SILETZ COMMUNITY HEALTH CLINIC POLICY

DENTAL

TABLE OF CONTENTS

SILETZ COMMUNITY HEALTH CLINIC	
Program	Dental
Policy	Dental Policy
Date Approved	10/16/98 (Infection Control), 08/03/99, 05/02/09 (Pain Management)
Date Revised	6/03/02; 11/05/05; 05/02/09; 05/05/12; 11/20/15; 08/05/17; 12/21/18; 04/16/21

PART 8A
Dental Clinic Introduction

I. PURPOSE

To establish standards of operation for the Dental Clinic including priority of care, staffing responsibilities, and provision of services.

II. POLICY

The policy of the Siletz Community Health Clinic (SCHC) is to ensure the highest quality of dental services to the patients in a family, friendly, and comfortable environment.

III. PHILOSOPHY AND OBJECTIVES

A. SCHC Philosophy and Goals

1. SCHC philosophy is that optimal oral health for each patient can be achieved through the combined commitment from the patient and dental provider. For the dentists and clinic it demands a personal commitment to strive for perfection in treatment, continually advancing the provider's expertise, and providing a state-of-the-art, comfortable dental facility to manage nearly all oral health conditions.

    a. SCHC's mission is to provide exceptional, comprehensive dental care to the patients in a family friendly and caring environment, educating and encouraging them toward a state of optimal oral health. SCHC will accomplish the mission through a:

        i. **commitment** to continuing education and sharing knowledge with each other and the patients.

        ii. **drive** to work together as a team and to respect every person's individuality.

        iii. **desire** for each patient to have a beautiful, healthy smile that will last a lifetime.

        iv. **persistence** to maintain a technically advanced, sanitary, and fully furnished facility to provide uniformity in the delivery of quality health care services.

B. Program Objectives

1. The primary objective of the dental clinic is to improve the oral health of the people whom we serve. Objectives will be accomplished by the provision of quality service in a timely manner, implementation of preventive dentistry programs, and patient

education as described in the following pages of this policy.

IV. PATIENT ELIGIBILITY, PRIORITY, AND HOURS OF OPERATION

A. Eligibility

1. Dental services are currently available to:

   a. PRC eligible members.

   b. Other documented Native Americans (Direct).

2. Check with the clinic for the most up-to-date eligibility information.

B. Priority

1. First Priority

   PRC eligible members.

2. Second Priority

   Other documented Native Americans (direct).

3. Third Priority

   Employees of the Siletz Tribe and its entities.

4. Fourth Priority

   Other patients based on availability of services.

C. Hours of Operation

1. The dental clinic hours of operation and various events change throughout the year. Check with the clinic for the most up-to-date hours of operation and schedule.

PART 8B
Dental Administrative Policies

I. CLINIC GUIDELINES

A. All patients must:

1. Be registered with Siletz Community Health Clinic.

2. Complete a dental health history form annually.

3. Sign in at dental reception (verifying their presence and identification.)

4. Receive an exam before treatment (comprehensive, periodic, limited, periodontal, etc.)

5. Be presented a signed treatment plan for any planned treatment.

6. Be responsible for any outstanding charges to their accounts.

II. SCHEDULING; NO-SHOW, LATE ARRIVAL, AND CANCELLATION; AND TELEPHONE

A. Scheduling

1. The Patient Care Coordinator (PCC) for dental is responsible for creating, scheduling, and maintaining the dental schedule for all dental personnel, with dental staff and the Dental Director serving in an advisory role.

2. When various dental staff cover the PCC position, they are held to the same policies as the PCC.

See "Dental Scheduling Procedure" for specifics.

B. No-Show, Late Arrival, and Cancellation

The Dental Clinic follows the Administration Policy on no-shows, late arrivals, and cancellations.

C. Telephone

1. Personal calls should be kept to a minimum and always brief with a focus on calls made during lunch or breaks.

2. Patient calls will mainly be answered by the PCC. Questions they receive concerning treatment specific questions will be forwarded to the appropriate dental

personnel by written or verbal message.

3. Telephone calls are to be answered promptly and with proper and professional phone etiquette.

III. DENTAL RECORDS

A. The Electronic Record

1. Dentrix is the software the dental clinic utilizes to chart treatment, record notations, store treatment documents, and process billing.

2. Dexis is the software the dental clinic utilizes to capture, process, review, and store radiographs and images related to patient treatment.

3. SCHC requires strict confidentiality of information for each patient's chart. Dentrix and Dexis software will maintain this confidentiality of each patient through a username/password encrypted login maintained by the IS department. The software also tracks all entries, deletions, editing, and access of a patient's dental record.

4. Patient's electronic dental record consists of these main sections:

   a. DENTRIX FAMILY CHART: The Family File stores and displays important patient information, such as the patient's name, address, phone number, medical alerts, birthdate, insurance coverage, employer, and referral information. Patients are organized by family in the Family File. The Family File helps to organize, store, and find patients and patient information.

   b. DENTRIX CHART:

      i. GRAPHICAL CHART: Provides a quick and easy way to enter existing, recommended, and completed treatment or conditions. Dentrix uses standard, easy-to-recognize textbook charting symbols. Treatment is color-coded so that a single glance at the patient's graphic chart will tell whether a procedure is a condition, preexisting treatment, treatment planned, or completed.

      ii. CLINICAL NOTES: Notes the dental provider types detailing the procedure, discussions, phone conversations and correspondences, and options given to the patient during the course of treatment.

      iii. DENTRIX PERIO CHART: Notes the written findings from the comprehensive periodontal evaluation provided by the dental health care provider.

      iv. TREATMENT PLANNER: Creates treatment plans based on the

provider's findings for the patients to view. It contains numerous information including fees, disclosures, sequencing, and recommended treatment.

c. PRESCRIPTIONS: Record of all prescriptions prescribed to the patient from dental clinic providers consisting of drug name, dosage, signature, and number of refills.

d. MEDICAL ALERTS: Record of all allergies, current medications, and medical alerts associated with each patient. Information must be personally populated by the staff or providers for this section to be used, if not, information is found in the document center on each health history form.

e. DOCUMENT CENTER

i. This section may contain the following: health histories, treatment plans, referrals and correspondences from outside providers, correspondences with the patient, gatekeeper forms, consents, and other information created outside of the program but pertinent to the patient's electronic dental record.

ii. Staff will initial the document before scanning each document into the respective patient's document center.

iii. Staff will verify that the scan has captured all data and is legible.

iv. Hard copies of the scanned documents are filed in the vertical file in the chart room according to the month they were received. Hard copies will be stored for a minimum of 12 months.

B. Database

1. Electronic dental records are maintained and stored on servers by the Information Services department and backed up nightly onto the servers during business days.

2. The dental clinic shall maintain patient records and radiographs for at least seven years from the date of last entry unless:

a. The patient requests the records, radiographs, and models be transferred to another dentist who shall maintain the records and radiographs;

b. The clinic gives the records, radiographs, or models to the patient; or

c. The clinic transfers the dentist's practice to another dentist who shall maintain the records and radiographs.

C. Patient Record Inactivation, Filing, Retention and the Transfer/Release of Records.

See "Health Information Policy."

D. Recall System

1. Staff will utilize Dentrix software to manage and process recalls ensuring appropriate and consistent dental care.

IV. EQUIPMENT AND SUPPLIES

A. Inventory for Supplies

1. There is an ongoing list of supplies utilized in the dental clinic.

2. Upon receipt of supplies, all supplies are put away and expiration dates checked. When supplies are nearly depleted, the items are written down or mentioned to the supply assistant to be ordered.

3. Product recalls are forwarded to the supply assistant via email by the distributor. Those lot numbers are verified by the supply assistant with the current stock and removed (if found on hand) and returned to the distributor or supplier.

B. Storage

1. Supplies are always taken from left to right, top to bottom, and front row to back row.

2. Stock in storage is put away by moving all old stock to the front of the shelf and placing new stock behind old stock.

C. New Equipment

1. New equipment training will take place during staff meetings and is coordinated by the supply assistant prior to use.

D. Selling Dental Products

1. SCHC does not sell any dental products to patients.

V. BILLING

1. As a courtesy, SCHC will directly bill the patient's insurance company to recover payment for all completed treatment. This includes submitting preauthorization for treatment electronically. However, ultimate responsibly for payment,

coverage, and preauthorization in a timely manner lies with the patient.

2. The Patient Accounts department maintains the current dental fee schedule.

3. Appointments for procedures that require a laboratory fee will not be scheduled until all financial obligations have been met.

See "Patient Accounts Policy."

VI. QUALITY IMPROVEMENT PROGRAM

A. Quality Improvement Program

1. Dental staff will hold regular, at least quarterly, program meetings and conduct regular peer review and program audits. Staff will maintain membership on the clinic's Medical Staff and attend all clinic meetings as required. Attendance of all staff is required at the All-Staff meetings. The Dental Director or designee is required at the monthly Planning/QI Committee, Safety Committee, Credentials Committee, and Clinical Care Review Committee meetings. Suggestions from the staff on ways to improve the operation of the dental clinic will be considered by the Dental Director and discussed with the person making the suggestions.

B. Patient Access, Compliance, and Education

1. Cleaning and Annual checkup

   a. A postcard will be sent to patients a month prior to the recommended time for dental cleaning and checkup.

   b. Pediatric Oral Prevention

   c. Well-child checkups incorporate a dental exam section. Pediatricians are also are encouraged to refer children to their dental provider.

   d. School age children receive annual screenings in cooperation with Head Start and the schools.

   e. A sealant program is conducted (if resources are available) to provide sealants, fluoride, home care supplies and oral health education for children attending the school.

2. Patient Education

   a. Dental staff utilize verbal and written communication methods when educating patients. This includes various complementary dental related brochures and visual aids. Verbal and written instructions are documented

in the patient's chart.

C. Chart Reviews

1. Dental providers will review provider and hygienist charts biannually and discuss the results during office meetings and with the respective provider.

PART C
Dental Treatment Policies

I. PRIORITIES AND DEFINING SERVICES

A. Service Priorities

1. The dental clinic has adopted the priorities for service as defined in the "Oral Health Program Guide for the Indian Health Service, Schedule of Dental Services." It consists of six levels of care ranging from Level I services (emergencies) deemed 'necessary treatment' up to Level VI services (complex rehabilitation) considered 'elective.' Level 1 services are considered mandatory treatment.

2. Treatment will be conservative with the goal of salvaging teeth that present with a reasonable prognosis for restoration and restoring the health of the soft tissues. Basic principles of restorative dentistry will be followed in the preparation, management, and restoration of carious, or otherwise damaged, teeth.

3. The dental clinic provides services consistent with the definition of dentistry according to the Oregon Board of Dentistry. In addition, the clinic provides services on a case-by-case basis and reserves the right to refer complex cases or those not permitted at the clinic to outside providers unaffiliated with SCHC, which would be the financial responsibility of the patient.

B. Types of Visits Defined

1. Examination Appointment

    a. Examination, diagnosis, and presentation of the patient's formulated treatment plan with multiple options and alternatives.

2. Treatment Appointment

    a. Actual treatment is rendered.

3. Post-operative Visit

    a. Evaluation of the treatment site to assure proper healing, removal of any necessary sutures, and adjustments to dental prosthesis.

4. Emergency Appointment

    a. A visit made on short notice to relieve an acute situation.

5. Recall Appointment

    a. Periodic examination and prophylaxis appointments scheduled at pre-determined intervals, as set forth by the health care provider, to ensure no active disease or pathology exists, and to ensure a proper standard of care for the patient.

6. Home Care Check

    a. An educational session to improve and verify proper dental hygiene.

7. Screening

    a. An information gathering appointment to determine future treatment and services rendered by the dental clinic or provider referral.

II. SERVICES OFFERED

A. Examination

1. New patients (never been seen at the dental clinic) and patients who have not been seen at the clinic for three or more years, receive a comprehensive exam before any procedures are scheduled. Exceptions to this rule are patients seeking emergency treatment. They will received a limited exam instead.

2. An annual periodic examination will be performed including the charting of the existing condition of the teeth and soft tissues on adults, biannual for children under the age of 18.

3. Periodic or comprehensive exams are required within 18 days post-prophy and/or periodontal maintenance appointment. If not, the patients must wait to schedule their next prophy/SRP/PM until after they complete an exam.

B. Emergency Care

1. The dental clinic is available for the treatment of a true dental emergency (i.e., traumatic damage to the oral cavity, acute infections, or discomfort not responsive to non-prescription analgesics). The dental clinic has designated emergency visit times for patients seeking treatment for a true emergency as time permits and in a timely manner. Gatekeeper on-call service provides after hour's coverage.

    See "Medical Staff Policy, Section VI After Hours Access/On-Call Services/Emergencies."

2. Patients not in immediate pain, and patients who are seeking routine care through emergency services, will instead be scheduled for a future appointment.

3. The aim of emergency treatment will be to alleviate pain only. Once the acute situation has been resolved, any other treatment will require an exam.

4. The emergency patient will be evaluated as time allows and will be treated to alleviate pain or infection.

5. Emergency conditions requiring immediate specialist services will require the Dental Director to make a Priority I referral through PRC.

6. Emergencies involving children will receive top priority. If the dental providers are unable to treat, they will complete steps to refer the child to a pediatric specialist.

C. Operative Dentistry

1. Amalgams for posterior teeth.

2. Composite resins for anterior and posterior teeth.

3. Silver Diamine Fluoride Treatment.

D. Prosthodontics

1. Porcelain fused to metal crowns (PFM), gold crowns (FGC), full porcelain/zirconia crowns, implant restorations, onlays/inlays, and bridges.

    a. Removable partial dentures.

    b. Complete dentures.

    c. Occlusal guards/splints.

2. Patients receiving upper and/or lower dentures, flipper, occlusal guard, retainers, upper and/or lower partial will be responsible for any costs incurred in replacing it if their prosthesis is damaged or lost within five years from the original delivery date.

3. Purchased/Referred Care will cover the costs for one replacement retainer, due to breakage or loss, for patients of the dental clinic's orthodontia program.

E. Endodontics

1. Endodontic treatment of select teeth based on case complexity.

F. Periodontics

1. Conservative treatment (periodontal maintenance, scaling and root planing, and

antimicrobial treatment).

2. Minor surgical treatment to include flap therapy, gingivectomy, and other procedures within the credentials of the practitioner.

G. Oral Surgery

1. Oral surgery procedures:

   a. Simple and surgical extractions.

   b. Preprosthetic alveoloplasty and soft tissue reduction.

   c. Biopsy of oral lesions.

2. Each surgical procedure will have a diagnosis and supporting clinical findings, documentation and dental films indicating the need for and being supportive of the surgical procedure. These findings and the diagnosis will be discussed with the patient prior to surgery.

3. Patient selection criteria will first meet the policy on patient eligibility. Patients are then screened by a dentist by considering the patient's medical history, treatment needed, provider's skill set, available equipment and staffing, approved privileges of the provider, and patient complexity and consent. If any of the above fails to meet the criteria for that provider or the policies, they will be referred to an outside provider to seek treatment.

4. A consent form will be used to summarize the diagnosis, risks, alternative treatments and the consequences of the proposed treatment and the alternatives to treatment and risks and benefits of not receiving treatment. The patient, the dentist (surgeon), and a witness will sign the consent form prior to the initiation of treatment. The consent form shall include a statement of anesthesia risks and operative tooth is marked on the dental diagram. Films, consents, findings, and diagnosis will be maintained in the patient's medical record. Patients will be receive both verbal and written post-operative instructions and are encouraged to contact the clinic if any issues arise.

5. All staff involved in direct patient treatment will be trained and certified in a health care provider equivalent CPR. Medical emergency training is required for each dental license renewal cycle. Emergency supplies are available in the dental laboratory to be used if a patient in the dental clinic experiences a medical emergency.

6. One dental provider authorized by the governing body will be present when patients are undergoing treatment. If no dental provider is available, dental emergency patients can be triaged in medical and sustained until a dental provider

is available.

7. Trained and experienced dental assistants will aid the dentist in the provision of care in providing dental surgery, at minimum one assistant to one dentist. These assistants will be CPR certified and trained in assisting for elective dental surgery. In general, hygiene staff practice without any assistance.

8. Pathology reports of biopsies performed in-house will be communicated to patients as soon as possible after results are obtained by SCHC.

H. Pedodontics

1. Pedodontic procedures:

   a. Amalgam/composite resin restorations.

   b. Stainless steel crowns.

   c. Pulpotomy.

   d. Space maintenance.

2. Routine Dental Care for Children (14 years and younger)

   a. The goal of the dental clinic is to provide pediatric treatment with maximum comfort and minimal anxiety. Since the clinic does not utilize methods such as HOM (hand over mouth) and papoose boards, the providers may refer depending on the patient's compliance level with treatment.

   b. The initial visit should occur upon eruption of the first tooth and no later than 1-year of age. A dental provider will provide definitive exams for all children. High-risk children will be identified using appropriate diagnostic indicators and given appropriate preventive and restorative services.

   c. The dental clinic has three rooms dedicated to nitrous oxide administration. Materials, supplies, and equipment will be on-hand and functional for the treatment of pediatric patients. The emergency kit will contain medications equipped to treat young patients.

   d. Parents and/or legal guardians must be present during all dental visits to fill out necessary forms and give consent for treatment, give consent for changes in treatment, be available in the event of a medical emergency, receive information about the child's dental health, ask questions, and learn proper health habits.

3. Pediatric Care Consent

See "Medical Staff Policy, Section V. Treatment of Minors."

I. Orthodontics

1. The dental clinic does not provide orthodontic treatment in-house but can refer out to orthodontic specialists.

2. Orthodontic treatment covered by Purchased/Referred Care is determined through a screening process and based on the funding available, eligibility of the patient, need, and patients selected. Orthodontists contracted with the tribe will perform the orthodontic treatment.

See "Dental Orthodontic Screening Procedure."

J. Preventive Services

1. Services

   a. Oral prophylaxis

   b. Oral hygiene instruction and training in preventive dental practices

   c. Topical fluoride application

   d. Occlusal Sealants

2. An oral prophylaxis will be performed on all cooperating patients on a schedule recommended by the hygienist or/and dental provider, e.g., 2, 3, or 4 times per year. A program of oral hygiene instructions will follow the appointment.

K. Radiology

1. Radiology procedures

   a. Periapical radiographs

   b. Occlusal radiographs

   c. Bitewing radiographs

   d. Panoramic radiographs

   e. Cone-beam computed tomography

2. Selection Criteria

   a. Dental Radiographic Examinations: Recommendations for patient selection and "Limiting Radiation Exposure 2012 Revised" document will be followed regarding the ordering of dental radiographs on patients.

3. Certifications

   a. All personnel taking radiographs must be certified by the Oregon Board of Dentistry in radiologic proficiency.

   b. Radiographic equipment needs to be surveyed at minimum every 3 years from a certified technician.

4. Monitoring

   a. Personnel involved in patient treatment will be given radiation monitoring badges to wear during patient treatment. These badges will be checked periodically and results will be provided to the staff member and appropriate actions taken to remedy any future exposures.

   b. If over-exposure is suspected the Dental Director will contact DHS – Radiation Protection Services.

5. Safety

   a. The dental clinic utilizes digital radiography to include CBCT, Panoramic, and intra-oral. Lead backed film and chemicals (used to process the films) are no longer utilized by the clinic.

   b. The Risk Management Policy will be followed to ensure mechanical, radiation, and electrical safety of all radiology equipment.

   c. Report #35 published by the National Council on Radiation Protection and Measurements states no known hazard to pregnant dental personnel or their developing fetus while exposing radiographs, if accepted safety guidelines are followed. Annually, dental personnel receive less than 1/50 of the mean equivalent radiographic dose suspected of causing fetal changes.

6. Technique

   a. The dental clinic will choose diagnostic radiographs to optimize patient care, minimize the total radiographic burden, and responsibly allocate health care resources. The decision to use radiographic diagnostic methods and their frequency should include an evaluation of caries risk,

development, dento-alveolar trauma, dentition, restorations, and any other conditions that are relevant in the provider's professional judgment.

See "Dental Radiology Service Procedure."

L. Sedation

1. Minimal sedation such as nitrous oxide or oral sedation may be a treatment option provided at the dental clinic. Patient selection is at the discretion of the dental professional and is dependent on patient's level of anxiety, medical history, and the comfort level of the dental professional.

2. All other sedation methods (general anesthesia, IV sedation, pediatric sedation, etc.) will require a referral to an outside provider.

M. Implants

1. Limited dental implant services may be available to Siletz tribal members. The dental clinic will screen cases and forward those approved to Gatekeepers for consideration. Criteria for dental implants include, but are not limited to, patient medical and dental history, current oral and bone health, and case complexity.

N. Referrals

1. Dental providers reserve the right to refer patients for treatment outside of SCHC if they feel it is in the best interest of the patient and the clinic. The dental clinic will offer contact information to the patient for providers and offices the patient can call to be treated.

2. Purchase/Referred Care

   See "Purchased/Referred Care Policy, Chapter 3."

3. Gatekeeper Referral

   a. Patients who are referred for dental treatment outside of the clinic and would like the tribe to cover the cost of the referred treatment will require approval through the Gatekeeper process. This is available to PRC eligible patients after all individual insurance avenues have been exhausted.

   See "Gatekeeper Referral Procedure" for specifics on this program.

4. Outside Referrals to the Clinic

   Occasionally patients are referred to SCHC from other clinics or private practices for specific dental work that has been recommended. Patients should be

appointed for a consult prior to any treatment rendered. Consults will confirm the appropriate diagnosis, treatment discussion, and treatment planning for the given referral service.

O. Treatment Plans

1. Treatment plans will be discussed with the patient and recorded that they understand the planned treatment. Treatment outlines will generally follow in this order (the provider reserves the right to modify or change the treatment order as is necessary):

    a. Treatment of pain and infection.

    b. Action to prevent the imminent death of pulp tissue and control the spread of infectious process.

    c. Restoration of carious teeth.

    d. Correction of periodontal problems.

    e. Provision of appliances for space maintenance or correction of growth patterns.

    f. Replacement of missing teeth with dentures and bridges.

III. PAIN MANAGEMENT AND ANXIOLYSIS

A. Objectives

1. Pain management outside of treatment.

    a. The dental clinic serves to assess, manage, and treat patients with an acceptable level of care addressing issues of pain and anxiety. Various services are available to patients under the guidance of the appointed care provider; it is the provider's discretion to alter or stop treatment and procedures at any time.

    b. Providers will utilize a number of tests to determine the nature and quality of pain. These measures will include but not be limited to: spontaneity of pain, duration of pain, what is eliciting the pain, quality of pain (sharp vs. throbbing vs. both), and Mankowski Pain Scale.

    c. The dental provider will utilize professional judgment, the patient's medical history, and an interview with the patient to determine how to treat the pain clinically. In some cases when treatment cannot be done at that moment, pain medication may be needed for the pain, and will be

prescribed based on the above analysis. To limit drug abuse potential, it is recommended that the dental provider confirms if patients are on pain contracts prior to writing analgesic prescriptions for their patients. Dental providers will closely ascertain prior to writing prescriptions for anxiolysis or analgesia that patients are not getting a variety of psychotropics, pain medication, and sleep medication from multiple providers through various channels.

d. The dental clinic is not in the position of managing chronic dental pain related to long term jaw osteomylitis, radiation osteonecrosis, pain from cancer, long term pain from temporo-mandibular joint disorders, or myofacial pain dysfunction syndrome. Patients requiring analgesics for more than seven days for any reason should be considered for specialty referral.

2. Dispensing Pharmaceuticals

a. To discourage drug-seeking behavior, treating doctors may elect not to prescribe narcotics if they feel such measures are not necessary or present a risk to patients who may potentially abuse prescription medication. Alternative pain management may be used that has less abuse potential.

b. The dental clinic follows provisions by the State of Oregon Dental Practice Act when dispensing medications.

c. Medicine specific to dental procedures (local and topical anesthetics, chlorohexidine rinses, fluorides, and periodontal medicaments), will be administered by the appropriate dental staff.

i. The dental clinic will be responsible for monitoring expiration dates and disposing of expired products according to manufacturer's recommendations.

d. Reversal agents such as Flumazenil and Naloxone are authorized by licensed dentists, registered nurses, and licensed medical providers.

3. Tracking Usage of Prescription Medications

a. The dental clinic prescribes all patient medications, except those used in dental procedure, through a pharmacy.

4. Emergency Kit Medication Exception

a. In the event of an emergency, the dental staff are authorized to administer prescription medications guided and recorded by a licensed dentist. The pharmacy will dispose of expired or unused medication from the kit.

b. The pharmacist will review the emergency kit and inventory.

c. If any unaccounted emergency kit medications are missing, dental staff will immediately report to the pharmacy to establish accountability and to take appropriate actions.

5. Pain management during treatment.

a. During all procedures, including minimal sedation procedures, patients are continually monitored for acute pain. Monitoring techniques are verbal, visual, and auditory. Verbal techniques include but are not limited to, asking the patient "are you ok?" or "how are you doing?" Some visual signs include wincing movements, tightening of the body or hands or sudden movement. Patients may also be instructed to give a signal if they feel discomfort, such as raising their hand. Auditory clues include the patient giving sounds associated with discomfort, such as grunting or saying "ouch". For diagnostic purposes, patients may be asked questions regarding the quality of pain and the duration of pain. They may also be asked to rate their pain on a visual pain scale to assess pain levels.

b. Management will include stopping any procedure that may be causing discomfort and ascertaining the source of pain. Local anesthetic may be applied within the maximum dose range allowed for each patient based on weight, age, and medical conditions. Post appointment pain control will be evaluated on a case-by-case basis according to expected outcomes.

c. Types of Anesthesia Services Available:

i. Local Anesthesia:

A) Topical Anesthetic.

B) Infiltration Anesthetic.

C) Block Anesthetic.

D) Periodontal Ligament Anesthetic.

E) Pulpal.

F) Intra-osseous Injections.

ii. Anxiolysis (Minimal Sedation):

A) Nitrous Oxide.

B) Oral Sedatives.

iii. The following are not offered:

A) Moderate to General Anesthesia.

B) Regional local anesthesia involving areas other than those confined to the oral cavity and its immediate environment.

d. Licensing

i. Local anesthetic is part of the training program for dentists and dental hygienists, and certification gained when licensed through the Oregon Board of Dentistry. Licensed dental hygienists can administer local anesthetic under the general supervision of the dentist. No supervision is needed for a licensed general dentist to administer local anesthetic.

ii. Oregon Board of Dentistry requires a separate minimal sedation permit for procedures combining nitrous oxide use and oral sedatives used concurrently. They also require a separate permit for nitrous oxide use. Training for these procedures is performed either during the provider's dental degree program or with a separate continuing education class.

iii. Permits are not required for one-time oral sedative use.

iv. Dentists or hygienists may administer nitrous oxide to their patients if they hold a valid nitrous oxide permit from the Oregon Board of Dentistry and hold a current BLS/CPR level certificate, ACLS certificate, or PALS certificate.

v. Anesthesia monitors shall maintain current certification in BLS/CPR and shall be trained in monitoring patient vital signs, and be competent in the use of monitoring and emergency equipment appropriate for the level of sedation utilized. (The term "competent" as used in this policy means displaying special skill or knowledge derived from training and experience).

vi. A licensee that does not hold a Moderate, Deep Sedation or General Anesthesia Permit may not administer, for purpose of anxiolysis or sedation, Benzodiazepines or narcotics in children under 6 years of age.

B. Guidelines for Anxiolysis (Minimal Sedation)

1. Purpose

   a. The dental clinic's intention is to create a relaxed, comfortable, and safe experience for the patient, with little or no anxiety and little or no memory of the appointment; however, some patients will become moderately sedated despite the intended level of minimal sedation.

2. Guidelines

   a. For patient aged 17 and younger, consent of a parent or legal guardian is required for minimal sedation and the parent or guardian must be present for all appointments.

   b. Oral anxiolytic agents are not given to patients under the age of 16.

   c. Patients who do not take their minimal sedation medication as prescribed demonstrate non-compliant behavior and will not be offered anxiolysis in the future.

   d. All assisting staff associated with the use of nitrous oxide shall be oriented to the use, control measures, and potential hazards of nitrous oxide. They are also directly supervised by the permit holder. Dental hygienists can administer under indirect supervision of the dentist.

   e. Nitrous oxide monitoring is recommended quarterly if it is used during the quarter. Manufacturer instructions are followed for proper testing and accurate results. Results are presented to participating staff.

3. Dental Sedation Procedure

   See "Dental Sedation Procedure."

IV. COMMERCIAL DENTAL LABORATORY

A. The dental clinic utilizes commercial dental laboratories for the benefit of the patients. Prosthodontic services include full and partial dentures made of acrylic and polyvinyl materials, crowns, fixed bridgework, and a variety of bleaching trays, fluoride trays, orthodontic appliances, etc.

B. Dental laboratories will be closely monitored for consistent quality of work delivered to providers in a timely manner.

C. Crowns will be closely monitored for fit, finish, shade, materials of composition, occlusion, proper contacts, embrasures, and retention on the model and clinically.

D. Dentures and partials will be closely monitored for fit, finish, shade, materials of composition, occlusion, and retention in the patient's mouth.

E. Labs with generous re-make policies are preferred so that patients who are unhappy with their appliances or dental prosthetics may have them re-made.

PART 8D
Dental Infection Control

I. DENTAL INFECTION CONTROL

A. General Introduction

1. Introduction

   The major goal of the dental clinic's Infection Control Program is to reduce the risk of cross-contamination to the patients and staff. Dental patients and dental health care providers can be exposed to pathogenic microorganisms including cytomegalovirus (CMV), HBV, HCV, herpes simplex virus types 1 and 2, HIV, *Mycobacterium tuberculosis*, staphylococci, streptococci, and other viruses and bacteria that colonize or infect the oral cavity and respiratory tract. These organisms can be transmitted in dental settings through:

   a. Direct contact with blood, oral fluids, or other patient materials.

   b. Indirect contact with contaminated objects (e.g., instruments, equipment, or environmental surfaces).

   c. Contact of conjunctival, nasal, or oral mucosa with droplets (e.g., spatter) containing microorganisms generated from an infected person and propelled a short distance (e.g., by coughing, sneezing, or talking).

   d. Inhalation of airborne microorganisms that can remain suspended in the air for long periods of time.

2. The dental clinic will follow the SCHC Infection Control Policy as well as the 2003 CDC Guidelines for Infection Control in Dental Health Care Settings. In addition, this infection control program is in general agreement with ADA, OBD, and EPA/FDA. Dental specific guidelines on top of these documents will be highlighted below.

3. Education and Training: *See* SCHC "Infection Control Policy."

4. Standard Precautions

   a. All patients and staff will be considered at high risk, all dental staff will practice standard precautions with all patients and materials as outlined in the SCHC Infection Control Policy.

   b. Patients who report to the dental clinic with a contagious disease in conjunction with their dental problem will not be seen until their condition is treated and their physician has deemed them safe to treat around other

dental staff and patients.

B. Hand Hygiene

1. The dental clinic will comply with the SCHC handwashing policy and dental surgical scrub procedure.

See SCHC "Infection Control Policy, Section VIII. Handwashing and Hand Protection"

See "Surgical Scrub Handwashing Procedure."

C. PPE (Personal Protective Equipment)

1. Dental staff will don appropriate PPE when working in the dental clinic as laid out in Part 14 SCHC Infection Control Policy and Part 18 Covid-19 Policy.

2. The wearing of lab coats (provided by CTSI) are encouraged during all treatment but at minimum, during aerosol generating procedures.

    a. SCHC is responsible for laundering the lab coats. Staff are responsible for changing when soiled or each day (whichever comes first) and placing used gowns in a biohazard laundry bag. A contracted laundry service provider will pick it up and launder it according to nationally recognized guidelines for healthcare.

D. Control of Dental Treatment Room Aerosols

1. Introduction

    Aerosols in the work environment present a significant health hazard for both the patient and dental staff. Aerosol spray primarily contains a large-particle spatter of water, saliva, blood, microorganisms, and other debris. This spatter travels only a short distance and settles out quickly. The spatter can land on the floor or near operatory surfaces, the dental health care personnel providing care, or the patient. It can also recirculate through the HVAC system.

See "Dental Aerosol Management Procedure."

E. Environmental Cleaning

1. Introduction

    The primary goal of the infection control program is to eliminate cross-contamination. Equipment and instruments found in a dental treatment room are constructed of many different materials possessing various concerns to infection control protocol. Various items are not easily cleaned and some materials are

adversely affected by the chemistry of the disinfectants. Smooth hard surfaces are ideal to maintain, while equipment items designed with fabric-covered cords, knurled buttons, deep grooves and furrows, or stippled covers complicate cleaning. Equipment design, materials, and form should be considered when purchasing new equipment. Certain semi-critical items, which are new and have not been in a patient's mouth or touched by saliva laden hands, need not be sterilized before use, e.g. new burs, rubber dams, pins for teeth.

See Manufacturer Instructions.

See "Environmental and Instrument Sterilization Procedure."

F. Dental Unit Waterlines

1. The formation of biofilm in waterlines is a significant health risk to providing clean sanitary dental services. The ADA has recommended that water from the dental unit waterlines contain no more than 200 CFU (colony forming units) of bacteria.

2. The dental clinic utilizes Dentapure 365 waterline cartridges in dental unit water bottles. This cartridge (tested and approved by the EPA) ensures that dental unit waterlines stay below 200 CFU for 1 year. The date to replace the cartridges is marked on the bottles and on the dental calendar.

G. Laboratory and Prosthodontic Materials

1. Introduction

Dental prostheses, appliances, and items used in their fabrication (e.g., impressions, occlusal rims, and bite registrations) are potential sources for cross-contamination and should be handled in a manner that prevents exposure of staff, patients, or the office environment to infectious agents. Communication and coordination between the laboratory, manufacturer, and dental practice will ensure that appropriate cleaning and disinfection procedures are performed in the dental clinic or laboratory, materials are not damaged or distorted because of disinfectant overexposure, and effective disinfection procedures are not unnecessarily duplicated.

See "Dental Laboratory Infection Control Procedure."

H. Dental Radiology

1. Introduction

In order to protect both patients and staff from cross-contamination during radiology procedures the dental clinic will maintain infection control standards similar to those performed in the treatment rooms.

See "Dental Laboratory Infection Control Procedure."

I. Instrument Sterilization, Shelf Life and Monitoring

See SCHC "Infection Control Policy, Section XXII. Medical Instrument Sterilization."

J. Operatory Occupancy

1. Access to the treatment area is restricted to the actual patient only, in order to reduce congestion, confusion, distraction, possible injury, and to maintain infection control standards. Exceptions to this rule are at the provider's discretion.

PART 8E
Dental Personnel Policies

I. PERSONNEL

A. Personnel Policy Manual

Dental clinic employees will comply with the CTSI Personnel Manual. *See* "Personnel Manual" available electronically on the CTSI network.

B. Employee Personal Appearance

1. Personal appearance should be professional. Staff to patient proximity during treatment, not commonly found in most other professions, is why personal hygiene habits are important. Therefore, the dental clinic reserves the right to inform staff if their hygiene is not acceptable.

2. The following are dress options for work in the dental clinic:

    a. Utilization of "scrubs".

    b. Wearing of clean, pressed, shirt/blouse, slacks, or dresses.

    c. Clean and closed toed shoes.

3. The following requirements should be adhered to:

    a. Clean, odor-free breath.

    b. Hair neatly combed and kept clean. Long hair tied into a ponytail to avoid impairing vision or contaminating the operating field.

    c. Fingernails clean and trimmed to avoid patient trauma and damage to latex gloves.

    d. Clean and neat clothing and uniforms.

C. Employee Conduct

1. Professional conduct is required in the clinic area. The subject matter discussed in the presence of the patient must show discretion and good taste, and should be generally concerned with clinic matters. Do not argue with a patient; let the provider handle disagreements before they get out of hand.

2. Patients are treated with the same care and respect staff would expect if they were a patient in this clinic.

D. Job Descriptions

1. Staffing levels are subject to funding, availability, and the needs of the tribe in conjunction with the Oregon Board of Dentistry recommendations for adequate and proper staff for the type of dental treatment provided.

2. The roster of personnel working directly with the dental clinic is as follows:

    a. Dental Director

    b. Staff Dentist

    c. Clinical Specialist (i.e. oral surgeon, orthodontist, etc.)

    d. Patient Care Coordinator

    e. Dental Hygienist

    f. Dental Assistant I

    g. Dental Assistant II

    h. Dental Assistant Trainee

E. Dental Orientation

1. New dental employees will undergo a dental clinic orientation coordinated by the QI Coordinator and Dental Director.

For checklist, *see* "Dental Orientation Procedure."
For procedures, *see* "Opening and Closing Procedure."

II. SAFETY AND FACILITY MANAGEMENT

A. Introduction

1. The dental staff will follow the plan set forth in the SCHC Infection Control Policy and Risk Management Policy maintained by the Siletz Community Health Clinic as well as the CTSI Safety Manual maintained by Human Resource. Guidelines specific for dental are discussed below.

B. Protocol for Injury with Contaminated Blood or Body Fluids

See SCHC "Infection Control Policy, Section XIX. Employee Health and Occupational Exposure Risk Mitigation."

C. Dental Hazard Communication Program

1. The Hazard Communication Program's purpose is to protect employees from hazardous materials in the dental clinic. Dental will follow the CTSI Hazard Communication Program.

See "CTSI Safety Manual."

D. Office and Natural Emergencies

1. A list of emergency telephone numbers and extensions is posted by each telephone.

2. Dental staff are required to understand the various protocols and know the location of equipment used in the management of hazardous incidents including fire extinguishers, AEDs, supplemental oxygen, biohazard waste bins, spill kits, and an emergency medicine kit.

3. Dental staff will participate in various periodic clinic reviews and emergency drills (i.e. fire, earthquake, code blue, etc.), usually without advance knowledge, to ensure proper function and coordination of staff roles in such emergency situations

E. Dental Clinic Fire Plan

Upon discovery of a fire, dental personnel will follow the Risk Management Policy.

See "Risk Management Policy."

F. Dental Clinic Power Failure

1. In the event of power loss while treating a patient, the goal will be to stabilize the patient safely and reschedule the appointment

See "Dental Power Failure Procedure."

G. Environmental

1. The dental clinic will utilize best practices to reduce or eliminate potentially harmful substances that might affect the environment.

See "Dental Waste Procedures."

H. Radiation Exposure

See "General Policies of the Dental Clinic, Part 8C.I."
See "CTSI Safety Manual."

PART 8F
Definitions

I. DEFINITIONS

A. AEROSOL. Particles of respirable size (less than 10 µm) generated by both humans and environmental sources that can remain viable and airborne for extended periods in the indoor environment; commonly generated in dentistry during use of handpieces, ultrasonic scalers, and air/water syringes.

B. ANXIOLYTIC AGENTS. A category of drugs used to prevent anxiety and treat anxiety related disorders.

C. ANESTHESIA MONITOR. A person trained in monitoring patients under sedation and capable of assisting with procedures, problems, and emergency incidents that may occur as a result of the sedation or secondary to an unexpected medical complication.

D. ADA. American Dental Association.

E. OBD. Oregon Board of Dentistry.

F. EPA. Environmental Protection Agency.

G. FDA. Food and Drug Administration.

H. ANTISEPTIC. Chemical agent applied to tissue to inhibit growth of microorganisms.

I. ASEPSIS. A pathogen-free condition.

J. MAY/CAN. Indicates freedom or liberty to follow, if deemed appropriate.

K. MUST. Indicates an imperative need and/or duty.

L. SHOULD. Indicates the recommended manner to obtain an acceptable standard. Alternative methods may be followed to meet the suggested standard.