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SECTION 1.1: CLINICAL OPERATIONS OVERVIEW

OFFICE OF CLINICAL OPERATIONS OVERVIEW
The Office of Clinical Operations ("OCO") is responsible for coordinating the clinical educational programs of the School. OCO coordinates the School's physical facility, equipment, supplies, staff, clinical schedules, patients, quality and risk assessment, and information management to provide each student with their clinical experience. This is accomplished through a collaborative and supportive relationship with all the School's communities: students, staff, faculty and patients.

OCO oversees numerous programs and operations including: Front Desk, Dispensary, Comprehensive Care Clinic, Dental Auxiliary Utilization (DAU), Risk Management, Quality Improvement, Adult Screening, Student Advocates, Patient Advocate, Clinical Privileges, Clinical Orientation, Clinical Policy and Procedures, and Clinical Information Management.

OCO faculty and staff pride themselves on their ability to meet the needs of a dental practice with approximately 180 dental and dental hygiene students, 40 full-time and approximately 200 part-time faculty in 12 academic divisions, 70 staff members, and 20,000 patient visitors each year.

OFFICE HOURS
The Office of Clinical Operations is open the following hours:
Monday - Friday 8:00 am to 5:00 pm

CLINICAL OPERATIONS FACULTY (OCO) AND STAFF
Associate Dean for Clinic Operations
Terrence Batliner, DDS, MBA

DENTAL STUDENT PATIENT CARE SYSTEM OVERVIEW
The School of Dental Medicine Patient Care System is designed to give dental and dental hygiene students a wide variety of clinical educational experiences while meeting the treatment needs of patients of record. The system is based on vertically integrated comprehensive-care groups with faculty group leaders who act as a general dentist mentors. Dental students are enrolled in Comprehensive Patient Care courses beginning with the spring semester of the DS2 year, and continuing through the fall semester of the DS4 year. ISP1’s begin this process in the Spring semester of their first year. It should be noted that reference to dental students should also be considered to refer to ISP students.

The primary goal of the Comprehensive Care Program is to fulfill our school’s commitment to providing a clinical learning environment which is patient-centered rather than procedure-oriented, yet still provides students a sufficient number and breadth of clinical experiences. The most important expectation and responsibility of dental students in the Comprehensive Care Clinic is that they deliver, in a timely manner, the comprehensive dental treatment appropriate to each patient. Each individual patient’s oral health needs, personal preferences, and their social, economic, and emotional circumstances must be sensitively considered. It is expected that students attend all scheduled clinic sessions and provide ethical, high quality, patient-centered care in all circumstances.

Students are given the opportunity to develop their skills and demonstrate their achievement of these 22 competencies while treating assigned patients in a comprehensive manner. Patients are selected based on their dental needs and ability to meet scheduling and financial obligations. Dental students are responsible for the management of all patients assigned into their "dental practice." Students are given the green light from the Competency Review Board to begin their Advance Clinical Training Program (“ACTS”). Dental hygiene students are also responsible for the management of all patients’ assignment up until they leave the program upon graduation. Each student's practice consists primarily of "comprehensive care" patients, but other patients classified as “limited care” patients are assigned as well. The OCO faculty and staff, in conjunction with other clinical faculty, form a support system for the students during their clinical educational experience.
Dental students begin their clinical experience in a limited fashion during their first three terms by observing and assisting upperclassmen, and participating in clinical exercises with each other. These DS1 and DS2 students are initially assigned into their Comprehensive Care Groups, although the assignments to group are re-assessed during the DS2 spring term. During the spring semester of their second year students begin work in the "Transition Clinic" on patients from a variety of sources including (1) new patients, (2) transfer patients, and (3) shared patients with upperclassmen. During the next several months, new and transfer patients continue to be assigned to students for diagnosis and treatment, based on the combined needs of the students and the patients.

During “transfer appointments,” dental students are required to account for all assigned patient. These appointments allow for a final evaluation by the student and faculty of remaining treatment needs and quality assurance of treatment completed.

Dental hygiene students begin their clinical experience during the spring semester of their junior year. Patients are assigned to dental hygiene students based on criteria established by the Dental Hygiene Department. All such patients will need to be either transferred to another dental hygiene student or a dental student for comprehensive care or discontinued from the program prior to the hygiene student’s graduation.

**Section 1.2: COMPETENCIES FOR THE NEW DENTIST**

**Competencies for the New Dentist**

Practicing general dentistry requires that a dentist possess the ability to incorporate understanding, skill, and values in an integrated response to clinical and other professional challenges. Competency statements have been compiled to describe the performance of UCDSDM graduates as they enter dental practice settings rather than students in individual courses. The statements should be seen as dynamic rather than static. As the practice of dentistry changes, so will the expectations for new dentists.

The competencies include professional/practice competencies as well as patient care competencies organized into five domains. The five domains are 1) professionalism and ethics, 2) assessment and diagnosis, 3) establishment and maintenance of a healthy oral environment, 4) restoration of form, function, health and esthetics, and 5) practice administration. These competencies apply to treatment or management of the child, adolescent, adult, geriatric and medically compromised patient. When graduates are expected to perform the necessary treatment procedures, the words such as “perform”, “provide”, “restore”, or “treat” are used. When the new dentist is likely to oversee treatment or to refer to another provider, the terms, such as “manage” and “recognize” are used.
Section 1.3 CLINIC/DEPARTMENTAL HOURS

School of Dental Medicine Building
   Clinic  .................................................. 6:30 a.m. – 6:00 p.m.
   Building .................................................. 6:30 a.m. – 12:00 a.m.

Pre-Doctoral Clinic Operations
   Student/Faculty Access  ............... 6:00 a.m. – 6:00 p.m.
   Students off Clinic Floor by 5:00 p.m. daily, unless completing treatment with faculty coverage

   Patient Care  .................... 10:00 a.m. – 12:30 p.m. and 2:00 - 4:30 p.m.
   Equipment and Operations Maintenance . 8:00 a.m. - 5:00 p.m.
   Front Desk  .......................... 8:00 a.m. - 5:00 p.m.
   Dispensary Window  ............... 7:30 a.m. - 5:15 p.m.
   Dispensary Staff [Spring/Fall Term] ............................ 7:30 a.m. – 5:30 p.m.
   Supply Counter  .................... 7:30 a.m. - 5:00 p.m.
   Supply Staff  .................... 7:30 a.m. - 5:00 pm
   Payment Staff  ............... 8:00 a.m. - 5:00 p.m.
   Payment Window  .................. 8:00 a.m. - 5:30 p.m.
   Radiology  .................... 8:00 a.m. - 5:00 p.m.
   OCO  .......................... 8:00 a.m. - 5:00 p.m.
   Emergency Clinic  ............... 9:00 a.m.-NOON and 1:00 p.m.- 4:30 p.m.
   Specialty Clinic  .................. 8:00 a.m. - 5:00 p.m.

Student Technique Support Lab and Student Lounges
   Sunday-Saturday  ..................... 6:30 a.m.-12:00 a.m.

Simulation Clinic
   Monday – Friday  ..................... 6:30 a.m.- 12:00 a.m.
Section 1.4 STUDENT DRESS CODE

SUBJECT: Student Dress Code

PURPOSE: To standardize the dress of students in an effort to promote professional standards with regard to safety, cleanliness, comfort and image.

GENERAL POLICY:
A neat, clean professional appearance is required in all areas of the building. This requirement applies to all students, faculty, staff, and residents. All articles of clothing worn in the School should be clean and in good repair.

This policy must be read in conjunction with the School's Exposure Control Plan. If a conflict arises between this policy and the School's Infection Control Policies, Infection Control Policies will prevail.

IMPLEMENTATION:
I. COORDINATION
The Associate Dean for Clinical Operations shall be responsible for coordinating the selection of clinical attire for each class prior to participation in clinical activities.

II. CLINIC GARMENTS
A. Outer Garments
   The decision to determine the proper outer garments typically rests upon whether the planned patient contact involves a potential for splatter. In order to err on the side of safety and to allow for ease of monitoring, the use of outer garments will be based on whether the provider is providing treatment to the patient, regardless of the potential for splatter. Treatment procedures are defined as any time the provider has the potential to contact saliva or blood of the patient, either directly (e.g., gloves) or indirectly (e.g., through instruments). Treatment procedures do not include chairside patient interviews and instruction.
   1. Disposable lab coat as approved and provided by the Office of Clinical Operations will be worn during all treatment procedures. The outer garment will have a high neck and protect the arms if splash and spatter are reasonably anticipated. Gowns should be changed for each clinic session or more often if visibly soiled.

B. Other Garments to be worn during Patient Treatment
   In addition to approved outer garments as listed in section II.A, students will be required to wear full surgical scrubs for all clinical patient care, whether or not there is a potential for splatter.
   1. Style and Color
      The Office of Clinic Operations will be responsible for coordinating the style and color of scrubs for each class prior to their entry into the clinic.
   2. Undergarments
      Undergarments, shirts or blouses must be fully covered by the student's scrubs.
   3. Footwear
      a. Dress or athletic shoes are acceptable, but they must be clean and in good repair.
      b. Shoes must protect and cover the foot (i.e. open toe or exposed dorsum of the foot is inappropriate).
      c. Heel height should not exceed 2 inches.
      d. Nylons or socks must be worn at all times.
   4. Glasses and Protective Eyewear
      a. Regular prescription or safety glasses must be worn during all clinical procedures with a potential for splatter of saliva or blood. Glasses should protect the student on the side through wrap-around styling or a side-shield.
      b. Other appropriate eye protection includes a full face shield used in conjunction with a mask or a combination mask/eyeshield system.
5. Jewelry  
   a. Chain type necklaces and stud-style earrings may be worn during all clinical procedures.  
   b. Smooth (wedding band style) rings may be worn if the operator wears gloves. Ring styles which may  
      puncture rubber gloves must be removed.
6. Security Badges  
   a. Each student/staff/faculty member will be assigned a security badge which is to be worn as a part of  
      all clinical attire. If you lose badge, please report it to the Office of Academic and Student Affairs  
      and campus security for a replacement.  Note: There will be a fee for each replacement.

III. CLINICAL LEVEL DRESS CODE FOR NON-TREATMENT ON THE CLINIC FLOOR LEVEL  
Students who are present on the main Clinic Level of the building, and are not involved in patient care, should be  
appropriately dressed as follows:
   A. Surgical Scrubs as described in Section II  
   B. Street Clothes  
      1. Both men and women may wear regular slacks or cords that are clean, neat and in good repair;  
      2. Women may wear either skirts or dresses that are full and long enough to allow for modesty and  
         comfortable movement;  
      3. Men are required to wear a dress shirt;  
      4. Women are permitted to wear a variety of blouse styles that are in good taste;  
      5. First Floor attire with an approved outer garment as described and limited in Section V.C.  
      6. NOT PERMITTED - Shorts, gym or sweat clothing, t-shirts or halter tops.

IV. PERSONAL HYGIENE  
   A. Hair  
      1. Hair should be neat, clean, and out of the field of operation. Surgical caps are required during surgical  
         procedures.  
      2. Shoulder length hair must be tied back at the nape of the neck so that it does not require handling during  
         the treatment procedure.  
      3. Short hair around the face, such as long bangs or "feathers" must be kept off the face.  
      4. Facial hair must be kept neat, clean and well trimmed.  
   B. Fingernails  
      1. Hands and fingernails must be kept immaculately clean.  
      2. Fingernails must be kept trimmed and well-manicured.  
   C. Personal Cleanliness  
      1. Body hygiene is required so that offensive body odors are avoided.  
      2. Preventive measures should be taken to maintain favorable oral hygiene and to prevent breath odors.  
         Eating strong foods (garlic, onions, etc) on clinic days should be avoided.  
      3. Strong perfumes, colognes or after-shave lotions should be avoided.  
   D. Make-up  
      Women are expected to wear a minimal amount of make-up. Moderation should be exercised due to the  
      close proximity of patients during treatment.

V. DRESS GUIDELINES FOR FIRST FLOOR CLASSROOM/LAB ACTIVITIES  
   A. Due to the presence of visitors in the School, the street attire described above in Section III is preferred.  
   B. A more casual attire is permissible with the following limitations.  
      1. Shorts, cutoff, T-shirts or halter tops, gym or sweat clothes are not permitted.  
      2. Clean shoes and socks must be worn.  
      3. A clean, non-clinical lab coat should be used for laboratory work.  
      4. Jeans that are clean and in good repair are permitted but not encouraged.  
   C. Any student who enters the patient care area, which includes the reception areas, clinical hallways, and  
      the treatment clinics, must wear at least a clean laboratory coat over acceptable street clothing. This pro  
      vision is intended to facilitate use of the appointment system, dispensary, and consulting with faculty. It  
      is not to be construed as a waiver of clinical attire requirements.
VI. DRESS GUIDELINES FOR SIMULATION CLINIC
Students will follow the same dress guidelines for the simulation clinic as for the regular clinic, with one exception: disposable outer gowns will not be worn in the simulation clinic. Students may wear laundered lab coats or scrubs while working in the Simulation Clinic.

VII. ENFORCEMENT
The spirit of the dress code is intended to nurture the professional image of the dental and dental hygiene students and the image of our school. In addition, the stated guidelines provide for both student and patient safety. It is hoped that all students will cooperate by complying with the code without enforcement being necessary. Recognizing that not all students share this point of view, enforcement shall be the responsibility of the supervising faculty who is authorized to take appropriate action in order to achieve compliance. These actions may include the following:

A. Warnings
B. Denials of access to clinics, classrooms or laboratories.
C. Reduction of grades where appropriate.

STUDENTS HAVE THE RIGHT TO APPEAL ANY DISCIPLINARY ACTION TO THE UCSDM CONDUCT COMMITTEE

Section 1.5 CLINIC SCHEDULES AND ATTENDANCE

Dental Students are scheduled into the patient care clinics jointly by the Offices of Academic Affairs (as published in the “academic course schedule”) and Clinical Operations (as published in the “coverage” and “block” schedules). Clinic contact hours vary from term to term and even week to week throughout the student’s four-year curriculum. Students have a combination of scheduled block rotations and general patient care clinical sessions to treat their assigned patient practice and other appointed patients.

Academic Course Schedule
Published by the Office of Academic Affairs and typically distributed to students one month prior to the start of each term. The schedule indicates when students are scheduled to be in a particular course or in the clinic. Students are encouraged to refer to the schedule online for any updates or changes in the academic schedule.

Clinic Coverage Schedule
Published by OCO and typically distributed to students one month prior to the start of each term. The schedule is developed to allow the students access to both group and specialty faculty on a regular basis each week and throughout the term. The coverage schedule ultimately establishes the template for the group and block rotation appointment books.

✓ Group v. Specialty Availability – Each session is staffed by a combination of group and specialty faculty. Group faculty are available each session for multidisciplinary coverage. Specialty faculty from divisions are available throughout most weeks, but not necessarily on a daily basis (e.g., endodontic faculty might be scheduled 4 – 5 sessions in a week.

✓ Student : Faculty Ratio – Most faculty have 6 openings each session that they are scheduled. There are exceptions to this (e.g., periodontal surgery is 1:2), and the number of students per faculty is indicated on the coverage page. Each faculty has a fixed number of students they may cover at any given time during the session. Exceptions in these coverage may only be authorized by the faculty themselves (or in the case of group faculty, their group coordinator).

✓ Schedule Changes - Occasional changes in faculty coverage that occur throughout the term are noted on the master schedule in axiUm and communicated to students in this manner.
Clinic Block Rotation Schedules
Published by OCO and typically distributed to students one month prior to the start of each term. Block rotations are mandatory and students may not appoint or treat any patients outside of the block in the general patient care clinic when they are scheduled on a block rotation, regardless of whether the student has been dismissed from the block rotation, except as noted. Covering general clinic faculty have the discretion to allow students to see other patients in the general clinic, if space is available, the program director of the block approves and there are extenuating circumstances that make it in the best interest of the patient to be seen at that time. Students are not allowed to trade or switch their block assignments without prior approval of the program director, group faculty and OCO.

It is intended that each student has the same number of contact sessions for each block rotation. However, it is typical that there is a slight variance due to such issues as class size and holidays. Depending on the block, there may be a great deal of variation as to the timing of each student’s participation in a block, but the ultimate session count will be relatively equal at the end of all rotations. Program Directors for each block rotation reserve the right to schedule additional time for students for a variety of reasons, most significantly to give the student opportunities to develop and demonstrate competency within the discipline.

Clinical Attendance
Students are required to attend all scheduled clinical sessions, with exceptions as noted below. Students are encouraged to treat their own scheduled patients, and those patients should be given first priority.

I. Attendance Monitoring - Clinic attendance is monitored through axiUm. Every patient encounter must be documented by the generation of an entry in axiUm, regardless of whether there is a fee associated with the patient visit. For those clinic experiences that do not involve direct patient care (e.g., clinical assisting), the student is responsible to contact their group coordinator to enter them in axiUm as the assistant provider, in order to get credit for the clinic session.

II. Alternative Clinical Activities - In the event that the student is unable to schedule their patient or has an unanticipated open appointment, the following will apply. If the student’s scheduled patients are unavailable for treatment, the student will be required to check into their group coordinator for assignments as indicated, with priority as determined by group coordinators and/or faculty:
   1. Treat patients scheduled by group or front desk staff on limited basis. Groups may schedule extra patients each session, including preventive maintenance, group emergencies, shared patients, etc.
   2. Emergency Clinic
   3. Oral Surgery Clinic
   4. Special Care Clinic
   5. Senior’s Dental Clinic
   6. Pediatric Dental Clinic
   7. Periodontal Surgery Assist
   8. Screening
   9. General Practice Residency
   10. Dental Faculty Practice
   11. Dental Assisting
   12. Record Audit and Quality Case Review
   13. Simulation Clinic Exercise

Students will be given clinical attendance credit only for the above listed areas. In the event that all of the above areas do not require student participation, the student may be directed to pursue other activities (ie: lab work, chart or practice organization, study, etc.). However, students are expected to remain available via page throughout the session, unless otherwise directed by group faculty or coordinator.
III. Excused Absences - In order to allow for personal time, students will be allowed up to four sessions of
excused absences per term, which may be either pre-arranged or approved as noted above on the same
day. OCO will coordinate and approve absences.

IV. Unexcused Absences - Failure to attend clinic will result in an "unexcused absence". Unexcused
absences will negatively affect the student's patient care clinic grade, and may be grounds for loss of clinic
privileges.

V. Coordination and Enforcement - The Office of Clinic Operations will coordinate and enforce this poli-
cy, with assistance of group coordinators and faculty.

**Section 1.6 CLINIC, SIMULATION CLINIC AND
TECHNIQUES LAB UP-KEEP & MAINTENANCE**

The upkeep and maintenance of all clinic and clinic support areas throughout the school is the joint responsibility
of students, faculty, UCDSDM staff and UCD Environmental Services.

**I. ENVIRONMENTAL SERVICES RESPONSIBILITIES:**
The specific details and full ranges of services provided by Environmental Services are available through Mark
Osvirk in Supply. Environmental Services retains the following primary responsibilities in all areas:
1. Floors
2. Trash Pick-up & Removal [both in between sessions and at the end of the day].
3. Stock Paper Towels
4. Rest Rooms

*Please note that environmental services will NOT clean countertops in any area or throw out any papers
or other trash/debris left out.*

**II. SCHOOL OF DENTAL MEDICINE STAFF RESPONSIBILITIES:**

A. Clinic
The dispensary dental assisting staff will have the responsibility of maintaining the East and West
Clinics and the first floor dental assisting staff will maintain the first floor clinics. The following
exceptions will apply:
1. Infectious waste containers will be emptied by floor and dispensary staff alternating
each month.
2. The Dispensary will have the following responsibility for both clinics.
   - Emptying and filling the disinfection bottles and tubs.
   - Maintaining the required stock level of disposable items that will be used to stock the
     clinics.
   - Performs a walk through each morning to annotate any units that are left in poor condi-
     tion by students.
   - A list of the units will be given to the clinic administrator for disposition to OCO.
The following are the areas of responsibility for both departments within the assigned clinics.

**Weekly**
1. A complete cleaning of each dental unit.
2. Clean/Exchange traps, if necessary.
3. Flush suction lines with cleaner.
4. Water line maintenance.
5. Check oxygen units and related equipment (ambubag, pocket masks).
6. Check needle discard containers, (turn full ones into the Dispensary for disposal).

**Daily**
1. A general upkeep of the dental units, (examples: remove tape, magazines, organize dispensing items).
2. Clinic Stocking:
   - Gloves
   - Masks
   - Hand Soap
   - Barriers
   - Gowns
3. Cabinet/Cart Stocking:

**B. Simulation Clinic and Support Lab**
The Supply staff will be responsible for stocking the materials and supplies necessary to run courses and practice sessions for students in these areas.

**C. Technique Lab**
The Supply staff will be responsible for stocking the materials and supplies necessary to run courses and practice sessions for students in these areas.

**III. STUDENT RESPONSIBILITIES:**

**A. Clinic and Support Lab**
Students are responsible for set-up and breakdown of their chair for each session. **This includes the following:**
2. Returning all items to their appropriate place including:
   a. Boxes of Gloves
   b. Sharps Container
   c. Unused Isolation Gowns
   d. Hand Mirror
   e. 2 x 2 Cotton Rolls, etc.
3. Returning magazines, newspapers and other items left by students or patients at the unit.
4. Removal of tape from unit counters and shelves.
5. Replacing lids on containers.
6. Disposal of trash in appropriate clinic containers.

**B. Simulation Clinic and Support Lab**
The Simulation Clinic will be open for student use Monday through Friday from approximately 6:00 a.m. to 10:00 p.m. During this time students are welcome to use this facility for additional practice and enhancement sessions. The facility will be unsupervised and is to be used subject to the following conditions
1. This is a clinic environment and not to be used as a laboratory area.
2. All rules and regulations as posted or otherwise described must be followed.
3. The facility must be maintained and kept clean.
   a. Remove all items from and clean the surface of the simulator.
   b. Stow tubing arms of the simulator in their proper position
   c. Make sure that simulator is off with stabilizing legs raised.
   d. Place the simulator completely under the counter in the left rear area of the knee space.
e. Place the foot control on the cradle Underneath the simulator.
f. Completely lower the operator’s stool then place it completely underneath the counter to the right of the simulator.
g. Turn off the operator’s light and return to the stowed position.
h. Return all unused dental supplies to the proper storage location.
i. Place all debris and used disposable items in the trash.
j. Remove all items from and clean the surface of the counter top with the cleaning solution provided.
k. Turn off any equipment used except the monitor.

4. Individual course directors have the right to limit the types of procedures you may perform in this facility outside of normal course hours.

C. Technique Lab

The Technique Lab will be open to students most days throughout the year according to published schedules. Students are responsible for the following:

1. Place brown paper over work area to protect benches.
2. Throw excess stone in trash cans; Do NOT rinse excess stone down drain to prevent clogging and abuse of plaster traps.
3. When using model trimmers, rinse them down with spray hose to prevent build-up and DO NOT USE WITH WAX ON MODELS [wheel will be ruined].
4. DO NOT leave bunsen burners on under the task lamps, lights will easily burn and melt.
5. When using burs in handpieces, make sure the bur is completely seated to avoid ruining the bur.
6. Remove all debris and dispose in trash.
7. Scrape to remove adherent debris (wax, stone, acrylic, etc.).
8. Wash surface with cleaner and wet rag or sponge as provided.
9. Clean shield of dust collector under running water.
10. Match chair number to unit, wipe clean, and push under bench.
11. Replace handpiece and air syringe to holders, task light to proper position.
12. Report any equipment problems to Chuck Unitt, stocking and facility issues to Terry Franks.

IV. FACULTY RESPONSIBILITIES:
Faculty will continue to be responsible to oversee that students and staff are following the University of Colorado School of Dental Medicine Exposure Control Plan. Violations in infection control protocol and techniques may be reflected in individual procedure grades and/or through patient management as monitored by the Office of Clinical Affairs. Faculty who note clinic up-keep issues should notify either the Office of Clinical Affairs faculty or, if specifically an environment services issue, may contact Terry Franks directly at 58741.

Clinic up-keep is the responsibility of every member in the Dental School. All in our program have a role to make sure that the clinic, simulation clinic and technique lab remain clean, efficient and safe. Thank you very much for your cooperation in this area.
Section 1.7 FRONT DESK

HOURS OF OPERATION
Front Desk/Reception: 8:00 a.m. – 5:00 p.m.

TELEPHONE PROCEDURES
All patients need to be contacted by telephone as soon as they are assigned to the student. It is advised that the student confirm all appointments and give their patients a home phone and the school’s main number (303-724-6900). If a patient has a long distance number, the call can be made from the school, a personal identification number will be issued by the Office of Support Services. The call must be made as follows: dial 9+1+area code+patient's phone number+student PIN #. The call is complete at this time. It is recommended that students keep a log of their long distance phone calls. Financial Affairs Office will contact the student to verify the calls placed by your ID number.

CONTACTING STUDENTS
Students will be contacted either by email or cell phone regarding patient issues. The first attempt will be to locate the student. If the student is not located in the school, then email or cell phone will be used.

Students should never leave their patients unattended during dental procedures. Students should instruct patients to call them outside of the Dental School clinics for routine matters (i.e., making appointments). It is highly recommended that students have a home answering machine and/or cell phone for routine messages from patients during the day. Students should minimize personal phone calls at the Dental School.

PATIENT CHECK-IN
Patients will check in at the Front Desk when they arrive. The staff will monitor and assist patients in the reception area who have not been met by their student. Students will be responsible to communicate to patients when they will be unable to seat them at the appointed time. All appointments will be checked in through axiUm. Students are asked to remain at their chair until they see their patients name turn red in the computer, indicating their patient has arrived. If after 15 minutes past the clinic start time, the student does not see their patient’s name in red, they may then go to the Front Desk to inquire about their patient’s status. Students should advise their patient, when confirming the appointment, to make sure they check in with the Front Desk, upon arrival.

If a student has not been out to the Front Desk, to get their patient, they will be paged as follows:
- Morning Session at 9:15 a.m.
- Afternoon Session at 2:15 p.m.

CLINICAL ATTENDANCE
All students are expected to attend each scheduled clinic session. Clinic attendance is monitored through axiUm software information system. Each patient visit requires an entry in axiUm, regardless of whether the patient is responsible for a fee for the service provided. If the patient cancels/fails, the student should sign an attendance form in their coordinator’s office. For those clinical activities that do not involve direct patient care for the student (e.g., clinic assisting), you must arrange this through your group coordinator to get credit for clinic participation.

CHAIR ASSIGNMENTS
All appointments and chair assignments are requested and scheduled through axiUm. If a student has a same day request for an appointment, they must see their coordinator. The student can view their chair assignments through their personal planner in axiUm. If a student’s patient cancels or fails their appointment, the student is required to let their coordinator know so the appropriate action, in axiUm, can be taken. Since the student is scheduled to be in clinic, at that time, they are required to stay on the floor or let their coordinator know where they can be found, if needed.
Section 1.8 ELECTRONIC RECORDS

RECORDS:
Records for current patients are electronic on axiUm. All paper charts are stored off site. If a paper chart is needed, it will be necessary to fill out a chart request card. Requests that are made by 10:00 am will be received the same day. The request cards should be placed in a basket at the supply counter. Charts should also be returned to this area.

Requests for Duplicate Records
All dental records, including any part thereof, are the property of the UCDSDM, however, patients retain the right to all information contained therein. Pursuant to C.R.S. 24-1-801 et seq., all requests for release of records must be received in writing, signed and dated by the patient or their legal guardian. No part of a patient’s dental record may be released to either the patient or his/her representative unless the written release is conveyed to the UCDSDM using the UCDSDM release form, or in a letter signed by the patient or the legal guardian of a minor child. All releases must be made by the Associate Dean for Clinic Operations or his/her designee with an accompanying entry in the treatment note indicating that copies of the record have been released. Release of the original record is only to be done under a court order and after a complete copy of the record has been made. Reasonable fees for duplication will apply.

Section 1.9 MAIN DISPENSARY

DISPENSARY OVERVIEW
A. The Main Dispensary is responsible to support students in the following patient treatment requirements.
   1. Maintenance and issue of materials and equipment.
   3. Accountability of all instruments, equipment and materials.
B. The Main Dispensary items are NOT for use in technique or senior labs. All Dispensary items are for clinic use only. Lab requirements are issued from “Support Services”

HOURS OF OPERATION FOR STUDENT ACCESS
1. Monday - Friday 7:30 - 5:15 P.M.

IN (Receiving) and OUT (Dispensing) WINDOWS:
The dispensary has one window for “issue” and one window to “receive”
1. "Out Window" - this window is for dispensing of instrument cassettes that have not been previously requested through axiUm. This window will not open prior to 7:30 a.m.
   a. Students will come to the "OUT" window to pick-up instrument cassettes not previously requested through axiUm. A student will never be allowed to pick up personal instruments for a fellow student.
   b. Student will pick-up additional items required for patient treatment and/or return setups not required for treatment to the "OUT" window.
   c. All instrument cassettes are brought up from central sterilization in stainless steel carts. Each clinic (East and West) has one cart from which the students receive their instruments. All instruments and equipment are scanned out to the student and recorded in axiUm.

2. "In Window" - This window is for the return of Dispensary items and student instruments not picked up by the mobile carts. This window will close PROMPTLY at 5:15 pm. Dispensary items in the possession of the student after 5:15pm will be placed NEATLY at the “In window”.
   a. Instruments/equipment are picked up at chairside by the dispensary staff or turned in at the window.
      Students are required to remove all gross debris and cements from instruments prior to returning the instruments. The staff member will pull up the student name in axiUm and the student will swipe their axiUm card to identify him/herself. The student will verify that all instruments/items are present (refer to cassette layouts in treatment room) (see attached layouts) and hand them to the staff
member. If any instrument is defective, dispensary will mark it with a piece of masking tape to alert sterilization to replace it, unless the student needs it promptly, the dispensary will replace right away. They will scan everything back into axiUm. All items are then taken to the “In window” for processing and transfer to central sterilization. Items missing will be charged out by sterilization.

3. **All Metal Impression Trays.** The Dispensary has depressed anterior trays available for check out. Trays will not be accepted for sign in unless they are clean.

**ANTIBIOTICS AVAILABLE FOR PRE-MEDICATION**

1. The dispensary has Clindamycin and Amoxicillin available in dosage consistent with AHA guidelines for SBE prophylaxis. This is for emergency situations and will not be used to supply a patient with all their “pre-med” requirements.

2. The dispensary has blank prescription forms for issue when any drug is needed for patient treatment, if unable to print it from axiUm.

**BROKEN OR LOST STUDENT INSTRUMENTS**

1. Students are not charged for broken instruments unless in the case of negligence.
2. Lost instruments will be charged to the student. A statement will be generated from axiUm and placed in the student’s mailbox at the beginning of the month.

**GLOVE OPTIONS**

- **Non-Sterile**
  1. Powderless nitrile gloves.

- **Sterile**

**PATIENT HYGIENE AIDS**

The Dispensary has numerous Hygiene aids available for patients. They are located in a hall cabinet outside the Dispensary.
Disposable Item Dispensing Locations:

**Supply Carts**  
- Anesthetics  
- Needles  
- Cavity Bases/Liners  
- Indicators  
- Etchants  
- Restorative Material  
- Occlusal Adjustment/Bite Registration  
- Fluoride  
- Cements  
- Sealants  
- Waxes  
- Floss  
- Blades  
- Finishing Strips and Discs  
- Restorative Bands  
- Peridex  
- Vaseline/Surgilube  
- 20% Isopropyl Rubbing Alcohol  
- Snap Acrylic and Monomer  
- All Disposables  
- Disposable Gowns

**Endo Cabinet**  
- Cotton Pellets  
- Cotton Rolls  
- Gauze  
- Saliva Ejectors  
- Tongue Blades  
- Rubber Dam  
- Calcijet  
- Files  
- Rotary Files  
- Eugenol  
- Cavit  
- Irrigating Syringes/Solution  
- Endo Needles  
- Paperpoints  
- Gutta Percha Points  
- RC Prep  
- Root Canal Cement
Section 1.10 PATIENT ACCOUNTING OFFICE

OVERVIEW
The Patient Accounting Office provides patient accounting services for the clinics in the School of Dental Medicine. This includes taking payments and providing a receipt of the payment to the patient, posting of charges and payments to patient accounts, billing of insurance and other third parties and of course answering any questions that may arise with individual patient accounts and the school’s payment policies.

STAFF
The patient accounting office has four (4) full time employees to help out in any way with regards to patient dental accounts. There are two additional payment staff located on the first floor of the school.

HOURS
The operating hours are 8:00am to 5:30pm, Monday through Friday.
PAYMENT POLICY
The policy of the School of Dental Medicine is “Payment is due when services are rendered”. The patient is responsible for paying for all dental treatment rendered regardless of insurance coverage. We gladly accept Cash, Checks, Visa and Mastercard.

Fixed and Removable Prosthodontics – The policy for fixed and removable procedures is as follows: the first half of the total charge is due prior to the start of a procedure and the second half or remainder is due at the completion of the procedure. Upon receipt of the first half payment this office will distribute a gold or pink card which allows the dispensing of gold or teeth respectively from the lab.

Please note also that per the rules and regulations of the University, we cannot cash or give change back on checks.

TEACHING CASE FEES, DISCOUNTS AND ALLOWANCES
There are five(5) types of discounts or allowances at the School of Dental Medicine, Student Discount, Professional Discount, Clinical Exams/Mock Boards, Education Discounts (“Teaching Case Fees”) and Quality/Risk Management Discounts. All of the discounts or allowances with the exception of Clinical Exams/Mock Boards must be approved in writing by the Office of Clinical Operations. Any discount offered at the School of Dental Medicine shall fall into one of the five discount categories and shall follow the appropriate guidelines illustrated in this policy. Research costs for supplies and services will be covered in the clinical overhead rate and expensed to the appropriate grant as direct charges.

Student Discount
A. For all services to students, the charge will be sufficient to cover overhead expenses as determined by supervising faculty, not to exceed 50% of the current UCDSDM fee.
B. Friends and relatives of school of dentistry staff, faculty, and students should not be provided care at discounted rates. This is not allowed per State and University policy.

Clinical Competency Exams
This includes two categories: (1) “Mock Boards” or “Regional Boards” that are limited to one examination date, and (2) Clinical Competency Exams. The division which is conducting the clinical examination has the discretion to implement clinical examination discounts within the limits set forth in this policy. The division must inform the Office of Financial Affairs and Office of Clinical Operations by written memorandum as to the amount and type of clinical examination discount to be applied.

Allowances are up to 100% discount on prophylaxis, scalings and fillings (except castings): up to 50% discount on all other dental services.

Education Discount
(Teaching Case Fees) A discount of up to 100% given for educational purposes on authorized teaching cases when it is determined to be in the best interest of the School of Dental Medicine. Procedures are as follows.
1. When faculty identify the need for designating a case a “teaching case” requiring a potential fee adjustment, the faculty member should consult with a Dental Faculty member in OCO. If the recommendation relates to a remake or Quality Management issue, the covering faculty should document the situation in the progress notes.
2. The Office of Clinical Operations (OCO) faculty member will review the case with the covering faculty and the financial office staff. If there is to be a fee adjustment, both the covering and OCO faculty will complete a Fee Modification form in axiUm.
3. OCO faculty or the student will be responsible to coordinate communication with the patient and Financial Office.
4. Covering faculty and students are responsible to properly enter treatment into axiUm, noting fee modification for proper recording on the patient account and billing to third party or responsible person.
Quality/Risk Management Discounts
On occasion there is a need to modify a treatment fee related to the School’s Quality or Risk Management Plans (ie: Remake a crown or resolve a patient conflict). All discounts and waivers recommended by covering faculty in all UCDSDM Clinical Programs must be approved by OCO Dental Faculty. Fee modifications in GPR and Faculty Practice should also be presented to and approved by the appropriate Director or Committee.

All fee modifications should be documented in axiUm and communicated to the finance office. (See Total Quality Improvement Plan, Risk Management Plan and Occurrence Report to determine the need to file an Occurrence Report Form with OCO).

COLLECTIONS AND LOCKED CHARTS
Financial holds will be placed on patient accounts when services rendered are not paid within a timely manner, or at the least 30 days after treatment has been rendered and no 3rd party billing is to be done.

At 120 days of non-payment an account is considered very delinquent and will be sent to the state collection agency. Typically patients who reach this point will not be reinstated for additional care at UCDSDM, regardless of whether or not they pay their amount due. A letter will be sent to the patient stating that the account will be turned over to our collection agency unless it is paid in full within the first 20 days of the month and that they have been referred out of our program. The chart will be locked in axiUm for all patients that are in a collection status. All patient charts are automatically locked by the clinic computer system when the account balance reaches 120 days delinquent. Any further dental care should not be rendered until the account balance is paid. When a chart is locked, a student is unable to access the patient in the computer system.

INSURANCE
The School of Dental Medicine accepts most dental insurance carriers except Medicare and HMO/DMO plans unless the School of Dental Medicine is specifically stated as a provider of those plans. We do not participate in many DMO or HMO plans, so please verify with your patients because benefits will not be available to them if they receive treatment at the School. PLEASE NOTE: The patient is responsible for full payment of all services rendered regardless of insurance coverage.

Insurance Forms
If your patient has dental insurance, they are responsible to bring in an insurance form and their insurance card or insurance information. Please bring this to the Payment Office for recording information in the clinic computer. Until the patient accounting office has received your patients insurance information the patient shall be considered as self pay for all procedures and no insurance will be submitted. Forms are generated through the computer system, axiUm.

1. Patient Responsibility – Any treatment plan that totals $200.00 or greater may be pre-approved by the insurance carrier.
2. Student/Faculty Responsibility Students are required to provide a treatment plan with a copy of any appropriate radiographs, to be submitted to insurance.
3. Payment Staff Responsibility – Staff will submit the insurance form to insurance with the appropriate radiographs, and/or documentation.

Preauthorization
Some insurance plans require preauthorization for treatment that totals $200.00 or greater. A preauthorization will be sent from the Insurance Company to the patient and the School of Dental Medicine detailing the benefits or non benefit of the patient’s coverage. Students should check with the Patient Accounting Office to determine if procedures like radiographs and preventive services can be performed prior to the return of the preauthorization. Once the payment office has received preauthorizations back from insurance carriers, a copy will be given to the group coordinators and indicated in the patient’s health record in axiUm.
Patient Insurance Information Sheet
All patients with dental insurance should be given a “Patient Insurance Information Sheet” available at the Patient Accounting Office (See attachment 10-C)

MEDICAID
The School of Dental Medicine accepts Medicaid patients on a limited basis. Medicaid dental coverage for most procedures is available to those who qualify until the age of 21. This means on the patient’s 21st birthday they no longer carry Medicaid dental benefits. The patient or the patient’s guardian should provide a current Medicaid card from the State of Colorado at each visit. The student must verify at each appointment the Medicaid card is current. On each visit ticket students need to write the patient’s date of birth and Medicaid number. The Medicaid number begins with a letter and followed by six digits. The only dental procedures not covered by the Medicaid program are orthodontic procedures which the patient is responsible for payment of these procedures. Certain procedures must be preauthorized prior to rendering treatment while other procedures do not need authorization. Since these are too numerous to list, students should contact the Patient Accounting Office if they have a Medicaid patient to determine the need for preauthorization.

GOLD/DENTURE CARDS FOR LABWORK
A gold or pink card is required prior to obtaining the required lab work. As previously stated in section 10-4 Payment Policy, any fixed or removable procedures requires half payment to start the procedures and the second half payment upon completion. When the first half is paid the Patient Accounting Office will issue either a gold or pink, which allows students to obtain required lab materials.

The gold or pink card needs to be given to the dental lab personnel. If you have any questions please feel free to talk with the staff in the Patient Accounting Office. We love questions!!

PATIENT INSURANCE INFORMATION
The University of Colorado School of Dental Medicine wishes to work with our patients to maximally utilize their dental insurance benefits. Dental insurance is a benefit for the patient provided by a third party, not the School. Although the School will assist the patient by providing information, it is the patient’s responsibility to know their insurance coverage and resolve any conflicts. The following information is provided to our patients to assist them in identifying potential roadblocks and pitfalls in utilizing their insurance.

I. KNOW YOUR INSURANCE COVERAGE: It is the patient’s responsibility to comply with the requirements of their insurance coverage. The School is willing to provide guidance as to general coverage issues when requested, but accepts no liability for information provided by its students, faculty or employees regarding insurance. The patient is solely responsible to determine the specific requirements of their plan by consulting with the insurance carrier, employer or other parties. Some typical considerations include, but are not limited to:

A. Preferred Providers: If your plan requires that you go to specific dental providers (i.e. “preferred providers”, “PPO”< “DMO”, etc), you must check with your insurance company directly to confirm if the School of Dentistry is an approved provider. Currently the School is not A PREFERRED PROVIDER FOR MOST INSURANCE PROGRAMS. The School does not take responsibility to make this determination.

B. Prior Authorization or pre-determination of Benefits: Some Insurance Plans require that patients notify the insurance carrier prior to the start of treatment, or risk losing benefits that would otherwise have been provided (“Prior Authorization”). Additionally, it is highly recommended that the patient confirm coverage in writing from the insurance carrier (“pre-determination”), especially if the patient decides to have treatment primarily based on coverage by their insurance. The School does not take responsibility to submit these documents to the insurance carrier.

C. Date of Coverage: Some insurance plans provide benefits for treatment based on the date treatment is started, other plans are based on the date when the treatment is completed. Other issues related to timing of treatment include annual deductibles; maximum annual benefit amounts; and new, discontinued or changed insurance plans. It is the patient’s responsibility to determine how their plan determines these and other issues related to how and when coverage applies.
Please note that the School will work with the patient to maximize their benefits by coordinating timing of treatment. However due to the sometimes unpredictable nature of dental treatment and the unique nature of the educational program, the School cannot assure the patient that treatment will either start or be completed by a specific date.

II. INSURANCE FORMS: The School will assist the patient by providing information necessary to file for benefits, pre-determination and/or prior authorization benefits. The School will also send the insurance forms in for the patient at the request of the patient. However, it is the patient’s responsibility to follow up if the insurance company fails to process the form in a timely manner or loses the form.

Section 1.11 EQUIPMENT OPERATION AND MAINTENANCE

DENTAL EQUIPMENT REPAIR

The dental repair department is responsible for providing (Dental Equipment Repair), and instruction in the proper use and care of the equipment for the entire school in such a manner as to minimize down time.

HOURS OF OPERATION

Monday-Friday: 7:30am-4:30pm; After 4:30pm: page Chuck Unitt @ 303-266-8785.

STAFF SUPPORT

Todd Hinshaw, Lead Dental Repair Technician
Direct Line: (303) 724-7150, Room 019 or pager (303) 266-8785.
Email: todd.hinshaw@ucdenver.edu

Raymond Ware, Dental Repair Technician/Instruments
Direct Line: (303) 724-7152, Room 019 or pager (303) 266-0766

EQUIPMENT OPERATION AND MAINTENANCE

• ADEC1040 Cascade dental chair
• ADEC Cascade over-the-patient delivery system
• ADECC dental light

Section 1.12 DENTAL PRODUCTION LAB

Treatment Planning/Mounting of Casts:
1. Articulators should be cleaned prior to mounting. This will help insure that the mountings are accurate so that the casts may be sent to our outside labs without your articulator.
2. Every diagnostic cast that is mounted for analysis will be mounted with a Facebow. Arbitrary mount of the cast in the middle of the articulator is not acceptable.
3. Diagnostic casts are to be mounted in Centric Relation.
4. All diagnostic casts, as well as working casts should be clearly labeled with the patient’s name and date of impression.
5. Fixed Partial Dentures opposing edentulous areas require a record base in the edentulous arch with diagnostic wax-up to determine the plane of occlusion, appropriate occlusal reduction, and the cusp angle for the FPD.
6. Triad tray material for record bases, interim and definitive prostheses will be obtained from the supply window. Denture teeth for diagnostic purposes can be obtained in the production lab. Please inform the lab tech of the cusp angle you desire for the final fixed restoration at the time you obtain the diagnostic denture teeth.

7. All RPD/Overdenture cases must be diagnostically mounted prior to design approval.
8. All RPD designs must be approved by a full-time restorative faculty member.
9. All overdenture treatment plans must be approved by a full-time restorative faculty member.

Occlusion:
1. Master casts for occlusal splints should be poured in MICROSTONE.
2. Students will block out undercuts on casts with plaster prior to waxing occlusal splints. A faculty member should check this step.
3. Palatal relief should be scribed in the palate with a No. 4 round bur denoting the palatal extension of the splint.
4. Mounted master casts must be checked by a full time restorative faculty member before waxing the splint. Separating medium must be applied between working cast and articulator mounting to allow clean separation for processing.
5. Cast will no longer be duplicated prior to waxing occlusal splints.
6. Once the occlusal splint has been approved by your instructor, the case will be sent to an outside lab for processing.

All Cases Submitted for Lab work:
1. Proper protocol for DISINFECTION of impressions, occlusal rims, crowns etc. must be followed prior to submitting the case to the Technical Support Lab.

Fixed Prosthodontics:
1. Mountings must be checked with articulating paper before submission to lab.
2. When mounting working casts on the articulator, access to the bottom of the die pins must be provided. Play dough is the preferred method due to its water soluble properties.
3. Dies should be trimmed to present an unambiguous margin, represent the root structure to facilitate proper emergence profile, and be clearly marked with a fine red pencil line (use the side of the pencil to make the line). See figure at right.
4. Dual arch impressions may only be used for fabrication of single crowns where the prepared tooth is bordered by adjacent teeth, not involved in any eccentric contact, and at the discretion of the covering faculty member. It may not be used for survey crowns.
5. Survey crowns require:
   a. Full arch impressions
   b. The retromolar pad be captured in the impression
6. Fixed Partial Dentures/Crowns opposing edentulous areas require a record base in the edentulous arch with diagnostic wax-up to determine the plane of occlusion, appropriate occlusal reduction, and the cusp angle for the FPD. This record base with wax occlusion rim will then be used to mount your FPD working cast and for the lab to wax the FPD or crown.
7. PFM restorations that are fabricated in our production lab will require final polishing of metal by the student.
8. THE STUDENT IS RESPONSIBLE FOR DEVELOPING THE POST & CORE PATTERN, INVESTING, AND CASTING THE PATTERN. This is his/her responsibility regardless of the method (direct or indirect) chosen to develop the pattern.
   a. The direct method is the method of choice here at the School of Dentistry. If the direct method is used, the student will develop the pattern directly in the clinic, invest the pattern ASAP (to prevent distortion), and then cast it. If for some reason the faculty/student chooses to use the indirect method, the student will be responsible for 1) pouring the master cast, 2) submitting it to the Technical Support Lab for Pindexing, when necessary, 3) creating the post & core pattern (which will need to be approved by the faculty prior to receiving the gold from the Technical Support Lab), and 4) casting the post & core.
b. EXCEPTIONS: If the patient requires multiple post & cores that are for multiple abutments for a FPD, requiring parallelism for path of insertion, the student may use the indirect impression technique, and have the lab fabricate the post & cores. In this event the master cast must be mounted in an articulator so that the appropriate occlusal clearance can be developed for the post & core.

9. OVERDENTURE ATTACHMENTS/COPINGS ARE NOT CONSIDERED CAST POST & CORES. As such, they are treated differently. Due to the technical skill required in developing an attachment that is parallel to the path of insertion of the prosthesis, the Technical Support Lab will fabricate all types of Overdenture/Overpartial denture attachments/copings. Students will not be allowed to develop patterns for overdenture/overpartial denture attachments. However, if the student chooses to, he/she may fabricate gold overdenture/overpartial denture copings that do not involve any type of attachment.

10. You will need to submit the following for each of the procedures listed in order for the laboratory technicians to provide you with a quality prosthesis. Please note: the laboratory technician will apply the cyanoacrylate and die spacer; DS is responsible for die trimming throughout your clinical experiences.

Rx: Make Die System
Submit: 2 vacuum mixed, die stone pours of the impression. Include the impression as well. MARK the 1st pour and 2nd pour

Rx: FGC, PFM
Submit: New Opposing Cast, Mounted Casts, Semiadjustable Articulator*, may require custom incisal guide table (A custom incisal guide table is required for all anterior restorations which are involved in anterior guidance) 2nd pour solid cast

Rx: All Ceramic Crowns
Submit: MARGINS SHOULD NOT BE TRIMMED OR MARKED ON CASTS FOR ALL CERAMIC CROWNS, 2nd pour solid cast, New Opposing Cast, Mounted Casts, Semiadjustable Articulator*, may require custom incisal guide table (A custom incisal guide table is required for all anterior restorations which are involved in anterior guidance)

Rx: Survey Crown
Submit: New Opposing Cast, Mounted casts, Semiadjustable Articulator* 2nd pour solid cast Survey & Design Cast

Rx: Solder Joint
Submit: Intraoral index on Fixed Partial Denture in GC Pattern resin

Rx: Splint
Submit: Blocked out cast mounted in CR for approval; submit waxed splint for approval prior to sending to outside lab

*Use of the Semi-adjustable articulator is indicated for use in any clinical situation of a patient requiring a custom incisal guide table, restoration of multiple single units, fixed partial denture, or opposing an edentulous arch.

**Indication for use of a simple hinge is limited to a single restoration with full arch casts mounted in maximum intercuspation. Use for posterior restorations in canine guidance situations only. Do not use the simple hinge articulator for a terminal tooth, terminal abutment, or survey crown, or for those teeth participating in eccentric guidance schemes for a removable partial denture.
When a dual arch or quadrant impression is used, there must be a tooth distal to the prepared tooth in both arches in order to verify the centric stop distal to the crown being fabricated.

**Removable Prosthodontics:**

1. In an effort to facilitate treatment progress, you are limited to working with no more than two instructors on any one removable case. If one of the instructors you are working with is a part-time faculty member, it is strongly advised that the second be a full-time faculty member. The faculty members covering removable partial dentures should be involved in the framework design phase. This is to help provide consistency for you and the patient.

2. All Kennedy Class 1 partially edentulous patients requiring mounting for restoration prior to the fabrication of an RPD framework should be mounted using a record base and a wax occlusion rim to ensure accurately mounted casts.

3. All custom impression trays for complete dentures must have tissue stops. This is to help you and your instructor identify impressions that have been overseated. If the tray material “shows through” the impression material in the areas of the tissue stop, you have overseated the impression, the soft tissue is most likely compressed and the denture will not fit your patient resulting in either a relin or the need to remake the denture. Therefore, this is an indication to remake the impression.

4. The outer aspect of the border molded custom tray should be trimmed prior to impression making to insure the denture border is not over bulked due to an inaccurate border impression. Please evaluate trays to insure their borders are not too thick.

5. Mandibular altered cast impressions must include the retromolar pad.

6. The posterior palatal seal must be identified at either the jaw relation or the wax try-in appointment, and scribed into the master cast prior to submission for final processing. This should be done chair-side, with faculty observation, referring back to the patient to ensure appropriate location and depth.

7. Mandibular wax rims are to establish the plane of occlusion. Therefore, the height of the wax rim should follow the mandibular lip line and not extend above 2/3 the height of the retromolar pad. This should be evaluated both at the jaw relations and at the tooth try-in appointment.

8. Use the mechanical guide table for all removable prostheses.

9. Verify all Centric Relation mountings at the tooth try-in appointment.

10. When fabricating overdenture attachments, a record base with an occlusal rim identifying the plane of occlusion must be submitted on the master cast so that the laboratory technician can wax the OD coping to fit within the confines of the prosthesis.

11. All Complete Dentures, Immediate Dentures, Overdentures, and Removable Partial Dentures should be waxed and festooned prior to submission to the lab for processing. The palate of the triad record base must be cut out and 2 thicknesses of base plate wax should be added to the palate as part of the waxing of the denture.

12. The prosthesis waxing should be luted to the cast; however, the wax should not cover the land area. Examples of festooning are in the CU Technical Support Lab; pictures are posted in the lab as well.

13. All Complete Dentures, Overdentures, and relines require a clinical remount.

14. **ALL** Removable Prostheses require a 24 – 72 hour and one week post-placement follow-up appointment. **A 24 hour post-insertion appointment is preferred.** However, if for some reason the patient is unable to make a 24 hour post-insertion appointment, they must be seen within the first 72 hours. These follow-up appointments should be scheduled when the insertion appointment is scheduled. The student will not be permitted to deliver the prosthesis if time constraints due to Holidays, Breaks, or the end of the semester will not allow both follow-up appointments. Therefore, the last day to insert a prosthesis is one week prior to the commencement of a break or the end of the semester.

15. Immediate Dentures will now be set by the lab such that the anterior teeth will be set directly on the cast prior to posterior tooth try-in. This will allow you, your instructor and your patient to evaluate CR, the plane of occlusion, and the esthetics at posterior tooth try-in.

16. Immediate Dentures

   a. Surgical Stents are required for all immediate dentures. The surgical stent does not need to be made of a heat-processed acrylic. It may be fabricated using a thermoplastic stent material.

   b. Immediate dentures should never be delivered on a Friday. All immediate dentures require
a 24-hour post-placement appointment. ALL immediate dentures must be inserted under the supervision of a full-time Restorative or Comprehensive Care Faculty member. The student is required to schedule the patient in the prosthodontic clinic (along with the surgical appointment) and to make arrangements with the covering faculty prior to the appointment. FAILURE TO MAKE SUCH ARRANGEMENTS WILL RESULT IN LOSS OF CREDIT FOR THE PROCEDURE.

17. It is important that you apply separating medium to the bottom of casts which will require future separation (split cast mountings).

18. During anterior tooth selection, consider size (including length), tooth mould (shape), then shade in this order. Size is determined by measuring the width of the maxillary anterior teeth on a curve (from cuspid to cuspid) using your wax occlusal rim to measure this. The location of the cuspids can be approximated by scribing lines inside the commissure of both sides of the mouth at rest and/or by extrapolating an imaginary line from the inner canthus of each eye downward to the ipsilateral ala of the nose.

19. You will need to submit the following for each of the procedures listed in order for the laboratory technicians to provide you with a quality prosthesis.

<table>
<thead>
<tr>
<th>Rx: Make RPD Framework</th>
<th>Submit: Master Cast (vacuum mixed pour of the impression; Diestone) Survey &amp; Design Cast Detailed Lab Prescription Opposing Cast</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rx: Flask &amp; Process</td>
<td>Submit: Verify palatal seal, Sealed prosthesis on master cast; Wax-up &amp; festooning completed. For max denture, palate cut and uniform layer of baseplate wax incorporated.</td>
</tr>
<tr>
<td>Rx: Denture Tooth Set-up</td>
<td>Submit: Mounted Casts; Semiadjustable articulator Incisal guide table set appropriately. “Tooth Card” signed, proof of payment</td>
</tr>
<tr>
<td>Rx: Prosthesis Reline</td>
<td>Submit: Prosthesis impression seated on new pour/cast. DO NOT SEPARATE from cast. Coordinate with CDT.</td>
</tr>
<tr>
<td>Rx: Prosthesis Repair</td>
<td>Submit: Detailed description on Rx. Coordinate with CDT.</td>
</tr>
</tbody>
</table>

Please make die system. Tooth no. X will be restored with a PFM/FGC. Return for mounting and die trimming.

FACULTY SIGNATURE

Please fabricate full coverage PFM restoration on tooth No. X. Porcelain occlusal surface. Make PFM with a facial porcelain butt. from mid-proximal to mid-proximal. Canine guidance
Materials: Gold – Olympia Porcelain – Vita Shade Y
FACULTY SIGNATURE

Please fabricate full gold restoration on tooth no. X. Chamfer finish lines as marked. Canine guidance. Materials: Midi 50
FACULTY SIGNATURE

Please fabricate surveyed PFM restoration on tooth No. X with metal occlusal and porcelain veneer. Thin metal collar facial termination. MO rest, Mesial guide plane, and 0.01” DB undercut
Materials: Gold – Olympia Porcelain – Vita Shade Y
FACULTY SIGNATURE

Please fabricate metal occlusal with porcelain veneer PFM restoration on tooth No. X. Facial termination should be porcelain butt. lingual termination should be metal collar. Canine guidance.
Materials: Gold – Olympia Porcelain – Vita Shade Y
FACULTY SIGNATURE

Please make PFM fixed partial denture. Facial finish lines are shoulders with bevels; palatal with chamfer finish line. Make minimal facial collars. Modified ridge lap pontic. Canine guidance. Return metal copings for try-in.
FACULTY SIGNATURE
In an effort to help clarify continued confusion regarding the writing of laboratory prescriptions, examples of laboratory prescriptions for both fixed and removable prosthesis are listed below. These are examples only; the prescription should reflect the unique situation that your patient presents.

**FIXED:**

### Section 1.13 DENTAL AUXILIARY UTILIZATION (TEAM OVERVIEW)

The DAU Staff is responsible for providing the dental students practice in the principles of four-handed dentistry. This is accomplished by providing staff support in order that the students experience the realities of the Dental Team. This includes planning, communication, time management, and chairside techniques.

Team Clinic also coordinates the support of the following clinics, based on the needs of the students, faculty and staff.

1. Comprehensive Care
2. Senior’s (Geriatric) Dental Clinic
3. Adult Screening

#### HOURS

- The Team Clinic hours are 7:30am – 5:30pm

#### PURPOSE AND OBJECTIVES OF DAU PROGRAM

The primary purpose of the DAU is to provide the dental student with practice in the principles of four-handed dentistry. This includes planning, communication, people and time management, and chair side techniques. Team principles are based on the premise that attention to the *process* increases the quality and quantity of the result while reducing stress fatigue.

Although there are no formal rotations, DAU staff support each Comprehensive Care Group on a daily basis. This provides an opportunity for the student to work as a dental team, primarily with a dental assistant and a faculty member.

#### PROGRAM OBJECTIVES

1. Demonstrate an understanding of efficient utilization of a chair side dental assistant by effectively applying the principles of work simplification, motion economy, instrument transfer and positioning of providers and patients.
2. Demonstrate an understanding of the team approach to delivering dental care by effectively applying principles and concepts relating to task delegation and quality assurance.
3. Demonstrate an understanding of personnel management in a dental practice by effectively applying principles and concepts relating to leadership and supervision, staff communications, auxiliary training and staff meetings.
4. Demonstrate an understanding of office engagement by effectively applying principles and concepts relating to appointment scheduling and clinical records.

#### CLINIC FORMAT

The Program also consists of four-handed experiences in a variety of clinical rotations including oral surgery, emergency, and screening, as well as assisting on the clinic floor in certain disciplines as assigned by covering comprehensive care faculty, including restorative and endodontic coverage. Any other sessions will be devoted to comprehensive patient care. Assistant assignments are determined by faculty at all times.

The Team rotation provides a unique opportunity to work as a team. This is an excellent opportunity to complete requirements and difficult procedures. A team approach routinely improves success. The quality of the experience
is dependent upon the type of patient treated. Because you are working closely with a dental assistant, communication with your assistant is essential.

TEAM STAFF
The Team staff is composed of professionally trained dental assistants. Many of them are certified and/or expanded function. They are experts in the process component of quality care. Please treat them with the respect you would grant any other dental professional.

HINTS FOR EFFICIENT TEAMWORK
1. Your assistant expects to work with you, and to assist you in the practice of dentistry. Any pointers you can share will help you both. Your goal as a team is to provide the best possible care for your patients.
2. Your assistant is a person. Please treat her/him respectfully. Be pleasant when requesting help from your assistant. It always helps to say thank you.
3. Your are expected to tell your assistant how you wish something done. If your assistant asks you a question, answer it to the best of your ability. They are asking for information that will help to assist you better. For the sake of efficient operation, try to let your assistant know a few seconds in advance when you wish to change instruments, or when you need something else.
4. Use accurate terminology in requesting an instrument, a service, or a material.
5. The dental assistants are well trained in four-handed dentistry procedures. Please feel free to ask them about any problems encountered when they are assigned to you. They are perfectly capable of teaching you what a well trained assistant can be expected to do.
6. All of us wish to know where we stand. Keep an open line of communication between you, the assistant, and the coordinator. Give compliments for correct actions. Call attention to errors as they occur, but DO NOT criticize in the presence of patients. To make a harsh correction palatable, sandwich it between compliments. An assistant deserves to know, in a matter of fact way, when work is satisfactory, exemplary, or substandard.
7. If you have any complaints about your assistant, discuss them with the assistant after the patient has been dismissed. If you are uncomfortable speaking with your assistant, please contact the DAU supervisor.
8. Respect the confidentiality of both the patient and the dental team.

ROLE OF THE DENTAL STUDENT
The dental student is responsible for the following aspects when working with a DAU staff member.

Characteristic Responsibilities:
1. Delegate procedures commensurate with auxiliaries’ abilities and interests, and adequately communicate duties to them.
2. Ensure patient welfare by establishing good rapport with patient and between patient and staff. Reinforce patient understanding of assistant and purpose of this session.
3. Exhibit acceptable performance of Team principles and techniques.
4. Perform all reversible and irreversible dental procedures and other procedures that auxiliaries are not trained to perform.
5. Insure accuracy of patient records.
7. Remain in patient care area at all times during performance of all delegated clinical procedures.
8. Oversee all financial activities to insure that patients are paying as care is rendered or have made the appropriate financial arrangements.

ROLE OF THE CHAIRSIDE ASSISTANT
She/he will have responsibility for assisting the student at the chair when assigned including: the passing and receiving of instruments, oral evacuation and retraction, and the preparation of materials. Faculty may allow DAU staff to perform expanded duties with the dental student as noted below, based on their assessment of the student’s skills and abilities.
Characteristic Responsibilities
1. Instruct the dental student in Team DAU principles.
2. Perform dental assisting procedures as outlined below.
3. Assist faculty in patient care and screenings.

Dental Assisting Procedures that may be Assigned/Delegated
1. Assist the dental student using four-handed dentistry techniques.
2. Prepare tray set-up for anesthetic, operative, prosthetic and endodontic procedures.
3. Record oral examinations as directed by the dentist.
4. Pour and trim models for diagnostic studies
5. Assist with the administration of local anesthetics.
7. Assist with the placement and removal of rubber dam.
8. Assist with the placement of bases and liners.
9. Assist with the insertion, finishing and removal of temporary restorations.
10. Assist with the insertion, contouring, and finish of silicate, composite and resin restorations.
11. Assist with the insertion, carving, and polishing of amalgam restorations.
12. Assist with First-Aid procedures.
13. Aid in the presentation of post-operative instruction.
15. Assist with restorative and endodontic procedures.

Section 1.14 AXIUM CLINICAL INFORMATION SYSTEM

Dr. Craig Passon provides guidance and training on the axiUm System numerous times throughout the year. For questions or concerns, please contact Dr. Passon at 303-724-7073.

Section 1.15 OCCURRENCE REPORTS

GENERAL POLICY
To formally document undesirable events which occur in the clinical setting which may have a detrimental effect on the learning process; the service to UCDSDM patients; or put the University at risk. All interactions, incidents and injuries should be reported utilizing the UCDSDM Occurrence Report form, available in OCO or through the program and group coordinators.

A. Reporting of Interactions
Interaction reports represent documentation of negative interpersonal interaction between patients, students, faculty, staff, or any combination thereof which may interfere with the normal patient care process; the learning process of the student; the job performance of UCDSDM employees; or the academic mission of UCDSDM. Students, faculty, or staff for appropriate action may submit these reports to the Associate Dean for Clinical Operations. The intent of this reporting procedure is to initiate conflict resolution and to resolve violations of clinic policy.

1. All Interaction Reports must be submitted to the Associate Dean for Clinical Operations within five working days following the occurrence. Report forms can be obtained from the OCO.
2. The Associate Dean for Clinical Operations shall be given full authority for the disposition of interaction reports. The counsel of the Patient Care Committee; Department Chairpersons or the Dean may be sought in the disposition of such occurrences.
B. Reporting of Incidents
Incident reports represent documentation of incidents that occur in the treatment of patients that may result in potential harm to patients. Such incidents may include medical emergencies in clinics or support areas or injuries to patients during treatment. This reporting procedure is required by UCD policy as a risk and/or quality management strategy. All incident reports are submitted to the Associate Dean for Clinical Operations for review and in turn may be forwarded to the Risk Management Officer for the UCD.

1. All Incident Reports must be submitted to the Associate Dean for Clinical Operations within one working day following the incident.

C. Faculty, Student and Staff Injury Reports
Injury reports represent documentation of injuries, which occur in the UCDSDM clinics to faculty, students and staff. Such incidents include bodily fluids exposures (needle sticks, puncture wounds and splashes to mucosal or non-intact skin), hazardous materials exposures, and other general injuries while in the clinic, simulation clinic and pre-clinical laboratories.

1. All Injury Reports must be submitted to the Associate Dean for Clinical Operations within one working day following the injury.

D. Documentation/Recordkeeping
1. Occurrence Reports– Forms are located in OCO, program and group practice coordinator offices. The form is a confidential reporting form which should be used to report negative interactions, incidents and injuries that occur related to the clinics. This reporting mechanism is part of the UCD Risk Management and Quality Management Programs, and also form the basis for reporting with the UCD Risk Management Office. These reports are considered confidential in anticipation of litigation. However, all information should be documented as if the involved student, faculty, staff and/or patient were able to review the documentation.

2. Disposition - The Office of Clinical Operations will maintain a file of submitted reports along with documentation of the disposition of the matter. All UCDSDM parties involved in the occurrence shall be notified of the disposition, if appropriate.

3. Review and Analysis – The Office for Clinical Operations will be responsible to review incidents and interactions in the clinic to determine any need for clinic operations modifications to reduce risk or improve quality of patient care. Modifications to clinic operations may be directly implemented by OCO if within the normal course of its function, or by program directors within the scope of their responsibilities. Modifications that involve changes in clinic policy will be referred to the Patient Care Committee. Review and analysis will be reported as appropriate to the Institutional Effectiveness Committee, consistent with the UCDSMD Institutional Effectiveness Plan.

E. Examples of Reportable Incidents
1. Treatment Issues
   • Delayed or untimely treatment by UCDSDM
   • Missed, inaccurate or untimely diagnosis resulting in delay or lack of treatment.
   • Treatment below standard of care
   • Complication of procedure
   • Adverse reaction to treatment or medication
   • Failure to follow treatment plan
   • Treatment provided without proper infection control.
   • Replace, remake or retreat procedures previously completed at UCDSDM.

2. Medical Emergencies in the Dental School Dental Medicine

3. Patient Interaction/Behavior
   • Patient refuses necessary treatment, which may result in immediate and/or significant harm to them.
   • Patient admits or is highly suspected of an altered neurological state in dental clinic due to alcohol or illicit drug usage.
• Patient who is verbally abusive or threatening.
• Patient who is physically abusive or threatening.
• Sexual harassment by patient (to student, staff, faculty or another patient).
• Patient who cause disruptions in School operations.
• Patients who have a billing dispute.
• Patients who express or who are suspected of being dissatisfied with care or who express litigious intent.
• Noncompliance Patient

4. School Operations
   • Treatment provided without proper faculty supervision.
   • Break in confidentiality.
   • Failure to provide dental emergency treatment in a timely manner for UCDSDM patients of record.
   • Treatment provided without proper written treatment plan and or faculty consult.
   • Failure to Follow Clinical Policy
   • Failure of Equipment or Instrument

5. Documentation
   • Incorrect Documentation
   • Incomplete/Inaccurate Documentation
   • Improper Treatment Plan
   • Improper Informed Consent
   • Improper Faculty Consult
   • Improper Medical History

6. Damage to Patient's Property

Section 1.16 FACULTY SUPERVISION OF PATIENT CARE

PURPOSE:
To control treatment of UCDSDM patients in an effort to prevent unauthorized care being rendered without proper supervision.

GENERAL POLICY:
Students are not permitted to administer any drugs or to proceed with any stage of patient care without the direct supervision of appropriate faculty. Failure to comply with this policy may result in disciplinary action by the Student Performance Committee and/or the Office for Clinical Operations.

IMPLEMENTATION:
A. WHEN FACULTY SUPERVISION IS REQUIRED
   Faculty supervision is required for all clinical procedures at the School of Dental Medicine.

B. INITIATION TREATMENT/PERMISSION TO PROCEED
   1. Students are required to receive permission to proceed with a treatment service from the assigned supervising faculty member prior to initiating any stage of treatment. Students may seat their patient 5 minutes prior to the formal start of the clinic session, and may proceed with verbal interactions with the patient including medical history review, informed consent and patient education
   2. The faculty grants formal permission by giving a start check in axiUm.
   3. Students are not authorized to proceed and faculty members are not authorized to grant permission to proceed if any of the following are present:
      • An unsigned and/or undated health questionnaire (updated within the last year);
• An absence of an approved treatment plan for treatment (exceptions for diagnosis, urgent care);
• An absence of documented informed consent (signed and dated by patient);
• A locked dental record [exceptions may be approved in writing in the treatment progress notes by the faculty of the Office of Clinical Operations;
• Failure to follow UCDSDM infection control procedures.

4. Limited Treatment Plans - In the event that it becomes advisable to proceed with treatment before a comprehensive complete treatment plan can be approved, supervising faculty may approve limited treatment. Limited plans should be documented in the axiUm patient information system, printed out and signed by the patient.

C. FACULTY AVAILABILITY
Supervising faculty are required to be available for students during the entire clinic session. It is the responsibility of the supervising faculty to provide alternative supervision if he or she will be temporarily unavailable.

D. COMPLETION OF TREATMENT/PATIENT DISMISSAL
Students are required to receive permission from supervising faculty prior to the final dismissal of the patient from the clinic. Supervising faculty have the discretion to determine whether a final faculty clinical evaluation is necessary prior to the patient's dismissal.

E. TREATMENT DOCUMENTATION
Students are responsible for timely documentation of all treatment they have provided to the patient. Treatment notes should be written according to section 2-15. Progress notes should be written during the same session that treatment is provided, or as soon thereafter as possible. Supervising faculty are responsible to be available to review and approve completed progress notes during each session.

Section 1.17 TOTAL QUALITY MANAGEMENT PLAN

The Quality Improvement Plan for the UCDSDM is based on sound principles of quality management. The program is led by the QA/QI Committee, a subcommittee of the Operations Committee. The Associate Dean for Clinic Operations chairs this committee along with the Operations Committee. He has 20+ years of experience in health care management running dental practices and hospital systems. He holds the designation of certified professional in health care quality. There is a three pronged approach to QA/QI at UCDSDM, quality monitoring, occurrence review and patient satisfaction surveys.

QUALITY MONITORING:
The program is designed to systematically study the treatment processes in the School, identify opportunities to improve, make changes to those processes, monitor the results of the changes and make more changes if necessary.

Over time, a series of monitors is studied and then efforts are made to improve the average performance on targeted items. For example, infections that require I & D after an extraction are reviewed. The rate of infection should be quite low, however, if it spikes up, it could mean problems in surgical technique, sterilization, or a number of other areas. A study would be undertaken to determine what caused the problem and what intervention should be made to correct the problem. Once the intervention is taken, the process must be studied to ensure the intervention had the desired effect. Can be obtained from the Associate Dean for Clinical Operations. With persistence, a continuous effort to look broadly and deeply at the processes involved in patient care will result in a march toward improved efficiency and quality.

OCCURRENCE REVIEW:
Every medical emergency, treatment misadventure, percutaneous injury, or patient safety event is to be reported to the Associate Dean for Clinic Operations. It is then taken to the QA/QI committee for review. The Committee looks for trends or problems that could be recurring and then orders actions designed to avoid the same problems in the
future. At times, the providers involved in a case may be asked to discuss events with the committee. These meetings are designed to be informative and not judgmental. The effort is to sort out the processes that led to the problem not to indict the provider. Once the issues are understood, changes can be made to avoid the same problem in the future.

PATIENT SATISFACTION SURVEYS:
Patient satisfaction surveys are done twice per year by an independent contractor. Clinical areas with poor satisfaction scores are studied and changes implemented. Patient satisfaction survey results are available from the Associate Dean for Clinical Operations.

Section 1.18 RISK MANAGEMENT PLAN OUTLINE

I. DEFINITION
The University of Colorado School of Dental Medicine Risk Management Program is designed to (1) identify, classify, and evaluate risks of loss to patients, employees, students, faculty, and visitors; (2) measure the potential frequency and severity of risks; (3) initiate action to eliminate or minimize these risks; and (4) integrate risk activities into the Quality Management Plan.

The Plan is designed to cover primarily risks associated to professional liability. The program also interacts closely with the related areas of Quality Management, Safety, and Hazardous Materials.

A. Risk - any situation, procedure or person which has the potential of directly or indirectly causing personal injury to patients, employees, students, or visitors.

B. Risk Management - the avoidance and control of exposure to predicted and other risks and the minimization of malpractice claims loss.

II. MISSION STATEMENT
The mission of the University of Colorado School of Dental Medicine Risk Management Program is to minimize adverse effects of loss through identification and assessment of loss potential and loss prevention. The Program is integral to the quality management of the School. The Risk Management Program interfaces directly with the University of Colorado Denver’s Professional Liability Risk Management Program, which has additional responsibilities of loss funding, risk financing, and claims management.

III. PROGRAM GOALS
A. The following goals are established for the Program:
1. To minimize or eliminate potential risk factors, thereby improving the quality of patient care.
2. To decrease frequency and severity of preventable injuries to patients, faculty, students, staff, and visitors.
3. To identify and classify risks of loss.
4. To measure frequency and severity of risks of loss.
5. To develop and implement methods to eliminate preventable risks of loss.
6. To evaluate risks which are not reasonably preventable.
7. To develop and implement methods to minimize frequency and severity of risks not reasonably preventable.
8. To develop and implement appropriate educational and training programs.
9. To improve effectiveness of communications between and among the patient, faculty, students, and staff.
10. To maintain current data on investigation and management of risks, claim settlement and awards in conjunction with the University of Colorado Denver Risk Management Program.
11. To maintain current data related to patient occurrences.
12. To integrate current data which relate to risk management issues from the following areas:
   a. Quality of Care
   b. Infection Control
   c. Patient Grievances
   d. Faculty Grievances
e. Student Grievances  
f. Staff Grievances  
g. Equipment Safety  
h. Facility Safety  
i. Staff Education  
j. Dental Faculty Clinical Privileges  

IV. PROGRAM ORGANIZATION  
The University of Colorado Denver Risk Management Program is operated and maintained by the Office of Clinical Operations faculty and staff. The Program works directly with the University of Colorado Denver Professional Risk Management Program, Self-Insurance Trust, and University Legal Counsel.

The Risk Management Program acts as a clearinghouse for the receipt and review of all occurrences taking place in the School of Dental Medicine or involving a covered party.

A. Responsibilities  
1. To analyze all occurrences, identify trends and recommend actions to correct trends.  
2. To seek dental faculty and staff input into the operation of the Risk Management Program.  
3. To assist in the education of dental faculty, students and staff in all matters pertaining to professional liability.  
4. To review all serious occurrences, claims and lawsuits in conjunction with the UCD Risk Management Program.  
5. To evaluate all serious occurrences, claims and lawsuits to determine if they represent substandard dental care or policy violation and to recommend methods for resolving or defending claims.  
6. To coordinate, as appropriate, activities with other committees related to quality issues.

B. Sources of and information input for the data base on risks include but are not limited to the following:  
1. Faculty, staff, students, independent contractors, and patients.  
2. Current and future School of Dental Medicine programs and activities.  
3. Patient care and administrative policies and procedures.  
4. Safety and other inspection and survey reports.  
5. Patient correspondence and complaints.  
6. Occurrence reports.  
7. Quality Management, infection control, clinic privileges, and other committee activities and reports.

C. Risk Management  
Risk management functions are designed to minimize potential risk factors, thereby improving quality of care; and include the following:  
1. Conduct safety and risk management surveys to assist in loss prevention.  
2. Loss control through educational programs.  
3. Occurrence investigation and documentation.  
4. Occurrence and statistical analysis.  
5. Participate with UCD Risk Management Program, University Legal Counsel and appropriate others in decisions to negotiate or settle claims.

D. Claims Management  
Claims Management is primarily the responsibility of the UCD Risk Management Program and the Trust Advisory Board. Obligation of the School of Dental Medicine is as follows:  
1. Forward all claims complaints, summonses, etc. to the University Legal Counsel.  
2. Fully cooperate with legal counsel and UCD Risk Management Program in investigation of occurrences and claims and defense of lawsuits.

E. Occurrence Reports  
1. Purpose - The purpose of occurrence reporting is to identify actual problems or potential risk circumstances that must be eliminated or minimized to prevent personal injury or property loss or damage. The four primary purposes are as follows:  
   a. An early detection system for problems and compensable occurrences.  
   b. A foundation for an early investigation of all potentially serious occurrences.
c. A data base for long-range problem detection, analysis and correction.
d. A cross-reference with other risk detection systems.

2. Occurrence Defined - For purposes of the Risk Management Program an occurrence defined as follows: Any happening, with or without injury, involving a patient, visitor or employee mishap or serious expression of dissatisfaction (if, in the patient's visitor's or employee's perception there has been or could be an injury, inappropriate treatment or neglect); or any actual or potential loss or damage to the physical facility.

Examples include but are not limited to the following: injury secondary to a procedure, drug error or reaction, fall, mishap due to faculty equipment, dissatisfaction with care or bill, suggestion of legal action, fire, theft, and request from attorney for a medical record.

3. Report Content - When a covered party becomes aware of an occurrence involving patient care, the covered party immediately is expected to provide the Risk Management Program with as much of the following information as possible:
   a. Reporting person's name and position.
   b. Name of injured party.
   c. Names of covering faculty, student, and staff involved.
   d. Date, time, exact location, patient condition and circumstances of the occurrence.
   e. Names of available witnesses.

Section 1.19 CLINICAL PRIVILEGES

All faculty, students and staff must have current approval for clinical activities granted by the Office of Clinical Operations ("clinical privileges"). Clinical privileges shall be granted and monitored by the Office of Clinical Operations in accordance with the following criteria.

Clinical privileges may be suspended or revoked at anytime by the Office of Clinical Operations due to unprofessional conduct or to protect the health, safety or welfare of patients, faculty, students or staff. Students may appeal the suspension of privileges to the Student Performance Committee. Faculty and staff may appeal the suspension of privileges to the Dean.

FACULTY CLINICAL PRIVILEGES

- Faculty Appointment
  Faculty must have a current faculty appointment approved by the Regents.
- Medical Status
  **Faculty must have the following:**
  - HBV Vaccination or antibody positive or informed waiver
  **It is recommended that faculty have the following:**
  - TB Screen
  - Basic Life Support
  Faculty must have current CPR certification when participating in clinical activities.
  - Faculty must have professional liability coverage through the University Trust or a private carrier. Part time faculty are NOT generally covered by the University Trust. All faculty should have a signed statement on file with OCO acknowledging their professional liability insurance coverage.
  - Dental or Dental Hygiene License
  Clinical faculty should have a valid dental or dental hygiene license from within the United States or Canada, preferably from the State of Colorado. Copies of all dental license(s) should be kept on file in OCO. Clinical faculty who do not have a U.S. or Canadian license may be granted clinical privileges based on a review of their qualifications, education, training and/or experience by an ad hoc committee of faculty. The ad hoc committee should include the Associate Dean for Clinical
Operations, department chair, division chair and at least two other members of the Patient Care Committee.

• DEA Number
  Faculty need not have a current DEA number, but must have a copy of their DEA certificate on file in OCO if they prescribe while in the scope of their faculty appointment.

• National Practitioners Data Bank
  All requests for information from the National Practitioner’s Data Bank will be made directly by the Office of the Dean. All review of responses will be done with the utmost confidentiality and maintain under strict security as determined by the Dean’s Office, and should NOT be kept with general personnel files.

STUDENT AND RESIDENT CLINICAL PRIVILEGES

• Student or Resident Status
  Students and residents must be currently enrolled in a Dental School Program.

• Medical Status
  Students and residents must have the following:
  • HBV Vaccination or antibody positive or informed waiver
  • TB Screen
  • Basic Life Support

  All students and residents must have CPR certification prior to direct patient care.

  Note that observation and limited assisting in the clinic is permitted with direct faculty supervision.

STAFF CLINICAL PRIVILEGES

• Employee Status
  The University must currently employ staff employees in good standing, or be participating in a working interview as approved by OCO.

• Medical Status
  Staff employees must have the following:
  • HBV vaccination or antibody positive or informed waiver

  It is recommended that staff employees have the following:
  • TB Screen
  • Basic Life Support

  All clinical staff must have current CPR certification when participating in clinical activities.

VISITING STUDENTS, FACULTY, AND PROGRAM PARTICIPANTS

The Office of Clinical Operations, consistent with the following, may grant faculty and students who are visiting the School of Dental Medicine:

• Status:
  Visiting faculty or students must document their status by a written letter from their institution stating faculty appointment or student enrollment. Program participants must be currently enrolled in a school-sponsored program or be verified participants in a University of Colorado clinical grant.

• Dental or Dental Hygiene License:
  Program participants who are engaged in direct patient care should have a valid dental or dental hygiene license from within the United States or Canada, preferably from the State of Colorado. Copies of all dental license(s) should be kept on file in OCO. Clinical faculty who do not have a U.S. or Canadian license may be granted clinical privileges based on a review of their qualifications, education, training and/or experience by an ad hoc committee of faculty. The ad hoc committee should include the Associate Dean for Clinical Operations, department chair, division chair and at least two other members of the Patient Care Committee.

• Professional Liability Insurance:
  The University of Colorado School of Dental Medicine does not provide professional liability coverage. All visiting faculty or students must have a written documentation of professional liability coverage.

• National Practitioners Data Bank
All requests for information from the National Practitioner’s Data Bank will be made directly by the Office of the Dean. All review of responses will be done with the utmost confidentiality and maintain under strict security as determined by the Dean’s Office, and should NOT be kept with general personnel files.

Section 1.20 INCLEMENT WEATHER PLAN & CAMPUS CLOSURE

Campus Closures
UCDHSC Administrative Policy Page 1
University of Colorado at Denver and Health Sciences Center

UCDHSC Administrative Policy
Title: Campus Closures
Prepared by: Assistant Vice Chancellor for Human Resources
Approved by: Vice Chancellor for Administration and Finance
Effective Date: June 1, 2007
Replaces: September 1, 2005
Applies: All campuses

A. Introduction
This policy establishes campus closure and related staffing expectations during inclement weather and other emergencies, and is applicable to all faculty, classified staff, exempt professionals and student employees. Circumstances which may require that UCDHSC campuses be closed include: inclement weather such as snow, ice, tornadoes and other weather related conditions, flood, fire, chemical spills, air pollution advisories and other similar natural disasters; and, acts of violent crime, terrorism and other major threats to personal safety.

B. Table of Contents
A. Introduction
B. Table of Contents
C. Policy Statement

C. Policy Statement
1. The decision to close the campuses is vested with the UCDHSC Chancellor or designee(s).
With guidance from the Office of the Governor, the University System President’s Office, media reports, law enforcement agencies and other emergency personnel, the decision to close a campus will be made under conditions that pose serious health and/or safety hazards to campus constituents. The primary criterion for closing the campuses will be the current or changing conditions of the campuses and the immediate environment. Closing considerations may include:
   a) Can the parking lots and buildings be accessible to employees by 6:00 am?
   b) Are the sidewalks clear and safe for use by 6:00 am?
   c) Are the roads cleared and negotiable by 6:00 am?
   d) Are there any state and or local warnings in place?
   e) How many consecutive days has the campus been closed?
   f) Is the infrastructure functioning?
       Domestic water Electrical
       Steam Shuttle
       Chilled water Circulator
       Telephones Public transportation
       Network Public emergency responders
   g) What are the conditions surrounding the campus or facilities?
   h) Will essential personnel be able to arrive at work and stay for an extended period of time?
   i) What’s the long-term outlook or weather forecast?
   j) How long can the campus/facility be kept open?
k) Are the affiliates impacted and or open?
l) Are state and local agencies open?

2. No individual school or department may formally announce an independent closing decision. UCDHSC has the authority to make campus closure decisions independent of city and state officials and is exempt from the State Inclement Weather Policy as established by the Governor for state employees.

3. Downtown Denver Campus
Employees assigned to the Downtown Denver Campus will observe Auraria Higher Education Center (AHEC) closure determinations. Such determinations will generally apply to the UCD buildings located near the Auraria Higher Education Center and off campus work locations associated primarily with this campus, unless otherwise specifically noted. For example, the UCD Chancellor or designee(s) may determine that UCD-specific Downtown Denver facilities should be closed, even if AHEC does not announce a closure, and retains all employment-related decisions.

4. Anschutz Medical Campus and the 9th Avenue Campus
The Chancellor or designee(s) have authority over the Anschutz Medical Campus, the 9th Avenue Campus and off-campus work locations associated primarily with these campuses. These locations will follow the same closure decision, unless otherwise specifically noted. University of Colorado Hospital (UCH) and other affiliates at the Anschutz Medical Campus have separate operating policies that affect their staff. However, every effort will be made to coordinate closure information with UCH and other affiliates, particularly to ensure appropriate medical care coverage.

5. Off-Campus Activities
Closures in the case of inclement weather also include the cancellation of off-campus activities. However, independent policies and procedures for closing may be determined for off-campus activities by the college, school or department.

6. Communicating Closure Decisions
The Office of Integrated University Communications is designated by the Chancellor to notify the news media of closures. Weather closures and emergency notification decisions will be made as early as possible to facilitate the most effective communication. Multiple communication avenues will be used whenever possible, to ensure broad access to the information. The primary sources of closure will include:
   a. Local television and radio stations and their websites
   b. The UCD website: www.ucdhsc.edu/index.htm
   c. The Auraria Higher Education Center website: http://www.ahec.edu/
   d. The 9th Avenue/Anschutz Medical Campus emergency information number (303-724-INFO)
   e. UCD broadcast e-mails
   f. Direct notification of department heads to inform faculty and staff members
   g. Department voice mail messages
   h. Department Phone Trees

7. Staffing Management
   a. Essential Employees - Certain employees, by nature of their assignments, may be designated ‘essential’, e.g., police, safety medical and critical facilities personnel. Appointing authorities usually identify these employees in advance and notify them of their status in writing. Specific incidents or circumstances may, however, require the immediate determination and notification that an employee must report during a campus closure. Since such essential employees are often expected to report to work during closures, they are required to be aware of the reporting and communication plan for their work area. Essential employees with parking privileges should park in their normal parking spaces. If unable, essential employees need to park in spaces that are accessible, without using handicap spaces. They will need to watch for special notices or communications regarding parking and other special situations as they report to work. Essential employees who do not report to work as assigned will be required to use personal leave or have their pay docked for that time period. Such absences will also be considered in the evaluation of the employees’ performance, including possible corrective or disciplinary actions.
   b. Employees Not Designated as Essential - Non-essential employees who are regularly scheduled to work must stay away from campus during closures. Those who are salaried will be paid as scheduled during that time and will not be charged earned leave. Given that closures only occur in cases of extreme weather or other safety concerns, the campus will not be prepared to accommodate the health and safety of non-essential employees.
8. Leave  
   a. Leave Accrual – Neither essential employees performing work on campus nor any employees performing work off campus during the closure will accrue any additional leave, i.e., they will not receive a “free day” because they worked during a closure.
   b. Leave Use - Employees who are on pre-approved or extended leave at the time of a closure may be required to use their earned leave, as planned, during the closure. As with all scheduled leave at any other time (regardless of a campus closure), leave requests may also be rescinded, amended or re-approved by appointing authorities as circumstances, plans and work schedules change. The Chancellor or designee(s) may also determine if any employees should be charged any earned leave, based on considerations such as the nature, severity and expected or actual duration of the closure, the campus calendar, the allocation of resources, consistency and fair employment practices.
   c. Non-Salaried Employees - Student, temporary or other hourly employees who do not earn leave will only be paid for hours actually worked, regardless of any closure.

The University of Colorado Denver emergency information number is 877 463 6070. If we were experiencing condition such as inclement weather which poses a threat to students, faculty, staff or visitors at any of the University of Colorado location, information including safety instructions or scheduled adjustments would be available at this number.

Section 1.21 RECOMMENDATIONS FOR FACULTY, STUDENTS AND STAFF WITH HBV, HIV, TB AND OTHER INFECTIOUS DISEASES

PREAMBLE
The University of Colorado Denver School of Dental Medicine recognizes the need to establish recommendations and support for faculty, staff and students infected with HBV, HIV, TB and other infectious diseases. It is the intent of the School to base this policy on the best scientific data available, fully realizing that later modifications may be necessary as knowledge of the virus increases. These policies are closely adapted from published CDC and ADA guidelines. It is also the intent of the School that this policy be consistent with all applicable federal, state and local laws, as well as University Policy. Throughout the policy, one disease, HIV/AIDS has been used as a primary focus and whenever possible, other infectious diseases are addressed. This is due to the fact that at this time, HIV disease has well-established resources, treatments and supportive services and can serve as a model for adaptation with other infectious diseases.

The CDC guidelines have established practice restrictions on HIV-infected health care workers. These guidelines base their restrictions on the definition of “invasive procedures,” which are generally defined to include procedures that involve surgical entry into tissues, cavities, or organs or repair of major traumatic injuries. The guidelines suggest that health care professionals who perform such invasive procedures should know their HIV status and if positive, they should not perform exposure-prone procedures unless they have sought counsel from an expert review panel.

The ADA Policy on HIV-infected Dentists states:
“Currently, there is no scientific evidence to indicate that HIV-infected health care providers pose an identifiable risk of HIV transmission to their patients...The ADA strongly affirms that Standard precautions are an effective and adequate means of preventing the transmission of HIV from dental health care workers to patient and patient and patient to dental health care worker.”

EXCERPTED FROM THE INFECTION CONTROL POLICY
II. PERSONNEL HEALTH ELEMENTS
6.5.1. **Immunizations and infectious disease screening policies:**

Immunizations are a significant and cost-effective preventive strategy and will be reviewed on an individual and confidential basis at the time of hire and as new evidence becomes available regarding newly applicable immunization programs. All students, faculty and staff who have direct or indirect contact with patient’s blood and/or saliva should be immunized with hepatitis B vaccine or show serological evidence of immunity (anti-HBs) to hepatitis B virus infection. Those who receive the vaccine series are recommended to be serologically tested according to current recommendations (6 weeks to 6 months after the third injection) for antibody immune status.

6.5.1.1. **Students:**

Hepatitis B vaccination or evidence of serological immunity (anti HBs) is required for students prior to clinical contact with patients and for post-graduate students prior to initial clinical activity. A baseline tuberculin skin test (TST) and/or chest x-ray is also required. Other required immunizations include measles, mumps and rubella (MMR), tetanus / diphtheria and polio. Annual influenza vaccination and Hepatitis A vaccination is strongly encouraged. Student health records are confidential and are maintained separately from academic records.

6.5.1.2. **Faculty and Staff:**

It is recommended that all faculty and staff with direct or indirect contact with patients and who may then be potentially exposed to infectious blood or other body fluids be immunized with hepatitis B vaccine or show serological evidence of immunity (anti-HBs). Hepatitis B vaccinations will be offered to employees at no charge. Current published protocols will be followed for the schedule of vaccination and recommended follow-up testing for seroconversion. Declination of vaccination for hepatitis B must be documented in writing and a record kept in confidential employee health record files. Staff and faculty with direct patient contact will be encouraged to consult with their physicians and obtain other immunizations recommended for prevention of transmissible infectious diseases: annual influenza vaccination, Hepatitis A vaccination, measles, mumps, rubella, and varicella (chicken pox). Immunization and declination records will be kept confidential. It is recommended that all faculty and staff whose duties include direct patient contact, obtain a baseline tuberculin skin test (TST) using the two step method.

6.5.2. **Potentially infectious medical conditions and related work restrictions:**

6.5.2.1. **Reporting Requirements for Suspected Communicable Disease:**

Any UCDSDM staff, faculty, or student including all undergraduate or post graduate students, who is aware or has reason to believe that she/he has a potentially communicable disease including those listed below, is responsible for reporting the information promptly to the Department chair and / or Clinic Manager who will report to the Associate Dean for Clinical Affairs. It is recommended to obtain medical evaluation and advice for such conditions as part of the determination for work restrictions. All personnel health reports will be handled in a confidential manner. Using appropriate medical guidance, the Dean shall make final determinations regarding restrictions, modifications of duties and assignments. Further, all students, staff and faculty are ethically and professionally responsible to monitor their own health conditions regarding their ability to provide safe care and minimize the risk of disease transmission.

6.5.2.2. The UCDSDM will use as the basis of illness related work restrictions, the recommendations listed in the CDC Guidelines for Infection Control in Dental Health-Care Settings, 2003, Table 1. pp. 8 and 9.

6.5.2.3. Recommendations regarding HIV infection or Hepatitis B e antigenemia when duties and assignments include patient contact during potentially invasive procedures:

Any UCDSDM student, staff or faculty member who knows or has reason to believe that she/he has such diagnosis which may compromise the ability to safely treat patients or work in a clinical setting, shall report this information immediately to her/his department Chair who will report to the Dean. All such reports will be handled in a confidential manner. Health care workers and students with infections shall not be subject to discrimination in employment practices. As per current recommendations, persons with acute or chronic Hepatitis B (i.e antigenemia) or those identified as HIV positive should not perform exposure prone inva-
sive procedures until counsel from an expert review panel has been sought. All records and review procedures are confidential.

6.5.2.4. Recommended Composition of Expert Panel:
1. An infectious disease specialist with expertise in infectious disease transmission.
2. The individual’s personal physician.
3. A UCSDSDM faculty member familiar with the individual’s clinical activities and/or job functions.
4. A state or local health care official.
5. An attorney familiar with anti-discrimination and civil rights issues in the workplace.
6. A member of the UCSDSDM Clinic Operations Committee.

6.5.2.5. Factors for Expert Panel review:
1. Current health status of the individual.
2. Scope of clinical tasks and assignments.
3. Degree of clinical or job skill level of the individual.
4. Risks posed by infection and current applicable laws and regulations.

6.5.2.6. Students, faculty and staff who believe they may be at risk of HIV or HCV should seek testing and counseling. Mandatory prescreening or testing is not required at this time.

6.5.2.7. Recommendations regarding active tuberculosis:
A chronic productive cough (3 weeks or more), bloody sputum, night sweats, fatigue, fever and continuing weight loss are together indicative of possible active tuberculosis. Any UCSDSDM student, staff, or faculty including office, administrative and support staff with this group of symptoms should be promptly evaluated for TB and not return to work until a diagnosis of TB has been excluded or until the individual is on therapy and a qualified physician’s determination is made that the individual is not infectious. All health care records and reports related to such conditions will be kept confidential.

6.5.2.8. Work Restrictions for other communicable diseases:
Students, faculty and staff should be restricted from patient contact during active stages of the following conditions:
Conjunctivitis (pink eye), active diarrhea, Hepatitis A, Herpes simplex and herpetic whitlow, measles, meningococcal infection, mumps, lice, pertussis, rubella, staphylococcus aureus with skin lesions, tuberculosis active, varicella (chicken pox), zoster (shingles with open lesions in potential contact areas), febrile respiratory infections with active cough, sneezing, and mucous drainage. Training will include references so that students, faculty and staff may appropriately recognize active stages of communicable disease and thus effectively self-monitor their ability to attend the clinic environment and provide safe treatment.

6.5.2.9. Record Keeping and Confidentiality:
Health status and records of staff, student and faculty will be monitored as they pertain to infection control protocols. This includes relevant medical evaluations, screenings and results, immunizations, exposures and post exposure management. The related records shall be kept confidential and in accordance with HIPAA compliance.
PATIENT RESPONSIBILITIES
As a Patient of Record at the University of Colorado Denver School of Dental Medicine (UCDSDM) It Is Your Responsibility To:

- Follow the treatment plan recommended and approved by the School.
- Follow UCDSDM rules and regulations affecting patient care and conduct.
- Provide accurate, current and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to your health.
- Make it known that you clearly understand a contemplated course of action, and what is expected of you.
- Assure that the financial obligations of your health care are fulfilled as promptly as possible.
- Be considerate of the rights of other patients and of school personnel.
- Remember that you are responsible for your actions if you refuse treatment or do not follow instructions.

PATIENT RIGHTS
As a patient of record at the University of Colorado Denver School of Dental Medicine you have the right:

- To treatment regardless of race, color, religion, gender, age, national origin, or individual handicap.
- To receive considerate, respectful care at all times and under all circumstances.
- To receive advance knowledge of the cost of treatment and to request and receive an itemized, detailed explanation of your total bill for your care.
- To reasonable, informed participation in decisions concerning your health care. To know who is responsible for authorizing and performing procedures and treatment. To know about and accept or refuse participation in research projects affecting your health and treatment.
- To obtain complete and current information concerning your diagnosis, treatment, and any known prognosis. (If it is not medically advisable to give a patient this information, it should be given to a legally authorized individual.)
- To continuity and completion of treatment started when patient has fulfilled all of their responsibilities.
- To receive treatment that meets the standard of care in the profession.
- To have access to emergency care.
- To have care provided that is consistent with total patient needs and is in an appropriate sequence.
- To reasonable safety insofar as the clinic practices and environment are concerned.
- To know the identity and professional status of all individuals providing services to you.
- To be informed of the School rules and regulations applicable to your conduct as a patient.
- To be informed of any continuing health care requirements following treatment.
- To personal and informational privacy:
  - To have any discussion or consultation involving your case conducted discreetly. Unless authorized by you, no one not directly involved in your treatment or the educational aspects of your treatment will be present at such a discussion or consultation.
  - To have your medical record read only by individuals directly involved in your treatment, including those who monitor its quality, and by students and faculty for educational and research purposes. Others may read your medical record only with your written permission, or that of your legally authorized representative.
  - To have all communications and other records pertaining to your care, including the source of payment for treatment, treated as confidential.

ACCESS TO DENTAL RECORDS
- You or your designated representative may inspect your dental record during regular office hours (8:00 a.m. - 4:30 p.m.) after giving 24 hours' notice to the Dental Records Department.
- You or your designated representative may obtain copies of your dental record by applying in writing to the School's Record Department. Copies are made and available within ten working days. The School will charge for the cost of copying. For further information about dental records, call (303) 724-6900.

PATIENT GRIEVANCE MECHANISM
You and/or your family may submit a request for information, or an expression of concern, orally or in writing, to the Office of Clinical Operations.
Section 2.2 PATIENT APPLICATION, SCREENING AND ACCEPTANCE INTO THE STUDENT PROGRAM

APPLICATION PROCESS
Patients who wish to become patients in the School of Dental Medicine pre-doctoral program call the School (303-724-6900) and are given an appointment for screening. Patients are appointed in the order in which they call. Screening is done at no charge to the patient, and does not guarantee acceptance into the program.

The undergraduate programs have aspects unique to the academic mission of the School, such as time commitment, fees, and length of time to complete care. Staff, students and faculty emphasize these features during the screening process.

SCREENING APPOINTMENT
The University of Colorado School of Dental Medicine conducts screenings throughout the year. Full-time faculty members in the Division of Comprehensive Care Dentistry supervise the screening process. Screenings by third- or fourth-year dental students, as well as second-year international students, occur periodically throughout the year. The screening appointment is not a thorough diagnostic examination, but rather a short appointment to determine an individual’s potential as a patient. Acceptance depends upon patient needs and desires, as well as suitability as a patient in the pre-doctoral program. A scale has been developed (Appendix A) that rates the patient in several areas, including Diagnosis/Treatment Planning, ASA status, Periodontics, Restorative Dentistry, Fixed and Removable Prosthodontics. The determined values are entered into the axiUm database in a sortable format for future assignment.

Acceptance into the pre-doctoral program depends on several factors, including but not limited to understanding of the special nature of a school program, realistic expectations, procedures appropriate to student abilities, availability of time and resources to obtain care in a timely fashion. Reasons for rejection as a student patient may include, but are not limited to, the following:

- Dental treatment needs or medical status are too complex and beyond the students abilities to properly treat the case without excessive faculty intervention. Complexity can be qualitative (difficult procedures) and/or quantitative (too many needs).
- Dental treatment needs are too simple to provide a good educational experience for the student.
- Dental treatment expectations of patient cannot be met by the School.
- Patients are unable to meet scheduling or financial obligations.

STEPS IN THE SCREENING PROCESS (Also see Section 2.5: Screening and Status)
When a patient calls for an appointment, initial demographic information is entered into the electronic data base, hereinafter referred to as axiUm. The status of the patient is entered as “New Screening” upon being appointed. Directions to and instructions for parking at the facility are provided.

On the day of the appointment, patients check in and are given a copy of the HIPAA and General Consent forms to review, after which they provide an electronic signature, and are given a copy to take home. Each patient is appointed for about thirty minutes, during which an abbreviated medical history is taken, chief complaint and patient expectations are determined, and a brief, non-invasive examination is conducted by the dental student. A preliminary evaluation is done using the previously-mentioned scale. Screening faculty members review the findings, and make a final determination regarding acceptance or rejection, and approve the findings and scale values in axiUm. Appropriate examination and radiographs are ordered and approved in axiUm. (See Section 2.5.)

If a patient is accepted for treatment, he/she is given a letter which reviews and reiterates what has been discussed, and which states the dollar amount needed for the subsequent examination and films. Patient status in axiUm will be changed to “Accepted,” and the name will be placed in a pool for future assignment to a student.

If a patient is rejected, he/she is given a letter which states the reason. If appropriate, the patient is referred for screen-
ing in the General Practice Residency. Otherwise, information about alternative sites/programs is provided. Patient status in axiUm will be changed to “Rejected,” which means the patient cannot be screened again except in special circumstances.

The following medically compromised patients are not routinely accepted for treatment by UCSDSDM students unless stable and coordinated with patient’s physician (referral to GPR is appropriate):

1. severe cardiopulmonary disease (uncontrolled hypertension, MI/CVA within the previous 6 months)
2. severe congestive heart failure/arrhythmia/insufficiency, in need of IV antibiotic coverage)
3. severe endocrinopathies (uncontrolled diabetes of any type)
4. hematological diseases (all types of hemophilia and coagulation disorders, leukemias, anticoagulant therapy)
5. severe renal insufficiency (post renal transplant, hemodialysis)
6. severe uncontrolled convulsive disorder (epilepsy)
7. active tuberculosis – referral to GPR while active

The following dentally compromised patients are not accepted for treatment:

1. Fixed Prosthodontics: Patients with severely worn dentition requiring full mouth rehabilitation.
2. Removable complete dentures: No or negative ridge, for whom implants are not feasible. Also, patients whose expectations appear unrealistic.

Time Commitment and Availability
Fees at the dental school are approximately 50% less than fees charged in private practice. The lower fees are in exchange for the increased amount of a patient's time that is required for treatment by a student. Patients who are accepted for treatment are expected to be able to meet at least one 3-hour appointment per week. Patients must also have a flexible schedule, and should be available for several different clinic sessions in a given week (AM or PM).

Payment Policy
Payment for services is required as they are rendered. Advanced payment of 50% of the total fee is required for laboratory-fabricated restorations and denture services. MasterCard, Visa and personal checks are accepted. Most dental insurance plans and Medicaid are honored. Most patients will need $100 to $250 per month for dental treatment at the School.

Patient Scheduling
Patients should give 48 hours notice if they cannot keep an appointment. Patients who fail to meet appointments 2 or more times may be referred to the Office of Clinic Operations for removal from our program.

Section 2.3 ACCEPTANCE OF MEDICALLY COMPROMISED PATIENTS

PURPOSE:
To minimize risk to the medically compromised patient during dental treatment in the student program.

GENERAL POLICY:
It is the intent of the University of Colorado School of Dental Medicine to provide safe, quality dental care to a broad range of patients in an educational environment. The focus of the pre-doctoral clinic is to provide students with fundamental experiences in various aspects of dentistry.

Patients who represent a high risk to themselves during routine dental treatment are not admitted to the pre-doctoral clinic. Patients who desire oral care may present with medical/oral health conditions that are best managed in a treatment environment other than an undergraduate training program. Extremely complex patients (medically and/or dentally complex) are most safely treated in a graduate program or the outpatient/inpatient hospital environment.
IMPLEMENTATION:
Patients are screened as described in Section 2.2. This includes health history, personal interview, and a brief clinical examination. In the screening scale (Appendix A), the ASA status has been rated for screening purposes as I, II, IIIa, IIIb, and IV. The IIIa status is described as medically compromised but stable, and would be accepted if all other screening criteria are met. If some question remains, but the patient is otherwise stable for acceptance, a medical consult may be sent with the patient, who would bring the completed form to the initial comprehensive examination. Other medical consults may be done as part of the comprehensive examination procedure.

The following guidelines are to be used in this decision making process:

A. The following types of medically compromised patient problems should NOT be routinely admitted for care in the undergraduate program at UCDSCM unless the patient has had an appropriate consultation and dental care is coordinated with the patient’s physician.
   1. Severe Cardiopulmonary Disease
      a. Uncontrolled hypertension (above 140/90)
      b. Previous MI less than 6 months
      c. Severe congestive heart failure
      d. Severe cardiac insufficiency
      e. Severe cardiac arrhythmias
      f. Previous CVA less than 6 months
      g. Patients in need of IV antibiotic coverage during appointments.
      h. Patients dependent on full-time oxygen delivery
   2. Severe Endocrinopathies
   a. Uncontrolled diabetes of any type.
   3. Hematological Diseases
      a. All types of hemophilia and other coagulation disorders
      b. All types of leukemias
      c. All anticoagulant therapy patients
   4. Severe Renal Insufficiency
      a. Post renal transplant
      b. Hemodialysis
   5. Severe Convulsive Disorder (Epilepsy)
      a. Unstable seizure history
      b. Seizures within one year
   6. Active Tuberculosis – Referral to GPR while active.

B. Hypertensive patients cannot be admitted if their blood pressure exceeds 140/90 without a written medical consultation with the patient’s physician, or faculty approval.

C. Medically compromised patients who are accepted should be carefully monitored as to their clinical progress within the undergraduate program. Supervising faculty should minimize the length and number of appointments for medically compromised patients whenever possible within the constraints of the educational program.
Section 2.4 TREATMENT OF THE PREGNANT PATIENT

PURPOSE:
To establish guidelines for treatment of pregnant patients

GENERAL POLICY:
Female patients of child bearing age who are pregnant or who may be pregnant may have treatment at the UCSD with certain modifications. Major reconstructive procedures, crown and bridge fabrication, elective oral surgical procedures and other significant procedures should be delayed until after the term of the pregnancy unless the patient is swollen or in pain. The dental care provider will consult with the patient's physician (primary health care provider) prior to providing dental care to the patient. Pregnant patients without a primary health care provider should seek care prior to receiving dental care. Referrals to the OB-GYN clinics at University Hospital may be arranged.

High risk pregnancy patients shall not be treated in the undergraduate clinic, and should be referred to the General Practice Residency for treatment. High risk pregnancy is defined as a pregnancy in which the mother is compromised by a systemic disease (i.e., diabetes mellitus, drug or alcohol addiction, hypertension, bleeding disorders, cardiovascular disease, lung disease, cancer, etc.) or the patient has a history of miscarriage, preterm (premature) labor, or spontaneous abortion. In general, treatment should be directed towards preventive care and the control of active disease. Elective procedures should be delayed until after delivery.

IMPLEMENTATION:
Patient Admission
1. Pregnant patients can be accepted for comprehensive care.
2. High risk pregnant patients should be referred to the General Practice Residency for treatment.

Treatment Planning
1. The UCSDM protocol for health data collection will be used to evaluate the patient's health status. Prior to prescribing medications, female patients of child bearing age should be questioned regarding the possibility of being pregnant, and post-partum patients should be questioned regarding breast-feeding.
2. Medical consults should be obtained prior to treatment. Telephone consultation should be obtained if written consultation is not feasible. Telephone consults must be documented in the treatment notes in the patient's axiUm record, and should be followed up with a written consult which will be scanned into the Attachments section of the electronic health record.
3. Patients without a primary health care provider (physician, nurse practitioner, nurse-midwife) should be referred to the University Hospital OB-GYN clinics and urged to seek a primary health care provider. A copy of the written referral will be scanned into the Attachments section of the electronic health record.
4. Emergency or urgent care procedures can be entered into axiUm directly as planned procedures. For non-urgent care, the axiUm treatment planning module will be used, treatment being phased and sequenced with regard to timing suitable for the pregnant patient (see Section D below.)

Radiation Hygiene
1. Use of ionizing radiation should be restricted to the minimal number of exposures needed to diagnose and treat the condition causing the dental emergency. Elective radiographs should be avoided during pregnancy.
2. Radiation safety procedures outlined in the UCSDM Clinical Policy R-500 should be followed if radiographs are to be taken.

Treatment Guidelines
1. Goal
The goal of treatment of the pregnant patient is to institute preventive measures and to control active disease, in consultation with the patient's physician to insure the safety of the mother and child.
2. Treatment considerations
   a. Maintain optimal oral hygiene, including prophylaxis, throughout pregnancy.
   b. Avoid elective dental care during the first trimester and last trimester.
   c. Avoid the use of unsafe medications* during pregnancy and in the post-partum
breast-feeding patient.

d. Delay major reconstructive procedures, crown and bridge fabrication, elective oral surgical and operative procedures until after delivery.

e. Refer high risk pregnancy patients to the General Practice Residency Clinic for triage.

3. Drugs of choice: Ideally, no medication should be administered during pregnancy, especially during the first trimester. However, drugs listed below may be given (with considerations as noted) if needed, unless otherwise contraindicated by the patients’ medical history or by the patient's physician. A medical consultation is necessary prior to prescribing any medication to a pregnant or potentially pregnant patient.

a. Analgesics: Acetaminophen and codeine (avoid in first trimester) are the drugs of choice.

b. Antibiotics: Penicillin and non-estolate erythromycin are the drugs of choice for oral infections.

c. Anesthetic: Local anesthetics such as lidocaine and mepivacaine with vasoconstrictor are acceptable.

d. Nitrous oxide analgesia is not acceptable during pregnancy in the dental school setting.

e. Sedative agents and medications utilized in conscious sedation are not acceptable during pregnancy in the dental school setting.

Section 2.5 PATIENT SCREENING AND STATUS

SCREENING FORM

Patient screening uses an abbreviated form in axiUm intended to reduce the time needed to identify potential treatment needs and desires, medical issues that may have an impact on treatment, and the patient’s desired timing of treatment (based on the patient’s schedule flexibility and finances). This information is intended to allow the patient to be treated to the level and at the pace that he/she desires, as well as to provide guidance for the students regarding their patient management responsibilities.

The following information is collected in axiUm during the initial screening appointment: (See sample axiUm Screening Form, Appendix B.)

• Chief Complaint, stated in the patient’s own words.

• Medical history and medications (abbreviated to determine critical information. A more detailed medical history is taken as part of the Comprehensive Oral Examination.)

• Vital signs

• Allergies

• Patient availability

• Patient expectations of treatment and outcomes

After reviewing the above information, the following derived information is also entered:

• ASA classification

• Treatment needs (see Screening Scale, Appendix A.)

• Determination of acceptance

• Reasons for rejection, as needed

• Comments (allows for text entry to further explain or expand on the findings/determinations of the screening process

After the screening session, the findings and determinations are reviewed by one of the covering faculty members. He/she signs the appointment sheet, which is then given to a Patient Care Coordinator.

Depending on the outcome of the screening appointment, status for all screened patients will be updated in axiUm to “Accepted” or “Rejected.”

• Records of patients with a status of “Accepted” are placed in a queue in axiUm, available for assignment to the next student in the “request” queue. Once assigned to a student, the patient status is updated to “Active.” This is done by a Patient Care Coordinator.

• Records of patients with a status of “Rejected” are placed in a pool in axiUm which is unavailable for rescreening. Exceptions may be noted in the record to allow rescreening if problems such as medical issues or availability, noted initially, have been resolved. This is done on a case-by-case basis.
PATIENT STATUS

Current status designations available in axiUm are as follows:

- Accept: Patients accepted at screening
- Active: Patients assigned for active treatment to a student
- Board patient: Patients who were screened by student candidates solely for licensing board examinations.
- Delay1: Patients who have requested delay, first delay period.
- Delay2: Patients who have requested delay, second delay period.
- Discontinued: Patients who have been dismissed from the program. Not to be reinstated without special consideration, if at all.
- Emergency: Patients whose initial visit to the school is for emergency care.
- Inactive: Patients whose treatment is discontinued for a variety of reasons, including but not limited to, moving out of the area, treatment complete at this site, no further treatment desired.
- Limited Care: Patients who have only one or two items requiring treatment, or who need definitive treatment such as endodontic procedures and stabilization. No comprehensive care is rendered without screening.
- Reject: Patients who were determined at screening to be not a good match for the pre-doctoral program
- Screen: New patients who are interested in becoming patients at UCDSDM

STUDENT AND FACULTY PARTICIPATION IN SCREENING:

Third- and fourth-year dental students, as well as second-year students in the International Student Program, are assigned to a rotation, with a minimum of four students assigned to each session. One or two faculty members from the Comprehensive Care faculty are assigned to each session. One dental assistant is assigned to assist in seating patients and resetting chairs and instruments.

Sessions typically occur once per week, with plans to expand to twice per week in future semesters, based on student and faculty availability. Since all patients have been entered into axiUm, they are assigned to specific students for the day. Once the session is completed, the patients seen are no longer part of the student’s patient pool.

Once the session is completed, students who have participated in the screening process are allowed to request one (only) of the patients accepted at that session. The remaining patients are placed in the “Accepted” queue, as previously described.

If students have a family member, friend, or patient referred by one of their own patients, or someone they have treated while on a rotation and wish to continue treating comprehensively, they may request an “overflow” chair for a session. These chairs make use of the time available from patients who fail to show for screening. Such patients will be assigned to the student who requested the chair.
## 2.5 APPENDIX A: SCREENING SCALE

<table>
<thead>
<tr>
<th>Scale</th>
<th>Diagnostic &amp; Treatment Planning</th>
<th>Fixed Pros</th>
<th>Operative</th>
<th>Perio</th>
<th>Removable: Complete Denture</th>
<th>Removable: Partial Denture</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Simple (ASA I): More routine dental treatment needed</td>
<td>No obvious fixed needs</td>
<td>No obvious needs</td>
<td>No supragingival calculus, No mobility, No gingival inflammation, Likely treated with an adult prophy.</td>
<td>No obvious removable needs</td>
<td>No obvious removable needs</td>
</tr>
<tr>
<td>2</td>
<td>Moderate complexity (ASA II): More complex dental treatment needed.</td>
<td>1 or 2 crowns likely 1 implant possibility</td>
<td>Simple restorative Minimal caries, PRR type lesions few in number Small in size Whitening.</td>
<td>Some inflammation, Minimal localized Supragingival calculus, Likely treated with an adult prophy.</td>
<td>Ready to go – no pre-pros surgery required</td>
<td>Ready to go – no pre-pros surgery. No restorative/crown needs that take priority</td>
</tr>
<tr>
<td>3</td>
<td>Complex (ASA III A): Complex dental treatment needed. Some treatment may be urgent.</td>
<td>Many units of fixed Replace many missing teeth Multiple implants</td>
<td>Cavitations observed clinically, Possible build-up(s) Possible endo Restorable with effort, Fixed level esthetics.</td>
<td>More localized problems, Supragingival calculus, Likely treated with some SRP. Generally good prognosis may have some localized poor-prognosis prognosis.</td>
<td>May need pre-prosthetic surgery Implants probable for reasonable success</td>
<td>May need pre-prosthetic surgery May have many restorative/perio considerations</td>
</tr>
<tr>
<td>4</td>
<td>Too complex for undergraduate clinic (ASA IIIb OR ASA IV)</td>
<td>Full mouth rehab Loss of VDO, extreme wear</td>
<td>Gross rampant caries Significant root caries Caries on most or all teeth Multiple endo very likely Some or all non-restorable.</td>
<td>Mobility Significant calculus generalized SRP x 4 quads Some or all teeth poor-prognosis prognosis</td>
<td>No or negative ridge, Patient expectations unrealistic</td>
<td>Compromised result likely, few or inappropriate teeth remaining, Patient expectations unrealistic</td>
</tr>
</tbody>
</table>

*Green – proceed; acceptance likely
Yellow – proceed with caution; complete or phased treatment acceptance a possibility
Red – stop; rejection likely*
Screening Info

Medical History: This short medical history gathers only medical information needed acceptability to help determine acceptability of this patient into the dental programs. This patient is accepted the comprehensive medical history form will have to be filled out. Does the patient have or ever had a history of any of the following. Please answer each item.

- Angina: No 4/30/2008
- Heart attack: No 4/30/2008
- Heart surgery: No 4/30/2008
- Heart defects: No 4/30/2008
- CVA: No 4/30/2008
- COPD: No 4/30/2008
- Oxygen dependent: No 4/30/2008
- Asthma: No 4/30/2008
- Hepatitis: Yes 4/30/2008
- Hepatitis B: Yes 4/30/2008
- Kidney disease: Yes 4/30/2008
- Type II: Yes 4/30/2008
- Seizures: No 4/30/2008
- Depression: Yes 4/30/2008
- Blood or bleeding disorders: No 4/30/2008
- Anticoagulant therapy: No 4/30/2008
- Autoimmune disorders: No 4/30/2008
- AIDS: No 4/30/2008
- Chemotherapy: No 4/30/2008
- Radiation therapy: No 4/30/2008
- Osteoporosis/bisphosphonates: No 4/30/2008
- Joint replacement: No 4/30/2008
- Wheel chair dependent: No 4/30/2008

Vital Signs

- Blood pressure: 143/85 4/30/2008
- Pulse: 67 4/30/2008
- Respiration rate: 12 4/30/2008
- Any other surgeries/hospitalizations: appendix 1955 4/30/2008
- Any other medical conditions: none 4/30/2008
- What are you allergic to?: Sulfa, PCN 4/30/2008
- ASA: II 4/30/2008

Screening

What is the patient's chief dental problem now? Pain in the UL; want to get more teeth to chew with

Classification: Please classify each treatment area from 1-4 based on the scale provided.

- Periodontal: 3
- Operative: 2
- Fixed Prosthodontics: 1
- Removable Prosthodontics: 2 4/30/2008
- Diagnostic and Treatment Planning 2 04/30/2008
Patient Considerations

Availability such as schedule flexibility
and pace of treatment.
Patient expectations.
Any other considerations?
Should this patient be accepted into
the comprehensive Care program?

If you answered "No" to the previous question then answer the following questions as indicated.

Dental needs too complex.
Medical condition is deemed too unstable/complex.
Patient management issues.
Unassignable to available students.
Other reason.

This patient is motivated,
will be a good patient for a DS3

Faculty Comments:

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Section 2.6 PATIENT ASSIGNMENTS

Each student is assigned a group of patients during their clinical years at UCDSDM. This patient pool is in essence the student’s own practice, although the School’s faculty members have the ultimate responsibility for the patient's treatment and care. Each student is responsible for managing his/her pool, with regard to appointment scheduling, patient accounts, patient communication, organization, treatment sequencing, and other basics of practice and patient management.

An attempt is made to provide equitable distribution among students and to accommodate each patient’s own unique treatment needs. After evaluating student experiences, a student, in conjunction with his/her Group Leader is able to request patients. Attempts are made to supply each student with patients:

• who have needs which will provide a good educational experience
• whose availability will be compatible with the student’s schedule
• whose treatment needs are consistent with or will advance the student’s skill level.

The patient pool provides the majority of clinical experience in each discipline. Monitoring student experiences is achieved through several mechanisms. These include, but are not limited to, the axiUm database, Comprehensive Care Group Faculty, and departmental/divisional patient tracking.

Students who find their patient pool lacking in certain experiences are able to request patients with those needs through axiUm, or with their group patient care coordinator, using the sortable scale discussed in Section 2.2. After requesting a patient, the next available patient (screened and accepted) who meets the requested criteria will be assigned to the student. The student is then responsible to appoint the patient for Oral Diagnosis through axiUm.

Each student is also assigned patients while participating in block assignments such as Emergency, Oral Surgery, Special Care, and pediatric rotations throughout their clinical years. Students share patient management responsibility with discipline faculty and staff while working in each block.

Types of Patient Assignments

1. New Patients - "New Patients" are those patients who have not been previously assigned to a dental student for Comprehensive (or Limited) care. These patients have been preliminarily accepted through the screening procedure, and have had an appropriate radiographic series and examination ordered in axiUm. (See Section 2.2.) Although certain patients may have already been treated in the UCDSDM Hygiene Program or Emergency Clinic, they will have been screened prior to student assignment.
2. Transfer Patients - "Transfer Patients" have been previously assigned and treated by another UCDSDM student. All transfer patients’ electronic charts will have been reviewed by the student’s group leader and approved for transfer.

3. Shared Patients - Within axiUm, patients may be assigned to and treated by more than one student. Typically these patients have needs which are best treated by multiple student providers due to timing of care, student availability, or student clinical experience issues. Such co-assignment may include sharing treatment with a dental hygiene student, or for a referral to another clinic such as Oral Surgery, or to a graduate clinic. axiUm requires that treatment and patient be assigned to the person providing treatment.

4. Limited Care Patients – Patients may be assigned for limited care only, such as to treat and stabilize an endodontically treated tooth. Once this limited treatment is complete, the patient, if new to the school, can be appointed for screening if he/she desires comprehensive care. Limited Care assignment requires a review of the patient’s medical history, a head and neck exam, and a brief examination to determine that limiting care to a single area is appropriate.

Special Patient Assignments

1. Transition Clinic (DS-2 Spring): Transition Clinic patients may be any type of assignment (new, transfer, shared). Procedures completed in the transition clinic are done at 50% of regular School fees. The Group Coordinators will schedule all patient appointments into transition clinic for the DS-2 students.

2. Pediatric Dentistry Block (As Scheduled): Students scheduled into the Pediatric Dentistry Block work in operator/assistant teams. Patients are scheduled by UCDSDM staff (2 patients per session per team). Pediatric Dental faculty members are responsible for the overall management of the pediatric patient pool.

3. Oral Surgery Block (As Scheduled): Students scheduled into OS Block have patients scheduled by Oral Surgery Clinic Staff. Students may request to see their own comprehensive care patients in OS Block, by coordinating with staff. Oral Surgery Faculty members are responsible for the overall management of the Oral Surgery patient pool.

4. Special Care Clinic (As Scheduled) Students scheduled into the Special Care Dentistry Block work two-handed, in operator/assistant teams and four-handed with professional staff. Patients are scheduled by UCDSDM staff (multiple patients per session per team). Applied Department Dental Faculty members are responsible for the overall management of the special care patient pool. Senior patients who were previously treated in a Senior’s Dental Clinic are now assigned only to students in the International Student Program.

5. Emergency Dental Clinic (As Scheduled): Students scheduled into the Emergency Dental Clinic work two-handed and four-hand with professional staff. Patients appointed into the Emergency Clinic are generally walk-in patients who are not patients of record of the dental school. Their care is palliative, although many of these patients eventually become patients of the school at a later date. Patients are scheduled by UCDSDM staff (multiple patients per session per team). Surgical Department Dental Faculty members are responsible for the overall management of the emergency clinic patient pool.

6. Alternative Clinical Activity Assignments (Throughout the year): Students who are unable to schedule a patient into open chair time, who have a late cancellation or no show, must report to their Group Coordinator. (See Section 2.7.) In the event a student is assigned a patient for a clinic session for treatment or diagnosis, responsibility for subsequent or follow-up care reverts to the initially assigned student. If no such relationship exists, such as for patients assigned to the group, the treating student must consult with his/her Group Leader or coordinator to determine his/her responsibility to the patient after their session.
Section 2.7 STUDENT RESPONSIBILITY FOR ASSIGNED PATIENTS

Students at UCDSDM develop a pool of patients who will allow a varied and rich experience in providing dental treatment. Adhering to the concept of patient-centered care, students have responsibilities as clinicians in the management and appropriate treatment of the patients assigned to them.

Each student is assigned to a group which is comprised of twelve to fourteen students in the same class. A faculty member from the Division of Comprehensive Care is designated as the Group Leader, and one of the Patient Care Coordinators is also assigned to the group. In TEAM meetings and in individual advocate meetings, the students, faculty member and coordinator work together to ensure that appropriate and timely care is provided to each patient and that each student obtains a sufficient variety of experiences to become a competent beginning practitioner.

New Patients - "New Patients" are those patients who have not been previously assigned to a dental student for Comprehensive (or Limited) care.

Student Responsibility:
1. Review patient’s Electronic Health Record (EHR) prior to scheduling.
2. Schedule patient for Comprehensive Oral Examination within 2 weeks of assignment.
3. Complete Oral Diagnosis and Treatment Plan within 4 weeks of assignment.
4. Contact group leader or coordinator within one week if unable to comply with OD obligations in a timely manner, or if case is inappropriate for the student’s clinical educational experience.
5. Document management or scheduling problems using the Contact Notes in axiUm.

Transfer Patients - "Transfer Patients" have been previously assigned and treated by another UCDSDM student.

Student Responsibility:
1. Review patient records and planned treatment/sequencing in axiUm prior to scheduling.
2. Schedule patient as appropriate, consistent with treatment plan, or within 2 weeks.
3. Contact Group Leader or coordinator within one week if unable to comply with scheduling obligations in a timely manner, or if case is inappropriate for clinical educational experience.
4. Document management or scheduling problems using the Contact Notes in axiUm.

Shared Patients - "Shared Patients," also referred to as “co-assigned patients,” are those new or transferred patients who are permanently assigned to more than one student provider (dental and/or dental hygiene) or who are part of a program such as the pediatric clinic. The secondary student(s) providing treatment are termed “student associate(s).” See below for Student Associate responsibilities.

Primary Student Responsibilities for Assigned Patients
1. Appropriately Sequenced and Timely Treatment - Appropriate appointment intervals may vary and depends on several factors, most significantly the quantity and quality of each patient's treatment needs, and the patient’s availability relative to the student's clinic schedule. In general, all active patients should be seen for one appointment every two weeks. Students should document in the patient treatment notes and in the Contact Notes any reasons for delays in appointing active patients for more than three weeks, and review with Group Leader, and if necessary, send appropriate letters.
2. Standard of Care - Students are responsible to provide care consistent with the School's Standard of Care document (see Clinical Dental Education Manual).
3. Emergency Care - Students must be available for each assigned patient's emergency care. During regular school hours, emergency care may be provided by another student in the same Group if the primary student is unavailable. After hours, the School makes available 24-hour emergency care for all patients of record (see Emergency Dental Care Policy and Procedures, Section 2.14).
4. Periodontal Maintenance and Periodic Examination - Students are responsible to provide timely periodontal maintenance therapy and periodic examinations to all assigned patients, according to appropriate recall intervals. This includes those patients who are still in active treatment under an incomplete treatment plan.
5. Transfer and Case Disposition - All active patients must be transferred appropriately, with all data in axiUm up-to-date and signed. The Group Leader for the transferring student must review each patient’s records regarding work completed at UCSDM by student, periodic examination and periodontal maintenance, and sign off on the transfer, before the patient can be transferred.

**Student Associate Responsibilities for Assigned Patients**

Patients, who are assigned to a program (e.g., comprehensive care group, pediatrics, special care clinic, etc.) or to a student, may be appointed to be seen by another student, termed a “student associate.” It is anticipated that these appointed patients will provide approximately 25 – 50% of the students’ clinical experience.

**Student Associate Responsibility:**

Student associates share in the responsibility of treating the assigned patients, and are expected to manage their co-assigned patients consistent with the patient’s classifications.

1. Review patient EHR and treatment plan with primary assigned student and/or program faculty prior to seeing patient to confirm timing and sequencing of care.
2. With patient and covering faculty present, confirm timing, sequencing and appropriateness of scheduled treatment.
3. Provide treatment as appropriate.
4. Provide follow-up care as needed, related to the treatment provided.
5. Coordinate rescheduling of patient with appropriate primary student provider or program faculty/staff.
6. Document management or scheduling problems using the Contact Notes in axiUm.

**Special Assignment/Block Rotation Patients**

1. Students are required to attend all block rotation assignments and be prepared to treat all appointed patients.
2. Program staff members are responsible for scheduling and appointing patients based on the program block schedule.

**Comprehensive Care Group Patients**

1. Students request appointments for their own assigned patients through axiUm.
2. Group coordinators may schedule a limited number of the Group’s unassigned patients each session, into open unassigned chairs in anticipation of a student being available as a result of a patient cancellation or failure to show. These patients must have faculty coverage, and are usually done at the last minute.
3. Student responsibility:
   If a student is scheduled to be in clinic or on rotation (OS, Emergency, Pedo, etc., in the clinic rotation block schedule), but has no patient available, or if a patient fails to appear for a scheduled appointment, the student must check in with his/her Patient Care Coordinator. The Coordinator will assign a group patient (see above) or an emergency patient whose primary student is unavailable. If no patient needs to be seen, the student may do other things, but is still expected to be available in the building if needed.

**Patient Assigned to Fellow Student**

1. A student may schedule an assigned patient with another student associate, but must have the approval of his/her Group Leader.
2. Group Leaders will approve the use of student associates with the consent of the patient and based on the best interests of the patient (e.g., timing of treatment, skill level of student provider, etc.).
3. The assigned student remains responsible for the overall management of his/her patient’s timing of treatment and quality of care.
Section 2.8 COMPREHENSIVE CARE GROUP
APPOINTMENT PROTOCOLS

Appointment Requests
Appointment requests are made within the “Personal Planner” module of axiUm. The process for making a new treatment appointment request is described below. Patient Care Coordinators will fill requests from within the “Scheduler” module of axiUm.

Appointment Request Guidelines
1. Patient appointment requests will be honored based on availability of chairs and faculty coverage.
2. Patients should be appointed with divisional faculty if available, then utilize Comprehensive Care faculty as a second option. This is intended to preserve the more flexible coverage provided by Comprehensive Care.
3. For multiple-appointment procedures, patients should be scheduled with previous covering faculty if possible, to allow for continuity of care.
4. From time to time, coordinators may need to move the student’s patient appointment to alternate faculty coverage. If a particular faculty member is needed, this should be made clear in the request.
5. Specific chairs will be assigned when the Coordinator fills the appointment request. Students need to confirm that the request is filled as needed before confirming the appointment with the patient.

Student Responsibility:
1. Students must coordinate the timely scheduling of their assigned patient practice consistent with the patient’s needs, availability, and with the phase and sequence of the treatment plan.
2. Students should make the next appointment request while their patients are still in the chair, at the end of each session of treatment. Patients should not leave the School without their next appointment requested.
3. Students must be available to treat patients and to check with their Group coordinator any time they are scheduled in patientcare clinic, regardless of whether they have open or scheduled time. Students with open appointment times may have patients appointed for them by the staff at any time. (See Section 2.7: Student Responsibility, Comprehensive Care Group Patients.)

Steps for Appointment Requests in axiUm:
1. Open the “Personal Planner” module (icon: green book, left of screen) and select the “Appointments” tab.
2. Click “Add New Record” button (icon: folder with green “+”).
3. Select a patient from the list in the right-hand column, or type the patient’s name in the search box at the top of the window. The patient’s name will appear in the list at the right. Double-click the patient’s name to open the “New Appointment Request” window.
4. In the “New Appointment Request” window, provide the information requested, including date, session, time, location, specific faculty member (if appropriate), length of appointment, discipline of covering faculty member.
5. From the “Treatment Plan” tab, select from the list of approved procedures (in the left-hand pane) the procedure(s) to be done at the appointment. WITHOUT THIS INFORMATION, appointment requests will not be honored. Double-click or use the arrow to move the selected procedure(s) to the right-hand pane.
6. Once all procedures have been selected, close the window. The procedures will appear in the start-check window when your patient is seated.
7. From the “New Appointment Request” window, accept the appointment. The request will be available to the Patient Care Coordinator, and will be filled in the order received.

Deleting an Appointment Request in axiUm:
1. If a patient is unable to keep a scheduled appointment, and the student is unable to fill that appointment with another patient appropriate to the coverage, the student must delete the appointment to make the chair available to another student.
2. Open the “Personal Planner” module (icon: green book, left of screen) and select the “Appointments” tab.
3. Locate and highlight the appointment from the list generated by the “Search” icon for the appropriate date range.
4. Click the “Delete Record” button. (icon: folder with red “X”)
The table is intended as a general guide to help students and staff select students under the most appropriate faculty coverage. It is NOT intended to dictate to faculty the scope of coverage that they may or may not choose to provide. Many faculty members are qualified and willing to cover students in procedures that are not indicated in this template (e.g.: a "restorative" faculty member may choose to cover a student for perio prophylaxis, emergency endodontic access and/or diagnosis). On occasion, faculty members, although qualified to perform a procedure themselves, may not choose to do so.

<table>
<thead>
<tr>
<th>Discipline</th>
<th>PROCEDURE</th>
<th>Comp</th>
<th>Care</th>
<th>Perio</th>
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<th>Rest</th>
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The following policy has been developed in the interest of establishing a consistent standard concerning the use of ionizing radiation within the School of Dental Medicine. This radiation use policy complies with the Federal Radiation Control for Health and Safety Act of 1968, the Consumer-Patient Radiation Health and Safety Act of 1981, and the Rules and Regulations Pertaining to Radiation Control from the Colorado Department of Public Health and Environment. The primary goal of this policy is to assure the safe effective use of ionizing radiation and to minimize the potential risk from adverse biological effects to patients, students, faculty, and staff.

1. Deliberate exposure of an individual to dental radiographic procedures for training or demonstration purposes shall not be permitted unless there is a documented diagnostic need for the exposure by a member of the University of Colorado Denver School of Dental Medicine faculty.
2. No operator (faculty, student or dental auxiliary) shall hold an image receptor in place for the patient during the exposure. The use of receptor holding devices, bite tabs, or other positioning devices should be used to position the receptor during exposure.
3. The operator must stand at least 1.8 meters (6 feet) from the patient and behind the barrier provided for each x-ray exposure cubicle in the School of Dental Medicine. The operator shall be positioned outside the path of the useful beam and be able to directly observe the patient during each exposure.
4. The tube housing, the cone, or the position indicating device for wall mounted x-ray machines must never be hand held during the exposure. If equipment is not stable, report the problem to the radiation protection supervisor for the School of Dental Medicine, and use another unit.
5. Radiographic machines designed for use with an intraoral image receptor shall limit the source-to-skin distance to not less than 18 centimeters (7 inches).
6. Only shielded open-end position indicating devices will be used in order to minimize scatter radiation.
7. When a cylindrically collimated x-ray machine is being used, the circular beam shall be limited to no larger than 7.0 centimeters (2.75 inches) at the end of the cylinder. When rectangular collimation is used, the useful beam at the end of the collimator shall not have a diagonal measurement of greater than 7.0 centimeters (2.75 inches).
8. Only digital image receptors shall be used. Traditional intraoral film of speed rating “F” may be used in emergency situations.
9. Each dental x-ray machine shall contain filtration of 2 mm of aluminum equivalent if operated at less than 70 kilovolt peak (kVp), and 2.5 mm of aluminum equivalent if operating at 70 kVp or above.
10. Leaded aprons will be used on all x-ray patients of the School of Dental Medicine as an additional precaution to prevent unnecessary scatter radiation exposure to the body of the patient. Thyroid shields shall be used in all situations, except when diagnostic information will be lost by their use (panoramic and some extraoral radiographic procedures).
11. Periodic radiation protection surveys and inspections will be made according to State Regulations. All recommendations by the radiation safety officer concerning collimation, filtration (HVL), beam alignment, roentgen output, radiation leakage, etc., will be implemented immediately.
12. All operators will follow prescribed exposure techniques. Appropriate exposure values will be mounted on the wall of each x-ray exposure cubicle or designated by the control panel of the x-ray machine. Instructions for scanning digital receptors will be available in the Oral and Maxillofacial Radiology area.
13. As a general policy, all newly admitted patients to the School of Dental Medicine must have adequate oral and maxillofacial radiographic examinations to assist in diagnosis prior to treatment in the school’s clinics. In all situations, the need for radiographs shall be determined by using high-yield selection criteria as the basis of professional judgment.

The following shall be adhered to in regards to criteria for exposure:

a. All radiographic imaging shall be prescribed in by a licensed dentist.
b. Imaging ordered on a routine basis or for screening purposes will not be permitted.
c. A radiographic examination shall not be ordered before the patient’s medical and dental history has been reviewed and an initial extraoral and intraoral evaluation has been completed.
d. If prior radiographs are available, they should be evaluated by a faculty member before new images are prescribed. Only those additional views needed for complete diagnosis and treatment planning should be exposed. The faculty member will determine if sufficient time has passed, since the patient’s last radi-
ographic examination, to warrant a new examination.
e. Imaging should be completed only on patients capable of compliance or under appropriate sedation.
f. Subsequent follow-up (recall) radiographic examinations for School of Dental Medicine patients will be based on the diagnostic need of the patient as determined by the faculty dentist after a thorough health history review and oral examination of the patient.
g. Imaging obtained for administrative purposes only, including those for insurance claims or legal proceeding, should not be made.
h. Images of patients shall not be made merely for the purpose of training or demonstration.
i. The following shall apply to dental board examination patients:
   1) Request for images for all board examination patients shall be ordered by a licensed dentist.
   2) Images on patients should not be made for testing purposes alone. Images acquired should contribute to the proper diagnosis and treatment of the patient.
   3) Images made on site for, or as part of, board examinations shall be made in compliance with the School of Dental Medicine’s radiation use guidelines.
   4) The type and number of images needed shall be dictated by the oral and maxillofacial disease clinically evident or suggested by the history or other tests.
   5) Images should not be required at specific time intervals to document treatment progress for board certification purposes. Rather, the clinical progress as monitored by the candidate (and his or her mentor in the case of a student) should be used as a guide to the need for imaging.
j. Newly admitted adult patients will generally receive a radiographic examination to determine a base-line for the patient. This may include a panoramic image, bitewings, selected periapicals, or a series of full mouth radiographs (FMX).
k. Edentulous patients may receive a complete edentulous periapical series, a panoramic image, or a combination of occlusal and periapical images as deemed appropriate by the faculty dentist. Nevertheless, edentulous surveys will usually contain fewer image receptors than a comparable FMX of dentate patients.
l. Patients under 12 years of age may receive either a complete child periapical survey and bitewings, a panoramic image with bitewings and selected periapical views (if indicated), bitewings only, bitewings and selected periapicals and occlusals, or no images if none are indicated. The complete child periapical survey will vary depending on the age of the child; however, all child surveys will contain fewer images than the adult periapical survey.
m. The radiation exposure of endodontic patients for pre-operative and post-operative images will be kept to a minimum level consistent with clinical requirements. The limits of exposure in each case will be determined by the professional judgment of the faculty dentist. Where possible, a single image at each stage of the endodontic procedure will be acquired. Multiple images from different angles may be acquired on a restricted basis and only when the information to be gained is considered to significantly enhance the diagnosis and treatment. When multi-angle projections are required, documentation of their need will be made in the treatment record by the supervising faculty.
n. Emergency patients will receive only those images needed to diagnosis and treat the immediate emergency problem.
o. The Dental Radiographic Selection Criteria Panel’s recommendations shall be followed in regards to radiographic examination of pregnant patients. Quoting directly, "Accordingly, there appears to be no rationale to preclude a properly justified dental radiographic examination because of pregnancy. In some cases, radiography may be arbitrarily deferred during pregnancy for purely psychological reasons.” Appropriate protective shielding of the patient will always be used.

14. Radiation monitoring of operator exposure will include the following:
   a. All members of the faculty and staff who regularly use x-ray equipment will wear film badge monitors at all times while at work.
   b. Records of monthly, quarterly, yearly, and total cumulative exposures will be kept as a permanent record and will be available for inspection by the employee.
   c. These employees should not receive more than 50 mSv (5 rem) each year, the radiation protection guide value. Quarterly readings above 10 percent of the radiation protection guide or 1.25 mSv (125 mrem) will be investigated.
   d. Operators who are pregnant should not be exposed to more than 5 mSv (500 mrem) during the term of their pregnancy.
15. Documentation of all images and radiation exposures will be maintained in the patient's electronic record. The patient's treatment record should include the date, prescription detailing type and number of images and any remakes necessary. The number of images acquired should also be entered.

16. The School of Dental Medicine will have a Quality Assurance Program designed to produce images of consistently high quality with minimal exposure. This program will consist of the following:

   a. Projection Techniques
      1) Before students will be allowed to acquire images on a patient, they will have didactic instruction in oral and maxillofacial radiology plus laboratory instruction in acquiring images on a mannequin.
      2) There will be direct supervision of all students during their first clinical experiences in radiology.
      3) All radiographic examinations will be reviewed for errors by faculty or staff immediately after they have been scanned or acquired. When practical, the patient will not be dismissed until indicated remakes have been completed. Students who must remake 4 or more images will be directly supervised and instructed by faculty and/or appropriate staff member.
      4) Receptor holders and alignment devices will be used to aid students in the correct alignment of the position indicating device, the receptor, and the area of interest.

   b. The x-ray equipment in the School of Dental Medicine will be inspected by an official of the institution at a frequency that complies with current federal and state regulations. The results of these tests and any corrective measures taken will be maintained by the School of Dental Medicine radiation supervisor. If during the routine use of any x-ray machine, an error is noted in its operation, the machine will immediately be put out of service until the appropriate corrective repairs can be made. Any suspected malfunction should be reported to the radiation supervisor so that appropriate corrective measures may be instituted.

   c. All digital processing systems shall be maintained and operated in such a manner that insures optimum diagnostic quality of images. The receptors should be inspected on a regular basis and any damaged or inoperable receptors will be removed from patient care activities.

17. Radiographic procedures will be completed following institutional infection control guidelines. All patients will be treated as potentially infectious and the following will be adhered to:
   1) Since potentially infectious patients may have no evidence of a problem, the patient's medical history will be evaluated for indications of infectious disease.
   2) Protective gloves, masks, and eye wear will be worn during receptor and tube placement and during digital processing to minimize risks to the operator and the patient.
   3) Operators will wash their hands as they enter the clinic and after removing their gloves at the completion of the procedure.
   4) Supplies and receptors will be kept on a covered work surface.
   5) Receptor holders will be sterilized prior to patient use and left unopened until the procedure begins. Disposable items and supplies will be used whenever practical.
   6) The control panel, tubehead, exposure button, and position indicating device will be covered with disposable plastic wrap. Any other surface likely to be touched during the radiographic examination will also be covered. At the completion of the procedure, all surfaces will be wiped down with the appropriate disinfectant.
2.10 ORAL DIAGNOSIS AND TREATMENT PLANNING PROCESS

Screening Appointment
(30 minutes) Comprehensive Care Faculty Coverage with DS-3 or -4, international students block rotation

- Brief medical history and examination during faculty screening session (screening form in axiUm)
- Treatment needs categorized into axiUm sortable format
- Acceptance per stated criteria
- Request for appropriate radiographs and examination
- Coordinators to make appropriate assignment to next available student (with regard to patient treatment needs and student experience needs)

First Oral Diagnosis (OD) Appointment
(2.5 - 3 Hrs) Radiology/OD and/or Comprehensive Care Faculty

- Begin OD (Health History interview with patient, reviewed and signed in axiUm with covering Faculty)
- Radiographs (taken in Radiology clinic)
- Gather other diagnostic data and record in axiUm
- Review findings and other data with covering faculty, obtain electronic signature from covering faculty
- Determine need for specialty consults
- Impressions and facebow/bite registration for mounted study models

Second Oral Diagnosis Appointment (if needed)
(2.5 - 3 Hrs) Comprehensive Care Faculty

- Complete remaining data entry, review and obtain electronic signatures from covering faculty
- Specialty consults determined and/or completed
- Begin to identify problems for Treatment Plan module in axiUm

If necessary: Specialty Consults/Initial Treatment
(1-3 Hrs) Group/Spec Faculty

- Specialty Consult
- Initial Treatment with Specialty, if appropriate

Case Presentation
(10-30 minutes) Comprehensive Care Faculty

- Faculty, student and patient
- Treatment plan options presented
- Faculty and patient: selection and approval (electronic signatures) of treatment options in axiUm
- Patient given copy of phased/sequenced treatment plan with fees
- This approval process provides informed consent for treatment

Outside Clinic Radiology and/or Comprehensive Care Faculty Consult

- Complete, review and obtain electronic signature for Radiographic Interpretation (axiUm)
- Use films and models to begin charting findings in axiUm
- Review medical findings and medications

Outside Clinic Comprehensive Care Faculty Consult

- Review and approve problems and diagnoses, and prepare detailed phased/sequenced treatment plan in axiUm Treatment Planning module
- Develop optional treatment plans, phased and sequenced
- Obtain faculty approval for one version for presentation
Patient Management: Nine Steps of Case Presentation

1. **Diagnosis:** Use educational aids whenever possible.
   “These radiographs show…”

2. **Treatment Alternatives:** Present “no treatment” as the first alternative –
   “If we don’t treat at this time…”
   If there is a clear choice that you would feel is the best treatment, present this alternative next –
   “The best approach is…”
   Present the remaining alternatives, starting with what you feel are in the patient’s best interest –
   “But, there are other alternatives…”
   Review the versions of treatment developed in axiUm by student and faculty member.

3. **Benefits, Risks, Prognosis and Patient Responsibilities:** Don’t minimize the patient’s responsibilities, including home care, future treatment potential and finances.
   “Let me explain what is involved in each of these choices…”

4. **Verify Patient Understanding:** Ask the patient to repeat back the alternatives, risks, responsibilities, etc.
   “Can you tell me in your own words what I have just described to you…”

5. **Clarify Patient Emotions:** As you note verbal and non-verbal cues from the patient, ask them how they feel about their choices. Resist the temptation to change the patient’s values at this time.
   “How do you feel about these alternatives…you seem concerned about…”

6. **Discussion:** Give the patient every opportunity to get any more information from yourself or the faculty.
   “Is there anything else you need to know to make a decision…”

7. **Treatment Decision:** Ask the patient to decide on a treatment alternative. Do not challenge his/her choices at this time. At best you will “sell” him/her on treatment he/she is not yet ready for, and it will many times result in “buyer’s remorse” that will be demonstrated through missed appointments, failure to pay and/or general dissatisfaction in treatment.
   “Based on everything we have talked about, what do you believe would be the best treatment for yourself…”
   At this time, the axiUm versions can be modified and consolidated to reflect the patient’s choice of treatment. Faculty approval can be obtained at this time.

8. **Post-Decision Encouragement:** Regardless of the choice of the patient at this time, give him/her positive encouragement.
   “Good, I think that’s a sound choice” or “That’s a good first step…” or even “I’m sorry you are unable to start treatment at this time, but at least you are aware of what your dental needs are…”

9. **Document:** Obtain the patient’s electronic signature in axiUm. Provide a printout of the sequenced treatment plan, including the patient signature, to the patient. If the patient elects not to start treatment, make sure to document this, and the reasons for refusal, in the treatment notes.

**Note:** The right of the patient to decide on his/her course of treatment is his/her non-transferable legal right. Do not allow the patient to put the responsibility of the decision in your hands (“whatever you think, you’re the dentist…”). If you allow the patient to shift the decision to the dentist, the patient no longer is assuming the risks of treatment and may not be truly committed to the treatment.

“I know it’s a difficult decision. Is there any other information I can give you so that you can decide?”
Section 2.12 INFORMED CONSENT

Policy
It is the policy of UCSDSM to provide dental care that preserves the autonomy and dignity of all patients. This requires that the faculty, students and staff recognize that health care is provided on the request of and for the benefit of the patient. Therefore, patients have the right to be informed about material aspects of their care and treatment prior to their consenting to undergo the same.

Consent affirms that the patient has the sole authority to determine what medical or dental treatment, if any, they will allow to be performed upon their body. **NO PROCEDURE SHOULD BE PERFORMED, EVEN IN AN EMERGENCY, IF THE PATIENT OR THEIR REPRESENTATIVE OBJECTS TO IT.**

A dental procedure performed without the patient’s consent is considered by law to be a battery, which may subject the dentist and/or the School to legal liability. This is applicable either when the dentist treats the patient without obtaining consent or when the dentist properly obtains consent for one procedure and performs a substantially different one.

In addition, even though consent may be obtained, the consent process may be so deficient that it would be considered negligence. Under this theory, the dentist has an affirmative duty to the patient, based on the dentist-patient relationship, to disclose relevant material facts and risks of treatment, and thereafter to obtain the patient’s voluntary, competent and knowledgeable consent.

Definition
Informed consent is the active, shared decision-making process between the dentist, or dental hygienist, and the patient. Although dental auxiliaries and other staff may assist, it is the dental, or dental hygiene, faculty and students who must obtain the informed consent. There are four basic elements which must be satisfied: (1) Adult patient (or emancipated minor) parent or guardian, (2) Competent patient (“sound mind”), (3) Informed decision, and (4) Voluntary decision.

Satisfying the Elements of Consent
1. Adult Patient, Emancipated minor or guardian
   a. Adult: A person 18 years of age or older.
   b. Emancipated minor: A minor fifteen years of age or older who is living separate and apart from his or her parent(s) or guardian(s) and is managing his or her own financial affairs, regardless of the source of income.
   c. Any person who has contracted a lawful marriage.
   d. Parents or legal guardian for minor. If parents are divorced, the parent with legal custody must give consent. If the parents have joint custody, then either parent may sign. Foster or step parent may not consent without documented authorization.
   e. Substitute decision-maker for incompetent adult, in order of priority:
      i. An agent appointed in a medical durable power of attorney.
      ii. A court-appointed guardian.
      iii. A proxy decision-maker under Colorado Law.
      iv. Consult with Office of Clinic Operations Faculty to clarify status of any substitute decision-makers prior to treatment

2. Competent
    Generally any decisions related to the patient’s capacity to consent to treatment should be made by the patient’s physician. A patient is competent to consent to treatment, or refuse treatment, if they have the mental capacity to make an informed decision about the proposed treatment. This capacity consists of:
    a. The ability to comprehend information relevant to the treatment decision which is being made,
    b. The ability to deliberate in accordance with the patient’s own values and goals, and
    c. The ability to communicate with caregivers.
3. Informed Decision
The patient must be able to make a knowledgeable decision, based on the information presented in terms a lay person can understand, including:
   a. The nature of the treatment provided;
   b. The purpose of the treatment;
   c. The benefits to be reasonably expected;
   d. The risks involved as well as their probability of occurrence;
   e. Expected treatment outcomes;
   f. Treatment alternatives, including no treatment, and their benefits and risks.
   g. If the patient does not speak English, no treatment should be rendered without first obtaining an interpreter for the consent process.

4. Voluntary Decision
The consent must include an offer to answer any questions and an instruction that the patient is free to accept or reject the procedure.

Methods of Obtaining Consent
1. Written Consent – Written consent on the appropriate form should be obtained whenever possible.
   a. General Consent – General consent is gained for patients (1) in the application and screening process, and (2) in oral diagnosis and treatment planning process and/or (3) in the emergency clinic. General consent is documented by patient electronic signatures in axiUm for the General Consent Form, Interim Treatment Plans and Treatment Plans.
   b. Specific Consent – Specific Consent is obtained for certain procedures and is documented on specified forms or by a signature in axiUm.
      i. Endodontic Treatment (Consent for Endodontic Therapy, in axiUm, electronic signature)
      ii. Oral Surgery (Consent for Surgery, axiUm, electronic signature)
      iii. Consent for Sedation (Consent for Sedation, in axiUm, electronic signature)
      iv. Implants (Consent for Surgery and Treatment Plan approval in axiUm, electronic signature)
      v. Denture Esthetics (Consent form in axiUm, electronic signature)
      vi. Consent for Restraint (Consent for Restraint, in axiUm, electronic signature)
      vii. Research (form as approved by the Colorado Multiple Institutional Review Board (303-724-1055)

2. Telephone Consent
   If it is not possible to obtain written consent, telephone consent may be used with approval from Office of Clinic Operations faculty or covering faculty. Consent by telephone must be witnessed and documented in the treatment notes in axiUm, indicating the exact time and nature of the consent given. Telephone consents must be witnessed by two individuals, including at least one supervising faculty member. Immediate steps should be taken to procure confirmation in writing as soon as possible, and which, once received, will be scanned into the Attachments section of the patient’s EHR in axiUm.

Section 2.13 TRANSFER, CASE COMPLETION AND REFERRAL

Transfers
Patients may be transferred from a student’s assigned patient pool with the advice and consent of the student’s faculty Group Leader, divisional faculty (with Group Leader’s agreement) and as a result of recommendation from the Office of Clinical Operations. It is the intent of the program to have assigned students complete all planned treatment prior to transfer to another dental student. However, transfers may occur in mid-treatment for reasons including timing of treatment, skill level of the student, student’s clinical experience profile, availability of students and/or the patient’s request. Most transfers should take place within the same Comprehensive Care group. Transfers should be made with the consent of the patient, unless the transfer is due to negative interactions between the student provider and the patient.
Protocols for the Transfer
1. Consultation between the student provider and Group Leader, outlining the request for change.
2. Consultation with patient, faculty (or his/her designee) and assigned student.
3. Review of treatment in the EHR in axiUm, recommending appropriate disposition. The transfer must be documented in the treatment progress notes and signed by the Group Leader of the transferring student.
4. The Clinic Coordinator for the transferring provider will complete the transfer within axiUm.

Referral within the UCDSDM Clinics
Patients may from time to time be referred within the UCDSDM clinical programs. Most common referrals are between the pre-doctoral program and Oral Surgery, Dental Hygiene, General Practice Residency and Faculty Practice.

Protocols for Referrals with the UCDSDM Clinics
1. Determine the need to refer from the Comprehensive Care Group as determined by Group Leader, including complexity of treatment, medical complexity, scope of treatment and/or patient preference.
2. Consult with patient regarding the need and rationale to refer him/her for care to another UCDSDM provider.
3. Enter information and rationale in Treatment Notes in axiUm.
4. Consult with responsible faculty or staff at the receiving area regarding the ability to accept and treat the patient.
5. Schedule the patient as appropriate.

Case Completions
Upon completion of all recommended dental treatment for a patient of record at UCDSDM, the student must consult with his/her Group Leader to determine the case disposition. Patients may be placed in the UCDSDM preventive maintenance program or referred to an outside provider.

Preventive Program: Preferred action is that all patients are given the option to continue as a patient in the UCDSDM preventive maintenance program. Patients who are placed in the program may be seen by a variety of providers including dental students, dental hygiene students or general practice or other residents. However, the program has limited capacity, and group and divisional faculty will help guide the student regarding recommended preventive care for his/her patients.

In any case, the dental student must review patient records with his/her Group Leader to ensure that all records are complete in axiUm (no “unapproved” or “in progress” items remaining.) In addition, periodic examinations and periodontal and preventive maintenance procedures must be up to date. At that time, the patient may be either transferred to the maintenance pool belonging to the Group (will be seen as needed by an available student when periodic maintenance or examination is recommended), to another dental student/dental hygiene student, or referred to private practice outside of UCDSDM.

Protocols for Case Completions
1. Appoint for periodontal maintenance, periodic evaluation and/or final treatment procedure as needed, with regard to the patient’s appropriate maintenance/exam schedule.
2. Complete data entry and treatment notes for the periodic evaluation and/or preventive maintenance as appropriate, with documentation in the electronic patient record in axiUm.

Patient Referrals to Outside Providers
Patients of record at UCDSDM may be referred outside of the School for initiation or continuation of dental care. Patients may also be referred outside of the School upon completion of recommended dental treatment. Patients may also be referred from the School if they have failed to fulfill their responsibilities as a patient (as outlined in the Patient Bill of Rights). These protocols are outlined in section 2.18, “Patient Attrition and Written Correspondence.”

Once the referral form has been completed, the Office of Clinical Operations and/or comprehensive care faculty/staff will then process the formal referral, including documentation in axiUm, written correspondence to the patient and dental record status change.
Protocols for Referrals to Outside Providers
1. Consultation with the Group Leader prior to patient appointment to discuss appropriate case disposition, review of rationale for referral, and appropriate documentation in the patient’s record.
2. Consultation with Office of Clinical Operations personnel as determined by the Group Leader.
3. Clinical appointment or telephone discussion with patient to explain referral and options for appeal.
4. Appropriate written correspondence through comprehensive care groups and/or the Office of Clinical Operations.

Section 2.14 EMERGENCY DENTAL CARE POLICIES

General Policy
The primary responsibility for emergency care and follow-up care of UCDSDM patients rests with the assigned student provider, working with covering faculty or GPR residents. In the event that a student provider is unavailable to provide care, patients of record may be seen in their UCDSDM Comprehensive Care Groups, Pre-doctoral Program Emergency Clinic or the GPR Clinic. These Clinics will also provide care to patients who are not patients of record on a space available, fee for service basis. **Abusive and uncooperative patients will not be treated, consistent with UCDSDM policies.**

Student Responsibility

**Student Availability:**
- Students must provide their patients with after-hours number to contact in case of emergency, as well as the UCDSDM dental emergency number, (303) 372-0000.
- **Students should not provide their own home numbers, but are required to have a pager or cell phone as a contact number for their patients.**
- Students must provide after-hours contact numbers to their Patient Care Coordinators. Office of Clinic Operations will be responsible to coordinate a master after-hours contact list for all clinical students.
- Students should remind their patients **NOT** to contact the UCH Emergency Room for dental emergencies.
- Students are responsible to be available for the emergency treatment of their assigned patients at all times, during or after regular clinic hours.

During Scheduled Clinic Hours: Students should be prepared to accommodate their patients’ dental emergencies within their regular clinic schedule. Group and clinic faculty and Patient Care Coordinators should be consulted to assist in prioritizing these patients and to make decisions regarding needed care for the regularly scheduled patients.

During Scheduled Classes: Students who are attending scheduled classes will not routinely be expected to provide care, and patients may be directed to contact the group coordinator to schedule emergency care with another student in the group or Emergency Clinic.

After Hours: Students should triage their patients initially by phone, and must contact the GPR resident on-call ((303) 372-0000) if there is potential need to see a patient after hours. If it is determined that the patient must be seen, the student should arrange to meet with the resident to provide care in the General Practice Clinic.

Pre-doctoral Program Emergency Clinic Operation:
Hours: 10:00 AM – 1:00 PM; 2:00 PM – 5:00 PM, the first 8 patients are seen in each session, Monday through Friday.

Scope of Care: All patients of record may be seen for emergency evaluation and palliative care. Walk-in patients are seen on a space available basis or no more than 8 patients per session. Patients may have minor restorative treatment if time permits, or if an additional student is available in the pre-doctoral clinics. Patients may be re-appointed and/or referred for treatment in the Emergency, Oral Surgery, Pre-doctoral Screening, Dental Hygiene, or General Practice Residency.
• Oral Surgery: Patients should be routinely referred to the General Practice Clinic for extractions during the session. In the event that the patient cannot be seen within a reasonable time, emergency faculty may choose to provide the treatment in the emergency clinic if it is in the best interests of the patient.
• Endodontics: Patients may be accepted through the Emergency Clinic for treatment limited to endodontics and/or build-up of a tooth. One-half down payment must be received prior to opening the tooth, with the balance due upon completion. Assigned patients will be referred to their dental student provider. In the event that UCDSDM is unable to assign the patient to a student provider in a reasonable period of time, the patient may be given the option of “open and refer” outside of the program, prior to opening the tooth. All endodontic patients must provide an electronic signature in axiUm after reviewing the Consent for Endodontic Treatment with a UCDSDM representative.

**Emergency Clinic Triage and Appointment Phone: (303) 724-6911**

**Patient Education:** UCDSDM staff should explain scope of services and financial policies with patients prior to scheduling appointments. Patients should be given written material describing scope of care and fees prior to being seated in the clinic.

**Patient Registration:** All patients must be registered in axiUm, and have read and signed (electronically) the General Consent and HIPAA forms.

**Fees:** All fees must be paid at the time of service and are applied regardless of the location of treatment. Fees do not include prescriptions, medications and/or follow-up care.
• Walk-in Patients: Patients must pay the emergency examination and anticipated radiographic fees prior to seating. All treatment provided is fee for service and should be handled under regular UCDSDM financial policies (payment is due on the day of the appointment, 1/3 down is expected for endodontic treatment, etc.).
• Patients of Record (including screened and unassigned patients): Emergency evaluation fees may not apply if the emergency is related to care rendered in UCDSDM Clinics (e.g., lost temporary, post-operative complication, etc.). All other treatment is provided on a fee for service basis as described above for the walk-in patient.

**Previously Discontinued or Delayed Patients**

Patients who are discontinued should be treated in the clinic for 30 days following discontinuance from the program if the emergency is a result of treatment rendered at UCDSDM.

**Financial Discontinuance** - These patients are expected to pay any anticipated fees prior to being seated in the clinic. Emergency care should be limited to short-term, acute care. After 30 days, patients who are discontinued from the program for outstanding accounts (e.g., “locked charts”) may be seen in the Emergency Clinic for treatment at the discretion of the covering faculty or the Office of Clinic Operations.

**Discontinued for Other Reasons** (e.g., missed appointments, etc.) – After 30 days, discontinued patients may be treated in the Emergency Clinic for treatment at the discretion of the covering faculty or the Office of Clinic Operations. Regular financial policies apply for these patients, on a fee for service basis. Patients discontinued because of disruptive or abusive behavior should not be treated.

**Exceptions to Immediate Payment of the Emergency Fee**

Emergency and Office of Clinic Operations faculty have the discretion to treat patients without immediate payment from time to time, most often when there are extenuating circumstances including treatment of a minor, when the patient is visibly swollen, or when failure to provide treatment would constitute a danger to the health of the patient.
Section 2.15 DOCUMENTATION OF TREATMENT

PURPOSE:
To create and maintain a legal record of all diagnostic and treatment services rendered by the UCDSCM and to comply with the confidentiality law of the State of Colorado.

GENERAL POLICY:
All dental records, including any part thereof, are the property of the UCDSCM. However, patients retain the right to all information contained therein. Records are to be stored as follows:
Paper charts are stored in the archives of the UCDSCM in a manner which fulfills both the requirements of the statute of limitations and confidentiality laws of the State of Colorado. Responsibility for compliance with this provision rests with the Associate Dean for Clinical Operations or his/her designee.

Active patient records exist in the electronic data base axiUm, and are stored on the dedicated servers. Access to records is restricted by provider status, passwords, and electronic security systems.

IMPLEMENTATION:
1. Access to patient records in axiUm requires a sign-in procedure and a password. Level of access differs depending on the user status: staff, faculty, student, financial personnel. (See 5.b below.)
2. Health Questionnaires: Health questionnaires must be completed in axiUm and approved by electronic capture of the patient’s signature. Updates of the health history must be done at reasonable intervals and signed by both the patient and supervising faculty, electronically as above. Patients with a more complex and dynamic health status should have the health history updated frequently. Students should seek the counsel of supervising faculty to determine appropriate update intervals.
3. Treatment Progress Notes: Treatment progress notes should be completed at the conclusion of each appointment as follows:
   a. Entries will be made in a note, either a “general” or “SOAP” format, electronically attached to the procedure(s) completed on that day.
   b. All entries should follow the "SOAP" or "modified SOAP" format.
   c. All entries by the student are date- and time-stamped by the axiUm system, and approved by supervising faculty. The supervising faculty member is responsible to sign each progress note electronically after reviewing the complete progress note.
   d. Each entry is dated within the axiUm system.
   e. Corrections to entries must be done through the axiUm system administrator, or the Group Leader, depending on the access level required.
4. Forms: Data collection and treatment notes, attachments and forms are to be completed in axiUm in a timely manner.
5. Confidentiality
   a. Students, faculty and staff must respect the confidentiality of patient records at all times.
   b. Access to the dental records should only be granted to those students, faculty and staff who are involved in the treatment of the patient, who are involved in the administration of the patient’s care (data processing, billing, etc.), who are involved in quality management, or for educational reasons as directed by faculty and shall be limited to those activities.
   c. Displayed records in the clinic and semi-public places should be shielded or minimized on the computer screen, if not the record of the seated patient.
   d. Medical Alerts appear on the screen for the active dental record.
6. Forgeries of faculty signatures, including inappropriate use of a faculty members’ signature card, are both illegal and a violation of the Code of Conduct of the UCDSCM. Such behavior will result in criminal and/or disciplinary action by the UCDSCM.
7. Requests for Duplicate Records
   All dental records, including any part thereof, are the property of the UCDSCM. However, patients retain the right to all information contained therein. Pursuant to C.R.S. 24-1-801 et seq., all requests for release of records must be received in writing, signed and dated by the patient or their legal guardian. No part of a patient's dental record
may be released to either the patient or his/her representative unless the written release is conveyed to the UCDSCM using the UCDSCM release form, or in a letter signed by the patient or the legal guardian of a minor child. All releases must be made by the Assistant Dean for Clinic Operations or his/her designee with an accompanying entry in the treatment notes indicating that copies of the record have been released. Original records are retained within the axiUm data base. A charge may be made for printing records of patients or their representative after one free copy has been provided.

8. All inquires regarding patient record should be directed to the Associate Dean for Clinic Operations for appropriate disposition. The contents of a patient's record are not to be discussed over the telephone except for consultation with other health care professionals.
Section 2.16 COMMONLY USED ABBREVIATIONS
Section 2.17 DELAYS AND DISCONTINUANCE OF PATIENTS AND WRITTEN CORRESPONDENCE

All written correspondence to patients related to treatment must be sent through the Office of Clinic Operations. Students are responsible to monitor their patient practice, document certain routine patient interactions in the contact notes in axiUm, and request appropriate written correspondence be sent to their patients. Written correspondence is intended to assist the student in managing his/her patient pool by either communicating UCDSMD appointment policies or shifting the responsibility of continuing care to the patient. During the course of treatment, many patients will move from an “active” to an “inactive” status. Although each case must be handled individually, most patient situations fall into one of several broad categories.

Unable to Contact
Difficulty contacting patients may be a result of disconnected phones, change of address, patient choosing to leave the program without notice. When the student has made unsuccessful attempts to contact the patient, the following steps should be taken:

1. Document all attempts to contact patient in the Contact Notes feature in axiUm.
2. Request the Patient Care Coordinator to send an Unable to Contact (UTC) letter, noted in Contact Notes.
3. Patients are asked to respond within fixed period of time (usually three weeks.) The letter (generated in axiUm) moves burden of continuing care to patient.
4. If patient responds within the stated time period, continue treatment.
5. If the patient does not respond, the patient may be discontinued.
6. Records of patients who contact the school after the stated time will be reviewed for reinstatement, new assignment and periodic exam, or rescreening. This will be determined by the group coordinator.

Delay of Treatment
Patient may choose to delay their treatment with their dental student for a variety of reasons including vacations, changes in work schedule, finances, health, etc.. All delays should have written correspondence verifying the patient’s delay.

1. Document the patient’s request to delay treatment in the Contact Notes feature in axiUm, noting the patient’s reason.
2. Request the Patient Care Coordinator to send a Delay of Treatment letter. This letter (generated in axiUm) requests that the patient respond within four months of his/her intention to continue care. This moves burden of continuing care to patient. Status of patient is changed to “Delay1.”
3. If patient responds within the stated time frame, continue treatment.
4. If no response, a follow-up letter is sent. A second “delay” may be granted.
5. Patients who contact the school at a later date will be rescreened or reassigned if appropriate.
6. If a patient does not continue care at the end of two delay periods, the patient is to be discontinued.

Missed Appointments or Difficult to Appoint
Patients are asked to give 48 hours notice if they cannot keep an appointment. Patients are told at initial screenings that if they miss more than 2 appointments and/or reschedule with less than 48 hour notice, or are unable to schedule and keep appointments on a regular basis, they are subject to being referred out of the program. When this initially occurs, students should do the following:

1. If patient calls regarding appointment difficulty, the student should express their concerns for the patient’s situation and attempt to identify if there is a barrier to care (e.g., financial difficulty, apprehension/fear, dental education, transportation, etc.) If the student can do anything to remove the barrier, the patient may be able to make the appointment. This contact is recorded in the Contact Notes feature in axiUm.
2. If the patient cannot keep an appointment, the student should express disappointment that the time was specially set aside for the patient. The student should remind the patient of the school’s policy and inform the patient that a “Missed Appointment” letter will be sent out by the School. Reschedule the patient if possible.
3. Document the patient’s missed or rescheduled appointment in the Contact Notes, noting the patient’s reason.
The “Missed Appointment” letter is documented in the Contact Notes, as well. Letter will outline the school’s policy with the patient.
4. After two such missed appointments, patient is subject to dismissal. Document, and discuss with Group Leader.
5. Continue treatment with patient until third failure. Note that in certain situations, it may be appropriate to discontinue a patient after one failed appointment. Consult with Group Leader regarding this.

Patient Requests Discontinuance from UCDSDM
From time to time, patients may choose to leave the UCDSDM system. Under these circumstances the student provider should do the following:
1. Document the patient’s request to discontinue treatment in axiUm, noting the patient’s reason.
2. The student should advise their Patient Care Coordinator to send a letter requesting patient to respond within fixed period of time if they do not wish to discontinue treatment. This action moves burden of continuing care to patient. Letters are documented in Contact Notes.
3. Patients will be informed that their records are available upon written request, for a reasonable fee. Emergency care is available on a fee-for-service basis for 30 days.
4. If patient responds within time frame, and wishes to continue treatment, patient may be reassigned.
5. If no response, patient will be discontinued signed by Group Leader.
6. Patients who contact the school at a later date will be reviewed for new assignment or rescreening, by group coordinator.

UCDSDM Discontinues Patient for Cause
From time to time, patients may not be able to fulfill their responsibilities. Typically these include failure to make timely payments, failure to make and keep appointments in a timely manner, failure to comply with behavioral expectations, and failure to come to mutual agreement on treatment philosophy. Under these circumstances the student provider should do the following:
1. Document the rationale to discontinue treatment in the Treatment Notes (requires faculty electronic signature) after consultation with Group Leader and Patient Care Coordinator, and with the patient (faculty or staff intervention with the patient is often appropriate).
2. The Coordinator is asked to send a certified letter to document the rationale for the dismissal from the program. The letter will state that emergency care will be provided for 30 days, that records are available upon written request for a reasonable fee and that they have a fixed period of time to contact the UCDSDM if they wish to appeal the decision in writing to discontinue treatment.
3. If patient requests an appeal within the stated time frame, the case will be reviewed within the Comprehensive Care group and in the Office of Clinic Operations.
4. Patients who contact the school at a later date will not be re-admitted into the program unless authorized by faculty in the Office of Clinic Operations.

Delays and Discontinuance due to Finance (also outlined in section 1.10)
The School ages accounts at 30, 60, 90, and 120 days past due. This information is available on the patient card in axiUm. At 60 days of nonpayment, the patient accounting office shall notify the student in writing of the patient’s status. Students must consult with the Payment Office staff to discuss why the patient hasn’t paid, and determine if the treatment rendered is incomplete (e.g., a three-unit bridge which is only temporarily seated). The patient shall also receive a letter of non-payment and will be informed that their treatment will be delayed until payment is received. The patient’s name will be added to a list of like patients, which is forwarded to the Office of Clinic Operations. At 60 days, the payment staff locks the record in axiUm. At this point, the student is unable to continue treatment. If patient’s account is brought up to date patients are required to pay for procedure prior to being seated for an appointment.

At 120 days of non-payment an account is considered very delinquent and will be sent to the state collection agency. Typically patients who reach this point will not be reinstated for additional care at UCDSDM, regardless of whether or not they pay their amount due. A letter will be sent to the patient stating that the account will be turned over to our collection agency unless it is paid in full within the first 20 days of the month, and that they have been referred out of our program. The chart will be locked in axiUm for all patients that are in a collection status. All patient charts
1. **AHA endocarditis prophylaxis recommendations on antibiotic choice, dosage and regimen (2007)**

<table>
<thead>
<tr>
<th></th>
<th>Antibiotics</th>
<th>Adult Dose</th>
<th>Child Dose</th>
<th>Pre-op Regimen</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Standard general prophylaxis</strong></td>
<td>Amoxicillin</td>
<td>2.0 gm</td>
<td>50 mg/kg</td>
<td>Orally 30-60 min before procedure</td>
</tr>
<tr>
<td></td>
<td>Clindamycin</td>
<td>600 mg</td>
<td>20 mg/kg</td>
<td>Orally 30-60 min before procedure</td>
</tr>
<tr>
<td><strong>Allergic to penicillin</strong></td>
<td>Cephalaxin†</td>
<td>2.0 gm</td>
<td>50 mg/kg</td>
<td>Orally 30-60 min before procedure</td>
</tr>
<tr>
<td></td>
<td>Azithromycin or clarithromycin</td>
<td>500 mg</td>
<td>15 mg/kg</td>
<td>Orally 30-60 min before procedure</td>
</tr>
<tr>
<td><strong>Unable to take oral medications</strong></td>
<td>Ampicillin</td>
<td>2.0 gm</td>
<td>50 mg/kg</td>
<td>IM or IV 30-60 min before procedure</td>
</tr>
<tr>
<td></td>
<td>Cefazolin or ceftriaxone</td>
<td>1.0 gm</td>
<td>50 mg/kg</td>
<td>IM or IV 30-60 min before procedure</td>
</tr>
<tr>
<td><strong>Allergic to penicillin &amp; unable to take oral medications</strong></td>
<td>Clindamycin</td>
<td>600 mg</td>
<td>20 mg/kg</td>
<td>IM 30 min before or IV immed. before</td>
</tr>
<tr>
<td></td>
<td>Cefazolin or ceftaxime*</td>
<td>1.0 gm</td>
<td>25 mg/kg</td>
<td>IM 30 min before or IV immed. before</td>
</tr>
</tbody>
</table>

*Cephalosporin should not be used in individuals with immediate-type hypersensitivity reaction; urticaria, angioedema or anaphylaxis to penicillins
† Or other first or second-generation oral cephalosporin in equivalent adult or pediatric dosage

Note: If unexpected bleeding occurs during a procedure a single antibiotic dose given within 2 hours after procedure is felt to be adequate

2. **Recommended conditions for use of antibiotic prophylaxis:**

**RECOMMENDED**

1. Prosthetic cardiac valves, including bioprosthetic and homograft valves
2. Previous bacterial endocarditis
3. Unrepaired cyanotic congenital heart disease (CHD) with or without palliative shunts or conduits
   a. Repaired CHD with residual defects at or adjacent to a prosthetic patch
   b. Completely repaired congenital heart defect with prosthetic material or device during first 6 months after procedure

**NOT RECOMMENDED**

- Almost everything else including: Isolated atrial septal defect
- Surgical repair of atrial septal defect, ventricular septal defect or patent ductus arteriosus (without residua beyond 6 mo)
- Previous coronary artery bypass graft surgery
- Mitral valve prolapse without valvar regurgitation
- Physiologic, functional, or innocent heart murmurs
- Previous Kawasaki disease without valvar dysfunction
- Previous rheumatic fever without valvar dysfunction
- Cardiac pacemakers (intravascular & epicardial) & implanted defibrillators

**ReCommended**

**Dental Procedures**

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

**Dental Procedures**

- Local anesthetic injections through non-infected tissue
- Placement of removable prosthetic or orthodontic appliances
- Fluoride treatments
- Taking of oral radiographs
- Orthodontic appliance adjustment
- Shedding of primary teeth
Nitrous oxide/oxygen is available for use by trained clinicians at the School of Dental Medicine. This policy is written as a reference and guideline for the School of Dental Medicine to insure that the quality and standards imposed on this modality of pain control is superior.

I. Indications: Nitrous oxide/oxygen is indicated for apprehensive patients, medically compromised patients, and patients with gag reflex.

II. Clinicians: Nitrous oxide/oxygen can only be given by students who have completed their 16 hour course of didactic and laboratory training in the correct administration of nitrous oxide and oxygen conscious sedation as promulgated by the American Dental Association document on Teaching of Pain and Anxiety Control. Residents and faculty members must also have evidence of this quantitative baseline of training either through certificate or documentation acceptable for certification by the Colorado State Board of Dental Examiners.

III. Equipment: All analgesia (nitrous oxide only) equipment shall be fail-safe, meaning that the equipment cannot function without an ongoing available supply of at least 100% pure oxygen. All machines currently employed for use at the University of Colorado Denver, School of Dental Medicine are portable machines requiring no central piping or large reservoir of gas. It should be noted that analgesia machines are to be readily available as primary tools of urgent medical care for airway support that allows an almost instant supply of 100% oxygen at 50 lpm. The equipment should be checked periodically for leakage and should never be used without scavenging equipment (see Appendix). To do so violates a significant standard of care issue. The integrity of the system for trace gas leakage will be periodically checked by infrared spectrophotometry.

IV. Post-Operative: All nitrous oxide administrations shall conclude with a minimum of 3-5 minutes of pure 100% oxygen – more if deemed appropriate by the clinician.

V. Documentation: All uses of nitrous oxide shall be recorded in a proper manner with information as indicated on the axiUm form CONSED – Nitrous Oxide Administration Record and save it as part of the patient’s permanent electronic record.

The use of nitrous oxide is encouraged for appropriate clinical experiences for the students and patients of the School of Dental Medicine and to be recognized as a useful and safe modality for pain control.

Qualifications of Faculty for supervising the administration of Nitrous Oxide Oxygen Inhalation
Colorado State Board rules require that all dentists who administer nitrous oxide/oxygen inhalation must meet certain requirements. The dentist must certify that they have met the training requirements when they apply for their Colorado Dental License.

These education/training requirements as listed in Rule XVII are:
1. As of January 1, 1994, in order to administer and induce conscious analgesia solely by means of nitrous oxide/oxygen inhalation techniques, a dentist shall complete accredited courses approved by the Board; a minimum of 16 hours, including 4 patient contact hours, is required.
2. A Colorado licensed dentist who has safely administered conscious analgesia solely by means of nitrous oxide/oxygen inhalation techniques within the State of Colorado for the three years prior to October 30, 1987, should be deemed to have satisfied, the education/training specified under this Rule.
Delegation: Nitrous Oxide/Oxygen monitoring and administration may be delegated under direct supervision to appropriately trained personnel. The supervising dentist is responsible for determining the maximum dosage of nitrous oxide/oxygen analgesia and must record the dosage in the patient chart prior to delegation. Dental hygienists and dental auxiliaries must meet the following training requirements to monitor and administrate nitrous oxide/oxygen under direct supervision:

1. A dental hygienist or a dental auxiliary shall complete accredited courses approved by the Board; a minimum of 16 hours, including 4 patient contact hours, is required.

Other State Board Requirements to note:

• Basic Life Support: The dentist and all personnel, including, but not limited to, dental hygienists and dental auxiliaries, who render patient care services in a dental setting where nitrous oxide/oxygen is administered shall have proof of current basic life support (BLS) knowledge and skills.

• Examination: “Prior to the administration of nitrous oxide/oxygen, the dentist, dental hygienist or auxiliary shall record, in the patient’s chart, the patient’s medical history and the pertinent physical findings.”

• Documentation: “When administrating nitrous oxide/oxygen, the dentist, dental hygienist, or auxiliary shall record, in the patient’s chart, the treatment given, the dosage administered and the patient’s response to treatment.”

• Emergency Care: “Prior to the administration of nitrous oxide/oxygen, the supervising dentist, dental hygienist, and auxiliaries shall have appropriate training to recognize the symptoms and reasonably treat the complications and emergencies incident thereto.”

The School of Dental Medicine shall keep records of faculty who meet the certification standards for the State of Colorado as listed above.

Section 4.0 CLINIC FEE POLICY

The UCDSMD is a State institution. Because of this, we must follow state regulations. You should be aware of the following:

• All procedures done in the SDM should be charged to the patient. If billings due not match the progress notes for a treatment visit disciplinary actions could result.

• Any variation from a listed fee must be approved through the fee modification process. Certain faculty members are authorized to approve fee modifications. To get a fee modification approved, you should fill out the fee modification form in axiUm and then ask a faculty member to review and approve the form.

• Due to State regulations, discounts are not allowed for relatives or friends.

• Students can be treated by other students using the student fee schedule which is discounted approximately 50% from normal pre-doctoral fees.

• Employees of UCD can be treated using the employee fee schedule which is discounted approximately 25% from normal pre-doctoral fees.

Section 5.1 MEDICAL EMERGENCY PROCEDURES

The school has a consistent and effective method of managing medical emergencies that occur anywhere in the building. Every clinical floor has at two or more emergency cabinets that contain oxygen, appropriate masks and bag valve resuscitation equipment. These cabinets are clearly marked. In addition, each floor has at least one automatic external defibrillator. These AEDs are marked with signs above the cabinets in which they are stored. Next to each cabinet is a red phone and a placard with instructions as to how to activate the emergency procedures within the school. The phones operate as follows: when the red phone is lifted, a red phone in the oral surgery area and a red phone in the surgical dentistry area ring. If oral surgery or GPR faculty are near by, they will answer the phone and respond to the emergency. If the phone is not picked up in 15 to 30 seconds, it will go to the campus police depart-
ment and they will in turn activate the city of Aurora EMS system. The response time to the School by the city is approximately 3 to 5 minutes.

All faculty and staff are asked to attend annual training sessions for emergency procedures in the school. The school has averaged approximately 6 actual emergencies per year. Each one is reviewed by the QA / QI committee and

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**Campus Police – Dial 911**
1. Give your name, state your problem and if it is an emergency.
2. Give your exact location – floor, area, and room number

**Fire – Dial 911**
1. Give operator your name, exact location of fire, what is burning, and any injuries.
2. Evacuate the area, close all doors and pull the nearest fire alarm box.

**Other Emergencies [Chemical Spill, Biohazardous Materials, Gas Leaks, etc.]**
- School Response Dial 40345
- Campus Response Dial 911 (if urgent)
1. MSDS Sheets located in dispensary, lab, supply and on-line.
2. Evacuate the area, close all doors as necessary.
3. Give operator your name, nature of incident, exact location, and number injured.

**Utilities and Building Repair**
- School Response Dial 41741
- Campus Response Dial 41777 (if urgent)

**Telephone Repair Service**
- Campus Response Dial 44357
Night and weekend emergency service dial 0 and request the on-call telephone technician.

**Dental Equipment Repair Service**
Page 303.266.8785
This number will page Chuck Unitt, punch in your chair number and he will respond during normal clinic hours. Back up support provided by John King (ext. 56311).
Section 5.2 SECURITY AND SAFETY PROTOCOLS

Section 6.0 INFECTION CONTROL AND EXPOSURE CONTROL PROTOCOLS

6.1. Introduction and Purpose:
Infection Control is an integral component of all procedures and patient care activities. The overall goal of an infection control program is to prevent or reduce risk of disease transmission among patient/clients, students, staff and faculty. This protocol is also intended to provide an educational model reinforcing the ethics and practices necessary to provide safe care to patients.

6.1.1. Rationale:
Dental care personnel including dental students, faculty, staff, laboratory and other support personnel are occupationally exposed to a wide variety of infectious materials and pathogens including body substances, contaminated supplies and equipment, and environmental surfaces. In addition dental care personnel are ethically and legally obligated to provide care which minimizes the risk of cross contamination and nosocomial infection to patient / clients.

Because pathogens may cause infections with serious complications including various types of hepatitis, AIDS, tuberculosis, etc. and because the chain of transmission is largely microscopic, infectious patients or staff may not be readily identified.

Therefore it will be the policy of the University of Colorado Denver, School of Dental Medicine (UCDSMD) to adhere to Standard Precautions. OSHA mandates this approach to infection control in which all human blood, body fluids including saliva, excretions, secretions, non-intact skin, and mucous membranes are treated as if known to be infectious for HIV, HBV, HCV and other bloodborne pathogens. Standard precautions are procedure specific, not patient specific.

6.1.2. Epidemiological Basis for infection control:
The spread of infection in health care is best described through the five components of disease transmission. One (1) is a sufficient source of infecting pathogens. Two (2) is a location or medium where the organisms are able to supply and multiply such as the blood stream or dental unit water lines. Three (3) is a route of transmission such as hands, surfaces, blood, water, air, droplet spatter, etc. The fourth (4) component of disease transmission is a portal of entry such as cuts or punctures or exposed mucosa. Five (5) is the reception of infectious agents by a susceptible host. Disease may be transmitted from patients to dental care staff; from dental staff to patients; and from patient to patient. Effective infection control disrupts one or more of those components. Precautions outlined in this protocol are based upon the measures recommended to protect against transmission of the benchmark bloodborne pathogens Hepatitis B (HBV) and Human Immunodeficiency Virus (HIV).

6.1.3. Regulatory Basis for Infection Control:
All protocols will be based on the most recent guidelines or regulations promulgated from the Centers for Disease Control (CDC) in the Guidelines for Infection Control in Dental Health-Care Settings 2003, MMWR, Dec. 19, 2003, Vol. 52, No. RR-17; and all laws currently in force from the Occupational Safety and Health Administration (OSHA), Bloodborne Pathogen Standard; and the Dental Practice Law of Colorado: Statute 12-35-129 (k) “Causes for denial of issuance or renewal – suspension or revocation of licenses – other disciplinary action – unprofessional conduct defined - (1) “The board may deny the issuance or renewal of, suspend for a specified time period, or revoke any license provided for by this article or may reprimand, censure, or place on probation any licensed dentist or dental hygienist after notice and hearing, which may be conducted by an administrative law judge, pursuant to the provisions of article 4 of title 24, C.R.S., or it may issue a letter of admonition without a hearing by certified mail for any of the following causes: (k) An act or omission constituting grossly negligent dental or dental hygiene practice or that fails to meet generally accepted standards of dental or dental hygiene practice.” Grossly negligent practice in relation to infection control is further defined in the Colorado Board of Dental Examiners Rules and Regulations.
3 CCR 709-1 Rule XXVII. Infection Control A. “Failure to utilize generally accepted standards of infection control procedures may violate 12-35-129 (1) (k), CRS.

6.1.4. Resources for this protocol:
Curriculum and standards from the American Dental Association (ADA), protocols cited in the OSHA Rules: Bloodborne Pathogen Standard; Needle Safety Act, charts and references listed in the CDC Guidelines for Infection Control in Dental Health Care Settings, 2003 and implementation guidelines from The Organization for Safety and Asepsis Protocol (OSAP) are the primary sources for this protocol.

6.2. Responsibility for implementation and monitoring infection control compliance:
The Clinic Operations Committee is responsible to review policies and protocols related to infection control in the UCDSDM. The Office for Clinical Affairs and ultimately the Dean will be responsible to oversee the implementation of these policies and protocols. It is the shared responsibility of faculty, staff and students at UCDSDM to recognize the need for implementation of standard precautions as outlined in this policy and to comply with standard operating procedures. Faculty members are ultimately responsible for supervision of clinical care and must ensure that compliance is adequate to maintain a safe treatment environment for patients, students and staff.

6.3. Employee Classifications
All employees of the University of Colorado Health Science Centers, School of Dental Medicine UCDSDM will be classified in accordance with OSHA guidelines into category I, II or III (29 CFR 1910.1030) according to their tasks/job related risk of exposure to infectious disease agents within 10 working days of employment.

**Category I** - Tasks that involve exposure to blood, body fluids or tissues.
Positions: All undergraduate and postgraduate dental students, ISP students, dental hygiene students, all full and part time clinical faculty, staff dental assistants including Central Processing and Dispensary, dental production laboratory technicians, dental equipment repair and maintenance staff, environmental services staff.

**Category II** - Tasks that involve no routine exposure to blood, body fluids or tissues, but employment may require performing unplanned Category I tasks.
Positions: administrative assistants assigned to clinical coordination, scheduling, financial, records; materials managers or dental stores staff.

**Category III** - Tasks that involve no exposure to blood, body fluids or tissues as a condition of employment.

6.3.1. Responsibility for Classification:
The Associate Dean for Clinical Affairs upon input by the appropriate department chair or designated staff person, will classify all personnel within UCDSDM for purposes of exposure to infectious disease agents. Employees include full and part-time faculty, post doctoral students, clinical dental assistants and dental hygienists, group practice coordinators, dental equipment repair technicians, dental laboratory production technicians and assistants, and contracted environmental services staff. Pre-doctoral dental and dental hygiene students, post graduate dental students, and ISP students are by definition in Category I.

6.4. Education and Training in Infection Control Rationale and Protocols
6.4.1. Credentials of trainers:
Training will be coordinated and provided by personnel with documented expertise. Name of trainer and credentials will be included as part of training records.

6.4.2. Students:
All UCDSDM predoctoral and ISP students will be trained in basic infection control protocols prior to their first direct patient care experiences. A review of basic infection control guidelines along with site specific training in UCDSDM protocols will be provided to postdoctoral and international ISP students prior to clinical activities. Update training will be mandatory for all students on an annual basis.

6.4.3. UCDSDM staff/faculty:
All UCDSDM clinical staff and faculty are required to complete initial training that will review all topics in this protocol. Initial training and OSHA safety information must be made available prior to clinical assignments. Update training will be mandatory for all staff at least annually. Faculty are encouraged and staff are expected to participate
Training will include department specific issues affecting infection control as identified by department supervisors. The Office of Clinical Affairs will be responsible to coordinate training.

6.4.4. Content of training:
- A description of exposure risks and pathogens inherent to clinical dental care and the epidemiology of disease transmission in dental settings.
- A review of the prevention strategies and protocols in place at the UCDSDM with emphasis on personal protective attire and equipment; hand hygiene; post exposure protocols and environmental management.
- Protocols for work restrictions related to illness or injury.
- Types of records that will be maintained for employees and methods to maintain confidentiality.

6.4.5. Training parameters
- Initial training within 10 working days of employment and before beginning assigned duties in patient treatment areas. Each clinical specialty area will be responsible for developing and providing acceptable training in procedures unique to that department. Specialty training is in addition to the basic training in standard precautions.
- All employees will be reviewed for understanding and compliance after initial training.
- Training updates will be provided during working hours at no charge to employees at least annually and whenever significant changes occur in equipment or protocols.
- Training must include all personnel with potential exposure to occupationally related hazards: all clinical staff, faculty, undergraduate students, graduate post-doctoral students and housekeeping/maintenance staff.
- Training records will be kept by the Clinical Manager for the duration of employment plus three years.

6.5. Personnel Health Elements
6.5.1. Immunizations and infectious disease screening policies:
Immunizations are a significant and cost-effective preventive strategy and will be reviewed on an individual and confidential basis at the time of hire and as new evidence becomes available regarding newly applicable immunization programs. All students, faculty and staff who have direct or indirect contact with patient’s blood and/or saliva should be immunized with hepatitis B vaccine or show serological evidence of immunity (anti-HBs) to hepatitis B virus infection. Those who receive the vaccine series are recommended to be serologically tested according to current recommendations (6 weeks to 6 months after the third injection) for antibody immune status.

6.5.1.1. Students:
Hepatitis B vaccination or evidence of serological immunity (anti HBs) is required for students prior to clinical contact with patients and for post-graduate students prior to initial clinical activity. A baseline tuberculin skin test (TST) and/or chest x-ray is also required. Other required immunizations include measles, mumps and rubella (MMR), tetanus / diphtheria and polio. Annual influenza vaccination and Hepatitis A vaccination is strongly encouraged. Student health records are confidential and are maintained separately from academic records.

6.5.1.2. Faculty and Staff:
It is recommended that all faculty and staff with direct or indirect contact with patients and who may then be potentially exposed to infectious blood or other body fluids be immunized with hepatitis B vaccine or show serological evidence of immunity (anti-HBs). Hepatitis B vaccinations will be offered to employees at no charge. Current published protocols will be followed for the schedule of vaccination and recommended follow-up testing for seroconversion. Declination of vaccination for hepatitis B must be documented in writing and a record kept in confidential employee health record files. Staff and faculty with direct patient contact will be encouraged to consult with their physicians and obtain other immunizations recommended for prevention of transmissible infectious diseases: annual influenza vaccination, Hepatitis A vaccination, measles, mumps, rubella, and varicella (chicken pox). Immunization and declination records will be kept confidential. It is recommended that all faculty and staff whose duties include direct patient contact, obtain a baseline tuberculin skin test (TST) using the two step method.

6.5.2. Potentially infectious medical conditions and related work restrictions:
6.5.2.1. Reporting Requirements for Suspected Communicable Disease:
Any UCDSDM staff, faculty, or student including all undergraduate or post graduate students, who is aware or has reason to believe that she/he has a potentially communicable disease including those listed below, is responsible for reporting the information promptly to the Department chair and / or Clinic Manager who will report to the Associate Dean for Clinical Affairs. It is recommended to obtain medical evaluation and advice for such conditions as part of the determination for work restrictions. All personnel health reports will be handled in a confidential manner. Using appropriate medical guidance, the Dean shall make final determinations regarding restrictions, modifications of duties and assignments. Further, all students, staff and faculty are ethically and professionally responsible to monitor their own health conditions regarding their ability to provide safe care and minimize the risk of disease transmission.

6.5.2.2. The UCDSDM will use as the basis of illness related work restrictions, the recommendations listed in the CDC Guidelines for Infection Control in Dental Health-Care Settings, 2003, Table 1. pp. 8 and 9.

6.5.2.3. Recommendations regarding HIV infection or Hepatitis B e antigenemia when duties and assignments include patient contact during potentially invasive procedures:
Any UCDSDM student, staff or faculty member who knows or has reason to believe that she/he has such diagnosis which may compromise the ability to safely treat patients or work in a clinical setting, shall report this information immediately to her/his department Chair who will report to the Dean. All such reports will be handled in a confidential manner. Health care workers and students with infections shall not be subject to discrimination in employment practices. As per current recommendations, persons with acute or chronic Hepatitis B (e antigenemia) or those identified as HIV positive should not perform exposure prone invasive procedures until counsel from an expert review panel has been sought. All records and review procedures are confidential.

6.5.2.4. Recommended Composition of Expert Panel:
1. An infectious disease specialist with expertise in infectious disease transmission.
2. The individual’s personal physician.
3. A UCDSDM faculty member familiar with the individual’s clinical activities and/or job functions.
4. A state or local health care official.
5. An attorney familiar with anti-discrimination and civil rights issues in the workplace.
6. A member of the UCDSDM Clinic Operations Committee.

6.5.2.5. Factors for Expert Panel review:
1. Current health status of the individual.
2. Scope of clinical tasks and assignments.
3. Degree of clinical or job skill level of the individual.
4. Risks posed by infection and current applicable laws and regulations.

6.5.2.6. Students, faculty and staff who believe they may be at risk of HIV or HCV should seek testing and counseling. Mandatory prescreening or testing is not required at this time.

6.5.2.7. Recommendations regarding active tuberculosis:
A chronic productive cough (3 weeks or more), bloody sputum, night sweats, fatigue, fever and continuing weight loss are together indicative of possible active tuberculosis. Any UCDSDM student, staff, or faculty including office, administrative and support staff with this group of symptoms should be promptly evaluated for TB and not return to work until a diagnosis of TB has been excluded or until the individual is on therapy and a qualified physician’s determination is made that the individual is not infectious. All health care records and reports related to such conditions will be kept confidential.

6.5.2.8. Work Restrictions for other communicable diseases:
Students, faculty and staff should be restricted from patient contact during active stages of the following conditions: Conjunctivitis (pink eye), active diarrhea, Hepatitis A, Herpes simplex and herpetic whitlow, measles, meningococcal infection, mumps, lice, pertussis, rubella, staphylococcus aureus with skin lesions, tuberculosis active, varicella (chicken pox), zoster (shingles with open lesions in potential contact areas), febrile respiratory infections with active
cough, sneezing, and mucous drainage. Training will include references so that students, faculty and staff may appropriately recognize active stages of communicable disease and thus effectively self-monitor their ability to attend the clinic environment and provide safe treatment.

6.5.2.9. Record Keeping and Confidentiality:
Health status and records of staff, student and faculty will be monitored as they pertain to infection control protocols. This includes relevant medical evaluations, screenings and results, immunizations, exposures and post exposure management. The related records shall be kept confidential and in accordance with HIPAA compliance.

6.6. Management of Patients with Infectious Diseases:
It will be the policy of the UCDSDM to follow Standard Precautions, treating all patients as potentially infectious. Infection Control policies are procedure based, not patient based. Faculty and students will exercise professional judgment in situations where patients present with obvious active symptoms of highly contagious infectious conditions such as uncontrolled coughing, active open lesions in areas likely to be contacted during treatment, etc. When possible, such patients should be counseled and treatment deferred.

6.6.1. Medical History
A thorough medical history must be obtained from each patient and signed by the patient or responsible party prior to initiating care at UCSDM. Faculty and student clinicians are required to review and update the history at subsequent dental visits. Medical histories must also be obtained and reviewed prior to clinical practice with student partners. In all cases, confidentiality and management of medical histories will meet HIPAA guidelines.

6.6.2. Policy for treatment of prospective patients suspected of active tuberculosis:
UCDSDM will not routinely treat known or suspected active TB patients, and will routinely screen for TB symptoms, defer elective treatment until a qualified health care professional provides evidence of treatment and tests indicate a non-infectious status; and refer such patients with emergency dental treatment needs to appropriate care settings. Patients screened with potential TB infections must be promptly provided with masks and isolated from the general patient population until referral arrangements are concluded.

6.7. Exposure Control Program: Exposure prevention
6.7.1. How exposures occur:
The School of Dental Medicine places a priority on exposure prevention. Occupationally acquired infections may occur through percutaneous injury (needle stick, cut, “poke” with contaminated instrument); or through contact of potentially infectious blood, saliva, tissues or other body fluids with mucous membranes of the eye, mouth, nose or non-intact exposed skin. Research indicates that burs, syringe needles, lab knives, and processing of contaminated instruments are the most common sources of “sharps” percutaneous exposure.

6.7.2. The University of Colorado School of Dentistry will emphasize use of evidence-based strategies most likely to reduce infection through sharps exposures:
• Immunizations especially Hepatitis B immunization.
• Personal protective attire and equipment including consistent use of gloves, masks, gowns, and appropriate eyewear.
• Passive engineering controls to limit exposure to percutaneous injuries (“sharps” exposures): cassette instrument holding and processing systems; closed solid side transport trays; automated instrument cleaning using ultrasonic instrument cleaners and automated instrument washers; disposable single use safety scalpels and related bladed items; and hard side biohazard sharps collection devices located at every treatment unit.
• Work practice controls incorporated into Standard Operating Procedures. Keep handpieces with projecting burs turned downward and out of the path of injury at chairside. Wipe debris from instruments using cotton rolls or damp gauze on tray, not held in hand; sharpen instruments using sterilized stones and only after sterilization and immediately prior to patient treatment; during treatment, transfer instruments using “safe zone” transfer techniques; use one handed recapping techniques described in this section during local anesthesia procedures.

6.7.3. Protocol for sharps management during local anesthesia and other procedures requiring needle recapping:
• A protect card should be placed on needle cap before use. Protect cards are located in the cart with the anesthetic carpules and needles.
• Needles may be recapped between injections.
• Never recap using two hands. Use one handed recapping: The cap may be placed on the clean tray and “scooped” up onto the needle and tapped into place. Avoid contaminating the needle during the scoop process.
• Alternatives include use of disposable or reusable devices to hold the cap during one handed recapping such as inserting the cap into the disposable foam tray, cassette cap holder or cardboard cap holder.
• Use hemostat or cotton pliers to remove used capped needles from syringes.
• All used anesthetic needles, broken anesthetic cartridges, and other “sharps” or blades will be discarded in the red rigid sharps containers located in each unit. Intact anesthetic cartridges may contain aspirated blood and may be disposed of in sharps containers.

6.7.4. Safe handling of other “sharps”:
Upon completion of patient treatment all disposable sharps will be segregated first and disposed into the rigid side red sharps disposal containers. (Scalpel blades; used endo files, orthodontic wires, etc.)

How exposures may occur: Occupational exposure to potentially infectious agents may occur through percutaneous injury (needle stick, cut, “poke” with contaminated instrument); or through splash / aerosolization/spill of potentially infectious blood, saliva, tissues or other body fluids with mucous membranes of the eye, mouth, nose or non-intact exposed skin.

6.8.1 Step by step protocol for post exposure management:
If a student, staff, faculty or patient experiences an exposure to infectious agents, immediate action is necessary.
DO NOT DELAY.
• Stop the task or procedure as quickly and safely as possible.
• If involved in patient care, do not dismiss the patient.
• Students will immediately inform the attending or supervising faculty. Staff or faculty must promptly inform the department supervisor and / or clinic manager.
• Supervising faculty should assist to temporize / stabilize the dental procedure in progress and reassure patient.
• Injured person should immediately cleanse wound or puncture sites using soap and water. Squeezing the wound is not recommended. Antiseptics are not recommended. Do not use dilute bleach solutions on skin wounds!
• Report incident immediately or within 24 hours. Obtain occurrence form and post exposure form from Clinic Manager. Forms are available on each floor / department. Complete the short information portion of form and take with you to Infectious Disease Clinic. Contact phone # for PEPLine is included on form.
• If known source patient, supervising clinical faculty will assist student clinician in discussion and request for baseline testing with source patient.
• Report to Infectious Disease Clinic within 2 hours of exposure. Injured person takes Post Exposure form with completed information portion, and source patient to the Infectious Disease group on the 7th floor of the Anschutz Outpatient Pavilion, 720-848.0191 (Clinic Hours: 8:30am-4:30pm). If unknown source patient or patient refuses consent, injured student, staff or faculty will immediately proceed to the clinic for testing and advisement.

Infectious Disease Clinic Hours:
<table>
<thead>
<tr>
<th>Day</th>
<th>Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday, Tuesday</td>
<td>8:00am-4:00pm</td>
</tr>
<tr>
<td>Wednesday</td>
<td>8:00am-4:00pm</td>
</tr>
<tr>
<td>Thursday</td>
<td>9:00am-4:00pm</td>
</tr>
<tr>
<td>Friday</td>
<td>8:00am-4:00pm</td>
</tr>
</tbody>
</table>

• If an incident should happen outside of these hours, injured person and source patient should go to the Emergency Room on the Anschutz Medical Campus.
• If source patient is willing to be tested but cannot go to Infectious Disease Clinic, alternative for testing source patient as recommended by IDC – “Draw 2 red tops immediately. Bring blood with you to clinic. Include patient name, SSN, DOB, home address.”
• Costs for UCDSDM employees (faculty and staff) and source patient are covered by UCDSDM.
Students are covered by their own health insurance.

• Occurrence form must be filed with Clinic Manager / Clinical Affairs within 24 hours of incident.
• Use of PEPLine: PEPLine is a confidential objective and reliable source of information to help assess degree of infection risk and recommended post exposure procedures based on that assessment. Use of PEPLine is recommended for reassurance of injured persons and faculty or health care providers involved in their care or counseling. PEPLine is NOT a substitute for prompt, timely post exposure testing and counseling. Contact PEPLine at 1.888.448.4911 (24/7) for confidential guidance on infection risk based on parameters of exposure.

6.9. Hand Hygiene / Rationale:
Effective hand hygiene is the single most important measure for reducing the risk of transmitting pathogens. Hand hygiene includes methods to decontaminate hands, reduce soil load, and maintain skin barrier integrity. Transient flora which are most frequently implicated in HAIs (healthcare acquired infections) are also the most easily removed by routine handwashing. Hand hygiene is essential in addition to the correct use of gloves because gloves become porous or develop tears during procedures. Preferred methods of hand hygiene will depend on the type of procedure, degree of contamination and need for persistence of antimicrobial action.

Maintaining intact healthy skin is encouraged as intact skin is the best personal defense against infection. Hand hygiene using newer alcohol hand rubs with emollients will reduce some of the irritation associated with frequent hand cleansing. Use of lotions formulated for use in healthcare environments will be encouraged.

6.9.1. Frequency, timing, and applicable agent for hand hygiene:

<table>
<thead>
<tr>
<th>When to perform hand hygiene</th>
<th>Recommended method and agent for hand hygiene</th>
</tr>
</thead>
<tbody>
<tr>
<td>First entry of the day / shift to clinic area</td>
<td>Handwash w/ soap &amp; water</td>
</tr>
<tr>
<td>Reentry to clinics after eating</td>
<td>Handwash w/ soap &amp; water</td>
</tr>
<tr>
<td>Immediately before donning gloves for patient treatment</td>
<td>Handwash or alcohol rub</td>
</tr>
<tr>
<td>Immediately after removing gloves after patient treatment</td>
<td>Handwash or alcohol rub</td>
</tr>
<tr>
<td>After removing gloves torn or punctured during treatment</td>
<td>Handwash w/ soap &amp; water</td>
</tr>
<tr>
<td>Bare hand touch of contaminated surface</td>
<td>Handwash w/ soap &amp; water</td>
</tr>
<tr>
<td>When hands are visibly soiled*</td>
<td>Handwash w/ soap &amp; water</td>
</tr>
<tr>
<td>Before leaving clinic area at end of shift or day</td>
<td>Handwash w/ soap &amp; water</td>
</tr>
<tr>
<td>Before and after processing contaminated instruments</td>
<td>Handwash w/ soap &amp; water</td>
</tr>
<tr>
<td>Before and after handling instruments in “clean” room</td>
<td>Alcohol rub</td>
</tr>
<tr>
<td>Before handling sterilized packaged goods</td>
<td>Alcohol rub</td>
</tr>
</tbody>
</table>

* Alcohol (antiseptic) hand rubs are not to be used when hands are visibly dirty or contaminated with blood or other body soils.

6.9.2. Correct method for routine hand asepsis using soap and water:
• Using foot activated faucets, wet hands with cool to moderately warm water and dispense enough soap to create slight foam all over hands, between fingers and above wrists. Interlace fingers and include thumbs during handwashing. Wash for at least 15 seconds (the “Happy Birthday Song”). Rinse thoroughly and dry skin prior to gloving to reduce chapping.
• Selected soap will be a liquid product with antimicrobial ingredients dispensed from disposable containers. Hand soap containers are not refilled.

6.9.3. Correct method for routine hand asepsis using alcohol based hand rub:
• Hand hygiene using a waterless alcohol handrub is effective for routine hand antisepsis throughout the treatment day between patients, before donning gloves, and after removing gloves.
• Dispense enough solution to keep hands moist with product while vigorously rubbing hands and fingers together for at least 10 – 15 seconds (Happy Birthday Song). Interlace fingers and include thumbs. Allow hands and forearms to dry before donning gloves. Do not rinse off after application.
• Selected product will demonstrate minimum 60 % ethanol or isopropanol and emollient agents.
• Alcohol rubs should not be used for hand hygiene when visible soil or organic material is present on hands.
6.9.4. Surgical hand hygiene will follow CDC guidelines using products with proven persistent antimicrobial properties for an extended 2 to 6 minute scrub.

6.9.5. Policy for lotions:
All students, staff and faculty are encouraged to monitor skin for sensitivities or possible allergic reactions to various soaps and materials. Use of lotions is encouraged to maintain skin condition. Only approved lotion products known to be compatible with healthcare procedures and glove materials should be used. It is discouraged to bring products from home for clinical use.

6.10. Personal Protective Equipment, Attire and Personal Hygiene
Rationale: UCDSDM guidelines for personal hygiene and appearance are intended to maintain asepsis in the clinic environment AND protect clinicians from exposure to infectious agents. In addition, the correct use of protective attire will also reduce the unintended transfer of infectious agents to the home environment. The following guidelines apply as appropriate to all clinic personnel – male and female - including faculty, pre and post doctoral students, international students, staff with patient contact, and any clinic employees who are likely to contact contaminated materials or surfaces.

6.10.1. Personal appearance and hygiene for patient treatment procedures:
• Secure hair away from the face and restrain from entering the treatment field.
• Beards or mustaches will be covered by face mask or shield.
• Jewelry on fingers, hands, arms or ears must not interfere with the effective use of gloves and masks. Jewelry on the hands and arms is discouraged during clinical sessions.
• Nails must be clean and short. Artificial nails are known to harbor soils and microorganisms and are highly discouraged.
• Intact healthy skin is a key element of infection control for health care workers. Use lotions to maintain skin health, wash frequently and at appropriate times, and inspect skin frequently for cracks and injuries that could increase risk of infectious agent transmission.
• Shoes worn in patient treatment areas must be clean and have solid closed toes.
• Neckties, scarves and necklaces should be covered by PPE during aerosol producing procedures.

6.10.2. Required PPE for patient contact:
Correctly worn masks, gloves, eyewear and gowns provide an important level of protection from infectious materials that may contact mucous membranes of eyes, mouth, nose and non-intact skin. The following barrier techniques will be practiced routinely in all clinics of the UCDSDM including the simulation clinic (with the exception of disposable gowns), as part of standard precautions and are required for the treatment of all patients.

6.10.3. Gloves:
Nitrile Gloves will be used in the UCDSDM and are a single use item, with a fresh pair to be used for each patient. Wear cuff of glove over cuff of lab coat or gown. Torn or compromised gloves will be replaced immediately and hands washed prior to regloving. Contaminated gloves must be removed when leaving the treatment cubicle and / or clinic treatment area. Upon return to treatment area, hands must be decontaminated with soap and water wash or if no visible soils, use alcohol rub, then fresh gloves may be donned upon returning to patient treatment. Surfaces should not be touched with gloved hands during treatment sessions unless barrier protected.

6.10.4. Masks:
Selected masks will have an intermediate rating of 98 % particle filtration at .1 micron and must be worn for all patient treatment. The mask must cover the nose and mouth and be correctly adjusted to stay in place. The mask collects aerosols and contaminated material during treatment. It should not be worn under the chin between uses as this allows the contaminated outer surface to touch the face, mouth, etc. Masks become saturated over time and must be changed a minimum of every 60 minutes or more frequently for high aerosol procedures such as ultrasonic instrumentation. Student clinicians will wear a fresh mask for each patient.

6.10.5. Eyewear:
Protective eyewear must be worn during patient treatment and includes goggles, prescription eyewear, or faceshields. (Faceshields do not take the place of masks.) Protective eyewear including prescription glasses
must have side-shields or eyewear “wraps” that offer side protection. Patients must also wear protective eyewear during all procedures including screening exams. All eyewear for clinicians and patients must be cleaned between patients with soap and water or if visibly soiled with splatter, cleaned and disinfected.

6.10.6. Gowns and lab jackets:
Protective clothing must be worn over scrubs or street clothes during clinic patient treatment sessions and any tasks generating potentially infectious aerosols such as instrument processing. Note: Scrubs are considered street clothes and must be covered by protective gowns or jackets in the clinical setting.

**Protective gowns or lab coats are intended to limit the transfer of soils and contamination in two directions:** from street clothes to patient treatment zones; and from aerosols and debris generated in the patient treatment zone that would otherwise be transmitted outside the facility, especially to home and family. Students will wear disposable gowns. Gowns and lab coats must be cleaned between patients with soap and water or if visibly soiled. Faculty and staff will wear approved clean lab coats or disposable gowns over scrubs during all clinical sessions when involved in patient care or while working in clinics where patient care is actively ongoing. Lab coats must cover street clothing where aerosols are most likely to contaminate. Neckties are a known vector of contamination and should be covered if worn.

6.10.7. Restrictions and removal of PPE:
Lab coats, gowns, masks, and gloves must NOT be worn outside patient treatment areas. Gowns and lab coats should be removed prior to eating. Cloth lab coats should be turned inside out when hung up in non treatment areas. Contaminated gowns may NOT be worn inside any of the laboratories. Do not wear gloves while manipulating items at rotary grinding or polishing lathes in the labs. Appropriate containers will be provided for the collection of contaminated jackets / laundry.

6.10.8. Recommended PPE for decontamination of dental unit treatment / operatory:
Gloves, masks, eyewear and gowns are required while cleaning and disinfecting environmental surfaces in treatment units. Utility gloves are the preferred level of hand protection during dental unit cleanup and for surface cleaning and disinfecting. Disinfectant chemicals may compromise the integrity of some glove products. There is also the risk of sharps exposures during treatment area cleanup.

6.10.9 Required PPE for receiving and processing contaminated instruments in dispensary areas and Central Processing:
Receiving and handling contaminated instruments, including those contained within cassettes, trays and baskets, is an exposure prone procedure. Heavy duty puncture resistant utility gloves, masks, protective eyewear and gowns must be worn when receiving and handling contaminated instruments, equipment and supplies.

6.10.10. PPE in dental laboratory areas:
Protective eyewear must be worn in dental laboratories. Masks must also be worn when grinding, using rag wheels or any other procedures likely to product dust and aerosols or when shields and dust collection devices are not installed. Gloves should NOT be worn while working at rotary devices. It is preferred that gowns or lab coats used during patient treatment be removed prior to entering dental labs. Gowns must be removed if visibly soiled.

6.10.11. PPE for Oral Surgery including implant and osseous involved procedures:
Sterile gloves will be worn by clinicians and assistants during all oral surgery and periodontal surgery procedures.

6.10.12. Latex exposure
The UCSD will use latex free products in all general clinics. Nitrile exam gloves are standard supply. Latex free products are made available for patient use in the orthodontic graduate clinics.

6.11. Instrument Processing and Decontamination

*Rationale and Purpose:*
Decontamination is the entire process of cleaning, transporting, processing and sterilizing instruments, objects and devices to make them safe for reuse. Instrument and device decontamination protocols are based on the concept that effective sterilization requires instruments and devices that are completely clean because debris acts as a barrier to sterilant contact with surfaces.

6.11.1 Classification of items for decontamination:
- Critical items include surgical instruments, scalers, etc. that penetrate soft tissue, bone or contact the bloodstream.
- Semi-critical items such as amalgam carriers, mouth mirrors, and film holders may enter the oral cavity, contact mucosa but do not penetrate soft tissues. All critical and semi-critical instruments and devices used for patient treatment will first be cleaned thoroughly, then heat sterilized or if not heat tolerant, at a minimum will be chemically disinfected in a high level disinfectant solution.
- Non-critical items contact only external intact skin and will be cleaned and disinfected with an intermediate level tuberculocidal disinfectant / cleaner and will be covered with barriers. (Radiology tube head and collimator, curing lights, etc.)

Special note for semi-critical device exception: Phosphor plates for intra-oral radiology are barrier protected for intraoral use. Barriers are single use and discarded when plate images are processed.

6.11.2 Instrument Decontamination Process – Operatory Treatment Area
- Instrument decontamination starts at the treatment area. As soon as possible upon dismissal of patient, student clinician and/or clinic assistant will prepare instruments for processing.
- Use recommended PPE - gown, eyewear, mask and utility gloves.
- Safely dispose of sharps first in the designated rigid containers including needles, anesthetic carpules if broken, used scalpel blades, discarded orthodontic wire, used endo files or burs that will be discarded.
- Remove and discard body tissue fragments or items soaked in blood or saliva to biohazard waste containers. Remove other trash and disposables from cassettes.
- Wipe cements and gross debris from cassette surface and instruments by wiping against damp gauze or cotton rolls on tray. (Never hold gauze in finger tips to remove debris from sharp instrument tips.)
- Make note of damaged or missing instruments and accessories.
- Sort endo files or bur sets if used into holders and note if replacements needed.
- Wipe gross soils from surface of handpieces using damp paper towels.
- Student clinicians and assistants are jointly responsible for transport of contaminated instruments and equipment to dispensary area via equipment carts.
- Transport instruments and loose items safely to dispensary receiving area. All items will be contained within cassettes or other holders. Do not allow instrument tips to protrude from cassettes or holders.

6.11.3 Instrument Decontamination - Dispensary receiving Area – General Protocols
- Manual cleaning of instruments and equipment will be minimized. Cassettes, ultrasonics, trays, enzyme pre-cleaning spray, automated instrument washers, closed cart transport systems and centralized processing are all in use to reduce sharps exposure incidents during instrument decontamination.
- Dispensary / “return” area clinical staff must wear gowns, heavy duty utility gloves, masks and protective eyewear while receiving and processing contaminated instruments.
- The receiving area of the dispensary will be organized and labeled to sustain a one way flow of items from dirty to clean.
- No food or beverages are allowed on counters, shelving, or carts in dispensary instrument cleaning area or supply storage area.
- Where possible, items used such as bar scanner should be barrier protected to reduce cross contamination.

6.11.4 Ultrasonic washers in dispensary areas:
- Cleaning solutions will be changed at least daily or more often based on soil load.
- Assistants will use drain baskets or file / bur holders to insert and remove items in ultrasonic cleaners. Never insert hands into ultrasonic solution when filled with contaminated items.
- Ultrasonic chambers will be kept covered during operation to reduce aerosols.
- Ultrasonic devices will be labeled with type of solution and dilution ratio to meet OSHA labeling requirements for secondary containers.
• Do not overload ultrasonic. All items must be submerged for effective cleaning.
• Rinse items thoroughly after removal from ultrasonic solution.
• Quality check effective function of ultrasonics monthly using foil test or Sonachek.

6.11.5. High level gluteraldehyde chemical disinfectant in dispensary areas:
• Use will be eliminated where possible by use of disposable or heat tolerant devices. Where essential, use will be limited to semi critical items that are not heat tolerant.
• Solution tubs must be labeled with name of solution and dated for use and expiration according to manufacturer’s directions for use life meeting OSHA labeling requirement for secondary containers.
• Solution will be kept covered.
• Items will be inserted and removed as a group. All items will be thoroughly rinsed and packaged / labeled for next use.

6.11.6. Decontamination of handpieces and other devices attached to air and waterlines:
• High and low speed handpieces, prophylaxis angles, ultrasonic scaling tips, and air / water syringe tips are all cleaned and / or flushed for 30 seconds after each use. All handpieces are heat sterilized prior to re-use on next patient.
• Saliva ejector tips, high volume suction tips are disposable and discarded after use.

6.11.7. Steps for receiving and processing contaminated items in dispensary area:
1. Scan bar codes.
2. Open cassettes and check for missing or damaged items. Remove trash if present.
3. Spray precleaning enzyme foam on instruments.
4. Clean endo file sets and bur sets in ultrasonic cleaning units. Rinse. Replace damaged or missing items for sets as labeled on “go-by” charts. Check for residual soil and reclean as necessary. Package dried sets for heat sterilization in the dispensary area.
5. Clean surfaces of handpieces, check for complete components, lubricate and bag for sterilization. All handpieces are sterilized between uses.
6. Contaminated instruments will be transported to Central Sterile Processing inside cassettes and trays via closed case transport carts.
7. As much as possible, contaminated items will be transported within 1 hour to Central Processing. All contaminated items will be transported in enclosed case carts. Because carts are loaded in dispensary area and outer surface is likely to be contaminated, clean exam gloves are recommended to handle case carts during transport.
8. Case carts loaded with contaminated items must be accompanied during transfer. Case carts will not be left unattended in the elevators.

6.11.8. Sterilization Procedures in the dispensary areas:
1. All items will be clean, dry and inspected for residual soils prior to sterilization.
2. Items such as burs or jointed pliers may be sprayed with anti-corrosive lubricant agent prior to sterilization.
3. All items are bagged for sterilization using medical grade paper/plastic self seal pouches.
4. An internal chemical indicator will be included inside every pouch.
5. All critical and semi-critical heat tolerant items are heat/steam sterilized.
6. All sterilizers in the dispensary areas are steam/heat sterilizers; gravity, prevac and forced air Statim.
7. Loading sterilizers: Improper loading is one of the most common causes of sterilization failure. DO NOT OVERLOAD sterilizer. All items must be loaded alternating paper to plastic. Do not load packages with paper side to paper side. Where possible load items on edges.
8. All table top sterilizers in the department dispensaries are monitored: mechanical cycle settings and controls are observed for each cycle; internal and external chemical indicators are used with every pouch, and biological spore tests are processed once per week for each sterilizer.
9. Sterilization records will be kept a minimum of one year in the department. Older records will be labeled and bundled for storage at on-campus warehouse.
10. Cycle parameters follow manufacturer’s directions. Gravity Tuttnauer sterilizers operate at 250 degrees F for 30 minutes after reaching correct temp. and pressure. Pre-vac Lisa sterilizers run at 270 degrees F for 5 minutes after vacuum pull. Statim sterilizer will be operated at parameters recommended by the manufac-
11. Items must be allowed to dry and cool before removing from sterilizer. Handling wet packs will cause contamination to “wick” inside packaging.

12. Check chemical indicators on each package and from each load to verify process prior to use in clinics. Do not use instruments if chemical indicators suggest sterilizer malfunction.

13. Handle and store packaged sterilized items carefully to keep packaging intact. Storage and use of sterile packaged goods is based on “event-related sterility”: Contents of pouches are presumed to stay sterile as long as packaging is intact and not contaminated by moisture.

6.11.9. Centralized Instrument Decontamination Department

Centralized instrument decontamination is used for the majority of instrumentation at UCDSDM. The Central Sterile area is organized as follows:

- The area is physically divided with contaminated “dirty” room, clean room, and sterile room. All processing flows from dirty to clean.
- Each area (dirty, clean and sterile) will be physically separated to reduce cross-contamination. Keep doors and transfer window shut between contaminated and clean zones, and keep office door shut that opens into contaminated receiving area.
- All case carts carrying contaminated items will be processed through a case cart cleaning cycle prior to entry into the “clean/sterile” side of Central Processing.
- No food or beverages in the instrument processing areas.

6.11.9.1. Contaminated Receiving Area Procedures

- Contaminated (dirty receiving side) receives transport case carts from all department clinics.
- Personnel must wear full PPE - mask, protective eyewear, heavy duty utility gloves, decontamination gown over scrubs when receiving contaminated carts and items.
- PPE supplies will be available in the contaminated receiving area.
- Disposable elements of PPE will be discarded prior to leaving contaminated receiving area, hands washed and utility gloves washed and air dried.
- Contaminated PPE (masks, utility gloves and gowns used when receiving contaminated carts) MUST be removed prior to using office area.
- Ultrasonic instrument cleaner will be labeled for solution in use and recommended dilution. All items will be completely submerged during ultrasonic cycle. Solutions will be changed when visibly soiled or drained at the end of day/shift. Equipment automatically drains when turned off. Tank will be manually rinsed between uses. Ultrasonic function will be monitored monthly with foil test or Soni chek.
- Contaminated items are in cassettes or transport trays. Contaminated items are loaded into automatic washer disinfectors. Wash cycles regularly in use are enzyme prewash, rinse, main wash, thermal disinfecting rinse and final lubrication/surface treatment cycle. All cycles are set as per the validated parameters listed by the manufacturer. Washers are tunnel style with loading on contaminated side and unloading on clean side.

6.11.9.2. Clean Room (Instrument Packaging)

- Clean dry instruments and cassettes are removed from washers on the “clean” side in the inspection and packaging room. Instruments and cassettes are thermally disinfected by washers.
- Cassette are opened and inspected for broken or missing items. Residual trash, etc. removed if still present. Cassette are closed and packaged for sterilization. Loose items are grouped according to procedure cards and bagged for sterilization.
- New instruments for replacements must be cleaned prior to storage in clean room.
- Technicians must wash or decontaminate hands with alcohol rub agent upon entering clean area. Hand jewelry, bracelets and artificial nails are sources of contamination and should be avoided. Hair should be restrained. Eye Protection and clean lab coats are required. Clean exam gloves may be used to maintain asepsis during instrument packaging.
- Sterilizers are loaded from the “clean” side and unloaded on the “sterile” side.
- Sterilizers will NOT be overloaded.
- All pouches must be loaded so that paper is next to plastic. Racks will be used to load pouches and cassettes on sides or edges.
• Pre Vac sterilizers provide dry packages at the end of the cycle. Sterile packs should be handled carefully to maintain intact packaging.

6.11.9.3. Sterile Room, Storage, and Quality Assurance
• Central Processing technicians must wash hands and don clean lab coats prior to working in sterile area.
• All instruments including individual items and cassettes are packaged for sterilization. Items are not flash sterilized or sterilized unwrapped.
• All Central Processing sterilizers are pre-vacuum sterilizers with dedicated steam lines.
• All Central Processing sterilizers are monitored: mechanical control check, external chemical indicators on all pouched items, chemical class V integrator in every load; daily Bowie-Dick vacuum draw tests for the main sterilizers in Central Processing; daily biological spore tests in the large main sterilizers. Biological indicators are incubated along with controls and records kept for each sterilizer.
• Storage of sterilized goods is based on “event related” sterility. Indefinite sterility is assumed for intact packaged items. Throughout processing, pouches will be monitored for intact packaging. If tears, pinholes or protruding items are noted at any point in processing, the entire package will be pulled for repackaging in a fresh pouch and resterilized.
• Dropped packages: Packaged items will be repackaged and resterilized if dropped on floor, even if packaging is intact, due to potential for cross contamination of external pouch surface on clinical treatment surfaces.
• All hand pieces are surface cleaned and lubricated in the dispensaries, packaged and heat sterilized in upstairs sterilizers or transported for sterilization in Central Processing.

6.11.9.4. Protocol for biological test failures:
The following protocol will be used for all sterilizers (table top, pre-vac, etc.).
• Identify the sterilizer associated with the failed biological test. Ensure that this equipment is not used for sterilization until basic parameters and retesting is completed.
• Verify that mechanical controls are set correctly and that recent chemical indicator tests run in that machine are changing appropriately.
• If mechanical controls are correct and chemical indicators are changing, immediately run a cycle with a biological spore test. Do not include items needing sterilization in this cycle.
• Determine if any oral surgery sets run in this sterilizer and recall for quarantine and reprocessing.
• Items other than implants do not necessarily need to be recalled; however if possible all items that can be traced and especially surgery packs should be repackaged and reprocessed in functioning sterilizers.
• Remove the sterilizer from service until 2nd spore test results show sterilization conditions are met.
• Review logs and records from interval since last negative BI. and review procedures for sterilizer operations, including loading and how spore test was run. Identify if operator error.
• If second BI shows failure, keep sterilizer out of service until inspection and repairs are followed by three consecutive successful BI tests.

6.11.9.5. Processing and Sterilization Protocol for implant cases:
All implants are received certified sterilized by the manufacturer. Only the super periosteal components of implant systems may be cleaned and sterilized for use.

6.11.9.6. Storage of sterilized items in Central Processing:
• All sterilized goods will be packaged. Items will not be unloaded from sterilizers until dry. Sterile packaged goods will be handled as little as possible. Packaging will be kept intact.
• Short term storage will occur on the “clean/sterile” side of Central Processing.
• Short term storage in departments and dispensaries will be on clean dry racks and bins in areas segregated from patient treatment and contaminated items. “Short term” is the period - usually less than one week elapsed - after sterilization and until items are requested for use.
• Storage will be based on “event related” sterility. All packages will be routinely inspected prior to use by clinicians for intact packaging prior to opening. Contents may be assumed to be sterile if packaging is intact. Dating is not required but may be used for infrequently used items.
6.12. Environmental Infection Control – Dental Units and Clinical Surfaces

6.12.1. Basic principles used at UCSDSM for environmental infection control will be based on classification of areas and surfaces as:

- **Housekeeping** – includes floors, walls, windows, blinds, sills, cabinets, sinks.
- **Zone of aerosolization** – patient unit chairs, stools, carts, computer screens.
- **Clinical touch surfaces** - areas likely to be touched with gloved hands during the course of patient treatment - keyboard, handpieces, air/water syringe controls, evacuation lines, light handles, chair back and controls, small equipment such as curing lights and ultrasonic scalers.

6.12.2. Facilities and equipment in place to reduce cross contamination:

- Smooth upholstery.
- Foot controls for patient chairs and faucets.
- Electronic paper-less record keeping.
- Unit dosing of supplies.
- Barriers will be used on all clinical touch surfaces and especially those that cannot be removed and heat sterilized. Barriers are single use and will be changed between patients. It is not necessary to reclean and disinfect covered surfaces as long as barriers remain intact and in place. Barriers must be removed in a manner that avoids contaminating surfaces underneath.
- Barrier protected surfaces include but are not limited to: patient chair back, delivery / docking arm for handpieces and evacuation lines, cart, handpiece controls, computer keyboard and mouse, light handles, operator stool adjustment, radiographic head, control panel.

6.12.3. Surface Cleaning and Disinfection:

- An EPA registered intermediate level disinfectant / cleaner will be used for all clinical treatment surfaces but especially clinical touch surfaces and adjacent countertops, and computer monitor screen cover. Disinfectants will be applied by wiping and towelettes. Sprays are not allowed in the clinics to reduce aerosols and protect electronic equipment.
- Disinfectant will be applied in the CDC recommended two step method: Clean surfaces first to remove soils. Apply disinfectant / cleaner thoroughly using sufficient wipes to clean all surfaces. Cleaning is critical to effective disinfection. Discard wipes. Reapply disinfectant with fresh wipes to completely cover surface with disinfectant. Allow total contact time of 10 minutes.

6.12.4. Dental Unit Set Up Step by Step:

1. Wash hands thoroughly with soap and water upon entering clinic and BEFORE touching any supplies or equipment. Remove personal items, backpacks, books, etc. from the treatment unit and store in student lockers. Don disposable clinic gown, eyewear, mask and clean gloves.
2. Water bottles may be left on units. Rinsing and disinfecting bottles is not necessary as all water used during treatment is continuously treated through a centralized silver ion system on the first and second floor clinics. Water for third floor clinic is treated from a centralized silver ion system. Treated water is then used in unit bottle systems. Bottles will be removed, disinfected and allowed to dry on a daily basis in 3rd floor Orthodontic department clinics.
3. Flush all lines for at least one minute prior to installing tips, disposables or handpieces.
4. Check treatment area for general cleanliness including floors, countertops, arms of unit. Use disinfectant / cleaner towelettes for spot cleaning. Remember – patients perceive infection control via visual assurance of a clean, neat treatment area.
4. Disinfect clinical touch surfaces using the two step method:
   - **Clean first** using an intermediate level tuberculocidal disinfectant with cleaning surfactants. Discard wipes or paper towels used for cleaning.
   - **Apply disinfectant** - dispense fresh disinfectant towelettes sufficient to reapply disinfectant to all clinical contact surfaces, counter tops and adjacent areas in the zone of aerosolization. Disinfectant total contact time is 10 minutes. Collect disposables and treatment items.
5. Wipe off excess disinfectant if necessary and ensure that seating areas of chairs and stools are clean and dry.
6. Place barriers over all clinical contact areas including: patient chair back, cart, keyboard, mouse, operator stool and height control, unit light handles and light switch, air/water handle, and controls for evacuation lines.
7. Attach air / water tip, evacuation tips and handpieces. Place sterile bur in chuck of handpiece and run for 30 seconds. Re-cover handpieces if they will not be immediately used. (After handpiece and bur are used during treatment, return to holder with bur end down.)

8. With clean bare hands collect disposable supplies, paper goods, biohazard bag, patient education and home care supplies, etc. Do not access supplies with gloved hands during patient treatment.

9. Seat patient, place bib and protective eyewear for patient. After initial conversation and medical history update, wash hands (soap and water or alcohol rub), place clinician PPE starting with mask, then eyewear, gloves last.

6.12.5. Unit clean-up or unit turn-over step by step between patients:
1. Students and clinical assistants will wear masks, eyewear, gowns and utility gloves during unit clean up.
2. Safely dispose of sharps first in the designated rigid containers. Remove and discard body tissue fragments or items soaked in blood or saliva to biohazard waste containers. Sort and remove other disposables and debris from cassette and discard in general trash. Discard disposable gowns and large barrier trash in large trash bins located at sides of clinic areas. Small trash receptacle at unit is only for smaller non-biohazard trash.
3. Do not allow gross debris or cements to dry on instruments. It is the joint responsibility of clinic assistants and students to start instrument decontamination as quickly as possible to avoid dried debris damaging instruments and cassettes. Wipe cements and gross debris from cassettes and instruments by wiping against damp gauze (Never use gauze in finger tips to remove debris from sharp instrument tips.)
4. Check for damaged or missing instruments and accessories required for that set. Separate endo files, holders and bur sets and note if replacements needed. If present, wipe gross soils from surface of handpieces using damp paper towels. Contaminated instruments and equipment will be transported to dispensary area via carts within cassettes or solid side pans.
5. Remove all surface barriers and place in general trash. Turn off unit light.
6. After unit light has cooled off, leave light cover in place and clean off with damp paper towels. If noticeable spatter cannot be removed or is inside cover notify a clinic assistant.
7. Flush all handpiece and air/water lines for one minute.
8. Use diluted evacuation line cleaner to suction at least one to two cups solution through each evacuation line of the unit.
9. Clean all clinical contact surfaces after last patient of day including surfaces covered by barriers. Use the disinfectant / cleaner towelettes. Check all unit surfaces including countertops, unit arms, computer monitor screen cover, etc. for any visible soils, especially blood spatter. All visible soils must be cleaned and the same area disinfected using the two step method: clean first, discard towelettes, obtain fresh towelettes, reapply disinfectant, allow 10 minute contact time. The upholstery of patient and clinician chairs, keyboards, and monitor covers may be cleaned with disinfectant wipes and then wiped off with plain paper towels dampened with water. If visible blood or other body soils are noted on upholstery or keyboards, the two step process should be used.
10. Replace unit light directly over chair. Raise chair slightly to allow floor cleaning.
11. Turn off unit control.
12. Change unit suction trap weekly.
13. Wash utility gloves with soap and water then remove and hang.
14. Wash hands thoroughly with soap and water prior to leaving clinic.

6.12.6. Limiting contamination via aerosols and consumable supplies
• Aerosols: All procedures will be performed to minimize the amount of splatter and aerosols by consistent use of high volume evacuation, proper patient positioning, pre-operative mouth rinses, rubber dam placement and effective use of PPE.
• Consumable supplies will be accessed with clean bare hands only. Where possible items will be unit dosed. When containers must be placed in the dental treatment area, containers will be barrier protected if they must be handled during patient care.

6.13. Water Lines and Evacuation Systems
1. Rationale for water line monitoring and treatment:
Dental unit waterlines can become colonized with microorganisms, creating complex slime layers (glycocalyx) and biofilm. Although cultured samples demonstrate limited pathogenic potential, Pseudomonas aeruginosa, Legionella species and other potentially pathogenic species have been isolated from some water lines. Further the CDC states: “Although no epidemiologic evidence indicates a public health problem, the presence of substantial numbers of pathogens in dental unit waterlines generates concern. Exposing patients or dental health care workers to water of undetermined microbiological quality, despite the lack of documented adverse health effects, is inconsistent with accepted infection control principles.” The American Public Health Association and American Water Works Association have set limits for heterotrophic bacteria in public water supplies not to exceed 500 cfu/ml.

2. UCDSDM uses a centralized Sterisil PureLine50 wall mounted, point-of-entry purification system connected to incoming municipal water supplies. This system provides treated water for all first and second floor clinics, autoclaves and drinking water dispensers. The system filters contaminates in the source water using prefiltering and automated reverse osmosis (RO) filtration. Water is further disinfected using UV irradiation. Water dispensed for autoclave use is filtered through additional deionization to reduce total dissolved solids.

3. Sterisil Corporation maintains the filters and ionizing cartridges and sends water samples for testing to a third party. Verification logs will be maintained in duplicate by Sterisil and UCDSDM Clinical Manager.

4. Procedures: Discharge water and air for a minimum of 20 – 30 seconds after each patient, from any device connected to the dental water system that enters the patient’s mouth (e.g. handpieces, ultrasonic scalers, air/water syringes).

5. ADEC unit antiretraction mechanisms are engineered to eliminate “suck-back” into water delivery lines.

6. Maintenance for ADEC unit evacuation lines and solids filters: Evacuation lines will be cleaned at least weekly with approved solution by clinic assistants.

6.14 Infection Control Procedures for Radiology


No chemical processing takes place at the school in conjunction with patient care.

6.14.2. Infection control procedures during radiographic exposures:

- All dental health care personnel including staff, students and faculty will wear standard clinical personal protective equipment including clean gloves, mask, eyewear and clinic coat or gown during radiographic procedures.
- A fresh barrier (chairsox) will be used on all “touch surfaces” of radiographic exposure equipment including the tube head and chair back. All areas likely to be touched during adjustment of the equipment must be covered. The control panel will also be covered with an adhesive barrier. It is the responsibility of the clinician taking the exposures to assure that fresh barriers are in place and that upon completion, contaminated barriers are discarded. All barriers must be changed between patients.
- Any surfaces not covered by barriers during the radiographic procedure that become contaminated should be cleaned and disinfected using the standard two step wipe, discard, re-wipe procedure.
- Lead aprons must be placed carefully to reduce the need for touching during the procedure. If a lead apron must be touched or otherwise becomes contaminated between intraoral film placements, it must be cleaned and disinfected using the standard two-step wipe, discard, re-wipe procedure.
- Phosphor sensor plates used for intraoral imaging will be inserted into single use disposable protective covers. Sensor plates are arranged on a clean disinfected template prior to exposure and collected in a disposable holder upon removal from the oral cavity. The template will be thoroughly cleaned and disinfected prior to re-use using the standard two-step protocol.
- All intraoral positioning devices are either disposable or heat sterilizable. Positioning devices should be rinsed off by student clinician prior to returning to Central receiving area. Devices will then be packaged and sterilized by staff.

6.14.3. Infection Control during processing

Exposed phosphor sensor plates covered by disposable barriers are collected in a disposable cup and transported to the image processing area. Covers are discarded onto a paper towel as sensor plates are inserted into the digital image transfer equipment. Clinicians will use gloves to remove contaminated sensor covers.
The image processing unit should not be touched during this process. If surfaces are accidentally contaminated during image processing, they must be disinfected prior to next use.

6.14.4. Extraoral image processing will utilize barriers over bite positioning devices.

6.15. Dental Laboratory Asepsis

All impressions, appliances, wax rims, bite/jaw registrations or other materials that have been placed in the patient’s mouth are a potential source of cross contamination. Also lab items such as burs, polishing wheels, points, pumice pans, lab knives can transfer contamination from case to case.

Therefore, UCSD dental laboratory infection control will be based on the “clean” lab concept: All impressions, appliances, wax rims, bite/jaw registrations or other materials that have been placed in the patient’s mouth will be disinfected in the clinic area BEFORE transporting such materials into any lab area including the first floor production lab. If dental prosthetic devices require adjustment or polishing that cannot be completed chairside, such items must be rinsed off and disinfected prior to entering the lab area.

6.15.1. Procedures for disinfecting impressions and prosthetic items.

- An intermediate level water based disinfectant – ready to use – with squirt top dispenser, and baggies will be supplied at each treatment unit. When it is anticipated that impressions or appliances will need to be disinfected, have disinfectant and several baggies out on counter ready for use on paper towel. All usual clinic PPE should be worn – clean gloves, mask, eyewear and gown.
- Upon removal of impressions, appliances, etc. from patient’s mouth, gently rinse off blood, saliva or other soils. If necessary obtain denture brush to remove debris from appliances. Shake gently to remove excess water. Place item inside baggie, squirt sufficient disinfectant onto item inside baggie to ensure complete coverage of all surfaces. Close baggie, allow 10 minute contact time. Remove gloves, wash hands.
- Rinse item gently to remove traces of disinfectant. Wash hands.
- Transport disinfected impressions, device, etc. inside clean baggie to lab area with bare hands. Do not transport contaminated items into labs or attempt to disinfect inside lab. Student and faculty clinicians must discard gloves and disinfect hands PRIOR to entering lab areas. Contaminated gowns must also be removed if visibly soiled with blood or if going to lab area that is not immediately adjacent to clinic.
- Before returning appliances and restorative items from lab to patient: reclean item with denture brush. Make sure to remove any excess dust, polishing materials, etc. Rinse. Disinfect in clinic area using same protocol in fresh baggie. Rinse thoroughly prior to returning to patient.

6.15.2. DO NOT WEAR GOWNS OR GLOVES to first floor in-house lab.

6.15.3. PPE and related safety issues for lab areas:

Many lab activities produce spatter or aerosol. Wear safety eyewear and mask. Secure hair away from face and check for loose clothing when working with rotary devices. Use built-in device to suction lab dust. Use built-in plastic face screens. Wash hands after leaving lab and before re-gloving for patient contact.

6.15.4. Cleaning and disinfecting lab equipment:

- All heat tolerant semi-critical items (used inside the mouth) must be cleaned and heat sterilized between uses: eg. metal impression trays, face bow forks, burs for chairside adjustment/polishing. Facebow earpieces should be cleaned and disinfected between uses.
- Shade guides must be single use disposable, barrier protected, or cleaned and disinfected between uses.
- Articulators will be cleaned and disinfected or barrier protected between uses (posterior posts & incisal pins may be barrier protected).
- Polishing lathe: Use unit dose fresh pumice, clean disposable tray and clean sterile rag wheel.
- Clean up splatters and spills immediately.
- A sharps container will be kept in each lab for disposal of contaminated sharps. (eg. Blades, broken lab knives, orthodontic wire from intra oral procedures, etc.)

6.15.5. All appliances, prosthetic devices received from internal or external lab production for delivery to the
patient must be disinfected prior to try-in if not clearly labeled as disinfected from the lab.
Rinse disinfectant off before inserting intra-ORally.

6.15.6. Adjustment or polishing of appliances, prosthetic devices, restorative items in the lab areas:
- If items require polishing or adjustments in the lab area after insertion in the patient’s mouth, they MUST be cleaned and disinfected before going into any lab area. Clean with denture brush at chairside, rinse, disinfect in clinic, discard gloves, wash hands.
- Before returning appliances and restorative items from lab to patient: reclean item with denture brush. Make sure to remove any excess dust, polishing materials, etc. Rinse. Disinfect in clinic area. Rinse thoroughly prior to returning to patient.

6.15.7. All items sent to outside lab facilities will be clearly labeled as disinfected & type of disinfectant used.

6.16 Infection Control Protocols for Oral Surgical Procedures
Procedures conducted at UCDSDM include biopsy, resection, excision, periodontal surgery and implants.
6.16.1. Hand hygiene for surgical procedures will follow CDC guidelines using antimicrobial hand soap with an extended technique for a minimum of two minutes.

6.16.2. All members of the surgical team involved in patient care will wear sterile surgical gloves.
If gloves become torn or otherwise compromised, they will be immediately (as soon as feasible) discarded, surgical hand hygiene performed and fresh sterile gloves donned.

6.16.3. Only sterile water will be used for irrigant or handpiece coolant.

6.16.4. A surgical irrigating apparatus will be used.
Tubing and components are single use disposable or autoclaved / sterile.

6.16.5. Implants will be used that are delivered sealed and certified sterile from the manufacturer.

6.17. Waste Management – regulated and non-regulated waste
Protocols meet regulatory requirements and guidelines of the CDC, OSHA, Federal EPA, and Colorado State Dental Law, Rules and Regulations for regulated medical waste.
6.17.1. Handling major spills of blood or other potentially infective materials such as vomitus: Person(s) handling spills of potentially infective material must don PPE for standard precautions including mask, eyewear, gown. Use utility gloves over exam gloves if sharp items may be encountered in spill clean-up. Spills will be contained as quickly as possible with dry absorbent material. If spill contains blood, treat with intermediate level (TB kill) disinfectant for 10 minute contact time, then spill may be wiped up and disposed of as regular trash.

6.17.2. Disposable Sharps
As described in dental unit post treatment clean-up, segregate and discard contaminated sharps including blades, needles, anesthetic cartridges with aspirated blood, files, burs, used orthodontic wire and bands and broken metal instruments into the rigid red biohazard sharps containers provided at every dental treatment unit. Sharps should be discarded first before any other unit clean-up. Containers will not be overfilled, maintained upright, replaced routinely and collected with other regulated biohazardous waste for pick-up. Containers must be closed prior to moving from area of use. Containers may not be reopened, emptied or re-used. Environmental Services / Housekeeping will not handle sharps or medical waste bags. Housekeeping will report the presence of any regulated or sharps waste that may be found in regular trash to the Clinic Manager for that floor. The clinic manager will identify the source and schedule a meeting for corrective action.

6.17.3. Other regulated non-sharp medical waste such as saturated bloody gauze will be collected into heavy duty marked biohazard red bags.
Red bags and contents may not be placed in regular trash. Red bags will be collected for pick up with other regulated medical waste.
6.17.4. Liquid blood and body fluids will be evacuated during the course of treatment and disposed through the evacuation and sanitary sewer system.

6.18. Handling of Biopsy Specimens
- Persons handling biopsy specimens must wear PPE for Standard Precautions. Biopsy specimens will be collected and transported in sturdy, leakproof containers labeled with biohazard symbol.
- If biopsy containers become visibly contaminated on the outside, they will be placed inside a heavy duty “red bag” with biohazard symbol imprinted.
- Upon completion of examination and pathology review, specimens must be treated as medically regulated waste. Tissues must be placed into leakproof containers and/or “red bags” labeled as biohazard waste and disposed with other regulated medical waste.

6.19. Handling of extracted teeth
- Extracted teeth may be given to the patient upon request. No special container or handling is required when returned to the patient.
- Extracted teeth will be collected for disposal as medical waste unless saved for educational purposes. Extracted teeth with amalgam should not be incinerated.
- Extracted teeth not containing amalgam collected for educational purposes: Clean and remove all blood and tissue. Keep moist with saline or plain water in closed leak proof container preferably labeled as biohazard. Sterilize teeth prior to use in steam autoclave for 40 minutes.
- Extracted teeth containing amalgam collected for educational purposes: Clean and remove all blood and tissue. Keep moist with saline or plain water in closed leak proof container preferably labeled as biohazard. Immerse in 10% formalin for 2 weeks.
- When using extracted teeth in educational activities, students must still use standard precautions as the best simulation of clinical practice.
University of Colorado Denver, School of Dental Medicine - Post Exposure Management Report Form

A body fluid exposure occurs when a person has been exposed to another person’s body fluids.
This includes needle, instrument, bur or file sticks and splashes to eyes, mouth or open skin (cuts).
This Policy applies to students, faculty, staff, and patients.

REPORT TO INFECTION DISEASE CLINIC WITHIN 2 HOURS OF EXPOSURE.
Take a copy of this form with you.

Step by Step Process:
1. If with a patient, stop treatment process as quickly and safely as possible. Avoid alarming patient with inappropriate remarks.
   DO NOT DISMISS PATIENT.
2. Wash wound immediately with soap and warm water. Squeezing the wound is not recommended. DO NOT use antiseptics on
   the wound. If eye is exposed, irrigate with one liter normal saline.
3. Immediately notify supervisor, or for students - the supervising faculty.
4. Stabilize treatment in progress and assure patient is comfortable.
5. Obtain a copy of this form, available on every floor and in every department. Complete information below.
6. Supervisors must notify clinic floor or dept. manager within 24 hours of incident. Clinic manager must notify Clinical Affairs.
7. If known source patient, fill out information below – pt. name, DOB, SSN, home address and phone.
8. If source patient consents, injured person takes this form and source patient and proceeds
   immediately to: Infectious Disease Clinic, Anschutz Outpatient Pavilion, 7TH floor. 720.848.0191.
9. If patient cannot go to ID clinic, alternative is to draw 2 red tops blood. Injured person then brings source patient blood and
   patient information with them to ID clinic.
10. Injured person will have blood drawn at ID clinic for baseline testing: HIV 1 / 2 AB, Hepatitis BsAB titer, and an ALT.
11. PEPLine: The Post exposure Protocol Hot line is helpful for counseling regarding level of risk and follow up recommendations:
   1.888.448.4911 (24/7). (PEPLine is NOT a substitute for prompt post exposure testing.)

Name of injured person ____________________________________________ Student Staff Faculty (circle)
Injured person’s normal duties / job description: __________________________________________________________
Time & Date Injury Occurred: ________________ Time / Date Reported: ________________
Location of exposure on injured person (e.g., “right index finger”)
Hep. B vaccination: Yes No Full Series? Yes No Post Titer Done? Yes No
HBV antibody status if known: ________________________________
Tetanus vaccination: Yes No Date of last Tetanus vaccination: ________________
Clinic/department where injury occurred: ________________________________ Supervisor: ________________

General Exposure Incident Information:
Is injury sharps related? Yes No Type of device: (circle) blade needle / gauge bur endo file instrument
Clinic/department where exposure occurred: ________________________________
Procedure or task in progress: ____________________________________________
How incident occurred: ________________________________________________

Describe the injury (depth of wound, gauge of needle): ____________________________________________

If fluid injected and volume of infectious material injected:

Mucous membrane exposure? Yes No Where? ________________________________
Source Patient Information: Source Unknown? Yes (if unknown, skip this section) DOB ________
Name ____________________________ Phone ____________________________
SSN ____________________________ Home Address ________________________________
From chart and medical history, list any known infectious disease status including HBV, HIV, HCV, etc.
__________________________________________
__________________________________________
Was there exposure of source patient to HCW body fluids during course of exposure incident? Yes No
(For example: Did student nick self with contaminated needle, then proceed with injection.)
If Yes, describe injury to source patient: ____________________________________________

Written Opinion received from Infectious Disease Clinic within 15 days: Yes No
Copy of Written Opinion filed in employee confidential medical record: Yes No
Copy provided to employee / student: Yes No

Note: If written opinion not received, check with ID clinic and injured person. OSHA requires the employer and the worker
both receive copies. Copy of written opinion must be kept in employee’s confidential medical record. Report must only con-
tain documentation that employee was informed of evaluation results and need for follow-up; and whether HBV vaccine was
indicated and if received.

All other findings or diagnoses remain confidential and not included in written report.