Therapy

08060 Interceptive Orthodontic Care, Transitional Dentition

## DENTAL GUIDELINES AND EVALUATION CRITERIA

Dentists directly employed, or who contract care for the Community Dental Center, are expected to provide that care in accordance with the following Guidelines. These standards have been written to allow dentists a maximum amount of flexibility with which to provide care, and do so in a manner which has been determined to be appropriate and of high quality. Dentists providing care for the Community Dental Center do so recognizing that their performance may be judged by any of the following evaluation criteria which are directly related to the Guidelines. This judgment being an integral part of the quality assurance/ continuous quality improvement programs

### **I. ORAL DIAGNOSIS:**

#### A. Patient Records

Criterion #1: The dental record is complete, and permits prompt retrieval of legible and timely information that is accurately documented and readily available to appropriate health care practitioners or authorized persons.

Method of Assessment: Chart review

Criterion #2: Each and every page in the record contains the patients name, identification number or social security number.

Method of Assessment: Chart review

Criterion #3: The dental record clearly documents the patients' identification and biographical data (name, social security or identification number, address, phone number, gender, date of birth, name and contact information of any legally authorized representative or individual to be contacted in event of emergency).

Method of Assessment: Chart review

Criterion #4: The patients positive or negative history of allergic or adverse drug, food, or substance reactions is prominently noted in the record as per protocols.

Method of Assessment: Chart review

Criterion #5: Pertinent past medical history (updated within one year of start of recorded dental treatment) is documented and easily identified. Notation regarding review of medical history prior to provision of dental treatment is found in the dental record progress notes.

Method of Assessment: Chart review

Criterion #6: The record of any patient who is taking one or more chronic medications contains a complete, accurate, up-to-date medication profile.

Method of Assessment: Chart review

Criterion #7: All entries in the patient dental record are recorded in ink.

Method of Assessment: Chart review

Criterion #8: Dental progress notes are sufficient in detail to clearly indicate:

- a. Date of service
- b. Specific tooth/teeth (quadrant/sextant)
- c. Diagnosis (e.g. caries, periapical abscess, pre-prosthetic, extractions, etc.)
- d. Procedure accomplished
- e. Materials used
- f. Type and dose of local anesthetic used
- g Name and dosage of other drugs administered (N2O/O2)
- h Name and dosage of drugs prescribed as entered on Rx blanks
- i. Complications encountered
- j. Provider signature (full signature and degree to be the first signature on page, initials as recorded with clinic administration office may be used for remaining entries)
- k. Auxiliary staff signature required if they make any entries (e.g. no-shows, cancellations, vital sign readings, etc.)

Dentist may utilize universally understood symbols or abbreviations but are encouraged not to develop personal abbreviations which will not be understood by a dentist reviewing the dentists charts.

Method of Assessment: Chart review

Criterion #9: For emergency visits the SOAP (or similar) format will be used in sufficient detail to determine differential diagnosis and treatment.

Method of Assessment: Chart review

## B. Examination and Diagnosis:

Criterion #1 Existing hard and soft tissue findings obtained by clinical and radio-graphic examination are recorded on patients dental record.

Method of Assessment: Chart review

Criterion #2: Diagnosis is consistent with findings.

Method of Assessment: Chart review

Criterion#3: A plan of treatment is available in the patient dental record and follows in general, the following order:

- a. Relief of pain and discomfort including nonelective surgery.
- b. Elimination of infection and factors predisposing to pathologic conditions.

- c. Thorough prophylaxis, instruction in oral hygiene, and other oral disease preventive therapies.
- d. Treatment of caries.
- e. Periodontal treatment which is incremental and based on assessment of the patient.
- f. Elective care.

Method of Assessment: The treatment plan should be appropriate for the patients age, sex and general health. The plan should indicate that the treatment provided is aggressive enough to bring the level of disease under control in a reasonable period of time. The plan should be sufficiently flexible that it may be altered to accommodate unanticipated results of previous treatment. The plan should reflect that every effort is made to reveal the full extent of the patients disease before expensive procedures are initiated (i.e. all severely carious teeth are excavated prior to asking patient to commit to an endodontic procedure on one of them). All changes to the treatment plan require documentation.

Criterion #4: Treatment plan is consistent with diagnosis.

Method of Assessment: Chart review

C. Radiographs: (This section is based upon the American Dental Association 1988 recommendations for prescribing dental radiographs - ADA Council on Dental Materials, Instruments, and Equipment).

Criterion #1: All radiographic exposures shall be ordered by the dentist according to patients conditions, the types and frequency of radiographs should meet the following broad classifications:

- A. Initial Adult Examination:  
An initial radiographic examination consisting of posterior bitewings supplemented with anterior and/or posterior periapical films and/or panoramic radiographs, as required by oral conditions, is recommended for all individuals 15 years old and older. Panoramic or full-mouth intraoral radiographic films are appropriate when the patient presents with clinical evidence of generalized dental disease, has a history of extensive dental treatment, requires assessment of position of unerupted teeth (e.g.: 3rd molar evaluation), requires evaluation of a fixed or removable prostheses or evaluation of periodontal bone loss.
- B. Initial Child Examination:  
Primary dentition (prior to eruption of first permanent tooth)  
Prior to the eruption of the first permanent tooth, bitewing films are supplemented with anterior and posterior periapical films as required by oral conditions when interproximal surfaces cannot be visualized or probed.  
Transitional Dentition (following eruption of first permanent tooth)  
Individualized radiographic examinations consist of periapical/occlusal views and posterior bitewings or panoramic examination. A full-mouth radiographic exam (panoramic or intraoral periapical) is performed beginning at age 9.
- C. Recall Examination:
  - 1. Bite-wings and/or periapical radiographs should be taken at intervals as required

by the patient's general condition and dental health history, typically, no more frequently than once/12 months. Factors which may require increasing the normal frequency of radiograph at recall examination:

- a) High level of caries experience
- b) History of recurrent caries
- c) Existing restorations of poor quality
- d) Poor oral hygiene
- e) Inadequate fluoride exposure
- f) High sucrose diet
- g) Poor family dental health
- h) Developmentally disabled
- i) Xerostomia
- j) Many multisurface restorations

2. In the absence of specific indications for more frequent radiographs, panoramic radiographs or a full-mouth intraoral periapical series should not be taken more often than once every five years.

D. Emergency Examination:

An appropriate diagnostic radiographic examination of the area in question.

Clinical and/or historical signs or situations which indicates that a radiographic evaluation is appropriate include:

1. Deep carious lesions
2. Pain
3. Swelling
4. Mobility of teeth
5. Clinical evidence of periodontal disease
6. Malposed or clinically impacted teeth
7. Fistula or sinus tract infection
8. Clinically suspected sinus pathology
9. Growth abnormalities
10. Evidence of foreign objects
11. Pain and/or dysfunction of the temporomandibular joint
12. Trauma
13. Previous periodontal or endodontic therapy
14. Familial history of dental anomalies
15. Presence of implants
16. Postoperative evaluation of healing
17. Unexplained bleeding
18. Unusual eruption, spacing or migration of teeth
19. Unusual tooth morphology
20. Abutment teeth for fixed or removable partial prosthesis
21. Interim endodontic exposures

E. Growth and development assessment:

Indicated at age 9 (transitional dentition) and at the approximate age of 17 to determine the disposition of developing and/or erupting 3rd molars.

Method of Assessment: Review of patient dental record and radiographs in patient chart. Radiographs should be appropriate for the signs and symptoms reported by the patient and for the examination provided.

Criterion #2: Dental radiographs are dated, mounted, identified with the patients name and chart number, and securely fixed to patients dental record.

Method of Assessment: Review patients chart.

Criterion #3: Density and contrast of radiographs are such that anatomical hard and soft tissue landmarks can be differentiated and identified.

Criterion #4: Radiographic image size is not distorted in the area of the mouth under study.

Criterion #5: Radiographs disclose no overlapping of image in the area of the mouth under study, except where tooth alignment does not permit open contacts.

Criterion #6: Radiographs disclose no cone-cutting.

Criterion #7: Bitewing radiographs include the distal surface of the erupted cuspids and the mesial surface of the most posterior erupted teeth.

Criterion #8: Radiographs adequately target the area requiring evaluation.

Method of Assessment

Criteria #3 thru #8: Assess the radiographs present in the dental chart taken within the past year. Radiographs should be viewed with a radiographic illuminator (view box). Applicable criteria used to determine diagnostic acceptability. The anatomy in the area under study should be visible and of diagnostic quality. Criterion #5, while of importance to dentists, cannot be used as a point of criticism as malocclusion may be the source of the overlapping.

Note: If a radiograph has a deficiency which does not compromise the diagnostic value, the radiograph will be considered acceptable. The peer review process should not encourage unnecessary radiographic exposure. The deficiency should, however, be pointed out to the evaluatee.

#### D. Radiological Protection:

Criterion #1: All dental auxiliaries who expose radiographs will possess all necessary state certifications to do so.

Method of Assessment: Observe posting of current staff certificates reviewing necessary documentation

Criterion #2: Lead protective devices are used on each patient during radiographic exposure.

Method of Assessment: Observe radiographic procedures directly to determine if protective devices are used in an appropriate manner.

Criterion #3: The tube housing or cylinder shall be stationary and positioned in close proximity to the film positioning device or skin of the patient when the exposure is made.

Method of Assessment: Observe directly whether the tube housing or cylinder is stationary and within 1/4" or less of the film positioning device or skin when the exposure is made.

Criterion #4: During exposure, radiographic film is not held in position by attending staff.

Method of Assessment: Direct observation of radiographic procedure.

Criterion #5: During exposure, tube housing or cylinder is not held by attending staff.

Method of Assessment: Direct observation of radiographic procedure.

Criterion #6: Operator is at least six feet from patient and not in the path of the primary beam or stands behind protect barrier during exposure.

Method of Assessment: Direct observation of radiographic procedure.

Criterion #7: Only necessary persons allowed in radiographic area during exposure.

Method of Assessment: Direct observation of radiographic procedure.

Criterion #8: Dosimeters (film badges) are worn by all dentists, hygienists, and dental assistants.

Method of Assessment: Direct observation of dental staff.

Criterion #9: Protective devices are properly stored to reduce creasing and damage.

Method of Assessment: Directly observe manner in which protective aprons are stored. They should not be folded over, creating creases and holes

Criterion #10: Radiological reports are maintained:

Dosimetry quarterly reports

Annual calibration of X-ray equipment.

Method of Assessment: Directly observe whether reports are on file and current.

Criterion #11: X-ray machines are tested by the states Dept of Environmental Protection Agency at least once every two years. Record of Inspection is maintained.

Method of Assessment: Annual inspection of logs at peer review visit.

Criterion #12: Protective aprons should receive an x-ray inspection every two years to reveal any flaws.

Method of Assessment: Annual inspection of logs at peer review visit.

## **II. PREVENTION:**

Criterion #1: All patients other than those seen only for emergency services have an individualized disease prevention plan based on the patients status and risk factors. The plan may include any of the following:

- a. Systemic fluoride
- b. Professionally applied topical fluoride
- c. Self-applied topical fluoride
- d. Fluoride toothpaste
- e. Pit and fissure sealants
- f. Preventive periodontal treatment
- g. Tobacco counseling
- h. Oral Health Instructions (OHI) and other health education
- i. Recall examination and prophylaxis

Method of Assessment: Review dental record for above information.

Criterion #2: Each dental prophylaxis provided meets the following standards:

- a. All plaque and other soft debris are removed from tooth surfaces. The use of disclosing tablets is encouraged.
- b. All coronal calculus is removed (includes all supragingival calculus and subgingival calculus up to 3 mm. below gingival crest).
- c. All teeth are polished with prophy paste / rubber cup to remove stain and plaque.

Method of Assessment: Review dental chart to determine if all aspects of prophylaxis are included in charting (e.g., Prophylaxis-scaling/polishing/discl. tab.).

Criterion #3: Children (ages 5-14) presenting with one new smooth surface caries will be treated with topical fluoride at their prophylaxis appointment unless it is determined that they have enamel fluorosis.

Method of Assessment: Review chart for documentation of fluoride applications and the factors supporting or not supporting that decision.

Criterion #4: Occlusal sealants are placed on susceptible unrestored or incipient carious pit and fissure occlusal surfaces of permanent first and second molars within two years of eruption.

Method of Assessment: Review of patient charts. Review should reflect that sealants are indicated for deep, narrow pits and fissures in a sound tooth. Sealants are not indicated if fissures are broad

and well coalesced, frank caries (dental involvement) is present, or many proximal lesions are present.

## **II. RESTORATIVE:**

Criterion #1: Treatment is explained to the patient (parent/guardian) before services begin, both at time of examination and repeated prior to treatment.

Method of Assessment: Direct observation of patients at time of examination and at initiation of treatment.

Criterion #2 Tooth preparation and restoration are designed to promote success and patient satisfaction.

Method of Assessment: Direct observation of completed restorations with an evaluation of:

- a. Caries removal
- b. Preparation design
- c. Base placement (if utilized)
- d. Contacts
- e. Marginal ridges
- f. Absence of overhanging margins
- g. Contour
- h. Occlusal anatomy

Criterion #3: Esthetics of anterior restoration satisfy the requirement for concealment and/or harmony of the restoration.

Method of Assessment: Direct observation of completed restorations should reveal that they are aesthetically acceptable, and not displeasing to the patient. The patient may be asked to comment on the appearance of the restorations.

Criterion #4: Instructions concerning restorative care are given to the patient (parent/ guardian postoperatively, and services planned for the next appointment are explained.

Method of Assessment: Direct observation of completion of a restorative dental appointment and/or review of chart to reveal documentation that post-op instructions were provided.

## **IV. PEDIATRIC DENTISTRY:**

### **A. Treatment Planning in the Primary Dentition:**

Criterion #1: It is recommended that primary posterior teeth with three or more carious surfaces or teeth receiving pulp therapy be restored with stainless steel crowns. If a decision occurs that these teeth be restored in another manner the reason for not using the crowns should be noted in the patients chart.

Method of Assessment: Chart review

Criterion #2: All carious teeth are addressed in the treatment plan. In some instances that may simply imply observation, it should, however, be documented as such.

Method of Assessment: Chart review

Criterion #3: Carious primary incisors should be restored if caries involves but one surface. If more than one carious surface exists the dentist may elect to crown or fill the teeth is based on strong evidence that there are virtually no negative implications in not restoring these teeth, orthodontic or otherwise. Follow-up care instructions should include discussion of possible BBTD and appropriate preventive oral hygiene instructions, which should be documented clearly in chart with a comment such as Acarious primary teeth not restored as per protocol.

If the dentist elects to restore carious primary incisors having multiple carious surfaces the treatment of choice is full coverage crowns.

Method of Assessment: Chart review

## B. Behavior Management of Child Patients

Criterion #1: The child's behavior and the restraint techniques utilized (verbal, physical, and/or chemical), if used for patients less than six years of age, is documented in the chart. The decision to utilize any or all of these methods is the individual decision of the attending dentist. If chemical agents are utilized, the attending dentist must be state certified in the sedation method selected. Restraint techniques and sedation require parent approval.

Method of Assessment: Chart review

Criterion #2: The response to behavior management techniques, if used for patients less than six years of age, is noted in the progress notes.

Method of Assessment: Chart review

## C. Space Maintenance:

Criterion #1: A space maintainer is placed when primary molars are prematurely lost prior to normal exfoliation, or reason for non-provision of a spacer is noted.

Method of Assessment: Chart review

Criterion #2: The space maintaining appliance spans the edentulous area adequately, allows for normal eruption of the permanent tooth, and does not impinge upon the soft tissue. Orthodontic band type space maintainers exhibit smooth marginal adaptation, adequate cementation and proper occlusion.

Method of Assessment: Direct observation

## **V. ENDODONTICS:**

### **A. Root Canal Therapy:**

Criterion #1: Patients symptoms, subjective and objective signs, a radiograph clearly showing the periapical region of the tooth and any other tests verifying the dentists diagnosis are recorded on the patients chart.

Method of Assessment: Chart review, radiograph review

Criterion #2: A clear description of the endodontic procedure is entered into chart. It must include the number of canals located and any deviations from normal which are encountered during the procedure (including perforations, calcified canals, etc.).

Method of Assessment: Chart review

Criterion #3: A postoperative radiograph(s) is to be available following final apical seal. All root canal procedures to have a minimum of a pre-operative radiograph and the post-operative radiograph.

Method of Assessment: Chart review, radiograph review

Criterion #4: A postoperative radiograph indicates complete obturation of all root canals within 2 mm of the radiographic apex, using non-resorbable filling material and a non-staining sealer on permanent teeth.

Note: N2 and root canal pastes of similar composition which have not been approved for use by the ADA are not to be used.

Method of Assessment: Review patients postoperative X-rays to determine adequate seal(s).  
Review chart to determine materials used.

Criterion #5: Esthetic restorative material is used on all lingual access preparations in anterior teeth.

Method of Assessment: Chart review

Criterion #6: A cusp-protecting restoration is used on posterior permanent teeth when either marginal ridge is violated or when remaining enamel structure is unsupported by dentin and lacks strength.

Patients should be informed prior to initiating an endodontic procedure before the procedure. It will, therefore, be more prone to fracture or splitting which may require that the tooth be removed. They should be informed that, ideally, all endodontically treated, multi-cusp teeth should be crowned. Should the patient decide to have the root canal procedure but not a laboratory fabricated crown, they should be told of the shortcomings of alternate methods of restoring the tooth. They should be informed that stainless steel crowns are very difficult to keep adequately clean over a long period of time and frequently allow recurrent, marginal caries. They should also be informed that cusp-protecting

restorations are weak but will, hopefully, fracture before the tooth should an excessive amount of stress on the tooth occur. They should be told that any restoration other than a laboratory fabricated crown should be considered a short-term, provisional restoration to be used only until the patient is able to have a laboratory fabricated crown placed. The patient's chart must reflect a conversation to this effect.

Method of Assessment: Chart review, postoperative radiographic review

## **VI. PERIODONTICS:**

Criterion #1: The record contains a written diagnosis by ADA-Case Type (Gingivitis, Early Periodontitis, Moderate Periodontitis, and Advanced Periodontitis).

Method of Assessment: Chart review

Criterion #2: The record contains the radiographic survey and periodontal probing values recorded at that initial examination visit when the initial periodontal evaluation occurred.

The preliminary diagnosis should be consistent with existing conditions observed in the mouth and/or documented. When definitive periodontal therapy is believed necessary for patients a periodontal work-up should be conducted. This includes probing and recording pockets of all teeth, a complete radiographic survey and evaluation, recording of furca involvement, mobility, occlusal evaluation and assessment of existing restorations. If definitive periodontal services are not planned the periodontal work-up should not be conducted.

Method of Assessment: Chart review

Criterion #3: All dentate patients 15 years or older being provided routine dental care are informed of their periodontal status, treatment needs, opportunities for self-care, and have a description of periodontal treatment planned. If a full scope of periodontal services is not available at the particular clinic, a chart notation should be made that the patient has been informed of their need for treatment at another facility.

Method of Assessment: Chart review

Criterion #4: Periodontal treatment is documented, and consistent with the need indicated by the initial diagnosis.

Method of Assessment: Chart review

Criterion #5 Communication with the patient is professional and on a level so that the patient understands the educational information and accepts scaling and root planning procedures. The provider is attentive to the patient's comfort level.

Method of Assessment: Direct observation of the interaction between dentist and patient during a case presentation discussion. Direct observation and evaluation of patient's comfort level during a root planning procedure.

Criterion #6: Supra and subgingival calculus are removed adequately during periodontal scaling procedure.

Method of Assessment: Direct observation and patient inspection following procedure.

Criterion #7: Hygienists who administer local anesthesia are appropriately certified to do so.

Method of Assessment: Question the hygienist about training and certification in local anesthesia. Observe display of certificate.

Criterion #8: All patients receiving periodontal care are placed on recall to insure appropriate monitoring of the disease process.

Method of Assessment: Observe the patients record for documentation of a recall in treatment plan.

Criterion #10 Follow-up evaluation of periodontal treatment effectiveness shall occur. Re-treatment prescribed and performed as necessary.

Method of Assessment: Observe patient chart to determine if post-operative or post-therapy evaluation has occurred.

## **VII. REMOVABLE PROSTHODONTICS:**

Criterion #1: Pre-treatment full-arch radiographs are available for all removable prosthetic patients (a panoramic or full mouth intra-oral series).

Method of Assessment: Review dental record.

Criterion #2: The overall oral condition and the condition of selected abutment teeth are possess adequate integrity to assure success of the intended prosthetic appliance (a minimum of five years of comfortable use shall be considered a successful prosthetic case).

Method of Assessment: A review of the radiographs, clinical exam, endodontic status, and perio charting will be used to determine the overall oral health and the probability of long-term (five year minimum) success of abutment teeth selected to support a removable prosthetic appliance.

Criterion #3: The appearance of the denture is aesthetically acceptable to patient an examiner.

Method of Assessment: The denture harmonizes with the patients facial appearance. The positioning, shape, and shade of the teeth appear natural. Vertical dimension is within normal limits. Clasps are not unnecessarily visible. The patient expresses satisfaction with appearance of the prosthesis. Documentation should be made in the chart as to the patients' acceptance of the esthetic appearance of the prosthesis.

Criterion #4: Denture stability / retention is within normal limits.

Method of Assessment:

- a. Ask patient if dentures stay in place while eating and speaking. The stability / retention of the prosthesis is consistent with the limitations imposed by the ridge anatomy present.
- b. Full denture test: Place forefinger on incisal edge of either maxillary or mandibular denture with sufficient force to blanch the finger. If denture becomes dislodged, it is considered to lack adequate retention / stability.
- c. Partial denture test: Place forefinger on any segment of the partial denture framework and press firmly. If partial denture should become dislodged or tips, it is considered to lack adequate retention/stability.

Criterion #5: Denture borders adapt to the soft tissue mucobuccal fold areas of the oral cavity and are not over or under extended.

Method of Assessment: Gently retract lip to minimum degree that will allow you to observe whether border of appliance approximates the mucobuccal fold. Note if dentures spring away from ridges during normal speaking or moderate separation of teeth.

Criterion #6: Occlusion within acceptable limits.

Method of Assessment:

- a. Check centric relation: Close patients jaw into centric relation (and/or acceptable habit position) by placing thumb on patients chin and gently directing mandible to the most retruded yet comfortable position while patient closes slowly into contact. Note whether simultaneous bilateral contact of the teeth occurs, and whether substantially all of the teeth on each side touch, if not, or if shifting or sliding occurs, then occlusion is considered to be inadequate.  
Note: For all tooth-borne removable partial dentures, the point of reference is centric occlusion (functional occlusion).
- b. Check eccentric relations: Ask patient to close and move jaw in all directions. Observe eccentric premature contact or lack of balancing contact on teeth from canine posteriorly and note any instability resulting from the eccentric relationship of the prosthesis. (Eccentric relation is considered adequate if none are noted.)
- c. Check occluding material: Determine if unglazed porcelain occlusal or incisal surfaces are contacting enamel, gold, alloy or composite resin. If so, rapid wear of the softer occluding surface will occur and occlusion must be considered unacceptable.

Criterion #7: Vertical dimension and anterior tooth arrangement are acceptable.

Method of Assessment:

- a. Check AS sounds: Ask patient to say key words, such as Mississippi, sixty-six, whiskey, seventy-seven. When making AS sounds, teeth should not contact. If so, appliance(s) is (are) considered inadequate.

- b. Check AF and AV sounds: Ask patient to say key words, such as forty-four, fine food, vim and vigor, Vivian. When making AF and AV sounds, the incisal edges of #8 and #9 teeth should contact the wet-dry (vermillion border) line of lower lip.
- c. Ask patient if teeth seem too long or too short.

Criterion #8: All ACardinal Rules of partial denture construction are met.

Method of Assessment:

- a. Rest seats (depth): Ask patient to remove partial denture. Observe clearance for rest seats with patient in centric occlusion. If unable to visualize, then place utility wax in patients' mouth and have patient close to centric occlusion. Remove wax and insert periodontal probe through wax in central area of identified rest seats until point of probe is exposed evenly with wax surface of opposite side. Determine visually whether wax in rest seat area is 1 to 1.2 mm thick.
- b. Rest seat (width): Observe whether rest seats approximate one-third of the width of the tooth (except in cingulum rests, and are positioned at a 90 degree angle to the long axis of the abutment tooth).
- c. Partial denture base: Inspect removed partial denture and determine whether base material covers all supporting areas. Ask patient to replace partial denture in mouth and then use mouth mirror to observe whether retromolar pad(s) or tuberosity(ies) are completely covered without impingement of soft tissues in flange areas.
- d. Arms of clasps in undercut zones: Attempt to dislodge partial denture from each abutment tooth by placing finger under retentive clasp and applying firm force occlusally. If there is no resistance to the force, then retention is considered inadequate. If too much force is required, excessive mobility of the tooth occurs, or if the patient expresses difficulty, then retention may be excessive.
- e. Guiding planes: Visually determine whether all guiding planes on abutment teeth are reasonably parallel to one another.
- f. Abutment teeth: Observe that abutment teeth are in a good state of repair and well polished.
- . The tissue bearing area: Note any areas of tissue impingement, inflammation, or hypertrophy related to the partial denture. The partial denture should not have caused any apparent tissue damage.

Criterion #9: All pertinent information concerning the prosthesis is recorded in the health progress notes. This must include shade, mould, and lab used. Also include lab fee quoted to the patient (if applicable), and a detailed account of any other costs which the patient is informed that they are responsible for paying. A copy of lab prescriptions (work orders) should be kept on file in chronological order.

Method of Assessment: Review patients' record.

## **VIII. FIXED PROSTHODONTICS:**

A. Crowns (all types)

Criterion #1: Smooth Marginal adaptation.

Method of Assessment: Inspect the margins of the crown to determine if the marginal adaptation is acceptable. The marginal adaptation of the crown should be considered unacceptable if gingival irritation or blanching of the tissues is being caused by the crown or if the tip of a sharp explorer can be inserted between the inner surface of the crown and the immediate tooth surface.

Criterion #2: Occlusal functions are acceptable.

Method of Assessment: Use articulating paper to assess premature contacts in centric and eccentric relations. Also observe whether there are heavy wear facets on any occluding surface by using mouth mirror and/or direct observation. If supra or infra occlusion was planned, it must be noted in the patients' dental record. Question the patient: A) Does this give you any discomfort or pain when you eat? B) Does it seem higher than your other teeth?

Criterion #3: Interproximal contact adequate to prevent food impaction

Method of Assessment: The contacts with the proximal teeth should be in the occlusal 1/3 of the proximal space and tight. Dental floss should pass through without tearing or shredding.

Criterion #4: Crown contour is physiologic.

Method of Assessment: Inspect the external contours of its cross-arch analog, if a natural tooth. If the mate is not present or grossly restored, utilize the contours of the tooth most nearly representative of the test tooth. Compare with the aid of mouth mirror:

- a. Buccogingival contour
- b. Linguogingival contour
- c. Marginal ridge contour
- d. Embrasure spaces have a v-shape which avoids impingement of soft tissue.
- e. Total buccolingual width

The periodontal health of the tissue around the restored tooth (teeth) should not differ significantly from other tissue in the mouth four weeks after cementation.

Criterion #5: Crowned, endodontically treated teeth have healthy characteristics which promote long-term success of the case.

Method of Assessment: Review the radiographs, clinical exam record, endodontic status, perio charting, clinical appearance of the crowned tooth.

Criterion #6: Porcelain shade blends favorably with remaining dentition.

Method of Assessment (criterion #6): Under natural light, inspect the crown with its cross arch analog using a Trubyte Bioform 24 button shade guide or Vita Lumen shade guide. If the mate is not present or is not a natural tooth, compare shades to the adjacent natural or opposing teeth. Shade blend should be within one shade of the matching button.

B. Fixed Bridges:

Criterion #1: Crowned abutments meet criteria #2, #4 and #6 listed under AA≡(all types) of this document.

Method of Assessment: Refer to item AA. Crowns (all types) of this document and apply the stated criteria and respective methods to be used for assessing whether the criteria are met.

Criterion #2: Pontic(s) meet(s) the principles of form and tissue adaptation.

Method of Assessment: Observe the form of pontic(s) by using mouth mirror and/or direct observation. Determine if:

- a. Facio-lingual width of the pontic(s) approximate(s) two-thirds of the normal width of the replaced teeth.
- b. Facial contour of the pontic(s) approximate(s) the normal contour of the replaced teeth.
- c. Gingival contour approximates the alveolar process and mucosa. Pontic is convex, enabling self-cleansing capability. Consider concave (ridge-lapped) pontics unacceptable. Thread dental floss through the embrasure and pass the floss mesiodistally between the apex of the pontic and the mucosa of the alveolar process. For pontic to be considered acceptable, the floss should pass freely without impingement or bleeding of involved tissues.

Criterion #3: Solder joints meet principles of adequate strength.

Method of assessment: Use mouth mirror and/or direct observation and apply following principles for determining adequate strength.

- a. Facio-lingual size of the solder joint should be about one-half of the facio-lingual width of the existing pontic.
- b. The occlusal gingival side of the solder joint should be about one-half of the distance from the occlusal (incisal) edge of the pontic to its gingival base.

Criterion #4: The overall oral condition and periodontal structures of the abutment teeth are adequate to support the prosthetic appliance(s).

Method of Assessment: Clinically observe abutment teeth and review the radiographs, clinical exam record, endodontic status, and perio charting. Observe that the prosthetic service provided is compatible with long term periodontal health of the supporting tissues associated with the abutment teeth.

Criterion #5: Esthetics are acceptable to the patient and examiner.

Method of Assessment: Ask the patient, Are you satisfied with the appearance of the bridge? If so, determine in your own mind if the existing porcelain surfaces of the pontic and retainers are in harmony with the remaining natural teeth. Determine whether there is an unnecessary and unsightly show of metal when smiling or talking.

If the patient is dissatisfied with the appearance of the bridge the reviewer must determine if the appearance of the bridge could be significantly improved by refabrication.

Criterion #6: Occlusal functions are acceptable.

Method of Assessment: Observe centric and eccentric movements: use articulating paper to assess premature contacts in centric and eccentric relations. Also, observe whether there are heavy wear facets (or shiny metallic surfaces) on any occluding surface of the bridge by using mouth mirror and/or direct observation. Question the patient: ADoes the bridge give you any discomfort or pain when you eat?

## **IX. ORAL SURGERY:**

A. Indirect Evaluation of Extractions/Surgical Procedures:

Criterion #1: The diagnosis leading to extraction or other surgical procedures is written in the dental records and is consistent with clinical findings.

Method of Assessment: Observe the patients dental record and determine whether documentation for the diagnosis is recorded, including the availability of a preoperative radiograph. History, clinical symptoms, problem assessment and diagnosis are noted in the patients' dental record in a SOAP or similar format.

Criterion #2: Appropriate diagnostic preoperative X-ray(s) are available in the patients' dental record.

Method of Assessment: Review of radiograph to assess presence of the entire tooth, including the apex of tooth (teeth) and surrounding pertinent anatomy.

Criterion #3: All pathology reports based on cytology or biopsy are present in the patient records.

Method of Assessment: Review patients' dental record. Results must be recorded in the patients' progress notes by the dentist. When a tissue biopsy is performed, the patient record must include documentation of indications for biopsy, a copy to the pathology report, and evidence that the patient was notified of the results and received proper follow up.

Criterion #4: Appropriate preoperative systemic antibiotic therapy is provided patients requiring such, as specified by the American Heart Association.

Method of Assessment: Review of patient Medical History record. Observe that those patients having noted a history of health problems suggesting antibiotic coverage have been questioned and/or their physician has been consulted for direction on the need for antibiotic coverage for any and all invasive dental procedures. If a prescription is written, it is documented that the patient has complied with the regimen prior to such procedures.

B. Direct Observation of Surgical Extractions:

Criterion #1: Standard principles of flap design have been accomplished, e.g. occlusal portion of flap design to extend at least one tooth adjacent to the interdental papillae both mesially and

distally from the tooth to be extracted (exception to this would be extraction of the most distal tooth in the arch). Vertical incisions extend obliquely so that the base of the flap is wider than its apex, the tissue of the retracted flap is not mutilated or torn, and the flap is full thickness in that it is not separated from the periosteum.

Method of Assessment: Observe the surgical flap procedure on patients present in the clinic receiving this service, or observe the flap design of revisit patients who receive this service and are present in the clinic for post-operative follow-up or suture removal.

Criterion #2: Pathologic tissue is completely removed. There is no evidence of residual periapical or periodontal pathology, including root fragments at the surgical site, unless removal is contraindicated.

Method of Assessment: Direct observation. If root fragment have been retained patient record should indicate that patient was informed of the decision not to pursue further surgery and the reason for the decision.

Criterion #3: Alveolar margin is smoothed, and displaced fragments of the alveolus and foreign particles are removed.

Method of Assessment: The examiner assesses these criteria by appropriate instrumentation and palpation, including a postoperative radiograph of the operative site when deemed necessary. When patients present in the clinic for postoperative follow-up or suture removal, the examiner may assess these criteria

Criterion #4: Soft tissue flap is repositioned into anatomical position and maintained there with suture or gauze pressure pack.

Method of Assessment: Inspect the surgical flap site to make certain the soft tissue is repositioned appropriately over alveolar bone without excessive tension.

Criterion #5: Oral and written instructions concerning postoperative care of surgical or extraction services are given to patient (parent/guardian) and documented in the record.

Method of Assessment: Observe whether oral and written instructions concerning postoperative care of surgical and/or extraction sites are given to the patient before dismissal.

Criterion #6: Informed consent is obtained for oral surgery procedures. This should include a discussion of risks, benefits, and alternatives to treatment.

Method of Assessment: Review patients' record and observe dentist providing informed consent discussion to a surgery patient prior to care. Should include risks, benefits, treatment alternatives, patients' signature, dentists name and date.

## **X. ORTHODONTICS:**

Criterion #1: Practitioners who are not board eligible or board qualified orthodontists shall be limited to simple, minor tooth movement using appliances intended to produce the intended result in six (6) months or less. Patients with orthodontic problems requiring longer term care should be referred to a qualified orthodontist.

Method of Assessment: Patient chart review should indicate dentists intended result. Chart should show that a discussion was held with the patient (or parent/guardian) concerning the goals and limitations of treatment.

## **XI. ADJUNCTIVE GENERAL SERVICES:**

### A. Drugs:

Criterion #1: Drugs prescribed for and/or administered to dental outpatients or inpatients are recorded in patients' primary health record.

Criterion #2: Drugs administered or prescribed are consistent with the written diagnosis.

Method of Assessment (#1 and #2): Review the described health problem(s) and determine the appropriateness of the prescribed drug(s) and daily dosage. Acceptable references, such as American Hospital Formulary Service, Facts and Comparisons, or Physicians Desk Reference may be used to resolve any differences of opinion.

Criterion #3: Appropriate preoperative, systemic antibiotic therapy is provided patients requiring such, as specified by the American Heart Association.

Method of Assessment: Review patients' medical history. Patients indicating history of conditions which place them at risk for Subacute Bacterial Endocarditis (SBE) have documentation of antibiotic prophylaxis and that at each invasive procedure encounter it has been documented that the patient complied with the prescribed antibiotic regimen.

Criterion #4: All suspected adverse drug reactions are recorded in the dental history and reported as outlined in the Adverse Drug Reaction section of the Procedures for Pharmacy Services. Any allergies to medication(s) are prominently displayed at the top of each and every sheet of the patients' progress notes. If no drug allergies exist, the acronym NKDA (no known drug allergies) shall be written at the top of each sheet of the patients' progress notes.

Method of Assessment: Review patients' dental history and progress notes of dental chart.

Criterion #5: When a sedative agent or nitrous oxide is administered, the patient record should display the drug(s) used, its route of administration, the dosage or concentration, monitored vital signs (BP, HR and RR), length of time of administration, any untoward reactions, restraints used, and patient's status at time of dismissal. Sedation (excluding Nitrous Oxide) shall be used following the policy on Conscious Sedation.

Method of Assessment: Chart review.

Criterion #6 Dentists administering sedative drugs (inhaled, oral, intramuscular or intravenous) shall demonstrate that they are appropriately trained to do so, are currently certified by the state licensing board, and have been granted privileges to do so by the Quality Improvement/ Professional Affairs Committee of \_\_\_\_\_ strictly adhering to the policy on Conscious Sedation.

Method of Assessment: Review of privileges and documentation of training in sedation for those dentists who administer sedative drugs.

Criterion #7: If there is no drug room in the clinic, controlled substances that are stocked in the dental clinic, for administration to patients must be adequately secured. Records of receipt and use must be maintained as outlined in Procedures for Pharmacy Services.

Other dangerous drugs that are stocked in the clinic for patient administration, including:  
– local anesthetic agents, must be kept in a locked cabinet, drawer or room during the hours when the dental clinic staff is not present.  
– Nitrous Oxide units must be locked or disabled by clinic staff during hours when clinic staff is not present to prevent its unauthorized use.

Method of Assessment: Review of clinic facilities, drug security protocol and key privileges with Dental Director and clinic staff.

Criterion #8: Prescriptions which are called into a pharmacy must be entered into the patient record within three (3) days of telephone order.

Method of Assessment: Review of clinic protocols with Dental Director and/or Office Manager.

Criterion #9: All drug stocks must be checked monthly for expiration. All expired drugs must be held for disposal by the clinics consultant pharmacist.

Method of Assessment: Review of clinic logs at peer review audit.

## **B. Emergency Care**

Criterion #1: Basic emergency diagnostic and treatment equipment must be available in case of life-threatening episodes.

Method of Assessment: Observe that any member of the dental staff can promptly locate and bring to chairside the following equipment:

- a. Sphygmomanometer (child and adult size cuffs)
- b. Stethoscope
- c. Ambu-bag and oxygen with mask and bags capable of positive pressure ventilation for children and adults.
- d. Oral pharyngeal airways (child and adult)
- e. An emergency drug kit based on the Pharmacy and Therapeutics Committee Minimum Standard.

Criterion #2: Emergency drug kits are stored and maintained as outlined in Procedures for Pharmacy Services except that the integrity of the kit will be verified each morning that the clinic is open.

Method of Assessment: Inspect emergency kit and assure that expiration dates have not passed on any medications, drug supplies are complete, and that a system is in place to regularly replace expired drugs and that a numbered security seal is in place assuring that unauthorized entry into kit has not occurred.

Criterion #3: The dental staff has received annual CPR training.

Method of Assessment: Current certification cards or a list of CPR certified staff should be available.

Criterion #4: A dental clinic emergency plan exists for management of medical emergencies and is understood by the staff.

Method of Assessment: Inspect the plans and interview staff for basic understanding of the plan and procedures. Review documentation that the plan has been reviewed annually and/or question the staff on emergency protocol.

Criterion #5: Emergency Oxygen is available at every operatory. Emergency Oxygen quantity is adequate for any emergency. Emergency Oxygen is checked every morning before patients are treated, a log is maintained indicating that such daily checks have occurred.

Method of Assessment: Review clinic logs at peer review audit.

#### C. Environment:

Criterion #1: All housekeeping activities have been performed before clinical day begins.

Method of Assessment: Observe the cleanliness and neatness of all areas of the dental clinic. If observation in the morning is not possible, then question the dental staff in accordance with the acceptability of the housekeeping activities being provided. Suggested areas to be considered are cleanliness of floors, walls, furniture, cabinets, dental chairs, dental units, wastebaskets, reception room tables, etc.

Criterion #2: The possibilities of mercury toxicity are minimized by the dental staff through the practice of good mercury hygiene.

Method of Assessment: Observe operations involving mercury transfer and determine whether mercury is handled carefully. A mercury spill kit is to be available in the facility. Scrap amalgam should be stored in a closed, labeled container under appropriate (e.g. x-ray fixer, commercial solution) liquid barrier. Water, mineral oil, or glycerin is not acceptable liquid barriers. Pre-encapsulated silver alloy is utilized to minimize the need to handle free mercury.

#### D. Infection Control Practices in the Dental Treatment Environment:

Criterion #1: An infection control policy for the dental facility has been reviewed and approved by the clinic's infection control committee/officer.

Method of Assessment: The infection control policy for the dental facility is accessible and available for review by dental clinic staff.

Criterion #2: The requirements of the AOSHA Bloodborne Pathogen Standard are met by having documentation of an exposure control plan, training, and immunization record.

Method of Assessment: Review of the dental staff, personnel records, and direct observation. All dental staff has been given the opportunity to be immunized for Hepatitis B and other diseases. Personnel records should provide dates of annual Tuberculin tests. Follow-up action is documented for employees with A positive findings which require attention.

Those staff members refusing the Hepatitis vaccine must be informed of the risks and are required to sign a form stating that the vaccine has been offered and refused. Refusal of vaccine and notation of possible consequences must be recorded.

Criterion #3: Accepted infection control procedures are practiced prior to, during and after patient care.

Method of Assessment: Direct observation

Criterion #4: A written schedule should exist which describes general sanitation and housekeeping procedures for the dental facility. Housekeeping services should be available to remove refuse daily and to clean floor coverings.

Method of Assessment: Review clinic's infection control manual.

#### E. Patient Preparation:

Criterion #1: Receptionist shall perform the following tasks for every patient visit upon their arrival to the dental clinic:

- a. When patient checks in they may, if convenient, sign patient register provided a method is used which precludes their viewing the names of any other patients (i.e. adhesive labels, sign in cards, etc.)
- b. Retrieves patient record and confirms that patients' birth date matches that of patient being seen.
- c. Reviews proposed treatment plan with patient, confirming that it addresses patients' immediate needs.
- d. Attaches note to chart indicating procedure to be performed (to be removed by dentist at completion of appointment.)
- e. Confirms that needed pre-medications, as indicated on chart, have been taken the prescribed period of time before being seated in treatment room.
- f. Places record in holding bin with patients name out of view of non-dental clinic staff.

Method of Assessment: Observe patient preparation procedures accomplished by dental receptionist.

Criterion #2: Chairside Dental Assistant shall perform the following tasks at each patient visit to prepare patient for dental procedure.

- a. Takes patient and patients' record to a prepared treatment room.
- b. Confirms identity of patient by matching birth dates of patient with that on patient record.
- c. Verifies that treatment plan for this appointment is the same as that anticipated by patient, and that it addresses the patients immediate needs.
- d. Reviews Medical Alerts on examination page, confirming that necessary pre-medications have been taken the prescribed period of time prior to appointment.
- e. Introduces patient to dentist as he/she enters treatment area, reviewing treatment planned, pre-medication taken (if required), nitrous oxide requests, other medical conditions known to the assistant which should be brought to the attention of the dentist.

Method of Assessment: Observe patient preparation procedures accomplished by chairside dental assistant.

# APPENDICES

APPENDIX A---CHART AUDIT CRITERIA/ AUDIT DOCUMENT

APPENDIX B---INFORMED CONSENT FORMS

APPENDIX C---INFECTION CONTROL IN DENTAL FACILITIES

APPENDIX D---CONTINUED COMPETENCY SKILL PROGRAM  
FOR CHAIRSIDE DENTAL ASSISTANTS

**COMMUNITY DENTAL CENTER  
CONSENT FOR SURGERY**

Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

I hereby authorize Dr. \_\_\_\_\_, and any other dentists of \_\_\_\_\_ to perform the following treatment or surgical procedure \_\_\_\_\_, and I understand that this is an **elective, urgent, or emergency** procedure (circle one).

I have been informed that the risks to my health if this procedure is not performed include, but are not limited to pain, infection, cyst formation, loss of bone around teeth causing their loss, and an increased risk of complications if surgery is postponed.

I have been informed of any possible alternative methods of treatment should any exist. Further, I understand that there are certain inherent and potential risks in any treatment or procedure, and that in this specific instance, such risks may include the following:

1. Postoperative discomfort and swelling that may necessitate several days of home recuperation.
2. Restricted mouth opening for several days or weeks.
3. Prolonged bleeding.
4. Nausea and vomiting (usually associated with medications prescribed for pain).
5. Postoperative infection requiring additional treatment.
6. Decision to leave a small piece of root in the jaw when its removal would require extensive surgery.
7. Damage to adjacent teeth, fillings, and crowns.
8. Stretching of the corners of the mouth with resulting cracking and bruising.
9. Opening into the maxillary nasal sinus or nose requiring additional surgery.
10. Prolonged drowsiness.
11. Change in occlusion and temporal-mandibular joint difficulty.
12. Injury to the nerve underlying the teeth resulting in numbness or tingling of the lip, chin, gums, cheek, teeth and/or tongue on the operated side. This may persist for several weeks, months, or in remote instances, be permanent.
13. Fracture of the jaw.

I consent to the administration of **local anesthesia (Novocain), nitrous oxide analgesia** or **oral sedation** in connection to the procedure referred to above (circle all that apply).

I certify that I have read the above and fully understand this consent for surgery, and that I understand that a perfect result cannot be guaranteed. If unexpected problems arise during the procedure, the doctor has my permission to do what is deemed necessary to correct the condition.

Drugs given at the time of surgery for sedative purposes or control of pain following the surgery may cause drowsiness and a lack of awareness or coordination. If instructed to do so, I will not drive or perform hazardous chores until I have recovered from the effects of these medications.

\_\_\_\_\_  
Patient's Signature Date

\_\_\_\_\_  
Parent or Legal Guardian (if patient under 18 yrs of age) Date

\_\_\_\_\_  
Witness or Interpreter Date

\_\_\_\_\_  
Dentist's Signature Date

**COMMUNITY DENTAL CENTER  
CONSENT FOR ENDODONTIC (ROOT CANAL) SERVICES**

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

I hereby authorize Dr. \_\_\_\_\_, and any other dentists of Community Dental Center to perform an endodontic (root canal) procedure on tooth (teeth) # \_\_\_\_\_, and I understand that this is an **elective, urgent, or emergency** procedure (circle one).

Root canal therapy is indicated when the pulp chamber of a tooth is contaminated by bacteria causing the canals to become infected. The procedure is accomplished when the dentist creates a small opening in the biting surface of the tooth that will allow it to be disinfected and then sealed with an inert rubber-like substance. The sealing of the canals prevents subsequent passage of bacteria into or out of the tooth.

I have been informed that the risks to my health if this procedure is not performed may include, but are not limited to: increased pain, swelling, loss of the tooth (teeth), loss of other teeth nearby, loss of the supporting bone, spreading infection, cyst formation, and/or deterioration of general health due to systemic infection.

I have been informed of possible alternative methods of treatment should any exist. Further, I understand that there are certain inherent and potential risks in any treatment or procedure, and that in this specific instance, such risks may include the following:

A failure to completely eliminate the infection requiring re-treatment, root surgery or removal of the tooth at a later date;

Post-operative pain, swelling, bruising, and/or limited jaw opening that may persist for several days

- Separation (breakage) of an instrument within the canal during treatment. Broken instrument tips are typically allowed to remain in the canal, and only rarely are they the cause of subsequent problems. If removal is indicated the patient may be referred to an endodontic specialist.
- Perforation of the root from within the canal can occur requiring additional treatment by a specialist. Such complications will occasionally result in the loss of the tooth.
- Damage to nerves supplying the teeth resulting in temporary or, in rare instances, permanent numbness or tingling of the lip, chin, or other areas of the jaws or face:
- Inability to adequately clean the canal(s) due to unforeseen calcified obstructions or severely bent roots. Under certain circumstances the patient may be referred to a specialist for successful completion of the procedure. Loss of the tooth may occur:
- A fracture of the treated tooth, occurring during or after endodontic treatment. Treated teeth sometimes break due to the tooth's loss of strength resulting from the procedure. In most cases a crown is recommended after treatment to prevent such an occurrence.
- Once treatment has begun, it is essential that it be completed in a timely manner. Root canal treatment will
- require from 1-5 appointments. Also, I understand that successful treatment does not prevent future decay or fracture of the treated tooth.

I understand the recommended treatment, the risks of such treatment, alternative treatments should any exist, and the consequences of doing nothing.

Patients Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent or Legal Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness or Interpreter \_\_\_\_\_ Date \_\_\_\_\_

Dentists Signature \_\_\_\_\_ Date \_\_\_\_\_

## DENTAL INFECTION CONTROL / DISEASE PREVENTION PROCEDURES

**I. PURPOSE:** To prevent the transmission of disease to dental health care workers and their patients.

**II. SCOPE:** Dentists, Dental Assistants, Dental Hygienists, any other at-risk personnel who may be required to provide service in dental operatories, laboratories, darkrooms or sterilization areas/rooms.

### III. PROCEDURE:

**A. Orientation:** All dental staff must read this procedure document and receive orientation on clinical infection control and safety protocols before any clinical responsibility is delegated to them. Upon completion of orientation and review of protocols, individuals will be asked to sign a document stating that they have read and received adequate training on the review of the hazards of the workplace and infection control in the dental environment.

1. **Immunizations:** All dental clinic staff are urged to have appropriate immunizations before engaging in the treatment of patients. All dental staff are afforded the opportunity to be immunized against Hepatitis-B, the cost of which shall be borne by (see policy IC.C.2)

2. **Blood-borne diseases:** Dental personnel will be given training to acquaint them with blood-borne diseases and their modes of transmission. This procedure has a section on blood-borne diseases entitled **AEpidemiology and Symptoms of Blood-borne Pathogens and Hepatitis B Vaccine**. It is required **that all dental personnel read this document**.

**B. Importance of Current Medical Histories:** Patient medical histories should be updated annually. Chairside Assistants should review pertinent information with doctor before patient treatment. Patient charts should reflect that a history review has occurred prior to any administration of medication or invasive procedure. Infectious diseases often can be present without overt symptoms. Further, some patients are reluctant to divulge facts about certain medical conditions; therefore, all patients are to be treated as being potentially infectious by observing and employing **AUniversal Precautions**.

**C. Universal Precautions:** Use approved protective attire and barrier techniques when contact with body fluids or mucous membranes (oral cavity) are anticipated.

- Wash hands (antimicrobial hand wash) before and after each patient contact.
- Wear gloves (exam, surgical, vinyl).
- Wear protective eyewear or goggles.
- Wear uniforms, laboratory coats, or gowns which are not to be worn out of the clinic environment.

**D. Darkroom Procedures:** Precautions should be taken in the darkroom when handling contaminated film packets to prevent cross-contamination. Contaminated packets should be opened in the darkroom using disposable gloves. The film should be dropped out of the packets onto a disposable towel without touching the film surfaces. The contaminated packets should be

accumulated in a plastic cup or another disposable towel. After all of the packets have been opened they should be discarded, gloves removed and films placed in the processor. Place film packets and gloves in the container marked BIO-HAZARD. Use heavy duty vinyl gloves (located in the darkroom) to disinfect darkroom with a disinfectant that is registered with the Environmental Protection Agency as a hospital disinfectant. When finished, remove the gloves and wash hands.

E. **Patient Treatment:** During patient treatment, all procedures should be performed in a manner that minimizes the formation of droplets, spatter, and aerosols, this can be accomplished by using high-volume evacuation and proper patient positioning. Dental personnel should limit the field of contamination by avoiding contact with objects such as charts, telephones, and cabinets during treatment.

F **Injuries and Sharp Items:** Safety precautions are to be taken to protect hands from injuries and disease causing pathogens. Wash hands (antimicrobial hand wash) before gloving and after degloving. Change gloves between each patient. Discard gloves that are torn, cut, or punctured. Avoid injury with sharp instruments and needles. Report all injuries, no matter how small, to your supervisor.

Handle sharp items carefully. Hemostats or pliers may be used to handle sharp items.

When it is necessary to recap needles, recap with a needle shield using a one-handed recapping technique to avoid accidental needle sticks. Place sharp items in appropriate containers labeled and designated for that purpose.

A container for disposal of sharp items is located either in each operatory or in that area of the sterilization room which is designated for the disassembling of trays after patient treatment.

I. **Disinfection of Treatment Rooms:** After patient treatment, all surfaces not protected with disposable barriers are to be decontaminated with a disinfectant which is registered with the Environmental Protection Agency (EPA) as a hospital disinfectant. This disinfectant is to remain in contact with the environmental surfaces for the period of time recommended by the disinfectants manufacturer. Protective attire (gloves, eyewear, and clothing) is to be used when performing this procedure. The disinfectants used may cause skin irritation, so it is highly recommended to refer to the applicable MSDS data for safety precautions to be followed when using these products.

J. **Handpieces:** The handpiece is one of the most challenging items to decontaminate. Decontamination should be accomplished in the following manner:

1. Following patient treatment, remove all blood and visible debris with an approved disinfectant:

2. Flush handpiece by running for 20-30 seconds (60 seconds after a long weekend) discharging water into a sink or container;
  3. Heat sterilize all handpieces, contra-angles, ultrasonic scaling tips and prophylaxis angles between each patient and lubricate as suggested by the manufacturer. Currently acceptable methods of heat sterilization include autoclaving and chemoclaving.
- K. **Three-way Syringe and High-Volume Evacuation Tips:** Saliva and debris will contaminate the 3-way syringe tip and high speed evacuation tips. 3-way syringe tips are to be heat sterilized. Disposable syringe tips are available and may also be used (discard after use) Wipe the 3-way syringe handle, syringe handle, saliva ejector coupling and hoses with an acceptable disinfectant after use (plastic sleeve type barriers may be used as an alternative). Evacuation tips are heat sterilized after each use unless they are the disposable variety, in which case, they are to be disposed of after each use. Flush the high-volume evacuation system with water. Then with an acceptable disinfectant solution (1 gallon of a 1:10 solution of chlorine bleach to water) at the end of each working day.
- L. **Dental Lights, Handles, Chair, Controls, and Dental Delivery Units:** Dental units, chairs, lights, and controls are to be wiped thoroughly with an acceptable disinfectant (EPA recommended as a hospital disinfectant) after each patient unless these surfaces have been covered with a plastic or fluid resistant paper barrier, in which case the underlying surfaces must be wiped with a disinfectant at the beginning of each day.
- M. **Burs and Mounted Diamond Stones:** Burs and diamonds are to be heat sterilized after use. The debris must be removed before they are placed in the ultrasonic cleaner. After all burs and diamonds are dried, they are placed in a bur block and sterilized in an autoclave or Harvey Chemoclave.
- N. **Cotton Products:** Cotton rolls and gauze are sterilized in individual packages or on a procedure tray for individual patient use. Store opened packages of gauze, cotton rolls and cotton pellets in covered containers. Use clean forceps for dispensing supplies for immediate use.
- O. **Tray Setup:** When possible, use tray setups so entering drawers and cabinets can be minimized. Think ahead when preparing for procedures. When cabinet drawers must be entered during a procedure to secure an instrument or supplies it must be accomplished with a sterile forcep or barrier to prevent contamination of the contents of the drawer.

- P. Nitrous Oxide masks: The mask and breathing tubes should be thoroughly wiped after each use with two separate gauze pads saturated with an acceptable disinfectant (EPA recommended as a hospital disinfectant).
- Q. Contaminated Waste: Refuse determined to be considered Ainfectious as per current regulations of the New Mexico Environmental Improvement Division shall be separated from all other and placed into covered containers having red or orange plastic liners or liners clearly labeled as bio-hazard to alert personnel of possible danger.

The current State Environmental Improvement Divisions definition of Ainfectious waste having dental implications is a limited class of substances that cause a probable risk of transmitting diseases to humans, including:

1. Pathological wastes and body parts (teeth and soft tissue);
2. Disposable equipment contaminated by highly contagious disease;
3. Blood and blood products;
4. Contaminated sharps and broken glass.

Limit materials which are red bagged to gauze and cotton balls soaked with blood, saliva and blood-stained paper goods, teeth or excised soft tissue. Sharps are to be tightly sealed in puncture resistant containers to preclude loss of contents.

All contaminated waste is collected from each container marked Abio-hazardous materials≅ at the end of each day. The dental personnel must wear gloves when performing this job. All bags are placed in a large red bag and taken to the designated holding areas within the clinic where it is deposited for removal by a contracted special waste hauler.

Full sharps containers which have been taped shut are to be taken to the aforementioned holding area and deposited in infectious waste containers in a similar manner.

- R. Eyewash: An emergency eyewash station shall be clearly designated in all clinics. These stations shall be located in either or both the dental laboratory or the sterilizations area/room. These facilities shall be clearly marked with an appropriate sign. They are to be used in the event of a chemical splash or to effect the removal of a foreign body from the eyes. In the event of a chemical splash water should be flushed into the eyes for a full 15 minutes, even if perceptible burning no longer occurs. The injury must be reported to the employee's supervisor.
- S. Spills of Chemical or Infectious Materials: Should any blood, infectious fluids or materials be spilled on the floor or any work surface, the spilled material should be wiped

up using an absorbent material in gloved hands, and dispensed of in the appropriate waste container. The area should then be thoroughly wiped down with a hospital grade, high level disinfectant or a solution of 1:10 household bleach and water and allowed to remain wet for 30 seconds before wiping dry.

Clinics should also maintain a mercury spill kit in the event that dental mercury should spill.

T. Impressions:

1. Polyether impressions should be sprayed with a 1:10 dilution of 5.25% sodium hypochlorite (bleach) solution, allowed to remain wet for 2-3 minutes only, and then rinsed with water before sending to laboratory.
2. Vinyl Polysiloxane impressions should be immersed in a 1:10 dilution of 5.25% sodium hypochlorite (bleach) solution, soaked for 10 minutes, rinsed and sent to laboratory.
3. Alginate impressions should be rinsed with water immediately after removal from mouth to remove blood and saliva. They should then be sprayed with a 1:10 dilution of sodium hypochlorite (bleach) solution, sealed in a plastic bag for 10 minutes and then poured immediately.

U. Shipping of Contaminated Articles: Any laboratory cases (impressions, models, prosthetic devices, etc.) and any contaminated equipment being shipped for processing or repair must be decontaminated before packaging with a disinfectant solution appropriate for the item being shipped.

V. Monitoring of autoclaves and chemiclaves: Dental clinics shall monitor each sterilization cycle with heat sensitive color change tapes or strips. These trips only indicate that an adequate heat level was attained and do not assure sterilization. In addition to the heat strips a biological monitoring device or spore monitor shall be cultured by dental staff on a weekly basis to assure that an adequate pressure was achieved and that the bacterial spore was killed by the sterilization process. Quarterly, a spore monitor should be sent to a qualified independent laboratory to verify the accuracy of the clinics in-house monitoring. In the event that the monitoring indicates that adequate sterilization was not achieved the dental clinic must do the following:

1. Immediately culture another spore indicator to determine if the first positive sampling was flawed.
2. Discontinue use of the sterilizer which is suspect until it is repaired or it is determined that the original test was in error.

3. Review all patient records of patients who have been treated to determine if medical histories reveal any serious infectious disease, e.g. AIDS, Hepatitis B, etc. If other patients have possibly been treated with instruments which did not undergo adequate sterilization, immediately notify the Clinical Director or the Dental Director for further direction regarding patient notification procedures. If no patients with serious infectious disease have been treated with instruments in question no patient notification is required.

## Epidemiology and Symptoms

### Of

## Blood-borne Pathogens and Hepatitis B Vaccine

Certain employees face a significant health risk as the result of occupational exposure to blood and other infectious materials because they may contain blood-borne pathogens. Hepatitis B (HBV) and Acquired Immunodeficiency Syndrome (HIV) are the two principal biological hazards employees are exposed to. These diseases are caused by the viruses, hepatitis B virus and immunodeficiency virus.

The modes of transmission of these viruses are similar. The sources of HIV and HBV exposure in the workplace setting are blood and other potentially infectious materials, e.g. body fluids, unfixed tissue or organ, HIV or HBV experimental cells.

Vaccination to prevent hepatitis B has been available since 1982. Due to the increased risk for occupational acquisition of HBV infection, this safe, effective vaccine is recommended for health care workers.

Available vaccines stimulate active immunity against HBV infection and provide over 90% protection against hepatitis B for 7 or more years following vaccination. Hepatitis B vaccines also are 70-88% effective when given within one week after HBV exposure. Hepatitis B immune globulin (HBIG) provides temporary passive protection following exposure to HBV. Combination treatment with hepatitis B vaccine and HBIG is over 90% effective in preventing hepatitis B following a documented exposure. Serious adverse effects from immune globulins (IG) administered as recommended have been rare.

Pre-exposure prophylaxis (hepatitis B vaccination) is recommended for health care workers as an important adjunct to universal precautions. The recommended series of three intramuscular doses of hepatitis B vaccine induces an adequate antibody response in greater than 90% of healthy adults. The primary vaccination is comprised of three intramuscular doses of hepatitis B vaccine, with the second and third doses given 1 and 6 months respectively. Hepatitis B vaccine should be given in the deltoid muscle for adults. Protection against illness is virtually complete for persons who develop an adequate antibody response after vaccination. The duration of protection and need for booster doses are not fully defined. Between 30% and 50% of persons who develop adequate antibody after three doses of vaccine will lose detectable antibody within seven years, but protection against viremic infection and clinical disease appears to persist. The most common side effect following vaccination has been soreness at the injection site.

The incubation period of hepatitis B is long (40-60 days; average 120 days) and the onset of acute disease is generally insidious. Clinical symptoms and signs include anorexia, malaise, nausea, vomiting, abdominal pain, and jaundice. The case fatality rate for reported cases is approximately 1.4%. HBV infection is a major cause of acute and chronic hepatitis, cirrhosis, and primary hepatocellular carcinoma.

The increasing prevalence of HIV amplifies the risk that health-care workers will be exposed to blood from patients infected with HIV. Health care workers are to consider all patients as potentially infected with HIV and/or other blood-borne pathogens minimizing the risk of exposure to blood and body fluids of all patients.

Adequate employee protection must be provided in a manner consistent with a high standard of patient care. Health risk can be minimized or eliminated using a combination of engineering and work practice controls, protective clothing and equipment, training, medical follow-up of exposure incidents, vaccination (if applicable), and other provisions. Universal precautions is a method of infection control in which all human blood and certain body fluids are treated as if known to be infectious for HIV, HBV, and other blood-borne pathogens. Universal precautions are intended to prevent parenteral, mucous membrane, and non-intact skin exposures of health care workers to blood-borne pathogens.

**APPENDIX D**  
**CONTINUED COMPETENCY SKILL PROGRAM**  
**FOR**  
**CHAIRSIDE DENTAL ASSISTANTS**

**Continued Competency Program for Chairside Dental Assistants**

All staff of \_\_\_\_\_ will at hire and annually, experience evaluations and/or training sessions in certain predetermined skill areas which pertain specifically to their job descriptions. Chairside dental assistants will be expected to master certain skills which are applicable to their positions.

Dental Directors shall implement a continued competency program which will assure the learning and competency of those skills listed in this document provided those skills are necessary to the dental practice of the specific clinic. If a dental director does not wish to delegate one or more of the following tasks to the dental assistant, the skill may be considered not applicable to that particular program.

The dental director may implement the competency review in one of the following ways:

1. A yearly demonstration/workshop wherein the dental director sets aside as many hours of a regular clinic day as needed to review, through demonstration and practical experience; all of the tasks on the attached list, or
2. A yearly review through direct observation of the dental assistant(s) as they exercise the tasks listed in regular working hours.

The skills which should be reviewed are:

Reviewed

1. Sterilization and preparation of contaminated instruments, (as prescribed by Dental Director), may include:
  - A. Gross cleaning - instruments should be scrubbed with a brush reserved for that purpose or cleaned with hard warm water spray.
  - B. Instruments should then be placed in ultrasonic device containing an approved ultrasonic cleaning agent for from 5-15 minutes, depending on size of load. \_\_\_\_\_
  - C. Rinse in cool water to remove ultrasonic cleaning

agent \_\_\_\_\_

D. Alcohol dip (90-100% isopropyl alcohol) to aid  
Drying. \_\_\_\_\_

E. Pat dry with towel or allow air drying. \_\_\_\_\_

F. Corrosion inhibiting instrument Amilk bath for  
instruments susceptible to corrosion may be used  
if autoclave is used. \_\_\_\_\_

G. Wrap or package instruments in appropriate bags  
or tray set up with appropriate barrier. Date bags  
or trays before sterilizing with date of processing. \_\_\_\_\_

H. Attach heat indicator strip (each load) and spore  
indicator (once weekly). \_\_\_\_\_

I. Sterilize in Autoclave or Chemiclave for  
prescribed length of time. \_\_\_\_\_

J. Store in drawers or shelves lined with paper. \_\_\_\_\_

2. Minor dental equipment maintenance, may include:

A. Dental light bulb replacement. \_\_\_\_\_

B. Fibre optic light bulb replacement. \_\_\_\_\_

C. Vacuum trap cleaning (weekly). \_\_\_\_\_

D. Cleaning of vacuum tip valve assembly. \_\_\_\_\_

E. Replacement of Air/water syringe valves, syringe  
tip assembly. \_\_\_\_\_

F. Airroter cartridge replacement. \_\_\_\_\_

G. Compressor tank bleed. \_\_\_\_\_

3. X-ray processing using sterile technique \_\_\_\_\_

4. Handwashing/gloving/protective clothing/mask/eye  
wear protocol. \_\_\_\_\_

5. Incubation/reading of spore strips. \_\_\_\_\_

6. Hand mixing of cements, may include:
- A. IRM cement \_\_\_\_\_
  - B.  $Zn_2PO_4$  cement
    - 1) luting \_\_\_\_\_
    - 2) base \_\_\_\_\_
  - C. Glass ionomer cement for luting \_\_\_\_\_
  - D. Zinc Oxide/Eugenol or other temporary cement for luting temporary crowns \_\_\_\_\_
7. Radiographic technique of assistants certified in this field.
- A. Placement of lead apron \_\_\_\_\_
  - B. . Explanation of procedure \_\_\_\_\_
  - C. Film placement using film holder \_\_\_\_\_  
Reviewed
  - D. Patients head positioning \_\_\_\_\_
  - E. Assistants position during exposure \_\_\_\_\_
  - F. Technique with gag reflex \_\_\_\_\_
  - G. Technique with small children \_\_\_\_\_
8. Alginate impressions for study models (if a delegated procedure) \_\_\_\_\_
9. Pouring alginate impressions \_\_\_\_\_
10. Trimming stone models \_\_\_\_\_
11. Polishing technique of assistants certified in this field (Assure that stained pellicle of primary teeth is removed adequately). \_\_\_\_\_
12. Fluoride administration of assistants certified in this field. \_\_\_\_\_
13. Emergency procedure protocol \_\_\_\_\_

Statement of certification:

I certify that I have reviewed each of the aforementioned skills  
with \_\_\_\_\_ (dental assistant) on \_\_\_\_\_ (date).

\_\_\_\_\_  
Supervising Dentists Signature

A copy of this form, certifying to the dental assistants review of skills should, upon completion,  
be sent to the Corporate Dental Director of \_\_\_\_\_.

## X-RAY GUIDELINES

The following Food and Drug Administration (FDA) dental X- ray guidelines are for people who have no tooth decay and are not at high risk of getting cavities:

Adults should have bitewing X- rays every 2 to 3 years.

Adolescents should have bitewing X- rays every 12 to 3 years.

Children should have bitewing X- rays every 1 to 2 years.

The FDA guidelines for people who have tooth decay or who are at high risk of getting cavities are as follows:

Adults should have bitewing X- rays every 1 to 122 years.

Adolescents should have bitewing X- rays every 6 to 12 months, until no tooth decay is evident.

Children should have bitewing X- rays every 6 months until no tooth decay is evident.

In addition, many dentists believe that all adults should receive a screening panoramic X- ray every 2 to 5 years.