**MANUAL**

**KENTUCKY PUBLIC HEALTH PREVENTIVE DENTAL HYGIENE PROGRAM**

**GENERAL INFORMATION FOR**

**PUBLIC HEALTH PREVENTIVE DENTAL PROGRAM**

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**I. PROLOGUE**

The initial responsibility for instilling professional standards of care, values, and skills within

dental providers resides with the professional and technical schools that provide the basic

training within the profession of dental hygiene. Boards of dental examiners test basic clinical skills and knowledge on select procedures as hygienists present themselves for licensure and registration. Ultimately, it is individual professional integrity, supported by technical knowledge, clinical skills, and continued educational development that provides the foundation for the provision of preventive dental services in a safe, effective, caring, and nondiscriminatory

manner. The Oral Health Program of the Kentucky Department of Public Health is responsible for assuring that the dental care provided in public health clinics meets or exceeds existing standards in regard to quality, quantity, appropriateness, need, and safety. However, no administrative body can guarantee through quality assurance reviews that standards of care are being met on a patient-by-patient, procedure-by-procedure, or day-by-day basis. The maintenance of professional standards of care, in terms of individual provider responsibility for the quality and appropriateness of services provided to individual patients, rests with the provider. Our goal is that every hygienist should strive for excellence through practicing fundamentally sound procedures at all times.

Essential to the accomplishment of the goals of the Kentucky Oral Health Program is adherence to uniform standards of practice, accepted clinical technique, and accurate recordkeeping. This

Manualhas been developed to acquaint public health registered dental hygienists employed in

Kentucky’s local health departments with the various clinical regulations, policies, recommendations, procedures, and forms used by the Program. This Public Health Preventive Dental Manualserves as a reference source regarding policies and procedures of the Oral Health

Program.

In addition to this manual, dental hygienists in public health settings in Kentucky must adhere to the guidelines and regulations presented in the Kentucky Dental Practice Act and related regulations.

**II. ADMINISTRATIVE RELATIONS**

Dental hygienists working in dental public health settings in Kentucky must be licensed or registered to practice dental hygiene and must hold a certificate as a Public Health Registered Dental Hygienist. The Dental Practice Act, for scope of practice, for any of the above mentioned professionals may be found in Kentucky Revised Statutes, Chapter 313. The dental hygienist is responsible for fees (registration, license and certificate renewal) imposed by the Commonwealth of Kentucky to keep all licenses, registrations and certifications current throughout the period of employment with the health department. All persons employed in dental public health in Kentucky should be familiar with the *Kentucky Dental Practice Act* and associated regulationsand strictly adhere to all laws regarding dental practice and professional conduct. The most current revisions of these governing laws are an addendum to this manual.

All statutes, regulations, policies and procedures promulgated by the Commonwealth of Kentucky, the Cabinet for Health and Family Services, Department for Public Health, the Division for Maternal and Child Health and the appropriate local health departments and their governing Boards of Health will be followed.

These rules include: attendance and leave procedures, work hours (including time of arrival and

departure), proper dress code, and other rules as set forth by the local health department. Job

performance planning, interim work reviews and employee performance evaluation will be

completed at the proper intervals, in compliance with Local Health Merit System Operations within the Division for Administration and Financial Management. Interaction and communication with supervisors and support staff will be conducted at appropriate intervals and in a professional manner. Collegiality with other health care providers within the department is encouraged, and in-house referrals should be made when appropriate.

The normal workday consists of 7.5 hours. And the standard work week is 37.5 hours. School-based staff may have different work hour expectations that should be clear between the dental team, the host site (i.e., school) and the employer/health department.

**III. LEVEL OF DENTAL SERVICE**

The purpose of this section is to outline the Oral Health Services guidelines regarding levels of

service and provision of care by dental hygienists working within the framework of the Preventive Dental Program. This was proposed, designed and accepted by the Cabinet and Department’s leadership as one of Primary Prevention. It is not one of interim restorative care, or extractions, even on extremely loose deciduous teeth.

**Primary Prevention**

All public health dental teams should provide primary preventive services appropriate for

the target population. Suggested primary preventive dental services include:

1. Oral Health Education

a) Caries Risk Assessment

b) Oral hygiene instruction

b) Dietary counseling

c) Trauma prevention education – bicycle helmets, seat belts/child restraints and mouth guards

d) Fluoride effectiveness

e) Oral cancer prevention (when appropriate)

2. Prophylaxis

3. Pit and fissure sealants

4. Topical application of fluoride varnish

5. Supplemental fluoride therapy (tablets or drops) as indicated

a) Community water fluoridation assessment

b) Individual well water analysis

c) Adherence to current supplemental fluoride dosage schedule

6. Referral of Patient to Local Dentist for establishment of a “Dental Home”

**IV. LEGAL ASPECTS OF TREATING MINORS**

Written consent for treatment must be obtained for each patient prior to an examination or any

subsequent preventive services. This policy is relatively straightforward when adults present themselves for treatment at a public health facility, yet the majority of patients treated in most of our public health dental settings are minors. The question that needs to be addressed is "When can a minor authorize or consent to any medical (dental) services?" Attached to this manual is Kentucky Law explaining the appropriateness of permission to provide services to a minor patient.

**V. DENTAL PATIENT RECORDS**

It is necessary that we standardize the dental patient records that are being used in our dental

public health clinics across the state. This assists in our standardization of our services, transparency of our intent as well as to facilitate the collection of service data for program evaluation. The electronic health record product, eClinicalWorks, ***must*** be utilized in all dental public health settings in all participating health departments until further notice.

It is essential that we have complete and accurate records on all patients. Therefore, when

admitting new patients, we are asking the hygienist to ensure that the dental staff completes all

sections of the dental patient record including the medical history, consent for service, charting

of the assessment, and thoroughly documents all services delivered to patients. The specific criteria and standards for public health dental records are delineated in the Protocols that guide public health registered hygienist and are incorporated as a supplement to the Department for Public Health’s Core Clinical Service Guide.

There must be a dental patient record for each individual seen in the clinic regardless of level of

care being provided or payment source. **Every dental patient must have a complete, accurate,**

**and up-to-date *Clinic Oral Assessment and Service Record* and a *Consent and* *Health History for Dental Services* as part of his or her dental record.**

In the area of recordkeeping, much of the information (e.g., patient identification, medical

history, and charting) will be obtained or recorded by the dental assistant or clerical personnel.

Standardized Charting **MUST** be used in all Public Health Preventive Dental Programs.

However, service entries ~~(progress notes)~~ are the responsibility of the registered dental hygienist, and all pertinent patient information should be reviewed and signed by the hygienist to ensure that it is correct, current, and complete.

Confidentiality of patient records and treatment is the “cornerstone” of building trust in a provider-patient relationship. **This confidentiality must never be compromised.** Preventive Dental Programs adhere to the same HIPAA standards and expectations that the other public health providers follow in clinical settings. Failure to maintain confidentiality of patient records may result in disciplinary actions up to and including termination of the employee.

The policies and procedures regarding Retention and Destruction of Dental Records are the same as those for other nursing/medical preventive services in the local health department.

Key identification information such as: name, gender, birth date, address, identifying number, and Medicaid number (when applicable) must be present. A consent form or permission for

services must be obtained from the patient, parent, or the patient’s legal representative before treatment is started. **It is required that a new medical history and signed consent form be completed for each patient annually**. Update the patient’s medical history at each visit,

in the progress note; document the date and any changes.

The Consent and Health History for Dental Services Form must be completed for each patient who is treated in a public health dental clinic. All health questions ***must*** be answered. Any medications or allergies should be noted. The health history must be dated and signed by the patient or legal representative. The health history should be updated at every visit and any change noted in the progress note.

An accurate and complete medical history is a prerequisite to patient treatment. Since

information obtained from patients, parents, or legal representatives is subjective, it can never be assured that all responses are accurate. Pertinent information may be unreported. A well-structured medical history together with appropriate follow-up to key responses should give the baseline patient data on which determinations are made concerning referrals, patient management, case planning, and services.

Complete charting of the oral assessment and preventive services rendered for each patient is imperative.

**A signed medical history and written consent for preventive services will be obtained for each patient prior to providing preventive services. Consent forms are in effect for one year from the date on the latest consent form.**

**VI. TREATMENT FACILITY**

The dental public health team should be located in a facility that provides for adequately sized

clinical operatories, adequate heating and cooling, and proper lighting to provide dental

treatment in optimal conditions. It is the responsibility of the hygienist to work with the host site to assure that the public health dental hygiene area is maintained in a manner that provides dental staff and patients with a clean and orderly place to work and receive dental care. The dental team, together, is responsible for assuring that the clinic has the necessary equipment and supplies.

**VII. EMERGENCY PROTOCOL**

Every dental public health clinic must have a written protocol for management of medical

emergencies consistent with a hygiene-only dental setting. Individual protocols are found in the CCSG Addendum for preventive dental hygiene programs. Every dental hygienist must maintain current certification in CPR throughout the course of employment. This is also a condition of licensure in Kentucky.

**VIII. QUALITY ASSURANCE REVIEW**

The Oral Health Program quality assurance program for preventive dental services is designed to provide an effective, objective, and uniform method of evaluating clinical preventive services to assure that high quality care is provided to all patients in a professional manner. The quality assurance review process should be an essential component of the employee's annual job performance cycle (i.e., job planning, discussion, interim reviews, and job performance evaluation). The Oral Health Program has developed a quality assurance review instrument for hygiene teams that deliver direct preventive care in health department settings. The purpose of this process is to assess and improve the quality of dental care delivered to health department patients. The professional competency of team is assessed by chart review (and when practicable) by direct observation of clinical care by the State Dental Director, or official representative. All hygiene teams who deliver direct preventive care in health department settings are to be reviewed at annually or as program needs dictate.

The record review portion of the Quality Assurance will be done by the State Dental

Director or official representative. During the record review portion of the Quality Assurance Review process, a minimum of 10 patient records will be reviewed, from the previous twelve months, i.e. if review is done in October ‘14 – you can review records with preventive service dates from October 2013-October 2014.

Records that are reviewed can be used only one time in the record review section. These records

are not to be used in the Direct Observation Of Care Section. This will ensure a review of the

comprehensive care provided by the hygiene team under review. When doing the Record Review, a note must be placed in the progress notes of the chart stating that the chart was reviewed as part of the QA exercise. Example: Date, Record Reviewed for QA, reviewer’s legal signature, with credentials (DMD, DDS, RDH).

During the Direct Observation of Patient Care, a notation must also be made in the progress note

section of the chart. **Example: Date, Record used for Direct Observation of Services Delivery for QA, reviewer’s legal signature, with credentials (DMD, DDS, RDH).**

There is evidence that a relationship exists between the quality of clinical record keeping and the

quality of care provided. Therefore, the focus of the quality assurance review program will be on

the evaluation of the dental records of individual patients as well as the direct clinical

observation of care.

To assure that dentist quality assurance review evaluations are completed as outlined in this manual, the review process will be overseen by the Oral Health Program. Hopefully, the "centralization" of dental quality assurance review will result in evaluations that are completed in an accurate and timely manner for all dental hygiene teams that provide preventive services in public health settings. The state dental director or official representative has the responsibility of assuring that necessary corrective action is taken to bring the evaluated team into compliance with the quality assurance criteria and standards of practice for public health hygiene. Besides improving individual performance, the findings from the quality assurance evaluations will be used to target specific areas of public health dental hygiene for long range planning for expansion and improvement.

**IX. GENERAL PREVENTIVE SERVICES INFORMATION**

Efforts should be made to provide pertinent and accurate information to parents, legal guardians and children concerning their role in the maintenance of good oral health. Each patient should

be given home care instruction to include oral hygiene care and dietary information.

Preventive Services should follow a logical sequence. Normally,

with minor variations, this is:

1. Caries Risk Assessment
2. Oral Assessment and Charting
3. Services Planning

3. Prophylaxis

4. Oral hygiene instruction

 Nutritional Counseling and Tobacco Use Assessment and Counseling, where appropriate

 5. Sealant Placement

 6. Fluoride Varnish

 7. Referral to Local Dental Home

A child should not be physically forced to accept preventive services. If reasonable persuasion does not result in the cooperation of the child, it is suggested that the child be referred to a pediatric dentist for treatment. This should be recorded in the progress notes and the parent or legal guardian informed of the decision.

Respect for and awareness of the dignity of all patients should be an integral part of all

interactions between patients and dental staff.

Accurate records must be kept in order to have available data on each patient’s dental

assessment, services rendered, and the effectiveness of the overall program.

**X. EMERGENCY SERVICES**

Dental emergency treatment is NOT within the scope of the public health dental hygienist. Assessment of possible dental emergency by the dental hygienist should result in a referral to a close-by dentist for immediate treatment of the emergency. The progress notes in the dental record should reflect the fact that the patient presented to the service site with an emergency condition and to whom the referral was made by the hygienist. It is also not within the scope of practice of a public health hygienist to extract primary teeth near natural exfoliation.

**XI. ASSESSMENT SERVICES**

A proper patient assessment consists of the patient’s state of oral health and the existence of any

abnormal condition including the causes and type of condition. The primary assessment tools are the dental history, medical history, caries risk assessment and clinical recording of visual assessment of the mouth and surrounding structures. The dental hygienist is responsible for obtaining adequate medical and dental histories for each patient. The medical history should be updated at each appointment and any change noted in the electronic health record. Any condition that may affect dental treatment is to be noted on the progress notes as well.

The scope of practice for a public health registered dental hygienist is limited to those patients that can be assessed as an “ASA Category I” or an “ASA Category II” patient. Others with a health status beyond these categories are not within the scope of a public health dental hygienist and should be referred to a dentist to oversee the care of these patients. If there is a question or compromising condition, the patient’s physician will be consulted. The new AHA Guidelines no longer require Prophylactic Antibiotics for an individual with a history of rheumatic fever.

A thorough intraoral assessment of the hard and soft tissues and extraoral ~~examination~~ assessment of the head and neck should be performed on all patients at an initial visit.

Findings for each tooth and its defective surface(s) should be recorded on the patient

Charting record.

**XII. PREVENTIVE SERVICES**

Ideally, dental prophylaxis, pit and fissure sealants, oral hygiene instruction, application of

fluoride varnish, and charting are performed at the preventive visit.

SEALANTS

The majority (90 percent) of dental caries in the permanent dentition of school-aged children is

located in pits and fissures. Numerous clinical studies have demonstrated that sealants are a safe

and long-term method of *preventing pit and fissure caries*. The use of dental sealants is a logical

approach for further improvement in children’s oral health.

Pit and fissure sealants should be applied routinely in public health dental ~~clinics~~ programs. Indications for

sealants include:

Recently erupted teeth with well-defined morphology

Individual/family history of past caries experience, and

Children at high risk for developing caries.

Contraindications for pit and fissure sealants have been defined as:

1. Presence of changes in color, consistency and contour suggestive of underlying decay
2. Occlusal table is not fully erupted

FLUORIDE SUPPLEMENTATION

The use of dietary fluoride supplements is one alternative method of providing fluoride

protection to the teeth of children, six months old thru 16 years of age, who consume fluoride deficient water with 0.8 ppm fluoride or less. Dietary fluoride supplements, in the form of daily tablets, drops, or vitamin-fluoride combinations, provide systemic benefits to developing teeth as well as topical benefits to erupted teeth.

When prescribed and used appropriately, fluoride supplements provide benefits similar to those

obtained from ingesting optimally fluoridated water over the same period of time. When

improperly prescribed, fluoride supplements may cause **mild** enamel fluorosis. Therefore,

systemic fluoride supplements should never be prescribed to children in fluoridated communities

who are receiving optimally fluoridated water (currently .7 ppm fluoride).

Because of an increase in the milder forms of dental fluorosis associated with fluoride ingestion

in excess of that necessary to prevent tooth decay, a conservative approach to fluoride

supplementation should be used in accordance with the revised guidelines listed in the protocols for public health hygiene programs as well as public health nursing programs. This protocol reviews the necessity of water testing, the submission of the water for testing and the resulting supplementation recommended and supplied upon receipt of the test for fluoride content. As described in the protocol, water testing is at no cost to the child, their family or the health department assisting in appropriate supplementation. Also, the supplements are provided to the family at no cost to that family or the health department.

FLUORIDE VARNISH APPLICATION

Dental hygienists are to follow the detailed protocol found both in the hygiene section of the CCSG and the public health nursing section of the CCSG relative to the application of fluoride varnish to patients.

**XIII. REFERRALS**

At a minimum, dental public health programs should provide comprehensive oral assessment and oral disease preventive services for those patients that fall within the scope of practice for a public health dental hygienist. It is important for all patients in a public health preventive program be referred to a local dentist for the establishment of a dental home. The public health preventive dental program is designed to be effective in the delivery of preventive services and patient education, but doesn’t take the place of the “Dental Home.”

The American Academy of Pediatric Dentistry defines the dental home as “the ongoing relationship between the dentist and the patient, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way. Establishment of a dental home begins no later than 12 months of age and includes referral to dental specialists when appropriate.” (<http://www.aapd.org/media/Policies_Guidelines/D_DentalHome.pdf>)

Each public health dental program will develop and maintain a list of local dental providers that can accept the program’s referrals into their practice. Such lists should be updated often as providers move in and out of a service area and make changes in the patients they accept.

“General Referral” is a routine referral that is made to the patient or legal guardian when no urgent needs are assessed. The establishment of a dental home for this patient results in a relationship in which routine preventive, restorative and surgical care is provided on a regular basis.

“Urgent Referral” is one in which the public health registered hygienist must work to move a patient with urgent dental needs into care in a swift and appropriate manner. This may include more assertive contact with the patient or the legal guardian, navigating the patient to a place of treatment and follow up that the treatment was, in fact, completed. A tickler system that is part of the current electronic health records is appropriate to use in this case.

Although basic hygiene training includes patient behavior management, it is recognized that uncooperative children will need to be referred on occasion to pediatric dentists.

All referrals for medical/dental consultation or treatment will be documented in the patient’s progress notes.

**XIV. QUALITY IMPROVEMENT REVIEW INSTRUMENT**

**AND**

**QUALITY ASSURANCE REVIEW INSTRUMENT**

**AND**

**GUIDELINES AND CRITERIA**

**FOR**

**STANDARDS OF ACCEPTABLE QUALITY**

**PUBLIC HEALTH DENTAL HYGIENE PROGRAMS**

**GUIDELINES AND CRITERIA FOR STANDARDS OF ACCEPTABLE QUALITY PUBLIC HEALTH DENTAL HYGIENE**

**DENTAL RECORD REVIEW (10 Records must be Reviewed)**

**PERFORMANCE AND DOCUMENTATION OF THE MEDICAL/DENTAL HISTORY**

1. A *Consent and Health History for Preventive Services and a Clinic Oral Health and*

*Service Record* are completed for each patient seen in the dental program, using the most current versions.

2. Key patient identification information (address, phone number, emergency information, and source of payment) is located in the patient chart.

3. The medical history contains **no** unanswered questions.

4. Medical conditions or medications requiring an alert are flagged. Alerts are to be flagged using appropriate stickers for Med Alerts and Allergies Stickers or red annotations are to be placed on the Clinic Oral Health Service Record.

5. The consent/medical history is signed and dated by the patient or parent/guardian and the

hygienist.

6. The medical history is updated at each appointment, and any change is noted on the progress notes.

**B. PERFORMANCE AND DOCUMENTATION OF THE PATIENT EXAMINATION**

1. Written (signed) consent for preventive services is obtained for all patients. Patient’s name must be clearly identified on the form.

2. Blood pressure recordings are taken at the initial visit of adult patients and prior to all surgical, invasive or stressful procedures.

3. Oral conditions including restorations, suspicious areas indicative of possible caries, periodontal status, oral hygiene status and any other pertinent observations are recorded for each patient undergoing preventive care.

4. Charting of the examination findings are completed in the appropriate chart utilized in the program.

**D. SERVICES**

The service plan for each patient is based on the history and assessment of the patient.

Preventive Services should follow a logical sequence. Normally, with minor variations, this is:

1. Caries Risk Assessment

2. Oral Assessment and Charting

3. Services Planning

4. Prophylaxis

5. Oral hygiene instruction

 Nutritional Counseling and Tobacco Use Assessment and Counseling, where appropriate

 6. Sealant Placement

 7. Fluoride Varnish

 8. Referral to Local Dental Home

**E. PROGRESS NOTES**

1. All progress notes are legible, dated, and signed by the hygienist on the date of service

in blue or black ink, using the provider’s legal signature, along with credentials (RDH).

2. All progress notes are in chronological sequence.

3. Documentation of services (treatment) rendered contains the following at a minimum:

(see example below)

a. Date of service

b. Description of the service

c. Materials used, if any – i.e. Sealant material or Varnish type

d. Additional comments on referrals, and/or post-visit instructions

4. Standardized charting of preventive services is completed in the appropriate chart

5. Broken appointments are documented in the progress note.

6. Copies of all correspondence from other providers are kept in the patient’s chart.

7. A plan for the next visit (if needed) is included in the progress notes.

8. Errors should never be corrected with white out. A line should be drawn through the mistake to avoid the impression that a record may have been altered.

**F. ~~PSRS~~ VERIFICATION OF ENCOUNTER** One encounter/patient record reviewed

1. Correct provider numbers are listed for this DOS.

2. Correct program codes are posted for this DOS.

3. Correct services and procedure codes are posted for this DOS per PSRS CDT Codes Manual and ADA Standardized Codes.

**GUIDELINES AND CRITERIA FOR STANDARDS OF**

**ACCEPTABLE QUALITY PUBLIC HEALTH DENTAL HYGIENE SERVICES**

**QUALITY OF PATIENT CARE SERVICES**

**A. ASSESSMENT**

1. **An initial or recall assessment is conducted on all patients.**

2. A proper assessment consists of the patient’s state of oral health and the suspected existence

of any pathology or abnormal condition including the causes and type of the pathology or abnormal condition. The primary tools are the history and clinical assessment.

3. Patients with suspected periodontal disease are informed of their periodontal possibilities,

and appropriate referrals are made for consultation and treatment.

4. The preventive plan for each patient is appropriate and is based on the history.

**Direct Observation of Patient Care QA review must include at least three patients of that site’s preventive dental program.**

1. Services include appropriate preventive procedures for each patient consenting to the program.

2. Professional prophylaxis, which removes plaque, extrinsic stains, and calculus, is performed at regular intervals appropriate to the individual.

3. Caries prevention in children includes, when appropriate, topical fluoride varnish, sealants, oral hygiene instruction and appropriate behavioral counseling (nutrition and/or tobacco use).

**INFECTION CONTROL**

# This program requires and monitors through quality assurance strict adherence to the current CDC *Guidelines for Infection Control in Dental Health-Care Settings*

1. Dental unit waterlines to all instruments (prophylaxis handpiece and air/water syringe) are flushed for one minute at the beginning of the each clinic day and for a minimum of 20-30 seconds after use on each patient. Dental unit waterlines must be treated with appropriate products (i.e. Sterilex), and all water monitoring recommendations must be

adhered to.

2. Critical and semicritical instruments – After thorough cleaning, all heat-stable Instruments, including handpieces, are heat sterilized. Handpieces, to include low speed attachments & motors *must be sterilized between patients*.

3. Noncritical instruments - After thorough cleaning using the Ultrasonic cleaner, all instruments and medical devices receive intermediate or low-level disinfection.

4. Disposable covers and disposable supplies are used whenever possible. Disposable items are never reused.

5. Hands are washed thoroughly before and after treatment of each patient with antimicrobial soap or hand sanitizer.

6. Protective attire (gloves; masks; and eye, face protection) is worn, by the dental staff.

**QUALITY ASSURANCE INSTRUMENT FOR**

**DENTAL HYGIENE RECORD REVIEW**

**Kentucky Department for Public Health**

**Oral Health Program**

 Chart Number

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Criteria |  |  |  |  |  |  |  |  |  |  |
| I. Medical and Dental History |  |  |  |  |  |  |  |  |  |  |
| Oral Assessment and Record Current |  |  |  |  |  |  |  |  |  |  |
| Patient Information Reviewed by Provider |  |  |  |  |  |  |  |  |  |  |
| Health History Reviewed |  |  |  |  |  |  |  |  |  |  |
| Conditions Identified and Flagged for Easy Identification |  |  |  |  |  |  |  |  |  |  |
| Signed and Dated |  |  |  |  |  |  |  |  |  |  |
| History Updated, When Appropriate |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
| II. Patient Oral Assessment |  |  |  |  |  |  |  |  |  |  |
| Consent for Treatment |  |  |  |  |  |  |  |  |  |  |
| Blood Pressure on Adults over 19 |  |  |  |  |  |  |  |  |  |  |
| Oral Conditions |  |  |  |  |  |  |  |  |  |  |
| Charting Completed |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
| III. Services |  |  |  |  |  |  |  |  |  |  |
| Appropriate |  |  |  |  |  |  |  |  |  |  |
| Treatment Sequence |  |  |  |  |  |  |  |  |  |  |
| Post-Service Instructions Given |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
| IV. Referral to Dental Home |  |  |  |  |  |  |  |  |  |  |
| Referral Resources Given to Patient |  |  |  |  |  |  |  |  |  |  |
| Urgent Referral Documented with End Result in Progress Notes |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
| V. Progress Notes |  |  |  |  |  |  |  |  |  |  |
| Complete, Dated and Signed |  |  |  |  |  |  |  |  |  |  |
| Chronological |  |  |  |  |  |  |  |  |  |  |
| Date of Service |  |  |  |  |  |  |  |  |  |  |
| Nature of Service |  |  |  |  |  |  |  |  |  |  |
| Sealant |  |  |  |  |  |  |  |  |  |  |
|  Tooth Identified |  |  |  |  |  |  |  |  |  |  |
|  Material Recorded |  |  |  |  |  |  |  |  |  |  |
| Varnish |  |  |  |  |  |  |  |  |  |  |
|  Material Recorded  |  |  |  |  |  |  |  |  |  |  |
|  Reason If Declined |  |  |  |  |  |  |  |  |  |  |
|  Post Service Instructions Provided |  |  |  |  |  |  |  |  |  |  |
| Broken Appointments |  |  |  |  |  |  |  |  |  |  |
| Corrections |  |  |  |  |  |  |  |  |  |  |
| Additional Information |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
| V. Verification  |  |  |  |  |  |  |  |  |  |  |
| Correct Provider Number Posted for this Date of Service |  |  |  |  |  |  |  |  |  |  |
| Correct Program Codes Posted for the Date of Service |  |  |  |  |  |  |  |  |  |  |
| Correct Service and Procedure Codes Posted for the Date of Service |  |  |  |  |  |  |  |  |  |  |
| Additional Services or Procedures Billed As Documented |  |  |  |  |  |  |  |  |  |  |

**QUALITY ASSURANCE INSTRUMENT FOR**

**DENTAL HYGIENE DIRECT OBSERVATION OF PATIENT SERVICE**

**Kentucky Department for Public Health**

**Oral Health Program**

 Chart Number

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Criteria |  |  |  |  |  |  |  |  |  |  |
| I. Medical and Dental History Reviewed |  |  |  |  |  |  |  |  |  |  |
| Patient Information Reviewed by Provider |  |  |  |  |  |  |  |  |  |  |
| Health History Reviewed |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
| II. Patient Oral Assessment |  |  |  |  |  |  |  |  |  |  |
| Consent for Treatment Recognized |  |  |  |  |  |  |  |  |  |  |
| Blood Pressure on Adults over 19 |  |  |  |  |  |  |  |  |  |  |
| Charting Observed as Completed |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
| III. Services |  |  |  |  |  |  |  |  |  |  |
| Appropriate |  |  |  |  |  |  |  |  |  |  |
| Treatment Sequence |  |  |  |  |  |  |  |  |  |  |
| Fluoride/Sealants Provided |  |  |  |  |  |  |  |  |  |  |
| Post-Service Instructions Given |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
| IV. Referral to Dental Home |  |  |  |  |  |  |  |  |  |  |
| Referral Resources Given to Patient |  |  |  |  |  |  |  |  |  |  |
| Urgent Referral Documented with End Result in Progress Notes |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
| V. Infection Control |  |  |  |  |  |  |  |  |  |  |
| Water Lines Flushed |  |  |  |  |  |  |  |  |  |  |
| Critical and Semi-Critical Instruments Properly Attended |  |  |  |  |  |  |  |  |  |  |
| Non-Critical Instruments Properly Attended  |  |  |  |  |  |  |  |  |  |  |
| Environmental Surfaces Properly Disinfected |  |  |  |  |  |  |  |  |  |  |
| Disposables Properly Managed |  |  |  |  |  |  |  |  |  |  |
| Waste Properly Managed |  |  |  |  |  |  |  |  |  |  |

**XV. INFECTION CONTROL POLICIES AND PROCEDURES**

**INTRODUCTION**

Percutaneous or permucosal exposure of dental personnel and patients to pathogenic microorganisms (viruses or bacteria) can cause infections that lead to debilitating or life-threatening diseases. In order to prevent or minimize the risk of transmitting disease occupationally, dental health care workers (DHCWs) should practice **STANDARD PRECAUTIONS** – an approach to infection control that assumes all human blood and certain body fluids are infectious for HBV, HCV, HIV, and other bloodborne pathogens. In addition, DHCWs should adhere to practical infection control practices including recommended

immunizations, personal protective equipment, sterilization, and disinfection. This practical approach to infection control, whether in a health department setting or in a portable dental care environment, requires commitment on the part of the entire dental hygiene team as well as availability of appropriate support including expertise, training, and adequate resources. All public health dental staff should routinely practice and adhere to the infection control policies, recommendations, and guidelines from the Centers for Disease Control and Prevention (CDC) and the Occupational Safety and Health Administration (OSHA). Although the dental environment may never be pathogen-free, well-trained, committed, and knowledgeable staff can significantly reduce the likelihood of occupational disease transmission.

**CHECKLIST FOR PREVENTIVE DENTAL PROGRAM WORKERS**

**Immunization**

All dental hygienists and dental assistants including part-time, and contractual who have patient contact and are at risk of effective exposure, shall be offered the Tetanus Vaccine. Dental Health Care Workers are at risk for exposure to and possible transmission of vaccine-preventable diseases; accordingly, vaccination against influenza, measles, mumps, rubella & tetanus may be appropriate for DHCW’s.

Hepatitis B Vaccine is made available, at no cost, to all employees who have occupational exposure to blood or other potentially infectious materials within 10 working days of assignment. (Federal Register Vol. 56 #235) (HSA Policy 8.2b). “At Risk” employees must sign an OSHA approved Declination Form if the choice is not to receive Hepatitis B Vaccine. (HSA Policy 3.9 & 8.2b)

All employees, including part-time and contractual, who have patient contact and are at risk of other effective exposure, shall be screened for Tuberculosis. (HSA Policy 8.2a) The Regional Health Officer shall determine the risk of effective exposure. -At the time of employment, or when employees are assigned to an area where they will have patient contact which could result in effective exposure, they shall receive a tuberculin skin test.

The skin test may be given at the health department at no cost to the employee.

-Employees identified as positive reactors at the time of employment or assignment to an area where they will have patient contact should receive a chest x-ray and be considered for preventive therapy.

- Employees who have patient contact and have a negative tuberculin test must have a tuberculin test at intervals adopted by the employing health department as long as the skin test remains negative.

- Employees who convert from negative to positive at any time after the initial test must be evaluated by the employing health department’s TB Program. If treatment of disease

or preventive therapy is indicated, it should be prescribed and monitored as with any other patient.

All dental hygienists, and dental assistants including part-time, and contractual, who have patient contact and are at risk of effective exposure, shall be offered the tetanus vaccine. At the

time of employment, or when the Tetanus booster needs to be updated, dental hygienists, and dental assistants shall receive the tetanus vaccine at no cost to the employee. If an employee refuses immunization, a refusal statement must be signed and placed in her/his personnel file.

**Before Patient-Based Preventive Services**

1. Review patient identification and medical history.

2. Flush all dental unit waterlines for one minute at the beginning of each day as well as 20-30 seconds after each patient.

4. Place disposable coverings to prevent contamination of surfaces or disinfect surfaces after treatment.

**During Patient Services**

1. Treat all patients as potentially infectious (i.e., practice standard, universal precautions).

2. Use protective attire and barrier techniques when contact with body fluids or mucous membranes are anticipated.

Wear gloves

* Wear a mask

 Wear protective eyewear

3. Use single-use, disposable items whenever possible.

4. Minimize the formation of droplets, spatters, and aerosols.

5. Use high-volume vacuum evacuation when appropriate.

6. Protect hands.

 Wash hands before gloving and after gloves are removed

* Change gloves between each patient
* Discard gloves that are torn, cut, or punctured

 Avoid hand injuries

7. Avoid injury with sharp instruments.

Handle sharp items carefully

**After Patient Preventive Services**

1. Clean instruments thoroughly.
2. Sterilize instruments.

Sterilize, whenever possible, all instruments that come into contact with oral mucous membranes, body fluids, or those that have been contaminated with secretions of patients. Otherwise use appropriate disinfection.

Monitor the sterilizer weekly with biological monitors. Place chemical indicator strips in packages prior to sterilization.

1. Clean handpieces and flush dental unit waterlines.

Flush handpieces, dental units and air/water syringes for 20-30 seconds between patients.

Clean and sterilize air/water syringe; otherwise, disinfect them.

Clean and sterilize low speed attachments and motors between patients.

1. Decontaminate environmental surfaces.

Wipe work surfaces with absorbent towels to remove debris and dispose of towels appropriately.

Disinfect with appropriate chemical disinfectant.

Change protective coverings on light handles, x-ray unit, and other items betweeen patients.

 5. Remove contaminated wastes properly.

Pour blood, suctioned fluids, and other liquid waste into drain connected to a sanitary sewer system.

Place solid waste contaminated with blood or saliva in sealed, sturdy, impervious bags; dispose according to local government regulations.

 6. Remove gloves and wash hands.

**SCREENING AND REFERRAL PROGRAMS**

Any dental screening and referral program or oral health survey designed for children or adults has need for adequate infection control protocols to assure that no cross-contamination occurs between the dental staff and the population being screened. Public health dental hygiene programs maintain a higher profile (i.e., a more visible role) in the community than the private sector because of school-based prevention programs and oral health promotion programs. Therefore, dental public health professionals should serve as role models in practicing and promoting sound infection control practices. At a minimum, these infection control protocols will include the following:

A. Precautions

1. Place used tongue blades in a trash bag and dispose of them properly. Place used mouth mirrors in an appropriate container with disinfecting solution until such time that the mirrors can be cleaned, bagged, and sterilized.

2. It is recommended that recording be done by another person. If this is not possible, you must ensure that all Infection Control Protocols are followed to prevent any cross-contamination.

B. Proper Handling of Waste

It is not practical or necessary to treat items that have had contact with saliva as infectious from the standpoint of requiring special waste disposal precautions. (MMWR, Dec 19, 2003, Vol. 52, No. RR17). Solid waste materials contaminated with saliva should be disposed of in the same

manner as with other solid wastes.