



# Dental Assisting Clinic Manual 2015-2016

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**SECTION ONE:**  
**Dental Assisting**  
**Sequence of**  
**Clinical**  
**Procedures**



## **SECTION 1: Dental Assisting Sequence of Clinical Procedures**

### **General Clinic Policies**

The even flow of patients through the clinic is dependent upon strict adherence to the rules and regulations governing the clinic. The student must be familiar with the contents of this manual before working in the clinic and learn the policies in regard to patient management, care of equipment, and clinical procedures.

### **Ethics, Conduct, and Clinic Attendance**

#### **Ethics**

1. Anything less than the highest order of professional conduct and understanding on the part of the student can only result in the loss of the patient's confidence in the student, the school, and the profession. Courtesy and consideration of the patient must prevail at all times. Grades and general standing of the student depend upon his/her total patient care.
2. Criticism of previous dental services is not considered ethical. Students will learn that many circumstances have a bearing upon the present condition of the mouth.
3. Anything involving the student and the patient is strictly confidential. Patient's information should not be discussed with classmates or anyone else except the patient and/or faculty on an as needed basis.

#### **Conduct**

1. Proper conduct and ethics encompass all the activities of the student. Students should conduct themselves in a professional manner at all times. Loud and boisterous talking in the corridors and clinic will not be tolerated.
2. The faculty and secretary should be addressed by their last names with the prefix Dr., Mr., Miss, Ms., or Mrs., whichever is correct, and the instructor should at all times be introduced to the patient. All adult patients should be addressed by their last names.

#### **Clinic Attendance**

1. The clinic will be open at specified times indicated in the student's class schedule. Students will be expected to follow published schedules for their respective classes.
2. Students will report in proper attire to the clinic as assigned at least thirty minutes prior to the scheduled clinic hours, patient or not, and stay in the clinic until excused. See CCCC Policies and Procedures Manual for policy on attire.
3. Students should not dismiss a patient until an instructor has given approval.
4. In the event a student does not come to clinic and fails to notify an instructor, a zero will be given for each missed clinical session and all missed sessions will be rescheduled at instructor discretion.

## EagleSoft Scheduling

The dental clinic is using EagleSoft, a powerful dental practice management software system, to keep track of all patients, appointments and accounts. The system is also used for the intraoral camera and digital radiography – both intraoral and panoramic.

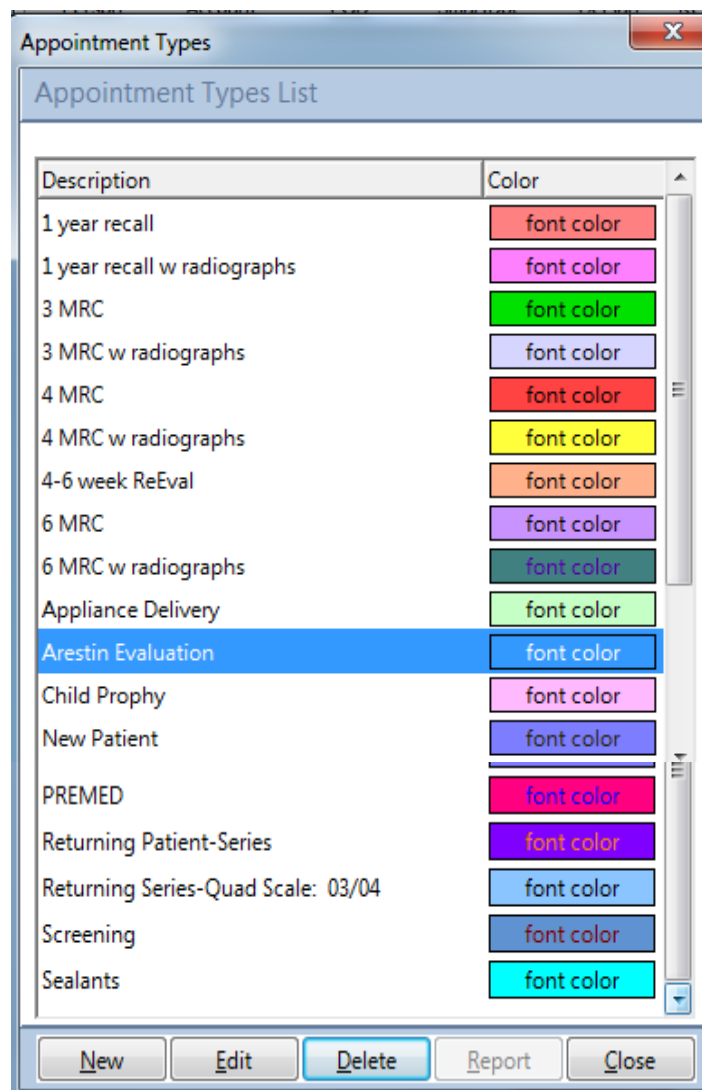
Here are a few basic tips to make your EagleSoft experience positive. You will be given a detailed EagleSoft orientation prior to beginning clinic.

1. Your username and password will be assigned to you. Do **not** share your password with another student. **Never** log in as another student – even if the other student asks you to. There is a way to track each user’s activities; therefore, you must always use your own login. If you go to a computer and someone else is logged on – log them off and login under your user name before proceeding.
2. If you forget your username and/or password, a full-time instructor can provide it for you. However, twenty professional responsibility points will be assessed.
3. Do **not** “X” out of any screen within EagleSoft. Always look for another way to leave the screen such as Close, Save, Cancel, OK, etc. Remember – red means stop – green means go!
4. When you finish using EagleSoft you must logoff to keep others from working under your login. Just click the logoff button in the tool bar. Do NOT close the program – just logoff.
5. When moving from one field to another – use the TAB key. Do NOT press ENTER.
6. When on the main page of EagleSoft, hold the cursor over any icon and it will label that icon to help you navigate to the appropriate screen.

### Scheduling Appointments

1. Open EagleSoft and logon.
2. In order to schedule an appointment for a patient, the patient must be entered into EagleSoft. Before trying to schedule, check to see if the patient has been entered into EagleSoft.
  - a. In the Front Office Window, click on the computer screen (OnSchedule).
  - b. Using the button in the menu bar, go to the date you wish to schedule.
    - i. ° = today
    - ii. << = back 7 days (1 week)
    - iii. < = back 1 day
    - iv. > = forward 1 day
    - v. >> = forward 7 days ( 1 week)
  - c. Find your assigned student provider.

- d. Click on 9:00am to get a blue bar {or the appropriate appointment time}.
  - e. Double click on the blue bar and the “Find” box will appear.
  - f. In the “Find” box, type your patient’s last name. The box below will show all patients with that last name.
  - g. If there are several patients with the same last name, you may have to scroll to find your patient. After you find your patient, double click on your patient’s name.
3. If the patient has alerts, a yellow box will appear. Check the alerts and click “OK”. This box will appear at various stages of the appointment process. Just click “OK” to close the box each time.
  4. An appointment block window will appear.
  5. At the appointment block window:
    - a. Verify that this is the correct patient.
      - i. Choose appointment type.



- b. Choose primary provider.
  - i. Open drop-down menu.
  - ii. Click on **your** (Student's) provider number (same as username). This one simple step will assure that this patient appears on your re-care list. You are responsible for printing a re-care list once a semester to assist you in identifying which patients are due to return.
- c. Change the number of units needed (a unit is 15 minutes). A two and one half hour (2 ½ hours) appointment will be 10 units.
- d. Click on service (lower left of rectangular white box). *2<sup>nd</sup> Year Students only*
  - i. Click on the circle by ADA Code.
  - ii. Enter ADA code for each service you plan to perform.
  - iii. Type in code and click on use.
  - iv. As each service appears, click "OK" to use or "CANCEL" if you will not use. You may have several ADA codes typed in box.
- e. When finished, click "OK" at top right.
- f. If you get the warning that "this provider normally does not..." or you have chosen the wrong chair or tried to schedule a patient when clinic is not in session, click "OK" then click and drag the block to the proper time/chair. When dragging blocks, be sure to look at the screen carefully to insure you are dragging exactly to the proper block location.
- g. If the patient requires premedication, a box will appear asking if you want to: "prescribe now, assign a task, or don't prescribe." Consult with CCCC faculty if needed and they will advise you,
- h. When you have completed the appointment, click on the red X at the top right to close "OnSchedule."
- i. If you do more or less than what was entered in under services for your patient, you must go back and add or delete in the appointment box BEFORE the patient is dismissed from the clinic. *2<sup>nd</sup> Year Students Only*

### **Block Scheduling**

(This is utilized for patients not yet in EagleSoft, last minute appointments, CA, Screening days)  
Failure to schedule in EagleSoft is a MAJOR error.

1. Select your chair number.
2. Right click on mouse.
3. Select "Schedule Services."
4. Select "Create Block."
5. Enter # of units.
6. Type in description block- Patient name, Screener, Still Looking, etc.

## Patient Privacy Act (HIPAA) –

- i.** This form is completed at the patient's initial appointment at the clinic and kept in the chart for the duration of time the patient is seen at Central Carolina Community College. (Once this form is completed and entered in EagleSoft- **(you do not need to update it.)**)
  - ii.** A copy of the Privacy Practice at CCCC should be made available to your patient during their initial appointment.
  - iii.** In EagleSoft, a check mark should be placed in the HIPAA block and Privacy Notice block in the patient information page to indicate the form is in the chart. The dates must match..
- a.** Under no circumstances are patients to be in your chair until they have been checked in properly! Even if they are your family or friends they must remain in the patient reception area and are not to be seated in the clinic until after an instructor is in the clinic and proper procedures are completed. Failure to follow proper check-in procedures or to seat a patient before a faculty member is in clinic will result in the assessment points deducted from your grade.
  - b.** Student clinicians/assistants may not leave the clinic floor without permission from an instructor.

**Central Carolina Community College Dental Hygiene Program  
HIPAA  
Consent for Purposes of Treatment, Payment and Health Care Operations**

I consent to the use or disclosures of my protected health information by the Central Carolina Dental Center for the purposes of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of the Central Carolina Dental Center. My “protected health information” means medical, billing and demographic information about me collected from me and created or received by the Central Carolina Dental Center for treatment, payment and health care operations. **I understand that diagnosis or treatment of me by the Central Carolina Dental Center may be conditioned upon my consent as evidenced by my signature on this document.**

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. The Central Carolina Dental Center is not required to agree to the restrictions that may request. However, if Central Carolina Dental Center agrees to a restriction that I request, the restriction is binding on the Central Carolina Dental Center.

I have the right to revoke this consent, in writing, at any time. The revocation will be effective upon receipt, except to the extent that Central Carolina Dental Center has taken action in reliance on this consent.

I understand I have a right to review Central Carolina Dental Center’s Notice of Privacy Practices prior to signing this document. Central Carolina Dental Center’s Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Central Carolina Dental Center. The Notice of Privacy Practices for Central Carolina Dental Center is also provided on the Central Carolina Community College Dental Programs website under patient admissions at [www.cccc.edu](http://www.cccc.edu). This Notice of Privacy Practices also describes my rights and Central Carolina Dental Center’s duties with respect to my protected health information.

Central Carolina Dental Center reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing the Central Carolina Community College website, calling the office and requesting a revised copy to be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative	Date
Name of Patient or Personal Representative	Date
Description of Personal Representative’s Authority	

**Central Carolina Community College  
Dental Hygiene Program**

**PATIENT RIGHTS AND RESPONSIBILITIES**

Central Carolina Community College Dental Programs is a teaching institution with a commitment to the education of health care professionals. Adults and children who receive care in our clinical programs are vitally important participants in this process. For that reason, we expect to make your experience a healthy and satisfying one.

We are committed to the highest quality of care. To do this, the patient or parents of the patients, and dental professionals must work together to develop the best relationships. A better understanding of your oral condition and your rights and responsibilities in the treatment of that condition will contribute to better care and greater satisfaction for all concerned. We realize that no set of guidelines can ever fully describe the special relationship that exists between you and your student dental hygiene provider. The purpose of this brochure is to enhance the mutual trust, cooperation, and respect which surround that relationship.

**YOUR RIGHTS AS A PATIENT**

YOU AS A PERSON – We are not only interested in providing you with dental hygiene services, but also in recognizing and respecting your dignity as a human being. You may expect to be treated with consideration and respect regardless of your race, creed, national origin, age, handicap, or sex.

SERVICES YOU NEED – We will inform you about what we can and cannot provide and help in making referrals for treatment elsewhere. You will also be informed of the need for and availability of appointments. When your relationship with the school ends, for whatever reason, we will tell you about your further treatment needs.

UNDERSTANDING YOUR PLAN OF CARE – You are entitled to a clear explanation of your dental problems, what treatment is recommended, what the alternatives are as well as any risks involved, who will provide your care, and approximately how long it may take. Complications encountered during therapy that may alter your plan of care or affect the outcome of your treatment will also be explained to you. If you are receiving dental hygiene services from our school, you can expect at least one recall appointment a few months after treatment is completed. This is our way of assuring that treatment is rendered at the dental hygiene school in a satisfactory manner, and to see if further care is needed.

CONSENT AND REFUSAL OF TREATMENT – You have the right to participate in decisions about your dental treatment and to have any questions answered before making a decision. Any treatment you receive will meet appropriate standards of care. You may also refuse treatment and expect to be informed of the possible consequences of your decision. If your refusal is not congruent with good standards of care, it may be left to your discretion to seek treatment outside the Dental Hygiene Clinic, and you could be considered for dismissal as a patient.

CONFIDENTIALITY – Discussions about your care will be done with as much consideration for

your privacy as possible. A copy of your treatment record will not be released without your written permission, except as required through an insurance contract or by law.

**YOUR RESPONSIBILITIES AS A PATIENT**

As a patient or the parent of a patient in our program, your responsibilities are:

To share honestly and completely information about your medical and dental history, previous illnesses, hospitalizations, exposure to communicable diseases, information about medications you are taking, allergies, and your current medical care.

To let us know when there are changes in your general health condition, or if you should experience complications or unusual discomfort following a treatment procedure.

To ask questions so that you can better understand the nature of your dental condition and the treatment provided.

To follow the instructions you are given, be available for services you need, and keep your scheduled appointments.

To be available at least one-half-day a week, starting at either 9:00a.m. for a morning appointment or 1:00 p.m. for an afternoon appointment; and if you are the parent of a patient under the age of 18, to be available during the entire treatment appointment.

To give at least 24 hours notice when canceling an appointment.

To be prompt in attendance for you, or your child’s dental visit.

To seek routine care from another source (such as a dentist in private practice), once the course of prescribed treatment and recall are complete. You may, of course, seek dental hygiene treatment here later if needed.

To be considerate and respectful of other patients, and of students, faculty and staff of Central Carolina Community College.

If you have any questions, concerns or problems with your treatment, please call (919) 777-7780, Monday through Thursday, from 8:00 a.m. to 4:00 p.m.

\_\_\_\_\_  
Signature of Patient/Parent or Legal  
Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness



## Cancelled or Failed Appointments

1. Open “OnSchedule” and go to the appointment block scheduled.
2. Right click on the appointment block and select “DELETE.”
3. Choose:
  - a. Failed – if patient did not show or cancelled within 24 hours.
  - b. Cancelled – if patient called to cancel at least 24 hours prior to appointment time
4. Unclick “Add this appointment to the quick fill list.”
5. Click “OK.”
6. At “There are services . . .” click “NO.”
7. Record the failed, cancelled, or no show appointment in the EagleSoft Record of Treatment.

## Changing a Scheduled Appointment

1. Open “On Schedule” and go to the appointment block you wish to change.
2. Right click on the appointment block and choose “Move the appointment/block.”
3. Using the arrows in the tool bar, go to the date and time you wish to move the appointment to (the appointment will show in the original location until the move is complete).
4. Click on appoint queue (double arrows on center left of screen).
  - a. Left click on patient and drag into preferred appointment slot.
  - b. Appointment will now disappear from the initial appointment and appear only in the new block.

## Review of the Health Questionnaire (Medical History) - Black

- The Health Questionnaire is completed at the Screening and New Patient appointment. This form is signed by the patient, screener/clinician and instructor. All entries must be in ink for legal purposes.
- Review and update the Health Questionnaire of a screened patient or a patient you have seen before. If the patient is a new patient to you, have the patient complete a new Health Questionnaire. Transfer information into Eaglesoft Medical History.
- You are responsible for all information on the medical history. By following up on information on the Health Questionnaire, you can gain valuable information. Use reference books such as the PDR and Drug Information Handbook for Dentistry to learn about drugs or diseases. Find out why a patient is on penicillin (you could contract strep

throat), why they had a chest x-ray (TB?), or why they had the hysterectomy (CA?). It is your responsibility to be able to answer any questions an instructor has concerning your patient's medical history. For patients requiring premedication, refer to your Clinic Manual section on premedication. The medical history must include all prescription medications that the patient is taking.

### **Sequence of Procedure:**

1. Review the patient's Health Questionnaire and Drug Summary prior to any treatment. This must be done at the beginning of every appointment.
2. **New Patients/Screening Patients**
  - a. Review dental interview and ask all necessary questions making sure that all information is entered into Eaglesoft accurately and signed by the patient using the signature.
  - b. Check that only patients of legal age (18 and over) have completed and signed the forms.
  - c. Health questionnaire forms of patients under age 18 must be completed and signed by parent or legal guardian.
  - d. If the parent or legal guardian has not completed and signed the health questionnaire and interview form, dismiss and reappoint the patients under 18.
3. **Subsequent Appointments**
  - a. Review the health questionnaire with the patient/parent.
  - b. Ask if there have been any changes in the patient's health **since the last visit**.
  - c. Write any significant changes in the comment section of Eaglesoft; have patient sign using the signature pad.
  - d. Have patient sign the health history form at every appointment and when changes are indicated. (ie: medication, illness, etc.)
4. **Evaluation of Health Questionnaire**
  - a. After patient has answered the health questionnaire questions, circle significant "yes" answers in red. Note significant "yes" answers in Medical Alert box and/or comment section in Eaglesoft Health History.
  - b. Ask appropriate follow-up questions to "yes" responses.
  - c. Record responses in comments section in Eaglesoft.
  - d. Any condition that may warrant precaution prior to dental treatment is noted in Eaglesoft alerts. Refer to your pre-clinic notes.
  - e. Record that the questionnaire has been reviewed on the Record of Treatment. Include any additional information that is deemed necessary.
  - f. Note pertinent information in a concise, scientific, legible manner in Eaglesoft.

- g. Take blood pressure, pulse, respiration, and temperature on every patient during your first appointment with them and every subsequent re-care appointment.
- h. Make sure your patient has signed and dated the medical history. If the patient is a minor, under 18 years of age, the legal guardian must sign the Health Questionnaire or treatment will not be rendered. Also, if the patient is under 14, the parent must remain in the reception area.
  - i. If a minor is not accompanied by his/her parent, a **notarized letter** signed by the parent stating permission to be treated by whomever is accompanying the child or the student to act in their behalf. All paperwork requiring parental signatures must be signed by the parent or guardian and presented at the time of check in.
- 5. **Significant Health Questionnaire Findings.** See medical referral section of this manual for further information.
- 6. **Procedures for Obtaining Physician's Approval-Healthcare Provider Communication**
  - a. The student involved must request the physician's approval for treatment via fax.
  - b. Annotate in Eaglesoft notes that written consent has been received from the physician via a fax bearing MD signature.
  - c. Depending on the patient's condition, if the physician cannot be reached the student may need to dismiss the patient and reappoint when medical consultation can be completed.
  - d. All correspondence is required to be scanned into Smartdocs in Eaglesoft. Student is responsible for ensuring that this is accomplished. Provide copy to Office Manager to be scanned.
- 7. **Procedures for Additional Medical Concerns**
  - a. **Patient Medications**
    - i. Be sure patient has taken medications prescribed for medical conditions.
      1. There will not be any dispensing of pre-medication on-site. Some dental practices will have on-site medications. But the dental hygiene clinic at CCCC does not maintain medications for patients.
      2. Inhalers and/or nitroglycerin are required to be readily accessible during treatment. Will be a critical error if not followed.
    - ii. Use an appropriate drug reference or call pharmacist for any information about unfamiliar medications. Note all pertinent information and/or precautions.
    - iii. Take appropriate precautions for medications, which may affect dental treatment.

1. **Bisphosphonates:** Bisphosphonates have been mostly used to treat osteoporosis but may also be used to treat cancers. Patients must be asked if they have a history of osteonecrosis while taking this medication due to the increased risk. Jaw osteonecrosis seems to be associated with trauma. Most cases occur after extractions and are located near the mylohyoid ridge. Of those not associated with extractions, they are commonly associated with dentures or exostoses. Chronic periodontitis also increases the risk of osteonecrosis development. Osteonecrosis will appear as exposed yellow-white bone. Sinus tracts and painful ulcers may also be present. Students should be aware of these symptoms and alert the instructor of this medication.
2. **Warfarin (Coumadin):** Warfarin is an oral anticoagulant used to prevent clotting. It interferes with the blood's clotting by blocking the production of the clotting factors (II, VII, IX, and X), which are vitamin K dependent and are synthesized in the liver. Indications for warfarin include atrial fibrillation, post-MI, or thrombophlebitis. Warfarin's major side effects relate to its action to increase bleeding with symptoms such as petechia, bruising, ecchymoses, hematuria (bleeding into the urine), or frank hemorrhage. Whether a patient will exhibit side effects from warfarin is difficult to predict and unrelated to the degree of anticoagulation present.

Warfarin's anticoagulant effect is monitored using the laboratory test for prothrombin time (PT). Within the last few years, PT has been replaced with the international normalized ratio (INR). The INR uses the prothrombin (PT) but corrects for the variability of the tissue thromboplastin used the laboratory where the test was performed. Therefore the INR can be compared among laboratories world-wide. Laboratories report their results either at the PT or the INR.

*Most dental references state that dental procedures can be performed if the PT ratio (ratio of patient's PT to the PT of the control) is  $\leq$  (less than or equal to) 2. A PT ratio of 1.8 would result in an INR of about 4.5. If the INR is less than 4.5, (or the PT is less than 2) most dental treatment can be safely performed. A recent INR is needed to assess the patient's anticoagulant status.*

#### **b. Guidelines for Management of Patients with Elevated Blood Pressure**

- i. Explain to patient what is to be done.
- ii. Determine and record every ADULT patient's blood pressure on first visit, each re-care visit and each appointment if the patient reports high blood pressure and/or a history of heart disease.

- iii. Identify possible medical emergencies related to the blood pressure and be prepared to handle the emergency should it occur.

<b>SIGNIFICANT HYPERTENSION IN CHILDREN</b>		
AGE	SYSTOLIC	DIASTOLIC
3-5	>116	>76
6-9	>122	>78
10-12	>126	>82
13-15	>136	>86
16-18	>142	>92

<b>CLASSIFICATION OF BLOOD PRESSURE FOR ADULTS AGE 18 &amp; OLDER**</b>		
Category	Systolic (mm Hg) (SBP)	Diastolic (mm Hg) (DBP)
Normal	<120 and	<80
Prehypertension	120-139 or	80-89
Stage 1 Hypertension †	140-159 or	90-99
Stage 2 Hypertension †	>160 or	>100

\*\* Not taking antihypertensive drugs and not acutely ill. When systolic and diastolic blood pressures fall into different categories, the higher category should be selected to classify the individual's blood pressure status. For example, 160/92 mm Hg should be classified as stage 2 hypertension, and 174/120 mm Hg should be classified as stage 3 hypertension. Isolated systolic hypertension is defined as SBP of 140 mm Hg or greater and DBP below 90 mm Hg and staged appropriately (e.g., 170/82 mm Hg is defined as stage 2 isolated systolic hypertension).

† Based on the average of two or more readings taken at each of two or more visits after an initial screening.

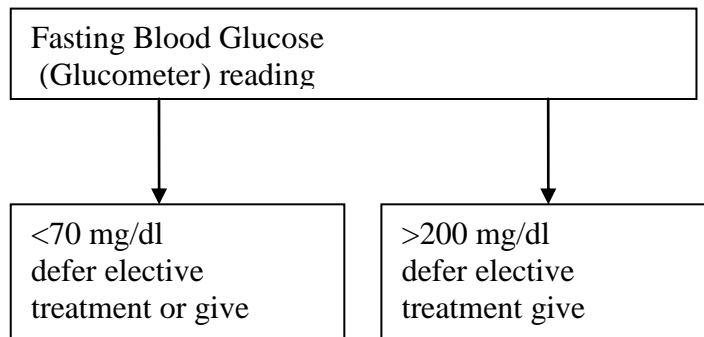
<b>DETERMINING RISK/PROVIDING DENTAL TREATMENT</b>	
<b>Normal/High Normal</b>	<i>Systolic 139 or lower or Diastolic 89 or lower</i> 1. No contraindications to elective dental treatment.
<b>Stage 1 HTN</b>	<i>Systolic 140-159 or Diastolic 90 – 99</i> 1. Retake and confirm blood pressure. 2. Proceed with elective dental treatment. 3. Monitor blood pressure during appointment.
<b>Stage 2 HTN</b>	<i>Systolic 160 or higher or Diastolic 100 or higher</i> 1. Retake and confirm blood pressure. 2. Emergency or non-invasive elective treatment only. 3. Monitor blood pressure during appointment. 4. Refer patient to physician for medical evaluation. 5. <b>Medical consult required prior to elective dental treatment.</b>
	<i>Systolic &gt; 210 or Diastolic &gt; 120</i> 1. Retake and confirm with alternative device, such as mercurymanometer type sphygmomanometer. 2. If blood pressure is unchanged, consider <b>immediate</b> referral of the patient to a physician or emergency room for evaluation. 3. No treatment of any type should be undertaken. 4. <b>Medical consult required prior to any dental treatment</b>

**c. Transmissible Diseases**

- i. Any patient presenting with active infection of a transmissible/communicable disease is to be evaluated for possible dismissal and reappointment upon discussion with the patient and consultation with a faculty member.
- ii. Patients presenting with a history of a transmissible disease must be evaluated as to present status of the disease. Consultation with the treating physician is to be made in determining carrier status of the disease, when appropriate. Modifications to dental treatment and possible reappointment will be made based on this evaluation.
- iii. Patients who present with clinical signs of Herpes Labialis (fever blisters) will be dismissed and reappointed no sooner than ten days to avoid the spread of Herpes Simplex Type I.

**d. Guidelines for Management of Patients with Diabetes**

## BLOOD GLUCOSE LEVELS



\*\*Decision-Making diagram for dental treatment of patients with diabetes depending on blood glucose levels.

## Restorative Charting – White

- Chart all existing restorations for each new patient as instructed in your preclinic class. In the CCCC clinic, use the EagleSoft charting portion of the program. Use radiographs

### Sequence of Procedure:

The Eagle Soft dental chart should be updated at each new exam in an appointment series. The student is responsible for accuracy and graded accordingly.

1. Select appropriate examination instruments and armamentarium.
2. Differentiate normal from abnormal and recognize disturbances or changes in the characteristics of teeth, including number, size, form, color, structure, and contact relationship.
3. Identify pathologic changes.
4. Accurately record findings of the examination.
5. Review recorded findings aloud, when asked, using appropriate dental terminology for verification by the clinical instructor/dentist.
6. Update dental charting after exfoliation and/or dental treatment.

## CHECK OUT

- The student is responsible for documenting all authorizations, prescriptions, recommendations, dental referrals, etc. It is also the student's responsibility to annotate patient information on the record repair form to give to supervising faculty to check the

documentation for all prescriptions, procedure authorizations, and forms in Eaglesoft. It is the student's responsibility to make notes in Eaglesoft of all of the above.

- Check out time varies per semester. See course syllabi for specific times.

## **DISMISSAL OF PATIENT**

- Escort the patient to their personal belongings and help them to get oriented. Do not rush them out of the clinic. Escort them to the clinic waiting area. Every patient should be escorted out of clinic.
- The student is responsible for his/her assigned area at the end of each clinic session. There should be no trash, extra forms, personal belongings, dust, dirt, etc. left in any assigned area.

**Paper records that need to be scanned into Eaglesoft Smartdocs as follows:**

1. Recent Health Questionnaire and Drug Summary (if not able to complete and sign in Eaglesoft)
2. Dental/Medical Referral

### ***DENTAL EMERGENCY AFTER HOURS***

If patients have a dental emergency after 5:00 p.m., please advise them to contact your local dentist.

## **COMPLETION OF DENTAL APPOINTMENT**

- Follow steps outlined in the Infection Control Section for disinfection of unit and sterilization of instruments.
- Students are expected to leave clinic area clean with unit turned off. Restock your unit drawers each day. Make sure the area around the sink is dry. The floor around chair and unit must be clean at all times. The dental light, arms of unit, base of chairs, cavitron platform, view boxes, and the computer should be free of dust and debris. Adjust chair, light, and bracket tray. Raise chair, place light over chair in line with other lights, and adjust bracket tray over the chair seat. Dry sink and counter top.
- Turn off the monitor. Swing the monitor out of the way of the dental chair.
- If there are any problems with your unit, record what is wrong on the dental *maintenance work order form* located with the other clinical forms. After completing this form, give to the instructor to sign and then to the office manager. You must acquire a full time faculty's signature on this form before turning it in to the office manager.
- Students are not to leave the clinic until ten minutes before the hour. If you have finished all your work, help fellow classmates. Check with the CA and screening student to help them complete their duties. Straighten the reception room, stock your cubicle, and ask the faculty if you can help them in any way! Be known as a team player and a helper - not as



the "first one out the door!" Students who leave early without permission will be assessed professional responsibility points.

### CLINIC ORGANIZATION CHART



**SECTION TWO:**

**Clinical**

**Requirements**

**and Disciplinary**

**Policy**

## SECTION 2: Clinical Requirements and Disciplinary Policy

### *Pre-Clinic/Clinic Evaluation Definitions*

#### Process Evaluation

A process evaluation is an evaluation that tests a particular skill, independent of other skills being learned and demonstrated. When evaluating a procedure by process, each defined step of the procedure is personally observed by the assigned faculty member, ensuring that the student has properly executed each step. Examples of process evaluation include the Teaching, Proficiency and the Competency evaluations. Plan for these evaluations in advance and place the process evaluation sheets and magnet in/on the bin outside of the operatory.

1. **Teaching** is a "practice" process evaluation (PE). Students perform a process evaluation/ proficiency without being formally evaluated. No grade is recorded for a teaching PE. During the teaching PE the instructor can offer appropriate coaching at each step, if necessary and desirable.

Teaching PEs provide both students and faculty with additional opportunities for one-on-one instruction. The use of teaching PEs is encouraged prior to proficiencies and competency evaluations as a means of solidifying the student's confidence in his/her ability to perform at a desired level of competence.

2. **Competency**- after the proficiency evaluation, competencies are completed at the stated mastery level. The student performs a competency evaluation *as listed in each clinical syllabus* until program requirements are met. The competency evaluation is intended to ensure that the student maintains the competence originally achieved with the proficiency evaluation and consistently performs at mastery level. The student must identify the patient as a competency patient and the instructor must give permission prior to the competency. The faculty member is not required to observe each detailed step of the criteria but must attempt to be present during some of the procedure. Once program requirements are met, the student is not observed and the procedure is evaluated within the end product evaluation. All competencies must be met by the end of the program. The student will not graduate unless these are completed.

Competencies will be tested as clinical skills develop: therefore, the level or difficulty of required competencies will increase with each successive semester.

If the student is unsuccessful at completing the competency exam successfully on first attempt, the student must meet with their supervising faculty before attempting the competency exam a second time. If the student is unsuccessful at completing the competency exam a second time, their course grade will result in an F. All students must meet 70% on a competency exam to pass. *(If a student attempts the competency exam two times and passes it the highest possible earned grade is 70%)*

## **DISCIPLINARY PROCEDURES/POLICIES OF THE DENTAL PROGRAMS**

Students enter into the Dental Assisting Program for the **purpose** of learning course information and skills necessary to become a well-trained dental professional. CCCC Dental faculty are dedicated to providing students access to all information needed to accomplish that goal; however, they cannot achieve an optimum learning environment when students fail to comply with training procedures. Compliance to all policies, rules, regulations, and course requirements helps ensure that each student is offered the best opportunity to be competent in all areas of dental training.

Disciplinary procedures are designed to:

- Realign a noncompliant student into the proper training form.
- Reinforce compliance for chronic disregard of Program policies.
- Provide safety mechanism for patients by applying a grade reflective of the severity of the violation.

### **ESCALATING PENALTY POLICY: NON-COMPLIANCE IN CLINICS/LABS**

#### **CRITICAL ERROR POLICY FOR CLINICS AND LABS\***

Critical errors include those violations that are of grave consequence to the professional and ethical training of the student and/or the safety of all persons present in the clinical and/or lab area. The intent of this policy is to encourage students to:

- Maintain ethics and care in the treatment of patients.
- Maintain safety of all persons working in the clinic as it pertains to asepsis, the use of sterilization equipment, monitoring of sterilization, and dissemination of sterile instruments.

**Critical Errors applying to all DEN courses and clinic: These critical errors include but are not limited to:**

### ***NON-CUMULATIVE CRITICAL ERRORS; PENALTIES DO NOT CARRY OVER FROM 1<sup>ST</sup> YEAR TO 2<sup>ND</sup> YEAR***

- All infection control errors; however, mass asepsis errors are cumulative errors (see next section)
- Chronic non-compliance with established policies and protocols.
- Medical History:
  - Failure to communicate medical history with faculty.
  - Failure to obtain a medical consult.
  - Failure to obtain appropriate signatures.
  - Failure to take a new medical history.
- EOE/IOE:
  - Does not perform EOE/IOE.
- Management:
  - Fails to obtain appropriate signatures.
- Communication
  - Fails to provide consulting faculty with appropriate information regarding patient treatment.

**\*\*Examples are not all inclusive\*\***

## ***CUMULATIVE CRITICAL ERRORS; PENALTIES CARRY OVER FROM 1<sup>ST</sup> YEAR TO 2<sup>ND</sup> YEAR***

- Mass Asepsis Critical Error: any breach in asepsis protocol that places the students, faculty, staff and/or patient population at risk. A critical violation of asepsis involves failure to maintain and follow established clinic protocol such as:
  - Failing to operate and/or monitor sterilization equipment according to training procedures/established protocol;
  - Disseminating instruments that have not been adequately sterilized;
  - Using or preparing to use instruments that have not been sterilized;
  - Other violations based on failure to follow established protocol in clinic that predisposes patients (and others) to infection or harm

A critical mass asepsis error places groups of people at a health risk; it is not an isolated incident where a student breaks the chain of asepsis and exposes themselves to pathogens from their scheduled patient or vice versa.

**\*\*Examples are not all inclusive\*\***

*Disclaimer: These lists are not all inclusive. Additional areas may be incorporated/assigned if necessary to increase compliance to clinical policies. Students will be informed via class announcements, clinical discussions, and/or notations made on clinical grade sheets or progress notes prior to imposing additional penalties.*

## **PENALTIES FOR CRITICAL ERRORS OF CLINICAL TRAINING**

**NON-CUMULATIVE CRITICAL ERRORS:** The student will be required to comply with the following penalties/reprimands:

### **1<sup>st</sup> offense:**

- A grade of ZERO (0) for that patient will be given.
- Remediation with clinical coordinator.

### **2<sup>nd</sup> offense:**

- A grade of ZERO (0) for that patient will be given.
- Remediation with clinical coordinator.
- Student will receive a letter of warning.
- Student must meet with the Dental faculty and sign an Admission of Critical Error Form that states his/her knowledge of the repercussions of a 3rd offense: (signature denotes acknowledgement not always agreement)
- Complete up to three (3) proficiency/competency evaluations on applicable clinical skills; student must score a minimum of 80% to be considered competent. Less than 80% will necessitate remediation in accordance to the instructions outlined in the course syllabus.

### **3<sup>rd</sup> offense:**

- Dismissal from program.
- Student will receive a dismissal letter.
- Possibilities of re-admittance will be discussed with the student.

- NOTE: Re-Admission or Advanced Placement Standing Policy will be followed if students desire to re-enter program.

**\*\*students are allowed 2 non-cumulative critical errors/semester prior to dismissal\*\***

**CUMULATIVE CRITICAL ERRORS:** The student will be required to comply with the following penalties/reprimands:

**1<sup>st</sup> offense:**

- A grade of ZERO (0) for that patient will be given.
- Remediation with clinical coordinator.
- Student not allowed in clinic until remediation is successfully completed. Any missed clinical sessions will result in a ZERO (0).
- Meet and discuss lessons learned/prevention techniques with the Dental faculty prior to re-admittance to clinic.
- Complete up to three (3) proficiency/competency evaluations on applicable clinical skills; student must score a minimum of 80% to be considered competent. Less than 80% will necessitate remediation in accordance to the instructions outlined in the course syllabus.
- Student must sign an Admission of Critical Error Form and state his/her knowledge of the repercussions of a 2<sup>nd</sup> offense: (signature denotes acknowledgement not always agreement)

**2<sup>nd</sup> offense:**

- A grade of ZERO (0) for that patient will be given.
- Remediation with clinical coordinator.
- Student will receive a letter of warning.
- Student must meet with the Dental faculty and sign an Admission of Critical Error Form that states his/her knowledge of the repercussions of a 3<sup>rd</sup> offense: (signature denotes acknowledgement not always agreement)
- Complete up to three (3) proficiency/competency evaluations on applicable clinical skills; student must score a minimum of 80% to be considered competent. Less than 80% will necessitate remediation in accordance to the instructions outlined in the course syllabus.

**3<sup>rd</sup> offense:**

- Dismissal from program.
- Student will receive a dismissal letter.
- Possibilities of re-admittance will be discussed with the student.
- NOTE: Re-Admission or Advanced Placement Standing Policy will be followed if students desire to re-enter program.

**\*\*students are allowed 2 cumulative critical errors over the course of the entire program prior to dismissal\*\***

*ALL INFRACTIONS ARE CONSIDERED ON A CASE-BY-CASE BASIS AND FACULTY DISCRETION MAY BE USED.*

**GROUND FOR DISMISSAL\***

Upon proof of any of the following, the student will be referred to the appropriate person(s) for discussion and evaluation of the violation. In accordance with the policies noted in the Dental Assisting Handbook/Orientation Manual and/or CCCC Student Handbook/Catalog, positive findings of the following ***may result in the student being dismissed from the program.***

- Neurological, sensory, physical and/or emotional problems that inhibit training or jeopardize the safety of the patient.
- Significant problems with eye/hand coordination that jeopardizes the safety of the patient and does not respond positively to training in a timely fashion.
- Drug and/or alcohol abuse
- Insubordination
- Disregard for Program policies
- 3rd Offense Mass Asepsis Errors
- Insufficient grades
- Excessive absences
- Stealing
- Cheating on quizzes, tests, or exams
- Plagiarism
- Falsifying Information: Recording or allowing to be recorded any information that is not the truth. Falsifying of information may occur in many ways: on medical histories, periodontal charts, treatment records, appointment plans, clinical assignments/reports, etc. Falsifying information may result in health concerns for the patient and thus legal action against the school: this cannot be allowed.
- Refusal to Treat a Patient: refusal to treat a patient who has been approved for treatment by the Program Director and/or Dental faculty is discriminatory and constitutes a critical error.

*\*Disclaimer: These lists are not all inclusive. Additional areas may be incorporated/assigned if necessary to increase compliance to clinical policies. Students will be informed via class announcements, clinical discussions, and/or notations made on clinical grade sheets or progress notes prior to imposing additional penalties.*

# **SECTION THREE:**

**Preclinical, Clinical and**

**Laboratory Infection**

**Control and Risk**

**Management Protocol**



## SECTION 3 Preclinical, Clinical and Laboratory Infection Control and Risk Management Protocol

### Goals:

Provide safe environment for our students, faculty, staff and patients that is in accordance with OSHA standards and supported by sound biological principles.

Provide a reasonable, but effective infection control model that will aid in the education and understanding of infection control issues that are in accord with the recommendations of the American Dental Association (ADA), the American Dental Education Association (ADEA), the Centers for Disease Control (CDC) and the Environmental Protection Agency (EPA).

Comply with the recent standards published by the Occupational Safety and Health Administration (OSHA). (See generally, "Occupational Exposure to Bloodborne Pathogens; Final Rule," *Federal Register*, Friday, Dec. 6, 1991 or 29 CFR 1910.1030; and "Guidelines for Infection Control in Dental Health-Care Settings-2003." *MMWR Vol 52, No RR 17.1, 12/19/2003*).

### Introduction

Scientific information as well as public and professional concerns over the risks of blood borne disease transmission has brought the topic of infection control in the dental environment to the forefront. An effective infection control policy requires the cooperation of students, faculty, and staff. This can best be achieved through education, demonstration, monitoring, and evaluation. Faculty bears the primary responsibility for infection control in the clinic. Since students are the primary providers of care, their actions will determine whether or not infection control is effective. All personal must monitor, practice and enforce established infection control procedures in order to assure students are conforming to these guidelines.

### Purpose

The purpose of infection control policies and procedures is to minimize the risk of transmission of blood borne and airborne pathogens to patients and dental health care personnel (DHCP) in the dental clinic setting.

This will be achieved by:

1. Hepatitis B immunization as well as vaccination for other appropriate diseases.
2. Tuberculosis screenings.
3. Education and training in infection control procedures.
4. Use of current and appropriate barrier techniques.
5. Preventing exposure of patients and DHCP to blood and other potentially infectious material (OPIM), including saliva.

6. Engineering controls and work practice controls.
7. OSHA regulations.
8. CDC and ADA recommendations.

## **I. Infection Control Protocol**

### **A. Standard Precautions:**

1. Blood and other body fluids, including saliva, of ALL patients is to be regarded as potentially infectious for HBV, HIV, and other blood borne pathogens.
2. *Standard precautions will be used for all patients.*

### **B. Upon review of health history**

1. Patients presenting to the dental clinic with ACTIVE infectious diseases will not be treated UNTIL the active infectious state has cleared or until a physician has approved the proposed treatment for that patient. A physician's note or notice from the health department is required prior to treatment in our facility.
2. Students presenting to the dental clinic with ACTIVE infectious diseases will not be allowed to treat patients UNTIL the active infectious state has cleared.
3. Patients presenting to the dental clinic with a positive history of hepatitis B, hepatitis C, or HIV must present a written clearance for treatment from their physician. Patients will be treated upon compliance.
4. Patients presenting to the dental clinic with a positive history of hepatitis A within the past six weeks must present clearance from their physician.
5. Infectious diseases may include, but are not limited to: conjunctivitis, herpes simplex, TB, varicella zoster, and viral respiratory diseases.

### **C. Engineering & Work Practice Controls**

Engineering controls reduce the exposure by removing the hazard or isolating the worker from the hazard. Work practice controls reduce the chance of exposure by altering the way a task is performed. The following are engineering and work practice controls utilized by the CCCC Dental Department:

#### **1. Personal Hygiene**

The following applies to all clinic personnel (student, faculty, and staff) who may come into contact with blood and OPIM.

- a. Hair must be neat, pulled back, and away from the face (no loose ends).
- b. Facial hair will be covered with a face mask or shield.

- c. Wearing of jewelry during treatment procedures: follow guidelines as specified in current course syllabus and/or Dental Hygiene/Assisting Orientation Handbook and Manual.
- d. Fingernails will be kept short and well-manicured (no colored polish or artificial nails, tips or gels)

## 2. Hand Washing

Hand washing is mandatory:

- before glove placement prior to treatment
- during treatment if infection control asepsis is violated or the glove integrity is compromised,
- after glove removal
- between patients
- before leaving the treatment area.

- a. **Hand Washing Protocol:** To be implemented at the beginning of the appointment, upon visible contamination of hands, and at any time that the integrity of the gloves becomes compromised.

Follow the hand washing procedures as demonstrated in Pre-Clinic Labs.

- b. **Antiseptic Hand-Rub Protocol:** May be used during patient care if hands are not visibly contaminated.

Using a “dime size” amount of a commercial hand antiseptic rub agent that contains 60-95% ethanol, vigorously rub the hands together with emphasis on the finger tips, nail beds, and ventral side of the hand until dry. This should take approximately 15 seconds. Example of products: Purell.

## 3. Personal Protection

Routine use of appropriate personnel protective equipment will be used since blood, saliva, and gingival fluids from ALL dental patients must be considered infectious.

### a. Non-Sterile, Non-Latex Exam Gloves

All individuals having patient contact will wear disposable gloves whenever there is contact with blood, saliva, or mucous membranes. Gloves must not be washed or otherwise reused. Gloves must be changed between patients. Gloves must be removed and hands washed before leaving the clinical area. Skin breaks should be covered with Band-Aids before donning gloves. Utility gloves shall be worn for housekeeping procedures.

**b. Masks and Eyewear (with solid side shields, and/or Face Shields)**

Disposable masks and protective eyewear will be worn. Change masks between patients or during treatment if the mask becomes wet. When not in use, the mask should not be placed on the forehead or around the neck. Protective eyewear is mandatory for the clinician and patient's use. Both sets of eyewear should be cleaned between uses, being certain not to handle them with unprotected hands until they have been decontaminated.

**c. Clinic Attire: Gowns and Clinic Jackets**

All students will routinely wear appropriate attire to prevent skin exposure and soiling of street clothes or uniform when contact with blood or saliva is anticipated. Clinical patient-care jackets must not be worn outside the clinic. Attire must be changed at least daily or when visibly soiled. When leaving the clinic for the day, clinic jackets must be placed in a clear garbage bag labeled with a biohazard sticker. It is recommended to wash soiled jackets independently of other clothes.

**d. Needle Recapping and Sharps Disposal**

To prevent needle-stick injuries, needles are **NOT to be recapped by moving the needle towards a body part, especially a hand**, but can be recapped using an appropriate one-handed technique or an appropriate recapping device. Used needles are to be disposed of in an appropriate puncture-resistant container and should not be purposefully bent or broken after use. Containers should be located as close as possible to an area of operation. Empty anesthetic cartridges, broken instruments, completed spore vials, microscope slides or other sharps must be disposed of in these same containers.

**e. Utility Gloves**

Sturdy, unlined utility gloves should be worn for all cleaning and disinfection of instruments, dental units, and environmental surfaces. Utility gloves have an increased resistance to instrument punctures. Utility gloves should be autoclaved regularly; weekly is recommended. Utility gloves must be replaced if the integrity of the gloves is compromised.

**4. Environmental Surface/Equipment Cleaning and Disinfecting**

Many blood-and saliva-borne, disease-causing microorganisms such as Hepatitis B virus, HIV virus, Herpes virus and Mycobacterium tuberculosis can remain viable for many hours –even days-when transferred from an infected person to environmental surfaces within dental operatories and other clinical areas. Since subsequent contact with these contaminated surfaces can expose others to many microbes and may result in disease

transmission, adequate measures must be used in each clinical area to control possible transmission from contaminated surfaces.

Identification of dental environmental surfaces:

- a. **“touch surfaces”** – surfaces that require contact and become potential cross-contamination points during dental procedures (emphasis on required). Many surfaces could be touched during dental procedures, but only a few actually require being touched.
- b. **“transfer surfaces”** – surfaces contaminated by contact with instruments or other inanimate objects. Handpiece holders and instrument trays are two transfer surfaces. Thought-out set-up and disciplined chair-side procedures will help reduce the number of transfer surfaces in the operatory.
- c. **“splash and splatter surfaces”** – operatory surfaces which are not “touch surfaces” or “transfer surfaces” or parts of items that enter the oral cavity (also referred to as: aerosol surfaces). Examples: parts of the patient chair not covered by the chair bag, including the base, arm rest, seat, etc., light cover or plastic shield, counter top and sinks.

A practical and effective method for routinely managing operatory surface contamination between patients is to use disposable blood/saliva impermeable barriers, such as plastic film and aluminum foil, to shield surfaces from direct and indirect exposure in combination with chemical disinfection. Removal of blood, saliva, and microbes is accomplished by routinely changing surface covers between patients. Time-consuming cleaning and disinfection procedures between patients can be minimized.

Only those chemical disinfectants that are EPA-registered hospital-level mycobacteria tuberculosis (tuberculocidal claim) agents capable of killing both lipophilic and hydrophilic virus at use dilution, are considered acceptable agents for environmental surface disinfection. Use of any chemical killing agent not so approved is unacceptable.

When deemed necessary, the surface disinfectant solution is to be applied with a **“wipe, discard, wipe”** technique. Although it is required to pre-clean surfaces with a disinfectant, it is recommended that all touch surfaces be disinfected at the beginning of the day prior to use of the first barriers, or at the end of the day after the last set of barriers are removed.

Use the following procedures:

- a. Using the multi-purpose disinfectant/decontaminate wipe, wipe the surface to be cleaned.
- b. Discard the wipe.

- c. Re-wipe the surface and allow the disinfectant solution to remain on the surfaces for the recommended contact time before placing barriers. (read and follow the manufacturer's directions).

SURFACE	PROTOCOL & FREQUENCY
<p><b>Touch &amp; Transfer Surfaces:</b> light handles/switch, main body of unit and cradles, hoses/nozzles, bracket tray handles, stool adjustment levers, patient head rest adjustment</p>	<p>Use barriers (covers) for all, unless the surface is an item that enters the oral cavity, which must be heat sterilized or disposable.</p> <p>Use the surface disinfectants <b>ONLY AT THE BEGINNING OF THE CLINIC DAY</b> prior to placement of first set of barriers <b>AND</b> when it is evident that the barrier has been compromised.</p> <p>Replace barriers between patients. Remove without causing cross-contamination. <b>NO</b> disinfection of a barriered surface is necessary. Just re-barrier.</p>
<p><b>Splatter Surfaces:</b> painted surfaces of unit, ie. Tray arms, patient chair back and seat, seat and back of operator stool, counter top, sinks</p>	<p>Use surface disinfectant.</p> <p>Some splatter surfaces may be barriered, such as patient chair, back of operator stool, and bracket tray, if desired.</p>

## D. Daily Protocol

### 1. Unit Preparation and Pre-Treatment Set-Up

- Wash hands, don mask, nitrile gloves and safety glasses.
- Clean, including dusting, the operatory and all equipment using an intermediate level disinfectant.
- Disinfect all “touch and transfer surfaces”, allow them to dry.
- Place barriers over all “touch and transfer surfaces” that may be contaminated during treatment.
- Make sure there is a biohazardous waste disposal bag in the designated can per operatory.
- Fill water bottle daily with fresh treatment water, install and wait for pressurization, then clear any air from line.

### 2. Patient Treatment

During **ALL** patient treatment, wear gloves, masks, and protective eyewear. Only touch surfaces related to patient treatment such as instruments, control buttons, plastic covered items such as computer mouse or keyboard. **NEVER touch personal body, mask, goggles, or any other unprotected surfaces during the treatment phase. Infractions of infection control may require student dismissal from the dental assisting program. Mass asepsis errors concern safety for the patient, students, and staff and will not be tolerated.**

### 3. Charting:

When an entry has to be made in the record during treatment, an appropriate barrier must be used over the computer keyboard and mouse.

### 4. Radiographic Procedures:

Infection control measures during radiographic procedures and related darkroom procedures should be consistent with other infection control policies.

### 5. High-Speed Evacuation:

High-speed evacuation should be used at all possible times when using the high-speed handpiece, water spray, ultrasonic scaler or air polishers or during a procedure that could cause spatter. Rationale: Appropriate use of high-speed evacuation systems has been shown to reduce spatter and droplets.

### 6. Three-way Syringe:

The three-way syringe is hazardous because it produces spatter. Therefore, caution must be used when spraying teeth and the oral cavity. When used, a potential for spatter must always be considered and appropriate precautions taken (for example, use of barrier protection.)

### 7. Dropped Instruments:

An instrument that is dropped **will not be picked up and reused**. If the instrument is essential for the procedure, a sterilized replacement instrument must be obtained.

### 8. Disposable Items:

Used disposable items must be discarded immediately to avoid contamination of other items. Medical waste (soaked with blood/OPIM) must be discarded in BIOHAZARD red bags located in designated can (biohazard sticker affixed to outside of can) in each operatory. Follow protocol for appropriate disposal.

## E. Clean-Up After Patient Treatment

**1. The following protocol may be used:**

- Remove gloves and wash hands immediately.
- Complete entries on all forms and records relating to the treatment and dismiss the patient. Return to clinic.
- Apply utility gloves, mask and glasses, remove all disposables and discard in appropriate containers.
- Place all contaminated instruments, syringes, needles and other sharps as well as any other reusable in a sealed plastic container and transfer to the sterilization area.
- Discard of any sharps into sharps containers located in central sterilization.
- Place contaminated instruments or cassette into a holding solution or ultrasonic cleaner immediately then return to operator.
- Remove all barriers and place into inverted chair bag and discard of entire bag into one of the black trash bag-lined waste receptacles located throughout the clinic, secure lid.
- Following operatory surface management procedures, clean, disinfect, and/or prepare the unit for the next patient (including flushing of water lines for 20-30 seconds). Any area covered by a barrier may be re-covered without cleaning and disinfecting if the barrier was not compromised.

**F. Instrument Recirculation****1. Transporting**

All contaminated instruments and instrument cassettes should be transported from the operatory to the sterilization area in a sealed plastic container provided between each operatory. Students should use heavy nitrile utility gloves when working with contaminated instruments.

**2. Containment**

All contaminated instruments and instrument cassettes that are not immediately placed in the ultrasonic cleaner must be submerged in an appropriate holding solution or otherwise confined to a limited area until such time as it may be cleaned.

**3. Decontamination**

Ultrasonic and other mechanical means of cleaning instruments have proven to be more effective and efficient and safer than hand-scrubbing and will be implemented if at all possible. Always use the ultrasonic cleaner with the lid in place. Rinse, dry and visually inspect items for bioburden/debris.



## **G. Renewal**

### **1. Heat Sterilization**

All contaminated re-usable instruments, including handpieces, must be sterilized in verifiable heat-sterilizing devices, must be thoroughly cleaned and heat sterilized before use in the treatment of another patient. All items must be packaged for sterilization in quality wrapping materials or pouches that will maintain sterility. The use of chemicals as a substitute for heat sterilization of these items is unacceptable. Biological monitoring is performed weekly on each sterilization device.

### **2. Chemical Sterilization/Disinfection**

All re-usable items that cannot be heat sterilized must be thoroughly cleaned and appropriately treated with EPA-registered sterilant according to manufacturer's instructions specified for sporicidal activity. Any use of a chemical disinfectant agent for infection control purposes that is not EPA-registered as a dental instrument sterilant/disinfectant is unacceptable.

### **3. Maintenance**

All packages that have been exposed to sterilization procedures must be stored in a manner that will prevent contamination. Sterile packages shall be placed on clean shelves or in clean drawers. All packages shall remain wrapped until needed and opened at chair-side at time of use.

## **H. Biohazard or Medical Waste Disposal**

All medical waste collected from each operatory is to be disposed of in a red biohazard bag located in designated receptacle per clinic operatory. At the end of the clinic day, the red bags from the biohazard receptacles will be collected; squeezed to remove excess air and inserted into the medical waste cardboard box, provided by the waste collection company, then sealed with packaging tape.

### **1. Body Fluid Spills**

All body fluid spills, such as vomit and blood, are to be cleaned and removed by designated personnel with the clinic spill kit located in the clinic. Call for assistance immediately. Protect the spill from contact with others until appropriate action has been taken.

## **I. Exposure Incident/Accidents**

Non-threatening, non-invasive accidents occurring in the classroom, laboratories, and/or clinic will be cared for according to the following procedures:

1. Students should report the accident to the supervising instructor immediately.
2. The instructor will direct the care of the wound and send the student to their personal physician or emergency room for care.
3. CCCC Accident (Incident) and OSHA forms must be filled out and delivered to the President, the three Vice Presidents, and Public Information Officer within 12 hours.

If you incur an exposure incident, do not make a scene in front of your patient. Quietly excuse yourself from the operatory and do the following:

For each of the following types of exposure you should:

1. ***Blood-Borne Incidents/Sharps Exposure:*** Accidents resulting in *blood borne pathogen exposures to the operator* and/or patient will be cared for according to the following procedures: Immediately remove gloves.
  - Immediately go to the sink and flush the wound under very warm water.
  - Thoroughly clean the wound(s) and surrounding tissue with running water and soap to ensure cleanliness.
  - Hold the site in a downward position; **DO NOT SQUEEZE** the flesh to extract/promote bleeding.
  - Have a classmate contact the instructor immediately.
  - The instructor will direct the care of the wound and send the student and/or patient to their physician or hospital emergency room for care.
  - CCCC Accident (Incident) and OSHA forms must be filled out and delivered to the President, the three Vice Presidents, and Public Information Officer within 12 hours.
  - If blood cannot be expressed or does not pool under the skin, it may be an exposure incident has **NOT OCCURRED** and no further action is required.
  - In regards to the patient: the patient will be asked for consent to be sent for baseline status if sero status is unknown.

Students are reminded that occupational exposure incidents occur; **students are not punished in cases of instrument sticks**. It is a flagrant error of judgment, however, to hide the incident and not report it to the instructors. All students who knowingly allow an incident/accident to go unreported are equally guilty of dishonesty and will be reprimanded in accordance to the Disciplinary Procedures of the Dental Hygiene/Assisting Program.

***\*for blood borne pathogen exposures, consult instructor immediately***

2. ***Splash On to Oral, Nasal, or Eye Mucosa***
  - Immediately seek assistance from nearest clinical instructor.

- In the event of eye and/or nasal splash, remove yourself immediately to the nearest eyewash station and cleanse your eye with copious amounts of water.
- In the event of oral mucosa splash, do the same. Rinse with an antimicrobial mouthwash.
- If at CCCC, the instructor will complete a CCCC Accident and Incident Report form & other documents as necessary.
- Report to the doctor's office or hospital to have injury and necessary preventive measures/tests taken. The student accident report form to obtain insurance claim form to place where services were rendered. (See attached forms).
- If on an off-site clinical rotation when an accident/exposure occurs, follow the policy for Accidents Occurring Off Campus.

### 3. *Eyewash Station:* What Every Employee/Student Should Know

1. Where the station is located in the clinic and laboratory
2. How to use the station
  - a. Lift the dust covers off the spray heads.
  - b. Push against foot pedal to start the flow. If no water comes out, be sure the water flow is turned on from the wall.
  - c. Lift the hand lever to turn the unit off.
3. When to use the station – when any potentially hazardous material contacts the eye(s)
4. Eye Irrigation – First Aid Information
  - a. Chemical exposure to the eye may cause damage from chemical conjunctivitis to severe burns. Therefore, remove all chemicals from the eye(s) quickly.
  - b. Signs & Symptoms of Exposure – local pain, visual disturbances, lacrimation, edema and redness
5. Basic Treatment for the Eye
  - a. Flush with water using a mild flow from the eyewash station and continue for at least 15 minutes.
  - b. Ask the victim to look up, down, and side to side as they rinse in order to better reach all parts of the eye(s).
  - c. DO NOT let the victim rub his/her eye(s).
  - d. DO NOT let the victim keep his/her eye(s) tightly shut.
  - e. DO NOT introduce oil or ointment into the eye(s).
  - f. DO NOT use hot water.
  - g. Notify medical authorities when someone is injured.
  - h. Use the incident report form to record details of the injury

## J. Dental Programs Hazard Control Policy

The Dental Program maintains a Hazard Control Program. The students, faculty, and staff are made aware of the various chemical and other hazards through the presentation of the program. It is the responsibility of each instructor to cover occupationally related hazards as they pertain to the courses they teach.

A copy of the Program's Hazard Control Policy is located in the Dental Department Office. This program contains all Material Safety Data Sheets for each chemical, and when necessary, ensures the labeling of secondary containers.

CCCC also maintains a campus-wide Hazard Communication Program due to the large number of hazardous chemicals and other substances maintained on the campus. **A copy of procedures is maintained by Frank Bedoe, Director of Campus Security and Safety (919-718-7211).**

## K. Accidents/Cross-Contamination Incidents Occurring Off Campus

Accidents/cross-contamination incidents that occur off campus to CCCC students while on school-sponsored activities should be handled according to school guidelines as follows:

1. **Wounds/Injuries:** Cleanse the wound appropriately and cover with appropriate material, i.e., Band Aid, 4 x4, etc. Prepare an Incident Report and send it to the Student Development Services. If the wound/injury requires a physician's intervention/assessment, take the student to the hospital or medical doctor.
  - Tell them this is a CCCC student, not an employee.
  - Student is to obtain a insurance claim form from SDS to give to the hospital or medical doctor that rendered services.
  - Life Threatening Injuries: Call 911
  -
2. **Cross-Contamination:** Immediately stop the procedure.
  - Remove contaminated gloves
  - Wash hands thoroughly using antimicrobial soap and warm water. Dry hands
  - Complete applicable cross-contamination follow-up steps (verify with rotation site).
  - Notified the instructor and extra-mural site of the cross-contamination and follow-up steps taken immediately following the incident.

## L. Clinical Rotations:

Dental Hygiene/Assisting students need to alert the dentist and/or office manager when an injury or cross-contamination incident has occurred. Follow the guidelines of the office and

contact supervising faculty at CCCC to fill out an Accident/Incident report that will be sent to Student Development Services after all signatures have been obtained. Student is responsible for picking an Insurance Claim form to turn into place where services were rendered.

## **II. MEDICAL EMERGENCY PROCEDURES**

The primary focus of action during a serious medical emergency is the immediate care of the injured person. Medical emergencies, which require immediate medical attention, should be handled by following these procedures:

### **A. Serious Injuries/Medical Emergencies (General Locations)**

- Stay with the injured person at all times; maintain an attitude of calm and reassurance.
- Control the environment (including bystanders) to prevent further injury or loss of privacy for the victim.
- Designate someone to call 911-describe the type of illness/injury and location.
- Designate someone to call the CCCC Switchboard Operator at \_\_\_\_\_. Advise the operator of the situation and steps taken already (“911 has been alerted”). The Switchboard Operator will notify the administration (Vice President and Dean).
- If a doctor, dentist, or a more “trained” person should be present, the more responsible/trained person should take charge until EMS personnel take control.

#### **DO NOT:**

- Allow movement of the victim if head, neck, or spinal injury is suspected.
- Attempt to place anything into the victim’s mouth.
- Once the victim has been transported to an emergency care center, caretakers, should stay and write a descriptive, detailed report of the accident or illness for CCCC and/or OSHA forms (full name, social security number, telephone number, address, time, date, place, etc).
- Submit report to the VP of Student Learning, VP of Student Services, VP of Administrative Services, Dean of Health Sciences, Administrative Assistant to the VP of Student Services, Controller, and Safety Coordinator.

### **B. Serious Injuries to Patients/Medical Emergencies in the Clinical Setting**

- During the treatment of patients, if a serious emergency occurs, the student should:
- Stay with patient at all times; instruct someone to immediately alert the supervising dentist and an instructor.
- Maintain an attitude of calm and reassurance.
- Control the environment (including bystanders) to prevent further injury or loss of privacy for the patient.

- Maintain an open airway; loosen restrictive clothing.
- Monitor and record the patient's vital signs. (Include a time chronology with all entries).
- Be prepared to administer cardiopulmonary resuscitation.
- Be prepared to succinctly relay health data, the events leading to the medical emergency, and the symptoms to the dentist or instructor.

### **C. Upon arrival of the supervising dentist:**

- The dentist will be in charge of directing emergency medical care of the patient.
- An instructor will be responsible for obtaining emergency equipment and supplies.
- The student operator and/or instructor should monitor and record the patient's vital signs and provide assistance as directed by the dentist.

### **D. If an ambulance is needed:**

- The dentist will direct a student or instructor to call 911, then the Switchboard Operator at ext. \_\_\_\_\_
- Advise the 911 operator that an ambulance is needed immediately at WB Wicker CCCC Dental Clinic. (Give address, etc.) *900 S. Vance St. Room 220E Sanford, NC 27330*
- Give the nature of the emergency.
- Return to the dentist to relay any messages or acknowledgments that an ambulance is on its way.
- The dentist will direct two or more students to monitor all building entrances and direct ambulance personnel to the emergency site.

### **E. Upon arrival of EMS personnel:**

- The dentist, instructor, and necessary students will maintain care of the patient until EMS personnel are ready to take charge.
- The dentist, instructor(s) and involved students will relay information to the CCCC Administration with a written descriptive, detailed report of the accident or illness for CCCC and/or OSHA forms (full name, social security number, telephone number, address, time, date, place, etc).
- Submit report to the VP of Student Learning, VP of Student Services, VP of Administrative Services, Dean of Health Sciences, Administrative Assistant to the VP of Student Services, Controller, and Safety Coordinator.
- The dentist will be responsible for documenting all information in the patient's record (with input from the student and instructor).

### **F. Miscellaneous:**

- All injuries (serious or minor) must be reported to the Department Chair and Dean. The Dean will then inform the President, all Vice Presidents and the Public

Information Officer. CCCC Accident (Incident) Forms must be filled out and submitted within 12 hours of the incident.

### III. EMERGENCY EQUIPMENT: LOCATION

#### A. First Aid Kits are Located:

- Dental Clinic, end of clinic near Operatory 5/6 on emergency cart
- Dental Materials/Simulation Laboratory Classroom: hung on wall near door
- Dental Radiology Clinic

#### B. Oxygen Tanks and Masks are located:

- Dental Clinic, middle near Operatory 10

#### C. Emergency Drug Kit is located:

- Dental Clinic, Dental Clinic, end of clinic near Operatory 5/6 on emergency cart

#### D. Eyewash Station is located:

- Dental Clinic, attached to sink between Operatory 1 and 2
- Dental Materials/Simulation Laboratory Classroom, attached to sink

### IV. EVALUATION OF EMERGENCY INVENTORY:

- Medical supplies should be updated routinely, at least once every three (3) months.
- The Program Director will appoint a faculty member to be in charge of evaluating the currency of the medical supplies and ordering of replacement as needed.
- Students and staff should be informed/reminded of this policy on an annual basis.
- The Program Director/Lead Instructor will be responsible for informing staff members; instructors will be responsible for informing their respective classes.

#### A. Emergency Cart Contents

*Emergency kits/first aid kits will vary per clinic rotational site. This list only pertains to the CCCC Dental Hygiene/Assisting Programs.*

Medical Emergency		
Adjacent to Op 10	2	Oxygen Tank Portable on a Cart
	1	First Aid Kits
	2	CPR masks w/ 1 way valve, filter, O2
	1 Box	Thermometer
	2	BP cuff – adult

	2	BP cuff – child
	1	BP cuff- obese
	1	BP monitor
	5	Stethoscopes
	1	Digital BP cuff- wrist
	1	Glucometer
	1 box	Glucose lancets
	1 box	Glucose strips
	3 boxes	Ammonia inhalants
	2	Cold compresses
In Sterilization	1	Master spill kit
Office Manager	1	OSHA Compliance System (MSDS)
	2	Eyewash stations
	1	AED 10 with accessories
Every Operator	1 box	Alcohol prep pads
	1	Poison antidote kit
	1	Blanket – 70% wool 62x80 gray item #B2186
	2	Pillow-waterproof/reusable item #B2183
	2	Disposable pen light

**Emergency Kit Contents:**

- 2 - EpiPen
- 3 - Ammonia inhalants
- 2- packs aspirin (on shelf)
- 1 – diphenhydramine (on shelf)
- 1 - nitroinual pump spray
  - 1- tube glucose 15
  - 2- albuterol inhaler
  - 1- CPR pocket mask



- 1- airway
- 1- 16" latex-free tourniquet

#### **First Aid Kit Contents**

- 40 – 3/4" x 3" plastic strips
- 20- assorted flexible strips
- 10- 2" x 3" plastic strips
- 1- ½" x 5 yd. waterproof adhesive tape
- 5- 2" x 3" nonadherent pads
- 2- 2 1/8" x 25/8" oval eye pads
- 1- 37" triangular bandage
- 1- ½ oz absorbent sterile cotton
- 1- 2" x 5 yd (stretched) elastic bandage
- 1- ½ oz first aid cream
- 2- ammonia inhalants
- 1- 5" x 9" combination pad
- 1- pair non-latex gloves
- 4- antiseptic wipes
- 1- cold pack
- 1- scissors
- 1- tweezers
- 1- first aid information

#### **Master Spill Kit (Sterilization above Sink, Simulation Lab)**

- 1- Biological spill powder
- 1- scooper and pan
- 1- pair safety glasses
- 1- pair nitrile gloves
- Disposable bags and biohazard labels
- Dispatch hospital cleaner
- Antisepetic handwipes

## **V. FOREIGN OBJECT POLICY**

Protocol for incidents involving patients swallowing various foreign objects associated with dental treatment provision-rubber dam clamps, bur, implant parts and pieces of scaling instruments:

- The provider should alert supervising faculty or the dentist.

- The provider will stay with patient, monitor vital signs, observe for acute respiratory distress, and make a preliminary diagnosis from the clinical signs and symptoms and the patient's response to careful questioning.

### **IN EVENT OF AN EMERGENCY CALL 911**

- Patient will need to be transported to the hospital for x-rays.
- Complete and Incident Report and forward it to the Student Development Services.
- Make an entry in the patient's record completely describing the occurrence, but do NOT refer to the Incident Report in your entry.
- If the patient refuses the radiograph, proper notation should be documented in the chart

**CENTRAL CAROLINA DENTAL PROGRAMS  
BLOOD OR BODY FLUID EXPOSURE INCIDENT REPORT**

INCIDENT:

DATE: \_\_\_\_\_ TIME: \_\_\_\_\_ am  pm  LOCATION: \_\_\_\_\_

Please Circle One:

Needlestick   Instrument Puncture   Bur Puncture   Blood Spatter/Mucous Membrane Exposure

Other (Specify) \_\_\_\_\_

**DESCRIBE:** Route of exposure (nature/location of injury):

\_\_\_\_\_

Circumstances under which exposure occurred:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

EXPOSED PERSON:

**Name:** \_\_\_\_\_ Hepatitis B Vaccination Series Completed? Yes  No   
 DH Student                       DA Student                       Dental Faculty

SOURCE INDIVIDUAL: If source individual is unknown, check here: 

Name of Source Person: \_\_\_\_\_ Age: \_\_\_\_\_ M/F \_\_\_\_\_

Record # \_\_\_\_\_ Phone: \_\_\_\_\_ County of Residence: \_\_\_\_\_

Name of Physician or Provider of Medical

Care: \_\_\_\_\_

City/Town: \_\_\_\_\_ Phone: \_\_\_\_\_

The statements below should be read to, or read by, the source individual before answering the last

question on this form. If source person is unavailable at time of exposure, check here  and contact

individual as soon as possible to obtain answer to last question.

1. You have reason to believe you have been exposed to hepatitis or AIDS.
2. You have had serum hepatitis (B or C) or yellow jaundice.

- 3.You had a blood transfusion between 1977 and 1985.
- 4.You have hemophilia, or have received blood products before 1985.
- 5.You have tested positive or have TB or tuberculosis.
- 6.You have taken illegal drugs by needle at any time since 1977.
- 7.You are a man who has had sex with another man at some time since 1977, even one time.
- 8.You have had syphilis, gonorrhea (clap) or another sexual disease since 1977.
- 9.You have had sex for money or drugs at any time since 1977.
- 10.You have had multiple anonymous sex partners since 1977.
- 11.You have had sex with prostitutes, even one time, since 1977.
- 12.You have been infected with HIV or have AIDS.
- 13.You have been with a sex partner who would answer “yes” to any on of the above questions.

Is any one of the above statements true for you?.....Yes  No  Don't Know

SIGNATURE OF SOURCE  
INDIVIDUAL \_\_\_\_\_

**CENTRAL CAROLINA DENTAL PROGRAMS**

**Foreign Object/Incident Report**

INCIDENT:

DATE: \_\_\_\_\_ TIME: \_\_\_\_\_ am  pm  LOCATION: \_\_\_\_\_

Please Circle One:

Needlestick

Instrument Puncture

Bur Puncture

Other (Specify) \_\_\_\_\_

**DESCRIBE:** Route of exposure or object swallowed (nature/location of injury):

\_\_\_\_\_

Circumstances under which exposure/ incident occurred:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PERSON INCIDENT OCCURRED::

**Name:** \_\_\_\_\_ Hepatitis B Vaccination Series Completed?

Yes  No

Last Tetanus Shot: \_\_\_\_\_

DH Student  DA Student  Dental Faculty  Patient

CONSENT TO BE X-RAYED AND FURTHER TREATMENT:

I consent to be taken to the hospital for necessary x-rays and treatment for the described incident that occurred while receiving treatment at the Central Carolina Dental Center.

Signature of Patient: \_\_\_\_\_

Witness: \_\_\_\_\_

REFUSED TO X-RAYS AND FURTHER TREATMENT:

I refuse to be taken to the hospital for necessary x-rays and treatment for the described incident that occurred while receiving treatment at the Central Carolina Dental Center.

Signature of Patient: \_\_\_\_\_

Witness: \_\_\_\_\_

## STEPS FOR FILING ACCIDENT CLAIMS

Revised 4/14

1. The Student Accident Report form is to be filled out by instructor and student. Return this form to SDS with both signatures as soon as possible.
2. The student or someone needs to take the insurance claim form to the place where services were rendered (hospital, drug store, doctor's office). Most of the time the medical offices will file the insurance form for the student.
3. ***This is secondary insurance.*** Coverage is an excess policy unless there is no other insurance in place. Other insurance includes, but is not limited to: Group Health Policies, Individual Health Policies and medical provision provided under any other insurance policies. Attach the primary carrier's Explanation of Benefits (EOB) showing payment or denial of each bill. "Primary Carrier" would include any and all other coverage that a participant may have.
4. **DO NOT PUT THE COLLEGE NAME ON THE INVOICE AT THE HOSPITAL OR DOCTOR'S OFFICE, THE BILL OR INVOICE SHOULD BE IN THE NAME OF THE STUDENT. THE INSURANCE COMPANY, (NOT THE COLLEGE) IS RESPONSIBLE FOR ALL CLAIMS.**
5. The instructor will forward the Student Accident Report form to Student Services. Student invoices will be sent to Stephanie Whitaker and patient invoices will be forwarded to Laura Musselwhite by faculty.

**Central Carolina Community College**

**Student Accident Report**

This Student Accident Report is for school use only. (An injured employee should contact the Business Office.) The staff member in charge of the student at the time of the accident should assist the student in completing this form. Copies should be sent to the Supervisor and Vice President of Student Services within twelve hours of the accident. Unsupervised off-campus accidents should be reported by the Department Chairperson as soon as information is known.

The injured student or other appropriate person should secure a Claim Form in Student Development Services for submission to the medical agency supplying treatment.

Name of injured: \_\_\_\_\_ Curriculum: \_\_\_\_\_  
 (Last) (First) (Middle)

Address: \_\_\_\_\_ Phone number: \_\_\_\_\_

Date injured: \_\_\_\_\_ Time injured: \_\_\_\_\_ Age: \_\_\_\_\_

Description of Accident:

Where did it occur? \_\_\_\_\_

How did it occur? \_\_\_\_\_

Activity engaged in: \_\_\_\_\_ Under school supervision? Yes No

Nature of injury: \_\_\_\_\_

Description of accident and injury: (Check all items that apply)

Part of body injured	Type of injury	Extent of injury
<input type="checkbox"/> Foot <input type="checkbox"/> Leg <input type="checkbox"/> Eye	<input type="checkbox"/> Burn <input type="checkbox"/> Bruise	<input type="checkbox"/> First Aid <input type="checkbox"/> Doctor
<input type="checkbox"/> Arm <input type="checkbox"/> Neck <input type="checkbox"/> Mouth	<input type="checkbox"/> Cut <input type="checkbox"/> Strain	<input type="checkbox"/> Lost time <input type="checkbox"/> Hospital
<input type="checkbox"/> Hand <input type="checkbox"/> Chest <input type="checkbox"/> Other	<input type="checkbox"/> Fall <input type="checkbox"/> Foreign Body	<input type="checkbox"/> No time lost <input type="checkbox"/> Other
<input type="checkbox"/> Back <input type="checkbox"/> Finger	<input type="checkbox"/> Slip <input type="checkbox"/> Other	<input type="checkbox"/> Sent home

Description of accident: \_\_\_\_\_

Description of group activity, if any, engaged in at time of accident: \_\_\_\_\_

Name of Doctor: \_\_\_\_\_ City: \_\_\_\_\_

Remarks: \_\_\_\_\_

\_\_\_\_\_  
 (Student's Signature)

\_\_\_\_\_  
 (Date)

**To be completed by staff member**

Check main cause of accident and explain:

Failure of equipment: ( ) \_\_\_\_\_

Failure of machine: ( ) \_\_\_\_\_

Personal error: ( ) \_\_\_\_\_

Other cause: ( ) \_\_\_\_\_

\_\_\_\_\_  
 Staff Member's Signature

\_\_\_\_\_  
 Date

(Use back of form for additional comments)



Summit America Insurance Services, L.C.  
 7400 College Blvd., Suite 100  
 Overland Park, KS 66210

**ACCIDENT CLAIM FORM**

<b>TO BE COMPLETED BY PARENT/PARTICIPANT</b>			
NAME OF PARTICIPANT (Last Name)	(First Name)	(Middle Initial)	SOCIAL SECURITY NUMBER
PARTICIPANT ADDRESS (Street)		(City)	(State) (Zip)
PHONE NUMBER	DATE OF BIRTH	MALE <input type="checkbox"/>	FEMALE <input type="checkbox"/>
DATE OF INJURY	TIME OF INJURY	TYPE OF ACTIVITY	
PLEASE MARK: _____ PRACTICE _____ GAME _____ TRAVEL _____ OTHER _____ _____ INTRAMURAL SPORT _____ INTERSCHOLASTIC SPORT			
DESCRIBE FULLY HOW AND WHERE THE INJURY OCCURRED _____ _____ _____			
PARENT/GUARDIAN NAME (Last Name)		(First Name) (Middle Initial)	
ADDRESS (Street)		(City) (State) (Zip)	
Do you have any other insurance, including but not limited to group or individual health and/or accident, government plan, or automobile plan? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, please give name, address, phone number, and policy number of this plan. _____ _____			
<b>AUTHORIZATION TO RELEASE INFORMATION</b>			
I authorize any Health Care Provider, Insurance Company, Employer, Person or Organization to release information regarding medical, dental, mental, alcohol or drug abuse history, treatment or benefits payable, including disability or employment related information, to Summit America Insurance Services, L.C., the Plan Administrator, or their employees and authorized agents for the purpose of validating and determining benefits payable. A photo copy of this authorization shall be as valid as the original.			
Signature _____		Date _____	
<b>AUTHORIZATION TO PAY PROVIDER</b>			
I authorize payment of charges associated with this incident directly to the physicians or providers. I further certify that the foregoing information is true and correct.			
Signature _____		Date _____	
<b>TO BE COMPLETED BY ADMINISTRATOR</b>			
NAME OF GROUP POLICYHOLDER			
ADDRESS OF POLICYHOLDER			
TELEPHONE NUMBER OF POLICYHOLDER			
I certify that the foregoing information is true and correct.			
Authorized Signature _____		Date _____	
Title _____			



### CLAIM FILING INSTRUCTIONS

1. Parent or guardian must complete claim form in full, unless student is 18 years old or older.
2. Attach current itemized physician, hospital, or other providers' bills standard insurance billing form: HCFA 1500 from physician or UB 92 from hospital). These forms must show the following:
  - Patients Name
  - Condition/Diagnosis
  - Type of treatment
  - Date expense incurred
  - Charges
3. Your coverage is an excess policy unless there is no other insurance in place. Attach the primary carrier's Explanation of Benefits (EOB) showing payment or denial of each bill. "Primary Carrier" would include any and all other coverage that a participant may have.
4. To expedite proper processing, submit claim form completed in full along with the above documents to the following address:

#### DOUG SUTTON INSURANCE SERVICES

P.O. Box 20104

Raleigh, North Carolina 27619

Phone: (919) 836-9993

NC Toll Free (800) 788-7771

Fax: (919) 836-9994

## VI. AVOIDING LIGATION

### A. Treatment Area

The Central Carolina Dental Center is a dental treatment area. Specifically, the dental treatment area is focused on our treatment cubicles and the immediate surrounding clinical area. This dental treatment area is restricted to dental treatment personnel and the patient being treated ONLY. No other person should be in the dental clinical services area. If for some reason an exception is required (e.g. a legal guardian is required), you should be granted permission from the dental Assisting faculty.

### B. Emergency

"Something has gone wrong" and the reasonable expected outcome is not attained. The "DUTY" of the doctor "owed to the patient" in case of an emergency is:

- Primary prevention from further injury or debilitation.
- Secondary relief from discomfort.

### C. Abandonment

The termination must be in writing to the patient and a copy must be included in the record. All procedures on a given treatment plan should be completed before termination of the school/patient relationship. The school has the legal obligation to continue treatment to a logical stopping point.

1. *Do it in Writing*
2. *Give Sufficient Notice*
3. *Offer to Refer*

### D. Before Dismissal

1. The patient must not be dismissed until he/she is signed out by a faculty member.
2. Faculty will make sure students have made proper entries in the treatment and progress notes before signing the students out.
3. Information should include type and amount of anesthetic used, including vasoconstrictors, information relating to patient relations and reactions, and any other information pertinent to treatment of the patient.

### E. Adequacy of Records

1. It is important that the tendency toward abbreviated and cryptic references be avoided. Many years may elapse between the creation of the record and the need to defend it.
2. Dentist's personal observations as to patient's disposition and attitude are appropriate. Such observations must be factual and not malicious. Such observations should not make judgmental or diagnostic statements that are outside the author's area of specialization.
3. A record of how well patients follow recommendations and treatment plan goals should be made. A record of all drugs prescribed, dosage, expected results and number of refills should be included.

### F. Consent

1. **Implied Consent:** grants permission to examine the patient.
2. **Informed Consent:** by court judgment, must inform the patients of all:
  - Risks
  - Consequences
  - Benefits
  - The Proposed Procedure
  - Alternate Procedures
  - Possible Consequences of No Treatment

3. The explanations must be done in "lay terms".

### **G. Late Entry or Addendum Protocol**

1. The late entry or addendum should be made in the Progress and Treatment Notes of the patient record using the date the entry is made.
2. The treatment date that the late entry or addendum references should also be listed.
3. The entry must be signed by a faculty member.

### **H. Correcting an Error in Charting**

1. The error should be corrected in the appropriate area of the patient chart and approved by a faculty member.
2. A statement of correction should be made in the Progress and Treatment Notes and signed by a faculty member.

### **I. Audit of Records for Adequacy of Documentation**

1. The administrative section for quality assurance will have responsibility for audit of patient records for adequacy of documentation.
2. Inadequacy will be brought to the attention of the student and the Program Director.
3. Students are required to present the Record Repair form that indicates if mistakes were made during the appointment timeframe.
4. Mistakes are indicated on the Record Repair form at the end of every appointment.
5. On a monthly basis, faculty will randomly select a chart from each student and audit the chart thoroughly with the Quality Assurance chart auditing form. Students will be informed of monthly errors found during the process. Errors will be addressed with the entire class as a means of correcting potential errors.

## **VII. GUIDELINES FOR MANAGING PATIENTS WHO MAY BE SEEKING PROFESSIONAL OR LEGAL CONDEMNATION OF PREVIOUS DENTAL TREATMENT**

### **Purpose:**

These guidelines are set forth to establish uniform procedures to manage patients who may express concern, or who may be seeking professional and/or legal advice regarding previous dental treatment.

### **Applicability:**

These guidelines apply to assigned clinical patients only. Unassigned patients seeking consultation will be handled under other established guidelines.

### **Philosophy:**

It is the position of Central Carolina Dental Center that we have the obligation to, with our best professional judgment; present a true and accurate assessment of the dental needs to every assigned patient. This assessment of dental needs should be based on a thorough diagnosis and approved treatment plan.

The dental treatment should restore optimal oral health and function, considering the current status of the patient. The development and presentation of the treatment plan is to obtain the goal of optimal oral health and function for the patient and is not intended as criticism of previous dental treatment. However, we should not avoid recommending the replacement of existing restorations, prosthesis or any other treatment when necessary to obtain the treatment goals.

**Precaution:**

The student and faculty are cautioned to refrain from making judgmental remarks concerning past or proposed future treatment. This is particularly important during the early phases of diagnosis. If the patient inquires about past or proposed future treatment, the patient should be told their condition and proposed treatment will be carefully reviewed a the time of treatment plan is presented.

**A. PROCEDURE****1. Treatment Plan:**

- Regardless of quality of previous treatment, the patient should be presented with an APPROVED treatment plan.
- It is unnecessary to dwell on previous treatment except as it relates to the patient's ability to maintain the future treatment.
- After the approved treatment plan is presented, if the patient expresses concern for the quality of previous treatment, the following procedures should be followed:
- The faculty member responsible for the treatment plan should be asked to explain the situation to the patient and carefully document the patient's concern in the progress and treatment notes.
- If, in the opinion of the faculty member, a problem may still exist, the Program Director of the involved discipline should be consulted and noted in the patient's record.
- The Program Director will make a final evaluation of the patient and make appropriate documentation in the progress and treatment notes in the consultation section of the patient's record.
- If the patient requests advice concerning steps to be taken to recover for previous dental treatment, he/she should be directed to contact the dentist who provided the treatment in question.
- If, after contacting the dentist who provided treatment in question, the patient still seeks advice concerning steps to be taken to recover for previous dental treatment, he/she should be directed to contact the local Dental Society who can assist him/her. This may be done by contacting the local dental society office.

## VIII. Additional Policies

**\*\*Non-compliance with any stated policy will result in disciplinary procedures or grade penalty assessment.\*\***

**A. Cell phones:**

Cell phones, tablets, pagers and PDA's must be turned off during preclinic, clinic and lab sessions unless faculty approves use.

**B. No Food in any clinic or lab area:**

- a. No food, drink or gum chewing in teaching laboratories or clinic areas.
- b. Everyone should clean his/her own lunch or snack debris by depositing it in the appropriate waste receptacles.
- c. Exercise care when transporting food and drink through the halls.

# **SECTION FOUR:**

## **Referrals**

## SECTION 4 Referrals

### Dental Referrals

In reviewing a patient's restorative charting, periodontal charting, or radiographs, many conditions will present themselves that need to be referred back to the patient's dentist. If this is the case, fill out a Dental Referral Form and have it ready for your instructor at check-out or attached to your x-rays when you turn them in to be graded. If your instructor agrees that the patient should be referred:

1. Explain to the patient why they are being referred.
2. Have patient sign the form.
3. You sign the form.
4. Have the referring faculty member/DDS sign the form.
5. Record on patient's Record of Treatment that a dental referral was made and **WHY**.
6. Give the patient a copy
7. Place a copy in the Office Manager's Scan File to be scanned into Smartdocs
8. Annotate referral in patient's notes

### Medical Referrals

In reviewing the patient's health questionnaires, many conditions will present themselves which will require you to decide whether treatment should be rendered or a medical consultation is indicated. To help you make this decision, the following is recommended:

1. Find out as much information as possible regarding the condition of the patient.
2. Refer to your Drug Information Handbook for Dentistry or call the patient's pharmacist to ask if the drugs the patient is taking may alter your treatment of the patient. Document your call in the record!
3. Take all the information you have gathered to your instructor. The instructor will decide if a medical referral is required.
4. If a medical referral is required, fill out Medical Referral form in SmartDocs and have an instructor sign, you sign and have the patient sign. Give the original to the patient and place a copy in the Scan Box to be scanned into the patient's record as a Smartdoc. Document on the record of treatment that referral was given and why. It is now up to your patient to see his/her physician and return the white copy of the form back to you before treatment is rendered. You may also choose to fax the document to the physician's office if the decision can be made without the patient scheduling an appointment. Place the completed medical referral with physician recommendation and signature in the Scan Folder to be scanned into the patient's record via Smartdocs. In the record of treatment, make an entry stating that the Medical Referral form has been

returned and the patient is released by the physician for treatment or any recommendation the physician documented.

### **Introduction:**

These protocols reflect sound medical/dental practice. They are not intended to be a rigid and comprehensive set of rules nor are they intended to replace the need for a medical consultation. They should, however, be helpful to all practitioners interested in a conscientious approach to medical and dental care.

#### ***I. Unacceptable Cases***

Consultation with physician may be required in some cases. You should use the health history questionnaire and patient interview to identify cases that are not acceptable in the dental hygiene clinic. This would include patients who indicate a history of the following:

1. Active herpetic lesion (labials, facialis, or oral)
2. Contagious skin conditions (impetigo, ringworm, scabies)
3. Head lice
4. Conjunctivitis
5. Elevated oral temperature (in excess of 100 degrees F)
6. Respiratory infections involving inflamed throat and/or elevated temperature
7. Active tuberculosis
8. Viral hepatitis (active cases only)
9. Cardiovascular accidents, cardiac bypass surgery or stroke within the last six months
10. Unstable angina
11. Other contagious conditions or diseases

#### ***II. Medical Consultation***

Patients with the following conditions will require a medical consultation record from his/her physician:

1. Stage II Hypertension >160/100 see pg. 74/75
2. Patients with a pacemaker, ascertain whether shielded or unshielded
3. Current anticoagulant therapy
4. Heart surgery other than bypass
5. Other systemic diseases, including cardiac arrhythmias, angina, congestive heart failure, renal and hepatic disease
6. Congenital cardiac defects
7. Surgically constructed systemic-pulmonary shunts
8. Congestive heart failure
9. Diabetes if the patient has not had the condition checked by a physician within the last year
10. Uncontrolled, unstable diabetes mellitus and uncontrolled Addison's Disease
11. Tuberculosis if the condition has been active during the last five years
12. Currently under cancer treatment (including long-term chemotherapeutic drug



- therapy)
13. Current or history of anticancer chemotherapy including use of chemotherapy drugs for noncancerous conditions ie. Methotrexate for rheumatoid arthritis
  14. Patients who report history of chemotherapy to determine possible use of bisphosphonates
  15. Post-irradiation of the mandible or maxilla with greater than 5,000 rads total dose
  16. Renal transplant and hemodialysis
  17. Glomerulonephritis or other active renal disorder
  18. Patient receiving interferon treatment
  19. Patients having had a splenectomy
  20. Chronic steroid therapy (over 10 days) within the last two years (20 mg./day)
  21. Blood diseases, especially acute leukemia, agranulocytosis, granulocytopenia aplastic anemia and agamma globulinemia
  22. Systemic lupus erythematosus
  23. Any immunosuppressed patient such as those with acquired immune deficiency syndrome (AIDS)
  24. Pregnant patient requiring anesthesia or any other medication
  25. Organ transplant
  26. Prosthetic Joint Replacement (Faculty discretion based on 2012 ADA Guidelines <http://www.ada.org/2583.aspx?currentTab=2#replace>)

## A. CONSULTATION LETTERS

### Indications for Physician:

The following is a listing of conditions found during medical histories in which a consultation with the physician will generally be indicated. This is not a total list of conditions needing consultation. Also, patients with these conditions will not always have to have a consultation letter sent. The evaluation of the doctors present will determine the specific times that consultation is necessary.

#### 1. Rheumatic Fever:

A history of rheumatic fever when it is not known whether there is residual rheumatic heart disease (or a heart murmur). Information needed from the physician should include whether a murmur is present or not and, if present, the type. Treatment may be rendered with prophylactic antibiotic coverage.

#### 2. Myocardial Infarcts:

Myocardial infarcts that have occurred within the last six months or patients who have had multiple myocardial infarcts. Information needed from the physician should include his/her evaluation of the cardiovascular condition and medications the patient is taking. Generally, no treatment until reply received.

#### 3. Tuberculosis

A recent history of tuberculosis or a history of tuberculosis in which there is a question as to the effectiveness of the treatment. Information needed from physician: What type of treatment did the patient receive; has there been adequate follow-up?

**4. Malignant Disease**

Any malignant disease currently under treatment or discovered within the last two years. Information to be requested from the physician should include the exact nature of the malignancy, the treatment rendered, and the prognosis.

**5. Bleeding or Clotting**

A history of bleeding or clotting abnormalities in which a diagnosis has been made. The physician should include the exact nature of the malignancy, the treatment rendered, and the prognosis.

**6. Congenital Heart Defects**

Physicians should be asked what type of defect is present.

**7. Uncontrolled Diabetes Mellitus**

Uncontrolled Diabetes Mellitus or a patient who is suspected of having diabetes mellitus and is not being treated for it. Patient receiving daily insulin needs a consultation prior to surgery (oral or periodontal) to adjust the amount of their daily insulin dosage to compensate for the decreased food intake. The physician needs to be asked his opinion of the control of diabetes in the patient.

**8. Jaundice**

Physicians need to be asked the cause of the jaundice: Was it the result of hepatitis, and what type hepatitis? Antigen-antibody levels, if available, need to be determined.

**9. Multiple Medications**

Multiple medications, four or more, especially if they involve corticosteroids, psychotropics, and anticoagulants or sedatives. The physician needs to be asked to verify that the medications are prescribed. Tactfully ask for what condition they are prescribed.

**10. Pregnancy:**

- a. Radiographs: Avoid during pregnancy.
- b. Anesthesia: Consult with attending dentist. A consultation letter is sent primarily to inform the obstetrician that dental treatment is being rendered.

**11. AIDS, HIV**

Determine the stage of the patient's disease, the opportunistic infections the patient has and what other associated conditions are present.

**12. Splenectomy**

Determine if the patient has had a splenectomy and the reason for the procedure, specifically if the patient has sickle cell anemia.

**13. Vascular Surgery**

Indwelling catheters and shunts. Determine if these are present. If a vascular graft, determine if artificial material was used. AHA endocarditis prophylaxis regimen to be used on all patients with artificial grafts, catheters and shunts.

#### 14. Joint replacements

Orthopedic prostheses including total hip, knees and elbows  
those with **joint replacements and rheumatoid arthritis**, systemic lupus erythematosus, disease, drug induced or radiation-induced immunosuppression.

*\*\*Faculty discretion to be used for additional medical conditions not listed above\*\**

### III. Antibiotic Prophylaxis

#### A. Premedication Procedures

In your Preclinic and Pharmacology courses, you are given information on when to premedicate patients before dental treatment.

1. If your patient has a documented need for premedication, you will need to discuss the need for them to obtain a prescription before their appointment. As you were taught in Pharmacology, the first drug of choice for premedication is amoxicillin, the 2<sup>nd</sup> drug is clindamycin, the 3<sup>rd</sup> drug is azithromycin, the 4<sup>th</sup> drug is clarithromycin, and the 5<sup>th</sup> drug of choice is cephalexin.
  - a. The standard regimen for prescribing amoxicillin is: 4 tabs of amoxicillin 500mg one hour prior to the dental appointment.
  - b. The standard regimen for prescribing clindamycin is: 4 tabs of clindamycin 150mg one hour prior to the dental appointment.
  - c. Above prescriptions are for one appointment. If your treatment plan calls for more than one appointment, dispense the proper number of tablets.
2. Always ask new patients on the phone when you are scheduling their appointment if they need to be pre-medicated. This will help you avoid wasting clinic time.

#### B. Premedication with Antibiotics

Patients with the following conditions will require premedication with antibiotics unless a consultation record from the patient's physicians has been received:

1. Previous history of infectious endocarditis
2. Prosthetic cardiac valve
3. Certain specific, serious congenital (present from birth) heart conditions, including:

- Unrepaired or incompletely repaired cyanotic congenital heart disease, including those with palliative shunts and conduits
  - A completely repaired congenital heart defect with prosthetic material or device, whether placed by surgery or by catheter intervention, during the first six months after the procedure
  - Any repaired congenital heart defect with residual defect at the site or adjacent to the site of a prosthetic patch or a prosthetic device
4. A cardiac transplant that develops a problem in a heart valve.

### **C. Infective Endocarditis:**

(IE – also called bacterial endocarditis [BE]) is an infection caused by bacteria that enter the bloodstream and settle in the heart lining, a heart valve or a blood vessel.

Although IE is uncommon, people with some types of congenital heart disease have a greater risk of developing it. The American Heart Association updated their guidelines in 2007 for preventing endocarditis. In the past, children or adults with nearly every type of congenital heart defect needed to receive antibiotics one hour before dental procedures or operations on the mouth, throat, or gastrointestinal, genital or urinary tracts.

This recommendation has changed and is much simpler. Now antibiotics are only recommended for these cardiac conditions:

- A prosthetic heart valve or a heart valve repaired with prosthetic material
- A history of endocarditis
- Heart transplant patients who develop abnormal heart valve function
- Certain congenital heart defects including:
- Cyanotic congenital heart disease (birth defects with oxygen levels lower than normal), that has not been fully repaired, including children who have had a surgical shunts and conduits;
- A congenital heart defect that's been completely repaired with prosthetic (artificial) material or a device (either placed by surgery or by catheter intervention) for the first six months after the repair procedure;
- Repaired congenital heart disease with residual defects (persisting leaks or abnormal flow) at the site or adjacent to the site of a prosthetic patch or prosthetic device.

Surgical procedures or instrumentation involving mucosal surfaces or contaminated tissue commonly cause transient bacteremia that rarely persists for more than 15 minutes. Bloodborne bacteria may lodge on damaged or abnormal heart valves or on endocardium or endothelium near congenital anatomic defects, resulting in bacterial endocarditis or endarteritis ("endocarditis" is used here for both endocarditis or endarteritis). Although bacteremia is common following many invasive procedures, only a limited number of bacterial species commonly cause endocarditis. It is impossible to predict which individual patient will develop this infection or which particular procedure will be responsible.

## **D. Bacteremia:**

Certain cardiac conditions are more often associated with endocarditis than others (see chart). Patients at risk are those who have congenital or acquired endocardial, endothelial, or valvular defects. Furthermore, certain dental and surgical procedures are much more likely to initiate the bacteremia that results in endocarditis than are other procedures. Prophylactic antibiotics are recommended for patients at risk for endocarditis whenever they undergo procedures likely to cause bacteremia with organisms that commonly cause endocarditis.

### **1. Time Parameters:**

Antibiotic prophylaxis is most effective when administered pre-operatively in doses that are sufficient to assure adequate serum antibiotic concentrations during and after the procedure. To reduce the likelihood of microbial resistance, it is important that prophylactic antibiotics be used only during the preoperative period. They should be initiated shortly before a procedure (one hour prior) and should not be continued for an extended period. In unusual circumstances or in the case of delayed healing, it may be necessary to provide additional doses of antibiotic even though bacteremia rarely persists longer than 15 minutes after the procedure.

### **2. Clinical Judgment:**

This statement represents the recommended guidelines to supplement the practitioner in his/her clinical judgement and is not intended as a standard of care for all cases. It is impossible to make recommendations for all clinical situations in which endocarditis may develop.

## **E. Bacterial Endocarditis Risk Reduction:**

Poor dental hygiene and periodontal or periapical infections may induce bacteremia even in the absence of dental procedures. Individuals who are at risk for bacterial endocarditis should establish and maintain the best possible oral health to reduce potential sources of bacterial seeding.

Antibiotic prophylaxis is recommended with all dental procedures likely to cause gingival bleeding, including routine professional scaling. If a series of dental procedures is required, it may be prudent to observe an interval of seven days between procedures to reduce the potential for emergence of resistant strains of organisms. If possible, a combination of procedures should be planned in the same period of prophylaxis.

### **1. Edentulous Patients:**

Edentulous patients may develop bacteremia from ulcers caused by ill-fitting dentures; therefore, denture wearers should be encouraged to have periodic examinations or to return if soreness develops. When new dentures are inserted it is advisable to have the patient return to correct any overextension to avoid mucosal ulceration.

**F. On-Site Pre-Medication: None**

There will not be any dispensing of pre-medication on-site. Some dental practices will have on-site medications.

**IV. Prescription Medication Contraindications****A. Phen-Fen (Dexfluramine, Fenfluramine, Phentermine, Adipex, Pondimin, Redux):**

ADA statement on HHS Warning to Former Phen-Fen Users: The U. S. Department of health and Human Services is now recommending that the estimated 4.6 million people who were taking the appetite suppressant drugs fen=phen (feluramine and phentermine) or dexfenfluramine or fenfluramine alone receive a complete physical examination and echocardiogram to determine if they have any adverse heart conditions.

**B. Warfarin (Coumadin):**

Warfarin is an oral anticoagulant used to prevent clotting. It interferes with the blood's clotting by blocking the production of the clotting factors (II, VII, IX, and X) which are vitamin K dependent and are synthesized in the liver. Indications for warfarin include atrial fibrillation, post-MI, or thrombophlebitis. Warfarin's major side effects relate to its action to increase bleeding with symptoms such as petechia, bruising, ecchymoses, hematuria (bleeding into the urine), or hemorrhage.

**C. Bisphosphonates: (Actonel, Actonel+Ca, Aredia, Boniva, Didronel, Fosamax, Fosamax+D, Reclast, Skelid, and Zometa)**

Antiresorptive agents often are used to treat osteoporosis, lowering the risk of related fractures. In rare cases, use of antiresorptive agents has been associated with osteonecrosis of the jaw. However, the risk of developing antiresorptive agent-induced osteonecrosis of the jaw (ARONJ) is low, with the highest prevalence estimated at 0.10% in a large sample of patients (n=952) who had taken oral bisphosphonates.

Although osteonecrosis can occur spontaneously, more commonly ARONJ has been reported after dental treatments—most often invasive procedures like tooth extractions—in patients treated with antiresorptive agents.

*\*\*This list is not all inclusive, always review every medical condition, medication and consult with faculty\*\**

# **SECTION FIVE:**

## **Supplies**

## SECTION 5                      Supplies

### Cubicle Organization

1. Cubicles in the dental clinic are used by three different groups of students and are no one group's personal "home".
2. All personal items must be kept in the student cabinets.
3. Do not tape anything to walls or place personal items in drawers! Anything you buy should be put in your student cabinet at the end of clinic.
4. See location of items as listed below in order to properly organize your cubicle. All units should be identical.
5. NO ITEMS WITH EXPIRATION DATES ARE ALLOWED TO BE STORED IN CUBICLES. *Exception: Topical Anesthetic*

#### Front Cabinet (Top Left)

- Water Bottles
- Alcohol Prep Pads
- ICX Tablets

#### Front Cabinet (Top Middle)

- OHI Aids, pamphlets, coupons
- Vaseline
- Floss holder
- Disclosing solution
- Dappen dishes (disposable)
- OHI Material
- Tooth Model/Toothbrush

#### Front Cabinet (Top Right)

- English/Spanish Translation Guide
- UltraLume LED 5

#### Front Cabinet (Recessed Countertop)

- Mirror
- Kleenex

#### Front Cabinet (Bottom Left Side)

- Prophy paste (coarse, medium, fine)
- Prophy angles
- Saliva ejectors
- Suction tips
- Hazardous waste bags



**Front Cabinet (Bottom Middle)**

- Ultrasonic (Cavitron)

**Front Cabinet (Bottom Right)**

- Topical anesthetic
- Needles
- Protectors
- Fluoride Trays

**Side Cabinet (Top Glass Cabinets-OHI Items)**

- |              |                   |                 |                    |
|--------------|-------------------|-----------------|--------------------|
| • Polident   | Biotene           | Glide Floss     |                    |
| • Toothpaste | Kids toothbrushes | Floss threaders |                    |
| • Floss      | Reach flosser     | Sensodyne       | Adult toothbrushes |

**Side Cabinet (Countertop)**

- Tongue Depressors
- Cotton rolls
- Cotton tipped applicators
- 2x2 gauze
- 4x4 gauze

**Top Drawer**

- Patient napkins
- Paper tray covers

**Bottom Drawer**

- Bouffant caps
- Pink Sterilex card

**Large Side Cabinet**

- Chair covers/Barriers
- Prophy angles

**Top Cabinet (in between cubicles)**

- Peridex (top shelf)
- Large gloves (top shelf)
- Small gloves (top)
- Medium gloves (bottom)
- Cups (bottom left)
- Paper towels (middle back)
- Masks (middle front)
- Sink stopper (bottom right)

**Top Cabinet (countertop in between cubicles)**

- Listerine Zero (left)

- Hand Sanitizer (right)

**Bottom Cabinet (in between cubicles)**

- Plastic Instrument Carrier
- Soap spray bottle
- PD Care spray bottle
- Large soap dispenser
- Dental vacuum line cleaner
- PD Care wipe container
- Small sharps container
- Purple nitrile utility gloves

**\*\*No personal items in drawers**

**\*\*No extra barriers are to be kept in the drawers**

Please use metal file holders to store patient paperwork and process evaluations for each appointment. A neat, clean work environment is both important and productive.

## Storage Room and Inventory

To request Inventory from Storage Room, fill out “Inventory Request Form” on clipboard in the right-hand corner of the secretary’s desk with information as follows:

- Name of Student Requesting Inventory
- Date
- Specific Inventory items needed
- Specific Quantity of each item needed

Hand “Inventory Supplies Request Form” to CA and notify the CA that you are requesting items to be pulled by 8:45. The CA will then pull the items indicated from the Storage Room and turn them over to the student requesting the supplies.

If an item is needed right away and an instructor sends you to get it from the store room, please fill out the request form for the item (s) you removed out of the store room and turn it in to the secretary.

### Example Form:

### Inventory Request Form

Name: \_\_\_\_\_

Date of Request: \_\_\_\_\_

ITEM REQUESTED (PLEASE BE SPECIFIC)	QUANTITY NEEDED

## Laundry Services

### Policy:

All students/faculty/staff/instructors will ensure that clean and sanitized towels are adequately laundered to promote clinical work flow of Dental Department.

### Procedure for Laundry Services:

1. Clean and soiled towels are to be kept separate in the laundry. Clean storage environment is designed primarily to prevent contamination of clean towels.
2. All soiled towels used within the Dental Department shall be placed in the “Dirty Towels” cabinet in Central Sterilization (CS) **INSIDE THE LINED CONTAINER.**
3. Once each liner is full of soiled DRY towels, the bag should be tied off and placed inside the laundry basket in CS.
4. Once the Dental Department has a full bag of soiled towels, the Dental Programs Office Manager is to be notified so that arrangements can be made for the soiled laundry to be picked up and cleaned.
5. Notify Dental Programs Office Manager to contact MacDuff’s Cleaners for pick up. 217 S Gulf St Sanford, NC 27330 (919) 775-7012

**SECTION SIX:**  
**Guidelines and Policies**  
**Regarding the use of**  
**Ionizing Radiographs**

## SECTION 6 GUIDELINES AND POLICIES REGARDING THE USE OF IONIZING RADIOGRAPHS

**Refer to the Radiology Manual issued during the DEN 112 Dental Radiology Course for complete information.**

**Endorsements:** The policy of Central Carolina Dental Center CCCC Dental Programs regarding the use of ionizing radiation will be endorsed by the American Dental Association, American Association of Dental Schools, American Academy of Oral & Maxillofacial Radiology, the National Center for Devices and Radiological Health (NCDRH), and North Carolina Department of Energy and Natural Radiation (NCDENR).

**Purpose:** Radiographic examination(s) must be ordered only after a complete review of the medical, oral and dental histories and following a thorough clinical examination. Diagnostic radiographic examinations provide essential information for diagnosis, treatment and prevention of oral and dental diseases. Diagnostic radiographs are thus an indispensable and integral component of dental practice authorized at the discretion of the dentist to benefit the patient based on specific selection criteria.

### I. SELECTION CRITERIA

#### A. Films & Frequency:

The following selection criteria will be utilized by Central Carolina Dental Center CCCC Dental Programs to determine films to be taken on patients, and their frequency.

#### B. Required Examination

1. All patients will be clinically examined and their medical and dental histories obtained prior to diagnostic radiation exposure.
2. A dental faculty member will review recommendations by dental hygiene students and determine which and how many films are to be ordered and exposed.

#### C. New Patients

1. New patients will be asked if recent radiographs are available during their screening visit.
2. If recent films or duplicates are not available, then an appropriate radiographic examination will be completed.

**D. Faculty Approval**

1. Radiology film/sensors or XCP kits will not be dispensed to students unless ordered by faculty.
2. Retakes will not be permitted until after the radiographs have been reviewed by the faculty.

**E. Retakes**

Non-diagnostic radiographs should be retaken by faculty or trained staff unless it is their opinion that the student can successfully retake the film; then, they must be **retaken under direct supervision**.

**F. Pregnant Patients**

Elective radiographs will not be taken on the pregnant patient, but emergency radiographs are permitted with proper leaded apron protection.

**G. Academic Purposes:**

1. For academic reasons radiographs **should not be repeatedly taken to obtain radiographs that are perfect if other radiographs contain similar diagnostic information**.
2. Routine examination will not be used on new patients to determine their acceptability as patients for students.
3. **Radiographic examinations must not be used routinely for checking progress of treatment.**

**II. RADIATION PROTECTION****A. Record Keeping:**

1. All patient exposures will be recorded in the patient's electronic record.
2. The date, type and number of radiographs will be recorded.

**B. Procedures:**

1. All exposures of patients will be performed using lead aprons and leaded cervical thyroid shields.
2. All exposures will be performed using the posted appropriate kVP, mA and time settings.
3. Users of X-ray generated equipment will follow good radiation hygiene practices.

4. During exposures, radiology personnel will stand behind shielded walls or doors, will not hold films for patients, and will observe patients through the leaded glass shields so that no unnecessary retakes occur as the result of tube, film or patient movement.

**C. Film Badges:**

All dental assisting faculty and students who routinely use ionizing radiation will wear dosimeter film badges that will be monitored monthly.

**D. Equipment Inspection:** refer to Radiology Manual

**E. Apron & Shield Inspection:**

Annually, all lead aprons and cervical shields will be visually inspected for cracks or defects and replaced if necessary. However, students must immediately report to the clinical instructor if cracks or defects are found on lead aprons and thyroid collars. Aprons and shields will not be folded, but hung when not in use.

**III. RADIOLOGY CLINIC HOUSEKEEPING**

**A. Responsibilities:**

Cleanliness is very important in all aspects of dentistry, and radiology is not an exception. Radiology cubicles, hallway and processing areas reviewed by students, visitors and patients will be cleaned by the assigned students who use them throughout the day.

**B. Cubicles:**

1. Floors should be free of film/sensor wrappers and tissue.
2. Lead aprons should be hung on their hangers.
3. Tissue and Stabe film holders should be kept available in the wall units in each cubicle for your use during the assignment.
4. Plastic headrest covers should be changed between patients.
5. **X-ray units should be placed against the wall when not in use.**
6. Remove all plastic wrapping from the X-ray machine and cubicle area after films have been evaluated, retakes completed and patient dismissed.
7. Countertops should be dried and orderly.

**C. Panoramic Cubicles & Hallway Outside Cubicle:**

1. Floors should be kept free of all debris.
2. Lead aprons should be stored by hanging them on a wall hanger.



3. Bite guards should be kept cleaned and covered with barriers.
4. Counter tops should be dry and orderly.

**D. Scan-X Room:**

1. The student(s) will be responsible to maintain the cleanliness of the Scan-X processing area.
2. PSP sensors must be clean and dry before carrying these items into the Scan-X room.
3. Students must not deliver PSP sensors to the Scan-X room with soiled protective barriers.
4. All PSP sensors should be placed in the sensor transfer box before delivery to the Scan-x processing area.

**E. Dark Room:**

1. The student(s) will be responsible to maintain the cleanliness of the darkroom.
2. The darkroom will only be utilized during DEN 112 procedures for the purpose of learning how to process radiograph film.
3. Students will not utilize regular film for creating radiographs for patients during clinical courses.

**IV. INFECTION CONTROL GUIDELINES IN DENTAL RADIOLOGY****A. Preparation:**

1. All non-disposable film holding devices (Rinn XCP, Snap-A-Ray) should be autoclaved prior to use. Rinn XCP set and Snap-A-Ray instruments may be signed out.
2. Hands should be washed with an appropriate disinfectant hand before and after glove use.
3. Gloves should be worn at all times when exposing and processing intra-oral radiographs.

**B. Materials and Supplies:**

1. Secure the patient record and desired number of film packets/sensors.
2. Review medical history.
3. Secure as many bite-wing tabs and STABE holders as needed from containers in each cubicle.
4. Place these on the counter in the radiology room, which should be covered with plastic or patient napkin.
5. Once the operator begins making radiographs, do not reach into these containers to secure additional supplies.

6. If additional supplies are needed, the operator should remove gloves, rewash hands and put on new gloves before reaching into the container.

### **C. Preparing Surfaces:**

Surfaces that will be touched by the operator during treatment, including tubehead, cone, control panel, exposure button, and chair armrests should be covered with plastic barriers prior to seating the patient.

### **D. Preparing Instruments:**

1. Film-holding devices (Rinn XCP) should be removed from the autoclave bag with gloved hands and placed on the covered countertop.
2. These instruments should go from the counter to the patient's mouth and back to the same counter.
3. Do not place used instruments on uncovered countertops or other areas in or out of the cubicle.
4. When work is completed, remove cotton rolls from XCP, wash, rinse and dry instruments.
5. Place instruments in a new autoclave bag for sterilization, or place them in plastic bag until they can be transferred to an autoclave bag.
6. Do not carry instruments in a lab coat.
7. Do not leave film-holding instruments on the counter in the viewing room or Scan-X room or darkroom.

### **E. Additional Precautions:**

All charts, books, and other material not essential in the delivery of treatment should be kept away from the treatment and darkroom/scan-x areas to avoid unnecessary contamination.

## **V. STEP-BY-STEP PROCEDURES FOR TAKING RADIOGRAPHS DURING CLINICAL COURSES**

### **A. Intraoral Radiographs (PSP):**

#### **Preparation**

1. Prepare the unit room by observing infection control procedures for this area. Make certain to use barriers on the PID, control panel keypad, and patient chair.
2. Check chart for proper forms with signatures or prescriptions from private dentist.
3. Use of Planmeca intraoral radiographic equipment:
  - The on/off button is located under the panel that is on the wall next to the patient chair.

- The control panel keypad is located on the wall outside the operatory entryway.
  - Press the mode button to select type of system being used: d=digital, p=phosphor plate, and O=film.
  - Rooms I, II, and III will require use of the phosphor plate sensor system. Room IV may be utilized for both phosphor plates and digital sensors. Film will only be utilized during DEN 112 with the use of DXTRR.
  - The kVp and mA are pre-set and no adjustment can be made. Exposure times are pre-set.
  - Use the control panel keypad outside the room to make adjustments for the teeth you are exposing based on patient size.
4. Place sensors on a clean paper towel that lines the area where you will be working.
  5. Make sure that the sensor transfer box is readily available so you may be able to insert EXPOSED sensors into the box for transport to the SCANX Imaging System.
  6. Place the lead apron and thyroid collar on the patient. Check the adjustment of the headrest to be sure the patient's head is in a stable, comfortable position. Ask the patient to remove eye glasses. Wash hands and glove, and then ask the patient to remove any removable dental appliances. Place dental appliance(s) in a denture cup.

**B. Activation of Radiation:**

1. Before exposing films, CHECK setting on the x-ray unit to be sure it is set for the proper radiographic area of interest.
2. The exposure button should be held down long enough to make the exposure complete.
3. An audible signal can be heard when an exposure is being made.
4. If you remove your finger too soon, the exposure will not be complete and the resulting image may be either non-existent or of a very light density.

**C. Handling and Processing of Exposed Sensors**

1. After removing the phosphor plate from the patient's mouth, place the plate in an area on the counter that will not be confused with the remaining unexposed film.
2. This may be in a plastic cup or on a clean paper towel.
3. This will prevent mixing exposed plates with unexposed plates.
4. Once all phosphor plates are exposed, carefully wipe down the plates with a 4x4 piece of gauze soaked with disinfectant.
5. Carefully tear open the phosphor plate covers and deposit the plates into the sensor transfer box.
6. Wash your hands.
7. Upon completion of the FMX, remove the lead apron and thyroid shield.

8. Take the full sensor transfer box to the Clinical Assistant and tell them that the radiology operatory will no longer be needed and that they may clean the operatory when available.
9. If the radiology area is not busy, the patient may wait in the radiology operatory while the Clinical Assistant develops the PSP sensors.
10. If the area is busy, escort your patient to your clinical operatory. (If using digital sensors, use appropriate protocol stated in the Radiology Manual.)
11. The Clinical Assistant will process the phosphor plates into the SCANX imaging system, mount the images in the proper mounting views, and deliver a printed copy of the images to a clinical instructor for review.
12. The instructor will initial the images upon approval and alert the Clinical Assistant as to whether or not retakes are required.
13. The Clinical Assistant will also count the PSP sensors and ensure that the plates are returned to the clinic for the instructor to count before returning to the PSP sensor holding area. (If using digital sensors, use appropriate protocol stated in the Radiology Manual.)

#### **D. Escorting Patient and Sterilization of XCP Equipment**

1. When escorting the patient to the dental clinic, the XCP equipment may be carried back to the clinic with a gloved hand.
2. DO NOT ask the patient to stand in the sterilization area while you handle equipment or perform sterilization procedures in the sterilization area.
3. This may result in a major error on your grade sheet.

#### **E. Retrieval of Completed Radiographic Images**

1. The clinical assistant will deliver the printed radiographs and a grade sheet to your operatory inbox to let you know that the radiographs have been safely entered into Eaglesoft.
2. The clinical assistant should let you know if retakes may be required and assist in bringing the patient back to the radiology lab for retakes.

#### **F. Retaking Radiographs**

1. If you believe that retakes are required at this point you will need to repeat the same steps of taking radiographs.
2. Ask the dentist/ radiology instructor/faculty to verify your conclusions.
3. Take only the retakes requested by the instructor/dentist.
4. If you administer retakes of radiographs without instructor approval, you will be subject to a "0" for the clinical session.
5. Inform the Screener that retakes will need to be added to the previous FMX taken that day. The Screener will follow the same protocol as utilized earlier.

**G. Distribution of Radiographic Images**

1. Print a copy of the radiographs for the patient so that the patient may take the radiographs to the dentist of their choice.
2. If a patient requests that electronic radiographs be sent his/her dentist, the office manager will help you with that process.
3. The office manager will need the name of the dental office and an email address will also be helpful.
4. When patients request to take the second set to their doctor, this must be documented in the patients chart.
5. The clinical dentist should be asked to perform an exam and evaluate the radiographs.
6. Any clinical findings should be recorded in the clinical notes and in dental charting.
7. Clinical findings should also be recorded on a patient referral sheet to be taken to the dentist of their choice.
8. All patients are encouraged to establish a dental home elsewhere from the CCCC Dental Clinic since CCCC is primarily providing educational experiences for students and not serving as a true healthcare provider.

**H. Disinfection of Radiographic Operatory**

1. The Clinical Assistant is responsible for cleaning the radiographic operatory.
2. The Clinical Assistant must wipe down lead apron and thyroid collar with 4x4 gauze saturated with disinfecting solution and then hang these items on hooks behind chair.
3. The Clinical Assistant must then push the tubehead against the wall with extension arm closed and PID down.
4. This resting position will extend the life of the extension arm.
5. The Clinical Assistant should then sanitize and disinfect the area, removing and disposing of barriers and any debris properly.
6. Prepare any items for sterilization as appropriate.
7. If a dentist is not available for pathology evaluation an instructor will perform a preliminary evaluation while the patient is still in the chair.
8. The radiographs and noted pathology will be placed in the specified box in the clinic for the dentist to evaluate as soon as possible.
9. If the dentist finds additional pathology, the dental department will call the patient and relay the dentist's findings.

**I. CCD RECEPTORS:**

1. With clean hands place CCD receptor in protective cover and cover keyboard with plastic drape.
2. Wash hands. With gloved hands proceed with exam.

3. When exam is complete remove gloves and wash hands, dismiss patient.
4. Then re-glove hands to remove protective covers from sensor and keyboard.
5. Wipe sensor and cord with a paper towel wet with disinfectant.
6. Remove gloves and wash hands.
7. Prepare room for next patient.

**J. Panoramic Images:**

1. When taking panoramic radiographs, come to radiology with washed hands and no gloves.
2. There is no need to wrap anything in this space.
3. Disposable bite blocks will be used. There is no need to cover bite blocks.
4. Clean the patient positioning area and wipe down the handles and temple holders of the panoramic unit after making the exposure.

**K. Eaglesoft 16 Radiograph transfer procedures:**

1. Right click over the radiograph set that needs to be transferred.
2. Select Transfer Exam.
3. Select patient that radiographs need to be transferred to.
4. Click “yes” to allow exam transfer.
5. Check to make sure proper transfer has happened.

## **VI. CRITERIA FOR RADIOGRAPHS**

Only films necessary to complete the diagnosis should be ordered. The professional discretion of the faculty must be used to determine which films are needed based on the conditions found during the clinical examination.

**Selection Criteria:**

- Guidelines for Prescribing Dental Radiographs
- U.S. Department of Health and Human Services
- Public Health Services
- Food and Drug Administration
- Center for Devices and Radiological Health
- Rockville, Maryland
- HHS Publication FDA 88-8274

**A. SUGGESTED GUIDELINES FOR PRESCRIBING DENTAL RADIOGRAPHS**

Patient Category	Child	
	Primary Dentition (prior to eruption of first permanent tooth)	Transitional Dentition (following eruption of first permanent tooth)
<b>NEW PATIENT *</b> <b>All New Patients to Assess Dental Diseases and Growth and Development</b>	Posterior bitewing examination if proximal surfaces of primary teeth cannot be visualized or probed	Individualized radiographic examination consisting of periapical/occlusal views & posterior bitewings or panoramic examination & posterior bitewings
<b>RECALL PATIENT *</b> <b>Clinical caries or high-risk factors for carries **</b>	Posterior bitewing examination at 6-month intervals or until no carious lesions are evident	
<b>No clinical caries and no high-risk factors for caries **</b>	Posterior bitewing examination at 12-24 month intervals if proximal surfaces of primary teeth cannot be visualized or probed	Posterior bitewing examination at 12-24 month intervals
<b>Periodontal disease or a history of periodontal treatment</b>	Individualized radiographic examination consisting of selected periapical and/or bitewing radiographs of areas where periodontal disease (other than nonspecific gingivitis) can be demonstrated clinically	
<b>Growth and development assessment</b>	Usually not indicated	Individualized radiographic examination consisting of a periapical/occlusal or panoramic examination

<p><b>* Clinical situations for which radiographs may be indicated include:</b></p> <p><b>A. Positive Historical Findings</b></p> <ol style="list-style-type: none"> <li>1. Previous periodontal or endodontic therapy</li> <li>2. History of pain or trauma</li> <li>3. Familial history of dental anomalies</li> <li>4. Postoperative evaluation of healing</li> <li>5. Presence of implants</li> </ol>	<p><b>B. Positive Clinical Signs/Symptoms</b></p> <ol style="list-style-type: none"> <li>1. Clinical evidence of periodontal disease</li> <li>2. Large or deep restorations                             <ol style="list-style-type: none"> <li>1. Deep carious lesions</li> <li>2. Malposed or clinically impacted teeth</li> </ol> </li> <li>5. Swelling</li> <li>6. Evidence of facial trauma</li> <li>7. Mobility of teeth</li> </ol>	<ol style="list-style-type: none"> <li>8. Fistula or sinus tract infection</li> <li>9. Clinically suspected sinus pathology</li> <li>10. Growth abnormalities</li> <li>11. Oral involvement in known or suspected systemic disease</li> <li>12. Positive neurologic findings in the head and neck</li> <li>13. Evidence of foreign objects</li> <li>14. Pain and/or dysfunction of the TMJ</li> </ol>
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**The recommendations in this chart are subject to clinical judgment and may not apply to every patient. They are to be used by dentists only after reviewing the patient's health history and completing a clinical examination. The recommendations do not need to be altered because of pregnancy.**

Adolescent	Adult	
Permanent Dentition (prior to eruption of third molars)	Dentulous	Edentulous
Individualized radiographic examination consisting of posterior bitewings & selected periapicals. A full mouth intraoral radiographic examination is appropriate when the patient presents with clinical evidence of generalized dental disease or a history of extensive dental treatment.		Full mouth intraoral radiographic examination or panoramic examination
Posterior bitewing examination at 6-12 month intervals or until no carious lesions are evident	Posterior bitewing examination at 12-18 month intervals	Not applicable
Posterior bitewing examination at 18-36 month intervals	Posterior bitewing examination at 24-36 month intervals	Not applicable
Individualized radiographic examination consisting of selected periapical and/or bitewing radiographs for areas where periodontal disease (other than nonspecific gingivitis) can be demonstrated clinically		Not applicable
Periapical or panoramic examination to assess developing third molars	Usually not indicated	Usually not indicated
16. Abutment teeth for fixed or removable partial prosthesis 17. Unexplained bleeding 18. Unexplained sensitivity of teeth 19. Unusual eruption, spacing or migration of teeth 20. Unusual tooth morphology, calcification or color 21. Missing teeth with unknown reason	<b>** Patients at high risk for caries may demonstrate any of the following:</b>  1. High level of caries experience 2. History of recurrent caries 3. Existing restoration or poor quality 4. Poor oral hygiene 5. Inadequate fluoride exposure	6. Prolong nursing (bottle or breast) 7. Diet with high sucrose frequency 8. Poor family dental health 9. Developmental enamel defects 10. Developmental disability 11. Xerostomia 12. Genetic abnormality of teeth 13. Many multisurface restoration 14. Chemo/radiation therapy

*Guidelines for Prescribing Dental Radiographs  
U.S. Department of Health and Human Services*



# **SECTION SEVEN:**

## **Radiology Forms**

## **SECTION 7                      Radiology Forms**

**RF 1:** Radiology Analysis & Grade-FMS/Individual Periapicals

**RF 2:** Bitewing Analysis-4 HBWX, 4 VBWX

**RF 3:** 7-Series Vertical Bitewing Analysis

**RF 4:** Panoramic Analysis

**RF 5:** Occlusal Analysis

**RF 6:** Radiographic Interpretation

**RADIOGRAPHIC ANALYSIS & GRADE**

FMX# \_\_\_\_\_ Radiology Room # \_\_\_\_\_

STUDENT: \_\_\_\_\_ DATE EXPOSED: \_\_\_\_\_ DATE SUBMITTED: \_\_\_\_\_  
 PATIENT: \_\_\_\_\_ AGE: \_\_\_\_\_ TYPE OF RADIOGRAPHS: FMS, Individual Periapicals

MG Magnified image	MAV Missing apices-or twilight too wide (VA not steep enough for paralleling)
BA Bump at apex (for PA=s only)	MCV Missing crowns-or twilight not wide enough (VA too steep paralleling)
BL Blurred film	MAF Missing apices (film placed too low or high in mouth-or failure of pt to bite)
OC Overlap of contact areas	MCF Missing crowns (film placed too low or high in mouth)
C Cone cut	E Elongation (VA not steep enough)
IDD Incorrect density - too dark	F Foreshortening (VA too steep)
IDL Incorrect density - too light	FD Film placed too distal (missing the mesial of tooth)
N No film present	FM Film placed too mesial (missed the distal of tooth)
UU Unequal distribution of teeth (BWV only)	A Angled occlusal plane (arch not parallel to floor-or trim angled in mouth)
OO Occlusal overlap - VA incorrect (BWV only)	H Handling error (fingerprints, scratches, spots, etc.)
ME Mounting Error	BW Backwards film

STUDENT'S SECTION		INSTRUCTOR'S SECTION	
TECHNIQUE ANALYSIS		TECHNIQUE ERRORS & PTS	ANALYSIS ERROR & PTS
		RADIOGRAPHIC AREA	
		1. MAX RT MOLAR	
		2. MAX RT PREMOLAR	
		3. MAX RT LAT/CANINE	
		4. MAX CENTRALS	
		5. MAX LEFT LAT/CANINE	
		6. MAX LEFT PREMOLAR	
		7. MAX LEFT MOLAR	
		8. MAN LEFT MOLAR	
		9. MAN LEFT PREMOLAR	
		10. MAN LEFT LAT/CANINE	
		11. MAN CENTRALS	
		12. MAN RT LAT/CANINE	
		13. MAN RT PREMOLAR	
		14. MAN RT MOLAR	
		15. RT MOLAR BW	
		16. RT PREMOL BW	
		17. LET PREMOL BW	
		18. LET MOLAR BW	
		<b>DEDUCTIONS</b>	
PAPERWORK = 5 points Total EACH FILM = 5 points per film TOTAL = 100% TECHNIQUE ANALYSIS = 1 point each error ANALYSIS = 1 point each error		<b>PAPERWORK</b>	Grade calculation formula: Eamed points divided by Maximum # of points multiply x 100=FINAL GRADE  Example: 5 films (5 films x 5 points each=40) + 5 max paperwork points (45) - 5 errors (1 point each)=40-5=35 (eamed points)/45 (maximum # of points) x 100=78 FINAL GRADE
		<b>FINAL GRADE</b>	

**RETAKE POLICY:** Consult with your instructor concerning retakes. Penalty of -5 points for needed retakes are applied at the discretion of the instructor. Retake without instructor approval=0 points earned and radiology remediation

Instructor Retake Signature: \_\_\_\_\_ Instructor Grade Signature: \_\_\_\_\_  
 COMMENTS:

**BITEWING ANALYSIS**

BWX# \_\_\_\_\_ Radiology Room # \_\_\_\_\_  
 STUDENT: \_\_\_\_\_ DATE EXPOSED: \_\_\_\_\_ DATE SUBMITTED: \_\_\_\_\_  
 PATIENT: \_\_\_\_\_ AGE: \_\_\_\_\_ TYPE OF RADIOGRAPHS: 4 HBWX, 4 VBWX  
 (Circle one)

- |     |  |     |   |
|-----|--|-----|---|
| MG  | Magnified Image  | BL  | Blurred film                                    |
| OC  | Overlap of contact areas   | C   | Cone cut  |
| IDD | Incorrect density - too dark   | IDL | Incorrect density - too light                   |
| OB  | Open bite, patient not biting tab  | OO  | Occlusal overlap - VA incorrect (BWX only)      |
| N   | No film present  | FM  | Film placed too mesial (missed distal of tooth) |
| BW  | Backwards film   | FD  | Film placed too distal (missed mesial of tooth) |
| UD  | Unequal distribution of teeth (BWX only)                                   |     |   |
| Å   | Angled occlusal plane (arch not parallel to floor-or film angled in mouth) |     |   |
| ME  | Mounting Error   |     |   |
| H   | Handling error (fingerprints, scratches, spots, etc.)                      |     |   |

STUDENT'S SECTION TECHNIQUE ANALYSIS		RADIOGRAPHIC AREA	INSTRUCTOR'S SECTION	
Retakes			TECHNIQUE ERRORS & PTS	ANALYSIS ERRORS & PTS
		1. RT MOLAR BITEWING		
		2. RT PREMOL BITEWING		
		3. LFT PREMOL BITEWING		
		4. LFT MOLAR BITEWING		
		DEDUCTIONS		
PAPERWORK = 5 points Total EACH FILM = 5 points per film TOTAL = 100% TECHNIQUE = 1 point each error ANALYSIS = 1 point each error		PAPERWORK		Grade calculation formula: Eamed points divided by Maximum # of points multiply x 100=FINAL GRADE  Example: 5 films (5 films x 5 points each=40) + 5 max paperwork points (x45) = 5 errors (1 point each)=40 (eamed points)45 (maximum # of points) x 100=55 FINAL GRADE
		<b>FINAL GRADE</b>	_____ Eamed Points/_____ Max # of points x 100=_____	

**RETAKES POLICY:** Consult with your instructor concerning retakes. Penalty of -5 points for needed retakes are applied at the discretion of the instructor. Retake without instructor approval=0 points earned and radiology remediation.

Instructor Retake Signature: \_\_\_\_\_ Instructor Grade Signature: \_\_\_\_\_

COMMENTS:

**7-SERIES VERTICAL BITEWING ANALYSIS**

BWX# \_\_\_\_\_ Radiology Room # \_\_\_\_\_



STUDENT: \_\_\_\_\_ DATE EXPOSED: \_\_\_\_\_ DATE SUBMITTED: \_\_\_\_\_  
 PATIENT: \_\_\_\_\_ AGE: \_\_\_\_\_ TYPE OF RADIOGRAPHS: 7 VBWX

- |     |  |     |   |
|-----|--|-----|---|
| MG  | Magnified Image  | BL  | Blurred film                                    |
| OC  | Overlap of contact areas   | C   | Cone cut  |
| IDD | Incorrect density - too dark   | IDL | Incorrect density - too light                   |
| OB  | Open bite, patient not biting tab  | OO  | Occlusal overlap - VA incorrect (BWX only)      |
| N   | No film present  | FM  | Film placed too mesial (missed distal of tooth) |
| BW  | Backwards film   | FD  | Film placed too distal (missed mesial of tooth) |
| UD  | Unequal distribution of teeth (BWX only)                                   |     |   |
| Δ   | Angled occlusal plane (arch not parallel to floor-or film angled in mouth) |     |   |
| ME  | Mounting Error   |     |   |
| H   | Handling error (fingerprints, scratches, spots, etc.)                      |     |   |

STUDENT'S SECTION TECHNIQUE ANALYSIS		RADIOGRAPHIC AREA	INSTRUCTOR'S SECTION	
Retakes			TECHNIQUE ERRORS & PTS	ANALYSIS ERRORS & PTS
		1. RT MOLAR BITEWING		
		2. RT PREMOL BITEWING		
		3. RT CANINE/LATERAL BW		
		4. CENTRAL BITEWING		
		5. LFT CANINE/LATERAL BW		
		6. LFT PREMOL BITEWING		
		7. LFT MOLAR BITEWING		
		DEDUCTIONS		
PAPERWORK = 5 points Total EACH FILM = 5 points per film TOTAL = 100% TECHNIQUE = 1 point each error ANALYSIS = 1 point each error		PAPERWORK  <b>FINAL GRADE</b>	_____ Earned Points / _____ Max # of points x 100 = _____	Grade calculation formula: Earned points divided by Maximum # of points multiply x 100=FINAL GRADE  Example: 8 films (8 films x 5 points each=40) + 5 max paperwork points (=45) - 5 errors (1 point each)=40-9=40 (earned points)/45 (maximum # of points) x 100=88 FINAL GRADE

**RETAKE POLICY:** Consult with your instructor concerning retakes. Penalty of -5 points for needed retakes are applied at the discretion of the instructor. Retake without instructor approval=0 points earned and radiology remediation.

Instructor Retake Signature: \_\_\_\_\_ Instructor Grade Signature: \_\_\_\_\_

COMMENT S:

### PANORAMIC ANALYSIS

STUDENT: \_\_\_\_\_ PATIENT: \_\_\_\_\_ AGE: \_\_\_\_\_ DATE: \_\_\_\_\_

**PANOREX GENERAL CRITERIA:**

1. Image should be properly recorded in Eaglesoft patient record.
2. Image should be centered on film.
3. Density of film should be neither too dark or too light.
4. Overall image or any part of image should not be blurred.
5. Maxillary and mandibular teeth should not overlap, occlusally.
6. No foreign object should be superimposed on the film.

PROBLEM	RESULTING ERROR	STUDENT ANALYSIS		VALUE 0 TO 10	INSTRUCTOR'S ANALYSIS	
		YES	NO		YES	NO
1. Lips not closed or tongue not on palate	1. Dark shadow over anterior teeth, & max apices					
2. Chin too high, Frankfort plane angled upward	2. <b>Palate and floor of nose over roots of max teeth &amp;/or max incisors blurred and magnified &amp;/or "REVERSE SMILE"</b>					
3. Chin too low, Frankfort plane angled downward	3. <u>Mand</u> incisors blurred &/or <b>CONDYLES MISSING</b> &/or <b>"EXAGGERATED SMILE"</b> &/or Inferior border of <u>mand</u> missing					
4. Ant teeth too forward on bite block, out of focal trough	4. Ant teeth blurred &/or appear "skinny" & out of focus					
5. Ant teeth too far back on bite block, out of focal trough	5. Teeth blurred &/or Ant teeth appear "fat" & out of focus					
6. <u>Midsag</u> plane tipped (perpendicular light not centered)	6. Side of head farthest from film appears magnified, side closest appears smaller					
7. Spine not straight, patient slumped or neck bent	7. Cervical spine obscures center of film					
8. Incorrect density (light or dark)	8. Selected wrong patient type					
9. Ghost images or superimposed images	9. Failure to remove earrings, other head/neck jewelry or dental appliances					
10. Lead apron	10. Incorrectly places apron, or uses a thyroid collar					
11. Image not centered	11. Head not centered, slanted to the side					
12. Entry of data in all places	12. Pt data not complete on Pan, <u>exg</u> , or record					
1. TOTAL POSSIBLE (120) - POINTS DEDUCTED = TOTAL EARNED 2. TOTAL POSSIBLE ÷ TOTAL EARNED) x 100 = GRADE ( _____ ÷ 120 ) x 100 = GRADE		GRADE _____				

COMMENTS:

Revised: 08/14

**OCCLUSAL ANALYSIS**

STUDENT: \_\_\_\_\_ PATIENT: \_\_\_\_\_ AGE: \_\_\_\_\_ DATE: \_\_\_\_\_

**OCCLUSAL GENERAL CRITERIA:**

1. Type of radiograph taken should be properly recorded in notes.
2. Image should be centered on film.
3. Density of film should be neither too dark nor too light.
4. Correct Central Ray for projection
5. No foreign object should be superimposed on the film.

PROBLEM	RESULTING ERROR	STUDENT ANALYSIS		VALUE 0 TO 10	INSTRUCTOR'S ANALYSIS	
		YES	NO		YES	NO
1. Correct size sensor not used	1. Maxillary and/or mandibular teeth not imaged. Excessive cone cut.					
2. Central ray not directed toward the midline of the arch toward the center of the film	2. Teeth not centered on sensor. <b>Excessive overlap/blurred image</b>					
3. Central ray is not directed at +65 degrees toward the center of the film (Maxillary Topographic), +60 (Maxillary Lateral Occlusal, Pediatric), -55 (Mandibular Topographic, Pediatric), 90 (Mandibular Cross-Sectional).	3. Excessive cone cut, overlap, necessary maxillary/mandibular teeth not imaged.					
4. All removable appliances/objects not removed from mouth.	4. Ghost image or superimposed images.					
5. Incorrect density (light or dark)	5. Selected wrong <del>kVP</del> , mA, <del>time</del> .					
6. Processing or handling errors	6. Finger prints, scratches, exposed film etc.					
7. Entry of data not in all places	7. Type of radiograph not recorded in notes					
1. TOTAL POSSIBLE (70) - POINTS DEDUCTED = TOTAL EARNED 2. TOTAL POSSIBLE ÷ TOTAL EARNED) x 100 = GRADE ( _____ ÷ 70 ) x 100 = GRADE		GRADE _____				

COMMENTS:

0-0000-00000

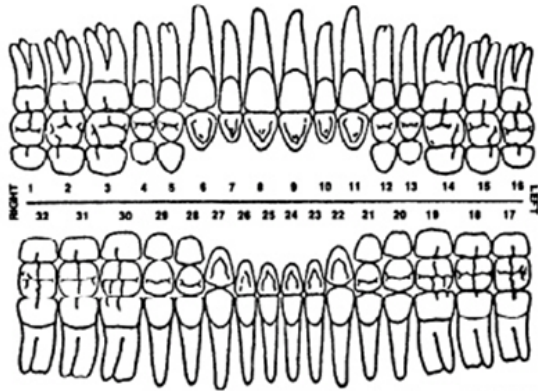
**Radiographic Interpretation**  
**Central Carolina Community College**

Student \_\_\_\_\_

Patient \_\_\_\_\_

Date of Exposure \_\_\_\_\_

BWX \_\_\_\_\_ FMX \_\_\_\_\_ PAN \_\_\_\_\_



Draw in a line for alveolar bone to represent height of bone.  
 Annotate carious lesions in red. Draw a blue c to represent calculus.  
 Anomalies: \_\_\_\_\_

July 30, 2014  
 RF 6

List radiopaque and radiolucent landmarks for each radiograph:

Maxilla:

R. Molar \_\_\_\_\_

R. Premolar \_\_\_\_\_

R. Lateral/Canine \_\_\_\_\_

Central \_\_\_\_\_

L. Lateral/Canine \_\_\_\_\_

L. Premolar \_\_\_\_\_

L. Molar \_\_\_\_\_

Mandible:

L. Molar \_\_\_\_\_

L. Premolar \_\_\_\_\_

L. Lateral/Canine \_\_\_\_\_

Central \_\_\_\_\_

R. Lateral/Canine \_\_\_\_\_

R. Premolar \_\_\_\_\_

R. Molar \_\_\_\_\_

Bitewings:

R. Molar: \_\_\_\_\_

R. Premolar: \_\_\_\_\_

L. Premolar: \_\_\_\_\_

L. Molar: \_\_\_\_\_



**SECTION EIGHT:**  
**Dental Materials**  
**Lab**

## SECTION 8                      Dental Materials Lab

### Working in the Laboratory

A schedule will be posted on the lab door for times the lab is free for students. A dental faculty member must be available to supervise in order for a student to work in the lab. Always double check to be sure an instructor is here and knows you are in the lab. Each student must sign in and have an instructor check him/her out before leaving.

The lab must be thoroughly cleaned before leaving. If the lab is left dirty by any student, lab privileges for the student will be revoked for the quarter. The use of the lab during the student's free time is a privilege. Don't abuse it.

### Model Trimmers

Model trimmers are expensive pieces of equipment. The machines must be properly cared for if they are to be kept in running order. Each student should take the responsibility to keep them properly maintained.

#### Operation Instructions for Model Trimmers

The following procedures must be adhered to when operating the model trimmer:

1. Wear your safety glasses, lab apron and pull your hair back.
2. Make sure machine is plugged in.
3. Make sure wheel is clean.
4. Turn on water valve on side of machine.
5. Turn on machine.
6. Water should run over wheel at all times.
7. Adjust water spray so that water does not splash.
8. Let the machine and water run for two minutes.
9. After use, follow maintenance instructions.

#### Maintenance of Model Trimmer

The following guidelines should be used in the general care and maintenance of the model trimmer:

1. Use water freely to keep wheel clean and sharp; check the spray tube to be certain that it is not clogged.

2. Before use, allow machine to run for two minutes; machines will often vibrate when first started due to water settling in the lower portion of the wheel; running the machine for a short while counteracts the vibration.
3. If motor refuses to start properly or begins to smoke, turn the machine off; continued use will burn up the motor.
4. At the end of use, allow wheel to run for two minutes; gradually pour in two green rubber bowls full of water over wheel; stop machine, use nail brush to scrub angle plate and wheel; turn machine on and give final rinse with a little water from bowl; clean out stone/plaster trap on side of machine; wipe off thoroughly to make sure no stone or plaster is left on the machine.

## Student Responsibilities

When a student uses the materials lab outside of class time, it is his/her responsibility to:

1. Put away supplies at end of each lab session.
2. Clean counters and lab benches in lab and prep room.
3. Replenish supplies such as model gloss, plaster, etc.
4. Clean model trimmers in lab and prep room.
5. Clean sinks in lab and prep room.
6. Clean lathes.
7. Sweep and mop floor in lab.

Please refer to the Sim Lab Assistant Evaluation form for detailed instructions to ensure lab cleanliness.

## Emergency Gas Shut-Off

In the event that a student believes there is a gas leak, notify the instructor.

## Supplies

The school provides for the students, at no additional charge, most of the materials needed for use in the dental materials lab. This is a privilege not to be abused. Supplies should not be wasted. Limits are not placed on the amount a student uses for the completion of a lab or to reach proficiency; however, we ask that the students be careful not to drop, spill, or contaminate materials. Tubes of materials should be wiped clean and returned to clean boxes. Molds should be left clean, free of stone and plaster. Bins of stone and plaster should be kept covered and scoops not transferred from one to another. When a student notices that supplies are running out, she should advise the instructor.

## Lab Bench Requirements

Each student will be issued the following instruments and supplies. They are issued at no cost to the student, but in the event an instrument becomes lost, damaged, or stolen, it must be replaced by the student. These are to be kept locked in the drawers provided. Expendable items such as cleaners will be continuously resupplied (upon request) by a lab instructor at the completion of a lab period.

### Student Supplies Purchased By Students

Protective lenses	Lab apron
Waterproof sandpaper	Ink pens
Pencils	Inch/cm ruler ruler

### Non-Expendable Items Furnished by Dental Department

Green rubber bowl	Alginate mixing bowl
Powder measurer	Plaster spatula
Curing light	Wood-handled Spatula
Glass plates (2)	#7 wax spatula
Amalgam	Amalgam well
Glass slab	Small Cement Spatula
Parchment mixing pad	Composite mixing pad
Lab knife	Dappen dish
Cement spatula	Dentiform (maxillary)
Amalgam carrier	Dentiform (mandibular)
Cotton pliers	Lab pan
Ball burnisher	Carver
Black Spoon	Dycal Instrument
Condensor/Plugger	Composite Instrument
R-50 Cord Packer	Matrix Retainer
Mirror	Explorer

### Expendable Items Furnished by Dental Department

2 x 2 gauze squares	Paper cups
Alcohol Prep Pads	Articulating Paper
Orange Solvent	Cotton Rolls

Name of Sim Lab Assistant \_\_\_\_\_

Date \_\_\_\_\_

**Key: Evaluate each step as: S = satisfactory or N = needs improvement****\*\*FE=Faculty Evaluation SA=Student Self-Assessment****\*\*Individual students are responsible for maintaining Station Drawers and Sim Manikins\*\*****Beginning of Lab Session**

	SA	FE	Tasks
1			SLA has arrived a minimum of 10 minutes prior to lab
2			<b>Compressors and Air units are turned on</b>
3			Sim Lab is clean and orderly
4			<b>Annotate any dirty areas or items left out:</b> ✓ - ✓ -
5			Create list of items needed from supply room to restock disposable items. ✓ -Gloves ✓ -Gauze ✓ -Masks ✓ -Hand Sanitizer ✓ -Disinfecting Wipes/Spray
6			Maintains asepsis

**Completion of Lab Session**

	SA	FE	Tasks
1			Ensure that individual Sim Manikins and stations are <b><u>clean</u></b> , free of debris and fully operational (Classmates should annotate any problems with Sim Manikins)
2			Clean countertops (spray, wipe, spray, wipe until no smear layer)
3			Clean ALL cabinets of dust, debris
4			Put away any supply items used during the lab session
5			Sweep/Mop any areas that have debris
6			Ensure that ALL water bottles are emptied
7			<b>Verify</b> Sim manikins are shut off & equip. replaced to original position
8			All dust, debris cleaned from base and crevices of operator chairs
9			Clean sinks then wipe with baby oil or orange solvent
10			Turn off all model trimmers (including water)
11			Restock supplies using list and refill all disinfectant wipe containers
12			<b>Verify</b> simulation lab is clean/closed (Annotate names of students in lab)
13			Maintained asepsis

Comments: \_\_\_\_\_

Instructor Signature \_\_\_\_\_

Date \_\_\_\_\_

Sim Lab Assistant Signature \_\_\_\_\_

Date \_\_\_\_\_

# **APPENDIX**

## **A**

**Appendix A: American Dental Assistant's Association Code of Ethics****CODE OF ETHICS****THE AMERICAN DENTAL ASSISTANTS ASSOCIATION PRINCIPLES OF ETHICS****FOREWORD:**

As an organization charged with representing a part of the professional individuals involved in the practice of dentistry, the American Dental Assistants Association has delineated the Principles of Ethics and the Code of Professional Conduct for members, officers, and trustees. The Principles of Ethics are general goals to which each member should aspire and are not intended to be enforceable as rules of conduct for dental assistants. The Code of Professional Conduct is intended for use as a guide for the evaluation of elected officials and members.

Each individual involved in the practice of dentistry assumes the obligation and maintaining and enriching the profession. Each member may choose to meet this obligation according to the dictates of personal conscience based on the needs of the human beings the profession of dentistry is committed to serve. The spirit of the Golden Rule is the basic guiding principle of this concept. The member must strive at all times to maintain confidentiality, and exhibit respect for the dentist/employer. The member shall refrain from performing any professional service which is prohibited by state law and has the obligation to prove competence prior to providing services to any patient. The member shall constantly strive to upgrade and expand technical skills for the benefit of the employer and the consumer. The member should additionally seek to sustain and improve the local organization, state association, and the American Dental Assistants Association by active participation and personal commitment.

# **APPENDIX**

## **B**



## **Appendix B      Code of Professional Conduct**

### **CODE OF PROFESSIONAL CONDUCT:**

As a member of the American Dental Association, I pledge to:

- ◆ Abide by the Bylaws of the Association
- ◆ Maintain loyalty to the Association
- ◆ Pursue the objectives of the Association
- ◆ Hold in confidence the information entrusted to me by the Association
- ◆ Maintain respect for the members and employees of the Association
- ◆ Serve all members of the Association in an impartial manner
- ◆ Recognize and follow all laws and regulations relating to activities of the Association
- ◆ Exercise and insist on sound business principles in the conduct of the affairs of the Association
- ◆ Use legal and ethical means to influence legislation or regulation affecting members of the Association
- ◆ Issue no false or misleading statements to fellow members or to the public
- ◆ Refrain from disseminating malicious information concerning the Association or any member or employee of the American Dental Assistants Association
- ◆ Maintain high standards of personal conduct and integrity
- ◆ To no imply Association endorsement of personal opinions or positions
- ◆ Cooperate in a reasonable and proper manner with staff and members
- ◆ Accept no personal compensation from fellow members, except as approved by the Association
- ◆ Promote and maintain the highest standards or performance in service to the Association
- ◆ Assure public confidence in the integrity and service of the Association

### **SECTION 1: Conduct of Members**

The conduct of every member shall be governed by the Principles of Ethics of the American Dental Assistants Association and of the constituent association and component society within

which jurisdiction the member is located. The member shall maintain honesty in all things, obedience to the dental practice act of the state in which employed and adherence to the professional ethics required by the employer.

## **SECTION 2: Obligations**

Every member of this Association shall have obligation to:

1. Hold in confidence the details of professional services rendered by any employer and the confidences of any patient.
2. Increase abilities and skills by seeking additional education in the dental assisting field, through services provided by this Association, the constituent associations and component societies.
3. Participate actively in the efforts of this Association and the constituent associations and component societies to improve the educational status of the dental assistant.
4. Refrain from performing any service for patients which requires the professional competence of a dentist, or is prohibited by the dental practice act of the state in which the member is employed.
5. Support these Principles of Ethics and the Pledge.

\*Principle of Ethics and Code of Ethics are the same thing.

# **APPENDIX**

## **C**

## **Appendix C     Dental Clinic Quality Assurance Plan**

### **Overview**

The provision of quality care is an expectation of the public and assuring that quality dental hygiene care will be provided is a major responsibility of the individual dental hygienist. As direct providers of care, dental hygienists are accountable for their actions. The purpose of the dental program's quality assurance plan is to establish standards and policies for evaluating the quality and appropriateness of oral health care provided by Central Carolina Community College's Dental Department.

The Dental Department stresses the importance of quality patient care through the Program's Philosophy Statement, Program Goals and Competencies, Statement of Patient Rights, Standards of Care, Clinic Policies, and Professional Responsibility Point System. Throughout the student's program enrollment, faculty encourages students to place patient needs over the completion of clinical requirements.

The quality assurance plan has been designed to provide a comprehensive framework for continuous review of established standards of patient care. By establishing high standards of care, as well as a system for monitoring and evaluating care, the program can identify continuous improvement goals.

### **Purpose**

The purpose of monitoring a process of care is to determine the quality of the dental procedures performed, the appropriateness of the treatment performed, the responsiveness of the treatment to the patient's needs, and the thoroughness of the documentation. The quality assurance plan serves as an assessment tool through which the dental hygiene program can determine strengths and areas needing improvement in the delivery of patient care.

### **Standards of Care**

Central Carolina Community College's Dental Program has adopted the Standards for Clinical Dental Hygiene Practice as defined by the American Dental Hygienist's Association. These standards focus on the provision of patient centered comprehensive care and evidence based practice. To ensure the standards are properly communicated, they are included in the Dental Hygiene Clinic Manual, which is distributed to all students, faculty, and staff.

### **Annual Review of Standards of Care**

Annually, the faculty reviews the Standards of Care, the Policy and Procedures Manual, the Dental Hygiene Clinic Manual, and the Infection Control, Hazard Control, and Radiation Protection Manuals to determine any necessary modifications and/or additions.

**The following are sources utilized in determining the need for changes in the Standard of Care:**

- Applicable federal, state and level statutes and regulations that define and guide professional practice.
- Updates provided by the American Dental Hygienist's Association.
- Accreditation Standards • Employer, Graduate, and Patient Surveys
- Advisory Committee
- Peer Review
- Clinical Site Evaluations
- Information obtained from dental meetings, conferences, and professional development.
- Feedback from adjunct faculty employed in private practices in the community.
- Student Evaluations

**Quality Assurance in the Clinic**

Numerous quality assurance procedures are implemented in the clinic to ensure high quality delivery of patient care. These procedures include the following:

- Dental Hygiene Clinic Manual
- Faculty oversight and review of patient care.
- Chart Audits
- Patient Satisfaction Surveys

**Dental Hygiene Clinic Manual**

The Dental Hygiene Clinic Manual is reviewed and revised as necessary on an annual basis. The Dental Hygiene Clinic Manual is distributed to all students and faculty and serves as a guide in the delivery of patient care in the clinic. The program's Standards of Care are included in the Dental Hygiene Clinic Manual. Standards of Care are stressed and reinforced in all clinical and didactic courses as noted in the course syllabi.

**Faculty Oversight and Review**

Faculty oversees and supervises all patient care provided by students in the clinic. A faculty member signs the medical questionnaire and drug summary, reviews the oral inspection and all charting, and approves the treatment plan. A patient classification system is utilized to ensure students do not perform patient care on patients whose needs are beyond the student's competency level.

During the treatment phase, an instructor is available to assist the student, observe clinical skills and interact with the patient. In the clinic, a flag system is utilized to indicate the student needs an instructor's assistance.

In the clinic, a flag system is used to indicate that students have completed a required task or need the help of an instructor.

**A. The flag system is as follows:**

1. **Black-** student is ready to have their Health Questionnaire and Drug Summary checked. A black flag is also used to request X-Rays.
2. **Blue-** student is ready to have their Intraoral/Extraoral Exam checked.
3. **Blue/Green-** Treatment Plan checked.
4. **Yellow-** student is ready to have a scale check.
5. **Green-** student is ready to have a polish check.
6. **Yellow/Green-** student needs scale and/or polish assistance from faculty.
7. **White-** student requests the help of DDS for anesthesia, dental charting, to check for decay, to evaluate X-Rays, to evaluate Health History, to request sealants, and/or to request dental/medical referral.
8. **Red-** Medical emergency.
9. **Blue/Yellow-** indicate student is ready to have a proficiency/competency graded.
10. **All-** Faculty review of clinical notes.
11. A plastic patient cup placed on top of your cabinet indicates you need help from the CA-screener.

This flag system provides the quality assurance that the student's work is checked and evaluated throughout the delivery of patient care.

**B. Evaluation Criteria, Tutorials, and Proficiencies**

Process evaluation is an evaluation that tests a particular skill independent of other skills being learned and demonstrated. When evaluating a procedure by process, each defined step of the procedure is personally observed by the assigned faculty member, ensuring that the student has properly executed each step. Examples of process evaluation include the tutorial, proficiencies, and the adjunctive service evaluations. Section 2 of the Clinic Manual addresses Evaluation Criteria, Tutorials and Proficiencies. Standards are established for the evaluation of each skill and guidelines are communicated to the students concerning the requirements for meeting the required proficiency. Through direct observation of proficiencies, faculty ensure the students are adhering to standards in the delivery of patient care.

**C. Clinic Privileges**

It is a privilege to provide oral health care to the public. As such, students must be compliant with the standards of care and rules and regulations. Given the trust of the public for the profession, the faculty plays a fundamental role in overseeing the treatment of any patient. As part of the partnership between the faculty and students, faculty continually monitor student performance in the clinic and gauge the well being of patients. Faculty are expected to withdraw the privilege of patient care at any time a student does not demonstrate skills and/or a level of knowledge that is necessary for the well being of patients.

**D. Medical and Dental Referrals**

In the Clinic Manual, section 5, provides comprehensive guidance concerning the necessity for the student to determine that the patient should receive a medical or dental referral. In reviewing the patient's health questionnaires the student is presented with many conditions which require them to decide whether treatment should be rendered or a medical consultation is indicated. Guidelines are provided for the students in order to assist with this decision. In reviewing a patient's restorative charting, periodontal charting or radiographs, many conditions present themselves that need to be referred back to the patient's dentist. In the clinical procedures, the student is provided guidance in making the decision that a dental referral is necessary. The faculty provides oversight and the final decision that medical and/or dental referrals are necessary.

**E. Monitoring the Completion of Patient Treatment**

Completion of patient treatment is an essential element of delivering quality patient care. The Dental Scoring Spreadsheet (DSS), utilized in the clinic, tracks completed and non-completed patients. Grade sheets of incomplete patients are transferred one semester to the next to indicate to faculty which patients have not been complete. Once a patient is accepted for treatment, all treatment must be completed before the student completes the program. Students must not allow for a large quantity of incomplete patients to accumulate. It is the students' responsibility to ensure that all patients are complete before completing the dental hygiene program. Students must submit to the faculty the rationale for any incomplete patient treatment, as well as a plan for completion. The instructor discusses any issues and or concerns with the student. Students must discuss their completion plan with the Clinic Coordinator. In May, a final incomplete patient print-out is obtained and the student is required to discuss their plans to complete the patient. If necessary, a system is in place whereby the patient could be re-assigned to the second year student's "little sister", who is currently a first year student.

**F. Chart Audit**

The dental record serves as the primary source of information documenting the care provided to the patient. On a regular basis, charts are audited based on the departments' standards of care. The faculty member conducts the chart audits using the Record Repair Form and notates the number of charts audited, the number of charts with discrepancies, and the number of charts with no discrepancies. The faculty member notates any discrepancy and discusses the chart audit report in a faculty meeting. Faculty provides suggestions and strategies to prevent the discrepancies in the future. The goal of evaluation through chart audits is to identify any problems and deficiencies in the provision of dental care, ascertain the cause of treatment deficiencies, and then inform faculty and students of these deficiencies so the department can improve their practice. Records containing deficiencies are identified to the student with a record repair form and the student must correct the chart entry by addendum and return record repair form annotating corrections to the instructor within 48 hours. Chart audit results and strategies are emailed to all faculty and results are reviewed with the students. The results are compared with those from previous semesters to document improvements or to identify the need for additional interventions.

**G. Patient Satisfaction Surveys**

Patient's perceptions of quality of care are documented by the Patient Satisfaction Surveys and through daily interaction in the clinic. Patient Satisfaction Surveys are requested after each patient has been treated in the clinic. The department head and faculty appropriately handle legitimate complaints and regularly interact with patients to ensure their satisfaction with patient care services. At the end of the semester, patient satisfaction surveys are summarized and data is shared with faculty and students to facilitate the ongoing improvement of services and professionalism.

**H. Quality Assurance for Radiography**

Quality Assurance is included as part of the Radiation Protection Manual as follows:

**1. Film Processing and Quality Assurance:****Basic Procedures**

- a. Unexposed film is stored in the storage unit and filing cabinet located in the radiology viewing area. Do not take film without an instructor's permission.
- b. Process films according to the specifications that is located above the processors in the darkroom.
- c. Always check expiration dates on film and the chemicals used in the processor. Do not use films or chemicals after the expiration date.
- d. If you find film or chemicals with expired expiration dates, give them to the Radiation Safety Officer (RSO). Also, when you notice that the supply of film or chemicals is low, notify the RSO.
- e. **When using an automatic processor:**
  - i. The clinical assistant in charge of the darkroom will turn the processors on and perform routine maintenance and quality control procedures at the beginning of each clinic. Do not process until quality control procedures have been performed and a notice has been placed on the darkroom door.
  - ii. The RSO is in charge of maintaining the processor according to the manufacturer's instructions. Do not open the processor or change settings without the permission of an instructor.

**2. Quality Assurance (QA) Tests**

- a. QA procedures for the automatic processor will be performed at the each lab or clinic session. The clinic assistant will utilize the visual image comparison method daily to test the automatic processor. If a problem occurs, the RSO should be notified immediately.
- b. QA procedures for the dental x-ray machines will be performed each semester by the RSO. The visual image comparison method will be used on the first clinic day of each semester.
- c. Safelight/darkroom checks will be performed on the first clinic day of each semester by the RSO.
- d. Records of the QA tests designated above and other services are located in the Radiology Viewing Area.



**Summary**

The Dental Department at Central Carolina Community College strives to provide opportunities for dental students to discover their talents and abilities and to achieve individual excellence in the delivery of patient care. The faculty and staff continuously encourage high ethical and professional behavior. Patient centered services are delivered from the perspective that the patient is the main focus of attention, interest and activity, and that the patient's needs are of utmost importance in providing care. The Quality Assurance Plan is designed to provide a framework for the assessment and evaluation of this high quality delivery of patient care.

- *This version of the Central Carolina Community College Dental Hygiene Clinic Manual was updated as of July 30, 2014. The guidelines and changes that have occurred in this version apply to both First Year and Second Year Dental Hygiene Students of the Central Carolina Dental Hygiene Program as decided upon by the Dental Hygiene Faculty.*