



**UNIVERSITY OF CONNECTICUT
SCHOOL OF DENTAL MEDICINE**

DENTAL CLINIC MANUAL

2008-2009

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INTRODUCTION

The University of Connecticut School of Dental Medicine offers comprehensive dental care provided by predoctoral dental students in multidisciplinary clinics or by postdoctoral dental residents receiving advanced training under the supervision of licensed clinical faculty. University Dentists, a faculty group practice, also provides comprehensive and specialized care for patients wishing to be treated by faculty.

The Clinic Manual gathers into one publication the principal policies and procedures for the management and care of patients in the School's predoctoral and postdoctoral clinics. Selected policies and procedures may also be adopted by University Dentists.

The Dental Clinics operate under specific policies adopted by the Clinical Affairs Committee [CAC]; some policies may have been approved and adopted by its predecessor, the Executive Committee of the Dental Staff [ECDS]. The Dental Clinics also follow policies adopted by the University of Connecticut Health Center and the University of Connecticut Health Center's John Dempsey Hospital when appropriate.

PATIENT CARE

Student providers are expected to greet all patients promptly for scheduled appointments. In circumstances where there is an unforeseen delay, patients should be informed as soon as possible. Patients should be seen in a timely manner, unless there are special circumstances such as medical issues, patient vacations, or work related commitments. It is the policy of the clinics that assigned patients should be seen at a minimum of once every forty-five (45) days to ensure appropriate continuity and progress of comprehensive care. Any lapse in continuity of care must be appropriately documented in the patient record.

PATIENT REGISTRATION AND SCHEDULING

All patients of the Dental Clinics will be issued a patient identification number (TOO#) during patient registrations on or before their initial visit to the University of Connecticut Health Center. The patient identification number is also known as the medical record number (MRN). An electronic database record containing demographic information is created and an identification number is permanently assigned to the patient in IDX, the Health Center's patient information system. The Dental Clinic's information management system, Quick Recovery, will automatically interface with IDX to populate the patient demographic database. The MRN is the medico-legal method that identifies the patients in all areas of the University of Connecticut Health Center and is required prior to the provision of any care in the dental clinics.

Scheduling of patients is the responsibility of the clinic reception staff. Predoctoral dental students will work with clinic reception staff to ensure appropriate scheduling of their assigned patients. Postdoctoral residents in specific training programs may be granted the authority and information system security to schedule patients directly.

The following is the School of Dental Medicine's policy pertaining to scheduled appointments. Strict compliance with the policy must be adhered to for every patient visit:

Patients are expected to be responsible and diligent in keeping scheduled appointments. If a patient fails to keep two consecutive appointments or three non-consecutive appointments without due notice to the provider, further treatment in the clinics may be denied. All missed or broken appointments must be appropriately documented in the patient record and in the information system. Patients should receive warning letters reminding them of the missed appointment policy. Patients shall be given final opportunities to continue their treatment or be removed as an active patient in the program.

Patients are expected to be on time for their appointments. If a patient arrives more than twenty (20) minutes late for a scheduled appointment, the patient may be denied treatment for that visit. The determination if a patient may be treated following a late arrival must be made in consultation of supervising faculty preceptors; the determination should be made in consideration of the planned treatment.

DENTAL CLINICS

The Dental Clinics in the School of Dental Medicine include:

At the University of Connecticut Health Center (Farmington, CT):

Dental Clinic #1	Postdoctoral Prosthodontics Postdoctoral Periodontics Predoctoral Periodontics
Dental Clinic #2	Postdoctoral Endodontics Predoctoral Endodontics
Dental Clinic #3	Predoctoral Team Clinic Treatment Planning Periodontics Operative Dentistry Prosthodontics
Dental Clinic #4	Predoctoral Team Clinic Treatment Planning Periodontics Operative Dentistry Prosthodontics
Dental Clinic #5	Advanced Education in General Dentistry Dental Emergency Service
Dental Clinic #6	Advanced Education in General Dentistry University Dentists
Dental Clinic #7	Postdoctoral Orthodontics Predoctoral Orthodontics University Dentists (Orthodontics)
Dental Clinic #8	Postdoctoral Oral and Maxillofacial Surgery Predoctoral Oral and Maxillofacial Surgery University Dentists (Oral and Maxillofacial Surgery)
Dental Clinic #9	Screening (Patient Intake) Oral Medicine/Oral Diagnosis Postdoctoral Oral and Maxillofacial Radiology Predoctoral Oral and Maxillofacial Radiology

At extramural sites:

Bank of America/Burgdorf Health Center	Postdoctoral Pediatric Dentistry Predoctoral Pediatric Dentistry
Connecticut Children's Medical Center	Postdoctoral Pediatric Dentistry Predoctoral Pediatric Dentistry

All clinical assignments and discipline allocation are subject to change according to patient care and educational needs. Clinical schedules will be established by the Clinical Affairs Committee and posted and distributed by the Office of Dental Clinical Affairs. The schedule is established to ensure appropriate availability of faculty preceptors for each clinical discipline.

All predoctoral student care must be scheduled in the appropriate clinic according to the posted schedule. Every effort must be made to ensure that patients are scheduled in the appropriate clinic based upon the planned treatment discipline. Deviations from the established clinical schedule may be made only with the approval of the predoctoral Team Leader or the Associate Dean for Education & Patient Care.

STANDARDS OF CARE

Consistent with its mission, the School of Dental Medicine is committed to providing high quality, comprehensive oral health care. The Standards of Care document is intended to be a source of information for students, residents, faculty, and staff engaged in patient care. In addition, it serves as a guide for evaluating quality of care as part of the School of Dental Medicine's Quality Measurements and Improvement (QMI) program.

STANDARDS OF CARE

SIX STANDARDS BASED UPON NATIONAL COMMITTEE ON QUALITY ASSURANCE (NCQA) STANDARDS

- I. **QUALITY** (*patients will receive high quality care*)
 - A. Patients will receive high quality care.
 - B. Patients will receive the most appropriate care the School can provide without regard to race, sex, national origin, color, religion, age, or disability.
 - C. Patients will receive a comprehensive or limited treatment plan including a hard and soft tissue exam and a head and neck exam prior to the initiation of care.
 - D. Patients will receive oral health care integrated with their total health care.
- II. **CREDENTIALS** (*patients will receive care from trained, licensed, or supervised personnel*)
 - A. Patients will receive care from appropriately trained providers.
 - B. Faculty members involved in patient care will be duly credentialed.
 - C. All providers involved in patient care will be certified in basic life support.
- III. **PATIENTS RIGHTS AND RESPONSIBILITIES** (*patients will receive adequate and appropriate information about school policies, procedures, options, and their responsibilities*)
 - A. Patients will be informed of their rights prior to the initiation of care.
 - B. Patients will be informed of their responsibilities and obligations prior to the initiation of care.
 - C. Patients will be adequately informed of treatment options prior to care being rendered.
 - D. Patients will be adequately informed of risks and benefits of treatment prior to care.
 - E. Patients will be treated with respect and dignity.
 - F. Patients will be treated in a safe environment.
- IV. **UTILIZATION AND MANAGEMENT** (*patients seeking treatment will receive appropriate evaluation and care*)
 - A. Patients will be treated in a timely manner consistent with the care being rendered.
 - B. The patient's chief complaint will be addressed in the treatment plan.
 - C. Treatment will progress in a logical, orderly fashion consistent with control of oral disease.
- V. **RECORDS** (*dental records will be maintained in a manner that is current, detailed, organized, and permits effective and confidential patient care and quality review*)
 - A. The patient record will be established and maintained to include documentation of all demographic data, medical and dental history, examination findings, consultations, radiographic and diagnostic data, and treatment procedures.
 - B. Patient records will be maintained in a manner that provides for access while maintaining patient confidentiality.
- VI. **PREVENTIVE HEALTH SERVICES** (*patients will be instructed on the maintenance of oral health and will receive appropriate follow-up visits*)
 - A. Patients will receive an evaluation of oral health risks and appropriate interventions offered.
 - B. Patients will receive appropriate follow-up consistent with oral and peri-oral findings.
 - C. Patients will be instructed on both the prevention of oral disease and the maintenance of oral health.
 - D. Patients will be offered continued oral health services following completion of active care.

PATIENT INFORMATION AND SCHOOL OF DENTAL MEDICINE TREATMENT POLICY

A patient information packet, explaining School of Dental Medicine clinic policies regarding patient rights and responsibilities as well as the treatment policies of the School, will be provided to each patients at their initial screening appointment. The information is also available on the School's website. Student and resident providers should be familiar with the information provided and ensure that their patients have read and understand the information.

PATIENT RIGHTS AND RESPONSIBILITIES

The faculty and staff of the University of Connecticut School of Dental Medicine are here to provide you with the best dental treatment possible. We believe that you have entrusted us with your dental care, therefore you have a right to receive certain considerations from the School of Dental Medicine.

1. **You have the right** to the most appropriate care the School can provide for your problem, without regard to race, gender, sexual orientation, national origin, color, religion, age, or disability.
2. **You have the right** to be treated kindly and respectfully by all personnel; to be addressed by your proper name and without undue familiarity; and to be assured that your individuality will be respected.
3. **You have the right** to know which members of the health care team (dental student, resident, and/or faculty member) are directly responsible for your care, including their names.
4. **You have the right** to ask your dental student and other members of the health care team questions and to receive answers from them concerning your dental condition, treatment and plans for your care.
5. **You have the right** to discuss any treatment, procedure, or operation planned for you with members of the health care team so that you may understand the purpose, probable results, and/or alternatives and risks involved before consenting to the agreed upon treatment plan.
6. **You have the right** to know what we feel is the optimal treatment plan for you as well as the right to ask us to modify or scale down that optimal plan to fit within your financial or time constraints, if possible.
7. **You have the right** to request an appointment to have your record reviewed by a faculty member who is familiar with your treatment.
8. **You have the right** to receive an estimate of the cost of dental treatment and to be informed of changes in the total cost, if changes in your treatment plan occur.
9. **You have the right** to withdraw consent and to discontinue participation in the treatment or activity at any time.
10. **You have the right** to receive assistance in the case of dental emergency.

**TREATMENT POLICIES OF THE SCHOOL OF DENTAL MEDICINE
[PATIENT RESPONSIBILITIES]**

We believe that we should be able to expect you, the patient, to help us accomplish our mutual goals by recognizing that you play an important part in your own care.

1. ***You are expected*** to provide members of the health care team with complete and accurate information regarding any health care problems you have or have had in the past and any medications or treatments you currently receive.
2. ***You are expected*** to keep appointments and meet financial payment obligations promptly so that care can be provided in the most efficient manner.
3. ***You are expected*** to follow the directives of the health care team and cooperate with all persons caring for you and to ask questions if you do not understand these directives.
4. ***You are expected*** to express complaints or concerns to the appropriate supervisory persons.
5. ***You are expected*** to be respectful and considerate of other patients.
6. ***You are expected*** to recognize that the School of Dental Medicine is an educational institution, and that dental treatment may proceed at a pace slower than you had anticipated.
7. ***You are expected*** to understand that the treatment provided is the best the health care team can provide but that there are no guarantees of permanence in any repair or treatment provided.

PATIENT SELECTION AND ACCEPTANCE

Patients are evaluated for acceptance into the School of Dental Medicine Dental Clinics at an initial *screening* appointment. All patients must be screened prior to assignment for comprehensive care in the predoctoral clinical program. Postdoctoral residency programs may elect to accept patients directly into their patient care programs without an initial screening appointment; such assignments are generally limited to patients requesting limited care or patients referred to a particular program by another health care provider.

At the screening visit, a faculty member determines a patient's global dental and medical status, their appropriateness for treatment by either a predoctoral or postdoctoral student is evaluated, and their ability to fulfill financial obligations is reviewed. All patients presenting for screening may not be accepted into the clinical programs.

Patients may be referred for a radiographic examination following the screening appointment. In general, patients accepted for treatment in the predoctoral program must have a radiographic examination prior to assignment to a student provider. Patients may provide the School with dental radiographs taken elsewhere, but radiographs taken elsewhere will be assessed for their diagnostic quality and appropriateness.

Records of patients accepted into the predoctoral program will be reviewed by the Team Leaders and assigned to primary and/or secondary student providers by the Team Leader. The assignment will be made based upon the global assessment made during the screening appointment and the educational needs of the students.

A complete and thorough treatment plan must be prepared for all patients following screening and acceptance. A sequential treatment plan must be completed prior to initiating any treatment except for emergency care. Only after a comprehensive treatment plan has been discussed and approved by the patient, discipline based faculty, team leader, and patient financial services, can the student begin treatment. In some instances (such as where final treatment cannot be determined until Phase I therapy is completed), a Phase I only treatment plan is developed prior to determining the need for additional, definitive (Phase II) care.

All planned treatment must be entered into the clinical information system and signed by the patient, provider, and patient financial services. The executed document serves as a guide to the patient's agreed-upon treatment and also as the basis for general consent for treatment; it also serves as a basis for a payment arrangement.

TREATMENT SUPERVISION

Each clinical procedure performed on a patient by a student provider must be supervised by a licensed clinical faculty preceptor. This includes any treatment provided to another student, friend, or family member. It is against University of Connecticut Health Center regulations and a violation of the Connecticut State Dental Practice Act for student providers to provide unsupervised dental care. Violation of this rule will result in the student's immediate dismissal from the clinics.

A faculty preceptor's permission is required to initiate a clinical procedure on a patient. A faculty preceptor must be present in the clinic until all work is completed and the patient has been dismissed from the clinic. Students must comply with regular clinic hours at all times to allow for proper faculty preceptor supervision.

All clinical procedures should be planned to permit adequate time at the conclusion of the clinic session to complete all necessary documentation and data entry. In general, care is recommended to be completed approximately twenty (20) minutes prior to the end of the clinic session.

PATIENT CONSENT

All consents for care must be signed and placed in the patient record prior to initiation of treatment. The patient must sign a general consent for examination prior to any evaluation. The treatment plan document provides for consent for planned treatment. Specific clinical procedures (i.e. surgical treatment) may require an additional, procedure specific consent process. Written documentation of consent must be signed by all adult patients who possess the capability for participate in the informed consent process. For patients who are not of legal age, or those who require a legal guardian, consent for care must be documented and signed by the parent or legal guardian.

The informed consent process is, in general, valid when all five of the following components are satisfied:

1. **Voluntariness** is a precondition whereby patients must not be coerced into making a decision and must be free from unfair persuasions and inducements.
2. **Information disclosure** includes informing patients of the nature of the procedure, its risks and hazards, anticipated benefits, and alternatives and risks and benefits of no treatment.
3. **Competence** indicates that a patient has the capacity to comprehend the disclosed information.
4. **Understanding** assures that once a competent patient is provide with information, he or she will understand it and be able to make a reasoned decision concerning treatment.
5. **Decision** results in the patient's accepting (i.e. consenting) or not accepting (i.e. refusing) treatment.

The following is the informed consent policy regarding the management and treatment of dental emergencies in which a minor is involved and is brought to the clinic by someone other than parent or legal guardian. Siblings, friends, or any persons other than legal guardian cannot provide consent. In instances where a minor presents with a dental emergency and is not accompanied by a parent or legal guardian, efforts should be made to obtain the consent of the parent or guardian before treatment is begun.

Telephone consent is valid when the following rules are observed:

1. The situation falls within the definition of an acute dental emergency. An emergency exists when the patient is experiencing immediate need for medical or dental attention and failure to secure consent for treatment would result in delay of treatment, increasing the risk to the patient's health or life.
2. The dental provider or one of the trained auxiliaries in the clinic makes a conscientious effort to contact one of the parents or guardian(s). Either parent may grant consent for a minor child except in the case of divorce where only one parent has legal custody.
3. A third party, not involved in the direct provision of care, listens to the conversation on the telephone and the parent is informed that the third person is listening.
4. The provider explains the situation to the parent or guardian and includes all the elements required for the consent to be valid.
5. Notes are made in the patient record of the conversation which are signed by all parties to the telephone contact.
6. A follow-up written consent is sent to parent or guardian for signature and subsequently placed in the patient record.

If neither parent nor guardian can be located, notes must be made in the patient record about the nature of the emergency, why immediate care was necessary, the care provided, and the fact that all attempts to reach the parent(s) or guardian(s) failed. In general, if a dentist, in the treatment of a minor, is of the opinion that any delay would compromise the dental or overall health of the patient, he or she may initiate the necessary treatment without obtaining parental or guardian consent, but only after reasonably attempting to locate a parent or guardian.

Emancipated minors do not require parental or guardian consent. A minor, in the State of Connecticut, is considered to be emancipated if (1) the minor is married, (2) the minor has military service, (3) the minor is a parent themselves, (4) the minor is willingly living apart from parent(s) and managing their own finances, or (5) a court has determined that it is in the minor's best interests to be independent from the parent(s).

If a provider has concerns about a patient's ability or competence to participate in the informed consent, the concerns should immediately be brought to the attention of a faculty member, Team Leader, or Associate Dean. Faculty may consult with the Office of the Attorney General for further clarification.

PREDOCTORAL TEAM CLINICS

The School of Dental Medicine's predoctoral student clinics are organized into two practice groups or Teams. A faculty Team Leader, supported by a Patient Care Coordinator, leads each Team. The Team Leader and the Patient Care Coordinator monitor all patient management, care delivery, and student progress. The Team Leader bears responsibility for the care of patients assigned to the Team. At the discretion of the Team Leader, patients may be assigned to a primary care provider and a variable number of secondary care providers. Multiple providers ensure that patients will receive timely, appropriate, comprehensive care independent from individual student progress. The team structure encourages and supports "clinic partners" between Year 3 and Year 4 students; patients may be concurrently treated by Year 3 and Year 4 students, with each student providing care commensurate with their level of training. Students are assigned to their team in Year 1, so that clinical experiences throughout the four year curriculum may be integrated within the team. Patients may also be treated by members of both clinical teams when deemed appropriate by the Team Leaders.

MANAGEMENT OF DENTAL EMERGENCIES

Patients of record of the School of Dental Medicine presenting with acute dental emergencies will be managed in their assigned area. Patients of record of the predoctoral program will be treated in the assigned Team. If the primary or secondary provider is unavailable (i.e. on extramural rotation), another member of the Team will be assigned to manage the patient's emergent issue as determined by the Team Leader or Patient Care Coordinator.

Patients of record presenting with dental emergencies while the predoctoral team clinics are not in session will be managed by the Dental Emergency Service, a component of the School's Advanced Education in General Dentistry residency program.

Unassigned patients (not currently patients of record) are seen by the Dental Emergency Service. The service provides 24 hour, 7 day per week coverage for the diagnosis and management of all dental emergencies. Emergency dental care on evenings, weekends, and holidays is provided by the service through the Emergency Department of John Dempsey Hospital.

If a patient of record contacts a predoctoral student provider and reports an acute emergency outside of regular clinic hours, the student should contact the resident on-call and discuss the patient's chief complaint.

STUDENT EVALUATION SYSTEM

The School of Dental Medicine provides care based upon patient needs, not on institutional or student requirements. Student advancement in the clinical domain is determined by an experience monitoring system and successful completion of competency based evaluations. The experience monitoring system provides experience credits for completed procedures and for completion of patient cases and re-evaluations. All procedures are proportionally weighted based upon estimates of the number of clinical hours that a student should require, on average, to complete the procedure.

Students will be provided with a report on their experience credits on a regular basis as a component of the Academic Performance Committee reports.

Students will be evaluated on domains of practice management, patient management, and professionalism by the respective Team Leaders on a regular basis as a component of the Academic Performance Committees reports.

PATIENT FINANCIAL SERVICES

Policies related to patient financial transactions must be followed during the treatment of all patients cared for by predoctoral students and postdoctoral residents in the School of Dental Medicine clinics. All predoctoral students, postdoctoral residents, and clinical faculty preceptors are responsible for implementing the policies.

Patients treated at the University of Connecticut School of Dental Medicine's predoctoral students and postdoctoral residents pay fees for dental care at reduced rates because of the additional time required to deliver the care. In general, fees for care provided by predoctoral dental students will be approximately 33-50% of prevailing community fees while fees provided by postdoctoral residents will be approximately 50-67% of prevailing community rates.

Patient financial arrangements related to care must be agreed upon prior to all limited or comprehensive care and adhered to by students, residents, and faculty during the course of treatment.

SCHOOL OF DENTAL MEDICINE TREATMENT FEES

The School of Dental Medicine clinics currently maintain four fee schedules: (1) predoctoral students – patients under the age of 21; (2) predoctoral students – patients 21 years of age and older; (3) postdoctoral residents – patients under the age of 21; (4) postdoctoral residents – patients 21 years of age and older.

American Dental Association Current Dental Terminology (CDT) coding is used to establish the coding within the clinic fee schedules. Certain clinic codes are internal codes, created specifically for the purposes of the School's clinics. Such internal codes will be tied to CDT codes for billing purposes.

School of Dental Medicine fee schedules are evaluated and revised on an annual basis or when deemed necessary by the Clinical Affairs Committee. Fee schedules are distributed by, and are available from, the Office of Dental Clinical Affairs and Patient Financial Services.

A dental procedure in progress at the time of a fee schedule change is billed at the fee in effect at the documented time the procedure was initiated. All financial arrangements, treatment plans, and financial contracts include a statement that the agreed upon fees are subject to change.

FINANCIAL ARRANGEMENTS

Patient treatment plans and patient case agreements must be signed by each patients prior to all care except for emergency care. A provider must not commence treatment without a fully executed treatment plan and cash agreement.

POLICY ON FINANCIAL RESPONSIBILITY FOR PATIENT CARE

It is imperative that a treatment plan be completed and discussed with all patients prior to the delivery of comprehensive or limited care. A treatment plan serves not only as a guide to the patient's agreed-upon treatment, but also as the basis for financial agreement.

With the exception of emergency care, no treatment may commence without a valid treatment plan in place.

All predoctoral and postdoctoral student providers assume financial responsibility for any and all treatment provided by them on their respective patients in the absence of a signed, fully executed treatment plan.

All financial liabilities must be cleared prior to completion of the predoctoral or postdoctoral program.

Approved by ECDS May 4, 2005
Implementation July 1, 2005

PAYMENT OF FEES

The School of Dental Medicine clinics operate with the general policy that dental care must be paid for at the time of treatment. Payment can be made in the form of cash, check, Master Card, or Visa. Partial prepayments (50%) are required for limited care procedures, all procedures involving laboratory costs, and endodontic treatment. Extended payment plans are offered only for comprehensive orthodontic treatment and extensive treatment plans with prior approval by predoctoral Team Leader or postdoctoral residency program director and the Associate Dean for Education & Patient Care.

THIRD PARTY PAYERS

The School of Dental Medicine only directly bills third party payers for Medicaid and Medicare covered services. For patients with other types of coverage, Patient Financial Services will provide a record of treatment to any patient with dental insurance so that the patient may submit a claim and be directly reimbursed by the insurance carrier to the extent coverage allows.

FEE REDUCTION AND EXEMPTION POLICY

Most School of Dental Medicine predoctoral and postdoctoral clinic fees are less than the usual, customary, and reasonable fees for the region. Fee waivers and reductions in the stated fees will be managed on an individual basis and a determination made by the predoctoral Team Leader or the respective residency program director. All fee reductions and waivers must be approved by the Associate Dean for Education & Patient Care.

Fee adjustments will generally fall into one of the following categories:

Educational: fees may be reduced or waived in a limited number of circumstances when the treatment is unusual in nature and valuable to the training program or while not unusual, of specific teaching value. Fees may also be waived or reduced in situations when a service is not covered by a third-party payer, however the service is required to provide quality continuity of care.

Boards: fees may be reduced or waived in circumstances when the treatment indicated is appropriate for specific examination scenarios and the patient would not otherwise be capable for paying for the service.

Post-treatment: fees may be reduced or waived in situations where treatment or services were rendered and because of extenuating circumstances, further direct retreatment (redo) or secondary treatment (redress) may be required.

POLICY ON INDIVIDUALS WITH FINANCIAL HARDSHIP

The University of Connecticut School of Dental Medicine provides dental services at significantly reduced rates. Fees are required to maintain quality of patient care and to cover basic expenses in maintaining the teaching programs. The School, as a component of the University of Connecticut Health Center, offers Charity Care for patients who meet certain eligibility requirements and have medically necessary care. Patients must apply for Charity Care with Patient Financial Services to be considered. The Charity Care policies do not provide for reduction of fees for comprehensive dental treatment.

SUSPENSION OF CARE OF PATIENTS WITH OUTSTANDING BALANCES

Patients are expected to remain current on their financial responsibilities. Patients with outstanding balances will be counseled by Patient Financial Services. Should a patient's financial balance become excessive with no recent payment history (i.e. greater than \$500 with no payments for greater than 60 days), further treatment may be postponed. All decisions to postpone or suspend care because of an outstanding account balance must be made by the Associate Dean for Education & Patient Care in consultation with Patient Financial Services and the assigned provider.

CLINICAL HOURS OF OPERATIONS

Regular clinic hours of predoctoral and postdoctoral dental clinics are Monday through Friday, from 9 am – noon and from 1 pm – 5 pm. On certain days of the week, afternoon clinic sessions for the predoctoral clinics may begin at 2 pm to accommodate didactic sessions and administrative functions.

Regular clinic hours of postdoctoral dental clinics may be modified or altered by the respective residency program director to accommodate the educational program.

No patient treatment is permitted outside of a regularly scheduled clinic session.

CLINIC ATTIRE

It is the responsibility of each predoctoral dental student, postdoctoral resident, staff, and faculty preceptor to maintain proper dress and a well-groomed, professional appearance. All apparel worn by students, residents, staff and faculty in the clinical area must consist of either professional clothing or appropriate scrubs. Scrub uniforms must be deemed to be acceptable by the clinic administration. If scrubs are worn outside the immediate clinical area, they must be covered by a white clinic/laboratory coat.

All individuals involved in clinical treatment must wear clean protective apparel; protective apparel is defined as School of Dental Medicine approved personal protective equipment (PPE)/precaution garments. All individuals involved in patient care must routinely wear precaution garments to prevent occupational exposures and to prevent soiling of street clothing whenever contact with any blood, saliva, bodily fluids, or aerosol is anticipated. Precaution garments must not be worn outside the immediate clinic area. Immediate clinic area is defined as dental operatories, the immediate surrounding clinical area, and the associated service corridors. Reception areas, restrooms, offices, general traffic corridors, lobbies, waiting rooms, record room, and patient financial services are not immediate clinic areas.

Jeans, tee-shirts, shorts, sandals, or unprofessional sneakers are never acceptable, are not professional attire, and therefore must never be worn in the clinical area.

Anyone in violation of the attire policy will be dismissed from the clinics.

CREDENTIALING OF CLINIC PARTICIPANTS

Each predoctoral student, postdoctoral resident, clinical faculty preceptor, and clinical staff member who has direct contact with patients in clinic are to be credentialed through the Office of Dental Clinical Affairs. Predoctoral dental students credentialing includes acceptable progress through the curriculum as determined by the Academic Performance Committees along with compliance with infection control, basic life support and bloodborne pathogen training. Postdoctoral resident credentialing includes acceptable progress through the residency program (as defined by the respective program) and compliance with infection control, basic life support and bloodborne pathogen training along with compliance with health center and state regulations which may vary amongst the residency programs. Faculty credentialing ensures compliance with requirements for professional licensure, basic life support, infection control and bloodborne pathogen training and compliance with health center and state regulations.

QUALITY MEASUREMENTS AND IMPROVEMENT

Quality assurance includes all activities that ensure that the quality of care provided to patients is of high quality. Quality of care is the degree to which patient services increase the probability of desired outcomes and reduce the probability of undesired outcomes. The Quality Measurements and Improvement Committee is charged with the implementation of activities to assess the quality of care provided in the clinical areas, evaluation of data to assess care, reassessment of data following implementation of corrective actions, and the development of process improvement.

A variety of quality measurement and improvement activities are conducted by faculty and staff on an ongoing basis. Patient satisfaction surveys are administered to patients to monitor the degree to which patients' expectations regarding various aspects of patient care are being met. Individual student record audits are conducted by team members and QMI staff to assess compliance with record keeping requirements (procedural audits) and the adequacy of patient care (analytical audits). Focused reviews using information obtained from chart audits and/or information obtained from other data sources are conducted to monitor and evaluate performance in specific aspects of clinical care. Results of these activities are discussed at monthly QMI meetings and, when necessary, are referred to the Clinical Affairs Committee or appropriate members of the administration for the development or modification of policies and procedures.

RISK MANAGEMENT

One of the most important elements of appropriate dental claims management is effective incident reporting. The Associate Dean for Education & Patient Care has responsibility for risk management for the School of Dental Medicine patient care activities. The Associate Dean and the Director of Risk Management of the University of Connecticut Health Center must be made aware of any incident involving a patient that could potentially lead to legal action. Responsibility for reporting an incident rests with every member of the School of Dental Medicine community – provider, faculty member, or staff member, who witnesses, discovers or has direct knowledge of a reportable incident or occurrence.

Events which should be reported as incidents include the following (1) any unfavorable outcome which a layman might attribute to poor care; this includes cases in which it is certain that there was no problem with the care; (2) any serious lapse in the quality of care regardless of outcome; (3) any patient threat of legal action.

Any serious incident, such as a major complication from a treatment procedure, or any aggressive comment or threat by a patient regarding legal action should be reported at once to the Associate Dean for Education & Patient Care, Team Leader, Patient Care Coordinator, Director of Quality Measurements and Improvement, or any member of the administration.

In all cases, a risk identification report (available from the Team Leaders, Patient Care Coordinators, Director of QMI, or the Associate Dean) should be completed to the Associate Dean immediately following the event. This policy includes all incidents related to care involving students, residents, staff and preceptors of the School of Dental Medicine even when delivered at extramural or affiliated institutions.

All students, faculty, and employees of the School are personally indemnified from any action resulting from the performance of assigned duties and responsibilities, as long as they are not reckless or wanton.

Protection of the institution's resources, faculty, students, and staff relies on strict adherence to the risk management policies described above.

PATIENT RECORD MANAGEMENT

Records of patients treated by predoctoral students and postdoctoral residents are the property of the School of Dental Medicine and are the responsibility of the assigned provider. Information contained within a patient record is confidential and must never be released or disclosed to anyone without the patient's (or patient's legal representative) written release, except for use by those School of Dental Medicine personnel who are directly involved with the care of the patient. No record must ever be transported by or released to a patient. All requests for copies of records must be referred to the appropriate record room personnel. A properly executed release (in accordance with University of Connecticut Health Center policies on the authorization for release of information [privacy and security of protected health information]) and payment of fees in accordance with State of Connecticut law is required prior to releasing copies of any record. Patient records requiring sequestration are secured by the Office of Dental Clinical Affairs.

All patient records are maintained in a centralized record room, with the exception of Orthodontic and emergency records, and are tracked by an electronic barcoding system. Requests for records are used 24-48 hours in advance for patient treatment, with the exception of emergency patients. Records are transported by designated staff to the respective clinic daily in the morning and returned by the end of the same day. All records must be returned on the day of issue.

All transfers of patient records are conducted and authorized by faculty or staff, not by students or residents.

All patients records must remain in the School of Dental Medicine clinical area. Records must never, under any circumstance, be stored outside of School of Dental Medicine clinical areas. A record may be brought to a faculty office or conference room solely for the purposes of the educational or clinical program. At no time may a record be removed from the University of Connecticut Health Center for any reason unless by court order.

Any infractions of the policy for management of patient records will result in disciplinary action.

For additional information on the security and privacy of protected health information, please see the institution's website [http://www.policies.uhc.edu/area/HIPAA_Privacy.html].

INFECTION CONTROL

Compliance with Guidelines

All clinical dental faculty, staff, predoctoral students and postdoctoral residents operating in the School of Dental Medicine's clinics must comply with the Infection Control Guidelines of the School of Dental Medicine and the University of Connecticut Health Center.

Guidelines

All clinical dental faculty, staff, predoctoral students and postdoctoral residents operating in the School of Dental Medicine's clinics must be familiar with the School's "Infection Control Program Information and Policy Manual" and the Health Center's "Infection Control Manual" and "Policy for the Control of Employee Occupational Exposures to Bloodborne Pathogens and Exposure Control Plan." These documents along with updates are available through the health center's website and/or email public folders.

Absence of Policy

Current recommendations and guidelines of the University of Connecticut Health Center's Infection Control Policy will apply where an absence of specific University of Connecticut School of Dental Medicine policy exists.

Purpose and Rationale

The purpose of these guidelines is to minimize the risk of cross-infection between patients and between patients and dental personnel.

The University of Connecticut School of Dental Medicine recognizes and concurs with current guidelines, statutes, and regulations for infection control, including the use of universal precautions, as published by the US Department of Health and Human Services Centers for Disease Control, the US Department of Labor Occupational Safety and Health Administration, the American Dental Association, and the Connecticut State Dental Association. The School of Dental Medicine abides by all policies and statements as described in the Health Center's "Policy for the Control of Employee Exposure to Bloodborne Pathogen and Exposure Control Plan" and the School's "Infection Control Program Information and Policy Manual."

Dental health care workers are exposed to the blood and saliva of patients which may contain a wide variety of pathogens capable of transmitting infections. Infections may be transmitted by blood or saliva through direct contact, droplets, or aerosols. Because all infected patients cannot be identified by history, physical examination, or readily available laboratory tests, all clinical faculty, staff, predoctoral students, and postdoctoral residents must deal with all patients as if they are infectious and adhere rigorously to universal infection control precautions in order to minimize the risk of exposure.

General Procedures (An Overview)

The following procedures must be considered routine for all patient care activities:

- a. **medical history:** a complete medical history must be obtained initially and updated for all patients at each subsequent visit. Specific questions concerning infections and current illness must be included.
- b. **minimize hazards of infection:** all procedures involving blood or potentially infectious materials shall be performed in such a manner as to minimize splashing, spraying, spattering, and generation of droplets.
- c. **gloves:** disposable gloves must be worn when contact with blood, saliva, mucous membranes, non-intact skin, or other potentially infectious materials can be reasonably anticipated. Gloves must be changed between each patient. Gloves shall not be used if they are peeling, cracked, discolored, punctured, torn, or when their ability to function as a barrier is compromised. Gloves shall not be washed or disinfected for reuse. Immediately after removing gloves, or any other personal protective equipment, hands or other skin surfaces must be washed thoroughly with an appropriate soap.
- d. **masks and face/eye protection:** masks in combination with eye protection devices, such as goggles or glasses with solid side shields, or chin length face shields, shall be worn whenever splashes, spray, splatter, or droplets of blood, saliva or potentially infectious materials may be generated and eye, nose or mouth contamination can be reasonable anticipated. Masks must be discarded immediately after treating each patient and prior to leaving the immediate clinical area or when they become damp or soiled, whichever occurs first. Eye protection devices and face shields must be removed prior to leaving the immediate clinical area. Dental Clinic Support services supplies surgical masks with splashguard shields. These particular masks are available for invasive high risk, high splatter procedures. Masks should never be dangled around the neck or left in place after leaving the operatory. When removing the mask, it should be handled by the elastic or cloth tie strings and not by the mask itself. All patients should wear safety glasses or their own personal glasses when receiving dental treatment. Safety glasses for this purpose are available in each clinical area. Safety glasses must be thoroughly cleaned or disinfected between patient visits.
- e. **personal protective clothing (protective body clothing):** appropriate protecting barrier clothing, such as, but not limited to, gowns, lab coats, clinic jackets, or similar outer garments shall be worn in occupational exposure situations. The type and characteristics of this clothing will depend upon the task and anticipated degree of exposure. Personal protective clothing is considered appropriate only if it does not permit blood or potentially infectious materials to pass through to or reach the healthcare worker's skin or clothing under normal conditions of use and for the duration of time which the protective equipment is to be used. If the garment is penetrated by blood or other potentially infectious materials, it must be removed immediately or as soon as possible. All contaminated laundry must be handled utilizing universal precautions and must be removed prior to leaving the immediate clinical area.
- f. **surgical caps and shoecovers:** surgical caps and shoecovers must only be worn in instances when gross contamination is anticipated, but is not indicated for routine dental care. Caps and shoecovers must be removed prior to leaving the immediate clinical areas.
- g. **care and disposal of protective equipment:** when personal protective equipment is removed, it must be placed in an appropriated designates area or contained for storage, washing, decontamination, or disposal.
- h. **use of rubber dam:** use of the rubber dam to minimize the formation of droplets, splatter, and aerosols is recommended whenever appropriate.

Exposure to Blood or Body Fluids

Exposure to blood or body fluids by needlestick, laceration, mucous membrane splash, or other accident can pose a serious occupational problem for healthcare workers. The main risk is possible transmission of viruses which may cause AIDS, hepatitis B, or hepatitis C. If a healthcare worker is exposed to blood or body fluids in the above manner, he or she should immediately and thoroughly clean the affected area and seek medical attention immediately or as soon as patient care reasonably allows:

Needlestick or puncture wound: immediately remove gloves and wash the contaminated area with an antimicrobial soap and water; apply an antiseptic, such as hydrogen peroxide and bandage

Eye/mucosal membrane contact: proceed to the nearest eye wash station and wash the area with copious amounts of cold water

Non-intact skin contact: wash skin thoroughly with an antimicrobial soap and water; apply antiseptic.

A dental clinic administrator, trained in the management of exposures, must be contacted immediately. The post-exposure administrator will explain the incident to the patient and request that the patient be tested for HBsAg, Hepatitis C and the HIV virus; the administrator will provide all necessary forms for the laboratory testing and direct the patient to the laboratory.

The exposed healthcare worker must seek medical attention from the Health Center's Employee Health Service; if the exposure occurs outside the hours of 8:00 am – 4:30 pm, Monday through Friday, the worker should report to the Emergency Department.

School of Dental Medicine employees (individuals who receive Health Center paychecks) must report injuries to the Human Resources Department; all others must report to Public Safety to complete the necessary reports.

Handwashing

Dental health care workers must wash hands before and after treating each patient [before glove placement and after glove removal] and after barehanded touching of inanimate objects likely to be contaminated by blood, saliva or respiratory secretions. Hands must be immediately washed when gloves are torn, cut or punctured. Gloves should be removed as soon as patient safety permits.

All dental health care workers with exudative lesions or weeping dermatitis, particularly on the hands, should refrain from direct patient care and from handling dental care equipment or supplies until the condition resolves.

Use and Care of Sharp Instruments and Needles

All health care workers should take precautions to prevent injuries caused by needles, scalpels, and other sharp instruments during patient care, when cleaning contaminated instruments and disposing of used needles, and when handling sharp instruments following their use. To prevent needlestick injuries, needles must never be recapped, purposely bent, broken by hand, or otherwise manipulated by hand. Contaminated sharps must be discarded immediately or as soon as feasible in containers that are closable, puncture resistant, leakproof, and labeled in accordance with OSHA standards. When no other alternative is feasible or when such action is required by a specific dental procedure, recapping or needle removal must be accomplished through the use of a mechanical device or a one-handed technique.

Handling of Extracted Teeth

CDC recommendations for infection control practices in dentistry state that the handling of extracted teeth used in dental educational settings differs from giving patients their own extracted teeth. Several states allow patients to keep such teeth because these teeth are not considered to be regulated (pathologic) waste or because the removed body part (tooth) becomes the property of the patient and does not enter the waste system.

Since the State of Connecticut does not have written guidelines or policies regarding extracted teeth, teeth may be returned to patients upon request after completing the following procedures:

- a. teeth must first be cleaned of loosely adherent tissue or debris by gently scrubbing with detergent and water
- b. teeth should then be wrapped in gauze squares which have been thoroughly saturated in a fresh solution of sodium hypochlorite diluted 1:10 with water and placed in a securely sealed ziplock bag. Personnel handling extracted teeth should do so wearing necessary personal protective equipment. Patients, parents and/or guardians should be advised that for infection control and safety reasons, the teeth are wrapped in sodium hypochlorite solution and should not be handled by children until they have been thoroughly rinsed
- c. providers must document in the patient record that the extracted teeth were given to the patient, parent, or guardian upon their request and that the appropriate infection control procedures were followed.

Management of Patients with Tuberculosis

The University of Connecticut Health Center has adopted a policy for control of occupational exposure to tuberculosis. Among other requirements, an isolation facility must be used for the management of patients with tuberculosis infection. Within the School of Dental Medicine, the isolation facility is housed within the AEGD program. Only non-elective dental procedures are provided to patients with active infection or during that period of time the patient is deemed to be potentially infectious.

HEALTH, SAFETY, AND THE LAW

Injury Reporting

All employee work injuries should be immediately reported to the direct supervisor. Medical treatment for work related injuries should be obtained from UCHC Employee Health Services between 8:00 am – 4:30 pm or from the Emergency Department at other times.

Post-Exposure Protocol

Exposure to blood or body fluids by needlestick, laceration, mucous membrane splash, or other accident can pose a serious occupational problem for healthcare workers. The main risk is possible transmission of viruses which may cause AIDS, hepatitis B, or hepatitis C. If a healthcare worker is exposed to blood or body fluids in the above manner, he or she should immediately and thoroughly clean the affected area and seek medical attention immediately or as soon as patient care reasonably allows:

Needlestick or puncture wound: immediately remove gloves and wash the contaminated area with an antimicrobial soap and water; apply an antiseptic, such as hydrogen peroxide and bandage

Eye/mucosal membrane contact: proceed to the nearest eye wash station and wash the area with copious amounts of cold water

Non-intact skin contact: wash skin thoroughly with an antimicrobial soap and water; apply antiseptic.

A dental clinic administrator, trained in the management of exposures, must be contacted immediately. The post-exposure administrator will explain the incident to the patient and request that the patient be tested for HBsAg, Hepatitis C and the HIV virus; the administrator will provide all necessary forms for the laboratory testing and direct the patient to the laboratory.

The exposed healthcare worker must seek medical attention from the Health Center's Employee Health Service; if the exposure occurs outside the hours of 8:00 am – 4:30 pm, Monday through Friday, the worker should report to the Emergency Department.

School of Dental Medicine employees (individuals who receive Health Center paychecks) must report injuries to the Human Resources Department; all others must report to Public Safety to complete the necessary reports.

Management of Medical Emergencies

In the event that a patient experiences a medical emergency, the provider must remain with the patient and summon assistance immediately from the nearest faculty member. The faculty member will determine if the situation is life threatening or non-life threatening and will initiate appropriate treatment intervention. The faculty member will determine which other individuals (students, staff, faculty) will assist in stabilizing the patient and assist in the management of the emergency situation.

At all times, the responsible faculty and provider remain with the patient. The clinic emergency cart should be brought to the area and prepared for use.

Appropriate treatment should be initiated immediately for non-life threatening conditions. If relief or improvement is not achieved, call 7777 for paramedic assistance.

For all life threatening emergencies:

- dial 7777
- state the nature of the emergency
- state the location
- state the nearest telephone extension
- remain on the line until told to hand up
- send available person(s) to nearest elevator and to provide directions for emergency personnel

Fire Emergencies

Dial 7777 to report fire or smoke. The fire department, police, and medical personnel all respond to this number.

Activate the nearest fire alarm if possible and announce a Code Red.

Evacuate the area if situation is threatening (i.e. fire is observed) or a public address announcement has been made.

A Code Red announcement will be used whenever there is a reported fire in the hospital or clinics. This includes the activation of a manual fire alarm, an automatic fire alarm, or a report received on the emergency 7777 line. When the Health Center's operator receives notification of such an alarm a Code Red will be broadcast giving the location. The automated alarms located throughout the clinics will be activated.

When the fire location is not in the area, evacuation is not necessary. An order for evacuation may be made by the Fire Department, the Police Department, Health Center administration, or by Dental Clinic Administration. If directed to evacuate, the primary responsibility of all personnel is the safety and security of patients and visitors, in addition to the safety and security of all students, faculty, and staff.

Emergency Clinic Closings

To minimize confusion about appropriate authority to close components of the University of Connecticut Health Center for emergency reasons (i.e. snowstorms), all students, residents, faculty, and staff should be aware of the following policy and procedures:

- a. the nature of the Health Center's activities requires that emergency closing decisions be made only by the Health Center. General announcements from any other State office (including the Governor's Office) do not constitute authorization for any unit to close or any employee to leave work. Employees required to work, when other employees are not, will be compensated accordingly.
- b. The Health Center's Vice President, or designee, in consultation with appropriate School and health center officials, will decide when circumstances are such that (1) all units of the Health Center will remain open and all students and employees will maintain usual schedules or (2) that only essential services will be conducted.
- c. If only essential services are to remain open, routine dental clinic operations will not remain open. All patient care in progress should be terminated at the earliest appropriate step which stabilizes the patient's oral status. If a decision for essential services only is made before normal work hours, students and employees are not expected to appear for clinical activities. Only the Dental Emergency Service is considered to be essential under these circumstances.
- d. Emergency closings will be announced and communicated to all units by members of the School's administration.

FACILITIES, EQUIPMENT AND MATERIALS MANAGEMENT

Dental Instrument, Supply and Equipment Procurement

An appropriate inventory of equipment, instruments, and supplies required for all of the dental procedures in comprehensive patient care are maintained in the clinics of the School of Dental Medicine.

The standard inventory of supplies and instruments is designed to meet all educational and patient care requirements. These supplies and equipment are dispensed without charge to predoctoral dental students and postdoctoral residents. It is important that supplies be used in an efficient and economical manner with minimal waste. To be able to maintain the policy of supplying these instruments and supplies without charge, certain instruments require special controls to maintain sterility, minimize excessive wear, or damage and minimize loss. For continuation of this policy, each provider's total cooperation is imperative.

Lists of all instrument cassettes, small equipment, and supplies needed to treat patients can be obtained from each clinical area and discipline. It is the responsibility of all providers that the completeness and integrity of all instrumentation be verified before use. Broken or missing instruments or supplies should be reported to a clinic staff member immediately.

At the completion of treatment, instruments should be cleaned using available heavy duty rubber gloves and instrument brushes. All instruments must be visibly clean, free of blood, cement or other materials. Instruments must be replaced in the appropriate cassettes prior to sterilization.

Sterilization

Instrument cassettes, large equipment and instruments and those items which require special handling (i.e. gas or ethylene oxide treatment) are sterilized in the Helath Center's Central Sterile Support. Cassettes will be delivered to Dental Clinic Central Support and distributed to the respective clinics. Small items and individual instrumentation and equipment are sterilized within Dental Clinic Central Support.

Reporting of Equipment Malfunctions

All equipment malfunctions or problems must be reported immediately to a clinic staff member with a description of the problem experienced. The dental assistant is responsible for ordering the appropriate service.

Portable Nitrous Oxide Sedation Units

In order to obtain a portable nitrous oxide sedation unit from Central Dental Support, it is necessary to present a nitrous oxide administration checklist. Instruction in the use of the checklists and instrumentation is provided in the predoctoral and postdoctoral curricula; the checklists are available in each clinical area. Portable units will not be accepted for return if any of the indicated steps and procedures have not been completed.

POLICIES

POLICY FOR MANAGEMENT OF PATIENT RECORDS SCHOOL OF DENTAL MEDICINE

All School of Dental Medicine patient charts are housed and secured in the Dental Record Room located within the Dental Clinics and are tracked by a bar coding system. The following are not included in the central record room system: University Dentists (Faculty Practice), Orthodontics, Dental Emergency Service records, and Pediatric Dentistry records, which are maintained at the Bank of America/Burgdorf Health Center and Connecticut Children's Medical Center.

The Dental record room is staffed Monday through Friday. The following rules will be enforced by record room staff:

1. Charts requested for patient treatment 48 hours in advance of the patient appointment will be pulled and transported by clinic staff to the respective clinic 24 hours prior to the appointment to allow for provider review. The charts will be returned to the record room that evening and brought back to the clinics the day of the appointment.
2. Records required for non-treatment issues may be requested by front desk staff at the discretion of the provider. These charts will be pulled within 24 hours and transported to the respective clinics by clinic staff.
3. Records required for immediate patient treatment (all legitimate "stat" requests) will be pulled immediately by record room staff upon requests submitted by front desk personnel at the discretion of a faculty member or team leader.
4. If it is known that a patient chart will be needed within 24 hours of return, that chart will be marked by the student (with the placement of a "sticky note") and returned to the clinic record basket by the record room staff.
5. All records must be returned on the day of issue and filed back within 24 hours of return. If not required, as required, additional charts will be held until outstanding charts are returned.

Patient records must never leave the clinic area.

Record room staff may not log out a chart unless it has been requested through the clinic information management system.

**UNIVERSITY OF CONNECTICUT
SCHOOL OF DENTAL MEDICINE**

POLICY ON FINANCIAL RESPONSIBILITY FOR PATIENT CARE

It is imperative that a treatment plan be completed and discussed with all patients prior to the delivery of comprehensive or limited care. A treatment plan serves not only as a guide to the patient's agreed upon treatment, but also as the basis for financial agreement.

With the exception of emergency care, no treatment may commence without a valid treatment plan in place.

All predoctoral and postdoctoral providers assume financial responsibility for any and all treatment provided by them on their respective patients in the absence of a signed, fully executed treatment plan.

All financial liabilities must be cleared prior to completion of the predoctoral or postdoctoral program.

Approved by ECDS May 4, 2005
Implementation July 1, 2005

CLINIC ATTIRE POLICY

Required attire for students, staff and faculty who are directly involved with clinical treatment includes clean personal protective apparel. Protective apparel is defined as SDM approved precaution garments. All employees and non-employees at risk must routinely wear precaution garments to prevent skin exposure and soiling of street clothes when contact with blood or saliva is anticipated. Precaution garments must not be worn outside the immediate clinic area. Immediate clinic area is defined as operatories, immediate surrounding clinic area and the associate service corridors. Reception areas, restrooms, offices, general traffic corridors, main lobby, record room, and patient financial services are not immediate clinical areas.

The following protocol related to the use of precaution garments must be followed to be in compliance with current infection control policies:

1. laundered garments are delivered to service corridors behind Dental Clinics 1-4 and 5-7. They are stored in service aisle carts for distribution
2. student, staff, and faculty preceptors may obtain appropriate garments from the clinic in which they are providing care
3. soiled garments are deposited into hampers in each clinic following each clinic session or when a garment is visibly soiled or contaminated
4. laundry bags of soiled garments are placed in designated laundry carts in the service aisle by clinic staff
5. bags of soiled garments are retrieved and clean garments are delivered by the laundry service on a daily basis.

All apparel worn by students, staff and faculty in the SDM clinical area must consist of professional attire or scrub uniforms. If scrubs are worn outside the immediate clinical area, they must be covered with a white laboratory coat. Scrubs must be acceptable by the SDM clinic administration. Jeans, tee-shirts, shorts, sandals, or unapproved sneakers are never acceptable, are not professional in appearance, and, therefore must never be worn in the clinical area.

Exceptions or clarifications to the above clinic attire policy must have prior approval from the clinic administration.

Adopted ECDS 6/13/2001

INFORMED CONSENT POLICY

All consents for care must be signed and placed in the patient record prior to initiation of treatment. The patient must sign a general consent for examination prior to any evaluation. The treatment plan document provides for consent for planned treatment. Specific clinical procedures (i.e. surgical treatment) may require an additional, procedure specific consent process. Written documentation of consent must be signed by all adult patients who possess the capability for participate in the informed consent process. For patients who are not of legal age, or those who require a legal guardian, consent for care must be documented and signed by the parent or legal guardian.

The informed consent process is, in general, valid when all five of the following components are satisfied:

1. **Voluntariness** is a precondition whereby patients must not be coerced into making a decision and must be free from unfair persuasions and inducements.
2. **Information disclosure** includes informing patients of the nature of the procedure, its risks and hazards, anticipated benefits, and alternatives and risks and benefits of no treatment.
3. **Competence** indicates that a patient has the capacity to comprehend the disclosed information.
4. **Understanding** assures that once a competent patient is provide with information, he or she will understand it and be able to make a reasoned decision concerning treatment.
5. **Decision** results in the patient's accepting (i.e. consenting) or not accepting (i.e. refusing) treatment.

The following is the informed consent policy regarding the management and treatment of dental emergencies in which a minor is involved and is brought to the clinic by someone other than parent or legal guardian. Siblings, friends, or any persons other than legal guardian cannot provide consent. In instances where a minor presents with a dental emergency and is not accompanied by a parent or legal guardian, efforts should be made to obtain the consent of the parent or guardian before treatment is begun.

Telephone consent is valid when the following rules are observed:

1. The situation falls within the definition of an acute dental emergency. An emergency exists when the patient is experiencing immediate need for medical or dental attention and failure to secure consent for treatment would result in delay of treatment, increasing the risk to the patient's health or life.
2. The dental provider or one of the trained auxiliaries in the clinic makes a conscientious effort to contact one of the parents or guardian(s). Either parent may grant consent for a minor child except in the case of divorce where only one parent has legal custody.
3. A third party, not involved in the direct provision of care, listens to the conversation on the telephone and the parent is informed that the third person is listening.
4. The provider explains the situation to the parent or guardian and includes all the elements required for the consent to be valid.
5. Notes are made in the patient record of the conversation which are signed by all parties to the telephone contact.
6. A follow-up written consent is sent to parent or guardian for signature and subsequently placed in the patient record.

If neither parent nor guardian can be located, notes must be made in the patient record about the nature of the emergency, why immediate care was necessary, the care provided, and the fact that all attempts to reach the parent(s) or guardian(s) failed. In general, if a dentist, in the treatment of a minor, is of the opinion that any delay would compromise the dental or overall health of the patient, he or she may initiate the necessary treatment without obtaining parental or guardian consent, but only after reasonably attempting to locate a parent or guardian.

Emancipated minors do not require parental or guardian consent. A minor, in the State of Connecticut, is considered to be emancipated if (1) the minor is married, (2) the minor has military service, (3) the minor is a parent themselves, (4) the minor is willingly living apart from parent(s) and managing their own finances, or (5) a court has determined that it is in the minor's best interests to be independent from the parent(s).

If a provider has concerns about a patient's ability or competence to participate in the informed consent, the concerns should immediately be brought to the attention of a faculty member, Team Leader, or Associate Dean. Faculty may consult with the Office of the Attorney General for further clarification.

Adopted ECDS 12/14/00

GUIDELINES FOR PREVENTION OF INFECTIVE ENDOCARDITIS UNIVERSITY OF CONNECTICUT SCHOOL OF DENTAL MEDICINE

Recommendations by the American Heart Association
Approved and Adopted by Clinical Affairs Committee (May 2, 2007)

Table 1 Cardiac Conditions Associated with the Highest Risk of Adverse Outcome from Endocarditis for Which Prophylaxis with Dental Procedures is Recommended

- Prosthetic cardiac valve
- Previous infective endocarditis
- Congenital heart disease (CHD)*
 - Unrepaired cyanotic CHD, including palliative shunts and conduits
 - 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**
 - Repaired CHD with residual defects at the site or adjacent to the site of a prosthetic patch or prosthetic device (which inhibit endothelialization)
- Cardiac transplantation recipients who develop cardiac valvulopathy

*except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD

**prophylaxis is recommended because endothelialization of prosthetic material occurs within 6 months after the procedure

Table 2 Dental Procedures for Which Endocarditis Prophylaxis is Recommended for Patients in Table 1

All dental procedures that involve manipulation of gingival tissue or the periapical region of teeth or perforation of the oral mucosa.

The following procedures and events do not need prophylaxis: routine anesthetic injections through non-infected tissue, taking dental radiographs, placement of removable prosthodontic or orthodontic appliances, adjustment of orthodontic appliances, placement of orthodontic brackets, shedding of deciduous teeth and bleeding from trauma to the lips or oral mucosa.

Table 3
Regimens for a Dental Procedure (Single Dose 30-60 minutes before procedure)

Situation	Agent	Adults	Children
Oral	Amoxicillin	2 gm	50 mg/kg
Unable to take Oral Medication	Ampicillin	2 g IM or IV	50 mg/kg IM or IV
	Or Cefazolin or ceftriaxone	1 g IM or IV	50 mg/kg IM or IV
Allergic to penicillins or ampicillin Oral	Cephalexin**†	2 g	50 mg/kg
	Or Clindamycin	600 mg	20 mg/kg
	Or Azithromycin or clarithromycin	500 mg	15 mg/kg
Allergic to penicillins or ampicillin and unable to take oral medication	Cefazolin or ceftriaxone†	1 g IM or IV	50 mg/kg IM or IV
	Or Clindamycin	600 mg IM or IV	20 mg/kg IM or IV

**or other first or second generation oral cephalosporin in equivalent adult or pediatric dosage

†cephalosporins should not be used in an individual with a history of anaphylaxis, angioedema, or urticaria with penicillins or ampicillin

TISSUE REMOVAL POLICY

All tissues removed during surgical procedures in the School of Dental Medicine clinics must be sent for pathological examination except for the following:

1. normal, carious, or periodontally diseased teeth
2. gingival tissue removed during subgingival debridement of teeth affected by inflammatory periodontal disease and gingival tissue or bone removed during surgical treatment of gingivitis, periodontitis or inflammatory drug induced gingival; hyperplasia
3. pulpal and periapical tissue removed during non-surgical or surgical treatment of pulpitis, pulpal infection and/or necrosis or periapical periodontitis secondary to pulpal disease or failed endodontic therapy
4. normal bone and soft tissue removed from non-diseased areas.

All removed tissues, including specific teeth, must be listed and described in the progress or operative notes.

Adopted ECDS 3/15/06

**SCHOOL OF DENTAL MEDICINE
MERCURY/AMALGAM MANAGEMENT PROCEDURES**

Dental scrap amalgam and any used, empty, closed amalgam capsules must be placed into a tightly closed, dry, wide mouth, screw top container with the label "contact scrap amalgam." This container must be kept closed when amalgam or capsules are not being added. Any defective capsule that cannot be emptied must also be placed with the scrap amalgam.

All suction traps must be changed or cleaned regularly. The frequency may vary from daily to weekly depending upon how often the chair is used for amalgam placement or removal. Vacuum lines must first be flushed and appropriate PPE utilized.

Extracted teeth containing amalgam must never be placed in regulated medical waster containers. Extracted teeth containing amalgam must be handled using similar procedures for disinfecting impressions and prostheses.

To reduce the potential for release of mercury into the environment:

1. rinse teeth under cold water to remove debris, saliva, and blood while wearing appropriate PPE
2. place teeth into a suitable container with powdered bleach; the container must be labeled
3. do not discard any contents from the container into a sanitary sewer line
4. call Research Safety Office for disposal

Clean up of amalgam spill:

1. spilled amalgam must be swept up immediately and placed into labeled amalgam waster container
2. spilled amalgam must never be placed into regular trash
3. contact Research Safety Office

Clean up of mercury spill:

1. never use latex gloves as mercury can penetrate latex
2. restrict area so that mercury is not tracked to other areas
3. if mercury was spilled in, on, or about a device with high temperatures, turn device off
4. contact Research Safety Office

Special Procedures

Never heat clogged amalgam carriers or any other instrument with amalgam debris with an open flame. Mercury can emit toxic vapors when heated to temperatures caused by open flame. If absolutely required, the process must take place under an approved chemical hood in a lab area.

Amalgam Separator

An amalgam separator was purchased September 18, 2003 and was installed on or before December 2003 in compliance with State of Connecticut Department of Environmental Protection directives.

Approved ECDS 2/21/06

**POLICY ON CARE DELIVERY TO PERSONS
WHO ARE DEAF OR HARD OF HEARING**

As a component of the University of Connecticut Health Center, the School of Dental Medicine has adopted the Health Center's policy on the care of patients with hearing impairments. The content of the Health Center policy can be found within the UCHC/JDH Hospital Administrative Manual in shared folders.

University of Connecticut Health Center
John Dempsey Hospital Administrative Manual
SECTION: Patient Care NUMBER: 08-009

SUBJECT: Care Delivery to Persons who are Deaf or Hard of Hearing PAGE: 1 OF 4

PURPOSE: To provide appropriate mechanisms of communication for patients and/or companions who are deaf or hard of hearing.

POLICY:

1. Mechanisms for communication for persons who are deaf or hard of hearing will be provided per the Consent Decree Regarding Health Care Services to People Who Are Deaf or Hard of Hearing, filed August 1998.
2. Definitions:
 - Information Office shall be defined as the center for communication. It will be located in the Department of Social Work and shall respond to telephone inquiries during normal business hours, and shall maintain a recording system for inquiries received after normal business hours (Monday-Friday, 8:00am-4:30pm). The Telecommunications Office in the Administrative Services Building (ASB) shall maintain a dedicated TTY telephone line and shall publicize its purpose and telephone number broadly within the UCHC and to the public.
 - Program Administrators shall be available 24 hours a day, 7 days a week to answer questions and provide appropriate assistance regarding immediate access to and proper use of the appropriate auxiliary aids and services available. They shall be defined as: Staff from the Social Work Office (contact Monday-Friday, 8:00AM-4:30PM, x2287) and Administrative Managers (contact at all other times through the page operator, x2626). These persons shall know where the appropriate auxiliary aids are stored and how to operate them, and will be responsible for their maintenance, repair, replacement, and distribution. They can also be reached via the dedicated TTY telephone line, (860) 679 -2242, in order for persons who are deaf or hard of hearing to contact them.
 - Coordinator, Interpreter Services is available Monday through Friday from 8:00 am – 4:30 pm at x 2289. The coordinator receives requests for interpreter services throughout UCHC and insures interpreters are available as requested. During normal business hours, the coordinator must be notified immediately of the admission of a patient or companion who is deaf or hard of hearing. At all other times, the Administrative Mangers must be notified.

PROCEDURE:

Assessment and Documentation:

1. The determination of which appropriate auxiliary aids and services are necessary, and the timing, duration and frequency with which they will be provided, shall be made by the UCHC personnel, in consultation with the Coordinator, Interpreter Services and the person or companion who is deaf or hard of hearing.
2. The initial assessment will be made at the time an appointment is scheduled or on the arrival of the patient or companion at the hospital, whichever is earlier. The communication assessment will be performed and documented as part of each initial patient assessment and will be documented in the patient's medical record.
3. Ongoing assessments will be conducted for all patient or companions who are deaf or hard of hearing and who have ongoing relationships with UCHC. Provision of appropriate auxiliary aids or services will be reconsidered as part of every routine assessment as appropriate, but, in no event, no less than every 24 hours for inpatients, and with every patient visit for outpatients. Ongoing assessments will be documented in the patient's medical record.

Services:

After assessment reveals the need for auxiliary aids and/or services for a patient or companion's communication needs, UCHC personnel will:

1. Initiate referral to the Coordinator, Interpreter Services for qualified sign language

interpreters and/or acquisition of appropriate equipment. Situations which could indicate this need for communication include:

- determination of a Patient's medical history or description of ailment or injury
- provision of Patient's rights, informed consent or permission for treatment
- religious services and spiritual counseling
- explanation of living wills or powers of attorney (or their availability)
- diagnosis or prognosis of ailments or injuries;
- explanation of procedures, tests, treatment, treatment options or surgery

- explanation of medications prescribed (such as dosage, instructions for how and when the medication is to be taken, and side effects or food or drug interactions)
- explanation regarding follow-up treatments, therapies, test results or recovery
- blood donations or apheresis
- discharge instructions
- provision of mental health evaluations, group and individual therapy, counseling, and other therapeutic activities, including grief counseling and crisis intervention
- explanation of complex billing or insurance issues that may arise
- educational presentations, such as classes concerning birthing, nutrition, CPR, and weight management

The preceding list of situations is neither exhaustive nor mandatory, and shall not imply that there are not other situations when it may be appropriate to provide interpreters for effective communication, nor that an interpreter must always be provided in these situations.

2. To initiate a referral for a qualified sign language interpreter during normal business hours, call Coordinator, Interpreter Services at x 2289. At all other times, call Family Services Woodfield (FSW), at **(888) 676-8554**. If FSW is unable to meet the time requirement, or the patient's needs, contact Connecticut Commission for the Deaf and Hearing Impaired, at **(860) 566-7414 or (860) 242-7698**. If you require further assistance contact the Department of Social Work (Mon-Fri, 8:00am-4:30pm at x2287) or the Administrative Manager (all other times through the page operator). **A referral must be made within 15 minutes of assessment, and the interpreter must be present within 2 hours or less, of the referral.**
3. To acquire auxiliary aids, contact the Staffing/Payroll Office, located in C2037, extension 4263. To acquire closed captioned televisions, contact Transportation Services. They can be reached 24 hours a day via beeper through the page operator, **x2626**. If further assistance is needed, contact the Department of Social Work (Mon-Fri, 8:00am-4:30 pm at **x2287**) or the Administrative Manager (all other times through the page operator). **Equipment shall be available to patient or companion within 10 minutes of the request.**

Training:

1. Initial training for new personnel regarding this decree will occur during Health System orientation, and will be conducted by the Organization and Staff Development Department.
2. The following UCHC personnel will receive annual mandatory training:

- All personnel who work or volunteer in the Information Office
- All Program Administrators
- All persons who will be responsible for training other UCHS personnel concerning coordination of auxiliary services to persons who are deaf or hard of hearing
- Emergency Department Personnel with patient responsibility
- Psychiatric/Social Work Personnel with patient responsibility in the psychiatric area

3. Special training, defined by area and role, will be provided to the following personnel on an annual basis:

- All Clinical Directors
- Personnel who perform admission functions
- Central registry
- General Information Desk
- All operators who receive incoming calls from the public

Steven L. Strongwater, M.D.

Hospital Director

Date Issued: 5/77

Date Revised: 5/80, 1/81, 1/86, 12/88, 12/94, 10/98, 11/98, 6/99, 5/00, 11/03

Date Reviewed: 12/91, 2/94, 5/97, 9/99

CARE OF PATIENTS WITH LIMITED ENGLISH PROFICIENCY

As a component of the University of Connecticut Health Center, the School of Dental Medicine has adopted the University of Connecticut Health Center's policy on interpreters/linguistic access for persons with limited English proficiency. The content of the Health Center policy can be found within the UCHC/JDH Hospital Administrative Manual in shared folders.

SUBJECT: Interpreters/Linguistic Access for Persons with Limited English Proficiency
PAGE: 1 of 3

PURPOSE: To provide appropriate mechanisms for communication with patients who have limited proficiency in English. The language barriers experienced by persons with limited proficiency in English can result in restricting their access to critical public health, hospital and other medical and social services to which they are legally entitled, and can limit their ability to receive notice of or understand what services are available to them.

POLICY:

1. Mechanisms for communication for persons who have limited proficiency in English will be provided in accordance with Connecticut law. In accordance with this law, it is acknowledged that:

- patients have the right to effective communication with health care providers.
- **patients' readiness to learn is assessed, including the existence of any language barriers.**
 - resources will be available within UCHS to support effective communication with patients who have limited English proficiency. These resources include the availability of qualified interpreters and access to Language Line.
 - family members and significant others:
 - ⌚ should not be required to interpret for patients.
 - ⌚ a family member or friend may be used as an interpreter: in an emergency situation pending the arrival of an interpreter, or if this approach is requested by the patient and the use of the significant other would not compromise the effectiveness of services or violate the patient's confidentiality.
 - ⌚ the patient must be advised that a qualified interpreter is available at no cost to the patient.

2. Definitions:

1. **Qualified interpreter: a person who is proficient in both languages and in medical terminology, and is trained in the ethics of interpreting.**
2. **Language Line: a telephone interpreter service that can be accessed 24 hours per day through the UCHC telephone operator. This service can be used as a supplemental source for interpretation until an interpreter is available.**

ASSESSMENT AND DOCUMENTATION:

1. All patients receiving care within the UCHS system will be assessed for their need for interpreter services in order to provide effective communication about their medical care.
2. The initial assessment will be made at the time an appointment is scheduled, or on arrival of the patient at the hospital, whichever is appropriate. The communication needs assessment will be performed and documented in the medical record as part of each patient assessment. A number of assessment tools/provision of care documents have been translated into non-English languages commonly encountered at UCHS. These documents include forms related to the admissions process and informed consent.
3. Signs identifying the non-English languages most likely to be encountered in UCHS are posted in public areas and on inpatient units.

SERVICES:

After assessment reveals the need for interpreter services, UCHS personnel will access the following resources:

1. A list of qualified interpreters is available through UCHC page operators by dialing "0."
 2. For scheduled appointments, arrangements should be made at the time the appointment is scheduled for an interpreter to be present for the appointment.
3. Language Line (available 24 hours per day) is a supplemental source for language interpretation. It is accessed as follows:
- Determine the spoken language of the individual/patient.
 - Dial "0" to be connected to the Interpreter Service. The UCHC telephone operator will ask you a couple of questions, i.e., name, department, name of patient, etc.
 - Once the connection is made to the Interpreter Service, they will assist through the rest of the process. Anything written can be faxed and interpreted into any language.

SUBJECT: Interpreters/Linguistic Access for Persons with PAGE: 3 of 3
Limited English Proficiency

CROSS REFERENCE:

Care Delivery to Persons who are Deaf or Hard of Hearing, Policy # 08-009

Steven L. Strongwater, M.D.

Hospital Director

Date Issued: 5/77

Date Revised: 7/85, 1/86, 2/88, 12/91, 3/94, 5/97, 5/00, 10/00, 10/03

