


DENTAL SERVICES TECHNICAL MANUAL

HEALTH SERVICES

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ARIZONA DEPARTMENT OF CORRECTIONS
January 1, 2010

 <p>ARIZONA DEPARTMENT OF CORRECTIONS</p>	<p>ER: 1100</p> <p>HEALTH SERVICES</p>	<p>OPR:</p> <p>H. S. D.</p>
<p>DENTAL SERVICES TECHNICAL MANUAL</p>	<p>DEPARTMENT ORDER: 1103</p> <p>INMATE DENTAL HEALTH CARE</p>	<p>SUPERSEDES: April 1, 2000</p> <p>EFFECTIVE DATE: January 1, 2010</p>

The pursuit of excellence in the care of inmates is a goal that requires objectivity, openness to change, creativity, critical abilities, and support and participation from all levels of the medical staff. This manual has been developed to serve as a guide for the correctional healthcare employees in pursuit of this goal. The contents should be considered as standards or procedures to best manage the dental program.

A special thanks to all the healthcare professionals who spent considerable time and effort and who provided valuable information and review.

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Interim Division Director
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Date

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Date

This manual has been published by the Dental Technical Manual Committee of the Arizona Department of Corrections, Health Services Division. Copies of all or part of this publication are permitted with the written permission of the Dental Program Manager.

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The purposes for the Dental Technical Manual is to:

1. Standardize procedures among facilities of the Arizona Department of Corrections.
2. Provide training for new hires.
3. Be a reference for staff.

Therefore, this manual is intended to promote a common understanding and to reduce the need to reorient inmates and/or retrain staff on operating procedures as they move and/or communicate within the Arizona Department of Corrections.

The development of standardized operating procedures will:

- a) Improve the continuity of dental care, communication and understanding with allied services.

Increase the efficiency and productivity of the dental staff thereby reducing operating costs.

- c) Enhance training and produce a more positive and cooperative atmosphere among staff and with inmates in the provisions of dental services.

This manual is to be taken as a directive and is an ideal standard toward which all should strive. The ability to meet this standard will depend on numerous factors, such as funding, staffing, physical resources, geographical location, etc., some of which are not within the dentists control.

It is not intended to preclude the professional judgement of the dentist.

This manual will be reviewed annually and updated as is necessary.

Health Services Mission Statement:

To provide constitutionally mandated health care to the inmate population in the custody of the Arizona Department of Corrections

Dental Services:

The mission of the Arizona Department of Corrections Dental Section is to provide quality, cost effective, dental health care to those incarcerated within an Arizona Department of Corrections facility, as required by law.

The U.S. Supreme Court, in its landmark decision of 1976 (*Estelle vs. Gamble*, U.S., 97 S. Ct. 285) established in the inmates' constitutional right to adequate health care under the Eighth Amendment. This decision has had a major impact on the delivery of health care in correctional institutions.

Court decisions resulting from inmate litigation have declared that unreasonable deprivation for medical and dental care is unconstitutional. The subsequent rulings assert that a states' failure to provide adequate medical and dental services is a violation of the rights of prisoners under the eighth amendments of the constitution which prohibits "cruel and unusual" punishment.

In today's litigious environment and with many court rulings to support the right of inmates access to medical and dental care it is imperative that a correctional dental program be geared to meet or exceed the standards set forth by such agencies as the American Public Health Association, The American Medical Association, The American Dental Association, The American Correctional Association, The National Institute of Law Enforcement and Criminal Justice and the Law Enforcement Assistance Administration.

Two critically important principles in the American Public Health Association Standards for Health Services in Correctional Institutions are:

That adequate health care for incarcerated individuals is a public responsibility to be borne jointly by the criminal justice and health care systems.

The level of health care service for those incarcerated should be of a standard comparable to that available to the community at large.

PRIORITIES

The following priority system has been developed to fairly and compassionately deliver dental care to those incarcerated in ADC.

Priority 1- (Emergency Care) - Requiring immediate assessment and/or such as:

Postoperative uncontrolled bleeding.

Facial swelling that is of a life threatening nature or is causing severe

facial deformity;

Fracture of the mandible, maxilla, or zygomatic arch;

Avulsed dentition;

Extreme pain that is non-responsive to the implementation of dental treatment guidelines; or Intraoral lacerations that require suturing to include the vermilion border of the lips.

Priority 2 - (Urgent Care) - Treatment necessary subsequent to the implementation of dental treatment guidelines such as:

Fractured dentition with pulp exposure;

Acute dental abscess;

Oral pathological condition that may severely compromise the general health of the inmate;

acute necrotizing ulcerative gingivitis (ANUG).

Priority 3 - (Routine Care) Conditions that require treatment to restore the form and function of an inmate's oral tissues and are not solely elective nor cosmetic in nature such as:

Caries;

Chronic periodontal conditions;

Non-restorable teeth;

Edentulous and partially edentulous patients requiring replacement (see Dental Procedure 77);

Presence of temporary, sedative, or intermediate restorations;

Non-functional broken prosthetic appliance if patient qualifies. (see 77)

Priority 4 - (Elective Care)

Incipient caries

TMJ disorders

Periodic examinations

Gingival recession/root sensitivity

Broken prosthetic appliance that remains functional.

Priority 5 - (Exempt Conditions) Those conditions that do not fall in the above categories and ARE NOT provided by ADC:

Fixed prosthodontics (crown and bridge).

Orthodontics

Removal of asymptomatic third molars or impactions without pathology;

Treatment of discoloration, stains, cosmetic defect.

Ridge augmentations, vestibular extensions/implants.

Routine Dental Prophylaxis.

OBJECTIVES

The ultimate clinical objectives of the dental care program are that inmates:

Are free of acute infection.

Have sufficient masticatory function so that eating, and general health of the inmate is adequately maintained.

Free from acute active dental disease.

Have a knowledge of basic oral hygiene in order to be able to practice self care and prevention.

Obviously, as long as inmates are continuously entering and leaving the correctional system, it will be impossible to completely satisfy these ultimate clinical objectives for every inmate. Most dental diseases are due to neglect of proper maintenance, the ultimate success of any dental program, public or private, lies in the degree/commitment and motivation exhibited by the patient to achieve that level of success.

PURPOSE

To provide administrative direction on all actions relating to the recruiting and hiring of prospective applicants for Health Services Division, employee performance, training and leave.

RESPONSIBILITY

It is the responsibility of the FHA to ensure that all personnel actions are in accordance with ADC Department Orders and Personnel Rules.

Performance Appraisal for Correctional Employees (PACE)

- (1) PACE is the process of evaluating an employee's performance in accordance with the Department of Administration PACE Administrative Manual. (Refer to Directors Instructions #30, Performance Appraisal For Correctional Employees)
- (2) The FHA is responsible for ensuring that every Health Services employee has current PACE document.
- (3) The FHA shall take into consideration PACE input by the respective Program Manager when completing PACE reviews on employees which the FHA supervises.

Training

- (1) The Department mandates a specific number of training hours for each employee yearly. Training requirements and hours may vary from year to year.

The FHA is responsible for ensuring that each new employee receives New Employee Orientation within sixty (60) days of hiring in accordance with ADC Department Orders 509 Employee Training and Education.

- (1) The FHA is responsible for ensuring that all facility health staff meet the annual training requirements.
- (2) If there is a need to develop training at the local health unit level to address a specific need, this can be done, however, all such training must be

approved by the Division Director, Health Services, prior to being implemented.

- (3) The new employee will view the ADC, Health Services, Orientation videos, especially Dental Services.

Leave Approval

- (1) The FHA is responsible for approving all annual and sick leave for those employees directly supervised by them.
- (2) The FHA shall monitor all leave requests of subordinate staff ensuring the maintenance of adequate coverage.

Industrial Injury/Short Term Disability/Long Term Disability/Family Medical Leave Act (Refer to Department Order 519, Employee Health Assessment, Accommodation, Alternate Assignment).

- (1) The FHA is responsible for approving all extended leave with or without pay up to 80 hours, and to ensure that FMLA has been offered to all employees who qualify.
- (2) All documentation shall be routed through Health Services Division Central Office for approval/disapproval of Division Director and for tracking purposes.

Overtime and Compensatory Time (Refer to Department Order 512, Employee Assignments and Work Hours, Compensation and Leave).

- (1) The FHA is responsible for ensuring that all non-emergency overtime or compensatory time is approved in advance of the work to be performed.
- (2) The FHA, in conjunction with the Dentist Supervisor, is responsible for reviewing all compensatory and overtime to determine if scheduling changes can be made.

CHAPTER 6 OFFICE DESIGN - EQUIPMENT AND SUPPLIES

**ARIZONA DEPARTMENT OF CORRECTIONS
DENTAL SECTION
STANDARDIZED DENTAL EQUIPMENT LIST 1999**

AMALGAMATOR, DENTAL

Digital timer
capsule cover
separate mulling button
time adjustment
Wt.= 9 lbs.

Crescent MSD 002-020

CASSETTE, DENTAL, INSTRUMENT

Lightweight Sterilon 2000 resin
Internal rail system with positioners
12 inst. capacity
11" X 8" X 1 1/2"
Loose parts section
Sterilized by steam, chemical vapor or gas(EtO)
Double latch, triple hinge
With small parts box and bur stand with hinged lid
Hu-Friedy IMS 1112 with IMS 1271 & 1272

CASSETTE, DENTAL, PROPHY/EXAM INSTRUMENT

Stainless steel
7 inst. capacity
8" X 4 1/2" X 1 1/4"
Sterilized by steam, chemical vapor or gas(EtO)
Internal rail system with positioners

CHAIR, DENTAL PATIENT

All steel construction
Multi-function foot control- five chair positions
Hydraulically controlled lift
Sliding armrests
Adjustable double articulating headrest

Automatic return
Chair rotates right or left 30 degrees with positive lock disc break
Smooth, SEAMLESS, button-free upholstery
Seat height 15" to 37"
ETL listed, CSA certified, ADA accepted.

Pelton & Crane Spirit 2000

AIR COMPRESSOR, DENTAL, TWIN HEAD

Twin head, oil-less ultra-dry dental air.
Positively vented crankcase and finned cylinder housing
Fan cooled
Built-in air drying system with purge tank
Stainless steel drying chamber
Purge control
Twin motors - HP
Sound reducing cover
208/230 Volts
8 Amps Full load
29" X 33" X 32" dimensions with cover
300 lbs. Shipping weight
12 Gal. tank size stores dry air
4.8 CFM peak
2.7 CFM continuous

AIR TECHNIQUES **AirStar 30C**

AIR COMPRESSOR, DENTAL, SINGLE HEAD

Single head oil-less ultra-dry dental air.
12 gal. tank
Fan air cooled head
Sound reducing cover
Built-in air drying system with purge tank
115 Volts
Full load amps - 15
_HP single motor
4.6 CMF peak
2.6 CMF continuous
250 lbs. shipping weight
28" X 33" X 32" with cover

Air Techniques **AirStar 21C**

CONSOLE, TREATMENT CABINET

High quality particle board covered and sealed with colored laminate.

Standard configuration

Touch latches on draws

Task lighting

5 outlet power strip

Full size x-ray view box

42" total width

72" high

15" high top storage unit w/o pass through

Assistants pull-out work top

33" from pull-out surface to floor

32" deep

Euro Design ETI SB

CONSOLE, DENTAL DIVIDER

Particle board core covered with colored plastic laminate

Storage hutch **with locks installed**

Two drawer sections

Deluxe 5 drawer section

Standard 4 drawer section

Drawers **with locks installed**

Wash station incl. sink, faucet and hardware

Foot control for faucet

Duplex electrical outlet in X-ray wall

X-ray wall w/extended counter and privacy panel

71" H x 21" W x 88" L

Euro Design SP4

CONSOLE, DENTAL ASS'T ACCESSORY CABINET

Sink section on RIGHT

Particle board core covered with colored plastic laminate

Doors of wood/laminate

Standard 1 drawer section -

Wash station incl. sink, faucet and hardware

Foot-operated faucet

32" extended counter top work area

Drawer module under work area

36" H x 33" W x 18" D

CONSOLE, DENTAL DOCTOR'S ACCESSORY CABINET

Sink section on LEFT

Particle board core covered with colored plastic laminate

Doors of wood/laminate

Standard 1 drawer section -

Wash station incl. sink, faucet and hardware

Foot-operated faucet

32" extended counter top work area

Drawer module under work area

36" H x 33" W x 18" D

BIOTEC AC9-120

DELIVERY SYSTEM, DENTAL

Over the patient, chair mounted delivery system, EURO STYLE

No tools required for conversion from left to right hand.

CHAIR:

Auto-touch pad plus six-way programmable foot control.

Automatic patient positioning and return settings.

Patient support system operated from control panel or foot control.

Sliding arm rests (both arms).

Hygienic, seamless, upholstery.

60 degree rotation

Hydraulic base

ETL listed, CSA certified, ADA accepted.

Double articulating headrest

Five year warrantee

INSTRUMENT CONSOLE:

Over the patient Euro Style

Closed water system

Non-water retraction valves

Water purge system

Individual handpiece drive air adjustment

Touch pad control for chair and light

Three handpiece automatic control

Stainless steel instrument tray (9 3/4" x 13 1/2")

Rotating tray holder

Internal umbilical

Wet/dry disc foot control with 7' of tubing

3 way syringe, autoclavable with removable tip

Built in fiberoptics
LCM tubing for KAVO handpieces
Built in curing light

ASSISTANT INSTRUMENT ARM

Mounts to back of chair
Swivels side to side
High and low volume suction
3 way syringe

DENTAL EXAM LIGHT -

Unit mounted light arm
Variable intensity
Range of 4500 to 6000 oK

Doctors and Assistants stools included

MARUS Empire Ellipse EL-3 package

DENTAL DELIVERY SYSTEM, MOBILE CART TYPE

Doctor's cart

Individual handpiece air pressure adjustment
Nonretraction handpiece water coolant
Individual water coolant adjustment
Water coolant on/off toggles
Master shutoff
Three handpiece automatic control (max. 4)
3 way syringe
Disc type foot controller
96" lightweight umbilical
One fiberoptic high speed handpiece tubing, 5 hole Kavo
One fiberoptic reversible slow speed tubing, 5 hole Kavo
One standard tubing, 4 hole
Fiberoptic light source, 2 handpiece - Kavo LS or equal
Quick disconnect air and water lines
Electric outlet
Air and water filters and pressure regulators
Manual air and water shutoffs
Utility box and cover for umbilical connection
Adjustable height cart stand

ADEC **2562**

DENTAL DELIVERY SYSTEM, MOBILE CART TYPE

Dental Assistant's Cart

Covered storage organizers with frame
96" umbilical
Electric outlet
Air and water filters and pressure regulators
Manual air and water shutoffs
Utility box and cover for umbilical connection
Arm-mounted assistant's instrumentation
HVE valve with tubing
Saliva ejector tubing with tip valve
3 way syringe
Central vacuum solids collector
Arm mounted instrument tray/tub holder
Left/right convertible
Adjustable height cart stand

ADEC 2615

MICROENGINE, DENTAL LAB,

Micromotor lab handpiece
Power source 120 AC, 50/60 Hz
Speed= 0 - 35,000 RPM
Foot control
Electronic circuit breaker
Standard type handpiece with quick release chuck
Sealed ball bearings
Thermal overload protection

Schein Z-35 (823-0989)

FORMER, DENTAL VACUUM

110 VAC
All aluminum construction
Rocker type switches
Meets UL requirements
Locking screw for vertical tension

T&S Dental, M1

HANDPIECE CONNECTOR

Multiflex LUX coupler
snap-on coupler with 360 degree swivel
ISO Type B
5 hole
adapts 5 hole fiber optic tubing to fit a Multiflex LUX
handpiece, SONICflex scaler or an INTRAFlex LUX handpiece.

KAVO 553-1550

HANDPIECE, DENTAL, HIGH SPEED

Super Torque Lux 3 type
Standard head size
Operates at 30 to 33 psi
Speed range to 360,000 rpm
Cellular optic illuminating element, single outlet
3 port internal air/ water spray coolant
Autoclaveable and chemiclaveable
Push button auto chuck
Internal automatic pressure valve

KAVO 647B

HANDPIECE, DENTAL, LOW SPEED

Intraflex Lux 2 type
Reduction angle motor 2.7:1
Speed range to 13,000 rpm
Fiberoptic illuminating element
Internal water spray coolant
With Reverse
Quick twist removable heads
Autoclaveable
Connectable to Kavo Multiflex Reverse type tubing
Intraflex Lux Latch Head
Ratio 1:1 with push button auto chuck
With lubricating nozzles (2)

KAVO 2307LN Motor and 68LDN Latch Head

HANDPIECE, DENTAL, LOW SPEED STRAIGHT

Intraflex Lux straight reduction motor
with straight nose cone
2.7:1 reduction
Speed range to 13,000 rpm
Operates at 43 psi
Non fiber optic
Chucking for straight burs and mandrels
Internal water/spray coolant
With lubricating nozzles

KAVO 2313LN

HANDPIECE, DENTAL, SCALER

Air driven handpiece
Water cooling through tip
Sterilizable
With Universal, Perio and Sickle tips
Self tuning
360 degree quick disconnect swivel

STAR SW

HANDPIECE TUBING, DENTAL, FIBER OPTIC,

Designed to be used with Multiflex handpieces
5 hole tubing
straight
7' tubing with 9' bundle OR
10' tubing with 12' bundle OR
12' tubing with 14' bundle OR
6' tubing with 10' bundle .
black, brown or gray - specify

KAVO 6282258

HANDPIECE TUBING, DENTAL, FIBER OPTIC, REVERSE SLOW SPEED

Designed to be used with INTRAflex LUX Motors-REVERSE
5 hole tubing
straight
12' tubing with 14' bundle

KAVO Reverse Multiflex 905-7561

LATHE, DENTAL, LABORATORY

Heavy Duty

1/3 HP, 115 V , 60 Hz, 1 phase

Totally enclosed, non-ventilated, continuous duty

two speed motor 1725 / 3450 rpm

3 yr Warranty

with Wells type quick chuck

With two 14" X 12" X 10" metal splash hoods

with Sta-Klean Plexiglas shields, light and insert pans.

U.L. listed /CSA certified

Manual thermal overload protection

Industrial grade ball bearings, sealed

Rubber feet

Balanced rotor and shaft

Two winding construction M/R 200 deg. C moisture resistant copper wire

Baldor 380WCT

LIGHT, DENTAL, CEILING MOUNT

120 V AC

Single-track ceiling mount

Light intensity adjustable- 1500 to 2500 foot-candles

Color temp. between 3600 and 4300 deg. Kelvin

Quartz-halogen type lamp

3" X 8" feathered edge light pattern

Rated bulb life- 8000 hours

Autoclavable, removable handles

Dichroic-coated reflector

Front of light totally enclosed with Lexan shield

Gas/spring arm movement

Single pole, threaded support tube with set screws

PELTON & CRANE LFT IIT

LIGHT, DENTAL CURING

110 VAC

Power supply- 15 1/2" X 11 1/2" X 4 3/4"

Built-in radiometer

Balanced handpiece with start button trigger
Halogen bulb in handpiece
Automatic shut off
Time selector, 10-, 20-, and 60 second exposures
Audible beeper signals shut off
8mm 60 deg. angle probe
Eye protection shield attached to probe
Probes sterilizable by autoclave, dry heat or cold.
Optional curing probes available

Dentsply/Caulk Spectrum Curing Unit

STERILIZER, DENTAL

Fully automatic touch pad controls
4 preprogrammed settings select time, temp.and pressure
One button fill, heat, sterilize and vent
Microprocessor monitors each cycle
Processing time as fast as 15 min.
Remains cool to touch
Alarms to warn of improper operation. Auto shut off and vent
9 7/8" X 17 1/2" chamber size
Self diagnostic program
Complies with ETL and ASME standards
Large 4 1/2 qt. reservoir
Safety door latch
110 V

Pelton & Crane DELTA 10

STERILIZER, CASSETTE AUTOCLAVE

Cassette serves as sterilization chamber.
External size: 413 mm x 451 mm x 152 mm
Cassette dimensions: 20 cm x 30 cm x cm
Total capacity using instrument rack: 15 handpieces
Total capacity: 50 instruments
Water reservoir: 4 liters distilled water
Weight: 53 lbs.
Electrical: 110V, 60Hz, 1300 Watts
4 cassettes included

SciCan 101102

STERILIZER, DENTAL, HANDPIECE

Automatic Dental handpiece sterilizer
Electric 110V
Sterilization time: 16 min @ 121 deg. C
Canister type
Cassette rack with 6 cassette capacity
6 handpiece cassettes
Cassette lifter handle

KAVO Klave 900-1020

STOOL, DENTAL ASSISTANTS

16" round seat cushion
five leg base 22" diameter
large dual wheel casters
pneumatic seat height adjustment
fixed foot ring
one lever seat tilt and lumbar support adjustment
vinyl covering
Deluxe body support
21 1/2" to 27 1/2" height adjustment

NAPA Classic CA5 RP23

STOOL, DENTIST'S

rectangular seat cushion
five leg base 22" diameter
large dual wheel casters
pneumatic seat height adjustment
fixed foot ring
one lever seat tilt and lumbar support adjustment
vinyl covering
18" to 23" height adjustment

NAPA Classic CS-5SP1

TRIMMER, DENTAL MODEL

1/3 HP
Ball bearing
110 V AC

60 cycle motor
12 " grinding wheel- coarse
Swing open front housing
adjustable table
with water shut off solenoid installed

Buffalo 61790A/61901

ULTRASONIC, INSTRUMENT CLEANER

117 VAC
50/60 Hz
2.5 amps
300 Watts
Auto timer - 30 min.
On/off switch
Tank dimensions inside = 15 1/2" X 9" X 6"
Gal tank
On/off drain valve - side drain
Built in heater 140 - 150 degrees F
42 kHz 850 Watts peak power
Holds 3 Hu-Friedy IMS cassettes
Includes Drain Basket #13518 and Cassett Rack #15185

Sonix, SS140

VACUUM, DENTAL CENTRAL

Wet evacuation dual pump system
Twin 1 HP
205 V min / 240 V max
16A @ 230V
Vacume level 10" Hg
20-125 PSI pressure range
Operatory control switch
Two independent pumps
Steel cabinet with 2 external switches and gauge
Air/Water separator

Den-Tal-Ez, MC-202

VIBRATOR, DENTAL LAB

120 VAC, 60 cycle

Variable power control
Round table
Rubber pad

Buffalo Dental #1A

X-RAY FILM PROCESSOR, DENTAL

115 VAC, 60 Hz, 8 amp circuit
Plumbing hook up kit- option #1
Process all intra-oral and extra-oral films incl. 8" X 10"
Standard processing time= 5.5 min.
Endo process time= 2.5 min.
18"H X 15"W X 25"D
Stainless-steel immersion heaters
Built in microcomputer controlled temperature sensors
Touch control keypad
Centrifugal-circulating agitators
LED display indicates temperature of developer and fixer baths.
Automatic control of time, temperature, chemistry agitation and replenishment.

Panoramic Daylight loader

A/T2000xr

X-RAY FILM PROCESSOR, DENTAL

No plumbing required
Chemistry temperature automatically maintained at 75 deg.
Process time - 6 1/4 minutes.
Film sizes - #'s 0,1,2,3,4
Tank cap: Developer & fixer=1 qt. Wash= 1 1/2 qts.
Daylight Loader
Dimensions= 25" W x 9 3/4" D x 15 3/4" H
115 volts, 5 amps
Modular plug-in heater bar
Process switch with temperature ready light
Modular film transport

Peri-Pro II

X-RAY, DENTAL ORTHOPANTOMOGRAPH

Adjustable Form of the focal trough - narrow/broad arch, flat/protrusive setting for

incisors

Automatic film marking system

Self diagnostic system with displayed error codes

Central control panel with hygienic wipe-clean surface

Touch controls, digital display

Motorized patient positioning

Triple light beam positioning system

Constant potential x-ray generator, microprocessor controlled operating frequency
80kHz

Switching frequency 80kHz

Microprocessor allows for expanded functions

Focal spot of 0.6 X 0.6 mm

Total filtration - 2,5 mm AL

Anode voltage - 60 - 80 kV

Anode current - 4-12 mA DC

Film size - 15x30 cm

Flat rigid metal film cassettes

Line voltage - 110 V, 50 or 60 Hz

Line current - 20 A

Tube voltage 57 to 90 kV

Tube current 5 to 12 mA

Exposure time - 2,5-18 s

Automatic regulation

Constant magnification ratio

Weight - 108kg

INCLUDES 6 AUTOMATIC MARKING CASSETTES

Planmeca PM2002 CC

X-RAY, DENTAL, WALL MOUNT

Wall mount

4" cone

120 V, 60 Hz line voltage

11 amp line current

Digital timer microprocessor

Time variable from 0.01 to 0 seconds in 0.01 intervals

Tube current 7.0 mA DC

65 KV

Focal spot 0.8 X 0.8 mm

Filtration mm Al eq.

Automatic line voltage compensation

UL classified

Max. reach 74"

Remote control panel

MDT, HDX

ULTRASONIC SCALER

Operating frequency: 24,500 or 30,000 cps - operator selectable.

Weight: 35 oz

Size: 1 1/4" H, 5 1/2" W, 7" D

Power: 115V, 50/60Hz 110VA

Foot pedal turns unit off when foot removed

Two ways to adjust scaling power - traditional power control knob and a turbo button.

Includes ONE EACH CAVITRON 30K TFI-10, 30K TFI-1, AND 30K TFI-3 INSERTS.

Parkell D575

ULTRASONIC SCALER

115 V, 30kHz ultrasonic scaler

Automatic lock-on fine tuning system

Single position footswitch

Steri-Mate detachable sterilizable handpiece

Water connect tubing with 1/4" quick disconnect

Weight: 9 lbs.

Dimensions: 4"H x 7 3/8" W x 8 5/8" D

Includes ONE EACH CAVITRON 30K TFI-10, 30K TFI-1, AND 30K TFI-3 INSERTS.

Densply CAVITRON MODEL 3000

VACUUM, DENTAL, SINGLE HEAD

1 HP single motor

115/230 Voltage

16/8 full load amps

20-125 PSI pressure range

Vacume 10" Hg

Air Techniques VacStar2

DELIVERY SYSTEM, DENTAL, PORTABLE

PORTABLE II DENTAL DELIVERY SYSTEM

Complete portable modular dental unit; control, air/vacuum and compressor modules, high strength aluminum, baked on finish, to include:

A) Control module

Retractable automatic control panel for three handpieces with straight tubing.
Three handpiece automatic unit:

- 1) Kavo fiber optic high speed with tubing
Multiflex Lux 2 type
Operates at 30 to 33 psi
Speed range to 360,000 rpm
Cellular optic illuminating element, single outlet
3 port internal air/ water spray coolant
Autoclaveable and chemiclaveable
Connectable to Kavo Multiflex type tubing
Push button auto chuck
Internal automatic pressure valve
With lubricating nozzle
KAVO 640B

Kavo fiber optic low speed with tubing
Intraflex Lux 2, reduction angle motor 2.7:1
Speed range to 13,000 rpm
Fiberoptic illuminating element
Internal water spray coolant
With Reverse
Quick twist removable heads
Autoclaveable
Connectable to Kavo Multiflex Reverse type tubing
Intraflex Lux Latch Head
Ratio 1:1 with push button auto chuck
With lubricating nozzles (2)

KAVO 2307L MOTOR or equal
KAVO 68LDN HEAD or equal

Dental scaler with tubing
Air driven handpiece
Water cooling through tip
Sterilizable
With Universal, Perio and Sickle tips
360 degree quick disconnect
Self tuning

TITAN SW or equal

Air/Water 3 way syringe

- 2) High volume ejector
- 3) Saliva ejector
- 4) Variable foot control
- 5) X-ray view box
- 6) Air/Vacuum Module:
- 7) Self contained water system/500ml reservoir
anti-retraction coolant water with office hook-up.
- 8) High and low volume evacuation system
5-20" hg adjustable
overflow shut off
waste container: liter, 6" diameter
waste transfer system for in-office use

Compressor Module:

1.8 CFM, filter/separator
sound level: 40 dB(A)
oil free, dry air
aluminum air tank: 3 gal.
cooling system
100 % duty cycle for uninterrupted operation
hermetically sealed

Electrical:

110v, 60 Hz, load current 12.4 A max.
Hospital grade wiring, 15 A breaker

Assembled dimensions: 16"D x 18 1/2"W x 38"H

DENTAL Works, 2000

X-RAY, DENTAL, PORTABLE

Output: 7.5mA - 65kVp
Voltage: 120V, 60Hz, 11 Amp
Automatic line voltage compensation

Tubehead: 4.5 x 6.5 x 8.5 (inches)
Cone: 2" diameter, 6" long
Power cord length: 6 feet, hospital grade
Exposure cord length: 8 feet
Time range: .15 to 2 seconds
Built-in thermal overload protection
Carrying case
Mobile floor stand with carrying case
Weight of unit: 18 lbs.

Min Xray, P200D

LIGHT, DENTAL, PORTABLE

Halogen exam light
Chair mount
3300 candlepower
24" folding arm mount
20" gooseneck
carrying case

CompTech, 6033

CHAIR, DENTAL, PATIENT, PORTABLE

Tubular aluminum construction
Multi position back adjustment
Scissor base
Double articulating headrest with adjustable pillow cushion
Removable arms with support slings
Adjustable seat height: 10" to 31"
Vinyl upholstery
Standard color
Carrier

DENTAL Works, 4020, 40

STOOL, DENTISTS, PORTABLE

Adjustable lumbar support
5 castor base
Adjustable height: 18" to 23"
Integral gas cylinder height adjustment
Vinyl upholstery

18 lbs.
Carrying case

CompTech, 4110

STOOL, ASSISTANT'S, PORTABLE

Full body support arm with ratchet release

5 castor base

Adjustable height: 25" to 34"

Integral gas cylinder height adjustment

Adjustable foot ring

Vinyl upholstery

22 lbs.

Carrying case

CompTech, 4110

PRELIMINARY DENTAL SCREENING AND EXAMINATION AT THE INTAKE FACILITY

1. **PURPOSE:** To provide a procedure for the initial dental examination of inmates committed to the Arizona Department of Corrections (ADC).
2. **RESPONSIBILITY:** The Dental Program Manager and Dentist Supervisor at each facility will be responsible for compliance with the requirements of this procedure.
3. **PROCEDURES:**
 - 3.1 Each inmate, including parole violators, upon entry into ADC shall receive a dental screening by a dentist or qualified health care staff trained by the dentist within 7 days of admission.
 - 3.2 Each inmate, upon initial entry into ADC, shall receive within 30 days of arrival at ADC, either a panorex x-ray or a full mouth series (FMS) of x-rays.
 - 3.21 For those inmates not receiving a panorex or FMS at the Reception Center, it will be the responsibility of the next receiving facility to take the x-rays.
 - 3.22. Those inmates re-admitted to the system who have not been examined by a dentist in the last six months, will have a complete dental examination within 30 days of arrival in ADC. The examining dentist will determine the need for dental x-rays.
 - 3.3 All dental radiographs shall be reviewed by a dentist.
 - 3.4 For those inmates examined by a dentist at the intake facility, a dental chart will be completed per the dental charting procedure. (See: Dental Services Procedure 770.3)
 - 3.5 Those inmates who were **not examined by a dentist at intake facility**, will be examined by a dentist, at the receiving facility, **within 30 days of arrival at ADC**. The dental chart review procedure will be followed. (See: Dental Service Procedure 770.4)
 - 3.6 If the inmate refuses the initial or re-admission x-rays or examination, Refusal of Treatment form shall be completed.

DENTAL PROCEDURE 770.2

DENTAL CLASSIFICATION SYSTEM

1.0 **PURPOSE:** To provide a standard classification system for the prioritization of dental treatment provided to inmates.

2.0 **RESPONSIBILITY:** The Dental Program Manager and Dentist Supervisor at each facility will be responsible for compliance with the requirements of this procedure.

3.0 **DEFINITIONS:**

3.1 *Dental Classification System* - A system that establishes priorities of dental treatment based on dental conditions diagnosed by institutional dentists and established as a total dental treatment plan.

3.1.1 *Priority 1 - (EMERGENCY CARE)*

Requiring immediate assessment and/or treatment such as:

1. Postoperative uncontrolled bleeding;
2. Facial swelling that is of a life threatening nature or is causing facial deformity;
3. Fracture of the mandible, maxilla, or zygomatic arch;
4. Avulsed dentition;
5. An extremely painful condition that is non-responsive to the implementation of dental treatment guidelines
6. Intraoral lacerations that require suturing to include the vermilion border of the lips.

3.1.2 *Priority 2 - (URGENT CARE)* - Treatment necessary subsequent to the implementation of dental treatment guidelines such as:

1. Fractured dentition with pulp exposure;
2. Acute dental abscess;
3. Oral pathological condition that may severely compromise the general health of the inmate.
4. Acute Necrotizing Ulcerative Gingivitis.

3.1.3 *Priority 3 - (ROUTINE CARE)*

Conditions that require treatment to restore the form and function of an inmate's oral tissues and are not solely elective nor cosmetic in nature such as:

1. Caries;
2. Chronic periodontal conditions;
3. Non-restorable teeth;

4. Edentulous and partially edentulous patients requiring replacement (See Dental Service Procedure 771.5);
5. Presence of temporary, sedative, or intermediate restorations;
6. Broken or non functional prosthetic appliance, if patient qualifies (See 771.5)Broken or ill fitting dentures or partials.
7. TMJ disorders
8. Periodic examination
9. Gingival recession or root sensitivity
10. Routine dental prophylaxis

3.1.4 - Priority 4 – (EXEMPT CONDITIONS)

Those conditions that do not fall in the above categories and **ARE NOT** provided by ADC

1. Fixed prosthodontics (crown and bridge).
2. Orthodontics
3. Removal of asymptomatic third molars or impactions without pathology;
4. Treatment of discolorations, stains, cosmetic defects.
5. Ridge augmentations, vestibular extensions/implants

4.0 PROCEDURES:

- 4.1 Upon initial examination, all inmates will be classified according to the dental classification system,

Priority 1 (EMERGENCY CARE)
 Priority 2 (URGENT CARE)
 Priority 3 (ROUTINE CARE)
 Priority 4 (EXEMPT CONDITIONS)

- 4.2 The priority classification should be re-evaluated and updated, if necessary, at each dental visit.
- 4.3 The scheduling of dental appointments for inmates will be based on the current relative priority of the inmate's dental condition within the dental classification system.

DENTAL PROCEDURE 770.3

DENTAL CHARTING

- 1.0 **PURPOSE:** To provide guidelines and requirements for the consistent completion of the ADC Dental Chart.
- 2.0 **RESPONSIBILITY:** The Dental Program Manager and Dentist Supervisor at each facility will be responsible for compliance with the requirements of these procedures.
- 3.0 **DEFINITIONS:**
 - 3.1 Dental chart - Form 700400102A & C. It is the form used to record the presence of dental restorations, pathology, pertinent medical history, treatment rendered, etc.
 - 3.2 Initial Oral Examination - A complete clinical evaluation required to establish diagnoses and formulate a total written treatment plan.
 - 3.3 Periodic Oral Examination - The examination of all oral hard and soft tissues using a periodontal probe, mirror, and explorer, and bite-wing, panoramic, or other radiographs as professionally indicated.
 - 3.4 Emergency Oral Examination - The examination performed during a limited appointment for the diagnosis and treatment of a specific chief complaint of the emergency or urgent classification.
- 4.0 **PROCEDURES:** The following sections of the dental chart should be completed as outlined. The dentist should have the complete medical/dental record available when he or she treats a patient.
 - 4.1 Front of chart.(bottom right)
 - 4.1.1 Fill in the inmate's:
Name: first, last
Date
ADC#
Date of Birth
Social Security # (if applicable)
 - 4.2 Section A-Existing
 - 4.2.1 Use **BLACK PEN** to color in existing restorations and to **X-out** missing teeth
 - 4.2.2 Perform periodontal screening and recording (PSR).
 - 4.3 Section B – Current Pathology
 - 4.3.1 Using a **RED PEN**, color in the areas of disease such as caries, lesions,

- fistulas, etc.
- 4.3.2 As treatment is given, use **BLACK ink** to color over the red areas to show that the restoration, extraction, etc., has been completed.
- 4.3.3 Tooth to be extracted has to be marked by double vertical red lines. After extraction, use **BLACK ink** to cross it out (X).
- 4.4 Section C – Service Planned/Tx Plan
Record the proposed treatment plan in this section and update as necessary
- 4.5 Section D - Priority
Refer to Dental Services Procedure 770.2 for the specifics on prioritization. The priority should be updated here and the color tag changed on the chart at each visit where a change in priority occurs.
- 4.6 Section E - Soft Tissue Exam/TMJ
Record findings of the initial soft tissue exam and periodic reviews denoting any abnormalities. Check the box YES or NO for "within normal limits" (WNL) and the TMJ exam.
- 4.7 Section G - Occlusion
Fill in the appropriate occlusion class for the inmate including notes on crowding, crossbites and oral hygiene levels as indicated.
- 4.8 Section H – Identifying Characteristics
List any characteristics that are unique to this inmate.
- 4.9 Section I - Comments
This section is for additional comments such as "patient states that he has upper partial denture".
- 4.10 Health History Section
- 4.10.1 Ask the inmate the question and record the presence or absence of the listed anomalies by checking the appropriate box. The inmate is not permitted to complete this section.
- 4.10.2 Use the "Date" and "Doctor" columns to record when and by which provider the Health history and soft tissue exam were reviewed.
- 4.10.3 There is space provided to "describe" any positive findings noted in the lower area of the history review section.
- 4.11 Treatment Record Section - services rendered and/or description of treatment.
- 4.11.1 Enter the inmate's name and number.
- 4.11.2 Using the accepted acronym eg., ASPC-F for Arizona State Prison Complex at Florence, etc., record the location where the treatment was rendered.

4.11.3 Date, teeth, and signature/stamp (full signature over the name stamp) columns should be filled out appropriately. The time of the encounter will be placed under the date (military time).

4.11.4 Record the treatment, services and other pertinent information in the center area.

4.11.4.1 The standard SOAP format will be used for recording all patient care notes. The following constitutes the accepted definitions of S.O.A.P. It is understood that all 4 steps are not necessarily done at each patient visit.

4.11.4.2 **S = Subjective Data** - Include symptoms, complaints, history and/or conversation concerning the problem and covering the time interval since the last entry (as indicated). Complaints may be quotes of patient's own words.

Common Abbreviations (See acceptable Abbreviaton Manual):

C/O = Complaint of
H/O = History of
TA = Toothache
WT = Wisdom Tooth (Teeth)

4.11.4.3 **O = Objective data** - Include physical examinations, signs, laboratory reports, evidence present on x-ray. Status of the soft tissue, oral hygiene level, and any x-rays, or the results of cultures, biopsies etc., should be recorded in this section. Positive as well as negative findings may be included ie, pain on percussion, lymphadenopathy, mobility etc. Record blood pressure; pulse; blood glucose (for diabetic patients).

0. Common Abbreviations:

O/E = On examination
STE = Soft Tissue Examination
EE = Emergency Examination
LE = Limited Examination
IE = Initial Examination
PE = Periodic Examination
WNL = Within Normal Limits
OH = Oral Hygiene
PA = Periapical (x-ray)
BW = Bitewing (x-ray)
Pano or Pan X = Panorex Type X-ray.

4.11.4.4 **A=Assessment** of the subjective and objective data. Usually, the diagnosis with appropriate statements about etiology, cause(s) of the problem, patient responses to the therapy and his/her coping ability. May include statements of prognosis or list of differential diagnoses.

0. Common Abbreviations:

Dx = Diagnosis
Diff Dx or DDx = Differential Diagnosis
Perio = Periodontal Disease
Prog =Prognosis

4.11.4.5 **P =Plan** - This is a statement specifying what is to be done and/or what procedure was performed at this visit regarding the problem. Also may include review of health history. Amount (in ml) and type of anesthetic used, prescriptions, instructions, and notes as to which teeth were filled, extracted, etc., must be included. This is also a convenient place to record plans for the next visit along with any time constraints that need to be recognized.

4.11.4.6 The plan stems directly from the rationale in the assessment and may include any or all of the following:

1. Diagnostic Plan - States what is to be done to make the data base more complete i.e. more x-rays, lab tests etc.
2. Therapeutic Plan - Indicates projected methods for curing, improving or palliating the problem.
3. Health Education Plan - Outlines the content of health teaching concerning the problem and the above mentioned diagnostic and/or therapeutic plans i.e., oral hygiene and postoperative instructions.
4. Common Abbreviations:
AM = Amalgam Silver Filling
CP = Composite Resin Filling
OHI=Oral Hygiene Instructions
PO = Post Operative Instructions
NV = Next Visit

For other abbreviations see Standard Abbreviations List.

1. Samples of SOAP Notes:

Emergency- Swelling, Abscess, Pain, etc.

S= "My upper right tooth hurts real bad."

O=Emerg. Exam only, 1PA, STE WNL except for red boggy gingiva, 1 PA x-ray shows tooth #3 decayed to bone level with periodontal involvement, excess calculus, plaque, materia alba etc.

A= #3 Deep caries, chronic irreversible pulpitis, periodontal disease, poor OH.

P= Review Health History, options risks and benefits (ORB) of treatment Discussed with questions & answers (Q&A), informed pt. of his gum disease (IGD), consent signed, 1.8 ml 2% mepiv. /c 1:20k levo. #3 extracted without complication OHI and POI were given.

Rx -Pen VK 500mg #30
Ibuprofen 800mg #12
NV- Complete exam, x-rays, treatment plan
Signature and Name Stamp

2. Routine- Cleaning, filling, etc.

S= "I've been waiting for a long time to get my teeth cleaned."

O= Initial exam with perio charting, 4 BW,STE WNL except for red and boggy gingiva, severe calculus, stains, decayed teeth as on chart

A= Generalized periodontics type II, Poor OH, caries # 2,6,31

P= Rev. Health History, options, risks and benefits of the Tx were discussed with pt.(Q&A), IGD, 4 quads supra gingival scaling, OHI.

NV- # 2,6,31 restorations
Signature and Name Stamp

3. Continuous or follow up treatment, i.e. Prosthodontics, suture removal, dry socket treatment, etc.

S= Continued treatment
O= Same as above (SAA)
A= SAA
P= F/P bite registration Shade NH#63

Signature and Name Stamp

- 4.11.4.7 All entries in the dental chart will be made under the authority and responsibility of the dentist .
1. It is recommended that the treating dentist write their own notes in Section I regarding the services rendered (description of treatment).
 2. The Initial Oral Examination will include, at a minimum, the following:
 3. Review of Medical History
 4. Hard and soft tissue exam as delineated by the dental chart
 5. Periodontal probing of selected teeth to include six measurements per tooth
 6. A treatment plan will be developed and documented for each inmate
 7. Appropriate classification of priority assigned.

- 4.11.4.8 Emergency Oral Examination requires, at a minimum, the following:
1. Review of Medical History;
 2. Completion of a soft and hard tissue examination;
 3. Charting of emergent condition and evident pathology.
 4. Updating of classification and treatment plan status, if applicable.

DENTAL PROCEDURE 770.4

CHART REVIEW AND CONTINUITY OF DENTAL TREATMENT

- 1.0 **PURPOSE:** To establish a uniform procedure for reviewing charts when an inmate moves from one facility to another. This procedure will aid in continuity of dental treatment, both at the initial examination stage, and during continuing treatment stages.
- 2.0 **RESPONSIBILITY:** The Dental Program Manager and Dentist Supervisor at each facility will be responsible for compliance with the requirements of these procedures.
- 3.0 **PROCEDURES:** A dentist or dental assistant trained by the dentist can perform the chart review for continuity of dental treatment. A list of new arrivals should be obtained from the Medical Records Librarian.
 - 3.1 The dental assistant/dentist should then obtain the medical/dental charts of the new arrivals for review.
 - 3.2 The chart review performed by the dentist should include the following:
 - 3.2.1 Evaluation of the Medical Record Problem List to determine if any high priority dental procedures are in process and/or if any medical holds relating to dental treatment have been violated in the transfer of the inmate to the receiving institution;
 - 3.2.2 Evaluate the treatment plan, if undergoing prosthetics, serial extractions or root canal, schedule the inmate for continuing treatment;
 - 3.2.3 Evaluation of the dental history to see if premedication is indicated so that proper arrangements can be made prior to scheduling any necessary appointments.
 - 3.3 If the preliminary dental screening indicate an urgent status then appoint the inmate as soon as possible. If intake dental examination has not been done, or the inmate has not been clinically examined by a dentist, the inmate should be scheduled to see the dentist within (30) days of his/her initial arrival at ADC.
 - 3.4 If the inmate has not been seen/treated for an outstanding Routine Care HNR at his/her previous facility, his/her name should be inserted on the routine care waiting list at the receiving facility by the date of submission of the HNR.
 - 3.5 An entry into the dental record indicating "chart review" signed by the dentist.

DENTAL SERVICE PROCEDURE 770.5

SCHEDULING APPOINTMENTS

- 1.0 **PURPOSE:** To provide a standard procedure for the scheduling of inmate dental appointments as a supplement to ADC Health Needs Request System/Procedure.
- 2.0 **RESPONSIBILITY:** The Dental Program Manager and Dentist Supervisor at each facility will be responsible for compliance with the requirements of this procedure.
- 3.0 **PROCEDURES:**
 - 3.1 Emergency dental care
 - 3.1.1 Inmates in need of emergency dental care should notify health services staff or security staff.
 - 3.1.2 After hours the nurse is responsible for the triage of the emergency dental complaints directed to him/her by the health services or security staff through the security shift commander.
 - 3.1.3 The nurse should contact the dentist on site or on the Urgent Notification List for directions/orders.
 - 3.2 Routine Care
 - 3.2.1 Inmates requesting dental treatment of a non emergent nature, may request a dental appointment by submitting a Health Needs Request Form to the health staff.
 - 3.3 Follow-up care
 - 3.3.1 For inmates who have been treatment planned and need continuing care, the following procedure is recommended:
 - 3.3.2 For those undergoing continuation of treatment such as root canal therapy, prosthetics or serial extractions, the dentist should re-appoint the inmate.
 - 3.3.3 For those requiring routine dental work, such as fillings, they will be required to submit a Health Needs Request Form for each visit, if they wish to continue treatment.
- 4.0 **IMPLEMENTATION:** This procedure will be implemented without change effective immediately.

DENTAL SERVICE PROCEDURE - 770.7

PROPHYLACTIC PRE-MEDICATION FOR DENTAL PROCEDURES

1.0 **PURPOSE:** To recommend prophylactic antibiotic regimen for patients at risk of developing bacterial endocarditis and other complications while undergoing dental treatment at Arizona Department of Corrections dental clinics.

2.0 **RESPONSIBILITY:** _____ The Dental Program Manager and Dentist Supervisor at each facility will be responsible for compliance with the requirements of this procedure.

3.0 **PROCEDURES:**

1. ADC staff dentists will prescribe appropriate antibiotic regimen to inmates with risk factors of developing bacterial endocarditis.
2. Antibiotic prophylaxis is recommended for the following cardiac conditions when an inmate is undergoing dental procedures known to induce gingival or mucosal bleeding.

HIGH RISK

0.2.0 Prosthetic cardiac valve, including bioprosthetic and hemograft valves.

3.2.2 Previous bacterial endocarditis, even in the absence of heart disease.

3.2.3 Congenital cardiac malformations including:

- Ventricular septal defect
- Patent ductus arteriosus
- Tetralogy of Fallot
- Complex, cyanotic heart disease
- Systemic - pulmonary artery shunt

MODERATE RISK

0.2.4 Rheumatic and other acquired valvular dysfunction, even after valvular surgery.

3.2.5 Hypertrophic Cardiomyopathy

3.2.6 Mitral Valve Prolapse (MVP) with regurgitation and/or thickened leaflets.

3. Other indications for antibiotic prophylaxis include, but are not limited to:

- Immunosuppression
- Hemodialysis

- Impaired host defenses

NEGLIGIBLE RISK CATEGORY:

4. Antibiotic prophylaxis is **NOT** indicated for patients with:

- **pacemakers or defibrillators**
- **prosthetic joint replacement (Premedication required the first or second years).**

3.4.1 Isolated secundum atrial septal defect.

3.4.2 Surgical repair of atrial septal defect, ventricular septal defect, or patent ductus arteriosus(without residual beyond 6 months).

3.4.3 Previous coronary artery bypass graft surgery.

3.4.4 Mitral valve prolapse without valvular dysfunction.

3.4.5 Physiologic, functional, or innocent heart murmurs.

3.4.6 Previous Kawasaki disease without valvular dysfunction.

3.4.7 Previous rheumatic fever without valvular dysfunction.

3.4.8 Cardiac pacemakers (intra vascular and epicardial) and implanted defibrillators.

5. Antibiotic prophylaxis will be initiated shortly before a procedure (1 to 2 hours). **A follow-up dose is no longer recommended.** In case of delayed healing or of a procedure that involves infected tissue, it may be necessary to provide additional doses of antibiotic.

6. Because endocarditis may occur in spite of appropriate antibiotic prophylaxis, ADC staff dentists should maintain a high index of suspicion regarding any unusual clinical events (such as unexplained fever, weakness, lethargy or malaise) following dental procedures in patients who are at risk for developing bacterial endocarditis.

7. Individuals who are at risk for developing bacterial endocarditis should be encouraged to maintain the best possible oral health to reduce potential sources of bacterial seeding.

4.0 Recommended prophylactic antibiotic regimen.

1. Oral Prophylactic Regimen:

STANDARD DRUG	DOSING REGIMEN
Amoxicillin	2 g orally 1 hr before procedure
<u>Amoxicillin/Penicillin Allergic Patient</u>	
Clindamycin	600 mg, orally 1 hour before procedure OR
Cephalexin or Cefadroxil	2 g, 1 hour before procedure OR
Azithromycin or Clarithromycin	500 mg, 1 hour before procedure
<u>Patients Unable to Take Oral Medications</u>	
Ampicillin	Intravenous or intramuscular administration of ampicillin, g, 30 min. Before the procedure.
<u>Ampicillin/Amoxicillin/Penicillin - Allergic Patients</u>	
Clindamycin	Intravenous administration of 600 mg 30 min. Before procedure.

DENTAL PROCEDURES WHERE ENDOCARDITIS PROPHYLAXIS IS RECOMMENDED

Dental extractions

Periodontal procedures including surgery, scaling and root planing, probing, recall maintenance.

Dental implant placement and reimplantation of avulsed teeth.

Endodontic instrumentation or surgery.

Subgingival placement of antibiotic fibers/strips.

Intraligamentary local anesthetic injections.

Prophylactic cleaning of teeth or implants where bleeding is anticipated.

DENTAL PROCEDURE 771.1

X-RAY PROCEDURE

1.0 **PURPOSE:**To provide a standard procedure that outlines the protective measures required for exposure, development and storage of dental x-rays.

2.0 **RESPONSIBILITY:**The Dental Program Manager and Dentist Supervisor at each facility will be responsible for compliance with the requirements of this procedure.

3.0 **PROCEDURES:**The overall objective is to reduce to a minimum, both patient and operator exposure to radiation while producing clinically acceptable radiographs.

3.1.Procedure for exposing radiographs:

Like other hazardous materials in the dental office, x-radiation must be handled judiciously. Minimum exposure can be achieved by using proper distance, shielding, optimum exposure time, and use of an x-ray film badge for monitoring exposure.

3.1.1 Patient's Protection:

3.1.1.1 Take a complete health history. With females, ask about pregnancy. Routine x-rays are contra-indicated for pregnant inmates, especially during the first trimester.

3.1.1.2 Always cover the patient with a protective shield.

3.1.1.3 Film holders should be used in order to protect hands and arms.

3.1.2 Operator's Protection:

3.1.2.1 Stand at least six feet away from primary x-ray beam or behind a protective barrier when exposure is made.

3.1.2.2 X-ray packet should not be held in patient's mouth, by the operator, when an exposure is being made.

3.1.2.3 Tube housing or cone should not be hand held by the operator during exposure.

3.1.2.4 The amount of scattered radiation reaching the operator should be kept to a minimum. Accumulative amount should be monitored with the film badges which are placed in rooms where dental x-rays are taken.

3.1.2.5 Only the persons required for the radiographic procedure and the patient should be in the room during film exposure.

3.1.2.6 Arizona Radiation Regulation Agency Notice to Employees (#ARRA-6, May, '87; See: page ARR-1) should be posted on the wall near the x-ray

machine in all dental clinics.

3.1.2.7 The x-ray unit should be covered and/or surface disinfected between patients.

3.2. Procedure for developing radiographs:

3.2.1 An automatic film processor is recommended for developing radiographs.

3.2.2 Follow the manufacturer's recommendations for operating the automatic film processor.

3.2.3 The automatic film processor should be cleaned according to manufacturer's cleaning instructions.

3.3 Procedure for mounting and storage of radiographs:

3.3.1 Radiographs should be completely dry before mounting.

3.3.2 Mounts should be used for mounting and storage of radiographs.

3.3.3 Standard label for radiograph should include:

*Inmate Name

*Inmate Number

*Date

*Name of the Doctor

3.3.4. The treating dentist is responsible to ensure that all radiographs are of diagnostic quality for the record.

DENTAL PROCEDURE 771.2

MEDICAL EMERGENCIES IN THE DENTAL CLINICS

1.0 **PURPOSE:** To provide a procedure for the handling of medical emergencies in Arizona Department of Corrections (ADC) dental clinics.

2.0 **RESPONSIBILITY:** The Dental Program Manager and Dentist Supervisor at each facility will be responsible for compliance with the requirements of this procedure.

3.0 **DEFINITIONS:**

1. *Medical Emergency* - Unforeseen medical condition of a dental patient during his/her treatment which requires prompt action.

2. *Classification* - For purpose of convenience and easy reference, common medical emergencies have been classified into:

- 3.2.1 Unconsciousness
- 3.2.2 Respiratory Difficulty
- 3.2.3 Altered Consciousness
- 3.2.4 Seizures
- 3.2.5 Drug Related Emergencies
- 3.2.6 Chest Pain

3. *Management Criteria* - Appropriate steps in the management of the common medical emergencies listed in above.

4.0 **PROCEDURES:**

1. Each dental staff should hold current Basic Life Support Certificate by the American Red Cross or equivalent.
2. Each staff dentist should be familiar with the criteria and the various steps in the management of common medical emergencies in the dental clinic.
3. Upon assessing that a medical emergency has taken place, the staff dentist may use the steps outlined in the management criteria to institute the emergency response.
4. If the condition is not outlined in any of the ADC Incident Management System (IMS) the staff dentist should use appropriate measures in instituting the emergency response.
5. Patients who experience medical emergencies should have medical clearance before continuation of routine dental treatment.

5.0 EMERGENCY DRUGS AND EQUIPMENT:

5.1 Each dental clinic will maintain a medical emergency kit to include the equipment and medications approved by the Health Services Division Director or designee.

5.2 Each kit will have a breakaway security seal and a sheet listing the contents. The drugs will have their earliest expiration date listed. Once a month the dentist will check the list and sign and date when it was checked. Any drug that is due to expire will be removed and sent to the pharmacy for replacement.

6.0 IMPLEMENTATION: This procedure will be implemented without change effective immediately.

DENTAL PROCEDURE 771.3

TRAINING FOR MEDICAL EMERGENCIES

1.0 PURPOSE: To ensure that dental staff have adequate skills to handle medical emergencies in the dental clinics.

2.0 RESPONSIBILITY: The Dental Program Manager and Dentist Supervisor at each facility will be responsible for compliance with the requirements of this procedure.

3.0 PROCEDURES:

3.1 All dental staff should have current CPR certification.

3.2 Medical emergency drills should be held *annually* at each facility. These drills should include the following:

3.2.1 Monitor vital signs

3.2.2 Administration of O₂ with Ambu Bag

3.2.3 Administration of CPR

3.2.4 Administration of CO₂ enriched air

3.2.5 Administration of medication

3.2.6 Coordination with medical staff

3.2.7 Review of responsibilities assigned to each staff member

3.3 Report of performance noting deficiencies in the drill and recommendations will be sent to the Dental Program Manager two weeks from date of drill.

DENTAL PROCEDURE 771.4

MEDICAL HOLD FOR DENTAL PROCEDURES

1.0 **PURPOSE:** To provide a uniform procedure for maintaining continuation of care for inmates who are in the process of receiving certain types of dental treatment.

2.0 **RESPONSIBILITY:** The Dental Program Manager and Dentist Supervisor at each facility will be responsible for compliance with the requirements of these procedures.

3.0 **PROCEDURE:**

- 3.1 It is recommended that medical hold be instituted when one of the following dental procedures is initiated.
 - 3.1.1 Reduction of Fractured Facial Bones
 - 3.1.2 Endodontic Treatment
 - 3.1.3 Prosthetics
 - 3.1.4 Any other condition requiring continued observation or follow-up by the attending dentist.
- 3.2 An entry describing the pertinent treatment is to be made on both the Problem List and the Continuous Progress Notes in the dental chart.
- 3.3 The dental staff will be responsible for informing the medical records department to enter the information into the AIMS computer system.
- 3.4 When treatment is completed the appropriate entries should be made on the Problem List and the Continuous Progress Notes in the dental chart.
- 3.5 The Medical Records Department should be informed when the medical hold is to be released.

DENTAL PROCEDURE 771.5

DENTAL PROSTHESES

1.0 **PURPOSE:** To establish criteria that will be used to determine the eligibility of an inmate for replacement of missing teeth, and priorities by which they will be provided by ADC.

2.0 **RESPONSIBILITY:** The Dental Program Manager and Dentist Supervisor at each facility will be responsible for compliance with the requirements of this procedure.

3.0 **DEFINITIONS:**

3.1. *Adequate Masticatory Function:* defined as an occlusion score of 16 points or more.

3.2 *Occlusion Score:* defined as the total of occlusion points scored as follows:

3.2.1 Occluding incisors and canines or canines = 1 Point, (i.e., #7 with #26 = 1 Pt.)

3.2.2 Occluding Bicuspid = 2 Points, (i.e., #4 with #29 = 2 Pts., #6 with #27 = 2 Pts.)

3.2.3 Functional 1st or 2nd Molars = 3 Points. (i.e., #3 with #30 = 3 Pts.) Note: 3rd Molars drifted to 2nd Molar position shall be recognized as functional occlusion and included when counting the occlusal score.

3.2.4 Wisdom teeth = 0 Pts.

4.0 **PROCEDURES:**

4.1 Full denture prostheses shall be constructed in accordance with the following:

4.1.1 First priority will be given to medically compromised patients who, as a result of missing teeth, are exhibiting a significant medical condition that can be ameliorated by return to adequate masticatory function.

4.1.2 Second priority will be given to those patients needing full upper or lower dentures, or both, as a result of extractions performed as part of an ongoing treatment plan, or who have lost teeth while in ADC.

4.1.3 Third priority will be given to those who entered ADC with missing teeth. (Edentulous upper and/or lower).

4.2 Partial denture prosthesis shall only be provided if the Occlusion Score is 15 or less and the patient does not have active caries, moderate or severe periodontal disease, mobility of abutments or inadequate oral hygiene, as evidenced by the presence of plaque, materia alba, stain, tartar, red bleeding gingiva. Consideration should be given if there is an opposing full denture, to which a partial denture would

- aid in stability. Partial dentures will be constructed in accordance with the following:
- 4.2.1 First priority will be given to medically compromised patients who, as a result of missing teeth, are exhibiting a significant medical condition that can be ameliorated by return to adequate masticatory function.
 - 4.2.2 Second priority will be those who qualify as a result of extractions performed as part of an on-going treatment plan, or who have lost teeth while in ADC.
 - 4.2.3 Third priority will be given to those who entered ADC with missing teeth.
 - 4.2.4 Patients will be restored to adequate masticatory function with one partial if possible (i.e., upper or lower, whichever increases the occlusion score to 16 or above).
- 4.3 Exception to the Occlusion Score can be granted by the Dental Program Manager if the teeth were lost as a result of assault or altercation which is supported by the appropriate documentation or there is a significant psychological need which is documented by a staff psychiatrist and psychologist and sent to the attention of the Dental Program Manager.
- 4.4 Fixed bridges, cast crowns or implants will not be provided.
- 4.5 Laboratory repairs of existing fixed prosthetics must have the approval of the Dental Program Manager.
- 4.6 Inmates will be provided prostheses based on priority.
- 4.7 No prosthetic replacements, other than first priority or where the teeth were extracted by ADC as part of a treatment plan that included replacement, will be started if the inmate has less than six months remaining in ADC.
- 4.8 Ridge augmentation or vestibular extension for improved retention of full dentures will only be considered if the patient is medically compromised, as stated in Sec. .1. Approval for outside consultation and/or performance of these procedures must be obtained from the Dental Program Manager.
- 4.9 A complete dental scaling will be performed before impressions are taken for construction of a partial denture(s).
- 4.10 Laboratory prescriptions shall only be signed by a dentist.

DENTAL PROCEDURE 771.6

REPLACEMENT OF DENTAL PROSTHESES PROVIDED AT STATE EXPENSE

1.0 **PURPOSE:** To provide a standard protocol for the replacement of full or partial dentures supplied to inmates by the Arizona Department of Corrections.

Any full or partial denture, made at state expense, remains state property until the inmate leaves the jurisdiction of the Arizona State Department of Corrections. This procedure applies to all dental prostheses provided at state expense.

2.0 **RESPONSIBILITY:** The Dental Program Manager and Dentist Supervisor at each facility will be responsible for compliance with the requirements of this procedure.

3.0 **PROCEDURES:**

3.1 Full or partial dentures provided to inmates at state expense will not be replaced routinely unless five (5) years have elapsed since the insertion of the appliance and only then if the examining dentist deems it necessary. Exceptions to the above will require the approval of the Dental Program Manager.

3.2 Each inmate requesting replacement of existing full or partial dentures supplied at state expense will be examined by a dentist. The dentist will then determine if a remake is indicated, in keeping with the procedure as written.

3.3 Broken or damaged prosthesis: If it is the opinion of the examining dentist that the inmate damaged his/her prosthesis in an attempt to get a new replacement, the dentist will take disciplinary action against the inmate for damage of state property. Replacement of such will require approval of the Dental Program Manager.

3.4 If the broken or lost denture/partial is the result of an altercation against the inmate, by another inmate or a security officer, written documentation (Significant Incident Report), as to this altercation must accompany the request for the new prosthesis.

3.5 If the broken or lost denture/partial is the result of a loss during inmate property transport or storage, written documentation (ADC inventory slip) must accompany the request for the new prosthesis. A claim should be filed, by the inmate with Risk Management for replacement.

3.6 If the loss or damaged denture/partial is the result of a county receiving facility, i.e., Sheriff's Department, County Detention Office, etc., the inmate will apply to these facilities for assistance. If the inmate receives no resolution from these facilities, copies of all Incident Reports, written communication and determinations must accompany request for assistance for new or repaired partial/denture at ADC expense.

3.6.1 Replacement of partial dentures is subject to the occlusion score criteria for adequate masticatory function outlined in Dental Service Procedure 77 . The criteria must be met for replacement prostheses whether the original prosthesis met those criteria or not.

DENTAL PROCEDURE 771.8

ENDODONTIC THERAPY

1.0 **PURPOSE:** To provide standard criteria for provision of endodontic therapy in Arizona Department of Corrections dental clinics.

2.0 **RESPONSIBILITY:** The Dental Program Manager, and Dentist Supervisor at each facility will be responsible for compliance with the requirements of this procedure.

3.0 **PROCEDURES:** Endodontic therapy is routinely not available in ADC. The presence of pulpal necrosis or irreversible pulpitis alone are not adequate to justify endodontic services as opposed to extractions.

3.1 The dentist must evaluate the total oral health of the inmate and in those very limited instances where the dentist performing the service feels that endodontics is warranted, then the following criteria must exist:

3.1.1 The tooth must be in occlusion.

3.1.2 There can be no more than two missing teeth in all four quadrants. (Excluding 3rd molars).

3.1.3 A low caries index must be present. (less than five carious teeth)

3.1.4 The overall periodontal status must be good, with pocket depth limited to 2-3 mm.

3.1.5 The patient must demonstrate excellent oral hygiene and have a past history of dental maintenance.

3.2 Endodontics may be performed in exception to the above when:

3.2.1 The tooth is a periodontally stable abutment tooth for an existing bridge or partial.

3.2.2 The tooth is an anterior tooth that can be adequately restored under ADC policy, and is periodontally sound.

3.2.2 The tooth is a critical abutment for a planned partial denture that is restorable and periodontally sound.

4.0 All endodontics should be performed under a rubber dam.

5.0 A pre and post treatment periapical x-ray will be taken.

DENTAL PROCEDURE 771.9

PROTOCOL FOR MANAGEMENT OF INMATES WITH FRACTURED FACIAL BONES

- 1.0 **PURPOSE:** To establish procedures for the provision of uniform protocol in the management of inmates with fractured facial bones.
- 2.0 **RESPONSIBILITY:** The Dental Program Manager and Dentist Supervisor at each facility will be responsible for compliance with the requirements of this procedure.
- 3.0 **DEFINITIONS:**
 - 3.1 *Facial Bones* - Maxilla, Mandible, Zygomatic Arches and the Cranial Bones joined to them.
 - 3.2 *Clinical Coordinator* - Person responsible for arranging transportation of inmates for health care purposes.
 - 3.3 *Staff Dentist* - ADC Dentist responsible for dental care at the respective facility/unit.
 - 3.4 *Contract Oral Surgeon* - A dental specialist contracted to provide specialized oral surgery services to ADC inmates.
- 4.0 **PROCEDURE:**
 - 4.1 Triage and Diagnosis:
 - 4.1.1 After notification of the medical provider and all injuries of a life threatening or higher priority nature have been brought under control - a Dentist shall be consulted regarding all trauma to the face, teeth, jaws and associated structures as soon as possible. Fractures of facial bones are emergencies and **referral** does not require ORC approval.
 - 4.1.1.1 After hours: the Urgent Notification Dentist shall be contacted by telephone.
 - 4.1.2 The Staff Dentist shall evaluate the following:
 - 4.1.2.1 The inmate's past medical history.
 - 4.1.2.2 The inmate's and/or staff's history of the current injury.
visual examination both intra-orally and extra-orally, if necessary.
 - 4.1.2.4 Radiographs of the head and neck shall be ordered by the staff dentist.
 - 4.1.2.5 After hours the evaluation and diagnosis regarding facial trauma may be conducted via the Emergency Room Physician at a

hospital that provides emergency services to the particular facility. The Urgent Notification Dentist shall obtain the clinical and radiographic data from the ER Physician by telephone.

- 4.2 Notification: Once a diagnosis of fracture of facial bones has been made, the following people shall be notified as soon as is possible.
 - 4.2.1 The contract Oral Surgeon may be contacted by the Staff Dentist to obtain his/her opinion based on the findings. The contract Oral Surgeon will specify when and where he wants to examine the inmate and radiographs.
 - 4.2.1.1 The Contract Oral Surgeon may also give orders at that time regarding pain medications, antibiotics, diet, activity, etc.
 - 4.2.1.1.1 Prescriptions
 - 4.2.1.1.2 Diet Orders
 - 4.2.1.1.3 NPO Orders
 - 4.2.1.1.4 Duty Status
 - 4.2.1.2 The staff dentist must also record the pertinent facts in SOAP format on both the Dental Chart and the Continuous Progress Record of the medical chart. (See procedure 770.3)
 - 4.2.1.3 A medical hold will be placed on the inmate.(See procedure 771.4)
 - 4.2.1.4 Note of the fractured bone is to be included on problem list.
 - 4.2.2 The Clinical Coordinator or Nurse in charge of arranging transportation must be notified by the staff dentist so that proper transportation to the contract oral surgeon or hospital can be arranged.
 - 4.2.2.1 The consultation report form, as well as verbal communication, is the mechanism for proper communication between the staff dentist and the contract oral surgeon (hospital) via the Clinical Coordinator.
 - 4.2.3 The Facility Health Administrator (FHA) is to be alerted as to the nature of the situation and the fiscal impact.
 - 4.2.4 The Dental Program Manager is to be notified and kept informed of the situation.
 - 4.2.5 The Dentist Supervisor at the facility is to be notified of the situation as it progresses and for follow up.

- 4.2.6 If the inmate must be moved to a new housing location within the same facility, remote from the staff dentists unit, the dentist at that unit/facility must be alerted to the presence of the new arrival.
- 4.2.7 If the inmate is moved to another facility, the staff dentist shall notify the Dentist Supervisor at the receiving facility directly by phone and follow up in writing.
- 4.3 Treatment: When the inmate returns from the oral surgeon or hospital, the Staff Dentist shall review and complete the consultant form and implement the orders to ensure continuity of care.
 - 4.3.1 A new consultation form is to be initiated and forwarded to the Clinical Coordinator to arrange for each follow-up visit to the oral surgeon.
 - 4.3.2 Appropriate notes of the treatment will be recorded in both the Dental and Medical Record.
 - 4.3.3 If the inmate returns with inter-maxillary fixation with rubber bands or other devices that he can easily remove by himself, he can be returned to his/her housing unit. Orders are to be written for the Nursing Staff in the continuous progress record portion of the medical chart by the staff dentist. These orders should include but are not limited to:
 - 4.3.3.1 Weekly examination of the inmate shall be done by the staff with appropriate documentation in the dental and medical record. Weekly weighting of the inmate will be ordered.
 - 4.3.3.2 If the inmate returns with inter-maxillary fixation using wires or other devices that can not easily be removed by the inmate, or that require the use of a wire cutters to remove, then he/ she will be moved to an ADC inpatient unit as soon as possible. Orders are to be written for the nursing staff in the continuous progress record portion of the medical chart by the staff dentist.
- 4.4 Completion:
 - 3.4.1 After the treatment is complete, the medical hold can be removed from the chart and the medical records staff should be informed as to the current status.
 - 3.4.2 .The pertinent orders and forms are to be discontinued as indicated and any wire cutters located and replaced in the appropriate place.
- 4.5 Refusal and Non-Compliance with Treatment:
 - 4.5.1 Refusal to submit to any part of the treatment or comply with any of the orders will be recorded in the medical and dental charts and an informed

written refusal form, signed by the inmate shall be obtained by the staff dentist or appropriate health care staff.

- 4.5.2 Any tampering with the appliances will be discussed with the inmate and recorded in the medical and dental charts.
- 4.5.3 Extreme deviations or hindrances that may compromise the outcome of treatment, should be reported to the treating Oral Surgeon, Facility Health Administrator, Dental Program Manager and Dentist Supervisor. If non-compliance is the problem an informed refusal of treatment form should be signed by the inmate.
- 4.6 This is a guideline to be used for instruction on documentation. It is NOT intended to preclude a medical or dental professional's judgment.

DENTAL PROCEDURE 772.1

INFECTIOUS & HAZARDOUS MATERIALS CONTROL

- 1.0 **PURPOSE:** This section has been written to address and standardize the infection control practices of the dental program in the Arizona Department of Corrections. The guidelines are generally consistent with those endorsed by national organizations and other federal agencies ie, OSHA, CDC, ADA etc.
- 2.0 **RESPONSIBILITY:** The Dental Program Manager and Dentist Supervisor at each facility will be responsible for compliance with the requirements of these procedures.
- 3.0 **PROCEDURES:** The Dentist Supervisor at each facility is the resource person for infection control/hazardous materials compliance for that facility.
 - 3.1 All dental staff members should be oriented/trained in infection control protocol and this training should be documented on Form 70400166.
 - 3.1.2 A yearly infection control training session with all dental staff involved in patient treatment should be conducted with appropriate documentation completed.
 - 3.2 All dental staff members should be advised of the benefits of, and offered a, Hepatitis B. vaccination.
 - 3.2.1 Potential risks and actual occupational injuries and illnesses should be documented using the appropriate forms.
 - 3.3 A hazardous materials log should be maintained on Form 70400174. Hazard communication training should be conducted for all dental staff members with documentation of the training and periodic review maintained.

DISPOSITION OF SHARPS AND HAZARDOUS MATERIALS

1.0 PURPOSE: To provide a procedure for the safe and effective handling, control and disposal of potentially dangerous items and materials in the correctional dental environment and to comply with the OSHA Hazard Communication Standard, 29CFR1919.1300.

2.0 RESPONSIBILITY: The Dental Program Manager and Dentist Supervisor at each facility will be responsible for compliance with the requirements of these procedures.

3.0 DEFINITIONS:

3.1 *Sharps* - Any instrument, implement or artifact, whether made of metal, glass or other substance, that could aid in the abuse of drugs or cause bodily injury. ie., needles, scalpels, broken glass, syringes, etc.

3.2 Hazardous materials - substances and/or materials that are a potential threat to human health and well being.

3.2.1 *Supplies* - Those products (chemicals) used in the delivery of dental services that have potential for causing harm to employees and others, ie., Formo Cresol, Bleach, Acid, etc.

3.2.2 *Infectious materials* - Those items that are contaminated with blood, body fluids or other infected media that pose a potential health risk to employees or others, should they come in contact with them i.e. extracted teeth, bloody gauze, dirty gloves, etc.

4.0 PROCEDURES:

4.1 Unopened containers of dental needles, local anesthetic carpules and disposable dental syringes will be stored in the pharmacy and may be requisitioned by a staff dentist.

4.1.1 Requisitioned items will be stored unopened in the pharmacy and only opened and counted at the time of their issuing. The counting will be performed and verified by a dental staff member and a pharmacy staff member. (Due to inaccuracy of manufacturers counts)

4.1.2 The pharmacy staff member will sign the requisition authenticating the order and numbers issued.

4.1.3 The dental staff member will sign the requisition authenticating the order and numbers received.

4.1.4 Dental and pharmacy will establish a day and time on which dental will routinely requisition their supplies. This day and time will be mutually

convenient to both staffs.

- 4.1.5 The supply will be accompanied by a proof of use sheet in reverse numbered decreasing perpetual inventory format. Dental will record each item on this sheet as it is used.
- 4.1.6 Supplies on hand in the dental clinic will be limited to a one weeks supply, i.e. (1) opened can or card (not to exceed 50 carpules) of each type of local anesthetic and (1) one opened box (not to exceed 100 needles) of each gauge needle. The maximum of each type of anesthetic carpules will be 70 and the maximum number of each type of needle will be 130.
- 4.1.7 Dental will keep their working supply in accordance with security policies for accountable items.
- 4.1.8 Off schedule requisitions may be necessary, but will be accomplished in accordance with the above parameters.
- 4.1.9 Other hazardous instruments and supplies are obtained and stored in the same manner as all other supplies in the dental clinic with the exception that only the minimum amount needed to provide services are to be kept in the operatory.
- 4.1.10 Dental tray set ups (IMS Cassettes) are encouraged to provide for accuracy in counting and safety in controlling instruments in the operatory area.

4.2 Accounting

- 4.2.1 A count sheet, or sheets, are to be maintained for each drawer and cupboard within the Dental Clinic, Lab, etc., where dental instruments are kept.
- 4.2.2 The count sheet will accurately reflect the number and type of instruments kept in the respective drawer, cupboard etc.
- 4.2.3 No loose instruments are to be stored in the Dental Operatory, rather, extra instruments should be kept in areas off limits to inmates, such as the pharmacy.
- 4.2.4 During clean up and sterilization, dental instruments should be verified by a visual check at the completion of each patient visit. The packet or cassette will be wrapped and the dental assistant checking and packing the instruments, will date and initial the package. By placing their initials on the pack, they are attesting to the fact that all instruments, in the pack, are accounted for and contained in the pack.
- 4.2.5 A daily inventory of all the dental instruments in the dental clinic will be conducted to maintain control and accurate records. An inventory will be performed before the first patient and again after the last patient of the day.

- 4.2.5.1 A copy of all the completed Inventory Sheets should be forwarded to the office of the Facility Health Administrator on a monthly basis for filing and distribution to the unit Chiefs of Security.
- 4.2.6 Each clinic should have a master list on file that accurately depicts the type and quantity of all dental instruments and hazardous supplies in the dental clinic area. The exact location may also be recorded.
 - 4.2.6.1 The master list only needs to be updated when items are purchased or discarded. All supplies that have an expiration date should be checked monthly. If the item is within 30 days of expiration, it should be flagged and disposed of when it expires as in . Anesthetic carpules that are to expire should be returned to the pharmacy for disposal.
- 4.2.7 Disposable Sharps such as needles, scalpels, carpules, etc. should be accounted for on the Daily Sharps Inventory.
 - 4.2.7.1 Copies of the Disposable Sharps Inventory should be forwarded to the FHA on a monthly basis, as well.

4.3 Disposal

- 4.3.1 Sharps are to be discarded in appropriate sharps containers that prevent puncture and inhibit retrieval from the container. The container should be labeled to show the nature of its contents.
- 4.3.2 Infectious waste and hazardous materials are to be discarded in appropriately labeled containers., ie. red bags, barrels, biohazard containers etc. for the safe and efficient removal and destruction of such material.

4.4 Hazard Communication Plan

- 4.4.1 Each facility should maintain a Hazard Communication Plan with MSDS File and all dental staff should be familiar with its contents.
- 4.4.2 All dental staff should know the location in the clinic where the HCP and MSDS File are maintained.

DENTAL PROCEDURE 773

CRITERIA FOR REMOVAL OF WISDOM TEETH

- 1.0 PURPOSE: To provide criteria for removal of third molars (wisdom teeth) from inmates committed to the Arizona Department of Corrections (ADC).
- 2.0 RESPONSIBILITY: The Dental Program Manager and Dentist Supervisor at each facility will be responsible for compliance with the requirements of this procedure.
- 3.0 PROCEDURES:
 - 3.1 Wisdom teeth should not be removed or referred to an outside provider for removal if
 - 3.1.1 They are asymptomatic.
 - 3.1.2 Symptomatic but can be treated by medications, oral hygiene practices, soft tissue removal, occlusal adjustment, or extraction of the opposing third molar.
 - 3.2 Removal should be considered:
 - 3.1.2 If, **AFTER CONTINUED TREATMENT AS OUTLINED IN 3.** , the condition persists or exacerbates.
 - 3.2.2 There is demonstrated pathology either by x-ray or clinical examination.
 - 3.2.3 There is the continuous presence of infection.
 - 3.2.4 The WISDOM TOOTH is affecting the adjacent tooth causing it to become loose or decayed.

DENTAL PROCEDURE 773.1

SUSPENSION OF DENTAL TREATMENT FOR NON-COMPLIANCE

- 1.0 **PURPOSE:** To provide a procedure for the suspension of dental treatment by ADC staff dentists when the inmate/patient is uncooperative in the execution of his/her dental treatment plan.
- 2.0 **RESPONSIBILITY:** The Dental Program Manager and Dentist Supervisor at each facility will be responsible for compliance with the requirements of this procedure.
- 3.0 **PROCEDURES:** It is well recognized that patient cooperation, including proper oral hygiene practice, is paramount for successful dental treatment.
 - 3.1 Each inmate bears the responsibility of cooperating with the dental treatment plan prescribed by the ADC staff dentist.
 - 3.2 The staff dentist may suspend further dental treatment when the inmate/patient fails to demonstrate the required level of cooperation.
 - 3.3 Adequate oral hygiene is demonstrated by the absence of plaque, materia alba, gingival inflammation and bleeding gingiva as viewed during a clinical examination.
 - 3.3.1 Inadequate oral hygiene results in a compromised prognosis for any dental treatment rendered.
 - 3.3.2 The extent of routine care provided shall be dependent on the responses and interest demonstrated by the inmate/patient in their oral hygiene.
 - 3.3.3 Routine care should not be provided when it is obvious that it will fail due to lack of basic oral hygiene practices.
 - 3.3.4 Suspension of routine dental treatment should not occur until after instructions in oral hygiene have been provided, documented and opportunity for improvement given.
 - 3.4 Disruption of treatment by the inmate, eg. loosening or removal of intermaxillary fixation devices, removal of surgical packing, non-compliance with directions, etc. may be interpreted as uncooperative behavior and result in the suspension of treatment.
 - 3.5 The dentist shall document, in the dental chart, the rationale for suspending routine treatment and the requirements for re-initiating the treatment plan.

DENTAL PROCEDURE 773.2

DENTAL SERVICES FOR INMATES WITH TERMS OF INCARCERATION OF 6 MONTHS OR LESS

- 1.0 **PURPOSE:** To define dental services available for those inmates with terms of incarceration 6 months or less.
- 2.0 **RESPONSIBILITY:** The Assistant Director, Health Services Bureau, Dental Program Manager, and Dentist Supervisor at each facility will be responsible for compliance with the requirements of this procedure.
- 3.0 **PROCEDURES:**
 - 3.1 Dental principles state that definitive dental treatment should not be initiated when there is insufficient time to achieve completion.
 - 3.2 Priority 1 (EMERGENCY) and Priority 2 (URGENT) care is available to all inmates regardless of the length of their sentence. (See: Dental Procedure 770.2 for priority of care definitions)
 - 3.3 Lower priorities of care are not routinely available for inmates sentenced to 6 months or less terms of incarceration at ADC.

DENTAL PROCEDURE 773.3

PERIODONTAL TREATMENT

- 1.0 PURPOSE: To define the types and extent of periodontal services available for inmates under the jurisdiction of the Arizona Department of Corrections.
- 2.0 RESPONSIBILITY: The Dental Program Manager and Dentist Supervisor at each facility will be responsible for compliance with the requirements of this procedure.
- 3.0 PROCEDURES:
 - 3.1 For those inmates diagnosed as having periodontal disease, and who have demonstrated the required level of oral hygiene practices, the following services are available on a priority basis:
 - Gross scaling
 - Subgingival scaling
 - Root planing
 - 3.2 Mucogingival surgery, alveolar osseous surgery and periodontal grafts are **not** provided by ADC.
 - 3.3 Available periodontal services should be scheduled according to the relative priorities defined in the Dental Classification System (See: DP 770.2).
 - 3.4 It is recognized by the dental profession that a key factor in successful periodontal therapy is patient compliance with oral hygiene practices. If the inmate/patient is unwilling to follow and demonstrate the prescribed hygiene measures, periodontal therapy should be suspended (See: DP 77).

DENTAL PROCEDURE 773.4

INMATES ENTERING ADC WHO ARE UNDERGOING ORTHODONTIC TREATMENT

- 1.0 **PURPOSE:** To ensure that those inmates entering ADC, who are undergoing orthodontic treatment, do not have that treatment interrupted or changed without the written approval of the orthodontist or dentist of record.
- 2.0 **RESPONSIBILITY:** The Dental Program Manager and Dentist Supervisor at each facility will be responsible for compliance with the requirements of this procedure.
- 3.0 **PROCEDURES:**
 - 3.1 When an inmate enters ADC with orthodontic appliances in place, the staff dentist will take a complete dental history, including the dentist of record's name and telephone number and address.
 - 3.2 The orthodontist of record will be contacted by the staff dentist and inform him/her that the patient is now an inmate at ADC. The orthodontist should be asked about the treatment plan and if he/she wishes to continue treating the inmate. . **IT WILL BE MADE CLEAR THAT ADC WILL NOT ASSUME ANY FINANCIAL RESPONSIBILITY FOR THE TREATMENT OF THE INMATE.**
 - 3.3 If the orthodontist wishes to continue treatment, the request will be submitted, in writing, to the Dental Program Manager. The request must include a projection of the time it should take to complete the treatment plan and the frequency of the visits.
 - 3.4 If the orthodontist does not wish to continue treatment of the inmate, he/she will submit a letter stating so and giving ADC the authority to remove the appliances and terminate the orthodontic treatment.
 - 3.5 No orthodontic treatment is to be provided by the staff dentist, except that of an emergency nature, without the permissions of the Dental Program Manager.
 - 3.6 If the dentist of record is unknown or unwilling to provide written permission to remove the appliance, then with written consent from the inmate, the staff dentist may remove the appliance. If the inmate refuses to sign the consent form then a Refusal of Treatment Form will be signed. If the inmate refuses to sign the Refusal of Treatment Form then two witnesses must verify his refusal and sign the form.

DENTAL PROCEDURE 773.5

INFORMED CONSENT AND RIGHT TO REFUSE

- 1.0 **PROCEDURE:** To ensure all dental examinations, treatments and procedures are governed by informed consent practice applicable in Arizona.
- 2.0 **RESPONSIBILITY:** The Dental Program Manager and Dentist Supervisor at each facility will be responsible for compliance with the requirements of this procedure.
- 3.0 **PROCEDURES:**
 - 3.1 When an inmate gives the dentist permission to perform an invasive dental procedure, he/she will be informed of the possible risks/consequences of the procedure. If the procedure includes the removal of one or more teeth, then the inmate will be notified if he/she is eligible for replacement teeth. (see Procedure 77)
 - 3.2 ADC form 70400106 will be completed and the inmate will be required to sign the form.
 - 3.3 The dentist and one other witness will also be required to sign the form.
 - 3.4 If the inmate refuses the examination, treatment or procedure, dental services for that appointment will not be provided and a Refusal of Treatment Form will be completed. The risks of the inmate's action shall be explained to him/her.
 - 3.5 The completed form will be filed in the inmates Medical Record.
 - 3.6 If the inmate refuses the examination, treatment, or procedure as part of a treatment plan, the dentist may determine if further treatment cannot proceed due to the deleterious effect on the overall outcome.

DENTAL PROCEDURE NO: 773.6

EQUIPMENT MAINTENANCE

- 1.0 **PURPOSE:** To establish a preventive maintenance schedule for major dental equipment.
- 2.0 **RESPONSIBILITY:** The Dental Program Manager and Dentist Supervisor at each facility will be responsible for compliance with the requirement of this procedure.
- 3.0 **PROCEDURES:** Each facility should maintain a log book continuing documentation of periodic maintenance.
 - 3.1 Equipment maintenance log sheets (Form # 70400163) are to remain near the respective equipment.
 - 3.2 Completed log sheets will then be transferred to the maintenance log book, and a blank log sheet replaced in the clear protective cover.
 - 3.3 Equipment should be maintained according to the manufacturer's recommendations.

DENTAL PROCEDURE 774

CHARGING INMATES FOR DENTAL SERVICES

- 1.0 **PURPOSE:** To provide guidelines for charging inmates for dental care in accordance with the Department Order 1101.
- 2.0 **RESPONSIBILITY:** The Dental Program Manager and Dentist Supervisor at each facility will be responsible for compliance with the requirements of this procedure.
- 3.0 **DEFINITIONS:**
- 3.1 *Health Services Fee* - In accordance with Department Order 1101 and for the purposes of this procedure, a \$3.00 charge made to an inmate for emergency and/or each health care appointment which is initiated by a Health Needs Request Form. **EXCEPTIONS** are:
- 3.1.1 Medical/dental visits initiated by medical or mental health care staff.
- 3.1.2 Medical/dental visits to health care providers for inmate referred by another health care provider.
- 3.1.3 Inmates processing through reception centers.
- 3.1.4 Juvenile inmates.
- 3.1.5 Pregnant inmates.
- 3.1.6 Seriously mentally ill inmates.
- 3.1.7 Inmates who are housed in the Special Programs Unit (SPU), including those with developmental disabilities and the Women's Treatment Unit.
- 3.1.8 Inmates who are housed in Unit 8 at ASPC-Florence or inpatient units at ASPC-Florence/Tucson and ASPC-Lewis.
- 3.1.9 Inmates who are inpatients at Alhambra Behavioral Health Treatment Facility at ASPC-Phoenix.
- 3.1.10 Inmates who undergo follow-up treatment specifically for their chronic conditions per provider request and for which there is no Health needs Request Form required.
- 4.0 **PROCEDURES:**
- 4.1 Inmates will be charged a Health Services Fee for all dental care requested by submission of a Health Needs Request Form or when seen on an emergency basis.

- 4.1.1 **EXAMINATION:** There will be no charge for dental examinations instituted by dental staff, i.e. initial and periodic dental exams or exams requested by other health care providers. There will be a charge for an examination that was requested by the inmate.
- 4.1.2 **ENDODONTICS:** A Health Services Fee will be charged for the initial visit ONLY. There will be no charge for follow-up visits initiated by the dentist, including the placement of the final restoration.
- 4.1.3 **PROSTHETICS:** A Health Services Fee will be charged for evaluating the patient on the initial visit ONLY. This charge is NOT for the appliance. There will be no charge for follow-up visits, including adjustments up to six (6) months after delivery. Replacement teeth will continue to be provided in accordance with Procedure 771.5.
- 4.1.4 **SURGERY:** A Health Services Fee will be charged for only the initial visit when the treatment calls for serial extractions leading to construction of full or partial dentures. When the inmate wishes to deviate from the dentist's treatment plan, i.e. does not want serial extractions but wants only one or two teeth removed at a time, then there will be a charge for EACH visit. In this case, the inmate will be instructed to submit an HNR when he/she wants additional teeth removed. Upon completion of the extractions and after sufficient healing has taken place, the patient will be instructed to submit an HNR to request the making of the replacement teeth. There will be a charge for the first visit only in accordance with section 4.1.3.
- 4.1.5 **PERIODONTAL:** A Health Services Fee will be charged for EACH treatment series, including cleaning. Root planning, curettage, etc. may require multiple visits for which there will be a charge. The inmate should be instructed, after each visit, to submit an HNR if he/she wishes to continue treatment.
- 4.1.6 **TMJ:** A Health Services Fee will be charged for the initial visit ONLY.
- 4.1.7 **EMERGENCY:** A Health Services Fee will be charged for all dental emergencies, including fractured jaws, unless the inmate has been first seen by another health staff member for the same emergency for which there was a charge.
- 4.1.8 **RESTORATIVE:** A Health Services Fee will be charged for EACH visit for the restoration of teeth. The number of teeth restored per visit should be based on the area anesthetized, the type of restorative material used and the severity of the lesion. After each visit, the patient will be instructed that if he/she wishes to have more teeth restored, they are to submit another HNR.

DENTAL PROCEDURE 779

DENTAL PRODUCTION REPORTING

- 1.0 **PURPOSE:** To compile statistical data that delineates dental services provided by each dentist.
- 2.0 **RESPONSIBILITY:** The Dental Program Manager and Dentist Supervisor at each facility will be responsible for compliance with the requirements of this procedure.
- 3.0 **DEFINITIONS:**
 - 3.1 *Facility* - Facility Name
 - 3.2 *Week Ending* - The date of the Sunday that ends the week.
 - 3.3 *Doctor* - Dentist's name.
 - 3.4 *Clinic* - Dental clinic where services were provided.
 - 3.5 *Clinic Hours* - The total number of hours, for that week, that the dentist worked providing the services that he/she reported on the form.
 - 3.6 *Non-Clinic Hours* - The number of hours that the dentist spent non-reportable duties, i.e., completing paperwork, attending staff meetings, etc. Do not include time off for sick leave, annual leave or other types of leave.
 - 3.7 *Pt. Treated* - Total number of patients treated.
 - 3.8 *No Shows* - The number of patients who did not show for their appointments.
 - 3.9 *Appointments Refused* - The number of patients who refused treatment either by choosing not to keep an appointment or refusing treatment once they were at the health unit.
 - 3.10 *Seen by O.S.* - The number of patients treated by an Oral Surgeon. This entry appears at the end of the form and is completed only by the DENTIST SUPERVISORS at each facility.
 - 3.11 *# of Proc* - The number of procedures performed for each procedure code. A list of code definitions is provided so that there is consistency in reporting throughout the system.
 - 3.12 *# of 911* - The number of inmates seen per DP 911.

See the Dictionary of Dental Services for more definition.

4.0 **PROCEDURES:**

- 4.1 Each dentist will record services provided for each patient treated in daily production sheet.
- 4.2 A monthly production report will be submitted to the Dental Program Manager every month, within the first week of the following month.
- 4.3 The Dental Program Manager will prepare quarterly reports summarizing the production statistics, using Arizona Health Care Cost Containment System (AHCCCS) dental fees schedule.
http://www.azahcccs.gov/commercial/provider_billing/rates/dentalrates.aspx.

5.0 MONTHLY PRODUCTION REPORT:

- 5.1 Each month of the fiscal year, a Dental Production Report is produced by the Dental Program Manager to include the following:
 - 5.1.1 Report by service rendered by each dentist at the facility
 - 5.1.2 Report by Facility
 - 5.1.3 Summary Report
- 5.2 When reading and interpreting these reports several different factors need to be kept in mind, such as; was there a security problem, equipment failure, interruption of utilities, such as; was there a security problem, equipment failure, interruption of utilities, scheduled meetings, shortage of staff, or other emergencies etc.
- 5.3 By analyzing these reports and other pertinent information, problems inhibiting productivity can be identified and a solution can be formulated.

DENTAL PROCEDURE 781

DENTAL SERVICES WAIT TIMES REPORT

- 1.0 **PURPOSE:** To provide a procedure for the gathering of information on the waiting times for a dental appointment for the dental treatment, Routine nature in the Arizona Department of Corrections (ADC).
- 2.0 **RESPONSIBILITY:** The Dental Program Manager and Dentist Supervisor at each facility will be responsible for compliance with the requirements of this procedure.
- 3.0 **PROCEDURES:**
 - 3.1 Each Dental Clinic will keep a record of inmates requesting dental care.
 - 3.1.1 The record should include the date the inmate requested treatment.
 - 3.2 The Dentist Supervisor will be responsible for the completion of the Dental Services Wait Times Report Form.
 - 3.3 A Dental Services Wait Times Report will be submitted to the Dental Program Manager, for each month.
 - 3.4 It will be sent no later than the second Monday of the month for the preceding month.

DENTAL SERVICE PROCEDURE 782

Continuous Quality Improvement - Peer Audit / Peer Review.

- 1.0 **PURPOSE:** To provide a system of continuing quality improvement of the dental services program through a peer audit system.
- 2.0 **RESPONSIBILITY:** The Dental Program Manager and Dentist Supervisor at each facility will be responsible for compliance with the requirements of this procedure.
- 3.0 **PROCEDURES:**
 - 3.1 Peer Audits
 - 3.1.1 All dental facilities will be audited by a Dentist Supervisor on a semi-annual basis.
 - 3.1.2 The Dental Program Manager will assign each Dentist Supervisor to a facility.
 - 3.1.3 The Dental Program Manager will develop the criteria to be used for each audit.
 - 3.1.4 Each auditing Dentist Supervisor will present an oral report to the facility Dentist Supervisor and Facility Health Administrator at an exit briefing.
 - 3.1.5 Each Dentist Supervisor will prepare and submit a report of the findings by the date specified by the Dental Program Manager.
 - 3.1.6 The Dental Program Manager will prepare a report of the findings of the audit for the Division Director, Health Services.
 - 3.1.7 This report will be presented to the Dentist Supervisor at the next Dentist Supervisor's Meeting.
 - 3.1.8 Each Dentist Supervisor will provide to the Dental Program Manager a plan for corrective action for those items found to be deficient at their facility.
 - 3.1.9 The Dental Program Manager will establish a due date for this plan.
 - 3.2 Peer Review
 - 3.2.1 Each Dentist Supervisor, while reviewing the dental charts at the assigned facility, will randomly select charts for peer review. There will be at least three charts reviewed in which a provider at that facility has made an entry. All providers at the facility will be audited.
 - 3.2.2 These charts will be reviewed for the following criteria:

- 3.2.2.1 Was the treatment plan appropriate for the conditions diagnosed.
- 3.2.2.2 For a specific entry, was the Assessment and Plan appropriate for the stated Subjective and Objective entries.
- 3.2.2.3 If medications were given or prescribed were they appropriate for the diagnosis.
- 3.2.2.4 Was the follow-up appropriate for the condition treated.
- 3.2.2.5 Was the outcome favorable.
- 3.2.2.6 A report of the findings will be submitted to the Dental Program Manager.
- 3.2.2.7 The Dental Program Manager will prepare a report of all findings to the Division Director, Health Services.

3.3 Per A.R.S. 36-411 & A.R.S. 36-445 these documents are not subject to discovery.

DENTAL SERVICE PROCEDURE 783

MONITORING BLOOD PRESSURE FOR DENTAL PROCEDURES

- 1.0 **PURPOSE:** To provide a procedure to determine the systolic and diastolic blood pressure of an inmate prior to initiating a dental treatment.
- 2.0 **RESPONSIBILITY:** The Dental Program Manager and Dentist Supervisor at each facility will be responsible for compliance with the requirements of this procedure.
- 3.0 **PROCEDURES:**
 - 3.1 **Blood Pressure**
 - 3.1.1 The inmate's systolic and diastolic blood pressure will be taken and recorded after the patient is seated in the dental chair but before the administration of a local anesthetic or any dental procedure.
 - 3.1.2 The values will be recorded in the SOAP notes.
 - 3.1.3 If the inmate's blood pressure is above 150/90 mm Hg, the blood pressure should be repeated after 5 minutes. If the blood pressure continues to be above 150/90 mm Hg, a medical provider should be consulted before proceeding with any treatment.

DENTAL PROCEDURE 784

PRECIOUS METAL

- 1.0 PURPOSE: To provide a standardized procedure for deposition and documentation of precious metal associated with extracted teeth.
- 2.0 RESPONSIBILITY: The Dental Program Manager and Dentist Supervisor at each facility will be responsible for compliance with the requirements of this procedure.
- 3.0 PROCEDURES:
 - 3.1 Precious metal removed from the oral cavity of an inmate by the dentist, should be cleaned sterilized, placed in an envelope and labeled with the inmate name, ADC# and description of the metal.
 - 3.2 Inmate property inventory form (See: Form 70501052) should be completed with name, ADC# and date. The contraband box should be checked under "Reasons for Inventory." Description of metal will come under column of "order." This form should be signed and dated by the dentist on the line entitled "Inventoried by officer #1".
 - 3.3 The white copy of the completed form should accompany the envelope to the property room. The yellow copy should be given to the inmate as a receipt and the pink copy should go in the dental chart as a record. Also necessary notes shall be made in the dental chart and signed by both the dentist and the inmate.
 - 3.4 If prevailing Federal and State Infection Control regulations require that precious metal associated with extracted teeth be disposed of by the dental office, the precious metal will be disposed of accordingly.
- 4.0 IMPLEMENTATION: This procedure will be implemented without change effective immediately.

DENTAL PROCEDURE 785

TREATMENT FOR TMJ DYSFUNCTION

1.0 **PURPOSE:** To recommend guidelines for evaluation and management of Craniomandibular Disorders (Temporo Mandibular Joint (TMJ) Dysfunction and Myofascial Pain Dysfunction (MPD).

2.0 **RESPONSIBILITY:** The Dental Program Manager and Dentist Supervisor at each facility will be responsible for compliance with the requirements of this procedure.

3.0 **DEFINITIONS:**

3.1 Temporomandibular Joint Syndrom (TMJ) - Refers to intrinsic joint pathology which may be ligamentous, capsular, bony degenerative, etc. The etiology is in the joint itself, or in a specific occlusal disorder.

3.2 Myofascial Pain Dysfunction - Refers to a medical entity which affects muscles anywhere in the body. This condition is unrelated to the occlusion, and is generally not amenable to occlusal therapy.

4.0 **PROCEDURES:**

4.1 **Evaluation:**

A thorough history of the patient's craniomandibular disorder must be taken by the treating dentist.

4.2 Basic examination shall consist of the following:

4.2.1 Joint palpation

4.2.2 Muscle testing (palpation)

4.2.3 Radiographic evaluation (panorex and/or transcranial)

4.3 The above are to be utilized to arrive at a preliminary diagnosis of TMJ Dysfunction.

5.0 **MANAGEMENT**

5.1 Treatment modalities are designed to reduce the actual muscle spasm, reduce joint inflammation, and thus relieve the pain. The treatment is strictly palliative in nature and is not directed at achieving a cure. All treatment rendered is **STRICTLY REVERSIBLE** and the hard and soft tissues are not altered in any way.

5.2 Treatment modalities may include:

5.2.1 Pharmacotherapeutics

5.2.2 Isometric exercise therapy

5.2.3 Psychological counseling to reduce stress

5.2.4 TMJ appliance/muscle relaxation splint

5.3 The above modalities may be done one at a time or in combination.

DENTAL PROCEDURE 786

EXPIRATION OF DENTAL MATERIALS AND DENTAL PHARMACEUTICALS

- 1.0 PURPOSE: To provide a standardized procedure so that dental materials and pharmaceuticals are kept current and properly disposed of prior to the manufacturer's expiration date.
- 2.0 RESPONSIBILITY: The Dental Program Manager and Dentist Supervisor at each facility will be responsible for compliance with the requirements of this procedure.
- 3.0 PROCEDURES:
 - 3.1 All dental materials that have a manufacturer's expiration date and are placed or inserted permanently into a patient and all pharmaceuticals that have a manufacturer's expiration date will be identified and so noted on the "Expiration Log".
 - 3.2 A written entry denoting the name of the item and its expiration date will be made on the log. This date will correspond to the date that is 90 days prior to the manufacturer's expiration date.
 - 3.3 On the first Monday of each month, the Dental Assistant will review the Expiration Log and note all items that are due to expire within the 90 day time frame.
 - 3.4 A Purchase Requisition will be completed immediately for those items due to expire and will be submitted through the chain-of-command.
 - 3.5 Upon receipt of the new stock, it will be checked for its expiration date and an entry made per section .If the item expires within 6 months of receipt, it will be returned to the vendor as unacceptable. A vendor deficiency report will be completed.
 - 3.6 The expiring item will be properly disposed of (see DP 772.2) and the replacement item will be added to the current inventory.
 - 3.7 All dental pharmaceutical items, i.e. local anesthetics and medications, will be co-monitored with pharmacy staff on a monthly basis. When these items are to be disposed of they will be returned to the pharmacy for proper disposal.
- 4.0 IMPLEMENTATION:This procedure will be implemented without change effective immediately.

DENTAL SERVICE PROCEDURE 787

Evaluation and Triage of Dental Health Needs Request

- 1.0 **PURPOSE:** To provide a dental evaluation and review for all inmates who submit an HNR with a dental complaint, including dental pain.
- 2.0 **RESPONSIBILITY:** The Dental Program Manager and Dentist Supervisor at each facility will be responsible for compliance with the requirements of this procedure.
- 3.0 **DEFINITIONS:** **HNR:** Health Need Request Form

Dental Classification System: Dental Procedure 770.2

Dental Assistant Evaluation: Collecting and recording by a staff dental assistant for a specific dental complaint of pain, oral bleeding or facial swelling (extra / intra oral).

Standing Medical Order: Toothache/Dental Abscess

4.0 EXCLUSIONS:

- 4.1 ASPC- Globe
- 4.2 SACRC
- 4.3 Papago Unit
- 4.4 Picacho Unit

5.0 PROCEDURES:

- 5.1 Upon receipt of an HNR, the staff dental assistant will evaluate the request using the Dental classification system (Dental Procedure 770.2). Any inmate whose request is considered priority one or two will be scheduled for clinical evaluation by the dental assistant that day or next clinical day.
- 5.2 The dental assistant's clinical evaluation will only address the complaint as defined under Dental Assistant Evaluation. The dental assistant will review the inmate health history perform an oral evaluation, and take dental radiographs, to assist in determining the severity of the dental condition.
- 5.3 The dental records and x-rays of those inmates who received a dental assistant evaluation will be reviewed and an appropriate dentist's acknowledgment within one business day (24 hours). In the event of the unit dentist being unavailable for consultation the dental assistant shall ensure that another complex dentist reviews the evaluations, within one business day. If no other dentist is available (onsite or on call), the dental assistant shall call the Dental Program Manager for a telephone

review. In the event the Dental Program Manager is not available the dental assistant shall discuss the inmate with an attending complex physician.

- 5.4 The primary treatment that may be rendered at this visit is treatment that will alleviate pain and/or infection per Standing Dental Order (toothache/dental abscess).
- 5.5 The inmate should be rescheduled for treatment by the reviewing provider based on the priority level of the inmate's dental condition within the dental classification system. If the reviewing provider has any question as to the significance of the dental assistant's evaluation, the dentist is to see the inmate within the next 24 hours or sooner.
- 5.6 The inmate should not be charged for the follow-up visit at in order to establish a definitive treatment for the condition reported in the HNR referred in Sec. 5.1.
- 5.7 The staff dental assistant evaluation SOAP notes and dental X-rays (if taken) shall be recorded in the dental section of the Inmate Health Record.

This section describes infection control guidelines for use during clinical activities. Careful attention to these practices will help during clinical activities. Careful attention to these practices will help to reduce the possibility of exposure to, and the transmission of the infectious agents. Infection control guidelines will be covered in phases:

- Pre-treatment
- Treatment
- Post-treatment
- Radiographic procedures

PROCEDURE:

The process of infection control begins during the period of preparation for clinical treatment. Paying attention to infection control at this time has several payoffs. In addition to reducing the risk of transmission of infectious agents during patient care, thinking ahead will make the treatment session more efficient, and will also make the post treatment infection control process easier and more effective.

1.0 Infection Control Procedures - Pretreatment

1.1 ***Remove unnecessary items from the operatory.*** The operatory should be arranged to facilitate thorough cleaning following each patient. This can be achieved by reducing the number of items that may become contaminated during patient treatment. Unnecessary items and unused or seldom used equipment should be removed. Keeping the operatory as uncluttered as possible reduces the number of items that could become contaminated and consequently makes posttreatment clean-up easier.

1.2 ***Preplan the materials needed during treatment.*** Careful planning before treatment begins is an important aspect of infection control. Set out all instruments, medication, impression materials and other items that are needed for a procedure. Thinking ahead minimizes the need to search for additional items or enter cabinets and drawers once gloves have become contaminated.

1.3 ***Utilize disposable items whenever possible.*** The use of disposable items saves time during cleanup and decontamination. Disposables also solve the problem of decontaminating hard-to-clean items such as the saliva ejector.

1.4 ***Use prearranged tray set-ups for routine or frequently performed procedures whenever possible.*** The use of prearranged trays containing the instruments and supplies required for a clinical procedure helps to eliminate the need to go into drawers and cabinets once you have started a procedure.

1.5 ***Use individualized, sterilized bur blocks for each procedure.*** Using individualized bur blocks containing only the burs required for that procedure helps to eliminate the

contamination of other, unneeded burs and makes clean up easier.

1.6 *If indicated, have the rubber dam setup on the tray.* When a rubber dam will be used during a clinical procedure, it should be included on the tray setup. In addition, include those items needed for high-velocity evacuation.

1.7 *Identify those items that will become contaminated during treatment.* While preparing the operatory prior to beginning a clinical procedure, consider which items will become contaminated during treatment. Decide whether to use a barrier to prevent contamination of these surfaces and items or to disinfect them when the procedure is completed.

The decision to use barriers or chemical disinfection should be based on individual circumstances. Barriers are quick and easy to use, and can be readily changed, but may be more expensive than chemical disinfection. In contrast, disinfectants are generally less expensive and are easy to use on flat surfaces, but they may stain or corrode some materials, may be toxic, and are difficult to use effectively on rough and odd-shaped surfaces.

If barriers are chosen, a number of readily available materials can be utilized. These include plastic wraps, aluminum foil, impervious backed paper, and commercially available polyethylene sheets and tubing. Some examples of the use of barriers follow:

Light handles may be covered with plastic wrap or aluminum foil. Disposable light handle covers are available commercially and some manufacturers offer removable light handle attachments that can easily be decontaminated.

The chairback may be covered with a polyethylene bag to protect the headrest, control buttons, and arms of the chair; or you may use a headrest cover and protect the control buttons with plastic wrap and the arms with polyethylene tubing.

Cover counter tops with plastic-backed paper covers. Covers facilitate the clean-up process following use of impression materials or cement.

Protect the controls of the air/water syringes, saliva ejector, high-velocity evacuator, and handpieces with polyethylene tubing.

1.8 *Place radiographs on the view box and review patient records before initiating treatment.* Do not leave the record on the countertop or handle it after beginning treatment. Place the record in a drawer or out of the operatory, so that it does not become contaminated. Entries into the record should be made before gloves are put on or after they have been removed and hands have been washed.

1.9 *Follow manufacturer's direction for care and maintenance of water lines.* Because bacteria may grow or accumulate within the water lines, follow the manufacturer's directions for care and maintenance of water lines within the handpiece hose, air water syringes, and ultrasonic scaler. Run handpieces and air-water syringes for at least 30 seconds each morning to flush out any residual material. Although there is a risk of infection from contaminated water lines, the magnitude of this risk is not

presently known. However, bacterial infections in medically compromised patients attributed to contaminated dental unit water lines have been reported. Some dental units are equipped with water check valves that prevent aspiration of microorganisms into the water lines. Other units do not have check valves, and capillary retraction of fluid may occur. For this reason, it is recommended that flushing of the water lines be done after each patient use. Systems for dental units that periodically disinfect the water lines are commercially available and should be utilized at the end of the day.

1.10 *Prepare personnel involved in patient care.* An essential pretreatment procedure is the preparation of all personnel involved in patient care. This includes the utilization of personal protective equipment (gown, eyewear, mask, and gloves) and handwashing.

Gowns protect skin and clothes from spatter of saliva and blood. For effective protection, a gown with long sleeves should be worn.

Protective eyewear must be worn during procedures that involve splash and spatter of saliva and blood, or that have the potential for creating projectiles. Shatter-proof goggles should be worn for protection against solid debris such as amalgam. As an alternative to protective glasses or goggles, a face shield may be worn.

A mask should be worn any time splash or spatter of saliva or blood is anticipated. Masks serve as barriers to protect the mucous membranes of the nose and mouth from spatter. Use a face mask for procedures such as preparing a tooth with an air-turbine handpiece, or polishing teeth with a slow-speed handpiece, as well as during ultrasonic scaling or other procedures likely to generate spatter and splash. The mask must fit snugly around the face. Use a new mask for each patient. Finally, the mask should not be left hanging around the neck or worn out of the operatory.

Gloves must be worn whenever you anticipate contact with blood or saliva of dental patients, or any objects contaminated with these fluids. The type of glove worn will depend on the procedure that is being performed.

Hand washing is one of the most important procedures for preventing infection. Hands should be washed before putting on gloves and after their use because of the possibility that gloves may have defects or incur tears not visible to the eye which may allow microorganisms to contact the skin. If a glove becomes torn or punctured, it should be removed and hands should be washed as soon as patient care permit. If hands become contaminated with blood, wash them immediately and thoroughly.

When washing your hands, try to minimize their contact with any surface to avoid re-contamination. Ideally, a foot-operated soap dispense should be used. Sinks with faucets that are elbow or foot operated and that are designed to minimize splash can help avoid re-contamination of washed hands. Lather hands well and rub them together for at least 15 seconds so that all surfaces are scrubbed, then rinse them well under a stream of water. If hands are heavily soiled, longer washing times may be needed. Before surgical procedures scrub hands and

arms to the elbows with an antimicrobial hand washing product for 5 minutes. Rinse and dry with a sterile towel. Towels used for drying hands after washing should be disposable or changed for each patients. Maintain well-manicured, short nails, and avoid wearing rings, fingernail polish, or false fingernails because these items provide places where microorganisms can collect and multiply and cannot be removed by hand washing.

2.0 Infection Control Practices - Chairside

- 2.1 *Use care when receiving, handling or passing sharp instruments.* Many of the instrument used in dentistry can easily cut glove and skin. When passing a sharp instrument, the proper technique is to keep the sharp end angled away from both yourself and your coworker.
- 2.2 *Take special precautions with syringes and needles.* Needle stick injuries are a major cause of infection in health care personnel. Needles should not be recapped, bent, broken or otherwise manipulated by hand. In the dental setting, because a patient may require a second injection of local anesthetic, and most syringes are not disposable, recapping is sometimes necessary. Never recap a needle using a two-handed technique. Instead, use one of the commercially available sheath holders or the “scoop” technique. In this technique, the cap is scooped up from the tray with the needle tip using only one hand. As additional protection against needle sticks, do not allow uncovered needles to remain on the instrument tray. It is far safer to dispose of them immediately after use in a puncture-proof container. Finally, never allow the point of needle to move in the direction of any part of your or a coworker ‘s body.
- 2.3 *Use a rubber dam whenever possible.* Rubber dams limit the splash and spatter of blood and saliva and should be used whenever possible to prevent contamination. Similarly, use high-velocity evacuation for all ultrasonic and air turbine procedures to reduce the amount of spatter of blood and saliva to which each dental operator is exposed.
- 2.4 *Avoid touching unprotected switches, handles and other equipment once gloves have become contaminated.* If objects are touched or handled, they should be carefully cleaned and disinfected at the end of the procedure.
- 2.5 *Avoid entering drawers or cabinets once gloves have become contaminated.* Adequate preplanning will reduce and often eliminate the need to reach into drawers and cabinets for additional items with necessary to do so no matter how well you have planned. There are several ways to handle this situation while maintaining effective infection control. You may simply ask another person for assistance; or you may use another barrier, such as prepackages aluminum foil squares or plastic gloves, to grasp the cabinet or drawer handle. However, if these options are not available, you must remove the contaminated gloves, and wash hands before entering a drawer or cabinet, and then re-glove before resuming patient treatment.

2.6 Do not use dental unit water for any procedure that involves cutting to the bone.

3.0 Infection Control During the Post-treatment Period

Procedure:

The infection control process continues after the patient has been dismissed. Although effective pretreatment planning will simplify your task, there are a number of things that should be done following patient care to further reduce the risk of transmission of infectious agents.

- 3.1 *Continue to wear personnel protective equipment during clean-up.* After patient care is completed, begin the cleaning and disinfecting process by removing contaminated gloves used during treatment. Following removal of gloves, wash your hands and put on a pair of utility gloves before beginning the clean-up. Continue to wear protective eyewear, mask and gown.
- 3.2 *Remove all disposable barriers.* All of the barriers placed before treatment, including light handle covers, polyethylene tubing and countertop barriers should be removed. Follow State and local regulations for proper disposal of wastes.
- 3.3 *Dispose of blood and suctioned fluids that have accumulated in the collection bottles during treatment.* Proper disposal of these fluids is essential. Identify a special purpose sink connected to a sanitary sewer that can be used solely for the disposing of blood, liquid wastes and suctioned fluids. After the blood and suctioned fluids are poured into the sink, use a solution of 1:10 household bleach to disinfect the dental unit collection bottle. The bottle should be completely filled and the solution should be kept in the bottle for 10 minutes before emptying and rinsing with fresh water. As an option, disposable suction collection systems are available. Again, be sure to follow State and local regulations regarding the proper disposal of liquid wastes.
- 3.4 *Clean and disinfect all items not protected by barriers.* All surfaces and equipment that were not protected by barriers and that are visibly contaminated by spray or spatter must be cleaned and then disinfected with an intermediate level surface disinfectant - for example, iodophor, phenolic solution, or diluted household bleach (sodium hypochlorite).
- 3.5 Remove the tray with all instruments to a sterilization/clean-up area separate from the treatment room. Ideally, dental offices should be designed with a separate room for instrument clean-up and processing for heat sterilization to reduce the likelihood that items already disinfected or sterilized may inadvertently become contaminated. Instruments should be picked up individually. Never pick up a handful of instruments because this should be used when handling double-ended instrument. Instruments should be cleaned in an ultrasonic cleaner rinsed thoroughly after cleaning. Let the instruments dry thoroughly; bag or wrap. The clean instruments are then ready for sterilization. Using the appropriate container (IMS cassettes, Peel-Vue bags etc.) sterilize the instruments according to the manufacturer's recommendations for your sterilizer. A steam autoclave

that accommodates IMS cassettes is the recommended standard for ADC dental clinics. Biological monitoring of the efficacy of the sterilizer should be done monthly. The types of non-pathogenic spores used in monitoring are specific for the different types of sterilizers; be sure to use the system designed for your sterilizer. The results and any action taken should be recorded in the Biological Log.

3.6 *Sterilization of handpieces between patients should be done.* Handpieces should be flushed - discharging the water into a sink or container. The manufacturer's recommendations should be followed for proper slushing of hand pieces, and for the use and maintenance of waterlines and check valves. The handpiece should then be scrubbed thoroughly with a detergent and water to remove any adherent material. Finally, sterilize it according to the manufacturer's instructions.

3.7 Waste that is contaminated with blood or saliva should be placed in sturdy, leak-proof bags. Bags should be disposed of according to State and local regulations. Sharp items, such as needles and scalpel blades, should be placed intact into puncture resistant regulations. Sharp items, such as needles and scalpel blades, should be placed intact into puncture resistant containers and disposed of according the State and local regulations.

3.8 **Handle sharp items carefully.** Appropriate procedures for handling sharp instruments include the following:

Wear sturdy utility gloves when cleaning contaminated instruments or other sharp items.

Avoid picking up sharp instruments by the handful

Keep hands away from rotating instruments.

Dispose of needles and other sharp items promptly and appropriately.

When handling sharp instrument, avoid any quick motions that would bring one hand toward the other or the instrument across the plane of any part of your body.

Use the proper technique when passing sharp instruments to another person (see discussion above).

Exposure to bloodborne microorganisms may have occurred if:

The skin is cut with a blood contaminated sharp item or punctured with a blood contaminated needle.

Blood is splashed on broken skin.

Blood is splashed in the eyes, nose or mouth.

If and exposure incident occurs, consider the recommendations for the management of exposures published by the Centers for Disease Control, ie. Recommendations for Prevention of HIV Transmission in Health Care Settings, MMWR, August 21, 1987, 36, No 2S: 16-17; and Recommendations for Protection Against Viral Hepatitis, MMWR, 1985, 34:313-324, 329-335.

4.0 INFECTION CONTROL DURING RADIOGRAPHIC PROCEDURES

4.1 Infection Control Procedures

4.1.1 Use barriers to protect radiographic equipment. In preparation for exposing periapical radiographs, place a polyethylene bag over the tube head so that it will be protected from contamination when it is positioned for various exposures. It is easier to protect the tube head by use of a barrier than to disinfect it using chemicals afterwards. The exposure control switch should be protected with a plastic covering if a foot-activated switch is not available. After the radiographs have been taken, place the exposed film in a paper cup for processing.

4.2 Use appropriate developing procedures. When automatic film processor with daylight loader is used, contamination of the fabric light shield is likely to be a problem. Because there is no practical way to disinfect this material, the following procedure is suggested to prevent contamination:

- a. Place the exposed film in a paper cup previously set aside for this purpose. Do not touch the outside of the cup with contaminated film or soiled gloves.
- b. Remove soiled gloves and put on a pair of clean gloves.
- c. Place the cup inside the daylight loader and close the lid.
- d. Place the gloved hands through the light shield, unwrap the film packet, and drop the film onto the surface inside the loader.
- e. Place the film wrapping into the cup. Remove the gloves, turn them inside out and place them in the paper cup.
- f. Drop the film in the chute for developing.
- g. Remove hands from the loader, lift the lid, and dispose of paper cup and waste.
- h. Wash hands thoroughly.

5.0 Summary

Infection control during patient care can be viewed as a four stage process. During the pretreatment period, that is, before the patient arrives, preplanning is the key to effective

infection control. Arrange the operatory so that all of the items that will be needed during the procedure are ready and items not needed are removed to reduce the number of objects that must be decontaminated later. Place disposable, protective coverings over items and surfaces likely to become contaminated. Protect yourself by washing your hands and by using personal protective equipment including eyewear, mask, gloves, and gown. At chairside, use care when handling sharp instruments and use the proper technique for passing instruments to reduce the possibility of puncture wounds and cuts. Use an appropriate technique for recapping needles if they must be recapped. Use a rubber dam whenever possible, and high-velocity evacuation to reduce splash and spatter. Avoid touching unprotected switches, handles, or equipment with contaminated gloves. During the post-treatment period, flush the high-velocity evacuation system and dental unit water lines. Clean visible contaminated environmental surfaces and then use an appropriate disinfectant according to manufacturer's directions. In a separate area (if possible) clean the instruments and hand pieces, then sterilize or disinfect as necessary. Again, exercise great care in handling sharp instruments. Handle suctioned fluids appropriately. Dispose of wastes appropriately and according to State and local regulations. Finally, remove personal protective equipment, and wash hands thoroughly.

During radiographic procedures, maintain infection control by protecting radiographic equipment with appropriate covers. In the darkroom, use appropriate procedures to prevent or minimize contamination.

There are no shortcuts to achieving the goals of infection control during clinical procedures. However, by following the practices presented here, the risk of infection can be managed more effectively.

INFECTION CONTROL DURING LABORATORY PROCEDURES

PROCEDURE:

It is necessary to pay attention to infection control procedures chairside/prior to shipping cases are returned from the commercial dental laboratory, and when working on cases chairside.

- 1.0 When working on a prosthesis chairside, make sure appropriate personal protective equipment is worn. Rinse with tap water to remove excess blood and saliva. Make adjustments and if utilizing lab equipment, make sure surfaces that will be touched with contaminated gloves are either covered with barriers or disinfected after each patient. If there is the potential of cross contamination to prosthesis, be sure to disinfect prosthesis prior to delivering to patient.
 - 1.1 If prosthesis is being sent to commercial lab for repair, rinse with tap water to remove excess blood and saliva. Disinfect with appropriate disinfectant for appropriate time and in appropriate manner (see recommendations to follow).
Send to lab.
 - 1.2 For dental impressions, rinse with tap water to remove excess blood and saliva. Disinfect. Rinse. Ship or pour up models.
 - 1.3 Items only contaminated by minimal contact with oral fluids do not require sterilization, but clean and disinfect. Work pans should be cleaned and disinfected at least daily. Rag wheels should be sterilized between cases.
 - 1.4 As cases arrive from commercial laboratory, disinfect and rinse prior to delivery to patient.
 - 1.5 When working with equipment that may cause a hazard of flying objects (trimming, grinding, and polishing procedures), be sure to wear appropriate eye protection. Also, when trimming acrylic, try to limit flying debris by using evacuation.

CHAPTER 9

HAZARD COMMUNICATION PLAN FOR ARIZONA DEPARTMENT OF CORRECTIONS

INTRODUCTION:

On August 24, 1987, the Occupational Safety and Health Administration (OSHA) of the United States Department of Labor published Hazard Communication Standard, 29CFR1910.1200, to take effect on May 23, 1988. The standard was written to ensure that the hazards of all chemicals produced or imported are evaluated and that this information is transmitted to employers and employees at their worksite. The standard requires that all employers inform and instruct their employees of the chemical hazards in their work place. Through this information and instruction, injuries and illnesses should be minimized. Please refer to Department Order 712, Tools/Hazardous Materials Control.

The primary responsibility for hazard determination lies with the chemical manufacturers or importers. They are to evaluate the hazards and prepare a Material Safety Data Sheet (MSDS) with the appropriate information and correctly label their product. Distributors of the chemicals are to provide this required information to the employers. The employers are to provide this information to their employees by means of a Hazard Communication Plan that specifies information on MSDS, Labeling, and Training.

To facilitate implementation of this plan, this clinic has named _____ to coordinate implementation of this Hazard Communication Plan.

The Hazard Communication Plan and MSDS file are available for employees to review at any time. They are located:

(Specific location)

1.0 Levels of Responsibility

1.1 *Employers:*

- a. Monitors/reviews program progress.
- b. Assures compliance with MSDS and label requirements.
- c. Assures mandatory education and training.
- d. Shall immediately refer employee with chemical accident to appropriate medical personnel.
- e. Shall inform outside contractors about potential exposures when those employees perform work in the office and provides them with access to MSDS file.
- f. Assures compliances with hazardous waste removal.

- g. Handles concerns of employees.

1.2 *Hazard Communication Plan Coordinator:*

- a. Maintains current employee list.
- b. Maintains training records.
- c. Maintains hazardous chemical list.
- d. Can demonstrate safe handling of hazardous chemicals.
- e. Be knowledgeable with the MSDS's and their use.
- f. Maintain MSDS file and keeps it current.
- g. Be knowledgeable with label requirements and monitors labels.
- h. Ensures compliance to safety procedures.
- i. Assures training when new chemicals arrive.

1.3 *Employees:*

- a. Responsible for practicing job safety.
- b. Attend training and education sessions and apply this information on the job.
- c. Read and become familiar with MSDS file.
- d. Become familiar with labeling protocol and keep them current.

2.0 *Identification of Hazardous Materials:*

2.1 Primary responsibility for hazard determination lies with the product supplier.

2.2 Once the hazard determination is made, the supplier must develop a Material Safety Data Sheet (MSDS) for each Material that contains hazardous ingredients.

2.3 It is the responsibility of the dental clinic to keep a current inventory list of hazardous materials used, along with the products MSDS. (See Inventory Sheet)

3.0 *Material Safety Data Sheet (MSDS)*

3.1 All employees shall have access to Material Safety Data Sheets.

3.2 The clinic has designated an employee as the hazard communication plan coordinator and this person is responsible for MSDS collection, updating, and availability.

If this person leaves, a new person will be appointed as soon as possible.

- 3.3 The hazard communication plan coordinator will ensure that as new products are received, the inventory and MSDS file will be updated and the rest of the staff will be made aware of the new hazard. If no MSDS is received with the product, the dental supplier or manufacturer will be contacted and a copy of the request placed in the MSDS file.
- 3.4 All employees will periodically review the Hazard Communication Plan and MSDS file.
- 3.5 At least yearly, the MSDS file shall be checked to see if there are any MSDS's that are no longer used or current.

4.0 *Labeling:*

- 4.1 The hazard communication plan coordinator shall ensure the hazardous material's label has the identity of the chemical, the type of hazard posed by the material, and the supplier's name and address.
- 4.2 If materials are placed in a secondary container, this unmarked container needs to have a label posted on it that indicates the chemical name and appropriate warning.
- 4.3 Rather than handwriting a new label, it is possible to xerox the label off the original container and tape the reproduction on the secondary container.
- 4.4 If the secondary container is stationary, labeling may be done by posting a placard on or near the stationary container.
- 4.5 All staff will ensure that the labels are legible, not defaced, nor removed. If they are, make additional labels when needed.

5.0 *Information and Training*

- 5.1 At the time of initial employment, employees will be provided with information and training on hazardous chemicals.
 - a. Employees will be provided the Hazard Communication Plan and MSDS file and are expected to become familiar with their contents, including the requirements of the OSHA Hazard Communication Standard, the list of hazardous chemicals in the office, the location of the MSDS file, the labeling protocol, etc.
 - b. This information will be reviewed on an annual basis and documented.
- 5.2 As new products are introduced to the work area, the hazard communication plan coordinator will plan training in identifying the physical and health hazard of the new chemical and present measures staff can take to protect themselves.