## Clinic Policy Manual for Faculty & Staff

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University of Washington School of Dentistry

MISSION STATEMENT

The School of Dentistry shares the University’s overall mission to generate, disseminate, and preserve knowledge, and to serve the region. The School is an integral part of the Warren G. Magnuson Health Sciences Center, and is an orofacial health care center of excellence serving the people of the State of Washington and the Pacific Northwest.

The School’s clinical goal is to prepare students to be well-trained orofacial health care professionals. The School’s research programs contribute to understanding biological, behavioral, social, biomedical, and clinical aspects of dental / orofacial health.

Through service, the School strives to improve the public’s health through outreach programs with attention to minority and underserved communities. The School values diversity in its students, staff, faculty, and patients. It seeks to foster an environment of mutual respect with objectivity, imaginative inquiry through lifelong learning, and the free exchange of ideas.

Updated 12/16/15
University of Washington School of Dentistry

CLINICAL GOALS OF PATIENT CARE AND
CLINIC MANAGEMENT

Philosophical Basis of the Patient Care System

The overall philosophy of the patient care system in the School of Dentistry is to create positive professional relationships between our patients and the health care providers of the School and provide patient-centered dental care.

The outcomes are threefold: to educate competent clinicians well prepared to enter the dental profession, to provide comprehensive dental care assessed by the quality improvement program, and to maintain an effective and fiscally sound clinical operation.

Patient Care Goals

The overall goal of the patient care system is to model ethical and responsible professional behavior while providing dental treatment to a diverse patient population which meets the standard of care. Specific goals are to:

- inform patients of the patient care process within the School of Dentistry.
- establish and maintain a professional and mutually satisfying relationship with patients.
- inform patients of their oral health care needs and treatment options.
- demonstrate a commitment to continually enhance our knowledge, skill and judgement.
- deliver care in a timely manner within the constraints of an academic setting.
- complete all planned treatment services authorized by the patient.
- deliver appropriate and quality care.
- make appropriate emergency services available to patients.
- provide patients with a safe and clean environment for the delivery of oral health care services.
- provide a recall program to monitor the oral health of the patients.
Clinic Management Goals

The goals of the clinic operation are to:

- maintain an effective and efficient patient care delivery system.
- maintain and communicate current patient care policies and procedures throughout School of Dentistry clinics.
- maintain a system of operation that can accommodate changes in the educational programs.
- maintain a patient care system that complies with the state regulated practice of dentistry.
- maintain a patient care system with fiscal integrity.
- operate a records management system that facilitates ready access to patient records for patient care providers.
- operate a quality improvement program for our patient care.
- maintain a positive, respectful and ethical atmosphere of cooperation and teamwork with classmates, staff, administrators and faculty.

Departmental Clinical Goals

Endodontics

The objectives of the predoctoral endodontic program are five-fold.

- The student should be able to differentiate between signs and symptoms caused by pulpal or periapical pathosis and those caused by other forms of orofacial pathosis.
- When pulpal or periapical pathosis has been identified, the student should be able to determine its cause, select and carry out appropriate treatment, and estimate the prognosis.
- The student should be able to complete, at a clinically acceptable level, those clinical procedures which are consistent with his/her experience level.
- The student should be able to identify those factors which affect the complexity of treatment in each endodontic case and distinguish between those cases which are
within his/her ability to manage effectively and those which should be referred to practitioners who can more appropriately provide for the care of the patient.

- The student should be able to accurately critique completed clinical procedures.
Oral Medicine

At the completion of the clinical programs in the Oral Medicine undergraduate curriculum the student will be:

- competent in obtaining a clinical history consisting of an interview, administration of history forms, and analysis of the data collected as related to the chief complaint, medical, dental and social history of the patient;

- proficient in completing a physical examination of the structures of the head, neck, and oral cavity appropriate to the modern practice of dentistry;

- competent in the use of other diagnostic methods including pulp testing, radiographic assessment, neurologic testing of the cranial nerves and use of auxiliary diagnostic tests as needed in the assessment of Orofacial problems;

- skilled in the recognition and clinical management of oral soft tissue disease and stomatitis, including development of an acceptable differential diagnostic list and identification of appropriate primary care treatments for each condition;

- competent in, the primary care, pharmacological management of oral soft tissue diseases including infections, immune based disorders and other forms of stomatitis;

- skilled in the recognition and primary care management of oral osseous and hard tissue diseases of the jaws and able to develop an acceptable differential diagnostic list and appropriate primary treatments for each condition;

- proficient in the recognition, diagnosis and primary care treatment of major types of acute and chronic Orofacial pain including pulpal and dental pathology, Temporomandibular disorders, and other major causes of facial pain;

- competent in, the primary care, pharmacological, physical and dental management of acute and chronic Orofacial pain states including Temporomandibular disorders and other major causes of facial pain;
• competent in the use of behavioral approaches in the assessment, diagnosis and treatment of chronic Orofacial pain and other oral soft tissue diseases;

• competent in the recognition, diagnosis and primary care treatment of most common salivary disorders and the management of their impact on oral health;

• proficient in the recognition and diagnosis of common neurosensory disorders of the mouth and jaws and their primary care management and referral;

• proficient in the recognition of risk factors for diseases of the oral, hard and soft tissues;

• competent in the diagnosis and treatment of dental emergencies;

• skilled in the taking and interpretation of intraoral dental radiographs;

• proficient in the assessment of radiographic quality and identification of causes of technical errors leading to loss of diagnostic quality of dental radiographs;

• competent in the interpretation of panoramic dental radiographs;

• competent in the use of a problem oriented approach in treatment planning of dental patients including medical management of compromising conditions and dental planning for the treatment of oral diseases and conditions; and

• competent in the primary dental care and medical management, in ambulatory dental settings, of patients with disabling conditions including developmentally, medically, mentally and physically disabling disorders.

Oral and Maxillofacial Surgery

At the completion of the clinical component of the undergraduate curriculum in Oral and Maxillofacial Surgery the student will be able to:

• Perform and document a physical examination appropriate for the clinical situation and compile, interpret and record a past medical history, then assess the capacity of a given patient to undergo prescribed surgical procedures.

• Formulate and document a surgical treatment plan based on clinical history, physical examination, and imaging and laboratory studies. The student will be able to integrate the surgical treatment plan with an overall comprehensive plan of care for each patient.

• Recognize and describe the common benign and malignant diseases, deformities, injuries, and abnormalities treated by Oral and Maxillofacial Surgeons.
• Understand and describe the indications and contraindications of the basic procedures performed by oral maxillofacial surgeons such as simple and complex dentoalveolar, orthognathic, temporomandibular joint and reconstructive surgery. This includes major and minor bone augmentation and maxillofacial and dental implants.

• Understand and describe the basic medical and surgical procedures employed by oral and maxillofacial surgeons as they treat common oral and maxillofacial conditions.

• Understand and describe the medical and surgical care associated with caring for patients who have experienced major and minor oral and maxillofacial trauma.

• Understand, describe and perform surgical and medical procedures needed by patients who present with oral and maxillofacial infections commonly seen in general dental practice.

• Discuss findings, diagnoses, and treatment options with their patients and obtain informed consent when surgical intervention is recommended.

• Understand and demonstrate the basic principles of exodontia. Students will be able perform simple dental extractions independently. Students will be able to assess the difficulty of proposed complex dentoalveolar and pre-prosthetic surgery and know when and how to refer patients for specialty care.

• Recognize and treat common complications arising after dentoalveolar surgery.

• Describe and demonstrate clinically knowledge of the pathophysiology and anatomy of acute orofacial pain and prescribe pharmacologic and basic psychological methods for treating patients in acute pain.

• Describe the pharmacology of commonly used oral sedative agents and demonstrate the clinical use of those agents in patients selected for conscious sedation based on clinical examination, medical history and proposed treatment needs. Students will be able to monitor those patients through the continuum of depressed levels of consciousness commonly seen in sedated patients.

• Understand and describe the indications and contraindications associated with commonly used pain and anxiety control measures including specialty-level parenteral medications and general anesthesia.

• Recognize, describe and, should the occasion arise, participate in the treatment of patients with surgical and medical emergencies in an outpatient clinical setting.

• Manage acute post-operative pain with medications. This includes demonstrating knowledge of the pharmacology of the commonly used analgesics and the potential for drug interactions in light of the patient’s medical history. Students will also demonstrate their ability to write prescriptions and communicate, when appropriate, with pharmacists.
• Formulate and list the features that support the differential diagnosis for an oral lesion, defect or deformity based on clinical history, physical findings, laboratory studies and radiographic images.
• Understand the indications for and procedures associated with simple biopsy techniques.
• Describe the definitive histopathologic features that characterize the final diagnosis of commonly seen oral and maxillofacial pathological processes.
• Describe the procedures and documentation necessary for referring a patient for specialty care.
• Describe and demonstrate the ethics and professionalism associated with making referrals for specialty care and accepting patients back into general practice after specialty care.
Orthodontics

At the completion of clinical studies, the students will be able to:

- differentiate between simple and complex orthodontic problems;
- provide interceptive, preventive, and limited corrective procedures for the mixed dentition patient;
- provide limited orthodontic treatment for the adult patient;
- provide consultation and referral to specialists in an efficient and knowledgeable manner; and
- assess the dentition and identify malocclusion

Pediatric Dentistry

At the completion of clinical studies, the students will be able to:

- recognize and explain the difference between primary and permanent teeth, particularly as they affect appropriate clinical protocol used, and provide treatment accordingly;
- recognize and explain the relative merits and uses of specific instruments and dental and biomaterials as they apply to dental restorations involving pediatric patients, and provide treatment accordingly;
- recognize and explain the specific steps involved in restoring primary and young permanent teeth with amalgam, stainless steel crowns, composite and glass ionomer materials, and provide therapy accordingly;
- recognize and explain the specific steps involved in providing pulp therapy for primary and immature permanent teeth, and provide treatment accordingly;
- recognize and explain preventive strategies for children, including diet assessment and counseling, fluoride therapy, oral hygiene techniques and other approaches, and provide appropriate clinical care and counseling;
- explain the procedures for providing care for traumatically involved primary and young permanent teeth;
- recognize and explain the principles involved in assessment and treatment of space management problems;
• recognize, explain, and demonstrate sound principles of patient management for pediatric patients; and

• create a treatment environment that fosters a positive attitude regarding personal oral health and regular dental care in the pediatric patient.

Periodontics

At the completion of the predoctoral clinical program in Periodontics the student will be:

• competent in the use of diagnostic periodontal methods and the making of a periodontal diagnosis;

• proficient in the making of a prognosis for the dentition from a periodontal perspective;

• competent in the sequencing and treatment planning of periodontal therapy in patients with periodontal diseases (severity type I-III cases - as defined by the American Academy of Periodontology);

• competent in the delivery of prophylactic periodontal care;

• competent in the delivery of non-surgical periodontal therapy in patients with periodontal diseases;

• proficient in uncomplicated minor periodontal surgery (flap debridement);

• competent in the pharmacological management of post-operative pain resulting from minor periodontal surgery;

• competent in the pharmacological management of anti-inflammatory and antibacterial agents in the treatment of periodontal diseases;

• competent in the provision of maintenance periodontal care;

• competent in the management of periodontal emergencies; and

• competent in the assessment and recognition of periodontal conditions requiring referrals and competent in making referrals to and working with specialists in Periodontics.
Prosthodontics

At the completion of clinical studies, the students will be able to:

- diagnose and treat the completely or partially edentulous patient which includes the delivery of complete dentures, immediate complete dentures implant supported or overdentures, removable partial dentures, and temporary removable complete or partial dentures;

- coordinate fixed and removable prosthodontic treatment if indicated with surveyed cast restorations;

- assess the general adequacy of a prosthodontic patient's diet and counsel the patient about diet and oral health;

- reline and repair removable complete and partial dentures;

- write a prescription, delegate and supervise certain prosthodontic procedures involving a dental technician; and

- recognize and describe clinical procedures and or problems requiring referral to a specialist for preparatory or comprehensive therapy.

- Describe and demonstrate the ethics and professionalism associated with making referrals for specialty care

At the completion of clinical studies, the students will be:

- exposed to the fields of removable and implant supported prosthodontics.

Restorative Dentistry

Students in the Restorative Dentistry clinical programs shall be able to:

- develop and apply suitable preventive regimens to forestall destructive processes involving the dentition, such as caries, attrition, abrasion, and erosion;

- provide appropriate diagnosis and treatment planning for the restoration of the dentition;

- critically assess and select appropriate biomaterials to aid in the restoration of the dentition;
• provide patients with dental restorations to satisfy patient needs in both form, function and esthetics without damage to adjacent teeth and tissues;

• Describe the procedures and documentation necessary for referring a patient for specialty care.

• Describe and demonstrate the ethics and professionalism associated with making referrals for specialty care and accepting patients back into general practice after specialty care.
- perform the requisite technical procedures necessary to provide patients with high quality dental restorations which will remain in service for a reasonable length of time; and

- re-evaluate patients periodically and assess the stability of existing dental restorations and provide replacements where appropriate.

**Pre-doctoral dental students shall:**

- understand the structure and organization of hospitals and procedures necessary for staff membership;

- become familiar with the dental management of medically compromised patients; and

- experience the provision of dental care in hospital-based clinics including the treatment of patients through a hospital emergency department.

Revised: 2/25/16
University of Washington School of Dentistry  
Predoctoral Clinics  

STANDARDS OF PATIENT CARE  

GENERAL CARE STANDARDS  

Admissions  

- All prospective patients shall be offered an admissions consultation within four weeks of contact by the patient when the admissions clinic is in operation.  
- During the admissions consultation appointment all patients shall be offered an information session and a brief oral examination.  
- Patients shall be admitted to the predoctoral clinics for treatment on the basis of matching the patient's needs with the scope of the predoctoral educational program to assure the delivery of care within an appropriate range of expertise of the students and the supervising faculty.  
- No patients shall be denied admission to the predoctoral clinics on the basis of race, color, creed, religion, national origin, sex, sexual orientation, age, marital status, disability, or status as a disabled veteran or Vietnam era veteran.  
- Patients who are denied admission shall be informed at the time of the decision and the reason for that decision shall be documented in the patient record.  
- Patients seeking limited services which are within the scope of the predoctoral clinical programs shall be admitted for care as long as the patients consent to limited treatment, the limitation of care is clearly documented, and such limitations are not detrimental to their health and well-being.  

Timeliness of Care  

- All comprehensive care patients shall be assigned to a student within eight weeks of admission when school is in session. (Exceptions: Selected prosthodontic patients, patients with specialized needs (e.g. veneers, implant) who may be assigned to honors students at limited times of the academic year.  
- Accepted patients with emergent needs will be treated or referred as appropriate to stabilize their oral health status.
• All patients shall have the opportunity to receive their comprehensive clinical examination (basic assessment) within four weeks of their admissions consultation when school is in session.

• Treatment plans shall be developed and then submitted to the Office of Clinical Services within eight weeks of assignment of a patient to a student.

• Adult patients shall have the opportunity to be seen at least once per quarter when school is in session. Pediatric patients shall have the opportunity to be seen at least once per month when school is in session.

• Adult patients with active oral disease shall have the opportunity to be seen at least once per month when school is in session.

Informed Consent

• All comprehensive care patients (or parents, guardians or responsible adults when treating a pediatric patient) shall be completely informed of their oral health needs prior to the onset of treatment. This informed consent shall include problem identification, treatment alternatives, cost estimates, time commitment required, and any significant risk or consequence associated with either the treatment or non-treatment of their conditions.

• All patients shall acknowledge their understanding of their oral condition, the proposed treatment, and the existence of treatment alternatives and cost estimates by signing an appropriate consent statement.

• All patients shall sign an appropriate consent prior to commencement of active treatment.

Patient Records

• A patient record shall be established and maintained which documents all diagnostic and therapeutic actions as well as significant communication related to patient care. The record shall include the health history, treatment consultation reports, dental charts, progress notes, correspondence related to care, laboratory reports, prescription data for medications, prescription data for dental laboratory services, and radiographs.

• Medical alert labels shall be attached to the outside of the patient record when the care provider's attention to previous health history findings are of significance to the process of care.

• Patient records shall remain confidential and be managed in accordance with Washington state law, chapter 70.02 RCW. The complete law can be found at the Washington State Department of Health website: www.doh.wa.gov.
Comprehensive and Limited Care

- All patients seeking comprehensive care shall be presented with a problem-oriented treatment plan proposal following all appropriate consultations and faculty approval and signature.

- All adult patients seeking comprehensive care shall receive a letter that contains an explanation of all elements of the treatment plan.

- Treatment plans shall be modified as necessary as treatment progresses to reflect the changing needs of the patient in terms of clinical conditions, response to therapy, financial considerations, and patient availability.

- At a minimum, treatment plans shall be updated annually.

- Limited care services shall be made available to patients who seek selected services such as, but not limited to, oral surgery, endodontics, and diagnostic services, as long as the service being sought is within the scope of the predoctoral program and will improve the oral health status of the patient.

- All comprehensive care patients shall be notified by mail of delay of care, or of severance of the professional relationship between the school and the patient.

Emergency Services

- Emergency services shall be provided for patients who are not patients of record on a space available basis during normal business hours regardless of the patient's ability to pay for services at that appointment.

- Pediatric patients who are not patients of record of the school shall not be seen for emergency care.

- Patients of record of the school who need emergency care during normal business hours shall be seen by their assigned student in the appropriate clinic regardless of their scheduled activity for that day.

- Pediatric patients of record of the school who need emergency care during normal business hours shall be assigned to a student for care or care shall be provided directly by a faculty member.

- Patients of record of the school who need emergency care after normal business hours shall be seen in the dental clinic at the University of Washington Medical Center.
• Pediatric patients of record of the school who need emergency care after normal business hours shall be referred to Children's Hospital and Medical Center.

• Patients who are not patients of record of the school who need emergency care after normal business hours shall be referred to the dental clinic at the University Medical Center and are subject to normal charges for emergency services.

**Patient Safety**

• Patients shall be treated in a sanitary workstation by care providers who use contemporary infection control and biohazards management strategies.

• Patient care shall be performed by or under the supervision of School of Dentistry faculty members licensed in the State of Washington.

• Patients shall receive diagnostic and treatment services in such a manner that is consistent with the patient's medical history and any medical consultations. This shall include the consideration of appropriate premedications, timing of the procedure, post-operative medications, choice of anesthesia and pain control, and the selection of the services to be rendered.

• Patients shall have health histories updated in such a manner that is consistent with the history of the individual patient. At minimum the history shall be updated every six months during active care.

**MEDICAL EMERGENCY**

• In case of cardiac arrest or other life-threatening emergencies, the EMS system shall be activated by calling Medic I at 9-911.

• In cases of serious, but not immediately life-threatening situations requiring follow-up medical care, the Emergency Department at UWMC shall be contacted at 8-4000.

• Faculty, clinical staff and students shall be currently certified in basic life support procedures.

• Appropriate and current medical equipment and devices, drug kits and first aid kits shall be available in each clinic.

**GENERAL DIAGNOSTIC STANDARDS**

**Examination Standards**
• All admitted comprehensive care patients shall be referred to the Diagnostic Clinic for a comprehensive clinical examination.

• All patients referred to the Diagnostic Clinic shall receive a complete head, neck and oral examination including periodontal and dental screening to detect the presence of odontogenic and other orofacial pathology. The assessment shall include a thorough medical, dental and social history and assessment of risk factors for oral and regional disease.

• All patients shall receive additional appropriate diagnostic tests when there are indications that such testing is reasonable and justified by symptoms or findings accumulated during the comprehensive examination. These diagnostic tests may include, but are not limited to, special clinical examination procedures such as joint function, neurological assessment and laboratory tests.

• Necessary intraoral and extraoral radiographic and other imaging modalities shall be ordered when clinical findings clearly indicate their need, and the results written into the patient record.

• Patients shall receive a written list of their problems, proposed or tentative treatments and need for medical or dental consultation before their diagnostic visit is completed. This tentative problem list shall serve as the guide for subsequent consultation and formulation of a plan of care.

• Any patient with history or clinical findings that suggest the need for medical, psychological or other professional consultations shall be provided with the written consultation order at the end of the diagnostic appointment and shall be provided with clear information about why the consultation is needed.
**Radiographic Standards**

- The decision to order and take radiographs shall be made strictly based on clinical symptoms and findings that demonstrate that imaging of the structure is necessary to make a definitive diagnosis or to make a decision on treatment or follow-up.

- The standards of the State of Washington regarding radiation safety shall be followed in making decisions on whether to expose a patient to ionizing radiation. Those same standards shall be used as the major decision criteria in practicing radiation safety during the exposure of patients to imaging modalities.

- All radiographs shall be labeled with the name of the patient and the exposure date and findings recorded in the patient record.

- All radiographic exposures shall be recorded in the Radiographic Log section of the patient record including the number and type of exposure, and the date of exposure.

- The use of intraoral dental radiographs shall be limited to the amount of exposure necessary to arrive at a diagnosis and the ordering and taking of films without clear clinical justification shall be avoided.

- The developing facilities and handling of radiographic images shall meet standards that prevent needless damage to films and loss of films.

- Radiographs shall be taken by non-dentists only when authorization is obtained from a licensed faculty member.

**TREATMENT STANDARDS**

**Periodontics**

- All patients seeking admission to the school for general care shall receive a periodontal screening examination using the Periodontal Screening and Recording (PSR) system.

- Comprehensive care patients with PSR scores of three or more in any one sextant shall be referred to the Department of Periodontics for management of their periodontal needs.
All comprehensive care patients being managed by the Department of Periodontics shall have the entire natural dentition evaluated for periodontal integrity upon entry into the periodontics program. Findings shall be recorded on a periodontal chart and stored in the patient record.

All comprehensive care patients being managed by the Department of Periodontics shall have the entire natural dentition evaluated for periodontal integrity as treatment progresses. New findings shall be recorded on a periodontal chart and compared with the initial clinical findings in the patient record to determine the efficacy of the care strategy.

All comprehensive care patients being managed by the Department of Periodontics shall not receive other than primary restorative, prosthetic, or orthodontic care until the patient's periodontal condition has been stabilized unless extenuating circumstances require a different treatment strategy.

Periodontal surgery shall not be carried out for patients needing such services until they demonstrate the ability to maintain an acceptable level of oral hygiene required for post-surgical long-term care.

**Prosthodontics**

Removable prosthodontic procedures shall be integrated with treatment services supervised by other departments in a master treatment plan. They will be provided in a logical sequence of care which is not influenced by the graduation requirements of students.

All removable prosthodontic restorations shall meet the standard of care of the profession before being accepted by the supervising faculty as a completed service. Wherever possible, all removable prostheses should exhibit the following features:

* maximum extension consistent with anatomy;
* a vertical dimension of occlusion which provides adequate interocclusal distance;
* occlusion in harmony with centric relation of the jaws and with bilateral balance in eccentric jaw positions;
* bases which are comfortable, stable and retentive to the degree permitted by the supporting anatomy;
* removable partial denture frameworks which seat passively on the teeth and have adequate retention; and
* prostheses which are esthetically pleasing to the patient.
• All treatment plans of patients assigned for prosthodontic treatment shall be reviewed and approved by the Prosthodontic advisor. This includes the design of removable partial dentures, the selection of the type of immediate denture, and the sequence of treatment.

• Oral tissues should exhibit good health before a definitive removable prosthodontic restoration is initiated. This includes, but is not limited to, control of caries and periodontal disease, treatment of inflammatory papillary hyperplasia, and removal of interfering soft tissues, teeth and tori. Interim appliances may be used during treatment of these conditions, but are intended to be used for a period not to exceed one year.

• Procedures used in the construction of all removable prostheses are described in the appropriate Prosthodontic syllabi and orientation manuals and shall be followed by students in treatment of patients.

• Nutrition counseling related to oral health shall be provided for patients reporting inadequate diets or clinical symptoms that may be related to nutritional deficiencies.

• All referrals for services to be performed by a Prosthodontic Laboratory shall be done in accordance with Washington state law.

• Appropriate follow-up care shall be provided in a timely manner under Prosthodontic supervision until an acceptable result consistent with the standard of care of the profession is achieved in the opinion of the Prosthodontic advisor. In general, at least six weeks of care are required post-insertion in order to ascertain patient comfort. All follow-up care is to be provided by the treating student until his/her graduation, except when away from the School on an extended block assignment.

Restorative Dentistry

• Restorative procedures shall be provided in a fashion which integrates with the overall treatment plan and sequence of care in a master plan of care. Restorative procedures shall be coordinated with the treatment provided by other disciplines and departments.

• The provision of restorative procedures is dependent upon the patients' needs and circumstances and neither the choice of procedures nor the sequence of care shall be influenced by graduation requirements of students.
Prevention of Disease

- All treatment plans shall include preventive services appropriate to the patient. This includes both professional services and patient actions.

- An essential component for dentulous persons is the reduction and removal of pathogenic plaque.
  * The patient shall be instructed in and encouraged to comply with appropriate oral hygiene practices.
  * A professional prophylaxis shall be accomplished at regular intervals appropriate for the individual. Efforts shall be made to remove all plaque, extrinsic stain and calculus. Enamel and cementum surfaces shall be polished and smooth.

- Caries prevention may include the following as appropriate for the patient:
  * Diagnostic tests for patients with high caries rates.
  * Provision of and/or prescription for topical fluoride.
  * Use of occlusal sealants.
  * Dietary evaluation and instruction.
  * Prescription for chlorhexidine to control cariogenic bacteria.
  * Recommendation for use of xylitol chewing gum.
  * Use of fluoride containing varnish.
  * Consultation with the patient's physician when drug induced xerostomia is present.

- Caries control treatment (restorations) may be performed for patients who demonstrate high caries activity. Materials of choice are reinforced zinc oxide/eugenol for posterior teeth and glass ionomer for anterior teeth. If this course of treatment is selected, all deep lesions should be treated with these materials as quickly as possible. In such cases the selection and placement of extensive crown and bridge procedures should be delayed until all caries activity has been eliminated.
Other areas of prevention:
* All tobacco use should be discouraged.
* Good dietary and nutritional habits shall be encouraged.
* Removal of mechanical and chemical irritants and highly cariogenic substances from the oral environment shall be encouraged (e.g., habitual use of lozenges, ill-fitting dentures).

Operative Dentistry

In general, treatments of choice for minimal to moderate loss of tooth structure not undermining cusps on posterior teeth include silver amalgam, compacted gold, or cast gold restorations. Exceptions include:

* Conservative class 1 or class 2 restorations where direct composite, indirect heat-cured composite or porcelain restorations may be appropriate if esthetics is a primary concern and occlusal function on the restoration is minimal.

* Involved teeth that are to be prosthetic abutments.

* Glass ionomer restorations for cases with cervical lesions and/or elevated caries activity.

* Selected cases where small class 1 and 5 lesions are restored with direct gold restorations.

In general, treatments of choice for minimal to moderate loss of tooth structure on anterior teeth not involving or undermining the incisal edge is composite resin. Anterior lesions of moderate depth in patients that exhibit high caries activity may be restored with glass ionomer cement. Cervical caries or erosion/abrasion lesions in anterior teeth may be restored with glass ionomer cement or compacted gold.

Where incisal edges of anterior teeth are involved, the following treatment is indicated:

* Use composites for cases involving incisal edges where minimizing the removal of sound tooth structure is desired.
* The use of labial veneers, where appropriate, to conserve tooth structure. Prognosis, as in all cases, should be explained to the patient.

* A general sequence of choices for the use of anterior restorations is as follows: 1) composite, glass ionomer; 2) labial veneer (resin or porcelain); and 3) complete crown (porcelain fused to metal or porcelain jacket).

- Where there is gross loss of tooth structure, such that there is insufficient tooth structure to support an indicated cast restoration, the tooth should be first strengthened with an amalgam foundation or cast post/core. Retention/resistance features may include pins, slots, wells, posts or intrapulpal chamber retention if endodontically treated.

- Complete crowns or partial coverage cast restorations are indicated when there is insufficient tooth structure left to support inlays, amalgams, composites, or glass ionomer restorations. When crowns are indicated on molars, and esthetics is not a concern, the material of choice is cast high noble metal. When esthetics is a concern, porcelain fused to metal should be used. An onlay should be considered when sufficient tooth structure is present but cusps need protection.

- Rubber dam shall be used whenever possible.

- Use of high speed burs and diamonds shall be accompanied by air/water spray.

- Pulp capping materials, such as calcium hydroxide, shall be used after deep caries removal where an exposure is suspected. Small, clean pulp exposures shall be capped using sterile instruments and materials. A protective base should be placed over the calcium hydroxide to protect the capped site before proceeding with a restoration.

- Zinc phosphate or glass ionomer cement are the bases of choice for thermal insulation. Reinforced zinc oxide/eugenol base may be used for thermal insulation if it was placed as a temporary restoration where all caries was removed and does not require removal for preparation of the definitive restoration.

- When extensive decay removal results in removal of all active caries (infected dentin) but removal of all inactive decay (affected dentin) will result in exposure of vital pulp, an "indirect" pulp cap may be accomplished by inserting a reinforced zinc oxide/eugenol temporary (IRM). After three months without clinical symptoms, the temporary material can be removed and a suitable permanent restoration placed.
• All restorations shall reproduce sound tooth contours, have flush margins, and restore interproximal and non-traumatic occlusal contact where feasible and desirable.

• "Esthetic" restorations shall match tooth shade and translucency as closely as possible.

Fixed Prosthodontics

• Prior to initiating fixed prosthodontic treatment for any tooth (teeth), a thorough evaluation of the current periodontal and endodontic status must be documented in writing. This includes evaluation of appropriate radiographs, probing depths, mobility, assessment of attached tissue levels, pulp vitality and assessment of plaque control.

• In the absence of specific contraindications (such as compromised general health status, compromised periodontal support or financial constraints), the replacement of choice, when one or two adjacent posterior teeth are missing and there is a tooth available as an acceptable abutment both anteriorly and posteriorly, is a fixed partial denture. This applies even when the missing teeth are in all four quadrants. However, it does not apply when a removable partial denture is necessary to replace teeth in the opposite side of the same arch. An implant-supported fixed partial denture can also be considered for the replacement of both anterior and posterior missing teeth.

• When up to all four of the incisors are missing in an arch and acceptable abutments are present, a fixed partial denture is the restoration of choice. This applies even if a removable distal extension partial denture is necessary to replace posterior teeth.

• The retainers of choice for fixed partial dentures are usually 3/4 crown, full crown, porcelain or resin veneered crown, or resin-bonded retainers, though alternative retainers may be indicated in some cases.

• If conditions are favorable, cantilever fixed partial dentures are acceptable for the replacement of lateral incisors with the cusp as the abutment. In special circumstances, a posterior replacement by a cantilever is acceptable, however double abutments are usually indicated. Buccolingual occlusal width should be reduced in such cases.

• Resin-bonded fixed partial dentures are acceptable for the replacement of teeth where there is no, or minimal, carious involvement or restoration of the abutments. Presence of existing restorations may temper the use of this type of retainer. Long span fixed partial dentures or periodontally compromised abutments are contraindications for resin-bonded fixed partial dentures. The retainer should fully cover any existing restoration(s).
• When posts or post and copings are necessary they should be separate from the crown or fixed partial denture abutment casting. It is essential that there be an adequate root to crown ratio for the post.

• Margins, contour and contact points shall be as for restorative dentistry. Contours of pontics should facilitate mechanical cleansing.

• Not all missing teeth should be replaced. As a rule, second or third molars, particularly when nonfunctional, should not be replaced. When there is no problem with mastication or esthetics, replacements are indicated primarily to preserve the remaining dentition. Therefore, the decision not to replace should be backed up with records and measurements of the teeth adjacent to and opposing the edentulous areas. Tooth position should be included in this analysis. This would enable the dentist to note whether deterioration and movement has taken place over time. In the event this occurs, the decision not to replace should be reversed. The patient shall be informed of the recommendation, its rationale and the prognosis.

• If malposed teeth are the primary reason for the rejection of a fixed partial denture, consideration should be given to orthodontic therapy.

• The materials of choice for fixed prosthetic restorations are high noble or noble metal castings with or without esthetic porcelain or resin veneers.

• Patients shall receive thorough instructions in special oral hygiene procedures related to fixed partial dentures.
Endodontics

The standards of care are based on the premise that endodontic treatment procedures should be of such quality that predictable and favorable results will routinely occur.

- The patient's medical history must be appropriately interpreted.
- Findings derived from clinical examination procedures must be appropriately interpreted.
- Access into the pulp chamber and canal space must be adequate to perform intracanal procedures but excessive tooth structure should not be removed.
- Canal instrumentation (cleaning and shaping) should be maintained within the original contour of the root canal space.
- The prepared root canal space should be obturated within 1.0 mm of the apical foramen or the radiographic apex.
- The solid core filling material should be contained within tooth structure.
- The prepared root canal space should appear to be completely obturated on post-treatment radiographs.
- Treatment procedures should be carried out in an aseptic manner.
- X-ray exposure should be limited to those radiographs required to effectively complete treatment.
- The comfort and safety of the patient must be provided for during the course of all treatment procedures.
- Treatment is considered on-going until the patient is completely comfortable.
Oral Medicine

Emergency Dental Care

- All patients seeking emergency evaluation and treatment in the emergency clinic shall be provided with the opportunity to be examined and treated during normal hours of operation.

- Patients with serious infections, traumatic injury and severe pain shall be evaluated within 24 hours or referred to community clinics that provide such care.

- The care provided in the emergency clinic shall be at the standard of general practice and necessary palliative treatments delivered including pulp removal, extractions, temporary restorations and treatment of soft tissue diseases and infections.

- Patients with acute pain and/or infection shall be provided with analgesic, antibiotic and other appropriate prescriptions.

- Infections and traumatic injuries beyond the scope of competence of those staffing the emergency clinic shall be immediately referred to the Oral & Maxillofacial Surgery service.

- Emergency patients shall receive written notification of their diagnosis and prognosis at the end of their emergency clinic visit.

Disabled Patient Care

- Patients with physical, emotional, medical and developmental disabilities shall be given full access to the service for diagnostic and emergency management.

- Patients with disabilities that are beyond the management skill level of the faculty and students shall be referred to the hospital dental service at the University of Washington Medical Center.

- The quality and timeliness of care for disabled patients shall meet the standard of the School of Dentistry except where the nature of the disability makes compliance impossible (e.g., uncooperative retarded patient, severe seizures and palsy states).

- Disabled patients shall have the same radiology, diagnostic assessment, recall and prevention protocols as routine patients.
Oral Medicine Care

- Patients of the Diagnostic Clinic found to have mucosal lesions, salivary dysfunctions, neurosensory disorders, chronic facial pain, and Temporomandibular disorders shall be referred to the Oral Medicine and Facial Pain clinic or assessed through immediate consultation with the Oral Medicine Service attending specialist.

- Patients with soft tissue oral disease and chronic facial pain managed in the Oral Medicine Clinic shall be assessed by a member of the Oral Medicine clinical specialty faculty in conjunction with assigned students. The faculty member will act as the continuing source of care for the patient.

- Lesions that represent potential risk of carcinoma or other destructive pathological processes shall be biopsied, studied through laboratory tests, or otherwise carefully followed to assure that the patient's risk of serious disease is not increased through inattention to follow-up.

- Patients seen in the Oral Medicine clinic shall receive appropriate pharmacological treatments, physical treatments and/or behavioral therapies in a timely manner.

- Private practitioners that refer patients to the Oral Medicine Clinic shall receive written notice that the patient has been scheduled.

- The diagnosis and treatment of TMD and chronic facial pain shall follow accepted authoritative guidelines for diagnosis and management such as the President's report from the ADA.

- Unsubstantiated treatments for TMD shall be restricted and the use of palliative therapies that alter jaw or tooth position resulting in surgery or orthodontic therapy will not be provided.

- The diagnosis and treatment of salivary dysfunctions shall include not only direct assessment and treatment of the gland defect but also primary prevention of potential dental disease which often results from xerostomia.

- Behavioral, stress reduction, cognitive therapy and physical treatments directed toward pain reduction shall be employed for those patients that demonstrate the need for such interventions through verbal report or from scores and diagnoses made using behavioral measures.
- Standardized examination techniques shall be used in the assessment of all patients with chronic pain or TMD with a major focus being the use of assessment techniques that have been demonstrated to be reliable.

- Diagnostic protocols for chronic facial pain shall include the use of medications as therapeutic trials to establish definitive diagnoses when specific laboratory or clinical tests do not exist.

**Oral & Maxillofacial Surgery**

- Patients shall have the benefit of an independent diagnostic opinion and an examination prior to the scheduling of any surgical treatment.

- Patients shall have adequate imaging studies prior to the rendering of a diagnosis and surgical intervention.

- Immediately prior to surgery the student shall record the patient's vital signs and coordinate care consistent with the findings in the medical history.

- All surgical care shall be performed only after attention has been given to the appropriate control of peri-operative and operative anxiety.

- Patients shall be given postoperative care instructions appropriate for the surgical procedure performed.

- Post-operatively the patient shall be given a telephone number for out-of-hours consultation in case of postoperative problems. The department shall provide 24-hour-a-day, 365 days per year emergency coverage for patients of record.

- All procedures shall be performed within the parameters of care as published by the American Association of Oral and Maxillofacial Surgeons.

- Prior to a patient being discharged, the faculty member shall see the patient and countersign the chart entry.

- When appropriate a postoperative follow-up outpatient appointment will be provided to the patient.
• All human tissue removed during surgical intervention shall be managed in accordance with the School of Dentistry Human Tissue Management Policy.

• Use of conscious sedation shall be carried out in accordance with the School of Dentistry Conscious Sedation Policy.

**Orthodontics**

• All comprehensive care patients shall be screened for debilitating malocclusions, either functional or esthetic. Orthodontic faculty will be available for consultation.

• The Department of Orthodontics will provide limited orthodontic therapy in the predoctoral clinic. Comprehensive orthodontic treatment shall be provided in the graduate or intramural practice clinics.

• Treatment provided in the orthodontic clinic shall be coordinated with the other involved disciplines.

**Pediatric Dentistry**

• The diagnostic process shall include assessments of the whole child. Physical, emotional and behavioral findings are to be evaluated. Consultation and referral to appropriate services are to be implemented. Consultation and referral may include a variety of health professionals and in suspected cases of child maltreatment, Child Protective Services and/or law enforcement are to be contacted.

• Treatment plans shall be designed to preserve and restore the primary and permanent dentition in order to foster normal growth and development of the orofacial anatomy and physiology.

• Treatment plans shall be designed to preserve and restore the primary and permanent dentition in order to promote desirable esthetics in the developing child.

• Disease prevention shall be an integral part of the patient's plan of care and shall be consistent with accepted prevention strategies.

• Space management therapy shall be delivered in accordance with the standards of the profession.
• Accepted behavioral management strategies shall be used as needed during the performance of diagnostic and treatment procedures.

• Consultations shall be sought from other specialty clinics within the School on an as-needed basis.

• Patients shall be referred for care that cannot be provided by the Department of Pediatric Dentistry.

COMPLETION & MAINTENANCE STANDARDS

Periodontics

• Patients with active periodontal disease shall be seen as individually prescribed for oral health maintenance visits and appropriate therapy. At a minimum, active periodontal patients shall be seen for periodontal maintenance every six months until they are released to the general care patient population.

Removable Prosthodontics

• Patient who have received removable prostheses, and whose treatment is complete, are inactivated upon the treating student's graduation, except for those receiving partial dentures opposed by a complete denture, or those with an overdenture. These patients shall be maintained on a yearly recall program.

• Prosthetic adjustment services shall be made available on an as-needed basis.

Restorative Dentistry

• At a minimum, all restorative patients shall be seen for preventive maintenance every year until they are inactivated as a patient in the school.

Endodontics

• Patients should be reexamined at appropriate time intervals to evaluate the success or failure of treatment.
Oral & Maxillofacial Surgery

- Patients shall be returned to the referring clinician promptly after adequate healing has occurred following surgical treatment.

- Long-term follow-up care may be undertaken by a supervising faculty in selected cases.

Orthodontics

- Patients with active orthodontic appliances shall be seen regularly (two to six week intervals). Patients whose active orthodontic treatment has been completed shall be supervised closely for two years and periodically thereafter.

Pediatric Dentistry

- Patients shall be scheduled for routine recall examinations every six months. In some cases patient requirements dictate a variable period of monitoring and follow-up care.
University of Washington School of Dentistry
Predoctoral Clinics

PREDOCTORAL COMPETENCIES

In the care of the child, adolescent, adult, geriatric and medically compromised patient, graduates from the University of Washington School of Dentistry shall possess the following knowledge, skills, and values. The corresponding Commission on Dental Accreditation (CODA) standard is noted with each competency, where applicable.

1. Graduates must be competent in the application of the basic principles of critical thinking, and problem-solving. They must be able to apply those principles to scientific inquiry and an analysis of research methodology, especially as they relate to the practice of evidence-based dentistry and the comprehensive care of patients. (CODA 2-9)

   **Intent:**
   Throughout the curriculum, the educational program should use teaching and assessment methods that support the development of critical thinking and problem solving skills. Included in this competency are knowledge and skills associated with the practice of evidence-based dentistry.

2. Graduates must demonstrate the ability to self-assess. They must be active participants in the development of professional competencies and the professional values and capacities associated with a self-directed professional that is dedicated to lifelong learning. (CODA 2-10)

   **Intent:**
   The educational program should prepare students to assume responsibility for their own learning. Students should be taught how to construct for themselves a learning plan that will allow them to apply new knowledge to patient care over a complete career as a health care professional.

3. Biomedical science instruction in dental education must ensure an in-depth understanding of basic biological principals, consisting of a core of information on the fundamental structures, functions and interrelationships of the body systems. This knowledge base must emphasize the oro-facial complex as an important anatomical area existing in a complex biological interrelationship with the entire body. In-depth information on abnormal biological conditions must be provided to support a high level of understanding of the etiology, epidemiology, differential diagnosis, pathogenesis, prevention, treatment and prognosis of oral and oral-related disorders. (CODA 2-11, 2-12, 2-13)
4. Graduates **must** be competent in the application of the biomedical sciences to the delivery of patient care.
(CODA 2-14)

**Intent:**
*Biological science knowledge should be of sufficient depth and scope for graduates to apply advances in modern biology to clinical practice and to integrate new medical knowledge and therapies relevant to oral health care.*

5. Graduates **must** be competent in the application of the fundamental principles of behavioral sciences as they pertain to patient-centered approaches to comprehensive care.
(CODA 2-15)

**Intent:**
*Behavioral science knowledge should be of sufficient depth and scope for graduates to apply these principles to the management of patients at all stages of life.*

6. [Graduates **must** demonstrate a basic knowledge of public health and how the analysis of population health and demographics affects and shapes the delivery of oral health care.]*

7. Graduates **must** be competent in managing a diverse patient population and have the interpersonal and communications skills to function successfully in a multicultural work environment.
(CODA 2-16)

**Intent:**
*Students should learn about factors and practices associated with disparities in health status among subpopulations, including but not limited to, racial, ethnic, geographic, or socioeconomic groups. In this manner, students will be best prepared for dental practice in a diverse society when they learn in an environment characterized by, and supportive of, diversity and inclusion. Such an environment should facilitate dental education in:*

- basic principles of culturally competent health care;
- recognition of health care disparities and the development of solutions;
- the importance of meeting the health care needs of dentally underserved populations, and;
- the development of core professional attributes, such as altruism, empathy, and social accountability, needed to provide effective care in a multi-dimensionally diverse society.

8. Graduates **must** be competent in applying legal and regulatory concepts related to the provision and/or support of oral health care services.
(CODA 2-17)
Intent:
As models for the delivery of healthcare change and evolve, students should be able analyze and change their professional practices accordingly. As third party reimbursement models change students should be capable of understanding the regulatory environment in which they will practice.

*Planned, currently being developed as competency in the new curriculum.

9. Graduates must be competent in applying the basic principles and philosophies associated with patient-centered practice management. They must understand various models of oral health care delivery, and how to function successfully as the leader of the oral health care team.
   (CODA 2-18)

Intent:
Graduates should recognize the importance of leadership to the efficient delivery of comprehensive, patient-centered oral healthcare as delivery models evolve over time. Graduates should have knowledge and basic skills to evaluate and begin to manage or participate in business models that provide dental care. They should have sufficient knowledge to manipulate and communicate information using technologies available in contemporary dental practice.

10. Graduates must be competent in communicating and collaborating with other members of the health care team in the provision of health care.
   (CODA 2-19)

Intent:
Graduates should understand the roles of members of the health care team and have educational experiences, particularly clinical experiences that involve working with other professional students and practitioners. Graduates should have educational experiences in which they coordinate patient care within the health care system relevant to dentistry.
Graduates should be aware of their professional obligations, to themselves, their profession, and their communities. Students should be taught the elements of exemplary leadership and mentoring. They should practice these behaviors during their pre-doctoral educational experience.

11. Graduates must be competent in the application of the principles of ethical decision making and understand their professional responsibilities in the provision of patient care.
   (CODA 2-20)

Intent:
Graduates should know how to draw on a range of resources, among which are professional codes, regulatory law, and ethical theories. These resources should pertain to the academic environment, patient care, practice management and research. They should guide judgment and action with regard to issues that are complex, novel, ethically arguable, divisive, or of public concern. The educational
program should teach students the importance of practicing in a culture of continuous improvement to prevent errors in treatment and the importance of disclosing errors to the appropriate parties when they occur.

12. Graduates must be competent to access, critically appraise, apply, and communicate scientific and lay literature as it relates to providing evidence-based patient care. (CODA 2-21)

**Intent:**
The education program should introduce students to the basic principles of clinical and translational research, including how such research is conducted, evaluated, applied, and explained to patients.

13. Graduates must be competent in providing oral health care within the scope of general dentistry to patients in all stages of life.
   (CODA 2-22)

14. At a minimum, graduates must be competent in providing oral health care within the scope of general dentistry including:
   (CODA 2-23)
   a. A comprehensive clinical oral and head and neck examination and the prescription and assessment of appropriate imaging studies which would allow the compilation of a list of current problems and diagnoses. Graduates should be able to formulate a comprehensive treatment plan and prognosis as well as obtain informed consent for the treatment prescribed. They should be able to implement general dental treatment plans in a timely way.
      (CODA 2-23a)
   b. The provision of risk assessment for caries, periodontal diseases, and head and neck cancer.
      (CODA 2-23b)
   c. The diagnosis and management of, in consultation with other dental and medical specialists when necessary, hard and soft tissue lesions and diseases of the oro-facial complex.
      (CODA 2-23k)
   d. The management of dental emergencies. (CODA 2-23m)
   e. Recognizing the complexity of needed treatment and identifying when referral is indicated. Graduates must know the limits of their professional expertise and when to seek consultation with other health care providers to facilitate patient care. (CODA 2-23c)

   [f. The management medical emergencies in dental practice, including the provision of basic life support.]*
g. The recognition of dental malocclusion and malformation and the need for space maintenance. This will require an understanding the essential elements of facial growth and dental development. (CODA 2-23n)

h. The provision of patient education in the prevention of oral and selected systemic diseases to promote oral and general health. (CODA 2-23d)

[i. Prescribing, administering and assessing the efficacy of pharmacological agents as part of the overall treatment plan.]*

[j. The diagnosis and management of patients presenting with common problems associated with acute and chronic orofacial and dental pain]*

*Planned, currently being developed as competency in the new curriculum.

k. The administration of local anesthesia and the employment of other measures, pharmacologic and non-pharmacologic, to control pain and anxiety. (CODA 2-23e)

l. The management and delivery of periodontal therapy. (CODA 2-23i)

[m. The management of dental caries and other diseases and malformations of the teeth.]*

n. The prevention and management of pulpal and periapical disease. (CODA 2-23j)

o. The performance basic hard and soft tissue surgery in the mouth. (CODA 2-23 l)

p. The restoration of the form and function of teeth. (CODA 2-23f)

q. The replacement of teeth including fixed, removable and implant supported prosthetics. (CODA 2-23h)

r. The management of dental laboratory procedures in support of patient care. (CODA 2-23g)

s. The comprehensive evaluation the outcomes of treatment. The graduate must be able to formulate recall strategies and revise prognoses as appropriate in a program designed to continuously improve the oral health of the patient. (CODA 2-23o)

[t. The treatment of medically complex and/or compromised patients.]*
The management of TMD as it presents in general dental practice.*

**Intent:**
Grades should be able to evaluate, assess, and apply current and emerging science and technology. Graduates should possess the basic knowledge, skills, and values to practice dentistry, independently, at the time of graduation. The school identifies the competencies that will be included in the curriculum based on the school’s goals, resources, accepted general practitioner responsibilities and other influencing factors. The comprehensive care experiences provided for patients by students should be adequate to ensure competency in all components of general dentistry practice. Programs should assess overall competency, not simply individual competencies in order to measure the graduate’s readiness to enter the practice of general dentistry.

*Planned, currently being developed as competency in the new curriculum.

15. Graduates **must** be competent in assessing the treatment needs of patients with special needs.  
(CODA 2-24)

**Intent:**
An appropriate patient pool should be available to provide experiences that may include patients whose medical, physical, psychological, or social situations make it necessary to consider a wide range of assessment and care options. The assessment should emphasize the importance of non-dental considerations. These individuals include, but are not limited to, people with developmental disabilities, cognitive impairment, complex medical problems, significant physical limitations, and the vulnerable elderly. Clinical instruction and experience with the patients with special needs should include instruction in proper communication techniques and assessing the treatment needs compatible with the special need.

16. Dental education programs **must** make available opportunities and encourage students to engage in service learning experiences and/or community---based learning experiences. (CODA 2-25)

**Intent:**
Service learning experiences and/or community-based learning experiences are essential to the development of a culturally competent oral health care workforce. The interaction and treatment of diverse populations in a community-based clinical environment adds a special dimension to clinical learning experience and engenders a life-long appreciation for the value of community service.

Updated: 02/11/2014-Core Planning Group  
Revised: 2/16/2014-Dean  
Revised: Dean and Associate Dean for Academic Affairs 10/01/2015  
Revised: Core Planning Group 10/30/2015
UNIVERSITY OF WASHINGTON
SCHOOL OF DENTISTRY

Subject: Affiliation Agreements

Policy Number:

Effective Date: October 2004

Revision Dates: August 2004, August 2016

PURPOSE

To provide a systematic process for establishing and maintaining affiliation agreements with participating institutions or organizational units. All Affiliation agreements should ensure that the same standards are in place at the extramural sites as at the main teaching site.

GENERAL POLICY

Affiliation agreements represent a binding, legal agreement for providing clinical instruction at locations outside the University of Washington's School of Dentistry clinics. These legal documents are required by the University of Washington Health Sciences and the School of Dentistry to indemnify its students and faculty. It is necessary for the agreement to be fully executed with original signatures and dated by both the University of Washington and the affiliating site to be considered complete.

Standard 1-6 of the ADA accreditation standards for dental education programs require dental schools to develop formal agreements with participating institutions which define the responsibilities of each institution with respect to objectives of the training experience, facilities, faculty supervision, and evaluation of students and support staff.

IMPLEMENTATION

A. PROGRAMS REQUIRING AN AFFILIATION AGREEMENT

An affiliation agreement is required when a student or faculty member from the School of Dentistry participates in the following types of programs:

1. Continuous regular instructional programs at non-University of Washington (UW) institutions, except Harborview Medical Center and other institutions which have inter-institutional affiliations with the UW Health Sciences Center.
2. Continuous residency programs at non-UW institutions.

3. Programs with students from other universities spending time at the University of Washington School of Dentistry on an elective rotation.

4. Programs/activities that are funded all, or in part, by grants and contracts to perform collaborative research/instructional training that takes place at non-UW institutions and where the affiliation terms are not otherwise incorporated within the grant, contract, consortium, or other related agreements or other documents.

5. The UW student-run Husky Smiles volunteer program.

6. Agreement on Academic Exchange used by visiting exchange faculty or students.

7. Proposed sites with the RIDE, Robert Wood Johnson, (RWJ) or other outreach programs to expand to states beyond Washington and perhaps to include private practice clinics.

B. FORMAL DOCUMENTATION

1. A proposal for a new affiliation agreement must be submitted by a Department Chair to the Office of the Dean prior to the initiation of an affiliation arrangement.

2. The draft affiliation agreement must be prepared using the University of Washington School of Dentistry Affiliation Agreement template (see Appendix A).

3. This template utilizes formatting and clauses specified by the UW Attorney General’s Office (AGO) and/or the School of Dentistry and includes:
   a. A statement of the purpose of the affiliation;
   b. Objectives of the affiliation;
   c. Names of the liaisons at the School of Dentistry and affiliating site(s) (including titles, addresses, telephone numbers, and email);

   Note: For affiliations involving clinical work without Department Faculty supervision, a site visit by the Department Faculty is required.

4. The draft affiliation agreement must be prepared using the University of Washington School of Dentistry Affiliation Agreement template (see Appendix A).
5. For international faculty exchanges that do not involve clinical work, an International Agreement Proposal Form (See Appendix B) will be sent to the Department Chair(s) to provide basic information to the Office of Global Affairs (OGA) regarding the specifics of the site collaboration and contact information needed for the draft Affiliation Agreement preparation.

C. APPROVAL PROCESS

Affiliation agreements are processed by the Office of the Dean:

1. Copies of the draft document are sent to the Department Chair and the affiliating site to request any changes to the initial draft.

2. If necessary changes are requested to the basic template, those changes are sent to the AGO for review.

3. Upon approval by the AGO, the document is sent to the signing parties at the affiliation site for final approval and signature.

4. Once the signed agreement is returned, the agreement will be routed in the following sequence for signature: AGO (if changes were made to the basic template), Department Chair(s), Dean of the School of Dentistry, and Executive Director of Health Sciences Administration.

5. Once the agreement is fully executed, the Authorized Records Monitor, School of Dentistry will scan the agreement into the Salesforce database as outlined in the Salesforce.com Records Scanning Policy (see appendix C).

6. Depending on the site’s preference, either a scanned copy will be sent electronically or a hard copy will be sent through the mail to the affiliated site. An electronic copy of the fully executed agreement will be forwarded to the originating department(s).

Affiliation Agreements which go beyond individual schools and colleges and have broader University implications will be forwarded by the Authorized Records Monitor, School of Dentistry, to the Administrator, OGA.

In addition, a copy of affiliation agreements with colleges and universities outside the United States for exchanges of faculty or students will be forwarded by the Authorized Records Monitor, School of Dentistry to the Administrator, OGA.
D. PERIODIC REVIEW

The agreements shall be reviewed every five years or earlier at the request of either party. At the end of the five-year period, the Authorized Records Monitor, School of Dentistry will review the agreement with the designated Department Chair(s). Upon review, if the affiliation is active and the terms of the agreement are still acceptable to all parties, the agreement will remain unchanged and will be designated for review in five years.

E. AMMENDMENTS

If there are any substantial changes to the terms that require revisions, the proposed changes will be drafted in an Amendment to Affiliation Agreement (See Appendix D) and sent to the AGO for approval. Depending on the scope of the changes, a new, updated affiliation agreement will be prepared and submitted for signature as provided in Section II above. If the Department Chair(s) indicate that the affiliation is no longer active, the Authorized Records Monitor will mark the agreement as inactive in the Salesforce Database.

Appendices:

Appendix A, University of Washington School of Dentistry Affiliation Agreement template
Appendix B, International Agreement Proposal Form
Appendix C, Salesforce.com Records Scanning Policy
Appendix D, Amendment to Affiliation Agreement

Dean of UW SOD:

______________________________________________________  _______ ___________________________
Joel Berg, Dean of the UW School of Dentistry    Date

APPENDIX A
UNIVERSITY OF WASHINGTON SCHOOL OF DENTISTRY

AFFILIATION AGREEMENT

This Agreement is made and entered into between the University of Washington School of Dentistry ("School"), located at 1595 NE Pacific Street, Seattle, Washington 98195 and XXX ("Training Site") located at XXX. The purpose of this Agreement is for Training Site, which is committed to training health care professionals, to provide desirable clinical learning experiences and facilities for dental student education. In consideration of the mutual covenants and agreements contained herein, School and Training Site agree as follows:

GENERAL PROVISIONS

1. School and Training Site agree that contemporaneous with or following execution of this Agreement and within the scope of its provisions, School and Training Site will agree on the operational details of the clinical education program. These details include, but are not limited to, the following:
   - Beginning dates and length of experience;
   - Number of students eligible to participate in the clinical education program;
   - Specific days, hours and locations for the clinical education program;
   - Specific learning objectives and performance expectations for students;
   - Specific allocation of responsibilities for the School's faculty Liaison, and Training Site's clinical education Supervisor and Preceptors, if any, identified elsewhere in this Agreement;
   - Deadlines and format for student progress reports and evaluation forms.

2. School and Training Site may develop letter agreements to formalize the operational details. Any such letter agreements will be considered to be attachments to this Agreement, will be binding when signed by authorized representatives of each party, and may be modified by subsequent letter agreements signed by authorized representatives of each party. Any conflict or inconsistency in this Agreement and its attachments will be resolved by giving the documents precedence in the following order: (1) this Agreement; (2) attachments to this Agreement in reverse chronological order.

3. School and Training Site will jointly plan the clinical education program and jointly evaluate students. Exchange of information will be maintained by on-site visits, letter, telephone, email, or other means of communication.

4. School and Training Site will instruct their respective faculty, staff, and students participating in the clinical education program, to maintain confidentiality of student and patient information as required by law and by the policies and procedures of School and Training Site.

5. There will be no payment of charges or fees between School and Training Site unless a program in the School of Dentistry executes a funding agreement for that program.
Students will not be entitled to any monetary or other remuneration for services performed by them at the Training Site. Nor will the training site otherwise have any monetary obligation to the school. Students assigned to the Training Site will remain students of the school and in no sense be considered employees of the Training Site.

6. There will be no unlawful discrimination against any program participant or applicant covered under this Agreement because of race, color, religion, national origin, age, handicap, status as a Vietnam era or disabled veteran, sex, or sexual orientation.

SCHOOL’S RESPONSIBILITIES

7. School will provide information to Training Site concerning its curriculum. School will designate an appropriately qualified and credentialed faculty member to coordinate and act as the Liaison with Training Site. School will notify Training Site in writing of any change or proposed change of its Liaison.

8. School will be responsible for instruction and administration of the students’ academic education program. School will have the final responsibility for grading students.

9. School’s faculty will communicate with the Training Site clinical education Supervisor(s) and Preceptor(s), if any, to discuss and evaluate the clinical education program.

10. School will provide the names and information relevant to the clinical education program before the beginning date of the clinical education program. School will notify Training Site in writing of any change or proposed change in a student’s status.

11. School will ensure completion of all required immunizations in accordance with CDC recommendations for health care workers, upon program entry and again each time standards are changed or updated. This includes annual tuberculosis screening. School will provide documentation regarding students’ compliance status (i.e. current status and expiration date) to Training Site upon request.

12. School will assign to Training Site students who have satisfactorily completed the prerequisite didactic portion of the curriculum. If School determines it necessary, students will also have evidence of completion of a CPR course based on American Heart Association or American Red Cross guidelines and related to the age group(s) with whom they will be working.

13. School will request a criminal background check through Washington State Patrol. School acknowledges that placement of each student at the Training Site is contingent upon background check information dated less than two years prior to the commencement of the practicum placement. Training Site acknowledges that School is not responsible for the accuracy of the information provided through this check and that School’s provision of this check information does not relieve Training Site of any of its legal obligations related to these background checks.
14. School will encourage each student participating in the clinical education program to acquire comprehensive health and accident insurance that will provide continuous coverage of the student during his or her participation in the education program. School will inform students that they are responsible for their own health needs, health care costs, and health insurance coverage.

**TRAINING SITE'S RESPONSIBILITIES**

15. Training Site will designate in writing Preceptors, if any, to be responsible for the clinical education program, and will designate in writing one person as the clinical education Supervisor, who will maintain contact with the School-Designated Liaison to assure mutual participation in and review of the clinical education program and student progress. Training Site will submit in writing to School the professional and academic credentials for the Preceptors and clinical education Supervisor. Training Site will notify School in writing of any change or proposed change of the Preceptors or clinical education Supervisor.

16. Training Site will supervise and provide students with a desirable clinical and/or non-clinical education experience within the scope of health care services provided by Training Site. Training Site will provide students with access to sources of information necessary for the education program, within Training Site's policies and procedures and commensurate with patients' rights, including library resources and reference materials.

17. Training Site will make available to students basic supplies and equipment necessary for care of patients/clients and the clinical education program. Within the limitation of facilities, Training Site will make available office and conference space for students and, if applicable, School faculty. Training Site will permit, on reasonable notice and request, the inspection of clinical and related facilities by agencies charged with responsibility for accreditation of School.

18. Training Site will submit the School's required evaluation reports.

19. Training Site retains full responsibility for the care of patients/clients, and will maintain the quality of patient care without relying on the students' clinical training activities for staffing purposes.

20. Training Site has the right to take immediate temporary action to correct a situation where a student's actions endanger patient care. As soon as possible thereafter, Training Site's clinical education Supervisor will notify School of the action taken. All final resolutions of the student's academic status in such situations will be made solely by School after reviewing the matter and considering whatever written factual information Training Site provides for School; however, Training Site reserves the right to terminate the use of its facilities by a particular student where necessary to maintain its operation free of disruption and to ensure quality of patient care.
21. On any day when a student is participating in the clinical education program, Training Site will provide to such student necessary emergency health care or first aid for accidents occurring in its facilities. The student will be responsible for the costs of all care. Except as provided in this Agreement, Training Site will have no obligation to furnish medical or surgical care to any student.

STUDENTS’ STATUS AND RESPONSIBILITIES

22. Students will have the status of learners and will not replace Training Site personnel. Any service rendered by students is incidental to the educational purpose of the clinical education program.

23. Students are required to adhere to the standards, policies, and regulations of Training Site during their clinical education program.

24. Students will wear appropriate attire and name tags, and will conform to the standards and practices established by School during their clinical education program at Training Site.

25. Students assigned to Training Site will remain students of School, and will not be considered employees of Training Site. Training Site does not and will not assume any liability under any law relating to Worker’s Compensation on account of any School student’s performing, receiving training, or traveling pursuant to this Agreement. Students will not be entitled to any monetary or other remuneration for services performed by them at Training Site.

LIABILITY COVERAGE PROVISIONS

26. Each party to this agreement will be responsible for the negligent acts or omissions of its own employees, officers, agents, or students in the performance of this Agreement. Neither party will be considered the agent of the other and neither party assumes any responsibility to the other party for the consequences of any act or omission of any person, firm, or corporation not a party to this Agreement.

27. School will defend, indemnify and hold Training Site harmless from any loss, claim or damage arising from the negligent acts and omissions of its employees, officers, agents, and students, including negligence in performing its obligations under this Agreement. School maintains a professional liability coverage program under the authority of RCW 28B.20.250, 253, and 255. Through that authority, School provides professional liability coverage for its employees, officers, agents, and students (while training in a clinical setting at Training Site) in the performance of this Agreement.

28. Training Site will defend, indemnify and hold School harmless from any loss, claim or damage arising from the negligent acts and omissions of its employees, officers, and agents, including negligence in performing its obligations under this Agreement. Training Site will maintain professional liability coverage with limits of not less than $1,000,000.
per occurrence and $3,000,000 annual aggregate (or an equivalent program of self-insurance).

29. Upon request, parties will provide proof of coverage upon execution of this Agreement. In addition, School and Training Site agree to notify each other in the case of material modification or cancellation of coverage, and to provide subsequent proof of coverage thereafter.

TERM

30. This Agreement is effective when fully executed and will continue until terminated. This agreement will be reviewed at the request of either party.

31. This agreement may be terminated by written notice one year prior to termination. Such termination shall not become effective for the students then enrolled in the clinical education program if such termination prevents completion of their requirements for completion of the clinical education program.

PROVISIONS REGARDING BLOOD-BORNE PATHOGENS

32. School will train each student in the clinical education program in universal precautions and transmission of blood-borne pathogens. Training Site will provide personal protection equipment that is appropriate for the tasks assigned to School’s students.

33. If a student sustains a needle-stick injury or other substantial exposure to bodily fluids of another or other potentially infectious material while participating in the clinical education program at Training Site, Training Site agrees to provide the following services:
   - Being seen by Training Site’s employee health service and/or emergency department as soon as possible after the injury;
   - Emergency medical care following the injury;
   - Initiation of HBV, Hepatitis C (HCV) and HIV protocol;
   - HIV counseling and appropriate testing.

The School or student will be responsible for the costs of any such care, testing, and counseling.

34. The source patient’s HBV, HCV, and HIV status will be determined by Training Site in the usual manner, according to applicable laws and regulations, to the extent possible.

MISCELLANEOUS PROVISIONS

35. Entire Agreement. This Agreement constitutes the entire agreement between the parties, and supersedes all prior oral or written agreements, commitments, or understandings concerning the matters provided for herein.
36. Amendment. This Agreement may be modified by a subsequent written Agreement executed by the parties.

37. Governing Law. The parties’ rights or obligations under this Agreement will be construed in accordance with, and any claim or dispute relating thereto will be governed by, the laws of the State of Washington.

38. Notices. All notices, demands, requests, or other communications required to be given or sent by School or Training Site, will be in writing and will be mailed by first-class mail, postage prepaid, or transmitted by hand delivery or facsimile, addressed as follows:

(a) To School:
Office of the Dean
University of Washington School of Dentistry
1959 N.E. Pacific Street, Box 356365
Seattle, WA 98195
Phone: 206-685-7309
Fax: 206-616-2612
Email: affilagn@uw.edu

(b) To Training Site:
Name:
Title:
Clinic:
Address
Phone:
Fax:
Email:

39. Each party may designate a change of address by notice in writing. All notices, demands, requests, or communications that are not hand-delivered will be deemed received three days after deposit in the U.S. mail, postage prepaid; or upon confirmation of successful facsimile transmission or confirmation of receipt from other form of communication.

40. Survival. School and Training Site expressly intend and agree that the liability coverage provisions of this Agreement will survive the termination of this Agreement for any reason.

41. Severability. If any provision of this Agreement, or of any other agreement, document, or writing pursuant to or in connection with this Agreement, is held to be wholly or partially invalid or unenforceable under applicable law, such provision will be ineffective to that extent only, without in any way affecting the remaining parts or provisions of this agreement.

42. Waiver. Neither the waiver by any of the parties of a breach of or a default under any of the provisions of this Agreement, nor the failure of the parties, on one or more occasions.
to enforce any of the provisions of this Agreement or to exercise any right or privilege hereunder, will thereafter be construed as a waiver of any subsequent breach or default of a similar nature, or as a waiver of any of such provisions, rights or privileges hereunder.

43. **Execution and Approval.** The parties warrant that the officers/individuals signing below have been duly authorized to act for and on behalf of the Party for the purpose of executing this Agreement. The parties may also include the signatures of individuals who are responsible for the clinical or academic education program.

44. **HIPAA.** School will direct its students to comply with the policies and procedures of Training Site, including those governing the use and disclosure of individually identifiable health information under federal law, specifically 45 CFR parts 160 and 164. Solely for the purpose of defining the students’ role in relation to the use and disclosure of Training Site’s protected health information, the students are defined as members of the Training Site’s workforce, as that term is defined by 45 CFR 160.103, when engaged in activities pursuant to this Agreement. However, the students are not and shall not be considered to be employees of the Training Site.

UNIVERSITY OF WASHINGTON  
SCHOOL OF DENTISTRY  

XXX (Training Site)

<table>
<thead>
<tr>
<th>Name</th>
<th>Date</th>
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<tbody>
<tr>
<td>Dr. David M. Anderson</td>
<td>Date</td>
</tr>
<tr>
<td>Executive Director, Health Sciences Administration</td>
<td>(Name)</td>
</tr>
<tr>
<td>Dr. Joel Berg</td>
<td>Date</td>
</tr>
<tr>
<td>Dean, School of Dentistry</td>
<td></td>
</tr>
<tr>
<td>Dr. Frank Roberts</td>
<td>Date</td>
</tr>
<tr>
<td>Director, RIDE Office of Regional Affairs</td>
<td></td>
</tr>
</tbody>
</table>

**Approved as to form:**
(signature not needed if standard pre-approved form is utilized)

<table>
<thead>
<tr>
<th>Name</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ms. Alice Becker</td>
<td>Date</td>
</tr>
<tr>
<td>Assistant Attorney General for “School”</td>
<td></td>
</tr>
</tbody>
</table>

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APPENDIX B
University of Washington
International Agreement Proposal Form

I. AGREEMENT SPONSORSHIP

UW faculty/administrator proposing this agreement:
Name: Click here to enter text.
Position/Title: Click here to enter text.
College/ School: Click here to enter text.
Department/Division: Click here to enter text.
UW Email: Click here to enter text.
Office Phone: Click here to enter text.

UW point of contact for questions regarding this proposal if different from individual named above:
Name: Sarah Van Houten
Position/Title: Program Operations Specialist
College/ School: Dentistry
Department/Division: Office of the Dean
UW Email: sarahv4@uw.edu
Office Phone: 206-543-0903

II. ACTIVITY DESCRIPTION:

Is this a new agreement or renewal of an existing agreement?
☐ New agreement or activity
☐ Renewal of an existing agreement

Indicate the general form(s) of cooperation contemplated by this agreement (mark all that apply):
☐ Joint research activities, publications and library exchanges;
☐ Exchange of invitations to scholars for lectures, talks, and sharing of experience;
☐ Exchange of invitations to scholars to participate in conferences, colloquia and symposia;
☐ Exchange of information in fields of interest to both parties
☐ Exchange of faculty for teaching and research
☐ Exchange of students for study and research
☐ Other (please describe) Click here to enter text.

Will activities contemplated by this agreement require any of the following (mark all that apply):
☐ Intellectual property or licensing terms
☐ Sharing of information, data, technology, business proprietary, human subjects or other sensitive data
☐ Hiring foreign nationals to perform work outside the US
☐ Establishing a legal presence outside the US
☐ Clinical work - observation and treatment of patients
☐ Do not know or not yet determined
☐ None of the above

Indicate the desired outcome of this proposal:
☐ General MOU (no intent to bind either party to any terms of agreement)
☐ Student Exchange Agreement
☐ Faculty/Staff Exchange Agreement
☐ Research Agreement
☐ Dual Degree Agreement
☐ Other (please describe) Click here to enter text.

Anticipated Term of Activity (five year maximum, subject to renewal)
Start date: Click here to enter a date.
End date: Click here to enter a date.

III. COLLABORATING INSTITUTION OR ENTITY
Name of Institution/Entity: Click here to enter text.
Sponsoring Division/Unit: Click here to enter text.
City: Click here to enter text.
Country: Click here to enter text.
Website: Click here to enter text.
Contact Person: Click here to enter text.
Position/Title: Click here to enter text.
Email: Click here to enter text.
Office Phone: Click here to enter text.

IV. DETAILS OF COLLABORATION
1. Briefly describe why this institution/entity was selected for collaboration and its specific strengths. How will this agreement benefit the UW and your unit?
   Click here to enter text.

2. Briefly describe any previous and/or current collaboration(s) or agreement(s) between your unit and this institution and outcomes achieved per this linkage.
   Click here to enter text.

3. Provide a brief summary of the proposed activity including expected outcomes and potential participants. Describe the current status/stage of these discussions.
   Click here to enter text.

4. What university resources and/or specific funding will be required to carry out the proposed activity?
   Click here to enter text.

5. If this is a renewal of an existing partnership, briefly discuss the outcomes achieved over the term of the agreement and evaluate the extent to which the purpose of the agreement was met.
   Click here to enter text.

V. AGREEMENT ENDORSEMENTS (Required) – please print form and obtain written signatures

Faculty/Administrator Sponsor ____________________________ Date: ____________________

Chair/Director or Dean ____________________________ Date: ____________________

Submit completed proposal with required signatures to:

Cameron Frisch
Office of Global Affairs
Box 351237

cfrisch@uw.edu
University of Washington School of Dentistry
Office of Regional Affairs
Salesforce.com Records Scanning Policy

Purpose
Retention of Records
The purpose of this document is to establish a consistent process that enables the Office of Regional Affairs and RIDE (ORA/RIDE) to replace paper records with scanned, electronic records while ensuring adherence to retention requirements. This process is based upon UW guidance and on Chapter 454-663 of the Washington Administrative Code (WAC).

All records have a specific amount of time they must be maintained, called a “retention period,” that is based on the content of a record. Retention periods are found on the University General Records Retention Schedule. Retention periods included in the Records Retention Schedule apply to all records regardless of their physical form or characteristics.

Once ORA/RIDE paper records are scanned according to the technical requirements outlined in this document, the paper records can be destroyed. It is, however, important to note that the retention period which would have been applied to the paper record must instead be applied to the scanned record. The retention period also applies to records originating and remaining in electronic form.

Technical Scanning Instructions
Formats and Scanning Densities
Black and white, gray, and color paper records can be scanned. Any kind of record can be scanned including color text documents, photographs, maps, plans, diagrams, and drawings.
- Scanners must be set at a minimum of 300 dpi (dots per inch); and
- Scanned records must be saved as searchable PDF files.

Quality Control
Scanned document images must be inspected visually to ensure they are complete (the entire document has been captured), clear and easily read. It is required that:
- At least every 10th page of each document is reviewed to ensure the scanning quality is consistent and the images are usable. If and when visual inspection raises doubts, the scanned records should be compared to the original paper document to ensure accuracy; and
- The number of original paper pages in a document is compared to the number of pages in the scanned record to ensure that every page of the document was scanned.

Image Enhancement
Problems with a scanned image can make it difficult to read and less than usable. If the scanned document is to replace the original paper record the following common problems must be corrected as noted.
- Speckles or spots on the scanned image that obscure its contents:
  - Clean the glass on the scanner and rescans the paper.
- Skewed images that are not properly aligned:
  - Rescan the paper so that the image appears straight.
- All portrait orientation pages should be rotated to read from left to right; all landscape orientation pages should be rotated with the top of the page facing the left.
- Sometimes only part of the document is captured by the scanner:
  - Rescan the paper so that it is properly aligned and the entire page is included in the scanned image.
- If the scanned record is of poor quality and is not clearly readable:
  - Reset the dpi (dots per inch) setting on the scanner to a setting higher than 300 dpi and scan again. Keep increasing the dpi until the record is as readable as possible.
Poor Quality Images
Sometimes the condition of the original paper record precludes a good quality scanned image from being produced. In these cases ORA/RIDE will document the problem to avoid future confusion over the poor quality of the scanned image, and retain the paper copy.
- The person scanning will confer with the ORA/RIDE authorized records monitor to make the determination of whether a scan is of usable quality.
- If the best scan is deemed unusable, tag the image with “best scan possible – paper retained”, using Acrobat Pro “Additional Metadata” in the Document Properties description tab.
- Keep the paper copy of the record in a location determined by the authorized records monitor.
- The scanned copy will still be electronically added to the appropriate account in the Salesforce database.

Managing Scanned Records
File Naming Convention
Scanned records will be named following a convention appropriate to the type of record. These conventions are noted in the Salesforce Naming Conventions document located on SharePoint.

Organizing and Filing Scanned Records
All scanned records will be uploaded as an attachment to the appropriate record in the Salesforce database. Scanned records should not be saved to thumb drives, the shared drive (F-drive), or to the hard drive on a personal computer.
The agreement renewal date and date of termination will be documented in a task connected to the Salesforce account. The task will include a due date for action so that records can be readily accessed and managed for renewal or destruction at the end of their retention period.

Modifying Scanned Records
It is important to ensure that the original content of a scanned record is not altered or modified once it has been finalized. Scanned records will be “read only” PDF format, to ensure that there is no improper alteration or modification. However, many times it is useful to add a note on a PDF using a text box or other Adobe annotation tool. This is not considered a modification of the scanned record and is an acceptable and practical way to make notes on an electronic record. Notes can also be added to the description box on the account in the Salesforce database.

Destruction of Scanned Records
All scanned documents must be kept through the duration of their retention period. The deletion approval process at ORA/RIDE includes:
- Approver: Typically the unit head or office supervisor. Responsible for authorizing the deletion of records at the end of the retention period.
- Authorized records monitor: Responsible for monitoring records retention and identifying records due for deletion and, upon approval, deleting the records.
- Only authorized individuals (positions) may delete files. Ability to delete files from the database or networked storage location will be restricted to authorized users only.
- NOTE: All records pertaining to ongoing or pending audits, lawsuits (or even reasonably anticipated lawsuits), or public disclosure proceedings must not be destroyed, damaged or altered until the issue is resolved. The Approver is responsible for monitoring which if any records are subject to such restrictions. Once the issue is resolved, the Approver must be informed that records may be destroyed before giving approval for records destruction.

Once a due date reminder appears on the homepage of Salesforce, the authorized records monitor will review the account and verify that the file has reached the end of its retention period. This individual will send the name of the document and the name of the related account to the ORA/RIDE’s Approver for destruction approval. Once the Approver returns the email with their approval, the authorized records monitor will delete the file and record the destroyed file on the Records Destruction Log. The log will include: document type, termination date, date deleted, deleted by, and deletion authorized by. The authorized records monitor will then make a note in the description box of the account indicating that the file has been destroyed.

Migration and Preservation Strategies
ORA/RIDE currently does not maintain any archival records or records with a retention period of more than 6 years that would require a migration and preservation strategy before the original paper documents can be destroyed. If this changes, a migration and preservation strategy will be added to this policy.

Salesforce Scanning Policy
January 2016
Security Standards
Salesforce.com utilizes some of the most advanced technology for Internet security available today. When the site is accessed using a supported web browser, Secure Socket Layer (SSL) technology protects information using both server authentication and data encryption.

Salesforce.com provides each user with a unique username and password that must be entered each time a user logs in. Salesforce.com issues a session “cookie” only to record encrypted authentication information for the duration of a specific session. The session “cookie” does not include either the username or password of the user. Salesforce.com does not use “cookies” to store other confidential user and session information, but instead implements more advanced security methods based on dynamic data and encoded session IDs.

Salesforce.com is hosted in a secure server environment (located off-campus) that uses a firewall and other advanced technology to prevent interference or access from outside intruders. All customer data is backed up on tape on a nightly basis, up to the last committed transaction. Salesforce.com further enhances reliability measures by storing all customer data on mirrored disks that are mirrored across different storage cabinets and controllers.

When an employee separates, their immediate manager is responsible for notifying all system owners and operators, or the designated system administrator handling the computer or communications accounts, to close all related accounts and remove all access capabilities related to the separated employee.

Upon receiving notification of termination, Salesforce will close the account on either the requested termination date or upon expiration of the salesforce.com contract. All salesforce.com data will be available for 30 days from the date of termination. The account owner can get an export of all data (including attachments) by using the Data Loader found under Setup - Data Management.

Office machines used to create scans or copies will be checked annually and any copies of records found will be deleted.
AMENDMENT TO AFFILIATION AGREEMENT

This Amendment (“Amendment”) is made and entered into effective as of (date), by and between a/an (description of entity, e.g. an Idaho non-profit corporation) (“Name of entity”) and the University of Washington on behalf of its School of Dentistry (“University”), and amends the Affiliation Agreement (“Agreement”) made and entered into effective as of (date) by and between _________ Any terms and conditions of the Agreement that are not expressly amended here shall remain in effect.

The following section below shall replace the same-numbered section of the Agreement.

UNIVERSITY OF WASHINGTON
ON BEHALF OF ITS SCHOOL OF DENTISTRY
(“School”)

By __________________________________________ Date __________________
Dr. Joel Berg, DDS
Dean
Health Sciences

[NAME OF PARTY]
(“Training Site”)

By __________________________________________ Date __________________
[Name of Signatory]
[Title of Signatory]
[Name of Organization]

Approved as to form

By __________________________________________ Date __________________
Jane Yung
Assistant Attorney General
Attorney for “Training Site”
PURPOSE

To provide guidance for students, staff and faculty utilizing the D1 Simulation Clinic (D-165) and Labs (D-165A & D-165B). This policy addresses access, security, and standards of cleanliness for the facility and clarifies expected standards of conduct, including student supervision, dress code, management of property, and policy enforcement/penalties for policy violation.

GENERAL POLICY

The D1 Simulation Clinic and Labs are operated in a manner consistent with other clinics in the School of Dentistry to simulate an authentic clinical educational environment. The D1 Simulation Clinic and Labs are governed by existing School of Dentistry clinical policies contained in the Clinic Policy Manual for Faculty and Staff, and guidelines in the Hazard Control in the Dental Environment. Additionally, students, staff and faculty are expected to adhere to abide by protocols in the Academic Regulations Manual, Principles of Ethics and Code of Professional Conduct and the University of Washington (UW) Student Conduct Code and by policies set by Course Directors utilizing the facilities.

I. Scheduled and Afterhours Use

First and second year students, currently enrolled in courses have priority to the D1 lab during scheduled courses and afterhours in order to ensure adequate time to completed their assigned work. Third and fourth year students and graduate students/residents from other departments may also use the D1 lab but with the understanding that current first and second year students have priority. Use of the D1 lab by students other than the first and second year students should not disturb scheduled classes, otherwise students may be asked to leave to minimize disruption and to accommodate the first and second year students. Authorized students must have their access cards to enter the D1 lab. The D1 lab can be accessed twenty-four (24) hours a day. As a rule, the School of...
Dentistry recommends that students refrain from accessing the D1 lab during the hours of 12:00 midnight to 5:00 am for safety reasons unless absolutely necessary. If students need to be in the D1 lab during these hours, students are asked to keep all doors locked and not allow access to person(s) who do not have an access card or proper UW identification.

II. Student Assignment to Stations and Pass-Through Boxes

An assigned pentagon seating system is utilized in the D1 lab to ensure space for the first and second year students. To avoid conflicts between students each seat is assigned to a first and second year student however, the second year student has priority for after-hours use. Each first and second year student is assigned a numbered and locked “Pass-through Box” for submitting or returning course projects and assignments.

III. Security

The premises is monitored by a digital video monitoring system and is for the primary purpose of ensuring the protection of school property and equipment in the D1 lab. It is also used to protect the safety of students outside the normal operating hours. The digital video is used for surveillance purposes and reviewed only in cases of student incident, damage, loss of school assets and/or materials. The doors to the facility have automatic locks and access is granted to holders of access cards only. Doors may not be propped or wedged open. Violation of the security rules may result in forfeiture of privileges and access to the D1 lab and/or up to dismissal from the School of Dentistry program. The Associate Dean for Clinics will consider the severity of the infraction and make the appropriate recommendation to the School Administration.

IV. Standards of Cleanliness & Safety

A Safety Evaluation shall be conducted and utilized by the Associate Dean for Clinics, Course Directors, and the Health & Safety Manager, and will consist of the following items:

<table>
<thead>
<tr>
<th>Clean treatment area</th>
<th>Instruments sterilized</th>
<th>Protective eyewear</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clean barriers in place</td>
<td>Proper sharps disposal</td>
<td>Clean mask used</td>
</tr>
<tr>
<td>Proper aseptic technique</td>
<td>Proper waste disposal</td>
<td>Clean intact gloves used</td>
</tr>
<tr>
<td>Surfaces disinfected</td>
<td>Clean and appropriate attire</td>
<td>Area free of food/beverages</td>
</tr>
</tbody>
</table>

V. Dress Code

Students should meet established clinical dress codes when working in the D1 lab. Because it is a simulation lab, students are required to wear appropriate
clinic attire, either scrubs or provided laundered gowns when performing procedures in the D1 lab. Street clothing must be covered with a gown; exceptions might be during a written exam or lecture-only period. All clothing, including scrubs, must be covered with a gown when working with human teeth or student patients.

VI. Damaged/Missing Items

Each student is responsible for their own supplies, instruments and equipment. Students are encouraged to engrave, mark, or label all personal or purchased equipment. Leased equipment is already tagged. Students are directed to report missing or damaged items within 3 days to the D1 Simulation Clinic staff. Where appropriate, the Principles of Ethics and Code of Professional Conduct outlines the process for reporting and reviewing violations involving the destruction or theft of property, which are also addressed in the UW Student Code. [reference]

VII. Enforcement and Penalties

The Associate Dean for Clinics is responsible for the D1 Simulation Lab and adjoining premises. Any concerns, incidents, and/or occurrences should be directed to the D1 Lab staff or the Associate Dean for Clinics immediately.

Unauthorized individuals must receive prior written permission to enter the D1 lab including adjoining areas; and must be supervised by a current student, staff, or faculty member of the School of Dentistry. Permission request can be coordinated by or with a D1 Lab staff person for approval by the Associate Dean for Clinics.

All other individuals who are granted access to the D1 Simulation Clinic and Labs (i.e. continuing education participants, Board examination participants, or any individuals that have not been listed in the aforementioned policy) will agree to follow all Health & Safety protocols, rules, and policies of the School of Dentistry upon entering the D1 lab and adjoining premises. In addition to the specific policies, applicable policies are found in the UW Student Conduct Code, School of Dentistry Clinic Policy Manual, Academic Regulations Manual, Principles of Ethics and Code of Professional Conduct and Hazard Control in the Dental Environment.

Dean of UW SOD:

[Signature]

Joel Berg, Dean of the UW School of Dentistry    February 2, 2016
Subject: Event Reporting

Policy Number:

Effective Date: February 2008

Review Date: October 2007, November 2011, October 2016

PURPOSE

To define events involving unsafe actions or conditions which create potential or actual harm to patients, visitors, or staff, faculty and students. This policy provides guidelines for correct notification, documentation, reporting, and evaluation of such events.

GENERAL POLICY

The reporting and documentation of events furnishes essential data used to assist department managers, responsible administrators, UW and Health Sciences Risk Management and the School of Dentistry Quality Improvement programs to follow-up, analyze and resolve of events to reduce future adverse outcomes and/or unsafe conditions.

IMPLEMENTATION

A. Reporting Responsibility

Any faculty, resident, student or staff who is aware of an unsafe condition or who is involved in or aware of a harm event (or an event that could have resulted in harm) has a responsibility to document the incident and report it to their supervisor.

1. Timeliness - All types of events should be reported within 24 hours of the event by School of Dentistry faculty, residents, students and staff.

   Harm: Any event resulting in harm should be immediately communicated to the Clinic Manager or appropriate supervisor of that area. If the event resulted in a hospital admission or patient death or neurological damage, call Health Sciences Risk Management immediately (598-6303) and the Associate Dean of Clinic Services (616-5931).
2. **Confidentiality** - All reporting and analysis of patient events or events is confidential under Washington state law as part of the School of Dentistry’s Coordinated Quality Improvement Plan. **Anonymous reporting of events is allowed.**

3. **Provide Immediate Medical Care:** For all exposures or aspirations, and accidents, the involved staff must do the following:

   a. **Notify** attending faculty and facilitates appropriate care and treatment for the patient, visitor or staff member.

   b. **First Aid** - Provide First Aid if necessary. Use first aid kit located in all clinics and labs. Contact health care provider OR if necessary, go to UWMC Emergency Room (normal fees apply.) Students may contact Hall Health at (206) 685-1011.

   c. **Exposure/Incident Hotline** – Call the hotline during school hours to report the event.
      - Between 8:00am—5:00pm: CALL Exposure Hotline at **206-351-2268**.
      - After 5:00pm: **GO** directly to UWMC Emergency Room.
      - **CPD Employees:** Contact your Clinic Supervisor and attending faculty member, then call the Exposure/Incident Hotline at **206-351-2268**.

The Health & Safety staff member assigned to the hotline will go directly to the scene of the event to coordinate follow-up with the patient and Employee health.

B. **Event Definitions**

   **Reportable Event:** A suspected or actual variation in a health care delivery process where the patient/visitor is affected.

   **Potential Event:** (Also known as a “close call” or “near miss” or “nice catch”): An error or variation in a health care delivery process that is discovered before the patient/visitor is affected.

   **Medication Event:** Any event that could cause or lead to a patient receiving inappropriate drug therapy, failure to receive appropriate drug therapy, or any unexpected outcome related to drug therapy, is considered a Medication Event. Medication events include, but are not limited to, Adverse Drug Reactions.

   **Adverse Drug Reaction:** An adverse drug reaction (ADR) is any unintended, undesired, and unavoidable noxious effect of agents administered to patients for diagnostic, prophylactic, or therapeutic indications.
Sentinel Event: An unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function.

The phrase, “or risk thereof” includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. Event has resulted in an unanticipated death or an actual or unanticipated major permanent loss of function not related to the natural course of the patient’s illness or underlying condition.

Health Sciences Risk Management (598-6303) and the Associate Dean of Clinic Services (616-5931) must be contacted immediately by telephone when a sentinel event occurs.

C. Documentation

Events involving patients are documented separately from events involving students, staff or faculty

1. Events involving Patients or Visitors
   a. Medical/Dental Record:
      A factual description of the event, the patient’s response, and treatment provided should be documented in the patient’s medical or dental record if applicable.
      **Note:** Do not reference the patient event report or any conversations with Health Sciences Risk Management in the dental record.
   b. Patient Event Form
      Any unsafe condition or event involving a patient or visitor is reported using the Patient Event Form (see Appendix A), and located at [http://www.dental.washington.edu/programs/health-and-safety/health-and-safety.html](http://www.dental.washington.edu/programs/health-and-safety/health-and-safety.html)
   c. Risk Master:
      The patient event is documented in the Risk Master system. This includes analysis of the patient record, input from faculty, student, and staff input from those involved in the event, a synopsis of all communication with the patient, and the resolution.

2. Events involving Students, Staff or Faculty
   [Online Accident Reporting System (OARS)]
Events involving a staff member or student injury are reported online via the OARS system at the following website:
https://www.ehs.washington.edu/ohsoars/index.shtm
(See Appendix B for sample OARS Report)

D. Analysis, Reporting and System Improvements

1. The Clinic Manager or supervising manager evaluates the event, recording their interventions on the Patient Event Form or in the OARS report as appropriate.

2. The Attending Faculty who was supervising has the primary responsibility for communicating unanticipated outcomes to the patient and family. (Refer to the Disclosure of Unanticipated Outcomes policy.)

3. The manager or supervisor of a “Care Area” reviews all of their event reports within 72 hours of the event (excluding weekends, holidays and/or extenuating circumstances.)

   a. OARS Report follow-up process
      o Once the event is submitted the OARS system will notify the listed supervisor for follow-up.
      o The supervisor will meet with all involved parties to identify preventive measures and root cause.
      o Any findings will be documented in the final submission of the OARS report.
      o The supervisor will determine if any other follow-up is necessary, including but not limited to, change in work or care area process, training of the individual, or conferring with H&S team for input.

   b. Patient Event Report Follow-up process
      o Once the patient event is submitted, it is entered into Risk Master by Patient Relations for tracking and trending purposes.
      o Patient Relations will follow-up with faculty and staff to identify potential system-based contributing factors; address any individual education, competency, or behavior issues; and to provide support as appropriate.
      o The Manager of Patient Services reviews all incident reports and enters them into Risk Master for tracking and trending as part of the School of Dentistry’s Coordinated Quality Improvement Plan.
      o Event reports are forwarded to the Director of Clinic Operations and to relevant faculty for follow-up as needed.
Health Sciences Risk Management is notified of events entered into Risk Master.
The Associate Dean for Clinics will provide quality, patient safety, and risk committees with quarterly reports.
Oversight of event management is provided by the Clinical Services Committee, the CQIP Operations Committee and the CQIP Oversight Committee to determine appropriate organizational responses to system issues.

RELATED POLICIES:
- Management of Patient Complaints/Grievances Policy
- Disclosure of Unanticipated Outcomes Policy

Appendices: Appendix A, Patient Event Form
Appendix B, Sample OARS Report

Dean of UW SOD:

Joel Berg, Dean of the UW School of Dentistry

October 24, 2016
APPENDIX A
PATIENT EVENT FORM

APPENDIX B
SAMPLE OARS REPORT: https://oars.ehs.washington.edu/Oars/LoginUWWashington
OARS Report Page 2
### Search for User

<table>
<thead>
<tr>
<th>Last Name:</th>
<th>First Name:</th>
<th>UW MailStop:</th>
<th>UWNetID:</th>
</tr>
</thead>
<tbody>
<tr>
<td>sun</td>
<td>samantha</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- [ ] Begins with
- [ ] Contains
- [ ] Exact

**OR**

- [ ] Begins with
- [ ] Contains
- [ ] Exact
- [ ] Exact

**Search UW Directory**  **Reset**

<table>
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<tr>
<th>Name</th>
<th>UWNetID</th>
<th>MailStop</th>
<th>Email</th>
<th>Home Dept. Name</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>SUN, SAMANTHA</td>
<td>samsun2</td>
<td>357131</td>
<td><a href="mailto:samsun2@dental.washington.edu">samsun2@dental.washington.edu</a></td>
<td>CLINIC SUPPORT SERVICE</td>
<td>+1 206 616-6996</td>
</tr>
</tbody>
</table>

**Select Person**

If the person not found, please provide all information using the button below.

- [ ] Create New User
- [ ] Cancel / Remove Selection
- [ ] Back to Report

OARS Report Page 3
### Classification (Please select level first)

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Near misses</td>
<td>Workplace Violence</td>
<td>Death (please call EH&amp;S immediately at 543-7262)</td>
</tr>
<tr>
<td>Incidents with no body injuries</td>
<td>Fire and Explosion</td>
<td>In-patient hospitalization of the Injured Party (please call EH&amp;S immediately at 543-7262)</td>
</tr>
<tr>
<td>Injuries requiring first aid</td>
<td>For EH&amp;S/Risk Management use only. WC cases</td>
<td>Accidents/Incidents occurred outside USA</td>
</tr>
<tr>
<td>Injuries requiring medical treatment (go to Level 2 if inpatient</td>
<td></td>
<td>For EH&amp;S/Risk Management use only. EH&amp;S special case</td>
</tr>
<tr>
<td>hospitalization is required)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Injuries involving lost work days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Injuries requiring restricted work or job transfer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loss of consciousness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Property damage</td>
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### Type of Incident

<table>
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<tr>
<th>Nature of Injury</th>
<th>Body Parts Affected</th>
<th>What caused the harm</th>
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</thead>
<tbody>
<tr>
<td>Open Wound: Laceration, Puncture, Scratch</td>
<td>Head</td>
<td>Bites / Scratches / Kicks</td>
</tr>
<tr>
<td>Burns</td>
<td>Eyes</td>
<td>Struck by Object</td>
</tr>
<tr>
<td>Sprains/Strains/Twist</td>
<td>Ears</td>
<td>Contact with Objects</td>
</tr>
<tr>
<td>Fracture/Dislocation</td>
<td>Nose</td>
<td>Overexertion</td>
</tr>
<tr>
<td>Pain/Inflammation/Edema</td>
<td>Mouth</td>
<td>Fall from Elevation</td>
</tr>
<tr>
<td>Electric Shock</td>
<td>Neck</td>
<td>Slip or Trip</td>
</tr>
<tr>
<td>Hearing Loss</td>
<td>Chest/Shoulders</td>
<td>Repetitive Motion Injury</td>
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<tr>
<td>Heart/Circulatory Diseases</td>
<td>Torso/Side</td>
<td>Bio-hazardous Materials/Infectious Diseases</td>
</tr>
<tr>
<td>Needlesticks/Sharps</td>
<td>Back</td>
<td>Needles/Sharps</td>
</tr>
<tr>
<td>Exposure to Potential Infectious Material</td>
<td>Abdomen</td>
<td>Noise</td>
</tr>
<tr>
<td>Splash</td>
<td>Buttocks</td>
<td>Fire</td>
</tr>
<tr>
<td>Poisoning by Substance</td>
<td>Elbows</td>
<td>Electricity</td>
</tr>
<tr>
<td>Respiratory Conditions</td>
<td>Arms</td>
<td>Chemicals</td>
</tr>
<tr>
<td>Mental/Emotional Distress</td>
<td>Fingers</td>
<td>Machinery</td>
</tr>
<tr>
<td>Allergy/Sensitivity Reaction</td>
<td>Hands/Wrists</td>
<td>Tools / Instruments</td>
</tr>
<tr>
<td>Chronic Irreversible Disease</td>
<td>Hip/Pelvis</td>
<td>Structures / Surfaces</td>
</tr>
<tr>
<td>Loss of Consciousness</td>
<td>Legs</td>
<td>Violence: Patient, Staff, Visitors</td>
</tr>
<tr>
<td>Skin Disorders</td>
<td>Knees</td>
<td>Radiation</td>
</tr>
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<td>Punctured Ear Drum</td>
<td>Feet / Ankle / Toes</td>
<td>Motor Vehicles</td>
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<td>Tuberculosis Infection</td>
<td>Groin</td>
<td>Non-human Primates</td>
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<tr>
<td>Non-personal Damage</td>
<td>Body Systems</td>
<td>Drugs</td>
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<tr>
<td>None</td>
<td>None</td>
<td>Patient Handling</td>
</tr>
<tr>
<td>Other</td>
<td>Other</td>
<td>Ergonomics</td>
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OARS Report Page 6
### Causes

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<th>Environment</th>
<th>Policies / Procedures</th>
<th>Human Factors</th>
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<tbody>
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<td>Defective Tools/Equipment</td>
<td>Inadequate Ventilation</td>
<td>Failure to Follow Procedures</td>
<td>Inadequate Training</td>
</tr>
<tr>
<td>Defective Material</td>
<td>Inadequate or Excessive Illumination</td>
<td>Appropriate Procedures Non-existent</td>
<td>Inadequate / Improper PPE</td>
</tr>
<tr>
<td>No Guards/Barriers</td>
<td>Air Contaminants</td>
<td>Inadequate Instructions / Procedures</td>
<td>PPE Not Used</td>
</tr>
<tr>
<td>Inadequate Guards/Barriers</td>
<td>Chemicals</td>
<td>Inadequate Planning / Preparation</td>
<td>Improper Lifting</td>
</tr>
<tr>
<td>Using Equipment Improperly</td>
<td>Noise</td>
<td>Inadequate Support / Assistance</td>
<td>Failure to Follow Established Protocol/Procedures</td>
</tr>
<tr>
<td>Inadequate Maintenance</td>
<td>Fire / Explosion</td>
<td>Other</td>
<td>Verbal Assault</td>
</tr>
<tr>
<td>Improper Equipment</td>
<td>Animal Action</td>
<td></td>
<td>Physical Assault</td>
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<tr>
<td>Other</td>
<td>Poor Housekeeping</td>
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<td>Inattention</td>
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<td></td>
<td>Inclement Weather</td>
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<td>Loss of Balance</td>
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<td>Slippery/Uneven surface</td>
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<td>Rushing</td>
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<td>Ergonomics Issues</td>
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<td>Phobia/Anxiety</td>
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<td>Other</td>
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<tr>
<td></td>
<td>Frost Bite</td>
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<tr>
<td></td>
<td>Heat Stress</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Suggested Corrective Actions (Precautionary Measures) to Prevent Reoccurrence

- Provide safety training
- Undertake hazard assessment
- Submit request for maintenance/repair
- Change work area layout / design
- Change/review work procedures
- Provide PPE
- Other

Suggested corrective action by the affected party:
PURPOSE

To establish guidelines for managing the credentials of the faculty of the University of Washington School of Dentistry.

GENERAL POLICY

Affiliate faculty of the University of Washington School of Dentistry shall be required to possess appropriate credentials in order to participate in the patient care process. Such credentials are required for either the supervision of care provided by a student (or resident), or for the direct provision of care by a faculty member. The requirements set forth in this policy shall meet the minimum standards required by state and federal law and University policy.

IMPLEMENTATION

I. New Faculty Appointments

A. Basic Credentials. Appointment as a faculty member in the School of Dentistry requires a review of the individual’s basic credentials. Faculty applicants shall be notified by the department chair of the requirement to complete the Faculty Credentialing Application (see Appendix A). Copies of the following documents must be attached to the Faculty Credentialing Application when applicable:

- professional and highest academic graduate degree diplomas
- Washington state professional license(s)
- DEA license
- Specialty board certification
- curriculum vitae
B. Supplemental Credentials. Faculty members who engage in the patient care process are required to comply with all applicable supplemental credentialing requirements:

The Faculty Credentailing Application and accompanying documentation must be submitted by the faculty applicant before s/he engages in didactic, preclinical or clinical instruction. New faculty appointees, who have submitted the required credentialing application materials, are granted temporary clinical privileges during the credentialing review process.

1. General Anesthesia and Sedation Credentials. A faculty member who administers or supervises the administration of conscious sedation with parenteral or multiple oral agents or general anesthesia must comply with authorization requirements (See WAC 246-817-701 through WAC 246-817-780).

2. Basic Life Support Credentials. A faculty member who administers or supervises administration of local anesthesia, nitrous oxide sedation, conscious sedation, or general anesthesia must have current basic life support certification.

3. Nitrous Oxide Credentials: Any provider administering, or supervising the administration of, nitrous oxidized must comply with the continuing education requirement (WAC 246-817-740). The law states that a dentist who administers inhalation sedation to patients must participate in seven hours of continuing education or equivalent every five years.

4. Supplemental Credentials. Faculty members who engage in the patient care process are required to comply with all applicable supplemental credentialing requirements.

II. Immunizations

All faculty are required to comply with federal and state law as well as university policy with regard to immunization for contagious disease as specified in the School of Dentistry Immunization Policy (see Appendix B).

III. Biohazardous Training

All faculty are required to comply with federal and state law as well as university policy with regard to training in the management of biohazardous materials and bloodborne pathogens (WAC 388-820-330; http://search.leg.wa.gov/pub/textsearch)
IV. Suspension of Clinic Privileges

Faculty members who do not comply with the requirements of this policy shall have clinic privileges suspended until the requirements have been met.

Appendices:

Appendix A, Faculty Credentialing Application
Appendix B, School of Dentistry Immunization Policy

Dean of UW SOD:

[Signature]

Joel Berg, Dean of the UW School of Dentistry

October 18, 2016

Date
# APPENDIX A

**Faculty Credentialing Application**

https://uwnetid.sharepoint.com/sites/sod/faculty-staff/Forms/Forms/AllItems.aspx

---

**FACULTY CREDENTIALING APPLICATION**

**I. PRACTITIONER INFORMATION**

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<th>E-mail Address</th>
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<table>
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<th>DEA Number (optional):</th>
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<th>NPI Number (optional):</th>
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<tr>
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<th>☐ Yes (please provide information below)</th>
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<th>Date Recertified</th>
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**II. PRACTICE INFORMATION**

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<thead>
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<table>
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<table>
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<th>Zip Code:</th>
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<td>( )</td>
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<table>
<thead>
<tr>
<th>E-mail Address:</th>
<th>Fax Number:</th>
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<tbody>
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**III. CURRENT PROFESSIONAL LIABILITY COVERAGE**

<table>
<thead>
<tr>
<th>☐ No</th>
<th>☐ Yes – Please provide policy/certificate face sheet</th>
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**IV. CURRENT PROFESSIONAL LIABILITY CLAIMS/LAWSUITS**

<table>
<thead>
<tr>
<th>☐ No</th>
<th>☐ Yes – Please complete Addendum 1 (attached)</th>
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</table>

**V. PRACTITIONER ATTESTATION QUESTIONS**

If your answer to any of the following questions is “Yes,” provide details as specified on a separate sheet. If you attach additional sheets, sign and date each sheet.

### A. PROFESSIONAL SANCTIONS

1. Have you ever been, or are you now in the process of being, disciplined, revoked, terminated, suspended, restricted, reduced, limited, sanctioned, placed on probation, monitored, or not renewed for any of the following? Or have you voluntarily relinquished, withdrawn, or failed to proceed with an application for any of the following in order to avoid an adverse action or to facilitate an investigation or a criminal or disciplinary investigation relating to professional competence or conduct?

   - a. License to practice any profession in any jurisdiction
     - Yes ☐ No ☐
   - b. Other professional registration or certification in any jurisdiction
     - Yes ☐ No ☐
   - c. Membership on any hospital or clinic medical staff
     - Yes ☐ No ☐
   - d. Clinical privileges at any facility, including hospitals, ambulatory surgical centers, skilled nursing facilities, etc.
     - Yes ☐ No ☐
   - e. Medicare, Medicaid, FWA, NIH (Office of Human Research Protection), governmental, national or international regulatory agency, or any public program
     - Yes ☐ No ☐
   - f. Professional society membership or fellowship
     - Yes ☐ No ☐
   - g. Participation in an HMO, PPO, IPA, PHO or other entity
     - Yes ☐ No ☐
   - h. Authority to prescribe controlled substances (DEA or other authority)
     - Yes ☐ No ☐

2. Have you ever been subject to review and/or disciplinary action, formal or informal, by an ethics committee, licensing board, dental or medical discipline board, professional association, or education or training institution?

   - Yes ☐ No ☐

3. Have you been found by a state professional disciplinary board to have committed unprofessional conduct as defined in applicable state provisions?

   - Yes ☐ No ☐

4. Have you ever been the subject of any reports to a state, federal, national data bank, or state licensing or disciplinary entity?

   - Yes ☐ No ☐

---

10/05/10 Rev
V. PRACTITIONER ATTESTATION QUESTIONS - Continued

**B. AFFIRMATION OF ABILITIES**

1. Do you have, or have you had in the last two years, any physical condition, mental health condition, or chemical dependency condition (alcohol or other substance) that affects or will affect your current ability to practice with or without reasonable accommodation? If reasonable accommodation is required, specify the accommodations required. If the answer to this question is yes, please identify and describe any rehabilitation program in which you are or were enrolled which assures your ability to adhere to prevailing standards of professional performance.  
   - Yes ☐  No ☐

2. Are you unable to perform any of the services/clinical privileges required by the position, with or without reasonable accommodation, according to accepted standards of professional performance?  
   - Yes ☐  No ☐

**C. LITIGATION AND MALPRACTICE COVERAGE HISTORY**

(If you answer “Yes” to any of the questions in this section, please complete Addendum 1 of this application.)

1. Have allegations or claims of professional negligence been made against you at any time, whether or not you were individually named in the claim or lawsuit?  
   - Yes ☐  No ☐

2. Have you or your insurance carrier(s) ever paid any money on your behalf to settle a professional malpractice claim (not necessarily a lawsuit) and/or to satisfy a judgement (court ordered damage award) in a professional lawsuit?  
   - Yes ☐  No ☐

3. Are there any such claims being asserted against you now?  
   - Yes ☐  No ☐

4. Have you ever been denied professional liability coverage or has your coverage ever been terminated, renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged)?  
   - Yes ☐  No ☐

VI. ATTESTATION AND CONSENT

I certify that all the information provided on this form and on any attached information sheets are true, accurate, and current. I acknowledge that any misstatements or omissions from this application constitute cause for denial of requested appointment and clinical privileges or cause for revocation of appointment and privileges. A photocopy of this application has the same force and effect as the original.

I specifically agree and consent to the disclosure and release of information to the University of Washington that assists in the verification of my academic and professional credentials and qualifications.

Applicant’s Name (print): ____________________________  Date: ____________________________

Applicant’s Signature: ____________________________

VII. DEPARTMENT AUTHORIZATION

I support the submission of this application. In the event of an adverse response to any attestation question in the Faculty Credentialing Application, I verify that I am aware of and have reviewed all information related to the occurrence.

Proposed Faculty Appointment: ____________________________

Proposed Date of Appointment: ____________________________

Department: ____________________________

Department Chair Name (print): ____________________________  Date: ____________________________

Department Chair Signature: ____________________________

VIII. SCHOOL OF DENTISTRY REVIEW

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<tr>
<th>Date</th>
<th>Reviewer</th>
<th>Recommendation</th>
<th>Signature</th>
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19/05/10 Rev
### Addendum 1. Professional Liability Claims and Lawsuits – Detail

Please list any current professional liability claim(s) or lawsuit(s), in which allegations of professional negligence were made against you, whether or not you were individually named in the claim or lawsuit. **Photocopy this page as needed and submit a separate page for EACH claim/event.** A legible signed practitioner narrative that addresses all of the following details is acceptable.

#### Date Suit or Claim Filed:

<table>
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<tr>
<th>Clinical details of the incident, with preceding events:</th>
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<th>Your role and specific responsibility in the incident:</th>
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<th>Subsequent events, including patient’s clinical outcome:</th>
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<th>Name and address of insurance carrier that handled the claim:</th>
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<th>Your status in the legal action (primary defendant, co-defendant, other):</th>
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<th>Current status of suit or other action:</th>
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<th>Date of settlement, judgment, or dismissal:</th>
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<th>If case was settled out-of-court, or with a judgment, settlement amount attributed to you:</th>
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Applicant's Signature: ___________________________ Date: ___________________________
School of Dentistry Immunization Policy

Employees (Faculty, Staff, and Student Employees), Volunteers, or Observers

Health-care professionals are at risk for exposure to and possible transmission of vaccine-preventable communicable diseases because of their contact with patients or infectious material from patients. Maintenance of immunity to vaccine-preventable diseases is therefore an essential part of prevention and infection control. The Employee Health Clinic (EHC) and the Hall Health Primary Care (HHPC) Immunization Clinic located at Hall Health Center follow recommendations for health care workers from the Centers for Disease Control and Prevention (CDC) and OSHA/DOSH occupational health mandates. All faculty, staff, student employees, volunteers, and observers who are in laboratories or dental clinics with patient contact and who thereby may be at risk of exposure to blood borne pathogens must demonstrate compliance with requirements for the following: measles (rubeola), mumps, rubella, Hepatitis B, tetanus-diphtheria-pertussis (Tdap), varicella (chicken pox), and tuberculosis (TB) screening. Patient contact may not begin until documentation of compliance with these requirements takes place.

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Requirement</th>
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<tbody>
<tr>
<td>Measles</td>
<td>Two vaccine doses of measles containing vaccine or a positive antibody titer. Doses must have been received after 12 months of age and at least one month apart.</td>
</tr>
<tr>
<td>Mumps</td>
<td>Two immunizations (regardless of birth year), or a positive antibody titer.</td>
</tr>
<tr>
<td>Rubella</td>
<td>One immunization or a positive antibody titer.</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>Evidence of immunity is required. The immunization series consists of three doses of vaccine. The first injection must be administered before staff, faculty, or volunteers enter the clinic. In addition, an antibody titer is required after completion of the series to prove immunity.</td>
</tr>
<tr>
<td>Td or Tdap</td>
<td>If no documentation of Td or Tdap then a single Tdap booster.</td>
</tr>
<tr>
<td>Varicella</td>
<td>Varicella (Chicken Pox): Serologic evidence of immunity or two immunizations given at least one month apart.</td>
</tr>
<tr>
<td>TB</td>
<td>Evidence of two PPD tests within the year prior to employment is required; otherwise a 1-step PPD will be done. History of BCG is not a contraindication to PPD testing. If you have had a documented positive TB skin test in the past, records specifying the test, without a cure report, and details of prescribed medication are required. Annual PPD skin testing (or symptom review for those not being tested) is required. Patient contact is not allowed unless documentation of this annual TB screening takes place.</td>
</tr>
<tr>
<td>Influenza</td>
<td>Recommended not required. Annual flu shots are recommended for health care workers who have contact with patients at high risk for influenza or its complications; those who work in chronic care facilities, and those with high risk medical conditions.</td>
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</tbody>
</table>

Employees (faculty/staff, student-employees):
The Employee Health Clinic @ the Hall Health Center screens each UW School of Dentistry employee for compliance, and bills back to the 500 department budget for any necessary vaccinations, TB screens or labs.

Please note: While an employee may choose to obtain the required Immunizations, labs or tuberculosis screening from their current health care provider, School of Dentistry employees must obtain clearance through the Employee Health Clinic by submitting their records to the Employee Health nurse for review. If employees have questions, they may contact the Employee Health Clinic directly at (206) 685-1026.

Volunteers and Observers:
School of Dentistry volunteers and observers are responsible for paying for the required Immunizations, TB screening or labs. Volunteers and observers are screened by a health provider at the UW Hall Health Center for compliance with the above-listed requirements.

If volunteers or observers have questions about their required Immunizations, they may discuss it with the health provider at the Hall Health Center once scheduled for an appointment. To contact the Hall Health Center appointment desk call (206) 616-2495.

Updated: October 2012
# Referral of School of Dentistry Employees / Student Employees/Volunteers/Observers to UW Employee Health Center at Hall Health for Immunization / T.B. Screening

<table>
<thead>
<tr>
<th>NEW Employee</th>
<th>CURRENT Employee</th>
<th>Volunteer</th>
<th>Observer</th>
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**Instructions**

This form is to be used to refer any School of Dentistry volunteer/observer to the appropriate health providers at: Hall Health Center to complete their immunization screening requirements. (Immunizations may be obtained by another healthcare provider, however verification must be done through Hall Health Center)

Volunteers/Observers contact: (206) 616-2495
Location:

Hall Health Center, 4060 East Stevens Way (across from the HUB), Seattle, WA 98195

The individual should bring any immunization records with them to their first appointment

**Department Information**

<table>
<thead>
<tr>
<th>Department Name</th>
<th>School of Dentistry</th>
<th>Box No.</th>
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<tbody>
<tr>
<td>Contact Name</td>
<td>Phone No.</td>
<td>Fax No.</td>
</tr>
<tr>
<td>Administrator Printed Name</td>
<td>Administrator Signature</td>
<td>Date</td>
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**Employee/Student Employee/Volunteer/Observers Information**

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Name</th>
<th>S.S. No.</th>
<th>E.I.D. No.</th>
<th>Faculty</th>
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<th>S.S. No.</th>
<th>E.I.D. No.</th>
<th>Notes</th>
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**To Be Completed by Employee Health Nurse at Hall Health or HHC Provider**

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**Notes from Employee Nurse or HHCPC Provider**

**Updated**: October 2015

**Reset Form**
PURPOSE

To define the specific duties required of clinical faculty during the supervision of students engaged in patient care.

GENERAL POLICY

Supervision of students of the University of Washington School of Dentistry during patient care is required by state law. Specific duties of the faculty engaged in this function are defined in this policy, including the essential documentation of that supervision.

IMPLEMENTATION

I. State Law

The following are relevant portions of Washington State Law relating to Dental Practice which establishes the legal basis for the supervision of unlicensed dental students engaged in patient care. The statue explains the requirement for faculty supervision of dental students. See:


PRACTICE OF DENTISTRY DEFINED. (RCW 18.32.020)

EXEMPTIONS FROM STATUTE. (RCW 18.32.030) NOTE section 3: Dental schools or colleges approved under RCW 18.32.040

II. Duties of Supervising Faculty

A faculty member who supervises a student during patient care must hold a current dental license (or a dental hygiene license, in cases where a faculty member is teaching within the scope of practice of a dental hygienist.) The faculty member must
also be in compliance with School of Dentistry and WA State requirements, such as, but not limited to, HIPAA, BBP standards, OSHA/WISHA standards, etc.

A. Location

The supervising faculty member must be punctual for clinic start times, maintain a physical presence in the clinic when predoctoral students are being supervised and remain until patients under their supervision are dismissed. Faculty supervising postdoctoral students must remain on call in the building during patient care.

B. Permission to Proceed

Predoctoral students must be granted formal permission to proceed with planned care by the faculty supervisor after completion of the following mental checklist:

1. Review health status.
2. Verify appropriateness of proposed procedure.
3. Verify accuracy of the radiographs.
4. Verify existence of the treatment plan and patient consent

C. Teaching Standards

Faculty must adhere to established standards of care of the dental profession and the School of Dentistry to teach within the parameters of departmental philosophy and protocols (see Clinic Policy Manual, Section 1-C Standards of Patient Care.) https://dental.washington.edu/policies/clinic-policy-manual/standards-of-patient-care/)

D. Professional Modeling

Faculty are expected to model professional behavior while supervising patient care. Clinical faculty are to preserve a humanistic learning environment for students and patients.

E. Treatment Documentation

Faculty shall assure that patient care is documented and verify the care by approving the treatment progress notes in the EHR.

F. Financial Management

Faculty are expected to:

1. Approve the treatment plan and verify fees are listed.
2. Assure the patient has signed the treatment plan acknowledging consent for care and acceptance of the stated fees.

III. Documentation of Supervision

A. Onset of Supervision

In keeping with School policy and the School’s Quality Improvement Program, care shall not be rendered until supervision is in place in any dental school clinic. As faculty supervision must be in place, faculty must be punctual for clinic start times. Supervision is documented when the faculty supervisor approves the treatment in the EHR. At offsite clinics, students likewise are not to proceed with care without permission from the supervising faculty (see RCW 18.32.030 and RCW 18.32.040).

B. Completion of Supervision

1. School Clinics

Daily clinical session supervision ends when all patients under faculty supervision are dismissed and all documentation is recorded in the patient record.

Dean of UW SOD:

__________________________________________________________
Joel Berg, Dean of the UW School of Dentistry        Date
PurPOSE

For subpoenas related to patient care, UW School of Dentistry faculty, residents, students & employees should contact Health Sciences Risk Management in the Health Sciences Center – (206) 598-6303; HMC – (206)744-9574; UWMC – (206) 598-6303. Health Sciences Risk Management serves as a liaison to the Attorney General’s Office for this purpose, so this will fulfill one’s obligation, as outlined in the University of Washington Handbook, to notify the Attorney General’s Office upon receiving legal process. Questions about non-patient care-related subpoenas (or other legal process) should be directed to the Assistant Dean of Finance and Administration.

GENERAL POLICY

UW School of Dentistry policy directs faculty, residents, students & employees to comply with their legal obligations to provide fact witness testimony related to subpoenas and similar court process. Under the law, the individual named in the subpoena has primary responsibility for ensuring that a response to the subpoena takes place; failure to do so can result in contempt citations and other sanctions from the court against that individual. The guidelines below are intended to assist faculty, residents, students & employees with this duty, while minimizing disruption to patient care.

IMPLEMENTATION

The following guidelines provide information and advice on what to do and expect if you receive a subpoena or request to testify as a witness in a lawsuit, administrative, or criminal proceeding, and/or a subpoena to produce documents relating to University business. Commonly asked questions and answers are summarized in Appendix A.

If the questions and answers below do not provide enough information, faculty, residents, students & employees should first notify their department Chair or the
Dean's Office. The faculty, resident, student or employee and their manager together may then contact the University of Washington’s Health Sciences Risk Management Department for further advice regarding patient care-related subpoena issues. Dental faculty may wish to contact their department Chair or other supervisory dentist, and/or seek further advice from Health Sciences Risk Management, or their own personal attorney. Health Sciences Risk Management will facilitate any necessary involvement of the Attorney General’s Office.

**Appendices:**
- Appendix A, Questions & Answers: Subpoena, Deposition and Testimony Guidelines
- Appendix B, Sample Trial Subpoenas

Dean of UW SOD:

Joel Berg, Dean of the UW School of Dentistry

Date
What is the meaning of “subpoena” and “subpoena duces tecum?”

A subpoena is a legal document requiring a specific person to appear and testify as a witness in court or at a deposition. A subpoena duces tecum (SDT) orders the person subpoenaed to produce books, documents, or other records under his/her control. It may also require the person to accompany the records and testify as a witness at a specified time and place. It is served upon the custodian of the required records, or upon an individual person named in the subpoena.

A subpoena or SDT is issued by an officer of the court or an attorney of record in the case, and is served on a named individual, department or organization.

What should I do if I receive a subpoena or a subpoena duces tecum?

The answer to this question depends on the following two factors:

- Whether the University of Washington, including any School of Dentistry Clinic, Harborview and/or UW Medical Center (UW Medicine), is directly or potentially involved in the case.
- The type of information requested.

How can I tell if the University of Washington is involved in the case?

1) Is the UW a party to the case?

If the UW is a party, this means that the UW will be listed in the caption (box in the upper left hand corner of the document) of the subpoena or subpoena duces tecum (the caption may say University of Washington, UW School of Dentistry, Harborview Medical Center, University of Washington Medical Center, or may list a clinic or affiliate name and/or an individual University of Washington School of Dentistry or School of Medicine provider name.)

2) What should I do if UW is a party to the case?

Immediately contact the University of Washington Health Science
If the subpoena is for an ongoing case that you already are involved in, direct any questions about depositions to the UW Office of Risk Management at (206) 543-3657. Ask to speak with the liability claims manager.

What should I do if UW is not a party to the case, but I believe that the case involves a potential quality of care issue for UW School of Dentistry or any Health Sciences school?
Immediately contact the University of Washington Health Science Risk Management Department. (Health Sciences Center – (206) 598-6303)

What should I do if UW is not a party to the case, and I do not think that the case involves a potential quality of care issue for UW School of Dentistry or UW Health Sciences School?
This depends on the type of information being requested.

1) **What if the subpoena is requesting medical records?**
   All subpoenas requesting release of patient-related records should be promptly sent to the Patient Records Office for processing. (B 307, Box 357131, Attention: Records Custodian). The treating faculty member will be notified, but the record preparation and release must be done by the record’s custodian to help ensure that the release is legally appropriate and that the medical record is complete. Do NOT attempt to gather or provide the medical or dental records yourself.¹

2) **What if I believe that release of my patient’s dental records to someone other than my patient) will be harmful to my patient?**
   Contact Health Science Risk Management for further advice. (206) 598-6303

3) **What if the subpoena also requests my testimony?**
   If this is the case, the subpoena will usually ask you to appear to

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¹ For example, most medical records may be released pursuant to a subpoena as long as a “notice of intent” to subpoena the records has been sent (and copied to the patient) 14 days in advance. However, certain types of records (e.g., mental health records) may be released ONLY upon express agreement of the patient or under a court order.
provide testimony, and the medical records request will take the form of a subpoena duces tecum asking to you bring records with you. A subpoena asking you to appear only as a “custodian” of the records usually will be handled entirely by Patient Records (they will notify you if your presence is required). You should call 543-5005 to coordinate transferring the subpoena to them and to answer any questions they may have about providing your patient’s records.

If the subpoena appears to be requesting your testimony as a health care provider for the patient, you should coordinate with the Record’s Office to make sure that the appropriate steps have been taken to permit release of the patient’s health care information (this applies to any records that have been requested, as well as to your actual testimony about your care of the patient). You would then follow the steps listed below under “fact” witness testimony.

4) What if the subpoena requests release of research records or data?
   Contact the manager of the UW Human Subjects Division, at 543-0098, for review and advice.

5) What if the subpoena requests something other than patient care information?
   You should contact the Assistant Dean of Finance and Administration at (206) 543-5494, School of Dentistry’s Dean’s Office if the subpoena does not appear to be related to clinical patient care. Patient care-related subpoenas generally involve a University of Washington School of Dentistry patient as a plaintiff, defendant, or victim (criminal case). Examples of subpoenas that should be initially referred to the Director of Compliance & Billing, School of Dentistry include, but are not limited to:
   • Subpoena from the Department of Justice or the Office of Inspector General;
   • A case that appears to involve a contract dispute, financial issues, patent issue or copyright issues.

6) It looks like I am being asked to testify as a healthcare provider. What should I do?
   This depends upon whether you will be testifying as a “fact” witness or as an “expert” witness.
a) What is the difference between a “fact” witness and an “expert witness”?

In a typical litigation setting, a “fact” witness was involved in the events at issue in the case, and testifies solely about his/her personal knowledge of those events (e.g., eyewitness testimony). Most fact testimony does not involve opinions of any kind. “Expert” witnesses, on the other hand, typically have not been personally involved in the events at issue in the case, but have reviewed them from a third-party perspective. These witnesses offer opinions about the issues in the case that are relevant to their areas of expertise.

Health care providers sometimes testify in the expert role described above; that is, they will review cases in which they were not personally involved and offer opinions in their areas of expertise. Even when health care providers who are involved in cases in the role of treating provider are asked to testify as “fact” witnesses, however, they actually function in a type of “hybrid” role, because expert opinions may be elicited if formulated as part of the basis of care. There are limits to the scope of the opinions that are properly asked of a health care “fact” witness, as described below.

Slightly different concepts apply in worker’s compensation (L&I) cases; see below.

(1) “Fact” Witness

A treating provider can be compelled to testify about the “facts” of his or her care of the patient. (See above for information about appropriate release of dental records.)

- Example: Dr. X., when you examined the patient in January 2002, what was his level of numbness?
- In connection with that testimony, the provider may appropriately be asked questions about his/her qualifications, including education, training, publications, etc. The provider may also appropriately be asked questions about medical opinions that he/she formed in connection with care of the patient. As a “fact” witness, the provider may appropriately decline to formulate a present opinion in the case. You do not need to formulate an opinion about matters that go beyond your involvement in providing care to the patient. Only testify on matters within the scope of knowledge of your practice or medical specialty.
• “Fact” opinion example (witness may be required to answer): Dr. X, based upon your examination of the patient in January 2002, what did you think was causing the patient’s pain?

• “Expert” opinion example (witness may decline to offer): Dr. X, on a more likely than not basis, do you believe that my client’s current problem was caused by the November 2001 accident?

(2) “Expert Witness”
A treating provider may also serve as an expert witness. As noted above, expert witnesses generally do not have personal knowledge related to the patient (aside from record review). If you have been subpoenaed regarding giving testimony about your own patient, you need not agree to provide “expert testimony” (see example above).

• You cannot be required to testify in an “expert” witness capacity unless you have previously agreed to do so.

(3) Worker’s Compensation (L & I) cases
If you are the provider for an injured worker (or someone with an occupational illness) in the state of Washington, you may be asked by the Department of Labor & Industries or the self-insured employer to provide information about your care of the patient related to the injury or illness. You also may be asked to provide certain specific types of expert opinion. Typically, these involve questions about “rating” the patient’s level and degree of disability under a state regulations scheme. Most of this activity takes place at the “claims management” level (i.e., through correspondence with the claims manager for the patient’s L & I claim), and does not involve attorneys or legal process. You may decline to offer a rating opinion, but you will need to provide requested information about your care of the patient (see §G below). If actual dental records are requested, follow the Record’s Office procedures described above.

You also may become involved in a claimant’s or employer’s “appeal” and you may be subpoenaed for testimony in an administrative hearing before the Board of Industrial Insurance Appeals. In most cases, you do not need to appear “live” at the hearing; it is
very common for the testimony of health care providers in these cases to be taken by “perpetuation” deposition.

Can I agree to be an expert witness?
Yes. (See below for witness compensation information).

Can I receive compensation for fact or expert witness testimony?
If you will be receiving any compensation for your testimony (beyond “statutory” fees; see below), you must follow the UW policies for outside consulting (see University of Washington Operations Manual, section D 47.3; for more information, see [link]). Members of UWD must also review and follow the subpoena and testimony policies developed by these organizations, as well as UWD Policy Regarding Expert Witness Testimony, the xxx – need to find xxx). Billing staff will assist in determining the appropriate charges for staff testimony as an expert witness.

Briefly, compensation for testimony involving UWD patients must be handled through UWD billing procedures. Compensation for testimony involving “outside” patients can be handled through outside consulting procedures.

a. **Special information regarding compensation as a fact witness**
   Payment for fact witness testimony is set by court rules and involves a minimal fee. However, many attorneys are willing to pay healthcare providers more than the mandatory fees required by the courts. If you wish to receive compensation for fact witness testimony beyond the “statutory” fees, your request for compensation must be discussed with the attorney requesting the testimony before the deposition or testimony. Questions about appropriate billing procedures should be referred to the UWD billing manager.

b. **If I am a non-billing employee, will I be paid my salary to testify if called, or would I have to use benefit time?**
   In most cases, your testimony would be considered part of the scope of your duties. You should discuss time and compensation issues with your manager.
What if the subpoena comes from a court outside of King County?
Subpoenas for testimony outside of King County are covered by special rules, including any witness fees to be paid in advance. These issues usually can be resolved through contact with the prosecutor’s office or other issuing attorney. Contact Health Sciences Risk Management (206)598-6303, which will refer you to the Attorney General’s Office if needed.

What if the subpoena arrives by mail or on very short notice before the trial or deposition?
Depending on the level of court where the case is filed, service by mail may be technically improper. You also may receive a subpoena that technically does not provide the required “reasonable notice.” However, that does not mean that these subpoenas should be ignored. These issues usually can be resolved through contact with the prosecutor’s office or other issuing attorney. Contact Health Sciences Risk Management (206.598.6303), which will refer you to the Attorney General’s Office if needed.

What if I am not available at the time I have been asked to testify?
Sometimes witnesses are subpoenaed to give deposition or trial testimony at a time that is inconvenient or when the witness is unavailable. When this occurs, contact the attorney and explain the situation and request an alternative time and date to provide testimony. An attorney is not obligated to change the subpoena to accommodate an individual’s request, but most are usually willing to schedule the deposition at a mutually agreeable time. Witnesses who are subpoenaed to give testimony at trial are frequently summoned to appear at the court on the first day of trial. Always contact the attorney who has issued the subpoena for trial testimony to arrange for the appearance time and date. Because trials are unpredictable, scheduling testimony during trial is more difficult. If it is not possible to alter one’s schedule, discuss alternatives with the requesting attorney such as a “perpetuation” deposition (generally videotaped).

I have not been subpoenaed, but an attorney has asked to meet with me or speak with me on the phone. What should I do?
This depends on the nature of the case. Follow the guidelines in the questions above. If UW is not a party to the case, and you do not think that the case involves a potential quality of care issue for UW School of
**Dentistry or other Health Sciences school**, you may agree to meet or speak with attorneys if they have the appropriate release of information forms signed by the patient. If indicated, the patient’s legally authorized surrogate may sign the authorization; this usually is acceptable only if the patient is incapacitated. For a deceased patient, the personal representative of the estate must sign the authorization.

In criminal cases, you may request a joint meeting with the prosecutor and defense attorney to minimize the amount of time necessary to answer their questions. The attorneys are not obligated to agree to a joint meeting, but may agree to it.

In civil cases (e.g., personal injury) that do not involve UW, you should not meet or speak “ex parte” (alone) with the defense attorney (i.e., the attorney who is not representing the patient) without a specific authorization from the patient to do so. **The exception to this is workers’ compensation**, where you may meet or speak with the employer’s attorney/representative or an attorney/representative for the Department of Labor & Industries without a written authorization from or on behalf of the patient. The discussion should be limited to health information relevant to the occupational injury or illness.

You are not obligated to meet informally with attorneys and may request to be deposed if the case is in litigation. You may request compensation in accordance with UWD policies when you meet with an attorney informally. The fee should be agreed upon with the attorney requesting the meeting in advance. Payment must be billed in accordance with UWD policies.²

**What if my patient or my patient’s attorney is asking me about another provider’s care (either UW or outside provider), and I have concerns about that care?**

You ultimately must decide what you are comfortable discussing with your patient or your patient’s attorney. However, here is some information that may be helpful to you when considering these issues.

- Taking a “legal position” with your patient may affect the therapeutic nature of the provider-patient relationship. It is perfectly appropriate to tell your patient you do not wish to become involved in legal proceedings (other than as a fact witness) in order to preserve a purely therapeutic relationship.
- If you express an opinion that could be considered an “expert”

² This refers to cases involving UWD patients. For cases involving “outside” patients (i.e., if you are a reviewing expert), you would not request to be deposed by the party retaining you, and you would not agree to meet informally with the other party.
opinion as described above (e.g., an opinion on the standard of care or causation of damages), you may properly be subpoenaed to testify as an expert witness.

- Often, patients who express dissatisfaction to you about other providers simply have unanswered questions. It may be more beneficial for you to try to facilitate communication between your patient and the other provider. For example, you may be able to resolve the issue by contacting the other provider and encouraging them to speak with the patient. This also will give you more complete information about the patient’s prior care (see below). **Staff should always include their manager or department director in these issues.**

- If the other provider is a UW provider, it would be more helpful to the patient, to you, and to UW if you contact Health Sciences Risk Management about your concerns. You will be able to tell the patient that you will initiate an investigation into their concerns. We will be able to coordinate an appropriate QI investigation, involve the other provider, facilitate communication with the patient, and share the results with them.

- Different providers can have differing views on clinical care. It generally is not helpful for a treating provider to directly criticize another provider’s care, especially without complete information. This is why retained expert witnesses do not offer opinions without reviewing all the relevant records and other information. In addition, if you do express an opinion without having all the relevant information, you eventually may be in an awkward position in the legal record.

- If you do express an opinion on standard of care and causation without a thorough review of all relevant information, you will make it difficult for the provider you are criticizing to defend what in fact may have been appropriate care.

- If you would like to discuss any of these issues, you may contact Health Sciences Risk Management (206) 598-6303.

I am pretty sure I will need to testify at deposition or at trial. What should I know about the process?

Answers to frequently asked questions about the process of testifying are below. If you have additional questions, you may contact Health Sciences Risk Management (206) 598-6303.

1) **Will a UW attorney go with me when I testify?**
   If the UW is not a party to the case, there generally will not be a UW attorney attending your testimony. This is the standard UW policy and procedure; however, there may be
exceptions to this general approach if the circumstances are unique. If there are concerns about whether the UW may be implicated in a case, contact Health Sciences Risk Management (206) 598-6303).

2) **Where will I give testimony?**
Testimony may occur in several different settings:
- At a deposition (usually held at a private office),
- At a hearing, or
- In a courtroom.
Testimony may be given only with attorneys present (at a deposition) or in the presence of a judge and/or a jury (at trial). In any of these testimony situations, the testimony is a formal statement given under oath or promise of telling the truth.

A deposition allows each party in a lawsuit or administrative hearing to question any other party or other witness in the case. Depositions are generally conducted prior to trial. A “perpetuation” deposition is like testifying at trial and will become part of the court record. If the deposition is taken solely for “discovery” purposes, the deposition testimony generally may be used at trial only if the witness’ trial testimony contradicts his/her deposition testimony, or if the witness is unavailable during the trial to testify in person. However, any discovery deposition may become part of the court record (a public record), and you should assume that might happen with your deposition testimony.

3) **What should I expect to occur when I testify?**
After being sworn in as a witness, you will be asked questions, usually by all of the attorneys representing persons or entities in the case.

Testimony as a witness is not a “grand rounds” forum. There may be strategic reasons why some issues are not explored during the testimony. It is not your responsibility to tell everything you know or believe to be important. Wait for the question. The “scope” of questioning is much broader in a discovery deposition than at trial or in a perpetuation deposition.

Both the questions and answers you provide will be recorded, usually by a court reporter. If testimony is provided at a deposition, a written transcript of the testimony will be prepared. As the witness, you will be asked whether
you want to read it or not. You may choose to read it and either sign that it is accurate or identify corrections. Alternatively, you may choose not to read it. This is your decision in a case where the UW is not a party to the lawsuit.

4) How should I conduct myself as a witness?
Guidelines for Testimony

- Tell the truth. You will be under oath. Giving an intentionally false answer is perjury, which is a crime. In addition, any false or inconsistent answers may be used to attack your credibility on all matters. Be honest. Be accurate. If only approximate dates, times, or distances are known, then give only your best approximation and say it is an approximation. If you answer mistakenly during testimony, simply say that you were mistaken and correct your statement.

- Discuss matters of concern in advance with either the UW attorney handling the case or with Health Sciences Risk Management (if no UW attorney is assigned; (206)598-6303. If you are concerned about something that might prove embarrassing or something that you have done, discuss it candidly with either the UW attorney handling the case or with Health Sciences Risk Management before giving testimony.

- Listen carefully to every question. Do not let the person asking the questions put you in the position of accepting half-truths on which further questions might be based. Be sure that you agree with each aspect of the question before answering, or clearly state any qualifications you believe are needed for complete accuracy.

- Be alert for leading or hypothetical questions. Some leading or hypothetical questions may result in a possible adverse conclusion.

For example, an attorney may ask, “Ordinarily, doctor, this result does not occur if the dentist uses reasonable care, right?” If you answer, “That is correct, this result does not ordinarily occur,” then you might have testified as an expert, perhaps against the UW’s position or against yourself. As an alternative, it may be more accurate to acknowledge that an adverse outcome is one of the inherent risks in the procedure.
Be careful when asked about “authoritative texts.” If you are asked whether a particular text is authoritative and you respond “yes,” that answer may be interpreted to mean agreement with every statement contained in that text. Instead, you may wish to recognize that a book or article expresses only that author’s opinion, that it may be an incomplete expression of that opinion, and that it could be out of date. It may be more accurate to testify that you rely on your training and experience, and although you do read certain journals, articles and books in your field, you do not believe that any one text is completely authoritative.

Answer in your own words and answer only the questions asked. Do not volunteer any additional information. Answer the questions with words that you normally use and feel comfortable using. Answer only one question at a time.

Pause before beginning each answer. This gives you time to reflect on the question, and it also gives the UW attorney (if one is present), or another attorney an opportunity to make any necessary objections.

Listen carefully to objections; something can be learned about the question from the objection. For example, an objection that a question is speculative may mean that you would need more information to be able to answer the question. If an objection is made to any question or answer, stop talking until you are directed to continue your testimony by the judge (at trial), the UW attorney or the examining attorney (at depositions). If there is no UW attorney at a deposition and you have serious concerns about answering a question, state that you need to consult with counsel and cannot answer until you have done so. Contact the UW Attorney General’s Office (206) 543-9220 for further advice. Do not provide those at the deposition with the basis for your concerns.

If you do not understand a question, say so. Ask for clarification or for the question to be repeated. If requested, the court reporter will repeat a question as it was recorded.

Do not guess or offer an opinion unless specifically requested to do so. A witness will generally be allowed to testify only to what s/he personally saw, heard or did. If you do not have personal knowledge, say so. Be willing to
acknowledge the limits of your knowledge or expertise. Do not guess or offer an opinion unless it is specifically called for, and then answer only after waiting to hear if there is any objection.

- Where appropriate, qualify your answers. Testify accurately based on your memory. It may be necessary to be vague about a date or fact if you are uncertain. If you are not sure, say so (e.g., “to the best of my recollection” or “as best as I can recall: or “I believe”). There is no need to apologize if you do not recall or know requested information.

- Avoid using absolutes unless you are certain they are accurate. For example, saying “I never” or “I always” may be problematic later.

- Avoid using the word “inadvertent”. One of the several definitions of “inadvertent” is “reckless, careless, and negligent”. Thus, the statement “I inadvertently nicked the artery” could suggest an admission of negligence. Instead, you should simply state what happened, such as, “The artery was nicked.”

- Indicate whether you are paraphrasing or quoting. In testifying regarding conversations, make it clear whether you are paraphrasing or quoting directly.

- Do not offer or bring with you documents that have not been appropriately requested in advance. If an attorney wants to obtain documents, other legal procedures may apply. This is especially true of dental records. **Attorneys who seek dental records should be referred to the Patient Record’s Office.**

- If you are presented with and asked about a document, read it carefully before you begin to answer. If you do not recall the document, or do not know what the document says or what its author meant, then say so. Do not guess at what it might have meant.

- Speak slowly, clearly and audibly. The court reporter must hear every word you say in order to transcribe your testimony. Let the examiner complete the question before you begin to answer. Try to answer “yes” or “no” when appropriate; do not nod your head or say “uh huh”.


• If warranted, make an oral statement about inappropriate actions. The transcript will reflect only what is said. It will not reflect, for example, that an attorney yells or hovers. If you are confronted with inappropriate actions such as these, you may say what is happening at the time, and the transcript will include the statement. However, do not let yourself be provoked into an argument with the lawyers.

• Be serious and polite at all times. Do not give cute or clever answers, as they may be misinterpreted. Avoid all obscenities, slurs, and references that could be considered derogatory or offensive to others. Remember that your statement may be read to a judge or jury, and thus become part of a public record.

• If you need a break, ask for one. Paying attention to your level of fatigue will help ensure effective listening and help avoid mental lapses that can result in problems with your testimony.

• Avoid casual conversation with opposing counsel. This applies before, during and after the deposition or trial.
The State of Washington to:

Mary Jones, DDS
University of Washington School of Dentistry
1959 NE Pacific St
Seattle, WA 98195

You are commanded to appear before:

Judge Green of the Superior Court of the State of Washington for King County at the King County Courthouse, 516 3rd Avenue, Seattle, Washington, Room W1005, on January 24, 2005, at 9:30 a.m., and testify in this case on behalf of the plaintiff, and to remain in attendance until you have given your testimony or you have been dismissed or excused by the court.

Dated: January 10, 2005

WILLIAMS LAW FIRM

By: Ann Williams
SUPERIOR COURT OF WASHINGTON
COUNTY OF KING

John Doe, Plaintiff,

vs.

Jane Smith, Defendant.

NO. 12345678-SEA

SUBPOENA DUCES TECUM

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on January 24, 2005, at 9:30 a.m., and testify in this case on behalf of the plaintiff,
and to remain in attendance until you have given your testimony or you have been
dismissed or excused by the court, and to bring with you the following documents:

Your entire medical record for John Doe.

Dated: January 10, 2005

WILLIAMS LAW FIRM

By: Ann Williams
Attorneys for Plaintiff
UNIVERSITY OF WASHINGTON
SCHOOL OF DENTISTRY

Subject: Vendor Access to UWSOD Students
Effective Date: August 1990

PURPOSE

To provide guidelines for access by outside persons or entities to dental students at the University of Washington school of Dentistry during normal business hours or during after-hour campus events.

GENERAL POLICY

The University of Washington School of Dentistry prohibits the interference of instructional, research, or patient care functions of the School by commercial and non-commercial vendors and organizations. Access is granted on a conditional basis and may be revoked if activities are deemed disruptive or if products or services represented are deemed to be illegal or harmful.

IMPLEMENTATION

I. Vendor Definition

A. Commercial Vendors

1. Commercial companies or vendors and their sales representatives or agents (e.g. dental equipment manufacturers or suppliers, and insurance, banking and loan companies.)

B. Non-commercial Vendors and Organizations

1. Branches of the military and their recruiters
2. Public Health and other government offices and staff
3. Professional associations (e.g. WSDA or ADA)
4. UW registered student associations (e.g. ASDA, HSDA)
5. Non-profit organizations seeking program enrollment (e.g. Great Shape! Inc./Jamaica)

II. Vendor Visits and Events

A. Educational Activities Provided by Vendors during Instructional or Clinic Hours

1. Commercial and non-commercial vendors are not allowed in classrooms, laboratories, and clinics within either the Health Sciences Center or extramural instructional sites while students and faculty are engaged in educational and patient care activities without the prior invitation or sponsorship of a School of Dentistry faculty member or department.

2. Coordination of educational activity by non-commercial vendors (e.g. ADA seminars) will be managed by either the Office of Student Services or the school department.

III. Additional Guidelines

A. Vendor Donations to the UW School of Dentistry

The UW School of Dentistry appreciates and welcomes vendor support to further the mission of the School. Vendors are encouraged to contact the UW SOD Office of Advancement about donations and gifts. Any cash donations to the UW School of Dentistry must be deposited in a UW-approved gift account and reported to the Office of Advancement.

B. Endorsement of Vendor Products or Services

Students are limited in their ability to endorse vendor merchandise or services. “Do not endorse any product or service on behalf of UW School of Dentistry without prior review by the Office of Attorney General, UW Health Sciences Section.” (From the Integrity at Work Handbook, available online at: https://dental.washington.edu/wpcontent/media/compliance/DentistryCompliance.pdf

IV. Revoking Vendor Access

The University reserves the right to deny access to any vendor whose activities would interfere with the education program or patient care, or whose products or services are deemed to be illegal or harmful to students.
Dean of UW SOD:

______________________________  ____________________________
Joel Berg Dean of the UW School of Dentistry    Date
Subject: Volunteer, Visitor & Observer Program

Policy Number:

Effective Date: September 1996

Revision Dates: November 2013, May 2016, August 2016

PURPOSE

Volunteers and observers are a valued resource to the School, assisting with a variety of clinical and non-clinical duties throughout the organization. In an effort to ensure a successful program, the following identifies the application process and requirements, which must be met prior to acceptance into the School of Dentistry’s Volunteer, Visitor & Observer Program.

GENERAL POLICY

A. The Volunteer, Visitor & Observer Program is designed to accept applicants as guests of the School to participate in the educational, clinical, and research programs, including:

- Dentists
- Dental assistants
- Dental hygienists
- Dental receptionists
- Pre-dental students
- Visiting dental students, Faculty, Dental Professionals and Pre-dental students

B. Volunteer positions are unpaid and must not be recruited to fill permanent or temporary positions of classified contract employees.

C. Participants must adhere to policies and procedures of the University of Washington and the School of Dentistry.

D. Any person participating in patient care or clinic support activities must proceed in accordance with state law related to the practice of dentistry, dental assisting and dental hygiene (based upon the scope of their duties) under the regulations of the Department of Labor and Industries.
E. Participants are required to complete certain regulatory trainings including HIPAA, Blood borne pathogens, General Health and Safety and Compliance.

F. Participants of the Program must register with the Dean’s Office by completing required documents noted in Appendix A-D.

G. All volunteers must receive a job description specifying the scope and limits of their duties from the department’s volunteer supervisor.

H. All participants must meet the requirements listed in Table A., prior to commencing their role.

I. Non-compliance with requirements may result in termination of volunteer status.

J. The volunteer’s supervisor will inform them of a change in status; however, the Associate Dean of Clinical Services or Director of Clinic Operations has the authority to do so.

K. The Associate Dean of Clinical Services may make exceptions regarding patient care activity on a case-by-case basis for visiting graduate-level dental students.

L. Visiting graduate-level dental students must show proof of existing professional liability coverage of at least $1 million per occurrence in order for their observation activities to be approved by the Associate Dean of Clinical Services.

DESCRIPTIONS AND REQUIREMENTS

A. Clinical Volunteers

1. Description:
   i. Licensed dentists and dental hygienists, dental lab technicians, dental receptionists, pre-dental students, dental assistants, and students working on dental assistant or hygiene credentials at schools with which a current affiliation agreement is established must have their credentials verified by the School.

2. Requirements:
   i. Sponsoring departments shall recruit, train and mentor their volunteers and provide the necessary supervision at levels required of paid employees performing the same duties. Volunteers can engage directly or indirectly in patient care.
   ii. Immunizations (Table B), Blood borne pathogen, General Health and Safety and HIPAA training

B. Non-Clinical Volunteers (Limited scope)

1. Description:
i. Any volunteer, including UW pre-dental students, whose duties do not include direct patient care, and whose assignment would not reasonably be expected to expose them to body fluids or other potentially infectious materials.

ii. Non-clinical volunteers, including those individuals interested in volunteering in research areas. Individuals interested in volunteering in research should review the Research-Laboratory volunteer service policy available from the School of Dentistry Oral Health Sciences Department.

2. Requirements:
   i. Sponsoring departments (including OCS) shall recruit, train and mentor their limited-scope volunteers and provide the necessary supervision at levels required of paid employees performing the same duties.

   ii. Limited-scope volunteers may work in an office or in clinics with duties limited to non-patient care.

   iii. Examples of job duties include, but are not limited to:
       a) Stamp and label bags; cut and tape bags for clinic use;
       b) Deliver and pick up items from sterilization;
       c) Deliver and pick up charts;
       d) Restock disinfected units;
       e) Assist with supply orders;
       f) Escort patients; or
       g) other such activities in which the volunteer is not directly engaged in patient care.

C. Observers

1. Description:
   i. Observers are individuals who are interested in a tour of the School's clinical, research or laboratory facilities.

2. Requirements:
   i. Persons in this category could be inadvertently exposed to body fluids or other potentially infectious materials. There are no training requirements for this category.

   ii. Observers will not be allowed to perform any patient care activity, including dental assisting tasks or limited scope volunteer duties related to clinical support or patient care.

   iii. Observers will be assigned a mentor who is a 3rd or 4th year dental student, staff or faculty member.
iv. The length of stay for an Observer generally will be less than one, but may not exceed five days.

D. Visiting Dental Students

1. Description:
   i. A person who is already enrolled in a dental or allied health training program at a school other than the University of Washington. Individuals in this category typically will be considered observers.

2. Requirements:
   i. Individuals in this category may be inadvertently exposed to body fluids or other potentially infectious materials.
   ii. There are no training requirements for this category if the length of the visit is less than thirty (30) cumulative days; however, individuals must show proof of student status at their home institution (i.e., a letter of good standing from their school and photo student identification).
   iii. Visitors whose stays are equal to or greater than thirty (30) cumulative days are required to take the UW’s HIPAA training.
   iv. Visiting dental students are not permitted to perform any patient care activity, including dental assisting tasks or limited scope volunteer duties unless accepted as a volunteer in that category.

E. Visiting Scholar

1. Description:
   i. A person who is currently employed as a health instructor or health care provider by a university, college, or health institution other than the University of Washington.

2. Requirements:
   i. Must adhere to the conditions and arrangements relating to visiting faculty as described in the Academic Personnel web site located at:
      http://www.washington.edu/admin/acadpers/visiting.scholar.html
   ii. In accordance with the University Handbook, Vol. II, Part 2, Section 24-34, and Vol. IV, Part 5, Section 17-5,
   iii. Licensure requirements of the State of Washington apply if engaged in the practice of dentistry while serving as a visiting scholar.
   iv. Academic personnel approve visiting scholar requests and issue ID cards. Visiting Scholar ID Cards must be obtained on-line at:
      www.washington.edu/admin/acadpers/forms/scholar.id.form.html

Commented [RSB5]: The University Handbook no longer exists. This link will need to be updated.
v. Visiting scholars must inform the School of Dentistry of their length of stay in advance of their appointment.

F. Confidentiality

1. Patient Care: Participants will respect the confidentiality of the patient’s clinical record as stipulated by University policy and by state and federal laws.

2. Student Academic: Written and/or verbal exchanges involving faculty and/or students (e.g., personal interactions, grade sheets, evaluations) must be kept confidential.

G. Application Procedures

1. All individuals wanting to serve as an observer or volunteer, must register with the School of Dentistry’s Volunteer & Visitor Program Coordinator, located in the Office of the Dean,

2. Applicants must complete application form(s) shown in Appendix A. These forms must be submitted and approved in advance of participating.

3. Limited scope and clinical volunteers must obtain immunizations required by the school of Dentistry listed in Tables B & C.

4. Visiting dental students must register with the Manager of Student Life.

5. Visiting scholars must register with the department administrator in their area of interest.

H. Proof of License/Certificate:

1. All dentists, physicians, dental hygienists, and other health care providers must meet licensure/registration requirements of the State of Washington to engage in direct patient care.

2. All health care workers engaged in direct patient care in which any form of anesthesia or sedation is administered must be currently certified in basic life support procedures and comply with Washington State regulations regarding anesthesia and sedation (WAC 246-817-740).

I. Liability Coverage:

1. General Liability: The University general liability insurance program covers all volunteers.

2. Professional Liability: Visiting clinical students and visiting clinical faculty engaged in patient care, and researchers who will be exposed to body fluids or other potentially infectious material, must show proof of a minimum
coverage of $1 million because they are not covered by the University self-insurance program.

J. Processing a Volunteer, Visitor and Observer application:

1. Identify participant’s classification.
2. Instruct volunteer candidates to submit appropriate paperwork and documentation to the Dean’s office
   i. Application forms (Appendix A)
   ii. Immunization clearance (Appendix C)
   iii. Data Security /Patient Confidentiality understanding form (Appendix D)
   iv. Criminal background check paperwork* (Appendix E)- Questions regarding findings on the WSP check will be reviewed with Associate Dean of Clinic Services or Director of Clinic Operations to determine if an applicant is accepted or rejected based on findings.

K. Document health insurance coverage or liability coverage, if applicable.

L. Create a Dean’s office notification of approval.

M. Department Responsibilities

1. Recruitment, selection, and training of department volunteers.
2. Obtain copies of licenses, certificates (dental license, CPR, specialty, etc.).
3. Orientation and training of volunteers according to protocol stated in departmental job description.
4. Provide a job description for the volunteer (Example- Appendix F)
5. Provide required training to include, but not limited to (e.g. on-the-job training, Blood borne Pathogens, Hazard communication and HIPAA training prior to receiving a volunteer schedule.
6. Develop auditable system for recording and reporting volunteer hours.
7. Evaluate and determine volunteers are meeting expectations of the assigned job description.

N. Volunteer Work-related Injuries

1. All accidents or injuries involving volunteer workers must be documented in OARS by the clinic supervisor within five (5) working days of the event.
2. All volunteer workers at the University of Washington are eligible for Worker’s compensation and benefits.
2. Volunteers must work under a job description and the assigned department must maintain a log of hours worked by all volunteers excluding Visiting Scholars.

3. Administrative Policy Statements section 4b:

4. Additional information on coverage for volunteers is available by calling the Office of Risk Management, 206–543–0183 or by sending an email inquiry to: claims@uw.edu.

O. Criminal Background Checks

2. Volunteers are bound by the same standards as employees with respect to findings on a criminal background checks.

3. Background checks will be conducted using the Criminal Conviction Disclosure Form (Appendix E).

4. Acceptance or rejection of an applicant whose WSP check indicates a criminal history will be made by the Associate Dean of Clinical Services or Director of Clinic Operations.
**TABLE A: Requirements for Volunteers, Visitors and Observers to the School**

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Clinical volunteer</th>
<th>Limited Scope/Non-clinical volunteer</th>
<th>Observer</th>
<th>Visiting Scholar; Clinical</th>
<th>Visiting Scholar; Non-clinical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approval from sponsoring department</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Immunizations</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>BBP training</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Use PPE while in clinics, labs or sterilization areas</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td><strong>HIPAA Training</strong></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Privacy, Confidentiality and Info Security Agreement</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Letter from Dean</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td>Only when faculty license is needed</td>
</tr>
<tr>
<td>Letter of good standing (from School or Professor)</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Provide proof of licensure or other credentials</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Provide proof of liability coverage</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>* WA State Patrol check</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Pre approval from Assoc. Dean for visits longer than 2 weeks</td>
<td></td>
<td></td>
<td></td>
<td>Submit signed Visiting Scholar Program Application</td>
<td>Submit signed Visiting Scholar Program Application (non-clinical form)</td>
</tr>
</tbody>
</table>

*Commented [RSB6]: I’d like to revisit the paper copy of HIPAA training approach. Now that we have Swank, we are capable of tracking volunteer, observer and visitor training online.*
TABLE B: Immunization Requirements:

<table>
<thead>
<tr>
<th>Immunization</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Measles</strong></td>
<td>Two vaccine doses of measles containing vaccine or a positive antibody titer. The doses must have been received after 12 months of age and at least one month apart.</td>
</tr>
<tr>
<td><strong>Mumps</strong></td>
<td>Two immunizations (regardless of birth year), or a positive antibody titer.</td>
</tr>
<tr>
<td><strong>Rubella</strong></td>
<td>One immunization or a positive antibody titer.</td>
</tr>
<tr>
<td><strong>Hepatitis B</strong></td>
<td>Evidence of immunity is required. The immunization series consists of three doses of vaccine. The first injection must be administered before volunteers enter the clinic. In addition, an antibody titer is required after completion of the series to prove immunity.</td>
</tr>
<tr>
<td><strong>Tdap</strong></td>
<td>If no documentation of Tdap then a single Tdap booster.</td>
</tr>
<tr>
<td><strong>Varicella (Chicken Pox)</strong></td>
<td>Serologic evidence of immunity or two immunizations given at least one month apart.</td>
</tr>
<tr>
<td><strong>TB</strong></td>
<td>Evidence of two PPD tests within the year prior to employment is required; otherwise a 2-step PPD will be done. History of BCG is not a contraindication to PPD testing. If you have had a documented positive TB skin test in the past, records specifying the test, a chest x-ray report, and details of prescribed medication are needed. Annual PPD skin testing (or symptom review for those not being tested) is required. Patient contact is not allowed unless documentation of this annual TB screening takes place.</td>
</tr>
<tr>
<td><strong>Influenza self-pay</strong></td>
<td>Recommended not required Annual flu shots are recommended for health care workers who have contact with patients at high risk for influenza or its complications, those who work in chronic care facilities, and those with high risk medical conditions.</td>
</tr>
</tbody>
</table>

TABLE C: Immunization Financial Responsibility:

<table>
<thead>
<tr>
<th>VOLUNTEER</th>
<th>FINANCIAL RESPONSIBILITY FOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visiting Student</td>
<td>Must obtain immunizations prior to visit.</td>
</tr>
<tr>
<td>Visiting Scholar</td>
<td>Must obtain immunizations prior to visit.</td>
</tr>
<tr>
<td>Public Volunteer</td>
<td>University of Washington- Hall Health Immunization Clinic will provide immunizations for a fee to the volunteer.</td>
</tr>
<tr>
<td><strong>Observer</strong></td>
<td></td>
</tr>
<tr>
<td>1. UW Student</td>
<td>Immunizations not required.</td>
</tr>
<tr>
<td>2. Non-UW</td>
<td>Immunizations not required.</td>
</tr>
</tbody>
</table>
Appendices:

Appendix A, Volunteer Program Application & Forms
Appendix B, School of Dentistry Immunization Policy
Appendix C, School of Dentistry Immunization Form
Appendix D, UW School of Dentistry Workforce Members
Privacy, Confidentiality, and Information Security Agreement
Appendix E, Criminal Convictions Disclosure Form
Appendix F, Sample Job Description

Dean of UW SOD:

Joel Berg, Dean of the UW School  Date

October 25, 2016
## Appendix A
Volunteer Program Application & forms

### Volunteer Program Application (Clinical)

#### Personal Contact Information

<table>
<thead>
<tr>
<th>Name</th>
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<table>
<thead>
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<table>
<thead>
<tr>
<th>Birthdate</th>
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<table>
<thead>
<tr>
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#### Current Employment

<table>
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<th>Length of current employment</th>
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#### Person to notify in case of illness or accident

<table>
<thead>
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<th>Name</th>
<th>Address</th>
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<th>Mobile phone</th>
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</table>

As a volunteer in the School of Dentistry, I agree:
- To follow all clinical and lab protocols, including infection control protocol
- To participate in any patient care only as approved by my preceptor/clinical supervisor
- To provide proof of all required immunizations
- To respect and maintain student academic and patient care confidentiality

I certify that this information is accurate and true to the best of my knowledge and I accept the above-stated conditions.

<table>
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<tr>
<th>Signature</th>
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#### Office Use

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<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
School of Dentistry Immunization Policy

School of Dentistry Immunization Policy

Health care professionals are at risk for exposure to and possible transmission of vaccine-preventable communicable diseases because of their contact with patients or infectious material from patients. Maintenance of immunity to vaccine-preventable diseases is therefore an essential part of prevention and infection control. The Employee Health Clinic (EHC) and the Hall Health Center Immunization Clinic located at Hall Health Center follow recommendations for healthcare workers from the Centers for Disease Control and Prevention (CDC) and OSHA/DOSH occupational health mandates. All Faculty, staff, student employees, volunteers, and observers who are in laboratories or dental clinics with patient contact and who thereby may be at risk of exposure to blood borne pathogens must demonstrate compliance with requirements for the following: measles (rubella), mumps, rubella, hepatitis B, tetanus-diphtheria-pertussis (Tdap), varicella (chicken pox), and tuberculosis (TB) screening. Patient contact may not begin until documentation of compliance with these requirements takes place.

Mumps: Two immunizations (regardless of birth year), or a positive antibody test.

Rubella: One immunization or a positive antibody test.

Hepatitis B: Evidence of immunity is required. The immunization series consists of three doses of vaccine. The first injection must be administered before faculty, staff, or volunteers enter the clinic. In addition, an antibody test is required after completion of the series to prove immunity.

TB: If no documentation of history or a single tuberculin test.

Varicella (Chicken Pox): Evidence of immunity or two immunizations given at least one month apart.

Tdap: Evidence of two Td/PVAR boosters within the year prior to employment is required, otherwise a 2-step TdV will be done. History of BCG is met a contraindication to Tdap testing. If you have had a documented positive TB skin test in the past, records specifying the test, a chest x-ray report, and details of prescribed medication are needed. Annual PPD skin testing (or sputum smear for those not being tested) is required. Patient contact is not allowed unless documentation of the annual TB screening takes place.

Influenza (swine flu): Recommended for all staff. Annual flu shots are recommended for healthcare workers who have contact with patients at high risk for influenza or its complications, those who work in chronic care facilities, and those with high-risk medical conditions.

Employers (Faculty/Staff, Student Employers):
The Employee Health Clinic at Hall Health Center screens each UW School of Dentistry employee for compliance, and bills back to the SOH department budget for any necessary vaccinations, TB screens or tests.

Please note: While an employee may choose to obtain the required immunizations, labs or tuberculosis screening from their current health care provider, School of Dentistry employees must obtain clearance through the Employee Health Clinic by submitting their records to the Employee Health nurse for review. If employees have questions, they may contact the Employee Health Clinic directly at (206) 685-1026.

Volunteers and Observers:
The School of Dentistry volunteers and observers are responsible for paying for the required immunizations, TB screening or labs. Volunteers and observers are screened by a health provider at the UW Hall Health Center or Licensed Healthcare Provider for compliance with the above listed requirements.

If volunteers or observers have questions about their required immunizations, they may discuss it with the health provider at the Hall Health Center once scheduled for an appointment. To contact the Hall health center appointment desk call (206) 685-1244.

Updated: August 2016
Appendix C
UW School of Dentistry Immunization Form

<table>
<thead>
<tr>
<th>NEW Employee</th>
<th>CURRENT Employee</th>
<th>Observer</th>
</tr>
</thead>
</table>

**INSTRUCTIONS**

This form is to be used to refer any School of Dentistry employees and volunteers/observers to the appropriate health providers at: The Employee Health Clinic or Hall Health Center to complete their immunization screening requirements.

**Appointments:**
Volunteers/Observers contact (206) 616-2495
Location:
Hall Health Center, 4060 East Stevens Way (across from the HUB), Seattle, WA 98195

The individual should bring any immunization records with them to their first appointment

**DEPARTMENT INFORMATION**

<table>
<thead>
<tr>
<th>Department Name</th>
<th>Box No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact Name</td>
<td>Phone No.</td>
</tr>
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</table>

**EMPLOYEE/STUDENT/VOLUNTEER/OBSERVER INFORMATION**

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Name</th>
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<tbody>
<tr>
<td>S.S. No.</td>
<td>E.D.D. No.</td>
<td>Faculty</td>
</tr>
<tr>
<td>E-Mail Address</td>
<td>Phone No.</td>
<td>COSTUME No.</td>
</tr>
</tbody>
</table>

**TO COMPLETED BY EMPLOYEE HEALTH NURSE AT HALL HEALTH OR A LICENSED HEALTHCARE PROVIDER**

- Individual has been cleared
- Nurse Printed Name
- Nurse Signature
- Date
- Individual needs to return on
- Date

**NOTES from Employee Nurse or Healthcare Provider**

- Hall Health Clinic Stamp

- License Healthcare Provider Signature
- Last Name, First Name
- Title

- NPI Number
- NPI Name of Licensed Healthcare Provider
- Office Phone No.

Updated: August 2016
Appendix D

UW School of Dentistry Workforce Members
Privacy, Confidentiality, and Information Security Agreement


PP-04 Attachment A
Revised 6/9/2016

UW School of Dentistry Workforce Members
Privacy, Confidentiality, and Information Security Agreement

For Patient, Confidential, Restricted and Proprietary Information

All UW School of Dentistry workforce members (including faculty, employees, students, trainees, volunteers, and other persons who perform work for UW School of Dentistry) are personally responsible for ensuring the privacy and security of all patient, confidential, restricted, and proprietary information to which they are given access including research data and student information referred to throughout this document as protected information.

I understand and acknowledge the following:

Policies and Regulations:
- I will comply with UW and UW School of Dentistry policies governing protected information (School of Dentistry has officially adopted UW Medicine HIPAA policies)
  - Privacy: https://depts.washington.edu/comply/privacy.shtml
- I will report all concerns about inappropriate access, use, or disclosure of protected information, and suspected policy violations to UW School of Dentistry Compliance (206-543-6331 or docomply@uw.edu)
- I will report all suspected security events and security policy violations to UW School of Dentistry Compliance (206-543-6331 or docomply@uw.edu)

Confidentiality of Information:
- I will access, use, and disclose protected information only as allowed by my job duties and limit it to the minimum amount necessary to perform my assigned duties. I understand that my access will be monitored to assure appropriate use.
- I will maintain the confidentiality of all protected information to which I have access.
- I will only discuss protected information in the workplace for job-related reasons, and will not hold discussions where they can be overheard by people who have neither a need-to-know nor the authority to receive the information.
- I will keep patient information out of view of patients, visitors, and individuals who are not involved in the patient’s care.
- I will keep protected information taken off-site fully secured and in my personal possession during transit, never leaving it unattended or in any mode of transport (even if the mode of transport is locked). I will only take protected information off-site if accessing it remotely is not a viable option.

Computer, Systems, and Applications Access Privileges:
- I will only access the records of patients for job-related duties.
- I will not electronically access the records of my family members, including minor children, except for assigned job-related duties. This also applies in cases where I may hold authorization or other legal authority from the patient.
- I will protect access to patient and other job-related accounts, privileges, and associated passwords.
  - I will commit my password to memory or store it in a secure place;
  - I will not share my password;
  - I will not log on for others or allow others to log on for me;
  - I will not use my password to provide access or look up information for others without proper authority.
Commented [RSB7]: This form has been updated. It is also now electronically signed online in Swank. I would like to consider having longer-term participants (30 or more days) get Swank accounts to complete this form. I recognize that we have a well-oiled paper-version of all this. But one of the reasons that the SOD invested in Swank was to automate required forms and training to make it easier to retrieve proof of signing or training.
Appendix E

Criminal Conviction Disclosure Form

University of Washington | Human Resources

CRIMINAL CONVICTION AND CIVIL FINDING HISTORY SELF-DISCLOSURE QUESTIONNAIRE

This questionnaire is ONLY used for those positions/appointments that are subject to a criminal conviction background check, and are not being filed through VAWWIL. PLEASE TYPE OR PRINT RESPONSES.

The University conducts a criminal conviction background check for positions that the University has identified as security/safety sensitive, including those covered by the Washington State Child and Adult Disclose Law (CADL). Having a criminal conviction and/or civil finding record does not necessarily disqualify an individual for employment at the University. However individuals with certain types of convictions or civil findings may be ineligible for employment in some positions, as required by law. You are being asked to complete this form because you have been identified as a qualified candidate for a position as an employee or volunteer. The information you provide will be used as part of the criminal conviction background/civil finding review process. If you have questions about the use of conviction/civil history information in the application process please discuss them with either the Office in charge of criminal justice operations (206-616-5444) or the Office of Human Resources (206-548-6200).

Full Legal Name: First Name: Middle Name: Last Name: Phone - Include area code: Email:

Position or type of work for which you are applying:

Do you have an adult and/or juvenile criminal conviction record?

☐ NO ☐ YES

If you answered YES for any conviction, provide the following details:

Name/location of court(s) Date(s) of conviction(s) The sentence(s) imposed

In a civil proceeding, have you ever been found responsible for domestic violence, abuse, sexual abuse, neglect, and/or exploitation of a child or a vulnerable adult? Civil proceedings include noncriminal judicial or administrative hearings and determinations that have been made by agencies such as the Department of Social and Health Services or the Department of Health. If you answer YES, you will be asked to provide details in the next question.

☐ NO ☐ YES

If you answered YES for any finding, provide the following details:

Nature of finding(s) Agency/court making the finding(s) Date(s) finding(s) made Penalties/restrictions imposed

Have you ever been convicted of any crimes related to the delivery of service under Medicare/Medicaid or any state or federal healthcare program, or convicted of any crimes related to delivery of a healthcare service or service delivery?

☐ NO ☐ YES

Have you ever been subjected to civil monetary penalties for conduct related to the delivery of services, supplies or other participation in Medicare/Medicaid or any other state or federal healthcare program?

☐ NO ☐ YES

Have you ever been excluded from providing services or supplies under Medicaid, Medicare or any other federally funded healthcare program?

☐ NO ☐ YES

Have you ever been subject to FDA disqualification?

☐ NO ☐ YES

If you answered YES to any of the above four questions, for each conviction, finding, or disqualification, provide the following details:

Nature of finding(s)/conviction(s)/disqualification Agency/court taking action Date(s) findings made Penalties/restrictions imposed

I certify that the information contained in my resume and all other application related materials I provide is true, correct, and complete. I understand that my eligibility for employment or appointment as a volunteer is conditioned on, among other things, the University’s receipt of a satisfactory criminal conviction report and any other proof of eligibility to work in the United States. I further understand that it can be denied employment or disqualified for any misrepresentation or omission in the information I provide. I also authorize the University of Washington to make inquiries regarding my education, work experience, references (unless otherwise stated), and criminal conviction/civil finding factors.

Signature:

Date: 3/11/13
Employing official instructions for using the
CRIMINAL CONVICTION AND CIVIL FINDING HISTORY SELF-DISCLOSURE QUESTIONNAIRE

The offer of employment you make to the finalist candidate for a position that meets one or more of the security/safety sensitive criteria, including positions covered by the Washington State Child and Adult Abuse Law (CAAL), must be made contingent on obtaining a satisfactory criminal conviction background result for the candidate (https://www.washington.edu/admin/hr/employs/hr3/backgroundcheck/background-check-criteria.html for security/safety sensitive criteria).

After you make the contingent employment offer, you may use this form to ask the candidate to disclose potentially disqualifying criminal convictions. After your candidate completes this questionnaire, contact your employment specialist.

If your candidate discloses a history of criminal conviction(s), your employment specialist will assist you to determine whether the disclosed conviction(s) disqualify the candidate from employment. If the candidate does not disclose a potentially disqualifying conviction, your employment specialist will initiate the criminal conviction background check process.
Appendix F

Sample Job Description

SCHOOL OF DENTISTRY
UNIVERSITY OF WASHINGTON
Office of Clinical Services

Job Description:
Clinical and Non-Clinical Volunteers in Office of Clinical Services

Duties:
Under general supervision perform clinical and non-clinical volunteer duties available to Dental Assistant externs, UAH pre-dental students and individuals from the public approved by the School of Dentistry Dental office.

Definitions:
Volunteers assist with and perform clinical and non-clinical duties serving dental students and clinic support in daily activities.

Typical Work May Include, but Not Limited To:
• Clinical - Tasks include but are not limited to:
  o Assist with sterilization duties (following documented training)
  o Assist with laundry services
  o Assist in labeling bags in sterilization
  o Deliver and pick up items for sterilization
  o Restock consumables supplies in carts and dental operatories
  o Cleaning/Disinfecting of dental units and applying suction control barriers
  o Storing the dental clip and assistant carts

• Non-Clinical - Tasks include but are not limited to:
  o Non-clinical office duties.
  o Assist with front desk duties to include, but not limited to reminder calls and assisting with phone lines.
  o Escort patients to and from the clinic.
  o Deliver documents, charts and x-rays between departments.
  o Maintain periodic inspections of patient waiting areas for cleanliness and organization with magazines and reading materials. Ensure any trash left behind.
  o Treatment pack assembly, stocking of mini labs

Minimum Requirements:
• Approval from volunteering department
• Washington State Fingerprint background check
• Bloodborne Pathogen training for Clinical volunteers
• Use of Protective Exposure Equipment (PEE) in clinic and sterilization areas

University of Washington School of Dentistry - Office of Clinical Services

• HIPAA training
• Data form security form completed
• Signed privacy/ confidentiality statement
• Signed dress code
• OSHA Hazardous Material Training (Clinical Volunteers)

Dress Code:
Volunteers will sign and follow the dress code of School of Dentistry for staff in the Office of Clinical Services.

Attendance:
• Volunteers working in the Office of Clinical Services will commit to the volunteer schedule.
• Volunteers will communicate with the Clinic Supervisor or Clinic Operations Manager when not able to commit to schedule and will call 24 hours before shift if unable to attend.
Subject: Inclement Weather and Suspended Operations
Policy Number:
Effective Date: December 2010
Review Dates: October 2011, November 2012, January 2015,
December 2015

PURPOSE
This policy defines the protocols for interruptions of operations during inclement weather, power or utility outages, fire, or for when the University declares suspended operations.

GENERAL POLICY
It is each employee's responsibility to know how to check on the operational status of the University. The University announces its operational status in a variety of ways including:

- On the University of Washington Home Page
- Through the UW Alert System
- Via the UW Information Lines Telephone Numbers 206-UWS-INFO (206-897-4636) and toll-free 1-866-897-4636

Patients will be notified of a change of operations via the SoD website, clinic voicemail messages, signage, and phone messages by staff when possible.

IMPLEMENTATION
I. When are the Inclement Weather and Suspended Operations Policies in effect?

The School of Dentistry Inclement Weather Plan applies only during inclement weather when the University has NOT declared suspended operations. The School of Dentistry Suspended Operations Plan is in effect only when the University suspends operations as described in the UW Suspended Operations Policy.
II. Inclement Weather Plan

During inclement weather all faculty, staff, and students are responsible for finding transportation to the School. Staff who cannot find a safe way to travel to work must notify their immediate supervisor that they will not be coming in, following standard operating procedures for their office or clinic. Staff who miss work due to inclement weather will be compensated according to the UW Inclement Weather Policy.

Staff who are able to come to work may be reassigned to cover for those who did not. All staff should check in with their supervisor or department administrator who in turn will report clinic needs to the Office of Clinical Services (OCS) for possible reassignments. If the clinic supervisor or administrator is unavailable, clinic staff should report directly to the OCS. Clinic Supervisors who find themselves understaffed and would like to request help to cover their clinics may contact other supervisors or the OCS to see if they have staff available.

The Associate Dean for Clinic Services has the authority to cancel the predoctoral clinics, whereas the Program Directors of each graduate program will determine whether or not to cancel their respective clinics. If canceled, it should be reported to OCS and the phone lines should be changed to indicate the closure. (See Appendix A for reporting protocol)

The Associate Dean for Clinical Services reserves the authority to reassign specialty clinic operations to the D wing based on staffing and patient census.

Departmental compensation will be determined for staff sharing based on the hours worked ‘out of department.’ Using the normal journal voucher form, departments will be compensated for staff time associated with reassignments. (See Appendix B)

III. Suspended Operations Plan

Definition of essential personnel

Two categories of personnel have been deemed as essential during suspended operations. Clinical personnel are those persons identified to come to School for purposes of treating patients who have urgent care needs. If operations are suspended on a payday, the Dean’s payroll coordinator will serve as essential personnel and distribute the pay checks for the entire school from the Office of the Dean, D322. If employees have difficulty entering the building, they can call the payroll coordinator at 206-685-8203. Checks will be available between 10 am and 2 pm.
Urgent Care Provision

The School will open the D4 Faculty Practice to provide urgent care during suspended operations. Two Dentists, 2 Dental Assistants/support staff and 2 Managers who can safely travel to the School will be designated as essential personnel, and will operate the clinic. These essential personnel should be verified by the Associate Dean of Clinic Services annually, in the fall, and have their Health Sciences IDs updated to reflect that they are essential personnel. Only staff designated as essential personnel are permitted to come to work during suspended operations. Essential personnel will be issued the appropriate keys to perform their suspended operations duties (e.g. clinic, sterilization, dispensary, etc.). (See Appendix C for protocol)

IV. Support Staff Functions

A. Notifying patients of suspended operations:

1. The manager or administrator of each department will be responsible for canceling patients in their clinics OR for contacting the designated personnel for purposes of cancelling patients. Staff can access the axiUm scheduler by remote access. Each administrator is responsible for designating the person in their department who will fulfill this function.

2. Essential personnel will have access to view all department patient schedulers for purposes of accessing all patients’ EHRs. The department administrator is responsible for updating their front desk phones to notify callers of the Suspended Operations and direct patients with urgent care needs to the Faculty Practice at 206-685-8258.

3. Essential personnel should post notices on closed clinics directing patients to Faculty Practice (with map) for urgent care needs. Clinics should have signs ready and post them on the clinic door the day before closure is expected. If it the UW does not suspend operations, the sign can be removed in the morning (See Appendix D).

B. Notifying the Office of the President of suspended operations:

1. The Dean’s office will inform the President’s office of any condition, as needed.

C. Registration & Records:

Registration will be done on paper forms (using our usual procedure for times when the network is down) for entry into axiUm when operations are reinstated. Temporary paper charts will be created for new patients and
current patients if necessary and subsequently entered into axiUm.

Payment will be collected at the time of service and processed by PAO staff when normal operations resume.

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**Appendices:**
- Appendix A, Reporting Protocol
- Appendix B, JV/Budget Form
- Appendix C, Suspended Operations Protocol
- Appendix D, Maps/Sign for Inclement Weather/Suspended Operations

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Dean of UW SOD:

Joel Berg, Dean of the UW School of Dentistry  
December 9, 2015
Appendix A

Reporting Protocol

- In the event of inclement weather staff, faculty, and students should verify the operational status of the School of Dentistry by checking the main UW website, by using the UW Alert System, or by calling 206-UWS-INFO (897-4636), toll-free 1-866-897-4636.
- During Limited and Suspended operations all incidents and injuries related to weather should be reported to the Office of Clinical Services (OCS). Staff incidents should also be entered into an Occupational Accident Report via (OARS), Patient incidents must also be reported in a Patient Event Form on the SoD website under the Health & Safety tab.

Notification Protocol

- Staff or Faculty arriving during limited/suspended operations should post notification of changes in operation (Appendix E) and check in with the Associate Dean of Clinical Services (206-543-5948 or 206-616-5931) to coordinate operations, patient care, and patient notification.
- Administrative staff in each department will update department voicemail notifying patients and staff of clinic operations.
- During limited operations all clinical areas should report to Office of the Dean operational status, patient, and staffing census.
- Departments with additional staff may be asked to float staff to departments experiencing staffing issues.
- The Director of IT will post the closure notice on the SoD website once the University has posted a notice of Suspended Operations.
- The Dean’s Office will notify the President’s Office once aware of the need to suspend operations in School.

Essential Personnel during suspended operations

- Essential personnel will report to the D4 Faculty Practice to assist with coordination of services during suspended operations. The Associate Dean of Clinical Services will triage staff. In the Associate Dean’s absence the faculty and staff listed as “lead” in the essential personnel table in Appendix C will triage staff.
- Personnel will conduct a survey of clinics within the school ensuring the appropriate signage is posted (Appendix D).
- Personnel will assume the roles and responsibilities during suspended operations listed in (Appendix C).

Administrative Staff

- Clinic Managers, supervisors, and leads designated within each department will remotely access axiUm to evaluate patients scheduled for treatment.
• Management staff will begin canceling and rescheduling of patients following the departments’ scheduling protocols.
• Management should communicate to essential personnel any patient who was not able to be contacted in the instance the patient arrives for scheduled visit.
Appendix B

Journal Voucher (JV) Form

<table>
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<th>Totals:</th>
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</table>

Detailed Explanation required:
Appendix C

Suspended Operations Protocol

In the event Operations are suspended by University of Washington Administration, the following protocol will be instituted to facilitate treatment of patients arriving at the School of Dentistry.

The School of Dentistry has identified essential personnel who will assist with operating the Urgent Care clinic located in D4 Faculty Practice. Essential personnel are identified annually by the Office of Clinical Services (OCS). Personnel identified by OCS will update their UW ID badge to indicate essential personnel (“Green” Coding on badge). These personnel have committed to coming to the School during suspended operations because they believe they can safely travel to the School and assist with suspended operations. (Personnel and roles listed below).

Essential personnel will be assigned operational and administrative duties to include but limited to:

- Facilitating patient notification of suspended operations.
- Posting of signage throughout school indicating Suspended Operations.
- Operation of Sterilization/Dispensary Services.
- Key Warden.
- Patient Registration.

Essential personnel will have access to keys for all clinical areas within the school i.e. Sterilization, Dispensary and Patient Services for chart access. In addition to keys, delegated staff will have open access to all clinic axiUm Schedules for cancellation of appointments.

Current Essential Personnel/Roles and Responsibilities as of 12/9/15

<table>
<thead>
<tr>
<th>Essential Personnel Role</th>
<th>Responsibility</th>
<th>Assigned Representative</th>
</tr>
</thead>
<tbody>
<tr>
<td>DDS</td>
<td>General Dentistry</td>
<td>Mats Kronstrom, DDS</td>
</tr>
<tr>
<td>Dental Assistant</td>
<td>Assist DDS in Faculty Practice Clinic Emergency Care</td>
<td>Kazuko Motoe</td>
</tr>
<tr>
<td>Dental Assistant/Sterilization/Dispensary</td>
<td>Operate dispensary and obtain needed items from Sterilization using protocol specific to emergency use during school closure.</td>
<td>Rebecca Johnson, Kazuko Motoe</td>
</tr>
<tr>
<td>Front Desk/Billing/Registration/Mgmt.</td>
<td>Oversight of on-site Suspended Operations</td>
<td>Debbie Eanes (lead) Christopher Carmen</td>
</tr>
<tr>
<td>Front Desk/Registration/Runner</td>
<td>Facilitate patient check-in, registration, collection of funds, patient notification of appointment status</td>
<td>Rebecca Johnson</td>
</tr>
<tr>
<td>Payroll Coordinator</td>
<td>Distribute pay checks</td>
<td>Christopher Deboli (lead) Debbie Eanes</td>
</tr>
</tbody>
</table>
*If main doors are locked, essential personnel will make arrangements to let patients access the patient areas. If you are unable to access the D4 Faculty Practice in Room D453, please call 206-685-8258.
UNIVERSITY OF WASHINGTON
SCHOOL OF DENTISTRY

Subject: Patient Recruitment for the Western Regional Examination Board (WREB)

Policy Number: 

Effective Date: February 2015

Review Dates: 

PURPOSE

To guide staff, students and faculty on how to properly recruit WREB patients.

GENERAL POLICY

Staff, students, and faculty shall properly recruit WREB patients in a manner that:

1. Respects Protected Health Information (PHI) of patients.
2. Is Consistent with the requirements of HIPAA regulations.
3. Ensures that patients receive excellent care and treatment.
4. Assists students in successfully fulfilling and completing the licensure requirements set forth by WREB.
5. Complies with state law governing the use of University resources.

This policy is intended solely to facilitate the provision of patients for the WREB licensure process while ensuring compliance with the School of Dentistry’s responsibilities under applicable law governing patient privacy and use of University resources. The UW School of Dentistry does not control or administer WREB sponsored activities.

IMPLEMENTATION

A. Electronic Records

Student providers may not access electronic records containing PHI (i.e. axiUm) with respect to patients who are not currently assigned to the provider’s patient roster by a Patient Care Coordinator (PCC).
B. Patient Consent

Before a patient can be considered a WREB candidate, the patient must be adequately informed about the process, review and sign a Western Regional Examination Board (WREB) PHI Consent Form (see Appendix A). The mentioned PHI form must be distributed to all patients who elect to participate in WREB as a patient and who are being screened at the UW School of Dentistry for such purposes. Patients must sign the consent form prior to a student receiving access to view a patient record.

C. Assignment of Patients for WREB

Pre-doc Student Assessment

If a student provider performs an assessment in any one of the clinics and discovers a lesion or periodontal condition that may qualify the patient to be a WREB examination candidate, the provider must inform a PCC with the identification of the patient and possible lesions and/or conditions qualifying him/her as a potential WREB candidate, along with the signed consent form. Thereafter, a PCC will review the patient chart and assign the consenting patient to a student provider who is preparing for WREB examinations and who is in need of a patient presenting the condition(s) at issue, for limited care.

Faculty or Graduate Assessment and Limited Care Option

If a faculty member or graduate student is performing an assessment in any one of the clinics and finds a carious lesion or periodontal conditions that would qualify the patient as a potential WREB patient, the faculty provider can present the option of obtaining limited care to the patient and requesting the patient sign a WREB consent form. If the patient consents to be a WREB patient, the faculty will notify the appropriate staff member and the patient will be referred to the PCC who will identify a student provider preparing for WREB examination and who is in need of a patient presenting the condition at issue, for limited care.

D. Role of Patient Care Coordinator

The PCC shall be the “clearinghouse” for patients who have consented to be a WREB patient and will have sole discretion to assign the patient to a WREB student candidate. The PCC will ensure (and make appropriate notations in the electronic health records) that the student and patient understand that the WREB student candidate will provide certain services as part of the WREB exam and that ongoing patient care will be the responsibility of the student or faculty provider who conducted the original assessment or screening.
It is the responsibility of the students to provide a PCC with a list of the types of patients and/or conditions they require to complete their WREB licensure. The PCC will assist the student in finding an appropriate consented patient but is NOT responsible for providing a WREB patient for the student candidate. Notwithstanding the School of Dentistry’s efforts to assist student providers, recruitment of WREB patients is ultimately the responsibility of the student candidate and not the responsibility of the School of Dentistry, Clinic Faculty and or staff.¹

This policy will remain enforce and can be revised and/or revoked at any time by the School of Dentistry’s Administration without advance notice. Any question and concerns should be referred to the Associate Dean for Clinics.

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**Appendices:**

Appendix A, Western Regional Examination Board (WREB) PHI Consent Form

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Dean of UW SOD:

Joel Berg, Dean of the UW School of Dentistry

Date

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¹ See also “2015 DENTAL EXAM Candidate Guide” WREB 2015; p. 13.
Appendix A
Western Regional Examination Board ("WREB") PHI Consent Form

Patient Authorization to Disclose, Release or Obtain Protected Health Information

I, ______________________, authorize UW School of Dentistry to disclose protected health information about me to dental students for the purpose of assisting them in the dental licensing exam process. I understand that the dental licensing exam process is directed by the Western Regional Exam Board (WREB), a national dental testing agency that is independent of the School of Dentistry.

UW School of Dentistry may disclose protected health information, including, but not limited to, my name, birth date, dates of treatment, treatment records that include medical and dental history, x-rays/imaging and dental and full facial photographs.

This authorization is valid for one year from the date on which it is signed unless I revoke this Authorization sooner.

I understand I do not have to sign this authorization in order to continue to receive care at the School of Dentistry. I may revoke this authorization at any time (except to the extent already relied upon) by sending a request in writing to UW School of Dentistry Compliance Office, Box 356965 Seattle, WA 98195.

________________________________________
Signature [Patient or person authorized to give authorization]:

________________________
Date:

If signed by person other than patient, provide reason, relationship to patient and description of their authority: ____________________________________________________________
**UNIVERSITY OF WASHINGTON**

**SCHOOL OF DENTISTRY**

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**Subject:** Patient Scheduling for Clinics, Operatory Assignments and Advanced Treatment Planning Sessions

**Policy Number:**

**Effective Date:** April 2015

**Review Dates:**

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**PURPOSE**

To inform the Class of 2015, Class of 2016, staff and faculty of new clinical protocols effective April 20, 2015 which are consistent with the Department of Restorative Dentistry policy on mandatory clinic attendance currently in force.

**GENERAL POLICY**

All students will be responsible for documenting patient appointment information into axiUm in a timely manner and for making themselves available for other clinical assignments if they do not have a patient scheduled.

**IMPLEMENTATION**

A. Patient Scheduling

- **48 Hour Scheduling Window**
  All students will have forty-eight hours (48) prior to their scheduled clinic slot to input their patient’s name into their axiUm schedule.

- **axiUm Notes & Confirmation**
  Students will be required to post in axiUm patient contact notes detailing when the patients were contacted and the confirmed appointment date and time.

- **Blocking Appointments**
  Students will no longer be allowed to input “Dentoform” or “place holder” patients into the axiUm schedule to block the appointment time. An exception would be for:
B. Operatory Assignments and Advanced Treatment Planning Sessions

4th year students who do not have a confirmed patient posted in their appointment book will either:

1. have their operatory either internally cancelled by the scheduler and reassigned to another 4th year student on the waitlist

   OR

2. be assigned a patient for advanced treatment planning during their scheduled session that same day.

   - 4th year students will be able to take advantage of Volunteer Advanced Treatment Planning activities in the Dental Admissions Clinic (DAC) and can do so by contacting Shirley Sampson, in D-333 or via email: bluestwn@uw.edu.

   - RESD points will be awarded to students for the performance of Advanced Treatment Planning of patients.

________________________

Dean of UW School of Dentistry:

Joel Berg, Dean of the UW School of Dentistry

Date

9-16-16
UNIVERSITY OF WASHINGTON  
SCHOOL OF DENTISTRY  

Subject: Antibiotic Prophylaxis for Bacterial Endocarditis  

Policy Number:  

Effective Date: November 2002  

Revision Dates: May 2007, October 2016  

PURPOSE  

To protect patients who are at risk for the development of infectious endocarditis (IE) subsequent to dentally-induced bacteremias.  

GENERAL POLICY  

The University of Washington School of Dentistry will adopts the current recommendations of the American Heart Association (AHA) and the American Dental Association (ADA) for the prevention of infectious endocarditis. This policy will automatically adopt the current guidelines of these organizations when they are published.  

IMPLEMENTATION  

I. Patients who are at risk for infectious endocarditis shall be treated using the current AHA and ADA guidelines for the prevention of bacterial endocarditis unless a significant medical reason documented by the patient’s physician or health care provider (including the attending dentist) exists for deviating from this policy.  

Previously patients with nearly every type of congenital heart defect needed to receive prophylactic antibiotics prior to dental procedures, but the AHA simplified it’s recommendations in 2007, and updated in 2015, and 2016. The practice of giving patients antibiotics prior to a dental procedure is not recommended EXCEPT for patients with the highest risk of adverse outcomes resulting from IE.  

See:  
http://www.heart.org/HEARTORG/Conditions/CongenitalHeartDefects/TheImpactofCongenitalHeartDefects/Infective-Endocarditis_UCM_307108_Article.jsp#.V6j4GrrgKUK  

and:
II. Primary antibiotic regimes for dental procedures are as follows:

TABLE 1. Regimens for a Dental Procedure (1)

<table>
<thead>
<tr>
<th>Situation</th>
<th>Agent</th>
<th>Adults</th>
<th>Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral</td>
<td>Amoxicillin</td>
<td>2 g</td>
<td>50 mg/kg</td>
</tr>
<tr>
<td>Unable to take oral medication</td>
<td>Ampicillin</td>
<td>2 g IM or IV</td>
<td>50 mg/kg IM or IV</td>
</tr>
<tr>
<td></td>
<td>Cefazolin or ceftriazone</td>
<td>1 g IM or IV</td>
<td>50 mg/kg IM or IV</td>
</tr>
<tr>
<td>Allergic to penicillins or ampicillin—oral</td>
<td>Cephalexin*†</td>
<td>2 g</td>
<td>50 mg/kg</td>
</tr>
<tr>
<td></td>
<td>Clindamycin</td>
<td>600 mg</td>
<td>20 mg/kg</td>
</tr>
<tr>
<td></td>
<td>Azithromycin or clarithromycin</td>
<td>500 mg</td>
<td>15 mg/kg</td>
</tr>
<tr>
<td>Allergic to penicillins or ampicillin and unable to take oral medication</td>
<td>Cefazolin or ceftriazone†</td>
<td>1 g IM or IV</td>
<td>50 mg/kg IM or IV</td>
</tr>
<tr>
<td></td>
<td>Clindamycin</td>
<td>600 mg IM or IV</td>
<td>20 mg/kg IM or IV</td>
</tr>
</tbody>
</table>

IM indicates intramuscular; IV, intravenous.
*Or other first- or second-generation oral cephalosporin in equivalent adult or pediatric dosage.
†Cephalosporins should not be used in an individual with a history of anaphylaxis, angioedema, or urticaria with penicillins or ampicillin.

Reference: Antibiotic Prophylactic Regimens for Dental Procedures © 2016, American Heart Association. All Rights Reserved. 50-1605 1606 The Council on Scientific Affairs of the American Dental Association has approved this statement as it relates to dentistry. National Center 7272 Greenville Avenue Dallas, Texas 75231-4596 www.heart.org
PURPOSE

To outline patient expectations for making and keeping dental appointments at the School of Dentistry.

GENERAL POLICY

The School of Dentistry is committed to providing quality care for dental patients as well as providing a successful clinical education for students. Dental students are in the process of learning to apply didactic knowledge in a clinical setting and are closely supervised by faculty. Accordingly, dental care in an academic setting is expected to take longer than in a private dental office.

To best maximize the limited clinic time available to students, the School requires that all patients sign an agreement as a commitment to this educational and clinical partnership. Patients must make an effort to remain available for appointments of varying lengths during their course of treatment over the academic quarter. Missed appointments or late arrivals could have a negative impact on the care process and the education of the student. Loss of clinic time can delay patient treatment and may slow a student in completing his or her educational program.

Patients who fail to meet their responsibilities in making and keeping dental appointments may have their care discontinued at the School of Dentistry.

IMPLEMENTATION

I. Appointment Management Protocol

   A. Distribution of Guidelines
To establish the School’s expectations regarding dental appointments, all new patients of the School of Dentistry must sign the Care Agreement (see Appendix A) and are given a copy of the Patient Rights and Responsibilities brochure (see Appendix B.)

B. Appointment Frequency and Duration

1. Patients should plan to spend as much as one 3-hour, regular (non-emergency) appointment every three weeks during a quarter once treatment has begun.

2. If a patient is unable to come frequently and stay for lengthy appointments, he/she will not be admitted to or allowed to continue in the School of Dentistry care programs.

3. This requirement can be waived at the discretion of the Department Chair or the Associate Dean for Clinical Services if unique patient circumstances arise which would prohibit compliance and the education of the student would not be inhibited.

C. Treatment Delay

1. Active patients admitted may be granted a delay of treatment which exceeds three months (an academic quarter) under the following conditions:
   a. The patient has demonstrated compliance with the appointment policy in the past.
   b. The delay is not detrimental to the patient’s health.
   c. The delay is approved by the Office of Clinical Services (OCS).
   d. The delay is documented in the patient’s dental record in both the contact notes in the electronic patient record and in a letter to the patient confirming the requested delay.

2. A patient who has been admitted to the Pediatric Dentistry clinical program is not eligible for a delay of treatment status unless extenuating circumstances are the cause of the treatment delay. Such requests shall be reviewed on a case-by-case basis by the department chair or designee.

D. Keeping Appointments

1. Appointment Cancellation
a. An appointment cancellation is defined as notice being given to the care provider by the patient at least 24 hours before the appointment that he/she cannot meet that arranged appointment.

b. Patients who cancel three appointments in a calendar year are subject to the discontinuance of care by the school.

2. Broken Appointment Protocol

A broken appointment is defined as failure to give the care provider notice 24 hours prior to a previously scheduled appointment that he/she cannot meet that arranged appointment.

Documentation of Broken Appointments

The care provider is responsible for documentation of cancellations and broken appointments in axiUm. The documentation shall include:

a. Cancellations
   When a patient contacts the school to cancel an appointment, the appointment status is changed in axiUm from ‘active’ to ‘cancelled.’ AxiUm logs the date, time and user that updated the appointment status. Staff making the update will select the time frame and/or reason the patient cancelled the appointment. A supporting contact note is added to document details of the cancellation.

b. Broken Appointments
   The axiUm appointment status must be updated to “failed” for patients who did not come to their appointment. This change must occur before the end of the appointment day and should be completed by the person(s) responsible for maintaining the clinic's schedule.

   Note: Only documented missed appointments shall be considered in the disposition of the continuation of care for a patient.

E. Disciplinary Actions

1. The following actions will be implemented unless special exception is made by the appropriate Department Chair, or designee:

   a. Comprehensive care patients who break three appointments per year are subject to the discontinuance of care by the school unless special exception is made by the appropriate Department Chair or designee.
b. Endodontic, limited care patients who fail an initial endodontic appointment are discontinued following the failure of that appointment.

c. Endodontic patients who break two appointments may be discontinued from care in the Endodontic department.

III. Care Discontinuance Protocol

A formal protocol is used for managing the warning to patients and possible discontinuance of patient care.

A. Warning Letter

1. A patient who has three cancellations within a year documented in the patient record, or one broken (no-show) appointment within a year shall be sent a warning letter (see Appendix C) reminding them of the appointment obligation they agreed to and the consequences of non-compliance.

2. A copy of the letter is scanned in the patient record and a contact note is made in axiUum. Departments that manage their own patient pools are responsible for this correspondence and documentation.

3. OCS is responsible for Student Clinic patients upon notification by either the scheduling staff, care providers or supervising faculty.

B. Discontinuance of Care Letter

The discontinuance of the care of a patient constitutes the legal severance of the doctor/patient relationship and is subject to provisions of the Dental Practice Act (WAC 246-817-380).

4. Failure to make and keep appointments constitutes justification for severing the relationship as long as the patient is appropriately notified in writing.

5. All discontinuance letters (see template in Appendix D) shall be managed by the Manager of Patient Relations in accordance with the law and the risk management policies of the School of Dentistry.

6. Departments that manage their own discontinuance protocol shall submit a written description of the protocol and form letters to the Manager of Patient Relations for approval. The basis for approval must meet state law and University policy.
Appendices:

Appendix A, Care Agreement
Appendix B, Patient Rights & Responsibilities Brochure
Appendix C, First Missed Appointment Warning Letter
Appendix D, Second Missed Appointment Warning Letter
Appendix E, Discontinuance Letter

Dean of UW SOD:

__________________________________________________________
Joel Berg, Dean of the UW School of Dentistry     Date
APPENDIX A
Care Agreement

Care Agreement

This form contains facts you should know about your dental care at UW School of Dentistry. If there is any part of this form that is unclear, you can ask questions about it. Your signature is required at the end of this form acknowledging that you have read this form (or had it read to you), have been offered a copy of the Patient Rights and Responsibilities brochure and agree to receive dental care from us and to the terms of this agreement.

UW School of Dentistry includes:

- Pre-Doctoral Student Clinic
- Dental Urgent Care
- UW Dentists Faculty Practice
- Advanced General Dentistry
- Oral Medicine
- Dental Education in Care of Persons with Disabilities
- The Center for Pediatric Dentistry
- Dental Fears & Research Clinic
- Oral Maxillofacial Surgery
- Endodontic Clinic
- Orthodontic Clinic
- Periodontic Clinic
- Prosthodontic Clinic

Your dental care team consists of dentists, dentists in advanced training programs, dental students, dental assistant's, dental hygienists, and other health care professionals. They will work together to diagnose and treat you. Photographs and other images of you may be used to keep a record of your care and treatment. These images may become part of your dental record.

SIGNATURE

By signing below, it shows that you have read this document and agree to receive healthcare from UW School of Dentistry.

<table>
<thead>
<tr>
<th>SIGNATURE (PATIENT OR AUTHORIZED REPRESENTATIVE)</th>
<th>PRINT NAME</th>
<th>DATE</th>
</tr>
</thead>
</table>

IF SIGNED BY PERSON OTHER THAN PATIENT, CHECK RELATION TO PATIENT:

- ☐ 1. Guardian
- ☐ 2. Durable Healthcare Power of Attorney
- ☐ 3. Spouse/Registered Domestic Partner
- ☐ 4. Adult Child(ren)
- ☐ 5. Parent(s)
- ☐ 6. Adult Brother(s)/Sister(s)

FOR MINOR PATIENTS:

- ☐ 1. Guardian/Legal Custodian
- ☐ 2. Court-authorized person for child in out-of-home placement
- ☐ 3. Parent(s)
- ☐ 4. Holder of signed authorization from parent(s)
- ☐ 5. Adult representing self to be a relative responsible for the minor's health

Last revised November 2, 2015
Thank you for choosing UW School of Dentistry to care for your dental needs. We welcome you and appreciate the opportunity to provide you with excellent dental care. This brochure will provide general information about our Dental Clinics. We encourage you to ask questions about any part of this information that is not clear to you.

Your Dental Provider
Dental students, graduate students and residents in training are under close supervision by experienced, licensed faculty members.

Dental Appointments
Student clinics. Appointments are scheduled from 8:30am - 12:00pm and 1:30pm - 4:00pm. Patients must be available for the entire appointment time. Appointment availability may be limited when the School is not in session.

Appointment timeliness in our Specialty Clinics and UW Dentists Faculty Practice.

Payment for Services
Payment is due at the time of service. We accept cash, check, CASH Health Card, Visa, MasterCard, and Discover. Please provide your dental insurance information upon registering as a new patient. Funds from your insurance plan network, our billing office will submit claims to your insurance company. Any co-payments are due on the day of service. If the School is not contracted with your insurance plan, you are responsible for the payment at the time of service. We do not offer payment plans.

Missed Appointments
If you miss an appointment or do not cancel within 24 hours, you may be charged a cancellation fee. Please note that chronic lateness to appointments or more than two cancelled or failed appointments may be cause for discontinuing your care.

Dental Urgent Care Clinic
If you are experiencing pain or swelling, please call the Dental Urgent Care Clinic between 8:00 am - 4:00 pm at 206-685-4370 to schedule an appointment. For after hours emergency care, please call UWMC Emergency Department at 206-597-4000.

Limited Care Treatment
Limited treatment is available to patients with referrals from private practices or referrals from School of Dentistry Clinics for patients with minimal needs.

Unattended Children
Children may not be left unattended in waiting areas and are only allowed in clinics for their own appointments.

Animals
In accordance with UW state animal control code and animal control policy, we enforce a no pet policy. However, service animals will be accommodated.

Parking
We do not validate parking. For maps and directions, visit:
dental.washington.edu/about/location-directions
PATIENTS HAVE THE RIGHT TO:

- Impartial, reasonable access to care and treatment regardless of gender, race, color, creed, religion, sex, sexual orientation, national origin, disability, age, or status as a disabled veteran.
- Care that is considerate and respectful of their cultural and personal values and beliefs.
- Have reasonable access to a certified interpreter or other language assistance if they do not speak or understand the English language.
- A reasonably safe and secure environment.
- Be free from all forms of abuse or harassment.
- Be fully informed of their dental needs and the alternatives for care and to be referred elsewhere when the School cannot provide the care a patient requests.
- Effective pain management. Pain will be addressed and managed as deemed appropriate by the care provider.
- Consideration for their personal privacy and confidentiality of information.
- Have access to a written statement that articulates the rights and responsibilities of patients.
- Access their own health information, request amendment to it, and receive an accounting of disclosures about it, as permitted under applicable law.
- Expect that appointments will be offered to them on a regular basis until the completion of their care, once they begin the care process.
- Request and receive an itemized and detailed explanation of their bills for services rendered.

- Expect that services rendered in the School meet the standard of care of the dental profession.
- Make complaints about their care according to the established policy and guidelines available in all patient care areas. Patients can freely voice complaints and recommend changes without being subject to coercion, discrimination, harassment, or unreasonable interruption of care, treatment, and services.
- Be informed of outcomes of care, treatment and services, including unanticipated outcomes.
- Patients and/or their legally authorized representative (guardian) have the right to make, in collaboration with their dentist, to be informed and make decisions involving their dental care, including the right to accept or refuse dental treatment and to be informed of the consequences of such refusal.

PATIENTS HAVE THE RESPONSIBILITY TO:

- Provide, to the best of their knowledge, accurate and complete information and to report any changes in their medical status to their care provider.
- Participate in discussions about their plan of care, ask questions, and to inform the care provider if they do not understand proposed treatment.
- Make and keep appointments, arrive on time, stay for the entire time scheduled, and provide a minimum of 24-hour notice to change or cancel appointments.
- Follow the treatment plan to which they agreed, including any recommended follow-up instructions. Patients are responsible for the outcomes if they do not follow the care and treatment plan.
- Know their insurance coverage, benefits, and other related information.
- Notify their dental care providers or a staff member if they have any complaints or concerns.
- Provide updated, accurate insurance and billing information (including name, mailing address, phone number, and any other information for billing purposes), and for meeting the financial obligations agreed to with the school.
- Provide accurate personal identification information.
- Inform the school if they have special needs.

Patients have the responsibility for the following School of Dentistry policies and guidelines affecting patient care and conduct:

- Patients may not disturb or interfere with their care provider, other patients, or the operations of the patient care and office areas.
- Patients may not conduct any illegal activities or substance use on the premises of the School of Dentistry.
- Patients may not engage in any discriminatory or harassing behavior toward staff, students, or faculty per University policy.
- Patients are responsible for being courteous to others.
- Patients are responsible for being respectful of the property of other persons and the School of Dentistry.

THE CENTER FOR PEDIATRIC DENTISTRY

General Information:

If your child is having dental care at the Center for Pediatric Dentistry (CPD), please review the following information below.

Dental Appointments:

Appointments vary in length and are scheduled from 8:30am - 12:00pm and 1:00pm - 4:00pm. Children must be accompanied by a parent or an individual with written prior authorization to consent for care of the child.

Broken Appointments:

3 Broken Appointments may result in limitations to scheduling availability. Please review the Broken Appointment Policy during registration at CPD.

Emergency Care:

For emergencies, please call CPD between 8:30am - 5:00pm. Monday through Friday at 206-543-5800. For after business hours emergency care, please call Seattle Children’s Hospital at 206-987-2000.

Parking:

Free parking is available on-site at the Washington Dental Services Building at Magnuson Park.
First Missed Appointment Warning Letter

Today’s Date

Patient Name
Patient Address
Patient Address

Chart #:

Dear Patient Name,

Our records indicate that you missed your appointment on [Missed Appointment Date]. Please call 206-616-6996 and we will be happy to schedule another appointment for you.

We request that you provide us with at least 24-hour notice if you must change/cancel your appointment. This courtesy allows us to schedule another patient who is also in need of dental care.

As a reminder, 3 missed or cancelled appointments may result in dismissal from the School of Dentistry.

We are committed to providing you with the best care possible. We look forward to seeing you at your next appointment. If you have any questions, please call us at 206-221-0778.

Sincerely,

Patient Services
UW School of Dentistry

APPENDIX D
Today’s Date

Patient Name,
Patient Address

Chart #:

Dear Patient Name,

Our records indicate that you missed your appointments on Date of First MA and Date of Second MA.

As stated in the previous letter we sent you, 3 missed or cancelled appointments may result in dismissal from the School of Dentistry.

We request that you provide us with at least 24-hour notice if you must change/cancel your appointment. This courtesy allows us to schedule another patient who is also in need of dental care.

Please call 206-616-6996 and we will be happy to schedule another appointment for you.

We are committed to providing you with the best care possible. We look forward to seeing you at your next appointment. If you have any questions, please call us at 206-221-0778.

Sincerely,

Patient Services
UW School of Dentistry

APPENDIX E
Discontinuance Letter

Today’s Date

Patient Name
Address

Chart #:

Dear Patient Name,

Our records indicate that you have failed and/or cancelled three scheduled dental appointments on (enter dates here).

In order for us to manage our patient’s dental needs appropriately and provide the necessary clinical experience for our students, we require our patients to be available for their scheduled appointments.

We regret to inform you that your care at the University of Washington, School of Dentistry has been discontinued effective (30 days from today’s date). We will provide emergency dental services only during this 30-day period. To schedule an appointment, please call Dental Urgent Care at 206-543-5850.

We recommend that you seek care immediately to avoid future damage to your teeth and/or supporting bone. Please contact your local dental society, which has a referral service to assist you in finding a new dentist who can meet your needs.

For a copy of your complete dental record, please contact our Patient Records Office at 206-543-7049 and they will provide a copy of your patient records, upon receiving your written authorization, for a nominal fee.

We wish you success with your new dentist.

Sincerely,

Patient Services
UW School of Dentistry
UNIVERSITY OF WASHINGTON
SCHOOL OF DENTISTRY

Subject:    UW School of Dentistry Comprehensive Medication Policy

Policy Number:

Effective Date: December 2014

Review Dates: June 2015

PURPOSE

This policy provides all School of Dentistry faculty and employees guidance in the following areas of drug management:

I. Drug Procurement, Distribution, and Control
II. Medication Storage and Security
III. Administration of Medications
IV. Dispensing of Medications
V. Medication Error Reporting
VI. Medications Reference Materials
VII. Responsibility of the Consultant Pharmacist
VIII. Closing a Health Care Entity

GENERAL POLICY

This policy provides comprehensive guidance on all areas of medications management in the UW School of Dentistry. Adherence to each component is fundamental to patient safety and compliance with Washington State law.

IMPLEMENTATION

I. Drug Procurement, Distribution, and Control

The UWMC department of pharmacy is responsible for the evaluation and appropriateness of all medications distributed to UW School of Dentistry Clinics. The clinics will have a reasonable supply of clinic stock medications as approved by the UW SOD Medication Oversight Committee. Medications approved for clinic stock will be evaluated for patient safety, regulatory and documentation compliance. All clinic stock medications will be cost transferred to the requesting departmental budget. These medications are intended for administration in the clinic.

1. UWMC Pharmacy will fill clinic stock orders from UWSOD Central Purchasing. All medications will be listed in an approved clinic stock requisition. The Associate
Dean of Clinical Services will assign a responsible designee to order and maintain the central medication inventory.

2. The pharmacy will only fill items officially printed on the clinic stock requisition form or submitted through the official secure online system. Items that are handwritten in will not be filled.

3. The medications will be delivered via sealed box including a copy of the requisition to UWSOD Central Purchasing. All medications will be received by the responsible designee assigned by the Associate Dean of Clinical Services. Medications received will be checked against the copy of the requisition sent by the pharmacy.

4. Requested medications will be cost transferred to the UWSOD Central Purchasing budget, and subsequently cost transferred to interdepartmental budgets. The clinic and UWMC Pharmacy will maintain a current file with a copy of the purchase request and the invoice provided by pharmacy for a minimum of 2 years.

5. Medications supplied, as clinic stock must only be administered in a UWSOD clinic and documented in the medical record. Patient supplied medications are not to be administered by clinic staff.

6. To request a new medication for clinic stock the following steps will need to occur:

   a) The Medication Oversight Committee will determine by majority vote that the medication should be added to the approved UWSOD stock requisition.

   b) The UWSOD Central Purchasing clinic manager will request addition or deletion to clinic stock list via the clinic stock email (clincmed@u.washington.edu).

   c) UWMC pharmacy will notify the clinic manager that the request has been received.

   d) UWMC pharmacy will review the request using one or more of the following criteria for adding or deleting medications from the clinic requisition form, CDM and fee sheet:

      • Medication requires no additional pharmaceutical admixing or compounding prior to administration.
      • Medication can be stored appropriately in clinic to maintain sterility and stability.
      • Medication can be stored securely as outlined in the medication
security policy.

- Medication is administered as part of a routine patient-care procedure conducted in clinic and does not require pharmacist order review prior to administration.
- Medications that pose a high allergy risk would require additional safety processes in place before being considered for clinic stock (antibiotics).
- Medications with a high acquisition cost would need to have a specialized process in place to insure appropriate billing and security before being considered for floor stock.
- If the medication is determined to be appropriate for clinic-stock the Pharmacy will contact the Revenue Cycle Management team to update the CDM or charge master and fee sheet.

7. Appropriate medication quantities will be stocked to minimize outdated medication and waste.

8. The consultant pharmacist will review inventory during the monthly unit inspection to ensure appropriate drug storage and control:
   a) Drug stock will be rotated as appropriate when new stock is delivered.
   b) Expired medications are removed from stock and taken to UWSOD Central Purchasing for quarantine. A representative from UWSOD Central Purchasing will arrange for regular disposal of quarantined drugs by an authorized reverse distributor.

9. Medications not included in the UWSOD stock requisition may be dispensed to patients by a prescription written by an appropriately licensed member of the UWSOD faculty.

II. Medication Storage and Security

To ensure the appropriate storage and security of medications located in the UW School of Dentistry Clinics.

A. Physical Area

1. The area where medications are stored is neat, clean and maintained at the appropriate ambient temperature and protected from light if necessary.

2. Medications are stored in secured areas only. Medications are stored in cabinets or rooms which are locked to prevent access by persons not designated to administer medications.

B. Storage Locations
1. Disinfectants and externals are separated from internals and injectables.

2. Antiseptics and cleaning solutions are stored in the original container; if they are mixed or poured into another container then they must be clearly labeled.

C. Refrigerated Medications

1. The temperatures of any medication refrigerators are logged daily on a temperature tracking form by clinic staff.

2. The temperature should be maintained between 2 – 6 degrees C (36-46 degrees F).

3. The refrigerators should be clean and free of excessive frost.

4. No food items are stored in medication refrigerators. If a non-medications item (e.g. supply) is stored in a medication refrigerator it must be segregated.

5. If a refrigerator is found to be outside of the required temperature range, appropriate action must be taken to return the temperature to the required range. In the event that medications are found to be unrefrigerated the consultant pharmacist must be contacted within 24 hours for assessment.

D. Emergency Medications

1. Emergency medications are stored in secure, tamper-proof containers.

2. An additional supply of emergency medications and locks are stored in UWSOD Central Purchasing as immediate replacement stock. To ensure the clinic has a continual supply.

3. The emergency containers are checked monthly by clinic staff.

4. The containers are sealed with a numbered plastic lock obtained from the UWMC Pharmacy. The medications are placed in the container by a licensed employee and sealed, assuring that the contents are complete and within the expiration date.

5. The expiration date of each medication and lock number shall be documented on an emergency checklist outside of the box to assist in assuring that the contents are within date and unadulterated.

E. Controlled Substances
1. Locations where controlled substances are stored require a manual perpetual inventory.

2. The date and time on which the inventory is taken must be indicated on the perpetual inventory log.

3. Controlled substances may be ordered by individual clinics by placing a purchase requisition with UWSOD Central Purchasing. The UW SOD institutional DEA license will be used for purchase of all controlled substances. Medications requiring a DEA 222 form will be authorized and procured using that form with the signature verification of the Associate Dean of Clinical Services or other authorized representative.

4. Controlled substances will be distributed from UWSOD Central Purchasing to individual clinics to be administered only by providers who are legally authorized to administer controlled substances.

5. Controlled substances stocked in clinics must be stored in a secure (locked) location.

6. Any controlled substance theft or loss shall be immediately noted on the inventory log and reported to the Clinic Manager and the Consultant Pharmacist.

7. Wasting of Controlled Substances
   
a. When a prepared dose is refused by the patient, canceled by the provider or a partial dose is administered, the dose shall be promptly disposed of in a sink. This action is recorded, signed and counter-signed by a second person who witnessed the destruction on the Controlled Substances Inventory Record.

   b. When a prepared dose(s) is accidentally destroyed, the person responsible shall record, sign and have a counter-signature by a second person who witnessed the accident on the Controlled Substance Inventory Record.

   c. All waste must be documented as witnessed by a second person who has legal authority to administer or dispense controlled substances.

F. Sample Medications:
   1. The UW School of Dentistry Clinics will not store or dispense sample medications.
2. Any exception to this policy must receive prior approval from the UWSOD Medication Oversight Committee and follow all regulations pertaining to safe handling and dispensing.

III. Administration of Medications

Drugs shall be administered only upon the order of a practitioner who has been granted clinical privileges to give such orders in accordance with state and federal laws and regulations governing such acts and in accordance with approved UW School of Dentistry policy. (WAC 246-873-090)

A. Safely Administering Medications in the UW School of Dentistry Clinics

1. Allergies of patient must be known before administering any drug. The provider and person administering the medication will verify that the medication is not contraindicated for the patient.

2. Qualified personnel administering the medication should always check the five RIGHTS:
   a) Right patient
   b) Right medication (including assuring the medication is not expired)
   c) Right dose
   d) Right route
   e) Right time

3. For routine medications, qualified personnel will:
   a) Read the medication to be administered
   b) Verify the patient name, date of birth, and medical record
   c) Ask patient to state name and date of birth
   d) Complete the documentation immediately

4. Qualified personnel include: Dentists, dental students, dental assistants, dental hygienists, and dental anesthesia assistants at UW School of Dentistry Clinics (within their scope of practice, department standard, in accordance with WAC 246-873-090, and WAC 246-817-701 through 246-817-790).

5. Medication Routes of Administration–The actual technique for giving medications via different routes includes: IV, Parenteral, oral, topical, inhaled and sublingual.

6. The UW School of Dentistry Clinics will not store or administer a patient’s private medication. All medication administered will be from a supply source ordered by the clinic.

7. Self-administration of medications shall occur only within approved
protocols in accordance with a program of self-care or rehabilitation. Policy and specific written procedures, approved by the appropriate faculty and administration shall be established by the consultant pharmacist.

B. Documentation of Medications Administered

1. All medications should be documented in the patient record immediately after administration.
2. Charting includes the medication name, dosage, route of administration, site, time and date.

C. Multi-dose Vials (MDVs) and Irrigation Solution Containers

1. The multi-dose vial will be inspected prior to each use and discarded if showing signs of contamination. Contamination could include any haze, color change, cloudiness, surface film, particulate matter, gas formation, blood tinged or any other suspicion of contamination. All multi-dose vials must be stored under appropriate conditions at all times before and after they have been opened.

2. When a multi-dose vial is used for the first time, the beyond use date will be written on the vial. The beyond use date is equivalent to the expiration date. The beyond use date is as follows:
   - Multi-dose vaccines: The manufacturers expiration date (exception: FluLaval which expires 28 days after initial stopper penetration)
   - All other multi-dose vials: 28 days after initial stopper penetration, or the manufacturer’s expiration, whichever is sooner.
   - Whenever sterility or stability is questioned or compromised

3. Irrigation Solutions (Sterile Water, Normal Saline) without preservatives must be labeled when opened and discarded 24 hours after opening.

IV. Dispensing of Medications

The practice of dispensing medications to patients directly from the clinics must be approved by UWMC Pharmacy. Medications dispensed to patients directly from the clinic as a take-home medication must be appropriately labeled according to all state and federal statutes. Patients must receive verbal instructions from the appropriately licensed practitioner prior to dispensing the medication. The practitioner must document the medication dispensed and the instructions provided in the patient’s medical record.

A. Documentation

1. Medications dispensed shall be documented in the patient’s medical
2. A log of all medications dispensed to patients will be kept on file in the clinic and reviewed by the consultant pharmacist every month.

B. Patient Verification

1. Verify patient by asking them to state their name and date of birth.

C. Labeling

1. Medications dispensed shall have a fixed label with the following information:
   a) name and address of the clinic  
b) name of the prescriber  
c) the name and strength of the medication  
d) prescriber directions  
e) name of the patient and date of birth  
f) date dispensed  
g) expiration date

2. Also included on the label must be the following statement: "Warning: State or federal law prohibits transfer of this drug to any person other than the person for whom it was prescribed."

3. The information contained on the label shall be supplemented by oral or written information from the prescriber as required by WAC 246-869-220.

D. Instructions to Patients

1. Patients must receive verbal instructions from the appropriately licensed practitioner prior to dispensing the medication.
2. The practitioner must document the instructions provided in the patient’s medical record.

V. Medication Error Reporting

An adverse event may be defined as any event or circumstance not consistent with the normal operations of the UWSOD and its staff, or the routine care of a patient. It may be an occurrence, complication, product failure, accident, or situation which could have or not resulted in injury/harm to a person, property loss or damage, significant patient or visitor dissatisfaction, or interruption in clinical services. Identified medication errors are immediately reported in the electronic (1) Patient Safety Network (PSN) reporting system or (2) UWSOD Incident Report or (3) Online Adverse Reporting System (OARS).

A. Reporting Errors
1. In Case of an Adverse Event in any procedure refer to UW SOD Event Reporting Policy.
   a) Immediately notify the senior faculty member or the clinic director in the department.
   b) The clinic director will notify Health Sciences Risk Management (598-6303)
   c) The faculty member with Health Sciences Risk Management or clinic director will inform the patient or family of the event as soon as possible.
   d) The dental team involved in the event will complete an incident report via UWSOD Incident Report.

2. All medication errors shall be immediately reported to the senior faculty member or the clinic director in the department. They shall be notified of any adverse reaction to the medication and will determine if additional intervention or treatment is required. Medication errors are documented in the Patient Safety Network (PSN) reporting system. The senior faculty member and the Clinic Manager will investigate the situation and review the event with the appropriate personnel. Medication error data is reviewed by the Consultant Pharmacist and the UWSOD Medication Oversight Committee.

C. Reporting of Suspected Adverse Drug Reactions

An adverse drug reaction (ADR) shall be defined as any response to a drug that is noxious and unintended and that occurs at doses used for prophylaxis, diagnosis, or therapy, excluding failure to accomplish the intended purpose.

1. Types of reactions to be reported:
   a) Idiosyncrasy – an uncharacteristic response of a patient to a normal dose and route of a drug.
   b) Drug-drug interaction.
   c) Allergic reaction and hypersensitivities.
   d) Side effects – an adverse pharmacologic effect of a drug not associated with the therapeutic purpose for which the drug is given.
   e) Unexpected detrimental effects not previously reported in the literature.
   f) Drug intolerance – lowered threshold to a normal dose of the drug.

2. Severity of reactions:
   a) Minor reactions: those reactions that do not require drug discontinuation, antidotal, or corrective therapy, or prolonged hospitalization.
   b) Moderate reactions: these reactions requiring corrective measures and/or discontinuation of the medication and/or prolonged hospitalization.
   c) Severe reactions: those reactions considered potentially life-threatening or fatal.
If any adverse drug reaction occurs, first provide prompt and immediate attention to the patient. Next notify the provider to confirm the reaction and to receive and implement appropriate orders.

3. Adverse drug reactions are reported in the following manner:

   a) For all suspected adverse drug reactions, report incident report electronically via Patient Safety Network.

VI. Medications Reference Materials

All medication reference lists and charts distributed in the UW School of Dentistry Clinics shall be reviewed and approved by UWMC Pharmacy before being posted for general use.

A. Reference Material Guidelines for Medical, Nursing and other Clinic Providers.

   1. New medication references to be considered for posting shall be sent to the Associate Dean for Clinical Affairs for review.

   2. The Associate Dean for Clinical Affairs or designee shall review the reference for applicability, safety and accuracy.

   3. The reviewed document shall, after review and approval, have an indicator displayed on the document, which shall identify the date and approval of the reference document.

   4. Posted documents shall be reviewed by the consultant pharmacist each year during routine unit inspections.

   5. The following references are available:

      a) Metric weight and measure conversion charts
      b) Poison control center contact information
      c) Consultant Pharmacist and Pharmacy Emergency Contact Information

VII. Responsibility of the Consultant Pharmacist

The UWMC Director of Pharmacy will designate a consultant pharmacist to be the pharmacist in charge for the UWSOD. The appointed consultant pharmacist will be employed by UW Medicine – University of Washington Medical Center and must be licensed to practice pharmacy in the state of Washington. The consultant pharmacist shall have the authority and responsibility to assure that the area(s) within the UW School of Dentistry Clinics where drugs are stored, compounded, delivered or dispensed are operated in compliance with all applicable state and federal statutes and regulations. (WAC 246-904-030)
A. Duties and Responsibilities of for the consultant pharmacist or pharmacist in charge of the UW School of Dentistry Clinics.

1. To create and implement policy and procedures relating to:
   a) Purchasing, ordering, storing, compounding, delivering, dispensing or administering of controlled substances or legend drugs.
   b) Accuracy of inventory records, patient medical records as related to the administration of controlled substances and legend drugs, and any other records required to be kept by state and federal regulations.
   c) Adequate security of medications and controlled substances.
   d) Controlling access to controlled substances and medications.

2. To assure that the Washington state board of pharmacy is in possession of all current policies and procedures related to medication management for the UWSOD Clinics.

3. To review all requisitions for medications including controlled substances.

4. To verify receipt of all medications including controlled substances ordered by the clinic.

VIII. Closing a Health Care Entity

It is the policy of UW School of Dentistry to notify the pharmacy board when a licensed Health Care Entity ceases to operate and ensure that any remaining medications are safely transferred and accounted for. (WAC 246-869-250 and WAC 246-904-100)

1. Whenever a Health Care Entity (HCE) ceases to operate, the consultant pharmacist shall notify the pharmacy board of the pharmacy’s closing not later than fifteen days prior to the anticipated date of closing. This notice shall be submitted in writing and shall contain all of the following information:
   a) The date the Health Care Entity will close.
   b) The names and addresses of the individuals who shall have custody of the prescription files and the controlled substances inventory records of the Health Care Entity to be closed.
   c) The names and addresses of any individuals who will acquire any of the legend drugs from the Health Care Entity to be closed.

2. Not later than 15 days after the Health Care Entity has closed, the Consultant Pharmacist shall submit to the pharmacy board the following documents:
a) The license of the HCE that closed.
b) A written statement containing the following information.
c) Confirmation that all legend drugs have been transferred to an authorized person (or persons) or destroyed. If the legend drugs were transferred, the names and addresses of the person(s) to whom they were transferred.
d) If controlled substances were transferred, a list of the names and addresses to whom the substances were transferred, the substances transferred, the amount of each substance transferred, and the date on which the transfer took place.
e) Confirmation that the drug enforcement administration (DEA) registration and all unused DEA 222 forms (order forms) were returned to the DEA.
f) Confirmation that all pharmacy labels and blank prescriptions which were in the possession of the HCE were destroyed.

Dean of UW SOD:

Joel Berg, Dean of the UW School of Dentistry    Date
6-19-15
PurposE

To establish guidelines for managing patients’ oral health needs who are accepted for care at the University of Washington, School of Dentistry.

General Policy

Comprehensive dental care consists of an in-depth evaluation of the patient, including the diagnosis of dental needs and desires which shall be addressed in a timely, appropriately sequenced, caring, and professionally responsible manner. This policy applies to all patients who are assigned to students and/or a department.

Patients who seek limited care at the School of Dentistry for specific services such as oral surgery, endodontics, restorative, prosthodontic, implant and emergency care may be accommodated as outlined in this policy.

Implementation

I. Patient Acceptance

Patient acceptance decisions are based on the oral health needs of the patient in relationship to the scope of the educational programs of the school.

Patients interested in becoming a patient of the Predoctoral Student Clinic are required to attend a screening appointment before being accepted for treatment. Initial screenings are completed at the Dental Admissions Clinic (DAC). The screening appointment includes a screening examination, identifying patient’s chief dental complaints/needs, panoramic radiograph and completing a health history form. At the end of the screening examination, each patient is informed of their dental needs. Patients are accepted based on the complexity of the patient’s needs in conjunction with the student’s educational needs.
Patients accepted to the Predoctoral Student Clinics are assigned to a dental student for comprehensive dental care in the Clerkship or General Practice (GP) program. The accepted patient is required to take additional radiographs prior to the treatment planning appointment.

Patients who register but fail to initiate care or delay their care for 2 years are no longer considered comprehensive patients of record. Should they choose to be reinstated, they must follow the usual admission and acceptance protocols and go through the usual intake process to ensure complete diagnostics are taken and recorded.

Patients who are not accepted to the Predoctoral Student Clinic are referred to one of the following clinics for limited or comprehensive care: Graduate clinic, Advanced General Dentistry (AGD) or the Faculty Practice clinic (UW Dentists).

The patient is scheduled for a consecutive appointment in the respective clinic for one of two exams: Exam Limited Problem Focused (ADA Code D0140) or Exam Comprehensive New/Established (ADA Code D0150).

During this appointment for comprehensive patients, the dental student conducts a detailed examination to evaluate the patient’s needs and develop a comprehensive treatment plan before beginning treatment. Additionally, consultations will be completed; urgent and preventive services (OHI, prophylaxes, caries control, temporary restorations) are initiated; and the comprehensive treatment plan is presented to the patient for signed approval.

Patients accepted for limited care will receive a limited problem focused/limited care exam. This exam is an evaluation that is limited to a specific oral health problem, complaint or procedure. Typically, patients receiving this type of evaluation present with a specific problem and/or dental emergency, trauma, acute infection or singular procedure.

The protocol for taking radiographs is outlined in Appendix A, Guidelines for Prescribing Dental Radiographs.

II. Assignment

Patients who are accepted for comprehensive care are assigned to predoctoral students.

III. Formulation of the Treatment Plan

A. Diagnosis and the Treatment Planning Process
The formulation of a treatment plan must take into account the present complaint, personal and family history, past medical and dental history, physical examination, and appropriate diagnostic tests and procedures. Vital signs shall be taken and recorded annually on all active patients and the Medical History Update Form (See Section 3F) must be completed as outlined in Appendix B.

B. Consults for the Comprehensive Care Treatment Plan

The treatment plan is to be developed from the supporting consultations, which must be signed by either a full- or half-time faculty member in the Departments of Restorative and Periodontic Dentistry, and the assigned faculty advisor in the Department of Prosthodontics (if applicable) as well as a faculty member from the respective departments in which other consultations occur.

C. Treatment Plan Approval for Comprehensive Care Patients

Once the consultations have been completed, the treatment plan is approved by faculty.

D. Treatment Plans for Limited Care Patients

Limited care patients may be referred to the School for a specific procedure by an outside agency or practitioner. Limited care includes amalgam, composite, veneers, single crowns, a bridge or periodontal care.

Limited care patients must complete a comprehensive oral examination under faculty supervision to determine whether to proceed with a diagnosed limited care, to reject, or to refer the patient for comprehensive care. Respective clinic directors determine acceptance of patients for limited care.

Family members of students may self-refer for evaluation of a specific procedure.

Treatment plans for new limited care patients will be developed to list the specific procedure(s) to be performed in the department in which the plan originates. Services to be rendered shall be limited to those consistent with the educational programs of the department(s) involved. Treatment plans for limited care patients shall include either a Patient Acceptance Agreement or list the exclusions of care in the treatment plan. The exclusions / limitations may be described in categories of needs via custom school codes rather than on a procedure basis (e.g., deep caries, abscess, missing teeth, etc.). Authorization for care and the limitations must be obtained by patient signature. (See Appendix C).

E. Periodic Oral Evaluations
Upon completion of all active care, patients receive a final treatment assessment and are invited to participate in the schools’ hygiene recall program. The recall examination should be performed every 12 months on patients whose care is in progress or has been completed. Patients in current treatment have at least one annual recall preventive maintenance visit. A patient who develops new treatment needs is assigned to a dental student for care.

During the recall preventive maintenance visit, a periodic oral examination (ADA Code D0120) is conducted. A treatment plan is then formulated and is authorized by a designated faculty member from the department in which the majority of care will be provided if the periodontal status is acceptable. Acceptable periodontal status is defined as no pockets greater than 4 mm in depth and no gingival inflammation. Patients who do not meet these criteria may be assigned to a student or to an alternate care provider.

The periodic recall examination (ADA Code #0120) shall include the following:

- Update of the medical history
- Assessment and recording of vital signs
- Extraoral evaluation
- Assessment of the head and neck areas
- Assessment of the oral mucosa
- Periodontal screening examination
- Examination of existing teeth
- Evaluation of existing appliances and prostheses
- Assess need for radiographs

A complete health history is to be taken on all patients every three years. Patients returned to active status after three years of inactivity are to complete a new health history before initiating treatment.

IV. Care Delivery

A. Consent

The treatment proposed and rendered must take into account the general health, availability, financial resources, and desires of the individual patient. Patients are to be informed about the oral health needs, treatment alternatives, expected outcomes, and significant risks and consequences of the proposed treatment. Patients shall also be informed of risks and consequences associated with not having treatment of their existing conditions.
Consent for either comprehensive or limited care must be obtained prior to the onset of treatment and granted by patients via their signature on the treatment plan, or on a separate consent form.

B. Timeliness of Care

1. The predoctoral student who is assigned a given patient will design a comprehensive treatment plan and make every attempt to complete the identified treatment. The exception to this is when a patient is assigned for limited care such as an Endodontic therapy assignment or limited Restorative treatment.

2. Treatment needs of patients that exceed the student's training, or that fall outside departmental requirements may be managed by graduate students; intramural faculty practitioners; and/or by referral to the private dental community.

3. No patient will be treated without a current and signed treatment plan with the exception of emergent and diagnostic care or in the case of a departmental or private limited care referral. Treatment plans must be updated, approved and signed by the patient, and approved in axiUm by a faculty member in whose department the majority of care will be provided. Treatment plans must be updated within 12 months from the original/previous treatment plan.

C. Delay of Care

If the patient is unable to comply with the stated guidelines a delay of care status must be approved and documented by the Patient Services office. This grants the patient and student an extension of the deadlines for treatment planning and care delivery.

IV. Care Sequencing

Treatment will be rendered in an appropriately sequenced manner reflecting the phasing detailed in the treatment plan.

A. Phase Descriptions

1. *Phase 1*: Diagnostic services as well as urgent care that is related to threatening oral conditions, discomfort, or impacting on the social needs of the individual patient.

Examples:
a) exams, radiographs, models  
b) gross caries  
c) acute pulpal disease  
d) acute periodontal disease  
e) fractured teeth

2. **Phase 2**: Non-urgent care that is related to the elimination of oral conditions which may ultimately impact on the patient's health and well being.  
   Examples:  
   a) routine restorative and periodontal treatment  
   b) essential prosthodontics  
   c) preventative services  
   d) elective extractions  
   e) symptomatic endodontic therapy independent of other services

3. **Phase 3**: Elective treatment that can be delayed more that six months without negative consequences for the patient.  
   Examples:  
   a) nonessential prosthodontics  
   b) orthodontics  
   c) composite veneering

4. **Phase 4**: Maintenance care which follows the completion of all planned primary therapy. This does not include maintenance care which may occur along with primary care services.

**B. Exceptions in Sequencing**

If the decision is made to alter the above sequence (e.g., construct a fixed partial denture without uprighting a molar, or fabricate a removable partial denture without first performing indicated periodontal surgery), then an appropriate entry should be made in the progress notes, approved by the patient, initialed on the visit slip, and signed by the student and instructor(s) of the appropriate department(s).

**VI. Case Completion**

At the completion of care, a final oral evaluation is done and the code UW 100 or UW106 is used in axiUm in conjunction with the Completed Treatment Review (CTR). Patients will be assigned for preventive maintenance following the completion of their primary care. Students are responsible for managing the completion of the treatment plan for their assigned patients.

Patient disposition must be indicated in the progress notes.
The guidelines listed in the *Clinic Procedures Manual* must be followed for referring patients to students, intramural faculty practices, and/or the private sector.

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**Appendices:**
- Appendix A, Guidelines for Prescribing Dental Radiographs
- Appendix B, Policy Statement Regarding the Updating of Medical Histories and Vital Signs
- Appendix C, University of Washington School of Dentistry Limited Care Agreement

Dean of UW SOD:

Joel Berg, Dean of the UW School of Dentistry

October 24, 2016
# APPENDIX A

## GUIDELINES FOR PRESCRIBING DENTAL RADIOGRAPHS

Modified after recommendations issued by the U.S. Department of Health and Human Services, Public Health Service, and the Food & Drug Administration. The recommendations in this chart are subject to clinical judgment and may not apply to every patient. They are to be used by dentists only after reviewing the patient’s health history and completing a clinical examination. The recommendations do not need to be altered because of pregnancy.

<table>
<thead>
<tr>
<th>ADULTS</th>
<th></th>
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<tbody>
<tr>
<td><strong>New Patient</strong></td>
<td></td>
</tr>
<tr>
<td>Radiographs of recent date (1-2 years old) of sufficient quality and quantity</td>
<td>Low Risk</td>
</tr>
<tr>
<td>High Risk</td>
<td>PAN + Bitewing</td>
</tr>
<tr>
<td>Previous radiographs more than 2 years old or more recent, of insufficient quality and quantity</td>
<td>Low Risk</td>
</tr>
<tr>
<td>High Risk</td>
<td>FMS + Bitewing (PAN)</td>
</tr>
<tr>
<td>No previous radiographs</td>
<td>Low Risk</td>
</tr>
<tr>
<td>High Risk</td>
<td>FMS + Bitewing (PAN)</td>
</tr>
</tbody>
</table>

| **Recall Patient** | Use available previous radiographs | Low Risk | Bitewing 24 – 36 month interval |
| High Risk | Bitewing 12 – 18 month interval |

<table>
<thead>
<tr>
<th><strong>CHILDREN AND ADOLESCENTS</strong></th>
<th></th>
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</thead>
<tbody>
<tr>
<td><strong>New Patient</strong></td>
<td></td>
</tr>
<tr>
<td>Primary Dentition</td>
<td>Bitewing if contacts closed</td>
</tr>
<tr>
<td>Transitional Dentition</td>
<td>PAN + Bitewing</td>
</tr>
</tbody>
</table>

| **Recall Patient** | Bitewing 12 – 24 month interval | Panoramic radiograph to assess 3rd molars and growth and development when needed. |

## CLINICAL SITUATIONS FOR WHICH RADIOGRAPHS MAY BE INDICATED INCLUDE:

### POSITIVE HISTORICAL FINDINGS

1. Previous periodontal or endodontics therapy.
2. History of pain or trauma.
3. Familial history of dental anomalies.
4. Post-operative evaluation of healing.
5. Presence of Implants.

### POSITIVE CLINICAL SIGNS/SYMPTOMS

2. Large or deep restorations.
3. Deep carious lesions.
4. Malposed or clinically impacted teeth.
5. Swelling.
7. Mobility of teeth.
8. Fistula or sinus tract infection.
11. Unexplained bleeding.
12. Positive neurologic findings in the head and neck.
13. Evidence of foreign objects.
15. Facial asymmetry.
16. Abutment teeth for fixed or removable partial prosthesis.
17. Oral involvement in known or suspected systemic disease.
18. Pain and/or dysfunction of the temporomandibular joint.
19. Unusual eruption, spacing, or migration of teeth.
20. Unusual tooth morphology, calcification, or color.

### PATIENTS AT HIGH RISK FOR CARIES MAY DEMONSTRATE THE FOLLOWING:

1. High level of caries experience.
2. History of recurrent caries.
3. Existing restoration of poor quality.
4. Poor oral hygiene.
5. Inadequate fluoride exposure.
6. Prolonged nursing (bottle or breast).
7. Diet with high sucrose frequency.
8. Poor family dental health.
11. Xerostomia.
12. Genetic abnormality of teeth
On entry to the School of Dentistry patient care system, each patient will have completed the Medical and Dental health history questionnaire; and the responsible student will have investigated items of concern -- if necessary, with guidance from a faculty member and, where appropriate, by means of consultation with the patient's physician. At this initial stage, the patient's vital signs will have been recorded as part of the basic assessment. The following policy statement provides guidelines for the updating of the health history, and for the repeat recording of the vital signs at intervals, both for patients on the recall system and for those who -- for whatever reasons -- have not been seen on a frequent and regular basis.

**On every visit for active treatment**, it is important that the student should begin the clinical appointment by asking the patient if there is any change at all in the patient's medical status. This applies to all visits for all patients under active treatment. This question should be a routine matter. If the patient indicates any change, then the student will need to pursue the matter with additional questions and update the medical history form. It is the duty of the patient to be truthful about their medical history and to report changes in their history to their provider.

Patient's vital signs must be recorded at the initial visit, then at recall visits. Patients of high risk shall be monitored at each visit.
## University of Washington School of Dentistry Limited Care Agreement

**APPENDIX C**

### Limited Care Form

<table>
<thead>
<tr>
<th>Student name:</th>
<th>Chart #:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient name:</td>
<td>Age:</td>
</tr>
<tr>
<td>☐ Friend ☐ Family</td>
<td>Telephone #:</td>
</tr>
</tbody>
</table>

**Patient's chief complaint/dental needs:**

**Requested dental treatment:**

**Required:**
- ☐ Restorative Exam
- ☐ Periodontal Exam
- ☐ 4 BW X-rays
- ☐ PA X-rays
- ☐ Prophy
- ☐ Other: ________________

**PCC Approval:**

<table>
<thead>
<tr>
<th>PCC name and signature</th>
<th>Date</th>
</tr>
</thead>
</table>

**Comments:**

**Faculty Course Director Approval:**

<table>
<thead>
<tr>
<th>Dr. E. R. Schudelharm 4th Yr. GP Clinic Clerkship Director</th>
<th>Date</th>
</tr>
</thead>
</table>

**Comments:**

**Patient Signature:**

<table>
<thead>
<tr>
<th>Date</th>
</tr>
</thead>
</table>

Prosthodontic, implant procedures and restoration of endodontically treated teeth will require approval by a full-time restorative or prosthodontic faculty prior to acceptance as a limited care patient. Please contact the Patient Services Office for questions. Dental Urgent Care patients will not be accepted as limited care patients – please refer to DAC.
UNIVERSITY OF WASHINGTON
SCHOOL OF DENTISTRY

Subject: Correct Patient, Correct Procedure, Correct Site Verification Process Policy

Policy Number:

Effective Date: September 2006


PURPOSE

To ensure the correct patient, receives the correct procedure on the correct site(s)/side

GENERAL POLICY

1. All relevant documents (e.g. referral forms, chart notes, medical history, treatment plan, informed consent, properly labeled studies and radiographs) will be available, reviewed and checked for accuracy and lab consistency, before the start of the surgery/procedure.

2. Consult/referral forms must have the tooth numbers and tooth/teeth description written out and the proper tooth/teeth circled.

3. All members of the team (attending and/or student, resident, nurse, and dental assistant) will conduct a final verification (time-out) before the procedure begins.

IMPLEMENTATION

1. Identification and verification of the correct patient, procedure and site(s)/side will occur:
   a. At the time the procedure is scheduled
   b. At time patient is being seated
   c. Anytime the responsibility for care of the patient is transferred to another caregiver
   d. Prior to the treatment team performing the procedure

2. Site(s)/side marking
   a. Because dental procedures are difficult to definitively site mark the following must occur:
      i. Review the dental record including the medical history, consult/referral forms, laboratory findings, appropriate charts, radiographs and informed consent form(s). Make
sure all information is consistent and matches with the radiographs.

ii. Confirm with the patient the specific procedure that is to be performed prior to any anesthesia or sedation.

iii. Ensure the radiographs are properly oriented and visually that the correct tooth/teeth have been charted.

iv. Conduct a final verification to verify patient, tooth and procedure with an assistant or patient at the time of the extraction (two person rule)

3. **Final Verification (time out)**
   a. All members of the dental team (e.g. dentist, student, resident) involved in the procedure will conduct a final verification (time out) for procedures meeting one or more of the following criteria:
      i. Informed consent
      ii. Moderate Sedation is administered
      iii. Non-reversible procedure
   b. The attending dentist must be present for the final verification.
   c. All member(s) present immediately prior to the procedure must verbally confirm the following:
      i. Correct patient
      ii. Correct procedure
      iii. Correct site
      iv. Correct position
      v. Availability of correct implants and special equipment or special requirements
      vi. Prophylactic antibiotics have been given (if ordered)
   d. Final verification (timeout) is documented on the progress notes/surgery form as “Timeout Performed at____ Hours” by the person completing the chart entry and followed by an attending signature.

**In Case of an Adverse Event in any procedure**

1. Immediately notify the senior faculty member or the Clinic Director in the department.
2. The Clinic Director will notify Health Sciences Risk Management (206-598-6303)
3. The faculty member with Health Sciences Risk Management or Clinic Director will inform the patient or family of the event as soon as possible.
4. The Dental team involved in a School of Dentistry patient event will complete a Patient Event Form available online at: [https://uwnetid.sharepoint.com/sites/sod/patient-event-form/Lists/PatientEventForm/Item/newifs.aspx](https://uwnetid.sharepoint.com/sites/sod/patient-event-form/Lists/PatientEventForm/Item/newifs.aspx)
5. For patient events occurring at UWMC, the event should be reported in the Patient Safety Net system accessible to practitioners who have UWMC credentials (e.g. oral surgeons.)
Dean of UW SOD:

Joel Berg, Dean of the UW School of Dentistry  Date
PURPOSE

To provide a mechanism for the provision of urgent care for dental patients at the University of Washington School of Dentistry.

GENERAL POLICY

The School of Dentistry provides urgent dental care throughout the year to individuals whether or not they are patients of record of the school. Service is provided throughout the workweek during regular clinic hours. After hours, individuals who are not patients of record are to be referred to the King County Dental Society. During normal clinic operating hours, active School patients are to be referred to their assigned students who will manage their emergent dental care. After hours, School patients will be referred to the UWMC Emergency Department.

IMPLEMENTATION

I. Source of Emergency Referrals

Patients might contact any department for emergency treatment. It is essential that staff in each department know the protocol for referring an emergency patient when contacted. The staff member should direct all patients to call the Dental Urgent Care Clinic for service at 206-543-5850 unless the nature of the emergency dictates that the patient should be treated in the department which has been contacted (i.e. oral surgery, pediatric dentistry, endodontics).

II. Emergencies Occurring During the Quarter

A. Inactive Patients

Patients who are not patients of record, or are awaiting assignment within the patient care system of the School of Dentistry ("new patients") are referred to the Dental Urgent Care Clinic during business hours. After hours, patients of
record who are unassigned will be referred to the UWMC emergency department. Patients who are not patients of record shall be referred to Seattle-King County Dental Society after hours.

Inactive patients who have an emergency related to recent treatment will be referred to the department in which such care was provided (e.g., tooth sensitivity following placement of a crown refer to Restorative Dentistry). Other emergencies shall be referred to Dental Urgent Care which will either triage them and make the appropriate referral, or render appropriate care.

B. Active Patients

1. Patients assigned to a student will be managed by that student. Emergent care has priority over routine care, therefore emergency patients shall be scheduled before routine care patients in appropriate clinics not referred to Dental Urgent Care. In the event that the student is unavailable to provide care due to personal illness, family emergency, or block assignment, the patient should be referred to the appropriate department to care for the emergency. For example, a known restorative problem should be referred to the Department of Restorative Dentistry. In the event that the nature of the patient’s emergency needs cannot be determined then the patient should be referred to the Dental Urgent Care Clinic. Students are to arrange for emergency care for their assigned patients by other students prior to participation in an extramural assignment.

2. Patients assigned to a specific department will have their emergent care needs managed by that department. If the patient’s emergent care needs are beyond the scope of the assigned department then the patient is to be referred to the appropriate department for treatment. Interdepartmental emergency consultations will be made available in each department.

3. Outside regular clinic hours: The patient should call the assigned student. In each discipline the student will have a back-up faculty member, assigned by the department, who is on-call. The student will either call this faculty member or the faculty member who supervised the care of the patient.

The faculty member will determine the seriousness of the situation. If the faculty member decides that the patient has to be seen immediately, the student will notify the patient to go to the UWMC Emergency Department. Usual charges will apply.

1A block assignment is defined as a scheduled clinical activity in which patients are provided for students by the supervisor of the block. The block may be either intramural or extramural in nature.
Dean of UW SOD:

Joel Berg, Dean of the UW School of Dentistry                      February 2, 2016
UNIVERSITY OF WASHINGTON
SCHOOL OF DENTISTRY

Subject: Disclosure of Unanticipated Outcomes

Policy Number:

Effective Date: March 2006

Review Date: February 2006, August 2016

PURPOSE

The School of Dentistry supports a patient’s right to make decisions about, and participate in, their treatment and plan of care. For patients to exercise this right they must be fully informed about all relevant outcomes in their care, including outcomes that are unanticipated.

GENERAL POLICY

It is the policy of the School of Dentistry to provide patients with appropriate and necessary information about all outcomes of care, treatment, and services, including unanticipated outcomes. Patient events including negative care outcomes are formally reviewed as a part of the School’s Coordinated Quality Improvement Program (CQIP). An unanticipated outcome of care is an outcome that was not expected in advance as being a desired outcome of care, treatment or services, including those that:

- Result in a significant change in the patient’s condition
- Require a significant re-treatment
- Create the need for unforeseen intervention
- Result in permanent harm to the patient
- Result in a hospitalization

IMPLEMENTATION

The attending faculty has primary responsibility for ensuring that the unanticipated outcome is disclosed to the patient. Care providers will promptly notify their supervising faculty or department chair of any unanticipated outcome of care. Involved providers will report the unanticipated outcome immediately in accordance with the School’s event reporting system (https://uwnetid.sharepoint.com/sites/sod/patient-event-form/Lists/PatientEventForm/Item/newifs.aspx) and will participate as requested in disclosure of the unanticipated outcome to the patient.
When multiple specialties or departments are involved in an unanticipated outcome, the attending faculty should contact the Associate Dean for Clinics to discuss the situation. The Associate Dean will involve Health Sciences Risk Management and others as appropriate. Such events are reviewed at the CQIP Operations Committee in order to assess the root cause of the event and determine if a clinical process or policy should be modified in order to prevent a reoccurrence of the event.

When an unanticipated outcome occurs, disclosure of the outcome to the patient should take place as soon as practical after the unanticipated outcome is identified and in a manner the attending faculty believes represents high quality, compassionate patient care. The patient should be stabilized and/or able to comprehend the information, unless it is determined that the patient’s family/guardian should be informed. The responsible care providers and/or Patient Relations staff will provide ongoing information to the patient/guardian as necessary or as it becomes available.

Disclosure should take place in a setting that supports the patient’s right to information, dignity and confidentiality. Health Sciences Risk Management along with the Patient Relations team is available to help any provider prepare for a disclosure discussion with a patient and to provide resource material and support.

Cross References:

School of Dentistry Informed Consent Policy

School of Dentistry Patient Rights & Responsibilities Brochure

Employee Assistance Program

Dean of UW SOD:

__________________________________________________  ___________ _____________________
Joel Berg, Dean of the UW School of Dentistry        Date
PURPOSE

In keeping with the School of Dentistry’s patient care goals, the School has a mechanism for receiving, responding to and resolving patient and family complaints concerning the quality of care, services, and facilities. Patients and families are informed of their rights to present complaints. Complaints are resolved in a fair and objective manner through the patient complaint process. The complaint is analyzed and, when indicated, corrective action is taken. Presentation of a complaint does not serve to compromise a patient's future access to care and is a key component to the School’s Quality Improvement Program. (See Appendix A, Quality Improvement Flow Chart)

GENERAL POLICY

All School of Dentistry faculty and employees serve as representatives of the School and are responsible for addressing a complaint when presented and making an appropriate referral. If a patient complaint cannot be resolved to the patient's satisfaction, the patient can file a formal grievance with the Patient Services. The Patient Relations staff have the responsibility for the investigation and resolution of all patient grievances with input from Clinic Directors of specific departments based on the nature of the complaint.

DEFINITIONS

Complaint: Any patient-initiated issue or concern about patient care, a care provider, access to care or service quality that is expressed verbally or in writing.

Grievance: Any complaint that cannot be resolved to the satisfaction of the patient or family member lodging the complaint. A complaint will be considered a grievance when the patient or family member verbally declines to accept the written resolution of a complaint or writes to request further review into a complaint.
IMPLEMENTATION

I. Filing a Complaint

Patients and family members can register their complaint(s) or comment(s) in writing, by phone or in-person. The patient can file a complaint with the manager at the point of care or service, or with the Manager of Patient Services. The patient also has the right to contact the Washington State Department of Health. Issues are investigated in a professional and timely manner to achieve resolution when possible. Complaints received by phone or in-person are acknowledged, verbally or in writing, and a timeframe for resolution is set at the time of contact. The timeframe is determined by the nature of the issue to be investigated.

The School’s goal is to acknowledge written complaints within five working days of receipt by the Manager of Patient Services (For privacy complaints related to UW School of Dentistry Privacy Practices, contact the Compliance Director. Such complaints will be investigated within 10 days of the complaint.) The full investigation and resolution process should not exceed 60 working days from receipt of complaint. If a complaint requires additional time for resolution, a timetable for resolution will be made with the input from the patient and School of Dentistry staff. The School will endeavor to respond to complaints in fewer than 60 days when practical to do so.

II. Resolving Complaints

A. Staff will initiate problem resolution (see Appendix B—School of Dentistry Resolving Patient Complaints Quick Reference Guide). If the staff member who receives the complaint cannot resolve the concern, the issue will be referred to the Manager of Patient Services. Staff will inform the patient or family member where their complaint is being referred. A description of the issue is conveyed by the referring staff to the Manager of Patient Services when possible to avoid having the patient or family member repeat his/her complaint (see Attachment 2: Patient Complaints Procedure).

B. Complaints regarding quality of care, informed consent or breach of patient privacy should be referred immediately to the Manager of Patient Services who will consult with the Associate Dean for Clinical Affairs, the Director of Quality Improvement and with Health Sciences Risk Management, as necessary.

C. If a comment/complaint card is received or if there is an in-person complaint, the staff person will review the process. If multiple departments are involved in resolving a complaint, the Manager of Patient Services will serve as a direct follow-up resource for the individual who registered the complaint.
D. If a complaint cannot be resolved to the patient’s satisfaction, the patient or family member will be told he/she has the option to file a grievance with the Manager of Patient Services.

III. Patient Grievance Process

If a patient chooses to initiate the patient grievance process, he/she can file a grievance with the office of the Associate Dean for Clinical Services. This office will complete the initial review of the grievance and present the issue to the Patient Grievance Committee. Complete investigation of the grievance will be assigned based on the type of grievance involved. Patients will be notified in writing of the receipt of their grievance within five business days. The resolution will occur within a timeframe agreed upon between the patient and the School. The School of Dentistry Patient Grievance Committee will be responsible for reviewing and resolving all grievances. Patients also have other forums for complaints, such as the Washington State Department of Health or the Seattle King County Dental Society.

IV. Notice of Complaint Process

Patients are notified of their rights regarding filing a complaint in the following ways:

A. The Patient Rights and Responsibilities brochure which is given to patients before or at the time of service.

B. Signs in reception areas and in clinics with contact numbers of the Clinic Manager and Manager of Patient Services.

C. Patient comment brochures which are available throughout the school.

V. Quality Improvement

Overall trends related to patient complaints are presented to the School of Dentistry Coordinated Quality Improvement Operations Committee (CQIP) and the School’s Clinic Services Committee, for performance and quality improvement.

Appendices: Appendix A, Quality Improvement Flow Chart
Appendix B, School of Dentistry Resolving Patient Complaints Quick Reference Guide

Dean of UW SOD:

Joel Berg, Dean of the UW School of Dentistry

February 25, 2016
Appendix A
QUALITY ASSURANCE PROGRAM FLOW CHART

Data
- Pt. Surveys
- Chart Audits
- Patient Comment brochures
- Fee Waiver Reports
- Safety Evaluations
- Patient Safety Survey

6) Implement Policy or Procedure

5) Approve Policy or Procedure

Departments

Faculty Council (monthly)
Deans & Associate Deans (Bi-monthly)
Executive Committee (Bi-monthly)

1) Collect and compile Data

3) Monitor, Assess and Report to CQIP Oversight Committee

CQIP Operations Committee
- Associate Dean of Clinical Services
- Director of Quality Assurance
- Director of Clinics
- Health Sciences Risk Mgt. Director
- Health Sciences Assoc. Risk Manager

CQIP Oversight Committee
- Dean
- Clinic Director
- Associate Deans
- Director of Quality Assurance

Revised 2-4-16
QUICK REFERENCE
RESOLVING PATIENT COMPLAINTS

**PROFESSIONAL STANDARDS** & **ACTION STEPS**

- **TAKE INITIATIVE**
  If a complaint is brought to you:
  - Take personal responsibility to see the problem through

- **ACT PROFESSIONALLY**
  Everyone should be treated with respect and dignity

- **PROVIDE THE BEST POSSIBLE CUSTOMER SERVICE**
  Every patient has a right to voice a complaint

**PATIENT VOICES COMPLAINT**
Listen actively to learn the problem or complaint

- **ASK QUESTIONS**
  To understand the problem, need or complaint

- **GIVE REASSURANCE**
  To convey your interest in helping the patient

- **SUMMARIZE THE PROBLEM**
  To show the patient you understand

- **THINK OF SOLUTIONS**
  To help solve the patient’s problem
CONSIDER ALTERNATIVE RESPONSES FOR SOLVING THE PROBLEM
- You are able to solve the problem within your role, or
- Refer the patient to the appropriate resource, or
- Obtain assistance if it is not clear how to solve the problem

AGREE ON A SOLUTION
You and the patient jointly develop a plan of response
Emphasize what you can do, not what you cannot do

ACT ON THE SOLUTION

PROVIDE CONTINUITY
If a problem is referred to another staff member, call ahead and explain the situation so that the patient does not have to repeat it again.

CLOSE THE LOOP
Notify the referring staff how the problem was resolved, what happened, and what will happen.

RECORD AND REPORT
If appropriate, fill out an incident report. Complaints are a valuable source of information for continuous performance improvement.
PURPOSE

To assure accurate documentation of care, referrals and consultations, correspondence related to care and to provide a legal and risk management support document for the University and the School of Dentistry.

GENERAL POLICY

axiUm is the UW School of Dentistry’s (UWSoD) comprehensive clinic management system that was implemented in July 2009. Together with MiPacs digital radiography which was launched in July 2011, it forms the backbone of the Health Information Management system. axiUm’s main functions include electronic health records, patient billing and insurance.

Privacy of patient records is protected by state confidentiality law and the records themselves are the property of the University of Washington School of Dentistry. The Associate Dean of Clinical Services or designee is the official record custodian for the school and Patient Services assigns patients to the appropriate care provider during care and consultation activities.

Storage and tracking protocols must be followed by anyone who uses or has access to patient records.

The content of the record must conform to the approved configuration and entries must comply with a standardized format.

IMPLEMENTATION

I. Overview

A. Ownership and contents

Clinical records include the patient chart and its contents, radiographs, laboratory, and other prescriptions, study models, and patient photographs. All
original copies of records are the property of the University of Washington and shall remain on the premises unless requested under subpoena. A duplicate record shall be made and retained in these circumstances.

B. Access and Security

Access to the axiUm resources can be both on-site and through remote access. The user of the UWSoD axiUm resources must comply with UWSoD policies, which in turn must comply with federal and state statutory and regulatory requirements. The user has the responsibility to protect access accounts, privileges, and associated passwords. The user must maintain the confidentiality of information to which he/she is given access privileges, and accept accountability for all activities associated with the use of his/her individual user accounts and related access privileges. Failure to comply with the above Privacy, Confidentiality, and Data Information Security Agreement may result in disciplinary action up to and including denial of access to information and suspension from school and/or termination of employment at the UWSoD.

C. Record Review

The Office of Clinical Services (OCS) shall be responsible for record review as defined in Section 5-1 b. of the ADA’s Accreditation Standards for Dental Education Programs (below):

Standard 5-1 b. THE DENTAL SCHOOL MUST CONDUCT A FORMAL SYSTEM OF QUALITY ASSURANCE FOR THE PATIENT CARE PROGRAM THAT DEMONSTRATES EVIDENCE OF: b. AN ONGOING REVIEW OF A REPRESENTATIVE SAMPLE OF PATIENTS AND PATIENT RECORDS TO ASSESS THE APPROPRIATENESS, NECESSITY AND QUALITY OF CARE PROVIDED.

D. Record Keeping and Progress Notes in axiUm

Patient records are an essential component of the delivery of competent and quality oral health care. All record must be authentic, accurate and objective. At each patient visit, the health history should be consulted and updated.

UWSoD is employing a standardized format, SOAP, for treatment notes. As a guideline, for patients seen on an emergency basis, axiUm notes should be entered at the end of the treatment day or no later than 24 hours in anticipation that the patient will be seen by other clinics and specialties for on-going treatment. In general, progress notes for regular treatment should be entered and approved no later than 7 days from the date of providing service.
E. Confidentiality and Release of Information

Patient records are protected by Washington state confidentiality law (see RCW 70.02, www.leg.wa.gov/rcw) and the federal Health Insurance Portability and Accountability Act (HIPAA). Access to patient records is limited to students, faculty, and staff who are involved with the patient’s treatment. Discussion about a patient shall be limited to issues related to their care and shall not be conducted so that inappropriate individuals could overhear.

Release of required information for third party carriers reimbursement shall be documented via signed patient authorization on the registration form.

Patient records used for research purposes are subject to state law as well as to the Human Subjects Policy of the University of Washington. Permission to view records of the general patient population for purposes of screening for research subjects, or to conduct research using patient records must be obtained from the Clinic Director and from Human Subjects Division and/or the Institutional Review Board. Records for clinical research subjects are to be kept in the clinical research center (RCDRC) and managed by the director of the center in accordance with state law.

Patients have a right to obtain a copy of their record and a reasonable charge may be assessed for the service as outlined in the state law. Request for duplication of records must accompany a signed Patient Authorization for UW School of Dentistry to Disclose/Release Protected Health Information form (see Appendix A). Duplication of requests shall be submitted to and prepared by the Patient Records staff. All attorney requests for records shall be reviewed by the Manager of Patient Services prior to release.

Patients may view their record upon request by appointment during normal working hours.

Grading information, administrative correspondence, incident reports, visit slips, and departmental memoranda are NOT part of the patient's record, therefore shall not be stored in the patient record nor should be released unless subpoenaed.

All employees, students and volunteers who are involved in patient care or have access to records are required annually to read and sign a Privacy, Confidentiality and Data Security Agreement (see Appendix B).

F. Archival Protocols
Both the state and federal governments have laws on healthcare record retention, but the federal law supersedes the state law. The Health Insurance Portability and Accountability Act (HIPAA) requires that all dental records be kept for at least six years after the patient’s last visit.

In accordance with University archival policy, records shall be retained on the premises for inactive comprehensive care adult patients for six years. Subsequently, they shall be transferred to University Records Center for the remainder of a 35-year retention period.

Records for pediatric patients follow the same protocol for up to 35 years. Records for limited care patients deemed to be of no research value are retained for up to 8 years following the completion of care.

II. REGISTRATION AND RECORD FORMAT

A. Registration

An electronic health record shall be created for all patients seen at the School of Dentistry. A permanent account number will be assigned to each patient record once the patient has completed the registration process which includes entering patient demographics, financial information and signing all consent forms.

All patients who receive care in the student clinics, including WREB patients, shall be registered as patients with the School of Dentistry.

B. Chart Contents

Patient radiographs are stored in the MiPacs system which is linked to aixUm. All radiographs must be prescribed and approved by the supervising faculty member. An unapproved image report will be run by the OCS on a regular basis to urge the care provider to obtain approval. Clinical privilege may be suspended for serious offenders.

In the same manner, patient clinical photographs may be stored either linked to aixUm or in school approved servers. To re-emphasize, all original copies of radiograph and photographic records are the property of the University of Washington and can only be released with the consent of the patient and with school’s approval.

Only forms approved by the Clinical Services Committee may be added to a record. Items in a record shall be limited to authorized contents as specified above.
C. Chart Assignment

Access to the patient record is given to pre-doctoral students by the Patient Services staff.

Patient reassignment, discontinuance of care, and inactivation are changes in a patient's assignment status which is determined by the Patient Services staff and the Manager of Patient based on disposition information contained in the record. Such a change in status shall be managed by the OCS. Students shall not “trade” patients or transfer their care without approval from either the faculty advisor, or from the Patient Services staff.

Upon graduation, the student must complete a audit of all assigned patients with their assigned Patient Care Coordinator. The student shall make a status of care entry in the treatment notes.

D. Dental Recordkeeping

The care provider shall document all significant patient communication in contact notes, as well as diagnostic and treatment services in the treatment history. Radiographs, photographs, consultations, and correspondence relating to patient care shall be retained in the patient record.

A medical history form shall be completed in axiUm for every patient prior to initiating care. It shall be electronically signed by the patient. The medical and dental history form shall be updated formally in axiUm for all patients annually. Medical alerts will populate in the “alerts” in axiUm when an adverse health condition is entered into the medical and dental history from.

Patients who are under active treatment shall be asked about their health status at every visit. Such informal inquiries about changes in health status shall be documented in the treatment notes and must update the medical and dental history form.

E. Treatment Plans

A current treatment plan and signed patient consent is required for all comprehensive care patients. Diagnostic and emergency services may be rendered during the development of a treatment plan; however, consent must be obtained and documented in the progress notes in these circumstances.
The student is responsible for the preparation of treatment plans for their assigned patients and may lose credit even if faculty supervise care without a treatment plan.

F. Progress/Treatment Notes

All appointments shall be scheduled in axiUm, including canceled and broken appointments. Progress/treatment notes must be entered by the care provider and properly approved/swiped by the supervising faculty member. Progress/Treatment notes shall be written using the SOAP format and shall include the date, department where treatment is rendered, teeth, and surfaces treated (or area of the mouth treated), and the body of the note. The body includes the diagnosis, the treatment (including materials used and their brand names), medications prescribed (including anesthetic used), post-operative instructions, and next visit plans. Sample Progress/Treatment notes of properly entered treatment notes using the SOAP format can be found in the Appendix (See Appendix C.)

Standardized abbreviations:
Standardized abbreviations shall be used for writing progress notes in order to save space and expedite chart entries and NC may be written after each of the SOAP segments in the entry to indicate there was no change from the previous visit (see Appendix D).

G. Amendements and Deletions

Correction to a treatment note or a late entry must be entered with the current date and must include the reason for the addendum or correction. Guidelines for amending and deleting notes can be found in the Amendment Policy for the Electronic Health Record (see Appendix E.)

The SoD prohibits deletion of treatment notes in axiUm except if the note was entered under the incorrect patient or a note was entered under the incorrect treating provider. Deleted notes are recorded in axiUm and can be recovered. The protocol for deleting notes in axiUm can be found in the Deleting Treatment Notes in axiUm policy (see Appendix F.)

H. Notice of Privacy Practices

Consistent with federal law, the UW School of Dentistry provides each new patient with a copy of its Notice of Privacy Practices, or, at a minimum, offers it to them at their initial visit and makes it available hard copy or electronically. The Notice includes contact information and detailed instructions on how patients can exercise their privacy rights.
Photo Releases

The UW SoD has several photo releases for specific scenarios. These photo releases authorize the SoD to disclose photographs of patients or students for a variety of purposes.

Appendices:

- Appendix A, Patient Authorization for UW School of Dentistry to Disclose/Release Protected Health Information
- Appendix B, Privacy, Confidentiality and Data Security Agreement
- Appendix C, Sample Progress/Treatment Notes, SOAP Format
- Appendix D, Standard Abbreviations
- Appendix E, Amendment Policy for the Electronic Health Record
- Appendix F, Deleting Treatment Notes in axiUm policy
- Appendix G, Notice of Privacy Practices
- Appendix H, Photo Releases

Dean of UW SOD:

Joel Berg, Dean of the UW School of Dentistry                                                February 2, 2016
APPENDIX A

Patient Authorization for UW School of Dentistry to Disclose/Release Protected Health Information
Patient Authorization for UW School of Dentistry to Disclose/Release Protected Health Information

Minors: A minor patient's signature is required in order to release the following information: (1) conditions relating to the minor's reproductive care, (2) sexually transmitted diseases (if age 14 and older), (3) alcohol and/or drug abuse and mental health conditions (if age 13 and older).

Patient Rights: I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment, or enrollment). I may revoke this authorization at any time except to the extent already relied upon by sending a request in writing to UW School of Dentistry Records Custodian Box 357131, Seattle, WA 98105. I understand that once the health information I have authorized to be disclosed reaches a noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under privacy laws.

I understand that I have the right to:

- Inspect or receive a copy of the protected health information
- Receive a copy of this signed form
- Refuse to sign this form for authorization to disclose or release my protected health information

I also understand that UW School of Dentistry will not base treatment or payment decisions based on receipt of this signed authorization, except in these cases: (1) UW School of Dentistry may condition research-related treatment on my signing or my providing an authorization for the use or disclosure of my information for such research; or (2) UW School of Dentistry may condition the provision of health care that is just for the purpose of creating health information for disclosure to a third party on my signing or my providing an authorization for the disclosure of the health information to such third party. An example of this is when a non-UW employer contracts with UW School of Dentistry to conduct TB testing for purposes of employee health screening.
APPENDIX B

Privacy, Confidentiality and Data Security Agreement
APPENDIX C

Sample Progress/Treatment Notes

SOAP Format

**Subjective Example:**

Patient has no orofacial complaints. Presents for comprehensive exam, treatment and plan, and dental prophylaxis.

**Objective Example:**

Vital Signs: BP 120/84 HR:62 P:__ TEMP:__ Head and Neck:__
Intraoral__: Periodontal:__ Dentition:__ XRAY:__

**Assessment Example:**

1. generalized gingivitis 2. dental caries.

**Plan Example:**

Med hx and radiographs rev’d, medications updated, pt took 600mg clindamycin 1 h prior to dental tx for__. Intra- and extra-oral exam; perio charting; 4 BW’s;; OHI, prophy. Rx-Prescription-items dispensed: Soft toothbrush and floss, clindamycin 300mg x 8 tabs: take 600mg 1 h prior to dental appts [indication?]. Next visit: Pt to rtc for restorative tx #12, referral to radiology for pan; 6 mo recall.

SOAP notes are usually used AFTER the initial visit for followup visits, so if this is the first visit, it probably would not be exactly relevant and applied. The main conceptual shift is to always check if patients have any complaints and always list their current problems and diagnoses. The plan always follows each problem and each diagnosis of the problem. This is a sea-change for many in dentistry but it can help avoid many problems with diagnosis. Using subheadings within the Plan is common, such as next visit (NV and prescription as RX). Some in our service like to start with the known problem, so it can be revised as P-SOAP for return visit, which is similar to PARTS.
## Standard Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</th>
<th>Abbreviation</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>AE</td>
<td>Acid Etch</td>
<td>OH</td>
<td>Overhang</td>
</tr>
<tr>
<td>Am</td>
<td>Amalgam (Insert brand used)</td>
<td>OHI</td>
<td>Oral Hygiene Instruction</td>
</tr>
<tr>
<td>B</td>
<td>Base (Insert type used)</td>
<td>PFM</td>
<td>Porcelain Fused to Metal</td>
</tr>
<tr>
<td>C</td>
<td>Composite (Insert brand used)</td>
<td>POI</td>
<td>Post Operative Instructions</td>
</tr>
<tr>
<td>C/R ratio</td>
<td>Crown-root ratio</td>
<td>Prep</td>
<td>Preparation</td>
</tr>
<tr>
<td>DR</td>
<td>Defective Restoration</td>
<td>PSA</td>
<td>Posterior Superior Alveolar</td>
</tr>
<tr>
<td>Ext</td>
<td>Extract</td>
<td>RC</td>
<td>Radiographic caries</td>
</tr>
<tr>
<td>FT</td>
<td>Fractured Tooth</td>
<td>RCT</td>
<td>Root Canal Therapy</td>
</tr>
<tr>
<td>FGC</td>
<td>Full Gold Crown</td>
<td>RD</td>
<td>Rubber Dam</td>
</tr>
<tr>
<td>GI</td>
<td>Glass Ionomer</td>
<td>ReCar</td>
<td>Recurrent Caries</td>
</tr>
<tr>
<td>HH</td>
<td>Health History</td>
<td>Rt. Car</td>
<td>Root Caries</td>
</tr>
<tr>
<td>IC</td>
<td>Incipient Caries</td>
<td>Rt. Prox.</td>
<td>Root Proximity</td>
</tr>
<tr>
<td>IA</td>
<td>Inferior Alveolar</td>
<td>Rx</td>
<td>Prescribed</td>
</tr>
<tr>
<td>INF</td>
<td>Infiltration</td>
<td>S &amp; RP</td>
<td>Scaling and Root Planing</td>
</tr>
<tr>
<td>LB</td>
<td>Long Buccal</td>
<td>SSC</td>
<td>Stainless Steel Crown</td>
</tr>
<tr>
<td>MGJ</td>
<td>Mucogingival Junction</td>
<td>V</td>
<td>Cavity Varnish</td>
</tr>
<tr>
<td>NV</td>
<td>Next Visit</td>
<td>ZOE</td>
<td>Zinc Oxide Eugenol</td>
</tr>
</tbody>
</table>
APPENDIX E

Amendment Policy for the Electronic Health Record
APPENDIX F

Deleting Treatment Notes in axiUm policy

Policy: Deleting Treatment Notes in axiUm
Effective Date: June 10, 2013
Revision Dates:

BACKGROUND AND PURPOSE

Occasionally, treatment documentation/note are inadvertently entered under the incorrect patient or under the incorrect treating provider. While the School of Dentistry emphatically prohibits the sharing of login and passwords (including axiUm swipe cards), it also recognizes that infrequent mistakes do occur. This policy clarifies when the deletion of treatment notes is appropriate.

POLICY

The School of Dentistry prohibits partial and/or entire treatment documentation/note deletion except in the following circumstances:

1. The documentation/note was entered under the incorrect patient
2. The documentation/note was entered under the incorrect treating provider

Documentation/note revisions and amendments are subject to the School of Dentistry’s "Amendment Policy for the Electronic Health Record"


Deleted notes are recorded in axiUm and if needed for audit, they can be recovered.

PROCEDURE

- Deletion privileges will be given to each Department Administrator, Clinic Manager and Clinic Supervisor. As a back-up, deletion privileges will be given to the School’s Associate Dean for Clinical Services, Patient Care Coordinators, Compliance Analyst and Compliance Director.
- Requests for documentation/note deletion will be directed to the Department Administrator, Clinic Manager or Clinic Supervisor in the department or clinic where the service/treatment was performed.
- Individuals with deletion privileges will delete the documentation/note only if it meets the circumstances stated above and below:
  1. The documentation/note was entered under the incorrect patient
  2. The documentation/note was entered under the incorrect treating provider
- Comments are not entered into axiUm when deleting notes. Deleted notes are recorded in axiUm and the reason for deletion can be easily determined.

Dean of UW SOD:

Jean Carver, Assistant Dean, Finance & Administration
June 10, 2013
APPENDIX G

Notice of Privacy Practices


APPENDIX H

Photo Releases
http://dental.washington.edu/wp-content/media/compliance/personal_photo_one_time_release.pdf (one-time waiver)
http://dental.washington.edu/wp-content/media/compliance/UW_Model_Release_publications.pdf (one-time publication)
PURPOSE

To educate patients on their rights and responsibilities related to dental care.

GENERAL POLICY

The University of Washington School of Dentistry is committed to respecting the rights and responsibilities of its patients who are accepted for care. These rights and responsibilities are recognized as important parts of the care process and are supported by all staff, faculty, and students throughout the School. Staff, faculty, and students will be educated about patient rights and their role in supporting these rights. All patients are provided with a copy of Patient Rights & Responsibilities.

Patient Rights

- Patients have the right to impartial, reasonable access to care and treatment regardless of one’s race, color, creed, religion, sex, sexual orientation, national origin, disability, age, or status as a disabled veteran.

- Patients have the right to care that is considerate and respectful of their cultural and personal values and beliefs.

- Patients have the right to have reasonable access to a certified interpreter or other language assistance if they do not speak or understand the English language.

- Patients have the right to a reasonably safe and secure environment.

- Patients have the right to be free from all forms of abuse or harassment.

- Patients have the right to be fully informed of their dental needs and the alternatives for care and to be referred elsewhere when the School cannot provide the care a patient requests.

- Patients have the right to effective pain management. Pain will be addressed and managed as deemed appropriate by the care provider.
• Patients have the right to consideration for their personal privacy and confidentiality of information.

• Patients have the right to have access to a written statement that articulates the rights and responsibilities of patients.

• Patients have the right to access their own health information, request amendment to it, and receive an accounting of disclosures about it, as permitted under applicable law.

• Patients have the right to expect that appointments will be offered to them on a regular basis until the completion of their care, once they begin the care process.

• Patients have the right to request and receive an itemized and detailed explanation of their bill for services rendered.

• Patients can expect that services rendered in the School meet the standard of care of the dental profession.

• Patients have the right to make complaints about their care according to the established policy and guidelines available in all patient care areas. Patients can freely voice complaints and recommend changes without being subject to coercion, discrimination, reprisal, or unreasonable interruption of care, treatment and services.

• Patients have the right to be informed of outcomes of care, treatment, and services, including unanticipated outcomes.

• Patients and/or their legally authorized surrogate decision maker(s) have the right, in collaboration with their dentist, to be informed and make decisions involving their dental care, including the right to accept or to refuse dental treatment and to be informed of the consequences of such refusal.

Patient Responsibilities

• Patients have the responsibility to provide, to the best of their knowledge, accurate and complete information and to report any changes in their medical status to their care provider.

• Patients have the responsibility to participate in discussions about their plan of care, ask questions, and to inform the care provider if they do not understand proposed treatment.

• Patients have the responsibility to make and keep appointments, arrive on time, stay for the entire time scheduled, and provide a minimum of 24 hours’ notice to change or cancel appointments.
• Patients have the responsibility to follow the treatment plan to which they agreed, including any recommended follow-up instructions. Patients are responsible for the outcomes if they do not follow the care and treatment plan.

• Patients have the responsibility to know their insurance coverage, benefits, and other spending accounts.

• Patients have the responsibility to notify their dental care providers or a staff member if they have complaints or concerns.

• Patients have the responsibility to provide updated, accurate insurance and billing information (including name, mailing address, phone number, and any other requested information for billing purposes), and for meeting the financial obligation agreed to with the School.

• Patients have the responsibility to provide accurate personal identification information.

• Patients have the responsibility to inform the School if they have special needs.

• Patients have the responsibility to inform the School when their treatment is not progressing with their provider by calling Patient Services at 206-221-0778.

• Patients have the responsibility for making necessary arrangements for childcare as the School does not provide child care. Children are not allowed into the treatment areas except for their own appointments, and may not be left unattended in the waiting areas.

• Patients have the responsibility for following the School of Dentistry policies and guidelines affecting patient care and conduct:

  o Patients may not disrupt or interfere with their care provider, other patients, or the operations of the patient care and office areas.

  o Patients may not conduct any illegal activities on the premises of the School of Dentistry.

  o Patients may not engage in any discriminatory or sexually harassing behavior toward staff, students, or faculty per University policy.

  o Patients are responsible for being considerate of the rights of others.

  o Patients are responsible for being respectful of the property of other persons and the School of Dentistry.
Information for Patients

The information below will provide general information about our Dental Clinics. We encourage you to ask questions about any part of this information that is not clear to you.

Your Dental Provider:
Dental students, graduate students and residents in training are under close supervision by experienced, licensed faculty dentist.

Dental Appointments:
STUDENT CLINICS: Appointments begin at 9:00 am or 9:30 am and 1:30 pm, depending on the clinic, and last two and a half hours. Patients must be available for the entire appointment time. Appointment availability may be limited when the school is not in session.

Appointment times vary in our Specialty Clinics and UW Dentists Faculty Practice.

Payment for Services:
Payment is due at the time of service. The School accepts cash, check, Citi Health Card, Visa, Discover, and MasterCard. Please provide your dental insurance information upon registering as a new patient. If we are in your insurance plan's network, our billing office will submit claims to your insurance company. Any co-payments are due on the day of service. If the school is not contracted with your insurance plan, you are responsible for the payment at the time of service. We do not offer payment plans.

Missed Appointments:
If you miss an appointment or do not cancel within 24 hours, we may charge you a cancellation fee. Please note that chronic lateness to appointments or more than two cancelled or failed appointments may be cause for discontinuing your care.

Dental Urgent Care Clinic:
If you are experiencing pain or swelling, please call the Dental Urgent Care Clinic between 8:30am - 4:30pm at 206-543-5850 to schedule an appointment.

For after-hours emergency care, please call UWMC Emergency Department at 206-598-4000.

Limited Care:
Limited treatment is available to patients with referrals from private practices or referrals from School of Dentistry Clinics for patients with minimal needs.

Unattended Children
Children may not be left unattended in waiting areas and are only allowed in clinics for their own appointments.

Animals:
In accordance with WA state administrative code animal control policy, we enforce a no pet policy. However, service animals will be accommodated.

Parking:
We do not validate parking.
For maps and directions, visit: dental.washington.edu/about-us/location-directions

Appendices: Appendix A, Patient Rights & Responsibilities Brochure

Dean of UW SOD:

October 13, 2016

Joel Berg, Dean of the UW School of Dentistry Date
Patient Rights & Responsibilities

SCHOOL OF DENTISTRY
UNIVERSITY OF WASHINGTON

Compliments and Concerns:
We want to provide the best care for you. Your feedback contributes to improving our service.

If you would like to share a compliment or concern about your experience as a patient, please contact our Patient Relations Office at 206-615-1022.

https://dental.washington.edu/patient/make-an-appointment/

THE SCHOOL OF DENTISTRY

Is committed to providing you quality, affordable and patient-centered dental care.

Thank you for choosing UW School of Dentistry to care for your dental needs. We welcome you and appreciate the opportunity to provide you with excellent dentistry. This brochure will provide general information about our Dental Clinic. We encourage you to ask questions about any part of this information that is not clear to you.

Your Dental Provider:
Dental students, graduate students and residents in training are under close supervision by experienced, licensed faculty dentists.

Dental Appointments:
STUDENT CLINICS: Appointments are scheduled from 9:30 am - 12:00 pm and 1:30 pm - 4:00 pm. Patients must be available for the entire appointment time. Appointment availability may be limited when the School's schedule is not available.

Payment for Services:
Payment is due at time of service. We accept cash, check, Visa, MasterCard, and Discover. Please provide your dental insurance information upon registering as a new patient. If you are in your insurance plan's network, our billing office will submit claims to your insurance company. Any copayments are due on the day of service. If this School is not contracted with your insurance plan, you are responsible for the payment at the time of service. We do not offer payment plans.

Missed Appointments:
If you miss an appointment or do not cancel within 24 hours, we may charge you a cancellation fee. Please note that this fee is assessed for appointments or more than two canceled or failed appointments may be cause for discontinuing your care.
PATIENTS HAVE THE RIGHT TO:
- Impartial, reasonable access to care and treatment regardless of race, color, creed, religion, sex, sexual orientation, national origin, disability age, or status as a disabled veteran.
- Care that is considerate and respectful of their cultural and personal values and beliefs.
- Have reasonable access to a certified interpreter or other language assistance if they do not speak or understand the English language.
- A reasonably safe and secure environment.
- Be free from all forms of abuse or harassment.
- Be fully informed of their dental needs and the alternatives for care and to be referred elsewhere when the School cannot provide the care a patient requests.
- Effective pain management, fees will be addressed and managed as deemed appropriate by the care provider.
- Consideration for their personal privacy and confidentiality of information.
- Have access to written information that articulates the rights and responsibilities of patients.
- Access their own health information, request amendment to, and receive an accounting of disclosures about, as permitted under applicable law.
- Expect that appointments will be offered to them on a regular basis until the completion of their care, once they begin the care process.
- Request and receive an itemized and detailed explanation of their bill for services rendered.
- Expect that services rendered in the School meet the standard of care of the dental profession.
- Make complaints about their care according to the established policy and guidelines available in all patient care areas. Patients can freely voice complaints and recommend changes without being subject to coercion, discrimination, reprisal, or unreasonable interruption of care, treatment and services.
- Be informed of outcomes of care treatment and services, including unanticipated outcomes.
- Patients and/or their legally authorized surrogate decision maker(s) have the right, in collaboration with their dentists, to be informed and make decisions involving the dental care, including the right to accept or refuse dental treatment and to be informed of the consequences of such refusal.

THE CENTER FOR PEDIATRIC DENTISTRY

GENERAL INFORMATION:
If your child is being seen at the Center for Pediatric Dentistry (CPD), please review the following information below.

DENTAL APPOINTMENTS
Appointments vary in length and are scheduled from 8:30 am - 12:00 pm and 1:00 pm - 4:00 pm. Children must be accompanied by a parent or an individual with written prior authorization to consent for care of the child.

BROKEN APPOINTMENTS
3 Broken Appointments may result in limitations to scheduling availability.

Please review the Broken Appointment Policy during registration at CPD.

EMERGENCY CARE
For emergencies, please call CPD between 8:00 am - 5:00 pm, Monday through Friday at 206-543-5400. For after business hours emergency care, please call Seattle Children’s Hospital at 206-987-2000.

PARKING
Free parking is available on-site at the Washington Dental Services Building at Magnuson Park.
Subject: Quality Assurance

Policy Number:

Effective Date: November 1993


PURPOSE

To develop a systematic and continuous protocol for assessing the patient care delivery system through the collection and analysis of reliable information.

GENERAL POLICY

Quality assurance is an on-going evaluation system that focuses on patterns of behavior rather than on isolated instances of behavior. Quality assurance is a mechanism for assessing the quality of care and implementing and evaluating changes in the patient care delivery system to maintain or improve the quality of care. Each service area within the School of Dentistry must play an integral part in the quality assurance system.

The benefits to be derived from a systematic quality assurance program include the documentation of the effectiveness of the educational and patient care programs, the identification of the areas of the educational and patient care programs that could benefit from improvements, and the establishment of a mechanism for on-going identification of strengths and weaknesses that will support plans for development, revision, improvement, and expansion within the University of Washington School of Dentistry educational and patient care programs.

CODA STANDARD 5-3

The dental school must conduct a formal system of continuous quality improvement for the patient care program that demonstrates evidence of:

a. standards of care that are patient-centered, focused on comprehensive care and written in a format that facilitates assessment with measurable criteria;

b. an ongoing review and analysis of compliance with the defined standards of care;
c. an ongoing review of a representative sample of patients and patient records to assess the appropriateness, necessity and quality of the care provided;
d. mechanisms to determine the cause(s) of treatment deficiencies; and
e. Implementation of corrective measures as appropriate.

IMPLEMENTATION

The dimensions of quality care have been defined to include structure, process, and outcomes of care. The structural dimension of care includes such factors as facilities, equipment, organization, administration, and personnel. The process of care refers to issues involved in the delivery of care such as diagnosis, sequence of care, appropriateness of care, and technical skill. This dimension of assessment of care can be performed prior to treatment (prospective reviews), during treatment (concurrent reviews), and following treatment (retrospective reviews). The outcomes of care refer to improvements in oral health, health, or other areas as a result of receiving dental care.

The elements of a quality assurance review in each of these dimensions must include the following:

- selection of an aspect of oral health care to be evaluated
- establishment of criteria and standards for quality oral health care which will be the basis for the assessment of quality
- comparison of the care/service that has been provided with the established criteria
- assessment of the quality based on the above comparison and the established standards
- action on the results of the evaluation to provide positive reinforcement for quality care or implement modifications to address deficiencies
- assure that actions result in maintenance or improvements in the quality of care

I. Structure

The Coordinated Quality Improvement Program (CQIP) consists of an Operations Committee which meets quarterly to review quality of patient care as reported through the Risk Master data base. This Committee reports to the
Oversight Committee where policy and procedure recommendations aimed at quality improvement, and patient safety are determined.

II. Process

The process evaluation of the quality assurance program is primarily built upon the dental record as the primary source of information on the care provided to the patient. The process evaluation includes, but is not limited to, chart audits, infection control assessment, and competency/proficiency exams.

A. Office of Clinical Services

On a quarterly basis, as a part of the Patient Advocacy Program, the Patient Services Representatives will conduct chart audits that evaluate basic components of care delivery and documentation.

B. Departmental Reviews

In addition to the record audits assigned for comprehensive care, patients also receive a thorough exam following the completion of their care (see Appendix A). Any treatment deficiencies found at this examination will be referred back to the clinics for treatment.

C. Health and Safety Task Force

On an ongoing basis, the Health and Safety Task Force will direct the Safety Assistant to present documentation of compliance with infection control and safety policies by faculty, students, and staff. The Health and Safety Task Force shall oversee compliance with Health and Safety regulations.

III. Outcomes

A. Office of Clinical Services

The OCS will conduct patient satisfaction assessments on an annual basis. The OCS will manage the compilation and dissemination of information gathered from the “Patient Satisfaction Survey” (see Appendix B) and the “Patient Comment and Complaint Brochure” (Appendix C).

B. Departments of the School of Dentistry

Each department will develop and submit to the OCS a protocol for post-operative review of treatment by types of procedures to assess the appropriateness and necessity of the care provided by students and faculty. On an annual basis, the departments will submit a report of the outcomes of the post-operative reviews. The OCS will be responsible for producing fee waiver reports and disseminating this information to the departments.
The dissemination of the results of quality assessment activities is essential for the use of the data in quality maintenance and improvement. Each department will be responsible for providing the results of quality assessment activities to the OCS. The OCS will be responsible for the maintenance of a comprehensive file on the quality assessment activities of the School of Dentistry.

Appendices:  
Appendix A, Completed Treatment Review
Appendix B, Patient Satisfaction Survey
Appendix C, Patient Comment and Complaint Brochure

Dean of UW SOD:

Joel Berg, Dean of the UW School of Dentistry    February 2, 2016
APPENDIX A

Completed Treatment Review
University of Washington
School of Dentistry

Date: ______________________   Patient #
Faculty: ______________________  Student: __________

CHIEF COMPLAINT:
Has the complaint been addressed?  O  Yes  O  No  O Not Applicable
If no, Why not?
O  Beyond Scope  O  Done Elsewhere  O  Overlooked
O  Patient Availability  O  Remission  O  Re-evaluation of need
O  Patient Decision  O  Financial Limitations
O  Medical Restrictions  O  Other __________

PLANNED CARE:
Has all planned care been provided?  O  Yes  O  No  O No Plan
If no, Why not?
O  Financial Limits  O  Patient Availability  O  Re-evaluation of need
O  Patient decision  O  Sequence of care not followed  O  Other __________

SERVICE REVIEW:  O  All Okay

Based on your clinical examination and considering the patient’s oral environmental factors, the care outcome is satisfactory except as indicated below:

<table>
<thead>
<tr>
<th>Ref. #</th>
<th>Department code</th>
<th>Tooth # or area</th>
<th>Comments on problems?</th>
</tr>
</thead>
</table>

Meets standard of care:  O  Yes  O  No

Comments:
________________________________________________________________________
APPENDIX B: PATIENT SATISFACTION SURVEY

WE CARE ABOUT YOUR CARE!
Please take a minute to tell us about your recent experience as a patient at the UW School of Dentistry. Patient responses are used in making changes in how we provide treatment and improve our service. Your feedback is anonymous unless you request a response from us (see bottom of survey). This survey is also available on line at https://catalysttools.washington.edu/survey/jarnold1/38404

Please CHECK only one response to each statement below:

<table>
<thead>
<tr>
<th>Appointment:</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Appointments were accessible when I needed them.</td>
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<tr>
<td>2. My calls were promptly returned.</td>
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<table>
<thead>
<tr>
<th>My Care Provider:</th>
<th></th>
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<tbody>
<tr>
<td>3. Talked to me with respect.</td>
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<td>4. Listened carefully to me.</td>
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<tr>
<td>5. Explained what was going to happen before each procedure.</td>
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<tr>
<td>6. Seemed concerned about not causing me pain.</td>
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<td>7. Used sanitary precautions and procedures.</td>
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<tr>
<td>8. Helped me to understand the overall plan for my treatment.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Staff &amp; Faculty:</th>
<th></th>
<th></th>
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<tbody>
<tr>
<td>9. The clinic personnel were courteous &amp; helpful.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>General:</th>
<th></th>
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<tbody>
<tr>
<td>10. The fees were reasonable.</td>
<td></td>
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<tr>
<td>11. I plan to continue to get my treatment at the School.</td>
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<tr>
<td>12. Overall, I was satisfied with my dental care.</td>
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</table>

| Additional Comments:             |                      |          |         |       |                |

If you would like a response please include your name and address or phone number:

Thank you very much for participating in our Patient Satisfaction Survey! Please return this form with your statement.
APPENDIX C

WE VALUE YOUR COMMENTS!

Please Let Us Know How We Are Doing

University of Washington
School of Dentistry
UNIVERSITY OF WASHINGTON
SCHOOL OF DENTISTRY

Subject: Patient Record Management

Policy Number:

Effective Date: December 2015

Review Dates:

PURPOSE

To establish uniform procedures detailing the responsibilities of dental providers (including Employee, Faculty, Affiliate Faculty, Pre-doctoral and Graduate Students) who administer treatment to patients of record within the School of Dentistry (herein referred to as “SOD”) to compile and maintain patient treatment records. This policy is intended to ensure that all patient recordkeeping is maintained by treatment providers at the SOD in a manner that is fully compliant with all relevant laws and regulations.

GENERAL POLICY

The SOD employs a patient Electronic Health Record (herein referred to as “EHR”) system called axiUm and a patient radiograph record system called “MiPACS.” Dental providers engaged in all levels of patient related clinical activity must adhere to strict policy guidelines and regulatory requirements when entering patient treatment notes and records in axiUm and MiPACS. Such requirements also apply to approval of student notes and procedure codes compiled during clinical teaching activity. This policy sets forth: (1) rules for timely input and/or approval of patient treatment notes and procedure codes; (2) monitoring and corrective actions taken for non-compliant treatment providers; and (3) an enforcement mechanism – that will ensure that SOD remains in compliance with all applicable statutory and regulatory requirements.

IMPLEMENTATION

I. LEGAL AND REGULATORY REQUIREMENTS

Washington state law governing the “Maintenance and Retention of Records” requires that dentists compile and maintain comprehensive and dated patient treatment records. The statute expressly states that, “[any] dentist who treats

1 Medicor Imaging Picture Archiving and Communication System – “MiPACS”
patients in the State of Washington shall maintain complete treatment records regarding patients treated" (Washington Administrative Code (WAC) section 246-817-310). Furthermore, such treatment records, once compiled and recorded under the above provision, must be maintained in compliance with federal law governing confidentiality of patient records under the Health Insurance Portability and Accountability Act of 1996 (herein referred to as “HIPAA”). Under HIPAA and the SOD’s EHR policy, the obligation to ensure patient confidentiality extends to:

“…electronic exchange [of] financial and administrative transactions [for] health claims or equivalent encounter information; [such as] health claims… healthcare payment[s]… [including] unique health identifiers… [i.e. procedure] codes… for appropriate data elements for […] transactions… [including] audit trails in computerized record systems… (HIPAA Sec.1173 (a) “Standards to Enable Electronic Exchange”).

II. PROVIDER OBLIGATIONS

The following are the requirements adopted by the SOD, concerning the obligation of our providers to compile and maintain proper patient treatment records (regardless of whether the patient visit is considered a paid visit or a no-charge follow-up visit)

A. Faculty – In recording treatment notes, faculty must utilize the SOAP format as stated in the SOD’s Health Information Management Policy, Section 3.1 of the Clinic Policy Manual for Faculty & Staff (herein referred to as Clinic Policy Manual). Notes must be completed, at the end of the treatment day or no later than twenty-four (24) hours following the patient appointment and in anticipation that the patient will be seen by other clinics and specialties for ongoing treatment and/or for revenue cycle purposes. Please refer to the Clinic Policy manual for clarification and structure of SOAP notes. Furthermore, if scanning of patient notes, treatment plans or any other format containing information that cannot be captured in an axiUm form is used, there must be a separate fully structured and formatted SOAP note in the axiUm format within the above-mentioned time frame. In sum, all patient recordkeeping must be properly and promptly recorded in axiUm and/or MiPACS.

B. Affiliate Faculty – Affiliate faculty must adopt the above-described policy utilizing the SOAP format but are required to complete and approve all treatment notes and procedure codes by the end of their assigned clinic session on the same day.

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3 See also RCW § 70.02 (reprinted at www.leg.wa.gov/rcw)
C. **Pre-doctoral, Graduate and Resident Students** – Students engaged in patient clinical activity in a pre-doctoral, graduate, or resident program at the SOD must also follow the patient recordkeeping standards set forth in the Clinic Policy Manual. Students at all levels should complete their notes and input treatment codes by the end of their clinical session on the same day, for faculty approval. It is the student’s responsibility to obtain required faculty approval of their patient chart notes and procedure codes within the twenty-four (24) hour guideline. If a student has been monitored by an affiliate faculty member – he/she must get such notes and procedure codes approved by the end of the session.

D. **All SoD providers – Enforcement of Policy** - Chart notes for Urgent Care Patients in 24 hours and for Routine Treatment at 7 days.

II. TRAINING, COMMUNICATION AND MONITORING

A. Training & Communication

The SOD will reinforce training and support its providers in complying with treatment record requirements by:

1) Creating and providing treatment providers with instructions on axiUm and MiPACS protocols for patient recordkeeping.

2) Creating and providing hands-on training and reference materials for treatment providers on accepted practices of patient recordkeeping.

3) Providing updates and/or refresher training to ensure compliance.

B. Monitoring

Monitoring will occur on two or more levels to quickly identify deficiencies and implement corrective measures before clinical processes interact with the revenue cycle process.

1) “Front-line” verification to ensure that patient recordkeeping is completed and approved for processing through the revenue cycle will be conducted by:
   - Clinic Floor Personnel – prior to the patient and treating provider going to the front desk and/or;
   - Front Desk staff – upon check out with treating provider and/or;
   - Clinic Manager – at the end of a session.
2) axiUm reports will be generated on a weekly basis to ensure continual compliance and as an added layer of checks and balances with respect to:
   - Lack of or missing treatment notes or procedure codes; and/or
   - Unapproved procedure codes and notes; and/or
   - Unacceptable standards or patient recordkeeping in axiUm (i.e. scanning or other form of recordkeeping not consistent with SoD standards)

3) Timely Reporting of infractions: Report on-going deficiencies past seven (7) days but no later than fourteen (14) days to the Associate Dean for Clinics for appropriate action.

III. ENFORCEMENT

A. Warnings

To ensure that the SOD remains in overall compliance with state regulations and licensing obligations, the following corrective actions shall be employed:

1) **First Warning**: Written communication via email and/or letter informing treatment provider and the department; suspension of clinic privileges (including faculty practice activities) if the issue is not corrected within 2 weeks from the time of the procedure. If compliance is met within timeframe, no formal record will be placed in faculty file.

2) **Second Warning**: Elevate infraction to Associate Dean for further action if not mitigated within thirty (30) days. A permanent record of infraction noted in treatment provider’s records; disciplinary action including, but not limited to suspension of faculty practice activities, a “non-meritorious behavior” citation, and further attention regarding performance of the faculty member.

Dean of UW SOD:

[Signature]

Joel Berg, Dean of the UW School of Dentistry

December 21, 2015


**UNIVERSITY OF WASHINGTON**

**SCHOOL OF DENTISTRY**

**Subject:** Emailing Protected Health Information (PHI)

**Policy Number:**

**Effective Date:** December 2015

**Review Dates:**

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**PURPOSE**

To guide faculty, staff, and students on the use of electronic communications with external third parties such as dental/medical clinics, hospitals, and individuals.

**GENERAL POLICY**

The University of Washington School of Dentistry (UWSOD or School) prohibits the e-mailing of protected health information (PHI) to external recipients unless the exchange is encrypted or meets qualifying conditions, detailed below.

**BACKGROUND**

Email is a convenient, effective, and highly popular means of communication between faculty, staff and students at the UW School of Dentistry and external third party organizations and individuals.

Privacy of patient records is protected by state confidentiality law and by HIPAA. The physical and electronic records belong to the School. The Associate Dean of Clinical Services or designee is the official record custodian for the School and Patient Services assigns patients to the appropriate care provider during care and consultation activities.

The electronic communication guidelines outlined in this policy must be followed by anyone at the School that is communicating PHI with a third party or private individual. Failure to follow the policy may result in disciplinary or corrective action.

**IMPLEMENTATION**

I. Definitions

A. *Protected Health Information:* A subset of individually identifiable health information maintained in health records and/or other clinical documentation in
either paper-based or electronic format.

B. Third party organization whose email domain is on UW Medicine’s Approved List. UW Medicine maintains a list of approved email domains that they have verified will support mandatory email encryption with uw.edu addresses. See Appendix A for a list of approved email domains.

C. Third party organization whose email domain is not on UW Medicine’s Approved List. Any third party whose email domain is not on the UW Medicine list of approved email domains. Sharing PHI with such entities may result in a loss of patient privacy.

D. Private Individuals. Any member of the lay or professional public, i.e. patients or their representatives.

II. Communication Technology Components

A. UW SoD Email Service. The email service that is currently in production at the UW School of Dentistry.
B. Secure Messaging. An online messaging service that enables secure transmission of information between a UW School of Dentistry user and a third party.
C. Electronic signature capture. A technology integrated into a workflow to capture electronic signatures from an individual or organization.

III. Usage Guidelines

This policy clarifies the following section of the SoD’s Compliance Handbook, page 11, under the header “Email, which reads: “Emailing PHI: Emailing confidential information, including protected health information (PHI) requires encryption. Confidential information, including PHI may not be sent between UW School of Dentistry workforce members and non-UW School of Dentistry workforce members without special encryption safeguards in place. Please contact IT & Computer Support before engaging in this type of communication.” It is no longer necessary to contact IT & Computer Support provided the user follows the appropriate standard listed below.

A. Communicating with third parties such as private practices, insurers, vendors, or other dental care professionals.

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<th>Statement</th>
<th>Rationale</th>
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<tr>
<td>1.</td>
<td>Email must not be used to communicate any patient information, text, or images, with third party organizations whose domain is not on the UW Medicine approved list.</td>
<td>When sent to most third parties, regular email contents and the attachments are sent in clear text, unencrypted.</td>
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2. Email can be used to communicate securely with any of the approved third party email domains documented by UW Medicine IT Services in their Approved Email Domains list (Appendix A)  
   UW Medicine has confirmed that these documented email domains are safe for sending PHI using email.

3. Patient information/imaging upload portals (e.g. eMix) may be put in place by third party providers for the purpose of sharing patient information. These systems may be used by a SoD department with the approval of a SoD Department Chair, Director of Compliance and Director of IT.  
   When approved, these systems are effective and highly viable alternatives to standard email.

4. For any mail domains not documented as safe by UW Medicine IT Services, email communication with third parties must take place in a HIPAA compliant manner. The UW School of Dentistry will provide a secure messaging solution that can be licensed and installed on a per user basis and used to establish secure messaging channels with third party providers.  
   Secure messaging solutions provided by the School of Dentistry must be used when sending PHI to third parties whose email domain is not on UW Med's Approved List

5. Images containing Patient Information that have been exported from UW SoD PACs systems (e.g. MiPACS, Dolphin, etc.) to a PC or other device for the purposes of emailing or uploading to a third party provider should be deleted as soon as possible after communication has happened.  
   Storing medical images on a PC or other device increases risk.

6. SoD users should not forward their uw.edu email to any third party service (such as Gmail or Hotmail, unless the domain is on the UW Medicine list of approved domains.  
   Consumer email solutions do not adequately protect PHI.

B. Communicating with Private Individuals such as patients

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<th>Statement</th>
<th>Rationale</th>
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<tr>
<td>1.</td>
<td>Secure e-mail communication with</td>
<td>Secure messaging is the safest form</td>
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individuals, either through an encrypted application or between secure domains (as mentioned above) is permitted. of electronic communication. Using your professional judgment, take reasonable steps to confirm the identity of the individual, and keep the amount of information you share to the minimum necessary. Electronically copy and paste exchanges into the patient’s axiUm chart in Treatment Notes.

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<th>2.</th>
<th>In cases where you or the individual initiate e-mail contact to discuss details related to their care, include the following language to warn the patient that e-mail over the internet is not secure, then note this in the patient’s axiUm record. Include the following language under your signature in any e-mail you send to patients:</th>
</tr>
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</table>
| “The above email may contain patient identifiable or confidential information. Because email is not secure, please be aware of associated risks of email transmission. If you are a patient, communicating to a UW School of Dentistry provider via email implies your agreement to email communication.

The information is intended for the individual named above. If you are not the intended recipient, any disclosure, copying, distribution or use of the contents of this information is prohibited. Please notify the sender by reply email, and then destroy all copies of the message and any attachments. See our Notice of Privacy Practices at [https://dental.washington.edu/wp-content/media/compliance/SoDPrivacyPractices.pdf](https://dental.washington.edu/wp-content/media/compliance/SoDPrivacyPractices.pdf).” |

| 3. | Clear statements regarding the risks of email and the option to capture electronic or paper-based consent must be readily available on the SoD website and at each patient clinic. | Consistency of experience |
Appendices:

Appendix A, UW Medicine Approved Email Domains
Appendix B, HIPAA guidelines re emailing Patients

Dean of UW SoD:

Joel Berg, Dean of the UW School of Dentistry

December 21, 2015
APPENDIX A
UW Medicine Approved Email Domains

The list is regularly updated and can be viewed here: http://security.uwmedicine.org/guidance/technical/electronic_comm/email/approved_list.asp
APPENDIX B
HIPAA Guidelines re emailing patients

http://www.hhs.gov/ocr/privacy/hipaa/faq/health_information_technology/570.html
UNIVERSITY OF WASHINGTON
SCHOOL OF DENTISTRY

Subject: Scanning and Storing Electronic Documents in the Patient Record
Policy Number:
Effective Date: September 2016
Revision Dates:

PURPOSE

To define the procedures and requirements for correctly scanning hardcopy documents into the patient health record in axiUm.

Creating an electronic record retention system for the patient health record improves operating efficiencies, reduces waste, and minimalizes physical storage space.

GENERAL POLICY

All School of Dentistry clinics and departments are no longer required to archive paper copies of documents scanned into the patient health record in axiUm. Scans produced following the UW Scanning Requirements outlined in this policy can legally take the place of paper records. Once properly scanned, paper records can then be destroyed.

Scanning or imaging is the process by which paper documents are copied and saved as digital images. These digital images or electronic records are saved as PDF (Portable Document Format) files only in axiUm. A list of Records Applicable for Electronic Scanning is found in Appendix A.

Scanning paper records does not automatically authorize the destruction of the source documents from which the scanned images have been created. When it is not possible to create a readable scanned image, the original paper document must be kept and UW records retention policies must be adhered to.
IMPLEMENTATION

I. Procedures

A. Technical Scanning Requirements

The requirements which follow are based on the UW Scanning Requirements. These requirements must be fully met to justify the use of scanned images as replacements for the original paper records.

1. Formats and Scanning Densities

Black and white, gray, and color paper records can be scanned. Any kind of record can be scanned including color text documents, photographs, and maps, plans, and engineering drawings.

a) Scanners must be set at a minimum of 300 dpi (dots per inch)
b) Scanned records must be saved as PDF only

2. Quality Control

Like all electronic records, scanned files must be accessible and readable for their full retention period. This includes finding the file, opening the file, and reading the file regardless of the software used in its creation.

Scanned document images must be inspected visually to ensure they are complete, clear, and easily read.

a) Scanned records must be compared to the original paper document to ensure accuracy
b) The number of original paper documents must be compared to the number of scanned records to ensure that every document was scanned

3. Image Enhancement

There are times where there is a problem with the final scanned image that makes it difficult to read and less than usable. If the scanned document is to replace the original paper record, these common problems must be corrected:

- Speckles or spots on the scanned image
  - Clean the glass on the scanner and rescan the paper
- Skewed images that are not properly aligned
  - Rescan the paper so that the image appears straight
All portrait orientation pages should be rotated to read from left to right
All landscape orientation pages should be rotated with the top of the page facing the left
• If only part of the document is captured by the scanner
  o Rescan the paper so it is properly aligned and the entire page is included in the scanned image
• If the scanned record is of poor quality and is not clearly readable
  o Reset the dpi (dots per inch) setting on the scanner to a setting higher than 300 dpi and scan again
  o Keep increasing the dpi until the record is as readable as possible
• If the condition of the original paper record precludes a good quality scanned image from being produced
  o Document the problem on the scanned record and indicate that the paper copy has been maintained and where it is located
  o The Clinic or the department will keep both the scanned record and the paper copy of the records that did not scan well

4. Filing Scanned Records

The School of Dentistry has daily incremental backups of data stored onto its servers. If a file is deleted or moved, the school’s system administrator can retrieve those backups up to 60 days from deletion. If a file is changed, up to 6 previous versions are retained for 45 days.

5. Procedure for Scanning Documents

All documents will be scanned according to a standard procedure to ensure documents are scanned into the correct patient record.

• Select appropriate patient name, date of birth or record number in axiUm using the rolodex module
• Correct patient name must appear on the bottom of the screen before starting the scanning process
• Under the Electronic Health Record module, select ‘attachments’ and under the ‘section’ tab select the appropriate clinic or department and select ‘images’ for radiographs
• Select ‘Create New Record’ and add the ‘Description’ which will include type of document and date of document
• Attach the scanned document by clicking on the ellipsis and select ‘OK’
• Confirm that the document has been appropriately scanned into axiUm
6. Modifying Scanned Records

It is important to ensure that the original content of a scanned record is not altered or modified once it has been finalized. Scanned records should be “read only” to ensure that there is no improper alteration or modification.

7. Computer Security Standards

Ensure that the unit I-drive folder where files will be stored is a secure folder only available to those who need access to the records stored there. It is critical that managers promptly notify sodit@uw.edu when an employee separates from their unit, so access capabilities can be removed.

All incidents of potential HIPAA Privacy and Security breaches should be reported immediately to the unit supervisor and the School of Dentistry Compliance Director. In addition, the Compliance Director should report the following Security breaches immediately to the appropriate authorities:

- Incidents involving national security information or national security systems to the University Facility Security Officer at 206-543-1315 or uwfso@uw.edu
- Incidents involving protected health information to the Executive Director of Health Sciences Administration
- Incidents unrelated to national security information, national security systems, or protected health information to the Office of the University Chief Information Security Officer (CISO)

8. Record Filing and Identification

Files containing scanned documents subject to the retention requirements of this policy will be stored only on approved network storage, which is located on the “\sod\files (T:)” drive. A folder for each department will be established on this drive and will contain Individual folders for each fiscal year (for example FY2015-2016), and each fiscal year file will be composed of monthly folders. Once a document is scanned it will be placed in the appropriate fiscal year and month files with the appropriate title, date, and patient name and record number.

9. Retention Requirements of Scanned Record
All records have a specific amount of time they must be maintained. This specific amount of time is called a “retention period.” Retention periods are based on the content of a record. Retention periods are found in the “University General Records Retention Schedule.” Retention periods included in UW General Records Retention Schedule apply to all records regardless of their physical form or characteristics.

- The paper record can be destroyed after it is scanned according to the technical requirements outlined in this document
- The retention period which would have been applied to the paper record must instead be applied to the scanned record in axiUm
- When it is not possible to create a readable scanned image, the School of Dentistry will keep the original paper document for the full retention period

10. Records Retention Process

An audit to identify and approve the deletion of records that have reached the end of their retention period will be conducted during the summer quarter annually by the Records Department. A report will be run through axiUm that lists patient records that have reached their retention period. Records cannot be deleted until the records retention schedule has been met and the department manager has approved their deletion. The staff person in the Records Department will delete the records and place a list of those records in the “Deleted Records” file.

11. Migration and Preservation Strategies

Patient Records from axiUm are stored on an Oracle database. Oracle has been the leader in database software and the School has the ability to migrate data to and from the Oracle database.

12. Scanned Documents Storage and Backup Policy

Network storage containing these scanned documents will be included in the department’s backup schedule for business-critical data. The School of Dentistry servers are backed up every business day by UWIT, who then stores the back-up data in two separate data centers, each in a different seismic zone.

**Appendices:** Appendix A, Clinical Records Applicable for Electronic Scanning
Dean of UW SOD:

[Signature]

Joel Berg, Dean of the UW School of Dentistry

October 13, 2016

Date
Appendix A
Clinical Records Applicable for Electronic Scanning

- Anesthesia/sedation logs
- Authorization to release PHI
- Chart Notes from Outside Clinic
- Fee waivers
- Insurance Cards
- Insurance Correspondence
- Insurance Explanation of Benefits
- Lab Prescriptions
- Lab Results
- Legal Correspondence
- Medicaid “Agreement to Pay” forms
- Medicare Advance Beneficiary Notices
- Patient Correspondence
- Patient Diaries
- Patient Identification
- Periodontal Charting from Outside Clinic
- Pictures of Patient
- Pre-Authorization
- Pre-Determination
- Referrals from Outside Clinic
- Treatment Correspondence
- X-rays from Outside Clinic
UNIVERSITY OF WASHINGTON
SCHOOL OF DENTISTRY

Subject: Antibiotic Prophylaxis for Joint Prostheses Infection

Purpose

To protect patients who are at risk for the development of prosthetic joint infection subsequent to dentally-induced bacteremias.

General Policy

The University of Washington School of Dentistry adopts the current recommendations of the American Academy of Orthopaedic Surgeons (AAOS) and the American Dental Association (ADA) for the prevention of prosthetic joint infection. This policy will automatically adopt any updated guidelines of the ADA and consider the guidelines of the AAOS when they are published.

Implementation

I. Patients who are at risk for prosthetic joint infection shall be treated using the current AAOS and ADA guidelines for the prevention of prosthetic joint infection unless a significant medical reason documented by the patient’s physician or health care provider (including the attending dentist) exists for deviating from this policy.

Previously in patients with joint prosthesis, AAOS recommended antibiotic prophylaxis but the AAOS recently changed their recommendations to be in line with the ADA. The practice of giving patient’s antibiotics prior to a dental procedure is NOT recommended EXCEPT for patients with the highest risk of adverse outcomes, such as those with a history of prosthetic infections, active, known diabetics, those with an HbA1c above 8.0/blood glucose > 200, or immunocompromising medical conditions (see “Indication Profile” on next page.)

See: AAOS: http://www.orthoguidelines.org/guideline-detail?id=1021
II. Primary regimes for dental procedures are listed in an online decision support application:

http://www.orthoguidelines.org/go/auc/default.cfm?auc_id=224995&actionxm=Terms

Reference:

PURPOSE

The Procedural Sedation Policy of the School of Dentistry is intended to support the safe and effective management of fear or anxiety associated with dental therapy. The goal of this policy is to provide the benefit of mild or moderate sedation to the dental patient with minimal risk of complications.

GENERAL POLICY

The use of medications and techniques to relieve pain and anxiety is an established and integral part of dental practice. The dental students and graduate students of the School of Dentistry not only administer local anesthesia but also use various inhalation, enteral, and parenteral agents to alleviate the fear and anxiety associated with dental treatment. Washington State Law establishes standards for the safe administration of sedative agents that the School of Dentistry policy meets or exceeds. Washington State Law defines Minimal sedation as a “drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected. Minimal sedation is limited to oral or intramuscular medications, or both.” Moderate Sedation “means a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

The School of Dentistry’s Procedural Sedation Policy should be considered to be the minimum standard within the school and its affiliated clinics. Clinicians must use appropriate physiological monitors or emergency equipment and medications to prevent or manage sedation-related complications and emergencies.

IMPLEMENTATION

I. Nitrous Oxide/Oxygen Sedation Alone or with One Oral Agent
A. Authorization

1. The student must have successfully completed the didactic courses of instruction in nitrous oxide/oxygen sedation before administering nitrous oxide. A faculty member who has completed a course containing a minimum of 14 hours of either predoctoral dental school or postgraduate education must supervise administration of nitrous oxide sedation by the student. Both the student and the supervising faculty must have current certification in Basic Life Support.

2. The student and supervising faculty member must review the current medical status and anxiety of the patient before making any decisions about whether nitrous oxide/oxygen sedation is indicated. If the patient or their guardian provides consents to receiving nitrous oxide/oxygen sedation, the supervising faculty member must certify that the student may obtain the equipment necessary to administer the nitrous oxide/oxygen sedation.

B. Administration of nitrous oxide

1. Before each administration of nitrous oxide/oxygen sedation, the analgesia machine is to be inspected. This inspection should minimally include checking the hoses and reservoir bag for leaks, making sure the gas cylinders contain enough gas to complete the proposed dental treatment, that all connections on the machine are tight and not leaking, and that the appropriate scavenging device is properly attached and in working order.

2. The patient must be continuously observed while nitrous oxide/oxygen sedation is administered. The patient’s blood pressure, heart rate and respiratory rate must be taken immediately before administering nitrous oxide/oxygen sedation and just before dismissing the patient at the end of the procedure when he/she has recovered from the sedation. For young children, it may not be possible to get an accurate blood pressure and then the clinician should document the reason for not obtaining it. If there are any adverse reactions, the vital signs (blood pressure, heart rate, and respiratory rate) must be measured and recorded as indicated.

3. Following the completion of nitrous oxide/oxygen sedation, the patient must breathe 100% oxygen for at least 5 minutes. The patient should be allowed to recover an additional 5 minutes following the administration of 100% oxygen. The patient can be released when he/she feels fully recovered and the post-sedation vital signs are within the patient’s normal range.
4. The Dean of Clinical Affairs or the Department Chairperson responsible for a clinic must identify and maintain a secure area(s) for the storage of equipment used for administering nitrous oxide/oxygen sedation (e.g., analgesia machine, compressed gas cylinders). Restricted access to this area is intended to prevent misuse of the equipment and accidents. The analgesia machine and associated equipment must be routinely inspected by the Office of Environmental Health and Safety for malfunctions and leaks.

5. After discharging the patient, the nitrous/oxide equipment must be returned to a secure area with restricted access. The analgesia machine hoses must be disinfected using standard methods established by the School of Dentistry after each patient use, and the disposable nosepieces discarded. If using reusable nosepieces (Proter), the inner piece should be processed through sterilization and the outer piece should be thoroughly wiped down with disinfectant.

6. The dental chart must contain a note documenting the duration of the sedation and concentration of the nitrous oxide that was used. In addition the patient's vital signs before the administration of nitrous oxide/oxygen sedation and before discharge must be recorded in the chart. Any adverse reaction to the nitrous oxide must also be documented in the patient's chart, including a description of the reaction, the actions taken to treat the reaction, and the outcome of the reaction and its treatment.

7. If the faculty member supervising sedation approves the concomitant use of a single enteral sedative with nitrous oxide/oxygen sedation, the patient must be given a prescription for the enteral medication and obtain it from a pharmacy. The medication should be administered by the clinician prior to the patient’s appointment. This is true for both adults and children. A patient who is administered an enteral sedative in preparation for dental treatment must be accompanied to and from the dental school clinic by a responsible adult. The patient must also be informed that he/she should not operate hazardous equipment or motorized vehicles (e.g., automobile), nor make important decisions for the 24 hour period that follows their taking the enteral sedative. The sedative and the dose prescribed needs to be recorded in the chart, as well as the time the patient takes the sedative and the duration and concentration of nitrous oxide. The name of the patient’s escort needs to also be recorded in the chart. Similar to the chart notations required for nitrous oxide/oxygen sedation described in #6, pre- and post-sedation vital signs need to be measured and recorded in the chart when single enteral sedatives are taken alone or with nitrous oxide and oxygen. Unwanted side effects and/or reactions need to also be documented in the patient’s chart as well as how they were managed and their resolution.
II. Moderate sedation with multiple oral or parenteral agents

A. Authorization

1. The student must have successfully completed the didactic courses of instruction in nitrous oxide/oxygen sedation and sedation with multiple enteral and parenteral agents before administering this type of sedation. The administration of such sedation may occur only under the supervision of a faculty member who has been issued a valid permit for Moderate Sedation with Parenteral or Multiple Oral Agents and/or General Anesthesia/Deep Sedation by the State of Washington.

2. The supervising faculty member must have a valid license to practice dentistry in the State of Washington and a permit from the federal Drug Enforcement Administration (DEA). The Department Chairs must submit a list of the faculty who are qualified to sedate patients to the Dean and Associate Dean of Clinical Affairs.

3. The student, staff, and supervising faculty member must be certified in Basic Life Support and Advanced Life Support or Pediatric Advanced Life Support.

B. Administration of sedation with multiple enteral or parenteral agents.

1. The student and supervising faculty member must review the patient's current medical status and anxiety to determine if sedation with multiple enteral or parenteral agents is appropriate. The student and faculty should confirm the NPO status of the patient prior to administering medications. Following evaluation of the patient, written consent for sedation must be obtained and a signed copy placed in the patient's chart. After consent and permission of the supervising faculty member are obtained, the student may obtain the appropriate sedative medications. The student administering the medication must be continuously assisted by at least one individual experienced in physiological monitoring of sedated patients. The physiological monitoring includes continual measuring of heart rate, respiratory rate, blood pressure, and hemoglobin saturation. The hemoglobin saturation is to be monitored with a pulse oximeter during sedation. Continuous monitoring of the heart’s electrical activity with an electrocardiograph is recommended but not required. Heart rate, respiratory rate, blood pressure, and hemoglobin saturation must be measured and recorded immediately before and after the procedure, as well as at appropriate (5 or 10 minute) intervals throughout the procedure. Vital signs and level of consciousness must be measured and recorded prior to patient dismissal.
2. A patient who is administered sedation with multiple enteral or parenteral agents for dental treatment must be accompanied to and from the dental school clinic by a responsible adult. The patient must also be informed that he/she should not operate hazardous equipment or motorized vehicles (e.g., automobile), nor make important decisions for the 24 hour period that follows their taking the enteral sedative. The name of the patient’s escort needs to be recorded in the chart. Pre- and post-sedation vital signs need to be measured and recorded in the chart when single enteral sedatives are taken alone or with nitrous oxide and oxygen. Unwanted side effects and/or reactions need to also be documented in the patient’s chart as well as how they were managed and their resolution.

3. Patients will be given a prescription to obtain oral medications from a pharmacy. Parenteral medications must be kept in a secure area within the School of Dentistry. Clinic personnel will dispense these medications after receiving authorization from the supervising faculty member.

4. The dosage and forms of medication dispensed must be noted and recorded in the patient's chart. The level of consciousness and the name of the patient's escort must be recorded prior to the dismissal of the patient.

5. Procedures for storage and disposition of controlled substances must follow the guidelines established by the federal Drug Enforcement Administration. The Associate Dean of Clinical Affairs and/or the Chairs of the appropriate departments must identify the secure areas and personnel that will maintain and dispense the controlled substances.

6. In addition to the suction capable of aspirating gastric contents from the mouth and pharynx, portable oxygen delivery system with face masks and a bag-valve-mask combination with appropriate connectors capable of delivering positive pressure, oxygen-enriched patient ventilation, oral and pharyngeal airway of appropriate size, a pulse oximeter, and sphygmomanometer and stethoscope, an emergency drug kit must be available for response to adverse effects. The kits may contain any emergency drugs that the supervising faculty require but must contain the following: sterile needles, syringes, tourniquet, narcotic antagonist, alpha and beta adrenergic stimulants, vasopressor, coronary vasodilator, antihistamine, parasympatholytic agent, intravenous fluids, tubing and infusion set, and antagonists for any sedatives that are used. Any adverse reactions must be documented in the patients chart and must include a description of the reaction, actions taken to treat the reaction, and outcome of the treatment.
Dean of UW SOD:

Joel Berg, Dean of the UW School of Dentistry

October 24, 2016
UNIVERSITY OF WASHINGTON
SCHOOL OF DENTISTRY

Subject: Fitness to Participate in Patient Care

Policy Number:

Effective Date: January 1990


PURPOSE

To establish fitness guidelines for dental health care workers such as students, faculty, and clinical staff to participate in the patient care process in a manner that is safe for the patient and meets the standard of care of the University and the dental profession.

GENERAL POLICY

The University of Washington School of Dentistry requires that students, faculty, and clinical staff are physically and mentally fit to participate in the patient care process. Dental health care workers must abide by the basic principle of "first do no harm." It is therefore the duty of the school to remove clinic privileges from such workers who are afflicted with a contagious disease, or are impaired by either physical or mental handicap; by side effects of medical therapy, addictive substances, or other agents which may impair the judgment and/or psychomotor skills required to perform clinical services.

IMPLEMENTATION

I. Duty

A. The Dental Health Care Provider

It is the duty of a dental health care provider not to participate in the patient care process if he/she is impaired in such a manner that would jeopardize the health and safety of the patient and other workers. Anyone who does participate in the patient care process must perform to the standard of care for both the management of the patient and actual services rendered. Such standards have been established by the School of Dentistry and the dental profession.

B. Supervisional Faculty and Staff
It is the duty of supervisional faculty and staff to counsel dental health care workers under their supervision when appropriate as to their fitness to participate in patient care (see Appendix A). It is also the duty of such supervisors to inform the Associate Dean for Clinical Services (or designee) of possible breaches of duty by participants in the patient care process. Documentation of such reporting will utilize the SOD Event Reporting system.

II. Breach of Duty

A dental health care worker who breaches this duty may have clinic privileges either suspended or revoked immediately by the Associate Dean for Clinical Services (or designee). The re-establishment of clinic privileges is subject to the review of the recommendation of the worker's physician and approval by the Associate Dean of Clinics and/or the Dean.

III. Confidentiality

All proceedings dealing with the revocation or suspension of clinic privileges of a dental health care worker will be conducted with the highest level of confidentiality.

Appendices:

Appendix A, Guidelines for the Removal of Clinic Privileges from a Dental Health Care Worker

Dean of UW SOD:

Joel Berg, Dean of the UW School of Dentistry  Date
APPENDIX A

Guidelines for the Removal of Clinic Privileges from a Dental Health Care Worker

I. Dental Health Care Worker

A dental health care worker is any employee or student who comes in direct contact with the dental patient or any instruments, supplies, intraoral equipment, or devices used in the treatment process. Such persons include students, faculty, clinical staff, dispensary staff, sterilization personnel, and laboratory technicians.

II. Contagious Disease

The dental health care worker is expected to avoid patient care during contagious stages of infectious conditions. Such conditions may include:

1. Colds
2. Influenza
3. Measles
4. Hepatitis (all types)
5. HIV
6. CMV (Cephalomegalovirus)
7. Infectious skin lesions
8. MRSA or other highly contagious diseases

If the worker is in doubt as to whether he/she is contagious, standard barrier techniques should be utilized until a medical diagnosis can be obtained. The Associate Dean for Clinical Services has the authority to suspend clinic privileges of any worker and to request a medical clearance from the worker's physician to resume clinical activities.

III. Physical and/or Mental Impairment

Dental health care workers must be able to render care in a safe manner which meets the standard of care of the school and the dental profession. In the event that the worker is unable to perform to such standards, then clinic privileges will be either revoked or suspended. Such conditions which may cause such impairment may include, but not limited to:

1. Physical handicap that cannot be accommodated
2. Mental handicap
3. Alcohol abuse
4. Side effects of medical treatment
5. Drug abuse
UNIVERSITY OF WASHINGTON
SCHOOL OF DENTISTRY

Subject: Hazard Control

Policy Number:

Effective Date: July 1994


PURPOSE

To provide policy for control of all hazards to patients, students, residents, staff, and faculty who are at the University of Washington School of Dentistry.

GENERAL POLICY

All activities for patient care, research, and instruction in the School of Dentistry are to be conducted safely and consistent with University of Washington Policies and procedures as stipulated in the Laboratory Safety Manual, Biohazards Safety Manual, and Radiation Safety Manual, in standards stated in the Washington Industrial Safety and Health Act (WISHA), in the "Recommended Infection-Control Practices for Dentistry," as published in the Morbidity and Mortality Weekly Report (MMWR) of the US Public Health Service Centers for Disease Control (CDC), and in rules and regulations of the Occupational Safety and Health Administration (OSHA), most recent revisions.

IMPLEMENTATION

I. Responsibility

Responsibility for hazard avoidance and protection activities rests with the Dean, and by delegation, with the Associate Dean of Clinical Services, Director of Clinic Operations, and the Director of Health & Safety. All students and workforce are expected to participate directly in assuring that safe working conditions for patient care, instruction and research are maintained and are required to comply with occupational and safety regulations which apply to their own actions and conduct. They are responsible for reporting accidents, injuries, incidents, and unsafe conditions to their supervisor and/or instructor. The School embraces a culture of...
safety and supports a concept of ‘See Something, Say Something’ by reporting concerns to a supervisor or the Director of Health & Safety.

II. Organization

School of Dentistry hazard prevention, control, and related activities will be managed by the Health and Safety Committee. This committee will report to the Associate Dean of Clinical Services or his/her designee and is responsible for coordinating hazard prevention, control, training and other activities between School of Dentistry academic departments, research laboratories, and clinical programs, including patient care clinics and clinical support laboratories, radiology, and related programs. The Director of Health & Safety will serve as liaison between the School of Dentistry and the Department of Environmental Health and Safety of the University of Washington. The Director will be responsible for assembling and maintaining current information regarding all University, State, and Federal regulations about hazards control and hazards avoidance.

III. Health and Safety Committee

The Director of Health and Safety will Chair the Health and Safety Committee and serve as the appointed member of the University’s Group 4 Safety Committee. The safety committee’s review will span the full range of hazards matters, including but not limited to infection control and asepsis, chemical (pharmaceutical, anesthetic, and hazardous materials), radiological and biological safety, waste disposal, safety orientation, education and training, work site and environmental safety, accident/incident reporting, emergency notification and services, and occupational health requirements.

It will also seek advice and information from the University of Washington Department of Environmental Health and Safety and such other resources as it may consider appropriate.

The Health and Safety Committee will function within the scope of a charge to be approved by the Dean. Charge will include but not be limited to the following mandates:

- In consultation with the Department of Environmental Health and Safety, the Committee will conduct an annual review and report to the Associate Dean of Clinic Services on the School’s compliance with all regulations regarding hazards in the workplace, including those associated with patient care.

- Recommend policy proposals and safety protocols to the Dean.

- Prepare reports as requested by the Dean.
• Respond to requests for data to support compliance with accreditation standards.

Its membership will consist of representatives from administrative unit, research laboratories, clinical services, and clinical faculty. Guests from the Department of Environmental Health and Safety attend as guests and content experts of the Committee. When additional expertise is required, the Chair may appoint additional members who may serve on the Committee for a limited period of time. The Health and Safety Committee will meet at least once per academic quarter.

IV. Infection Control

Infection control, like all health/safety matters is a universally shared responsibility for everyone in the School of Dentistry, who is involved in patient care and research.

Accordingly, the Associate Dean for Clinical Services will be responsible for the safe operation of all clinical areas and associated support services, including clinical laboratories.

In discharging this responsibility, the Associate Dean for Clinical Services will prepare specific rules for appropriate acquisition, use, and disposal of all clinical supplies and materials, for appropriate and safe dress, arrangement, cleanliness, and waste disposal in the dental operatory and dental laboratory, and for safe practice of clinical dental and dental laboratory procedures. These specific rules will incorporate recommendations of the Health and Safety Committee and the Department of Environmental Health and Safety, which have been approved by the Dean.

The Blood borne Pathogens and Hazard Communication manuals describe these standards and be posted on the SOD website. As a standard School of Dentistry reference, this document will be available to every department, research laboratory, dispensary, every dental laboratory, and be maintained on the School of Dentistry’s website (https://dental.washington.edu/health-and-safety/). This process will assure that all elements of clinical hazards control are being taught to students so they may be safe practitioners, not only in the clinics and dental laboratories of the School of Dentistry, but also when they enter into dental practice.

Principal investigators and their department chairs will be responsible for safe operation of their respective research laboratories and research facilities. Principal Investigators will be guided by rules and guidelines found in the University Laboratory Safety Manual (http://www.ehs.washington.edu/manuals/fsm/), the Biohazard Safety Manual, https://www.ehs.washington.edu/rbsbiosafe/bsmanualindex.shtm, and the Radiation Safety Manual (https://www.ehs.washington.edu/manuals/rsmanual/) of
the University of Washington, and such other related rules and regulations as may apply.

Dean of UW SOD:

[Signature]

Joel Berg, Dean of the UW School of Dentistry  February 2, 2016
American Dental Association (ADA) standard 6.1.3 requires that "all tissues removed are subjected to gross and/or microscopic examinations with findings noted in the patient’s record."

GENERAL POLICY

In keeping with the ADA standard 6.1.3, all tissue removed anywhere within the University of Washington School of Dentistry must be sent to the Oral Pathology Biopsy Service (OPBS) for examination. Exemptions from this policy are listed below (see Implementation, Section II A.). It is up to the discretion of the attending pathologist to determine if the tissue will be examined “gross only” or “gross combined with histopathologic examination.” By far, the majority of the cases fall in the latter category. On rare occasions, specimens are submitted to other laboratories for specialized studies. However, all non-exempt tissues removed within the University of Washington, School of Dentistry (UW SOD) must be accessioned and submitted for histopathologic examination. A record of exempted tissue (gross only) will be dictated by the attending pathologist and kept on file in the office of the OPBS.

IMPLEMENTATION

I. Specimen Handling

All tissues removed from patients within different clinics including the Emergency Clinics and Hospital Dentistry, regardless of the site of removal of the tissue, should have an Oral Pathology laboratory request form accompanying the specimen (see Appendix A). This may be completed by a dental student, resident, attending faculty, or dental assistant assisting in the procedure.

The dentist removing the specimen will provide the following pertinent information, which includes:

1. Patient: His/her address, phone number
2. Patient's: Age, sex, and race
3. Specimen: Location, clinical presentation, risk factors
4. Procedure performed
5. Provisional/preoperative diagnosis
6. Dentist/physician’s name, address and phone number

It is imperative that the patient's full name, the site of the specimen, the attending’s full name and the date of removal of the specimen be accurate and clearly recorded on this form. The specimen should be placed into a container with 10% buffered formalin (standard fixative) labelled with patient's name. Other fixatives are required for special studies such as immunofluorescence studies in which case the specimen should be placed in a special transport medium known as Michel's solution. The specimen along with the Oral Pathology laboratory request form is taken to the OPBS office located in Room B202 for prompt processing. When unusual studies are necessary, special handling and fixation of the specimen may be arranged through the OPBS office staff or with the attending Oral Pathologist by calling 543-4440.

The final signed written report of the diagnosis is usually available within 24 hours of the time of receipt of the specimen (weekends excluded). If special studies or unusual handling of the specimen are required, a provisional diagnosis can usually be obtained verbally within 24 hours of the receipt with the exception of tissue that requires decalcification.

Patients will be informed that there will be a separate charge for these pathology services. Such services would be included in the treatment plan when appropriate.

II. Specimen Categorization

A. List of Tissues Exempted from Accessioning in the OPBS:

Note: The removal of such tissues and their disposition must be documented in the patient’s chart.

1. Periodontal tissue specimens from patients clinically diagnosed with periodontal disease. All tissues removed during periodontal procedures showing signs of pathology other than periodontal inflammation are to be submitted for gross and/or microscopic examination.

2. Dental devices such as implants, etc.

3. Foreign body, unless the dentist requests an identification

4. Teeth
5. Tissues and organs for transplantation, including bone submitted to the bone bank

6. Portions of bone and other tissues removed for access to an operative field

7. Dental pulp tissue

B. Tissues for Gross Examination Only

1. Oral soft tissue or bone from plastic and/or reconstructive procedures, other than those performed for malignant neoplasms

2. Teeth, at the dentist's or patient's request

3. Foreign body, at the dentist's or patient's request

4. Portions of bone removed for traumatic fracture

III. Review of Outside Slides for Patients Referred for Treatment to UWSOD:

The OPBS strongly recommends that outside slides for patients referred to the UWSOD for definitive therapy is reviewed by an oral pathologist within the UWSOD. The purpose of this policy is to provide the attending clinicians at the UWSOD with a consistently high standard of care by minimizing the possibility of misdiagnosis or misinterpretation. This recommendation helps maintain a classification and grading system known to UWSOD faculty so that a familiar and reliable basis for management is maintained. The policy for review of outside pathology slides on patients referred here for definitive treatment is as follows:

A. The outside pathology slides on which the patient's diagnosis was based should be formally reviewed by a UWSOD oral pathologist and a formal written report be generated and included in the patient's chart before treatment is administered at the UWSOD.

B. If the pathology slides were reviewed by a pathologist within the University of Washington, School of Medicine (UWSOM) & Medical Center system, the necessity for a second review by an oral pathologist at the UWSOD can by waived but it is recommended that the slides be informally reviewed by a UWSOD oral pathologist. If the oral pathologist disagrees with the diagnosis rendered by the UW SOM pathologist, a formal report should be generated and included in the patient’s chart. If in agreement, the patient’s chart should contain a preoperative note from the UWSOD attending explaining the mechanism that is being invoked.
C. In addition, outside pathology slides can be reviewed by the OPBS pathologist on any patient referred to the UWSOD for consultation or treatment at the request of the attending dentist.

IV. Report Management

Pathology reports must be filed in the patient's dental record and in the Division of Oral Pathology. The following should be expected from each pathology report:

A. Each tissue specimen should generate a dated and signed report. The report becomes part of the patient's record.

B. If a specific test is performed in a referred laboratory, the name of the laboratory performing the test is included in the report. If this laboratory generates its own report separate from that of the OPBS, an original copy will be attached to the Oral Pathology report. Both reports will be part of the patient's record. A copy of the reference laboratory report will be kept in the OPBS Office.

C. The oral pathologist signing the report is responsible for the diagnosis and microscopic description of the specimen.

D. Diagnoses made from specimens are expressed in acceptable terminology of a recognized disease nomenclature and are coded for retrieval.

E. In all cases, a certain degree of microscopic description is recorded.

V. Disposal of Human Tissue

The tissue received by the OPBS is usually fixed in a 10% buffered formalin. Most of the specimens are paraffin embedded and stored as blocks for as long as possible. Certain tissues such as teeth are fixed (if submitted unfixed), saved for approximately three months and then drained of fixative, double bagged and carried to the autopsy room at the Division of Surgical Pathology, School of Medicine to be incinerated.

Dean of UW SOD:

________________________________________________________________________
Joel Berg, Dean of the UW School of Dentistry  Date
UNIVERSITY OF WASHINGTON
SCHOOL OF DENTISTRY

Subject: Ill or Compromised Patient Dismissal

Policy Number:

Effective Date: January 1994


PURPOSE:

To minimize the possibility of harm to University of Washington School of Dentistry patients who may be compromised due to illness, chronic conditions, medication or other substances during dental appointments and to protect staff, faculty and other patients from communicable diseases and other transmittable conditions.

GENERAL POLICY:

Patients who display signs of illness or other communicable conditions during a dental appointment will be assessed by supervising faculty who will determine whether or not dismissal from the appointment or other action such as termination of care is necessary. Termination of care recommendations shall be made with faculty approval. If patients report or display signs of illness, communicable conditions, or appear otherwise compromised in a student clinic, the assigned student will request a patient evaluation from a faculty member.

PROCEDURE:

Illnesses and Chronic Conditions

1. If a patient reports or displays signs of illness, the supervising faculty member will determine if the patient should be dismissed and if any precautions should be taken following the appointment (driving restrictions, physician's assessment, post-operative instruction, etc.).

2. The person listed in the patient's registration as “emergency contact” will be notified if deemed necessary by faculty evaluation.

3. The School will assist in arranging transportation for the patient if the patient is too ill to leave on his/her own and emergency contact is not available.
Parasites
The transmission of parasites generally occurs in close contact with an infested individual and/or infested clothing. The risk of transmission to those in the general vicinity of an infested individual or his/her clothing without close contact is very low.

1. If a patient displays signs of parasitic conditions such as lice, mites (including scabies) or ticks, the supervising faculty member will remove the patient from clinic.

2. The area will be wiped down with disinfectant before the clinical space is used again. (A thorough cleaning of the area where parasites were discovered and where an infested personal sat or where infested clothing lay works best.)

3. Contact Employee Health at 685-1026 with specific health concerns regarding a situation.

Compromised Due to Medication or Other Substance

1. If a patient displays signs of being compromised due to medication or other substance, the supervising faculty member will determine if the patient should be dismissed and if any precautions should be taken following the appointment (driving restrictions, physician's assessment, etc.).

2. The person listed in the patient’s registration as “emergency contact” will be notified if deemed necessary by faculty evaluation.

3. The School will assist in arranging transportation for the patient if the patient is too compromised to leave on his/her own and emergency contact is not available.

Dean of UW SOD:

Joel Berg, Dean of the UW School of Dentistry

February 2, 2016
UNIVERSITY OF WASHINGTON
SCHOOL OF DENTISTRY

Subject: Infection Control

Policy Number:

Effective Date: March 1992


PURPOSE

To provide policy regarding infection control which is designed to minimize biohazard risks to patients, students, residents, staff, and faculty who are associated with dental care and dental research at the University of Washington School of Dentistry.

GENERAL POLICY

All patient care, laboratory procedures and equipment management in the School of Dentistry is to be carried out in an environment and with techniques consistent with guidelines set forth by the US Public Health Service Centers for Disease Control (CDC), the Occupational Safety and Health Administration (OSHA), the Washington Industrial Safety and Health Act (WISHA), as well as state and local regulatory boards.

It is the policy of the University of Washington School of Dentistry that all students, faculty, and staff care for patients within their level of competence without regard to infectious disease status when it is appropriate to do so. Specific strategies for treatment of individuals with an infectious disease should be discussed with the supervising faculty member prior to treatment. (Refer to Treating Patients with Highly Infectious Diseases policy.)

Affiliated clinics are expected to comply with federal, state, and local regulations relating to infection control when university students are participating in their clinic or laboratory programs.

IMPLEMENTATION

The infection control policy along with the companion manual entitled, Blood Borne Pathogens Manual, (herein referred to as “BBPManual”) are designed to establish guidelines and procedures to prevent transmission of Hepatitis B or HIV. All dental health care providers (HCP) are responsible for obtaining a copy of the
It is ultimately the responsibility of the individual providing care, whether it be student, resident, faculty, or staff, to insure that appropriate care is rendered in a safe environment, with appropriately processed and handled instruments and materials to minimize chances of contamination and subsequent disease transmission. This applies not only to clinical procedures, but also those procedures performed in the laboratory. The laboratory phase of care should also be done on appropriately processed appliances and impressions, and with aseptic technique. It is the responsibility of faculty and staff associated with patient care to monitor compliance with standards for care outlined in this policy and in the manual. Staff in sterilization facilities and dispensaries are likewise charged with the obligation to insure strict compliance with protocols for the prevention of cross contamination. Individuals who are found to be in violation of these standards are subject to sanctions as outlined in the personnel and professional conduct policies of the University of Washington.

I. Medical History and "Universal Precautions" (Body Substance Isolation)

It is not possible to determine the infectious disease status of individuals through a review of the medical history alone. Patients may be unaware of their condition or the mechanism of disease transmission. Others may choose not to reveal a known condition to health care workers.

Furthermore, the infectious disease status of patients may change with time, and assumptions made about disease status may not be valid in perpetuity.

Proper review of the health history is imperative to insure that patients receive appropriate care for their condition, but since all conditions may not be disclosed with this review, it is essential that all body fluids from all patients be considered infectious and all patients be treated with the same high standard of infection control practice, employing "UNIVERSAL PRECAUTIONS" for all care, as defined by the Center for Disease Control (CDC).

II. Personal Hygiene and Appearance

All individuals with patient contact will adhere to high standards of personal hygiene, and will dress in a clean, professional manner appropriate to the care provided as outlined in the BBP Manual.

III. Use of Personal Protective Equipment

All students, faculty, and staff shall use appropriate personal protective equipment (PPE), as well as mechanical protective devices or procedures to minimize skin contact with potentially infectious materials. These precautions
will be maintained during the treatment of patients and in laboratory procedures with any items contaminated with blood, saliva, or gingival fluids. See chapter three of the manual for details on the use of personal protective equipment.

IV. Personal Protection: Training, Immunization, and Infected Worker Protocols

All faculty, staff, and students who work in or in support of clinics and/or laboratories shall receive training on blood-borne disease risk, epidemiology, and transmission in the dental setting. They will be immunized in accordance with University of Washington Health Science Center policy (see appendix A of the BBP Manual) as a condition of employment, or acceptance into clinical dental education programs.

As described previously within this policy, it is expected that all dental patient care within the University of Washington will be provided with appropriate barrier protection as defined in chapter three of the manual. It is further expected that students, staff, and faculty will correctly report any body fluid contacts occurring during patient care.

Protocols are in place for counseling and testing of source patients and recipients in the event of accidental, potentially inoculating events. Health care providers who have infectious diseases shall not perform certain invasive procedures in order to reduce the risk of disease transmission to patients. (See Fitness to Practice policy.)

V. Management of Dental Environment

Surfaces of fixtures or non-sterilizable equipment and materials which are potentially contaminated by blood or other body fluids during the course of dental care shall be covered with disposable barriers or cleaned and disinfected after use to minimize potential for disease transmission between patients. (See BBP Manual for clinical asepsis protocols.)

VI. Aseptic Clinical Techniques

Dental health care workers will employ techniques during the care of patients which will assure that diseases are not transmitted between patients or between providers and patients by reason of contamination of materials or supplies as outlined in the BBP Manual.

VII. Instrument Sterilization

All reusable heat stable instruments, sonic and ultrasonic scalers as well as prophy angles that come into contact with the patient's blood, saliva, teeth, or mucous membranes must be cleaned and heat or gas sterilized (steam, dry
heat, unsaturated chemical vapor, ethylene oxide are acceptable methods of sterilization) before use on another patient.

Dental handpieces are to be processed in compliance with the Centers for Disease Control guidelines which state, "Equipment and devices that touch intact mucous membranes but do not penetrate the patient's body surfaces should be sterilized when possible or undergo high level disinfection if they cannot be sterilized before being used for each patient." (July 12, 1991 CDC) and with Washington Administrative Code (WAC 246-816-701 to WAC 246-816-730) which states that dental handpieces must be heat sterilized before use for each patient.

Only sterilizers that are routinely spore-tested and demonstrate repeated ability to kill spores are to be used for sterilization of instruments. Sterilizers must be spore-tested weekly and monitored with chemical indicators on every load. Records of these tests are to be maintained by the School of Dentistry's sterilization staff.

All items to be sterilized must be properly cleaned (preferably in an ultrasonic cleaner) and must be packaged before sterilization in covered cassettes/trays, Nyclave bags, paper/plastic pouches, or sterilization wrap.

Those items which will be destroyed by a heat sterilization method, but can be submerged in a solution, must be cleaned, dried and sterilized in an EPA-registered, ADA-accepted glutaraldehyde solution using a submersion time and product concentration that achieves sterilization following the manufacturer's label directions (6-10 hours).

VIII. Waste Management

Waste generated during the course of dental care will be disposed of in a fashion consistent with University, local, and State regulations. The waste categories that are regulated include:

A. Items referred to as "sharps" which are discarded: Used and unused needles, anesthetic cartridges, scalpel blades, sutures, instruments or broken glass

B. Human materials and foreign bodies removed during surgery

C. Blood contaminated material

See chapter five of the manual for waste management procedures.
IX. Laboratory Asepsis

All materials and appliances from the clinics destined for laboratory work shall be disinfected prior to leaving the clinic. In addition, all appliances and materials coming from the laboratory phase of care will be disinfected and rinsed prior to try-in and insertion. All laboratory aspects of dental care will be carried out in a manner which will minimize the potential for disease transmission by contact with appliances or materials contaminated by human body fluids. This policy also extends to preclinical instructional use of human material such as teeth. Any procedures done on extracted human teeth must be done on disinfected or sterilized teeth, and must include the use of personal protective equipment (PPE) for the operator.

X. Equipment Monitoring

Equipment involved in infection control procedures will be monitored on a regular basis to insure efficiency of function as described in the BBPM manual.

XI. Confidentiality

Confidential medical information may be accessed only in accordance with University of Washington Health Sciences policy and Washington State and Federal Law. Exchange of confidential medical information is authorized when such information is necessary for the training and teaching of health care providers and students, and is specifically related to the care of the patient. See chapter five of the manual for confidentiality procedures.

XII. Products, Devices and Equipment Review

Products, devices and equipment used for infection control (e.g., personal protection, dental environment management or instrument asepsis/sterilization) shall be reviewed and approved by the Health and Safety Committee prior to incorporation into the clinics of the School of Dentistry.

XIII. Affiliated Clinic Programs

A condition of an affiliation agreement shall be that the clinic must meet the requirements defined in federal, state, and local laws relating to infection control when university students are functioning at the affiliated site.
Course directors are responsible for the verification of compliance and shall communicate that to the Associate Dean for Clinical Services upon request. Conversely, students from an outside institution must function under compliance with federal, state, and local regulations related to infection control and University policy.

Dean of UW SOD:

[Signature]

Joel Berg, Dean of the UW School of Dentistry February 2, 2016
PURPOSE

To provide procedures for the prevention and management of medical emergency situations in the clinics of the School of Dentistry.

GENERAL POLICY

Accepted patient assessment techniques shall be utilized to identify and properly manage patients who present as a high medical risk. In the event of a serious medical emergency the approved protocol for managing the emergency shall be followed.

Minor medical emergencies such as cuts, burns, and chemical exposures which require first aid shall be managed in accordance with the safety policies of the University of Washington.

Documentation of medical emergencies shall be done in accordance with the School’s Safety and Quality Improvement Program and when appropriate, State law.

All providers should acquaint themselves with the location and contents of, the first aid kits and the emergency equipment available in the clinics.

IMPLEMENTATION

I. Major Medical Emergencies

A. Prevention Strategy

Patient assessment techniques which meet the standard of care shall be used to determine the appropriate management of a patient during dental visits. Patient assessment and management shall include, but will not be limited to, the following:
1. All patients of the School shall have an adequate medical history with appropriate medical alerts and an assessment of vital signs once every year including pulse rate, blood pressure, and respiratory rate which are recorded in the patient record.

2. Coordination of dental care with the patient's physician when indicated by the patient's medical history. Always take note of any medical history alerts in the patient record and take precautions consistent with alert.

3. Referral of patients with significant medical complications to clinical facilities (e.g., AGD clinic) which have the appropriate equipment and expertise to safely manage the patient.

4. Selection of local anesthetics which are compatible with the patient's medical condition.

5. Prescription of appropriate premedication regimens, post-operative medications, and instructions related to the dental procedure (e.g., diet, rest, etc.).

6. Appointment of patients at times and for durations to be consistent with the medical condition and treatment of the patient.

7. Avoid use of any medication, product, or device to which a patient has an allergy.

B. Preparation

In all clinical sites within the School, the following emergency equipment shall be readily available and appropriately maintained:

1. Portable oxygen supply with regulator

2. Disposable oxygen mask and tubing

3. Bag-valve-mask combination (or Pocket Mask®) and oral airways

4. Oro-pharyngeal suction

5. AED are available in the locations below:
   - Faculty Practice
   - Advanced General Dentistry
   - DECOD
   - Dental Urgent Care/ Oral Medicine
• Endodontics
• Graduate Pros
• Orthodontics
• Oral Surgery
• Pre-doc clinic on D2 and D3
• D1 Simulation Clinic and Labs (D165)

6. Standard emergency drug kit consisting of:

• Albuterol Inhaler
• Baby Aspirin 81 mg tablet
• Benadryl (Diphenhydramine) 25 mg tablet
• Nitroglycerin 0.4 mg sublingual tablet #100
• Epi-Pen 0.3 mg syringe
• Instaglucose
• Ammonia Inhalants

For sites where parenteral or multi-agent conscious sedation is administered, additional equipment and emergency drugs for ACLS are required (i.e. OMFS, Perio, AGD Clinic, & Dental Fears).

Similarly, sites in which deep sedation or general anesthesia are administered are required to have extensive additional equipment as required by the Disciplinary Board (WAC 246-817-760, which can be accessed at the following link: http://search.leg.wa.gov). Basic drug kits are provided by OCS. Additional drugs required by Level I clinics are maintained by the department.

C. Medical Emergency Procedures (potentially life threatening)

In any situation in which a loss of consciousness or other potential medical emergency is suspected, the following procedures are to be instituted in sequence. The protocol is posted in each clinic cubicle and updated annually (Appendix A).

1. Patient placed in a supine position, except in cases of congestive heart failure (CHF)

2. Airway opened, and oxygen administered

3. Vital signs taken, pulse, respiratory rate, and blood pressure

4. Call for appropriate medical assistance*

5. Provide symptomatic treatment
6. Patient transported only when stable or by EMS personnel

*In cases of cardiac arrest or other life-threatening emergency, activate the EMS system by calling Medic I at 911. State the nature of the problem, therapy instituted (e.g., CPR). When possible, call from a School land line, then the call will go directly to UW Police. If necessary to use a cell phone, make sure to state that you are calling from the University of Washington Health Sciences Building. The School’s street address is 1959 Pacific Ave. Make sure to provide your wing, room number and, identify the meeting place at the loading dock between the D- and B-Wings. State that a person will meet the aid car there and escort them to the site of the emergency. Stay on the line to allow the dispatcher to ask questions; let the dispatcher hang up first.

D. Medical Emergency Procedures (non-life threatening, non-body fluid exposure)

Use First Aid kit, if necessary. Contact personal health care provider or Hall Health Primary Care Center (685-1011) OR in other serious, but not immediately life threatening, situations requiring follow-up medical care the Emergency Department at UWMC can be contacted by calling 8-4000. Ask to speak to the attending physician or resident and state the nature of the problem and therapy provided. The patient may be billed for treatment if it is unrelated to dental care. If indicated, the patient can be transported to the Emergency Department, located on the second floor of the east wing of the UWMC. Wheelchairs are available in Oral Medicine, DECOD, Oral Surgery, and on D3. Note: Campus Health Services at UWMC is for body fluid exposures ONLY for staff, faculty, and students.

E. Aftercare Procedure

1. In all cases of medical emergencies, patients should receive an appropriate level of follow-up care, including return evaluation in the School of Dentistry, or care by the patient’s physician.

2. The Director of Patient Relations and the student/provider shall contact the patient and/or the patient's family when appropriate following the medical emergency to coordinate the resolution of medical bills related to the emergency and to express concern for the patient and/or family.

II. Minor Medical Emergencies

A. Minor Injuries during Patient Care

Faculty, students, and staff who receive puncture wounds, lacerations with instruments or devices contaminated in the patient care process, or
experience splatter in the eyes with body fluids from a patient shall receive appropriate first aid on site and contact the UWMC Employee Health Nurse (Campus Health Services, Room NE210 in the main hospital) at 598-4848.

Body Fluid Exposure Procedure for Dental Students, Staff, and Faculty

1. Immediately remove soiled clothing and wash exposed area with soap and water. (Use eyewash station or saline rinse in case of eye exposure.)

2. Notify supervising faculty.

3. Note the severity and type of exposure and assess likelihood that patient is at risk for HIV.

4. Call the SOD exposure counselor hotline at (206)351-2268 and a staff counselor will come to discuss the School protocol with the patient and escort them to UWMC for a blood draw.

5. If a SOD workforce member receives a bill from the UWMC, it should be delivered to the Director of Patient Relations within 30 days or you will be responsible for payment. Delivery may be made in person to the Patient Services Office in Health Sciences room B-452B or mailed to the Office of Patient Services, Attn: Manager of Patient Relations, Box 357131, Seattle, WA 98195-7131.

B. Minor Injuries Unrelated to Patient Care

Minor injuries in the workplace which are not related to patient care shall be treated by trained personnel using First Aid kits provided by the University. Persons specifically trained in First Aid shall be identified in both the B- and D-wings to provide appropriate First Aid. A Patient Event Report must be completed for all incidents and emergencies using the online form found at https://mydental.washington.edu/patient_event_form/ (Appendix B).

C. Maintenance of First Aid System

A designee in each clinic shall appointed and will be responsible for the maintenance of First Aid Kits in their clinic. The Director of Safety is responsible for arranging ongoing trainings schoolwide.

III. Event Reporting

A. Event Reports
In accordance with the School’s safety program, all patient injuries and medical emergencies shall be reported to the OCS within five working days of the incident. Use the Event Report form in Appendix B for such reports. The OARS reporting system should be used of student and employee accidents and medical emergencies.

B. Dental Disciplinary Board Reports

Any injury related to a dental procedure which results in the hospitalization, or death of a patient must be reported to the Dental Quality Assurance Commission (DQAC) Disciplinary Board of the State of Washington within 30 days of the incident (WAC 246-817-780 accessed at the following link: http://search.leg.wa.gov ). Principal parties are to report such events to the OCS using the confidential event reporting system stated above. The provider involved in the event must report to the DQAC, and in student cases, the Associate Dean of Clinic Affairs or delegate will submit the report.

IV. Basic Life Support (Health Care Provider Level “C”)

A. Clinic Personnel

All students, faculty, and staff who engage in direct patient care must be certified in "Basic Life Support" at least every two years.

B. Non-clinic Personnel

All employees are encouraged to receive training in "Basic Life Support" even if they are not involved in patient care. Such training may be useful in providing emergency assistance to co-workers, visitors to the School, and family members.

Appendices: Appendix A, Medical Emergency Procedures  
Appendix B, Patient Event Report

Dean of UW SOD:

[Signature]

Joel Berg, Dean of the UW School of Dentistry  February 2, 2016
APPENDIX A

Medical Emergency Procedures

NON LIFE-THREATENING EMERGENCIES
- Use the first aid kit if necessary - first aid kits are available in all clinics and laboratories.
- Contact your personal health care provider OR, if necessary, go to the UW Medical Center Emergency Room (normal fees will apply)
  - Students may contact Hall Health at 685-1011
- Notify supervisor/instructor
- Report the incident within 24 hours- see below for guidelines

LIFE-THREATENING EMERGENCIES
- Call 9-1-1
- Keep victim still and comfortable
- Administer first aid if trained
- Send someone to meet the ambulance at the loading dock between B & D wings opposite South Campus Center to assist responding emergency personnel
- Report the incident within 24 hours- see below for guidelines

9-1-1

BLOODBORNE PATHOGEN EXPOSURE
- Notify supervisor/instructor
- EYES: Immediately wash eyes at eye wash station for 15 minutes while holding eyelids open
- OTHER:
  - 1. Scrub exposed area thoroughly with soap and warm water for 15 minutes
  - 2. Remove the contaminated needle or instrument from the work area
- Between 8:00AM and 5:00PM Notify supervisor/instructor and call the Exposure/Incident Hotline at 206-555-2268
- After 5:00PM: Go directly to the UWMC Emergency Room and notify the Exposure/Incident Hotline at 206-555-2268 by leaving a detailed message
- Report the incident within 24 hours- see below for guidelines

If injured person is a patient or a visitor, report incident via Patient Event Form Link:
https://myeucm.washington.edu/patient_event_form/
(Note: To log in, enter your main User Name with sof, before it (for example: sofjanesmith)
and your main SOD password (the same one you use to log onto your computer for work)

If injured person is student, staff or faculty, report incident via OARS Link:
http://www.oars.washington.edu/oars/index.htm

Emergency Contact Information
APPENDIX B

https://mydental.washington.edu/patient_event_form/

![Patient Event Form](https://mydental.washington.edu/patient_event_form/)

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your name*</td>
<td>Your email address*</td>
</tr>
<tr>
<td>Event Date</td>
<td>Form Date</td>
</tr>
<tr>
<td>Gender</td>
<td>Location of Event</td>
</tr>
<tr>
<td>First Reported By</td>
<td></td>
</tr>
<tr>
<td>Dept</td>
<td>Location Not Known</td>
</tr>
<tr>
<td>Brief Description of Event:</td>
<td>What, Where, When, Why (limited to 1500 characters)</td>
</tr>
<tr>
<td>Optional - Causes and/or Contributing Factors to this Event: How could it have been prevented? (limited to 500 characters)</td>
<td></td>
</tr>
<tr>
<td>Action Taken by Reporter, If any: (limited to 500 characters):</td>
<td></td>
</tr>
<tr>
<td>Name of Manager Notified</td>
<td>Date</td>
</tr>
<tr>
<td>Action Taken by Your Manager: If any: (limited to 500 characters):</td>
<td></td>
</tr>
</tbody>
</table>

Submit
PURPOSE

To establish protocols designed to minimize radiation exposure to patients and operators; to promote sound radiological health practices, and to promote proper infection control during radiographic procedures.

GENERAL POLICY

The responsibility for clinical radiation safety and infection control lies with every individual involved with diagnostic radiology including faculty, students, clinical staff and other individuals who are responsible for the proper use and maintenance of radiation equipment and supplies (including film, darkrooms and processors). The ultimate goal of this policy is to operate under the ALARA concept (As Low As is Reasonably Achievable) with regard to radiation exposure.

The principles of infection control as applied to clinical radiology and described in this policy and in the infection control manual of the School entitled, Hazard Control in the Dental Environment, shall be utilized in all dental school clinics where such services are rendered.

IMPLEMENTATION

I. General Radiation Safety Issues

A. Compliance Statement

The policies and criteria outlined herein adhere to both Federal and Washington State regulations of Radiation Protection and adopt the principles of the FDA Guidelines for Dental Radiographic Examinations. They have been developed in cooperation with the Radiation Safety Section of the Environmental Health and Safety Department of the University of Washington. It shall be the obligation of all members of the School of Dentistry who are involved in diagnostic radiology to:
• adhere to accepted protocols for the safe operation of radiologic equipment and supplies for their own protection and for the protection their patients.

• follow sound and logical radiological health practices and to report any suspected health hazards to the proper administrative authority.

• adhere to the infection control policy of the school during radiographic procedures.

B. Responsibility for Monitoring

The Radiation Safety Section of the Environmental Health Department is responsible for implementation of radiation safety measures and controls thereof. Annual inspections are performed including but not limited to:

• Measurements of radiation in controlled and non-controlled areas.

• Performance of x-ray units in respect to State and Federal regulatory codes.

• Identification of non-compliance with University policy or regulatory codes.

• Evaluation of radiological safety programs by observing their effectiveness in providing protection and the level of compliance.

The Director of Oral Radiology, School of Dentistry, shall act as a liaison between individual users of radiation and the Radiation Safety Officer of the University of Washington and assist the Radiation Safety Officer in the implementation of the Radiation Safety Policy.

C. Authorized Users

The use of diagnostic x-ray equipment in the practice of dentistry at the UW School of Dentistry shall be restricted to those individuals described in this section.

*Predoctoral Students:* The operation of x-ray equipment by predoctoral students is authorized but limited to the following restrictions:

• The operator shall have didactic and preclinical training and a passing grade in oral radiology.

• The x-ray exposures shall be authorized by a clinical instructor of the School of Dentistry as evidenced by the instructor’s signature on the prescription.
• A clinical instructor shall approve the quality of the radiograph as evidenced by the instructor's signature on the record.

Graduate Students: The operation of x-ray equipment by unlicensed graduate students is authorized but limited to the following restrictions:

• The operator shall possess a dental degree.
• The x-ray exposure shall be authorized by a member of the faculty of the School of Dentistry as evidenced by the faculty member's signature on the Request for Radiographic Exam form as outlined in the Clinic Procedures Manual, section 5-F, Managing Radiographs.
• A member of the faculty shall be available for consultation when required.
• A faculty member shall approve the quality of the radiograph as evidenced by the faculty member's signature on the record.

Radiology Technicians: The operation of x-ray equipment by School of Dentistry radiology technicians and staff is authorized but limited to:

• The x-ray operator shall have adequate training in radiographic techniques.
• The x-ray exposure shall be authorized by a member of the faculty of the School of Dentistry as evidenced by the faculty member's signature on the prescription.
• A member of the faculty should be available for consultation when required.
• A faculty member shall approve the quality of the radiograph as evidenced by the faculty member's signature on the record.

Faculty members: All members of the faculty of the School of Dentistry possessing a dental degree are authorized to prescribe radiographic examinations.

D. Radiation Protection Standards

Occupational doses for individuals are:

• an annual limit is to be the more limiting of: total effective dose equivalent being equal to 5 rem (0.05 Sv) or the dose equivalent to any organ, tissue, or extremity (other than the lens of the eye) being equal to 50 rem (0.5 Sv). The annual dose equivalent limit to the eye will become 15 rem (0.15 Sv).
- WAC 246-221 requires assessment and control of fetal doses. A pregnant worker should voluntarily declare her pregnancy in writing to her employer and include her estimated date of conception. The embryo/fetus should not receive a dose equivalent greater than 0.5 rem (50 mSv) during the entire pregnancy. Special dosimeters can be provided to declared pregnant workers to evaluate fetal doses.

- occupationally exposed minors (under 18 years of age) should not receive an dose equivalent in excess of 0.5 rem (50 mSv)

Monitoring will be required for any individual who could potentially receive a dose in excess of 10% of any applicable limits.

Any individual monitoring device used for monitoring the dose to the whole body shall be worn at the unshielded location of the whole body likely to receive the highest exposure. When a protective apron is worn, the location of the individual monitoring device is typically at the neck (collar).

Any additional individual monitoring device used for monitoring the dose to an embryo/fetus of a declared pregnant woman shall be located at the waist under any protective apron being worn by the woman.

II. Guidelines for Prescribing Dental Radiographs

A. General Principles

The goal of every radiographic examination will be to seek information which will influence the diagnosis and treatment of the patient, thereby providing a benefit which otherwise could not be realized.

The exposure of each patient will be as individualized as feasible. There shall be no "routine" radiographic examination. Radiographic examinations shall be carried out solely based on clinical indications. Radiographs shall not be taken solely for legal, documentary, teaching, or administrative purposes.

To minimize unnecessary radiation to the patient, previous radiographs of the patient should be obtained. These will serve as important guides for the ordering of new radiographs and to provide a better understanding of disease progress.

B. Prescription Guidelines

The Guidelines for prescribing dental radiographs are based on the recommendations issued by U.S. Department of Health and Human Services, Public Health Service, F.D.A., and shown in Appendix A and the standard for
requesting a referral to Radiology is in the Clinical Procedures Manual, section 5F, Managing Radiographs.

III. Radiation Protection Measures for Patients and Personnel

A. Patient Protection from Ionizing Radiation

- The authorized user shall employ those operating parameters (kVp, mA, exposure time, film screen combinations, and collimation), which result in the lowest possible radiation dose to the patient and still produce desired diagnostic information.

- A lead impregnated apron is recommended to shield the trunk of the body and the gonads of the patient. The lead equivalent of the apron should be at least 0.25 mm.

- A thyro-cervical shield is recommended to protect the patient’s neck when the use of it does not interfere with the retrieval of diagnostic information. This shield shall be provided for children. When it will not interfere with the examination.

- Before any exposure is initiated the operator shall ensure that the tube head has its proper and stable position.

- Film holders with indicators for proper x-ray beam alignment are recommended for intraoral periapical and bitewing radiography. Rectangular collimators are recommended in combination with these film holders.

- Retakes should be approved by a faculty supervisor and should be taken only for a valid clinical reason, not for the purpose of improving the esthetics of the radiograph.

B. Personnel Protection from Ionizing Radiation

- In no instance shall the x-ray operator or an assistant hand-hold a film during exposure.

- During each exposure the operator shall stand behind a protective barrier. Only the patient should be in the path of the useful beam.

- Neither the tube housing nor the cone shall be hand held during exposure.

- When a patient needs assistance or reassurance during exposure, then a third party, such as a member of the patient's family, may be allowed to stay in the x-ray room to assist with the procedure, provided that the individual is issued appropriate protective devices and instructed to stay out of the path of
the primary beam. The third party shall not be pregnant or under the age of eighteen.

C. Recording of Radiographic Procedures

An entry which includes the date and type of exposure shall be made in the Radiology Log of the patient's dental record for each radiographic procedure performed. Patient records shall be reviewed by the faculty with respect to record entries in the Radiology Log and in the progress notes. All films or film mounts shall be labeled with the patient's name and date of exposure and stored in the patient's record. All intraoral films are to be mounted and labeled. Large extra-oral films are to be labeled directly on the film using identification labels.

D. Facilities Management

The management of radiology equipment and facilities shall be in compliance with state law and university environmental health and safety policy as described in Appendix B. The Intraoral Dental X-ray Unit Test and Instructions (Form RSO 404) shall be used in the evaluation of facilities as displayed in Appendix C.

Darkroom equipment and procedures: In addition to the regular maintenance of darkroom equipment and change of processing chemicals regular evaluations of the performance of the processing systems shall be undertaken. The Division of Oral Radiology will regularly provide standard dental radiographs which have been exposed under standardized conditions. These developed radiographs will be analyzed and recorded. Other currently accepted techniques for this evaluation can also be employed. Records for each processor system should be kept in which dates and results of tests should be noted. In each Department or facility where processing of radiographs takes place an individual shall be designated the responsibility for the processing unit. This individual shall be responsible for the daily supervision of procedures and equipment and shall report faulty function etc. to the maintenance office. In turn, the maintenance office shall keep logs of services and report disturbances to the Office of clinical affairs and the Safety officer. A standard test film shall be used to determine the performance of each processing unit used in the school. Deviation from normal shall be reported to the Office of Clinical Affairs.

Viewing facilities: It is the responsibility of each department to keep viewing equipment and facilities in an adequate operating condition.

E. Radiographic Image Quality Control

In an effort to maintain radiographic image quality at a high level, each radiographic examination shall include a critical review of image quality with respect to projection, exposure, and possible processing errors or artifacts.
Remedial measures such as reinforcement of instructions, individual tutorials, etc., should be employed.

Audits: At least once a year randomly selected records of dental school patients and radiology process should be reviewed by Office of clinical affairs with regard to prescription and recording of radiographic procedures as well as image quality.

IV. Radiographic Duplication

Access to a duplicate of radiographs is a legal right of each patient of record. Patients, or their designated representatives may obtain such duplicates using the protocol in the Patient Records policy.

Appendices:

Appendix A, Guidelines for Prescribing Dental Radiographs
Appendix B, Radiographic Equipment and Facility Management

Dean of UW SOD:

Martha Somerman, Dean of the UW School of Dentistry
October 8, 2009
Appendix A

GUIDELINES FOR PRESCRIBING DENTAL RADIOGRAPHS

Modified after recommendations issued by U.S. Department of Health and Human Services, Public Health Service, Food & Drug Administration. The recommendations in this chart are subject to clinical judgment and may not apply to every patient. They are to be used by dentists only after reviewing the patient's health history and completing a clinical examination. The recommendations do not need to be altered because of pregnancy.

### ADULTS

<table>
<thead>
<tr>
<th>NEW PATIENT</th>
<th>Radiographs of recent date (1-2 years old) of sufficient quality and quantity.</th>
<th>low risk</th>
<th>bitewing</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>high risk</td>
<td>PAN + bitewing</td>
</tr>
<tr>
<td>Previous radiographs more than 2 years old or more recent, of insufficient quality and quantity</td>
<td>low risk</td>
<td>PAN + bitewing</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>high risk</td>
<td>FMS + bitewing (PAN)</td>
</tr>
<tr>
<td>No previous radiographs</td>
<td>low risk</td>
<td>PAN + bitewing</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>high risk</td>
<td>FMS + bitewing (PAN)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>RECALL PATIENT</th>
<th>Use available previous radiographs</th>
<th>low risk</th>
<th>bitewing 24-36 month interval</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>high risk</td>
<td>bitewing 12-18 month interval</td>
</tr>
</tbody>
</table>

### CHILDREN AND ADOLESCENTS

<table>
<thead>
<tr>
<th>NEW PATIENT</th>
<th>Primary Dentition</th>
<th>bitewing if contacts closed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Transitional Dentition</td>
<td>PAN + bitewing</td>
</tr>
</tbody>
</table>

| RECALL PATIENT | bitewing 12-24 month interval | Panoramic radiograph to assess 3rd molars and growth and development when needed. |

### CLINICAL SITUATIONS FOR WHICH RADIOGRAPHS MAY BE INDICATED INCLUDE:

### POSITIVE HISTORICAL FINDINGS

1. Previous periodontal or endodontic therapy
2. History of pain of trauma
3. Familial history of dental anomalies.
### 4. Post-operative evaluation of healing

### 5. Presence of implants

#### POSITIVE CLINICAL SIGNS/SYMPTOMS

<table>
<thead>
<tr>
<th>1. Clinical evidence of periodontal disease</th>
<th>2. Large or deep restorations.</th>
<th>3. Deep carious lesions</th>
</tr>
</thead>
<tbody>
<tr>
<td>16. Abutment teeth for fixed or removable partial prosthesis.</td>
<td>17. Oral involvement in known or suspected systemic disease.</td>
<td>18. Pain and/or dysfunction of the temporomandibular joint.</td>
</tr>
<tr>
<td>19. Unusual eruption, spacing or migration of teeth.</td>
<td>20. Unusual tooth morphology, calcification or color.</td>
<td>21. Missing teeth with unknown reason.</td>
</tr>
</tbody>
</table>

#### PATIENTS AT HIGH RISK FOR CARIES MAY DEMONSTRATE ANY OF THE FOLLOWING:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Poor oral hygiene.</td>
<td>5. Inadequate fluoride exposure.</td>
<td>6. Prolonged nursing (bottle or breast).</td>
</tr>
</tbody>
</table>
Appendix B

Radiographic Equipment and Facility Management

Dental x-ray rooms
Dental x-ray rooms are to be in compliance with Washington Administrative Code (WAC) 246-225-030 (General Requirements/Plan Review). These regulations address items necessary for a proper evaluation of safety and shielding requirements.

New or remodeled dental facilities are exempt from WAC 246-255-030 conditions requiring submission of shielding calculations and floor plans to the State of Washington Department of Health for plan review.

A qualified expert (as determined by State of Washington Department of Health) must evaluate safety and shielding requirements of all new or remodeled installations using National Council on Radiation Protection and Measurements Report No. 49.

Dental x-ray equipment
Dental x-ray equipment is to be in compliance with Washington Administrative Code (WAC) 246-225-110 (Intraoral Dental Radiographic Systems).

Items addressed in the WAC include: (1) source to skin Distance (SSD), which should be 18 centimeters or more for equipment operated at the University of Washington; (2) field limitation, which should be contained within a circle having a diameter no greater than 7 centimeters (3) adequate timers and exposure controls; (4) exposure reproducibility; and (5) operating controls.

Radiographic Quality Assurance
RQA entails a system of policies and procedures with the aim to ensure that the radiographic diagnostic facilities produce consistent high quality images and minimizing the risks to patients and providers.

Periodic surveys and inspections
  x-ray apparatus and related items
All intraoral x-ray machines are generally inspected twice per year. One inspection for general safety characteristics and adherence to WAC 246-225-110 is done yearly by the UW Radiation Safety Office of Environmental Health and Safety. A similar inspection is also done yearly by the Scientific Instruments Division at the University of Washington. Occasional inspection by the State of Washington Department of Health also occur.

  dose measurements
Estimates of patient dose measurements are taken at the time of inspections by the Radiation Safety Office and Scientific Instruments staff. In addition, area measurements are made by Radiation Safety Office staff to evaluate exposure potential to operators and nearby personnel.
PURPOSE
To establish a fast track for patients who swallowed an object to radiology, bypassing a possible long waiting time and charges in the Emergency Department.

GENERAL POLICY
Swallowed objects may represent a significant health hazard as well as a malpractice risk. Timely treatment can prevent serious complications.

IMPLEMENTATION
If a patient under your care swallowed an object (castings, implant components, orthodontic band, etc.) during your treatment, it is judicious to assume it has been aspirated, even if the patient exhibits no symptoms of airway obstruction. Aspirated objects pose an immediate hazard to the patient’s life. Swallowed objects may also pose a serious health risk.

1. Check to confirm that your patient has a patent airway. If the patient has trouble breathing, lips turning blue or skin turning a dusky color, not able to speak or shows any signs of distressed breathing, call 911 immediately or send someone to call 911 for help (see Appendix A, Medical Emergency Protocol and Appendix B, Emergency Quick Reference Lanyard Card.)

2. Reassure the patient chairside.

3. Inform your supervising faculty and the Clinic supervisor.

4. Inform the patient of the need for a chest x-ray to determine the location of the object.
5. Obtain a prescription order form to UWMC radiology services (See Appendix C, RRR Clinical Research Requisition Order Form U2535 & Instructions) from the dispensary and have the supervising faculty sign it, authorizing the imaging order.

6. You or a staff member should transport the patient in a wheelchair to the UWMC Radiology/Imaging Services located on the second floor in the SS wing, room SS-202A for appropriate radiographs. (Note: The patient will be registered into the UWMC system at the radiology service if they are not a current patient of the center.)

7. If the patient is absolutely certain he/she ingested the object rather than aspirated it, it is still optimal to refer for medical evaluation and follow-up imaging. In every instance, referral to a physician is the most prudent course of action, as it demonstrates that you are acting in the patient’s best interest. Explain to the patient that there can be instances of aspiration without symptoms.

8. Document the event in the patient’s EHR, your actions following the event, and the patient’s decision about follow up. This should include your recommendation of a medical evaluation, including imaging, how the patient was transported for medical evaluation and by whom, and any telephone discussions with the medical facility and treating physician. A copy of the treating physician’s report should be added to the patient’s record.

9. Document all preventive measures (rubber dam, pharyngeal drape, etc.) that had been taken to prevent the swallowing or aspiration of the object and any pre-treatment referrals or discussions about referrals.

10. Complete an online event report using the Patient Event Form at MyDental (see Appendix D, Patient Event Form.)


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**Appendices:**

- Appendix A, Medical Emergency Protocol
- Appendix B, Quick Reference Emergency Card
- Appendix C, RRR Clinical Research Requisition Order Form & Instructions
- Appendix D, Patient Event Form

---

Dean of UW SOD:

__________________________   __________________________
Joel Berg, Dean of the UW School of Dentistry    Date
APPENDIX A: Medical Emergency Protocol

Medical Emergency Procedures

NON LIFE THREATENING EMERGENCIES

- Use the first aid kit if necessary – First aid kits are available in all clinics and laboratories.
- Contact your personal health care provider OR, if necessary, go to the UW Medical Center Emergency Room (normal fees will apply)
  - Students may contact Health at 685-1011
  - Notify supervisor/instructor.
  - Report the incident within 24 hours – see below for guidelines.

LIFE THREATENING EMERGENCIES

- Call 9-1-1.
- Keep victim still and comfortable.
- Administer first aid if trained.
- Notify supervisor: they or their delegate will meet emergency personnel at the following location:
  - Health Sciences: Between B & D loading dock Center for Pediatric Dentistry: Outside Surgery Center
  - Report the incident within 24 hours – see box below for guidelines.

9-1-1

BLOODBORNE PATHOGEN EXPOSURE

- Stop work immediately.
- EYES: Immediately wash eyes at eye wash station for 15 minutes, while holding eyelids open.
- SKIN: Scrub exposed area thoroughly with warm soapy water for 15 minutes.

Health Sciences:
- Between 8:00 Am and 5:00 PM: Notify supervisor/instructor. AND notify the Exposure/Incident Hotline at 206-351-2268.
- After 5:00 PM: Go directly to the UWMC Emergency Room.
  - Notify supervisor.
  - Notify supervisor or faculty to manage contaminated instruments/needle.
  - Supervisor will start exposure process.
  - ALL: Report the incident within 24 hours – see box below for guidelines.

Emergency Contact Information

Emergency: 9-1-1
Non-emergency UW Police: 206-485-UWPD (8971)
Exposure/Incident Hotline: 206-351-2268

If injured person is a patient or a visitor, report incident via Patient Event Form Link: https://dental.washington.edu/health-and-safety/event-reporting (Note: To log-in, enter your main User Name with sod) before it (for example: sod/janesmith) Enter your main SOD password (the same one you use to log onto your computer for work)

If injured person is student, staff or faculty, report incident via OARS Link: http://www.ews.washington.edu/oars/index.htm
APPENDIX B: Emergency Quick Reference Lanyard Card

BODY FLUID EXPOSURE

1. Provide immediate first aid
2. Notify supervisor/instructor
3. Call Exposure/Incident Hotline 206-391-2364
4. Seek medical care
   - M-F 8am-5:15pm: Go to Employee Health MEDC
   - M-F 8am-5pm: Call Employee Health 206-598-2000
   - After 5pm: Report to UWMC ER (2nd floor)
   - Off site locations: Follow established protocol

EVENT REPORTING (206-221-6538)

Complete the appropriate report:
- CARES for events involving students/staff/faculty
- Patient Event Form for events involving patients/families
- MSDS: Questions about hazardous material refer to My Chem or call EH&B

SCHOOL OF DENTISTRY
APPENDIX C:
RRR Clinical Research Requisition Order Form U2535 & Instructions

<table>
<thead>
<tr>
<th>CIRCLE EXAM(S) DESIRED:</th>
<th>CT</th>
<th>MRI</th>
<th>FLUORO</th>
<th>RADIOLOGY</th>
<th>ULTRASOUND</th>
<th>INTERVENTIONAL</th>
<th>NUCLEAR MEDICINE</th>
</tr>
</thead>
<tbody>
<tr>
<td>OUTPATIENT CLINIC</td>
<td></td>
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<tr>
<td>INPATIENT UNIT</td>
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</tbody>
</table>

**Today's Date:**

**Location:**
- UWM Main
- Roosevelt Clinic

**To be scheduled on:**
- Clinics to call to schedule
- Patient will call to schedule
- Radiology to call patient to schedule

**EXAM REQUESTED:** SPECIFIC ANATOMICAL AREA OF INTEREST

1) 1 view Abdom
2) PA CXR

"Exam protocol approved by Radiology per Leigh Ann Russell"

**COMPARISON IMAGING STUDIES:**
(type, where and when)

**REASON FOR EXAM:**
DIAGNOSIS, SPECIFIC SIGNS/SYMPTOMS, RELEVANT HISTORY, AND PRIOR EXAMS

- Evaluate for possible swallowed foreign body
- Cancell PA Chest if FB visualized on abdomen.

**PLEASE PRINT ORDERING MD/PRACTITIONER (FIRST / LAST NAME REQUIRED) ORDERING**

**MD/PRACTITIONER SIGNATURE**

**MED STAFF ID**

**BEEPER#**

**PRECAUTIONS:** (Please mark all that apply)

- PREGNANT
- Allergies
- Weight
- Contrast/Iodine Allergy
- Abnormal Renal Function
- Diabetes
- Dialysis
- History of Renal Compromise

**COMPLETE FOR MRI:**
- Cardiac Pacemaker
- Neuro Stimulator
- Aneurysm Clips
- Metal Worker
- Cochlear Implant
- Sedation needed

**COMPLETE FOR ULTRASOUND:**
- Pregnant
- Gravida
- EDC_______ by LMP of________
- Prev US on________ weeks

**PT. NO.**

**NAME**

**DOB**

**UW Medicine**
Harborview Medical Center – UWM Medical Center
University of Washington Physicians
Seattle, Washington

**RRR CLINICAL RESEARCH REQ ORDER**

*U2535*

*U2535*

WHITE – MEDICAL RECORD

UH2535 REV JUL 10
INSTRUCTIONS to complete the UWMC Radiology RRR Clinical Research Form for SOD workforce members is below.

1. TODAY’S DATE:

2. ORDERING MD/PRACTITIONER: Print the complete the name of the SOD attending faculty – both first and last name are required. (Leave the MED STAFF ID# blank.)

3. MD/PRACTITIONER SIGNATURE: Attending SOD faculty should sign on line

4. BEEPER NUMBER: Enter the phone number for the D2/D3 Clinic Manager – 221-3038 or Other__________________

5. PRECAUTIONS: Check boxes or fill in any information which may apply pertaining to pregnancy, allergies and medical conditions listed.

   In the box in the lower right corner list:

6. PATIENT NUMBER (Pt. No.): list the UWMC Patient number, NOT the SOD patient number.

7. PATIENT NAME: Complete full name

8. DOB: Month, date and year

Location of UWMC Radiology/Imaging Services:
APPENDIX D: Patient Event Form (online at MyDental)
Subject: Treating Patients with Diseases of High Risk

Policy Number:

Effective Date: February 5, 2009

Revision Date: December 2014, September 2016

PURPOSE

To provide a clear clinical protocol for treating patients with known diseases that are highly infectious and/or have elevated rates of mortality. These include (but are not limited to) Ebola Virus Disease (EVD), Middle East Respiratory Syndrome (MERS), highly drug resistant Methicillin-resistant Staphylococcus aureus (MRSA), active tuberculosis (TB), Severe Acute Respiratory Syndrome (SARS), and influenza (flu).

GENERAL POLICY

UW SOD recommends that clinicians evaluating patients suspected of possible high-risk diseases should apply standard precautions (e.g., hand hygiene), airborne precautions (e.g., masks), and contact precautions (e.g., standard personal protective equipment). Until the disease has been positively identified and precisely defined, full PPE also should be worn for all contact with such patients. As a general rule, patients who are positively identified as having EVD, MERS, MRSA, SARS, flu, or active TB with positive sputum, or any other high-risk disease, should not be treated in the UW SOD dental clinics. Such patients shall be referred to a facility that is equipped to manage highly infectious patients.

Although the Zika virus infection is considered a serious condition, there is no known risk of transmission in the dental environment at this time. Clinicians and patients appear to be adequately protected by the use of established infection prevention protocols. The Centers for Disease Control (CDC) provides up to date information on Zika for healthcare providers at: http://www.cdc.gov/zika/hc-providers/index.html. In addition, the CDC’s “Key Zika Considerations for Healthcare Settings” can be found at: http://www.cdc.gov/zika/pdfs/key-zika-considerations.pdf

In cases where a patient with a suspected high-risk disease requires emergent dental care, treatment along with disinfection protocols, should be provided only by fully trained faculty and clinical staff, not students.
The following policy aims at divisions and departments that routinely encounter patients with potential serious infectious illness that has either not been identified, or there has been a delay in recognizing patients with serious infectious illnesses at the start of an epidemic.

IMPLEMENTATION

I. EVD, MERS, MRSA, active TB, SARS, flu and other high-risk diseases:

A. Administrative Measures

1. Educate dental personnel about the risk, management and protective strategies for each disease, including specific infection control, case identification, and patient screening questions.

2. Periodically check the websites for the Centers for Disease Control and Prevention and the World Health Organization to keep abreast of new developments and recommendations.


4. Periodically check UW Medical Center materials for the latest information on high-risk diseases.

5. Continue to implement and reinforce strict infection control measures and be aware of protocol for managing patients deemed to be high-risk.

6. Place signs in reception areas and operatories advising patients to notify the dentist or other dental personnel if they have infection, fever or respiratory symptoms.

7. Establish a written protocol for referring patients with suspected highly infectious diseases to facilities that can evaluate and treat them properly.

8. Modify health history practices to include screening questions that address any high-risk diseases based on information
available from resources mentioned above. Make sure these questions are asked at every patient visit and do not limit screening questions to specific patient populations.

9. If “yes” responses place patients in a high-risk category, have the patient don a surgical mask. Raise your concerns with the patient, and then refer the patient to the appropriate UW medical facility (UW Hospital Emergency Department (206) 598-4000, or, if a high risk situation, telephone the UW Hospital Emergency Department triage nurse (206) 598-8366 for immediate evaluation and diagnosis. If indicated, notify the medical center that you are sending a patient to be evaluated for the specific high-risk disease identified.

B. Engineering Measures

1. Using appropriate PPE, escort the patient to the “holding area” for evaluation by medical personnel.

2. If an area has been contaminated, it should be closed until appropriate decontamination has been completed.

C. Dental Personnel Protection

1. Disposable gloves must be changed after every patient. Non-sterile nitrile disposable gloves should be provided for hand barrier protection. During potential high infectious risk exposures, emergency department staff should double-glove to protect against inadvertent glove perforations.

2. Chin-length plastic face shields or surgical masks and protective eyewear are a must. Make sure the mask covers the mouth and the nose.

3. Reusable gowns should not be reused until washed. Disposable gowns should be properly placed in a biohazardous waste container.

D. Cleaning & Disinfection

1. Use a hospital-grade disinfectant or 1:100 dilution of household bleach. Make sure the disinfectant is compatible with our dental equipment.

2. Disinfect any equipment and surfaces with which the patient has come into contact before the next patient is seen.

E. Hand Hygiene
1. Wash hands often with soap and water for at least 20 seconds between patients. If soap and water are not available, an alcohol-based waterless hand rub may be used when hands are not visibly soiled.

F. Additional Precautions

If exposure to a patient’s body fluids has occurred and it is not possible to obtain a history, the patient should be regarded as infectious and all appropriate measures should be taken.

1. Any blood or saliva-contaminated instruments are potentially infectious and should first be disinfected, then sterilized using moist heat (steam) sterilization or chemical sterilization, then cleaned and heat-sterilized once again. Gloves and protective clothing should be worn while collecting and cleaning contaminated materials and instruments.

2. Spills of blood and other infected materials should be covered with a disinfectant solution before washing thoroughly. Protective clothing and gloves should be worn while cleaning accidental spillages of this nature. Used cloths and mops must be sterilized before being disposed of or reused.

3. Clothing worn during treatment and cleanup should be removed only when all cleaning and sterilizing is complete. Such clothing should be regarded as infectious and collected and disinfected prior to normal laundering to clinical standards. Clothing should be removed in the clinical area.

4. Wash and disinfect hands, forearms and areas of exposed skin thoroughly following removal of gloves and protective clothing after completion of treatment.

Appendices:

Appendix A: Tables on EBV, MERS, SARS. TB & Influenza
Appendix B: CDC Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis
Appendix C: ADA Statement on the Treatment of Patients with Infectious Diseases of Uncertain Transmission
Appendix D: HIPAA Privacy in Emergency Situations
References: CDC Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5417a1.htm


ADA Resources: http://www.ada.org/en/member-center/oral-health-topics/ebola_resources

Dean of UW SOD:

Joel Berg, Dean of the UW School of Dentistry

October 24, 2016
**APPENDIX A: Tables on EBV, MERS, SARS, TB & Influenza**

**Ebola (Ebola viral disease), a severe hemorrhagic viral disease (like Marburg)**

- **Cause**
  - A rare and deadly viral respiratory illness caused by a filovirus of the genus *Ebolavirus*, first discovered in 1976

  There are five identified Ebola virus species, four of which are known to cause disease in humans. Filoviruses can cause severe hemorrhagic fever in humans and nonhuman primates.

  Only two members of this virus family have been identified: *Marburg* virus and *Ebola* virus.

  Ebola viruses are found in several African countries. Ebola was first discovered in 1976 near the Ebola River in what is now the Democratic Republic of the Congo.

  Since then, outbreaks have appeared sporadically in Africa. Past outbreaks have occurred in the Democratic Republic of the Congo (DRC), Gabon, South Sudan, Ivory Coast, Uganda, republic of the Congo (ROC), and imported cases to South Africa.

  There is a current outbreak of Ebola virus disease in the West Africa countries of Guinea, Liberia, and Sierra Leone (as of December 2014).\(^i\)

- **Symptoms**
  - Fever
  - Severe headache
  - Muscle pain
  - Weakness, fatigue
  - Muscle or body aches
  - Abdominal (stomach) pain
  - Diarrhea
  - Vomiting
  - Unexplained hemorrhage (bleeding or bruising)\(^ii\)

- **Transmission**
  - Direct contact is required – transfer of body fluids

    Relatively few viral particles are necessary to cause infection

    - Direct contact means that body fluids from an infected person have touched someone’s eyes, nose, or mouth or an open cut, wound, or abrasion.
- Ebola has been detected in blood and many body fluids. Body fluids include saliva, mucus, vomit, feces, sweat, tears, breast milk, urine, and semen.

- Ebola virus is transmitted through direct contact with the blood or body fluids of a person who is sick with Ebola;

- The virus is not transmitted through the air (like measles virus). There is no evidence indicating that Ebola virus is spread by coughing or sneezing.

- However, droplets (e.g., splashes or sprays) of respiratory or other secretions from a person who is sick with Ebola could be infectious, and therefore certain precautions (called standard, contact, and droplet precautions) are recommended for use in healthcare settings to prevent the transmission of Ebola virus from patients sick with Ebola to healthcare personnel and other patients or family members.iii

  ➢ Risk of transmission of Ebola virus from a patient to a healthcare worker depends upon the likelihood the patient will have confirmed EVD combined with the likelihood and degree of exposure to infectious blood or body fluids.
  ➢ That risk depends on the severity of disease.
  ➢ Severe illness is strongly associated with high levels of virus production. In addition, close contact with the patient and invasive medical care can increase opportunities for transmission.

In general, the majority of febrile patients presenting to the ED do not have EVD, and the risk posed by patients with early, limited symptoms is lower than that from a patient hospitalized with severe EVD. Nevertheless, because early symptoms of EVD are similar to other febrile illnesses, triage and evaluation processes in the ED should consider and systematically assess patients for the possibility of EVD.

**NEED TO KNOW**

Elective dental care on patients suspected of infection with a highly infectious disease (such as Ebola virus) should not be performed until the person’s symptoms have fully resolved and a physician has cleared the patient for treatment.
Patients suspected of infection with a highly infectious disease should be further evaluated by faculty. A medical evaluation may be sought.

With patients suspected of infection with Ebola virus, healthcare providers will use the algorithm “Identify, Isolate, and Inform: Emergency Department Evaluation and Management of Patients with Possible Ebola Virus Disease”


Note there are alternative causes of febrile illness (e.g. malaria in travelers, etc.)

<table>
<thead>
<tr>
<th>EVALUATION PROTOCOL</th>
</tr>
</thead>
<tbody>
<tr>
<td>✷ A thorough health history</td>
</tr>
<tr>
<td>✷ Targeted patient interview regarding fever, travel, and signs and symptoms of infectious disease.</td>
</tr>
<tr>
<td>✷ Vital signs including temperature. Note that recent use of aspirin or an NSAID can lower a fever and cause a false negative response to fever.</td>
</tr>
</tbody>
</table>

Clinics are encouraged to use the screening form “Health Screening questions for UW Dental patients” currently in use by the UW Dental Urgent Care Clinic.

1. This screening form is used in reception areas,
2. Patients self-report symptoms and travel risks,
3. “Yes” responses reviewed by faculty,
4. On patients deemed at risk of infectious disease, determination made to delay elective care, proceed with treatment, or refer for medical assessment.
Assessment of risk –
1. travel to countries where Ebola is found
2. contact with Ebola patients such as family and friends in close contact with Ebola patients, healthcare providers who have come in contact with an Ebola patient
3. AND signs and symptoms of Ebola

As of March 31, 2016:

Countries with widespread transmission (the entire country):
- None

Countries with former widespread transmission and current, established control measures\(^1\) (the entire country):
- Liberia\(^2\)
- Sierra Leone\(^3\)
- Guinea\(^4\)

Cases in urban settings with uncertain control measures:\(^5\)
- None

Cases in urban settings with effective control measures:
- None

Previously affected countries\(^6\) (these countries currently Ebola free):
- Nigeria (Lagos, Port Harcourt)
- Senegal (Dakar)
- Spain (Madrid)
- United States (Dallas, TX; New York City, NY)
- Mali (Bamako)
- United Kingdom (Scotland, England)
- Italy (Sardinia)

\(^1\)This category also includes countries that have experienced widespread transmission but are transitioning to being declared free of Ebola. The World Health Organization (WHO) is responsible for determining when a country will be
declared free of Ebola virus transmission. Public health authorities in these countries should maintain active surveillance for new cases of Ebola and identify, locate, and monitor any potential contacts.

2 On May 13, 2015, CDC changed the country classification for Liberia to a country with former widespread transmission and current, established control measures.

3 On November 10, 2015, CDC changed the country classification for Sierra Leone to a country with former widespread transmission and current, established control measures.

4 On December 29, 2015, CDC changed the country classification for Guinea to a country with former widespread transmission and current, established control measures.

5 Transmission in urban areas indicates the potential for spread through international air travel. Control measures in these countries are considered to be uncertain because of the inability of public health authorities to identify, locate, or monitor a large proportion of potential contacts. People arriving from these countries should be screened upon entry.

9 In these countries, which previously had locally acquired or imported Ebola cases, at least 42 days (two incubation periods) have elapsed since the last day that any person in the country had contact with a person with confirmed Ebola.

**IDENTIFY, ISOLATE, INFORM**

**Healthcare facilities and providers should be able to:**

1. **Rapidly identify patients** with relevant exposure history AND signs or symptoms compatible with Ebola virus disease (EVD).

2. **Isolate** any patient with relevant exposure history AND signs or symptoms compatible with EBV.
3. **Immediately notify the hospital.facility infection control program** that a patient has been identified who has relevant exposure AND signs or symptoms compatible with Ebola virus disease.

4. Discuss with the hospital.facility infection control program to **transfer the patient to a medical assessment area** for further evaluation and testing. Local and state public health agencies should be notified (usually by the hospital/assessment facility).

5. Confirmed EVD patients should be transferred by the hospital to an Ebola treatment center (currently University of Washington Hospital and Harborview Hospital (as of December 2014)).

**To evaluate patients suspected of infection with Ebola virus, use the CDC algorithm located on the CDC website.**

“Identify, Isolate, Inform: Emergency Department Evaluation and management of Patients with Possible Ebola Virus Disease”


| Severity | Ebola virus disease is a rare and deadly disease. Though not highly contagious (not spread airborne, requires direct contact), Ebola is highly infectious (causes disease once exposed).

Person-to-person transmission follows and can lead to large numbers of affected people.

No FDA-approved vaccine or medicine (e.g., antiviral drug) is available for Ebola.

Symptoms of Ebola and complications are treated as they appear.

Experimental vaccines and treatments for Ebola are under development, but they have not yet been fully tested for safety or effectiveness.

Recovery from Ebola depends on good supportive care and the patient’s immune response. People who recover from Ebola infection develop antibodies that last for at least 10 years, possibly longer. It is not known if people who recover are immune for life or if they can become infected with a different species of Ebola. Some people who have recovered from Ebola have developed long-term complications, such as joint and vision problems. 

vi
**Prevalence**

Since March 2014, West Africa has experienced the largest outbreak of Ebola in history, with multiple countries affected. (see “Evaluation protocol” section above)

In response to the outbreak, CDC activated its Emergency Operations Center to coordinate technical assistance and control activities with other U.S. government agencies, the World Health Organization, and other domestic and international partners. CDC also deployed teams of public health experts to West Africa. Widespread transmission of Ebola in West Africa has been controlled, although additional cases may continue to occur sporadically. However, because of ongoing surveillance and strengthened response capacities, the affected countries now have the experience and tools to rapidly identify any additional cases and to limit transmission.

**Incubation time**

Symptoms may appear anywhere from 2 to 21 days after exposure to Ebola, but the average is 8 to 10 days.vii

**High risk factors**

Healthcare providers caring for Ebola patients and family and friends in close contact with Ebola patients are at the highest risk of getting sick because they may come in contact with the blood or body fluids of sick patients.

**Prevention**

General precautions:

- **Respiratory hygiene/cough etiquette**
  - Practice hand hygiene. Wash your hands often with soap and water, especially after you cough or sneeze. Alcohol-based hand cleaners are also effective.
  - Cover your nose and mouth with a tissue when you cough or sneeze. Throw the tissue in the trash after you use it.
  - Avoid touching your eyes, nose or mouth. Germs spread this way.
  - Try to avoid close contact with sick people.
  - If you get sick with influenza, the U.S. Centers for Disease Control and Prevention recommends that you stay home from work or school and limit contact with others to keep from infecting them.

- Masking and separation of symptomatic persons.
- Wear appropriate personal protective equipment (PPE).
Practice proper infection control and sterilization measures. For more information, see Information for Healthcare Workers and Settings.

Precautions with patients at risk of Ebola Virus Disease:

- Predoctoral students are not to treat patients suspected of highly infectious diseases such as Ebola virus disease. Faculty should evaluate and further medical evaluation accessed.
- Isolate patients with suspected Ebola Virus Disease from other patients. A private room for patient interview and assessment is available next to the UW Dental Urgent Care Clinic in B229.

  - If interviewing (and only interviewing) patients with suspected Ebola virus infection, use standard personal protective equipment (PPE) - (provider will have no contact with body fluids including saliva, and there is no risk of patient vomiting or creating droplets)

    - If contact with body fluids is likely, healthcare providers will use appropriate personal protective equipment (PPE) for management of patients with Ebola Virus Disease – this is a higher level of personal protective equipment than normally used in regular dental clinics (see CDC information on “Guidance on Personal Protective Equipment To Be Used by Healthcare Workers During Management of Patients with Ebola Virus Disease in U.S. Hospitals, Including Procedures for Putting On (Donning) and Removing (Doffing)”). viii

    - Before any dental treatment, patients with suspected Ebola virus infection will require medical evaluation. The UW Medical Center is to be notified and appropriate transport arranged.

    - Any treatment of patients with suspected Ebola virus will occur in secure areas designed and dedicated for highly infectious diseases. UW Medical Centers and Harborview Medical Center both have areas prepared for patients with suspected Ebola virus infection.

    - Any treatment of patients with suspected Ebola virus infection will be done by experienced clinicians with special training in management of patients with Ebola virus infection.

Notify health officials if you have had direct contact with the blood or body fluids, such as but not limited to, feces, saliva, urine, vomit, and semen of a person who is sick with Ebola. The virus can enter the body through broken skin or unprotected mucous membranes in, for example, the eyes, nose, or mouth. ix
CDC Hand Hygiene in Healthcare Settings:
http://www.cdc.gov/handhygiene/

Hand Hygiene Basics:
http://www.cdc.gov/handhygiene/Basics.html
http://www.cdc.gov/vhf/ebola/symptoms/index.html
http://www.cdc.gov/vhf/ebola/transmission/qas.html
http://www.cdc.gov/vhf/ebola/treatment/index.html
http://www.cdc.gov/vhf/ebola/symptoms/index.html
http://www.cdc.gov/vhf/ebola/hcp/procedures-for-ppe.html
Middle East Respiratory Syndrome

<table>
<thead>
<tr>
<th>Cause</th>
<th>a viral respiratory illness caused by a coronavirus called MERS-CoV – first reported in Saudi Arabia in 2012</th>
</tr>
</thead>
</table>
| NEED TO KNOW | • Patients should be referred for medical evaluation if  
  o Have symptoms of upper respiratory infection (see symptoms below),  
  o AND have traveled to the Arabian Peninsula within the last 14 days  
    (Saudi Arabia, United Arab Emirates (UAE), Qatar, Oman, Jordan, Kuwait, Yemen, Lebanon, Iran, etc.),  
  o OR had contact with symptomatic travelers from the Arabian Peninsula within the last 14 days.  

• Cases currently limited geographically to Arabian Peninsula countries (Saudi Arabia, United Arab Emirates (UAE), Qatar, Oman, Jordan, Kuwait, Yemen, Lebanon, Iran, etc.) and countries with travel-associated cases of MERS.  

• Additional information available on CDC website:  

| Symptoms | Fever (take your temperature twice a day)  
  Coughing  
  Shortness of breath  
  Other early symptoms to watch for are chills, body aches, sore throat, headache, diarrhea, nausea/vomiting, and runny nose.  

If you develop symptoms, call ahead to your healthcare provider as soon as possible and tell him or her about your possible exposure to MERS-CoV so the office can take steps to keep other people from getting infected. Ask your healthcare provider to call the local or state health department.  

Last updated: 12/09/2014  
For updated information please visit the Center for Disease Control MERS information  
Transmission factors

**MERS is contagious only to a limited extent.** The virus does not seem to pass easily from person to person unless there is close contact, such as occurs when providing unprotected care to a patient.xi

Severity

About 30% of people confirmed to have MERS-CoV infection have died.

Prevalence

Cases limited to Arabian Peninsula countries (Saudi Arabia, United Arab Emirates (UAE), Qatar, Oman, Jordan, Kuwait, Yemen, Lebanon, Iran, etc.) and countries with travel-associated cases of MERS.

So far, all the cases have been linked to countries in and near the Arabian Peninsula. This virus has spread from ill people to others through close contact, such as caring for or living with an infected person. However, there is no evidence of sustained spreading in community settings.xii

CDC continues to closely monitor the MERS situation globally and work with partners to better understand the risks of this virus, including the source, how it spreads, and how infections might be prevented. CDC recognizes the potential for MERS-CoV to spread further and cause more cases globally and in the U.S. We have provided information for travelers and are working with health departments, hospitals, and other partners to prepare for this.

**MERS in the U.S.** On May 2, 2014, the first U.S. imported case of MERS was confirmed in a traveler from Saudi Arabia to the U.S. On May 11, 2014, a second U.S. imported case of MERS was confirmed in a traveler also from Saudi Arabia. The two U.S. cases are not linked.

More information about MERS in the US and Arabian Peninsula can be found at http://www.cdc.gov/features/novelcoronavirus/index.html

Incubation time

2 to 14 days

High risk factors

People with diabetes, kidney failure, chronic lung disease, and people who have weakened immune systems.

Transmission

MERS-CoV has spread from ill people to others through close contact, such as caring for or living with an infected person. Infected people have spread MERS-CoV to others in healthcare settings, such as hospitals. Researchers studying MERS have not seen any ongoing spreading of MERS-CoV in the community.

All reported cases have been linked to countries in and near the Arabian Peninsula. Most infected people either lived in the Arabian Peninsula or recently traveled from the Arabian Peninsula before they became ill. A few people became
infected with MERS-CoV after having close contact with an infected person who had recently traveled from the Arabian Peninsula.\textsuperscript{xiv}

Public health agencies continue to investigate clusters of cases in several countries to better understand how MERS-CoV spreads from person to person.

<table>
<thead>
<tr>
<th>Prevention</th>
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</thead>
</table>
| - Respiratory hygiene/cough etiquette  
- Masking and separation of persons with respiratory symptoms  
- Use standard personal protective equipment (PPE) for droplet precautions |

Healthcare personnel should adhere to recommended infection control measures, including standard, contact, and airborne precautions, while managing symptomatic close contacts, patients under investigation, and patients who have probable or confirmed MERS-CoV infections.\textsuperscript{xv}

http://www.cdc.gov/coronavirus/mers/
http://www.cdc.gov/coronavirus/MERS/about/symptoms.html
http://www.cdc.gov/coronavirus/mers/about/transmission.html
http://www.cdc.gov/coronavirus/MERS/risk.html#peninsula
### Severe Acute Upper Respiratory Syndrome (SARS) – (no cases since 2004)

Last updated: 12/09/2014

For updated information please visit the Center for Disease Control SARS information [here](http://www.cdc.gov/sars/)

| **Cause** | a viral respiratory illness caused by a [coronavirus](http://www.cdc.gov/sars/infection/index.html), called SARS-associated coronavirus (SARS-CoV). SARS was first reported in Asia in February 2003. The illness spread to more than two dozen countries in North America, South America, Europe, and Asia before the SARS global outbreak of 2003 was contained.  
Since 2004, there have not been any known cases of SARS reported anywhere in the world. |
<table>
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<tbody>
<tr>
<td><strong>Frequently asked questions about SARS</strong></td>
<td><a href="http://www.cdc.gov/sars/about/faq.html">here</a></td>
</tr>
<tr>
<td><strong>Prevention</strong></td>
<td></td>
</tr>
</tbody>
</table>
- Respiratory hygiene/cough etiquette  
- Masking and separation of persons with respiratory symptoms  
- Use standard personal protective equipment (PPE) for droplet precautions  
  |

### Cause

A contagious and an often severe airborne disease caused by a bacterial infection of *Mycobacterium tuberculosis*.

Tuberculosis (TB) is a disease caused by germs that are spread from person to person through the air. TB usually affects the lungs, but it can also affect other parts of the body, such as the brain, the kidneys, or the spine.¹⁷

### NEED TO KNOW

Elective dental care on patients suspected of active TB disease should not be performed until the person is declared non-infectious by a physician.

**Latent TB:** Persons with latent TB are not infectious and can be treated in the dental office under standard infection control precautions.

**Active TB:** Persons with symptoms suggestive of active TB should be separated from other patients, instructed to wear a mask, assessed for the urgency of their dental care, and referred for medical evaluation and care.

Urgent dental care for a person with TB disease should be provided in a facility with the capacity for airborne infection isolation that has a respiratory protection program in place. Standard surgical face masks are not designed to protect against TB transmission. Dental personnel should use respiratory protection in accordance with CDC and OSHA requirements.

Dental students should not be providing treatment to patients with active TB disease.

### Symptoms

- A bad cough that lasts 3 weeks or longer
- Pain in the chest
- Coughing up blood or sputum
- Weakness or fatigue
- Weight loss
- No appetite
- Chills
- Fever
- Sweating at night¹⁸

### Transmission factors

Active Tuberculosis is contagious. TB is spread through the air from one person to another.
**Not everyone infected with tuberculosis becomes sick.** As a result, two TB-related conditions exist: latent TB infection and TB disease.

**Latent TB infection:** Persons with latent TB infection do not feel sick and do not have any symptoms. They are infected with *M. tuberculosis*, but do not have TB disease. The only sign of TB infection is a positive reaction to the tuberculin skin test or TB blood test. **Persons with latent TB infection are not infectious and cannot spread TB infection to others.**

Many people who have latent TB infection never develop TB disease. Some people develop TB disease soon after becoming infected (within weeks) before their immune system can fight the TB bacteria. Other people may get sick years later when their immune system becomes weak for another reason.

**TB disease:** people are sick from TB germs that are active, multiplying and destroying tissue in their body. They usually have symptoms of TB disease. People with TB disease of the lungs or throat are capable of spreading germs to others. They are prescribed drugs that can treat TB disease.

<table>
<thead>
<tr>
<th>Severity</th>
<th>A person with TB can die if they do not get treatment.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevalence</td>
<td>Varies by country</td>
</tr>
<tr>
<td></td>
<td>One third of the world’s population is infected with TB (over 2 billion people).</td>
</tr>
<tr>
<td></td>
<td>In 2013, 65% of all TB cases and 90% of multidrug–resistant TB cases in the United States occurred among people born in other countries.</td>
</tr>
<tr>
<td></td>
<td>Nearly 50% of these individuals were born in just five countries.</td>
</tr>
<tr>
<td></td>
<td>9,582 TB cases (a rate of 3.0 cases per 100,000 persons) were reported in the United States in 2013</td>
</tr>
<tr>
<td>High risk factors</td>
<td>For people whose immune systems are weak, especially those with HIV infection, the risk of developing TB disease is much higher than for people with normal immune systems.</td>
</tr>
<tr>
<td></td>
<td>Once a person is infected with TB bacteria, the chance of developing TB disease is higher if the person: has HIV infection; been recently infected with TB bacteria (in the last 2 years); has other health problems, like diabetes, that make it hard for the body to fight bacteria; abuses alcohol or uses illegal drugs; or was not treated correctly for TB infection in the past.</td>
</tr>
<tr>
<td>Transmission</td>
<td>TB germs are put into the air when a person with TB disease of the lungs or throat coughs, sneezes, speaks, or sings.</td>
</tr>
</tbody>
</table>
These germs can stay in the air for several hours, depending on the environment. Persons who breathe in the air containing these TB germs can become infected; this is called latent TB infection.

**TB is not spread by**
- Shaking someone’s hand
- Sharing food or drink
- Touching bed linens or toilet seats
- Sharing toothbrushes
- Kissing

**Prevention**
- **Prompt detection and referral of suspected infectious patients**;
- Airborne precautions;
- Treatment of people who have suspected or confirmed tuberculosis (TB) disease.

The most critical risk for healthcare-associated transmission of M. tuberculosis in healthcare settings is from patients with unrecognized TB disease who are not promptly handled with appropriate airborne precautions.

**Travelers and high risk environments**

Avoid close contact or prolonged time with known TB patients in crowded, enclosed environments (for example, clinics, hospitals, prisons, or homeless shelters).

Travelers who will be working in clinics, hospitals, or other health care settings where TB patients are likely to be encountered should consult infection control or occupational health experts. They should ask about administrative and environmental procedures for preventing exposure to TB. Once those procedures are implemented, additional measures could include using personal respiratory protective devices.

Travelers who anticipate possible prolonged exposure to people with TB (for example, those who expect to come in contact routinely with clinic, hospital, prison, or homeless shelter populations) should have a tuberculin skin test (TST) or interferon-gamma release assay (IGRA) test before leaving the United States. If the test reaction is negative, they should have a repeat test 8 to 10 weeks after returning to the United States. Additionally, annual testing may be recommended for those who anticipate repeated or prolonged exposure or an extended stay over a period of years.

**If you think you have been exposed**

Contact your health care provider or local health department to see if you should be tested for TB. Be sure to tell the doctor or nurse when you spent time with someone who has TB disease.
**Concern:** Multi-drug resistant tuberculosis (MDR TB) exists and, rarely, extensively multi-drug resistant tuberculosis (XDR TB). Drug resistant TB is a public health challenge.

Additional information available:

CDC TB 101 for Health Care Workers

CDC TB Factsheet “General” information

CDC TB Factsheet “Infection Control in Healthcare Settings”
Influenza (seasonal influenza, the flu)

<table>
<thead>
<tr>
<th>Cause</th>
<th>Caused by <strong>influenza viruses, which infect the respiratory tract</strong> (i.e. nose, throat, lungs)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Unlike other viral respiratory infections, such as the common cold, the flu can cause severe illness and life-threatening complications in many people</td>
</tr>
<tr>
<td></td>
<td>There are several influenza viruses such as the swine flu (H1N1, and H3N2), and the avian flu (H5N1, H7N9, and the highly pathogenic H5N1 with only sporadic human infections).</td>
</tr>
<tr>
<td></td>
<td>Note: <strong>other respiratory viruses</strong> can also circulate during flu season and cause symptoms and illness similar to those seen with flu infections. Non-flu viruses include <strong>rhinovirus (one cause of the “common cold”)</strong> and <strong>respiratory syncytial virus (RCV, more common in children).</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NEED TO KNOW</th>
<th>Elective dental care on patients suspected of infection with known highly infectious disease (such as influenza) should not be performed until the person’s symptoms have resolved.</th>
</tr>
</thead>
</table>
|              | **Use standard infection control**  
|              | 1. **Wash hands** thoroughly and frequently. And use alcohol-based hand sanitizers.  
|              | 2. **Contain your coughs and sneezes.** Cover your mouth and nose when you sneeze or cough. Cough into a tissue or the inner crook of your elbow to avoid contaminating your hands.  
|              | 3. **Avoid crowds.**  
|              | 4. **When you are sick, stay at home** so you do not infect others. |
|              | **Assess patients for evidence of infectious disease**  
|              | 1. Health history questionnaire  
|              | 2. Direct health interview  
|              | 3. Signs and symptoms (fever, cough, sore throat, etc. – see below)  
|              | 4. Faculty consult and patient assessment  
|              | 5. Refer for medical evaluation when appropriate |
Avoid working on patients who are sick.

<table>
<thead>
<tr>
<th>Symptoms</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Fever or feeling feverish/chills</td>
<td>• muscle or body aches</td>
</tr>
<tr>
<td>• cough</td>
<td>• headaches</td>
</tr>
<tr>
<td>• sore throat</td>
<td>• fatigue (tiredness)</td>
</tr>
<tr>
<td>• runny or stuffy nose</td>
<td>• some people may have vomiting</td>
</tr>
<tr>
<td></td>
<td>and diarrhea, but this is more common in children.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Transmission factors</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Spread to others up to about 6 feet. Most experts think the flu virus are spread mainly by droplets made when people with flu cough, sneeze, or talk. These droplets can land in the mouths or noses of people who are nearby or possibly be inhaled into lungs. Less often, a person might also get flu by touching a surface of object that has flu virus on it and then touching their own mouth or nose.</td>
<td></td>
</tr>
</tbody>
</table>

Most people with the flu have mild illness and do not need medical care or antiviral drugs. If you get sick with flu symptoms, in most cases, you should stay home and avoid contact with other people except to get medical care.

- You can get the flu from patients and coworkers who are sick with the flu.
- If you get the flu, you can spread it to others even if you don’t feel sick.
- By getting vaccinated, you help protect yourself, your family at home, and your patients.

<table>
<thead>
<tr>
<th>Severity</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Flu is unpredictable and how severe it is can vary widely from one season to the next depending on many things, including:</td>
<td></td>
</tr>
<tr>
<td>• what flu viruses are spreading,</td>
<td></td>
</tr>
<tr>
<td>• how much flu vaccine is available,</td>
<td></td>
</tr>
<tr>
<td>• when vaccine is available,</td>
<td></td>
</tr>
<tr>
<td>• how many people get vaccinated, and</td>
<td></td>
</tr>
<tr>
<td>• How well the flu vaccine is matched to flu viruses that are causing illness.</td>
<td></td>
</tr>
</tbody>
</table>

Influenza (the flu) can be a serious disease that can lead to hospitalization and sometimes even death. Anyone can get very sick from the flu, including people who are otherwise healthy.

<table>
<thead>
<tr>
<th>Prevalence</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>It is estimated that each year on average 5% to 20% of the population gets the flu and more than 200,000 people are hospitalized from seasonal flu-related complications</td>
<td></td>
</tr>
</tbody>
</table>

Flu seasons are unpredictable and can be severe.
Over a period of 30 years, between 1976 and 2006, estimates of flu-associated deaths in the United States range from a low of about 3,000 to a high of about 49,000 people.

Some people, such as older people, young children, pregnant women, and people with certain health conditions are at high risk of serious flu complications.

**Incubation time**

Most healthy adults may be able to infect other people beginning 1 day before symptoms develop and up to 5 to 7 days after becoming sick. Children may pass the virus for longer than 7 days.

Symptoms start 1 to 4 days (average 2 days) after the virus enters the body. That means that you may be able to pass on the flu to someone else before you know you are sick, as well as while you are sick.xxix

Some people can be infected with the flu virus but have no symptoms. During this time, those persons may still spread the virus to others.

**High risk factors**

Anyone can get the flu (even healthy people), and serious problems related to the flu can happen at any age.

Some people are at high risk of developing serious complications:

- **Children** younger than 5, especially younger than 2 years old
- **Adults 65 years and older**
- **Pregnant women**
- **American Indians and Alaskan Native** seem to be at increased risk.

- People of any age with certain chronic medical conditions such as:
  - Asthma
  - Neurological and neurodevelopmental conditions (including disorders of the brain, spinal cord, peripheral nerve, and muscle such as cerebral palsy, epilepsy (seizure disorder), stroke, muscular dystrophy, spinal cord injury)
  - Chronic lung disease (chronic obstructive pulmonary disease (COPD) and cystic fibrosis
  - Heart disease (congenital heart disease, congestive heart failure, coronary artery disease)
  - Blood disorders (such as sickle cell disease)
  - Endocrine disorders (such as diabetes mellitus)
  - Kidney and liver disorders
<table>
<thead>
<tr>
<th><strong>Prevention – every day precautions</strong></th>
<th>Follow general every day precautions that help prevent the spread of germs that cause respiratory illness:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• <strong>Practice hand hygiene.</strong> <em>Wash your hands often</em> with soap and water, especially after you cough or sneeze. Alcohol-based hand cleaners are also effective.**</td>
</tr>
<tr>
<td></td>
<td>• <strong>Cover your nose and mouth with a tissue when you cough or sneeze.</strong> Throw the tissue in the trash after you use it.</td>
</tr>
<tr>
<td></td>
<td>• <strong>Avoid touching your eyes, nose or mouth.</strong> Germs spread this way.</td>
</tr>
<tr>
<td></td>
<td>• <strong>Try to avoid close contact with sick people.</strong></td>
</tr>
<tr>
<td></td>
<td>• <strong>If you get sick</strong> with influenza, the U.S. Centers for Disease Control and Prevention recommends that you <strong>stay home from work or school and limit contact with others</strong> to keep from infecting them.</td>
</tr>
</tbody>
</table>

Additional information on infection control in healthcare settings can be found at:

- CDC “Healthcare-associated infections”
  [http://www.cdc.gov/hai/prevent/ppe.html](http://www.cdc.gov/hai/prevent/ppe.html)

- CDC “Guidelines for Infection Control in Healthcare Personnel, 1998”

Please note that previous “Guidelines for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare settings, 2007” has been replaced by the:

- CDC “Infection Prevention and Control Recommendations for Hospitalized Patients with Known or Suspected Ebola Virus Disease in US Hospitals”

- Metabolic disorders (inherited metabolic disorders, mitochondrial disorders)
- Weakened immune system due to disease or medication (people with HIV or AIDS, cancer, or those on chronic steroids).
- People younger than 19 years of age who are receiving long-term aspirin therapy
- People who are morbidly obese (Body Mass Index, or BMI of 40 or greater).

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**Prevention – every day precautions**

- **Practice hand hygiene.** *Wash your hands often* with soap and water, especially after you cough or sneeze. Alcohol-based hand cleaners are also effective.
- **Cover your nose and mouth with a tissue when you cough or sneeze.** Throw the tissue in the trash after you use it.
- **Avoid touching your eyes, nose or mouth.** Germs spread this way.
- **Try to avoid close contact with sick people.**
- **If you get sick** with influenza, the U.S. Centers for Disease Control and Prevention recommends that you **stay home from work or school and limit contact with others** to keep from infecting them.

Additional information on infection control in healthcare settings can be found at:

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Please note that previous “Guidelines for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare settings, 2007” has been replaced by the:

- CDC “Infection Prevention and Control Recommendations for Hospitalized Patients with Known or Suspected Ebola Virus Disease in US Hospitals”
Prevention - vaccination

The **best way to prevent seasonal flu is by getting a flu vaccination each year.**

The CDC Advisory Committee on Immunization Practices (ACIP), and the Healthcare Infection Control Practices Advisory Committee (HICPAC) recommend that **all U.S. health care workers get vaccinated annually against influenza.**

Everyone 6 months and older should get vaccinated against the flu every year. Get vaccinated soon after vaccine becomes available in your community, ideally by October. Immunity set in about two weeks after vaccination.

Flu season in the United States occurs in the fall and winter. The peak of flu season has occurred anywhere from late November through March.

Additional information available:

CDC Hand Hygiene in Healthcare Settings:
http://www.cdc.gov/handhygiene/

Hand Hygiene Basics:
http://www.cdc.gov/handhygiene/Basics.html

http://www.cdc.gov/flu/about/qa/disease.htm
http://www.cdc.gov/flu/about/disease/symptoms.htm
http://www.cdc.gov/flu/professionals/acip/clinical.htm
http://www.cdc.gov/flu/about/disease/high_risk.htm
http://www.cdc.gov/flu/healthcareworkers.htm
APPENDIX B: CDC Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis

CDC Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis (4/06)


The tuberculosis (TB) infection-control measures recommended by Centers for Disease Control and Prevention (CDC) in 1994 were implemented widely in health-care facilities in the United States. The result has been a decrease in the number of TB outbreaks in health-care settings reported to CDC and a reduction in health-care-associated transmission of Mycobacterium tuberculosis to patients and healthcare workers (HCWs). This report updates TB control recommendations reflecting shifts in the epidemiology of TB, advances in scientific understanding, and changes in health-care practice that have occurred in the United States during the preceding decade. The 2005 CDC document places emphasis on actions to maintain momentum and expertise needed to avert another TB resurgence and to eliminate the lingering threat to HCW, which is mainly from patients or others with unsuspected and undiagnosed infectious TB disease.

Dental procedures could stimulate coughing and dispersal of infectious particles, however, the generation of droplet nuclei containing M. tuberculosis as a result of dental procedures has not been demonstrated. Patients and dental HCWs share the same air space for varying periods, which contributes to the potential for transmission of M. tuberculosis in dental settings. For example, during primarily routine dental procedures in a dental setting, multi-drug resistant TB might have been transmitted between two dental workers. As a result, the 2005 CDC report provides recommendations to prevent the transmission of M. tuberculosis in dental health-care settings. The 2003 CDC Dental Infection-Control Guidelines also addressed TB. Highlights of the recommendations for dentistry include:

- Infection control policies for each dental health-care setting should be developed, based on the community TB risk assessment. The policies should include appropriate screening for latent TB infection and TB disease for dental HCWs, education on the risk for transmission to dental HCWs, and provisions for detection and management of patients who have suspected or confirmed TB disease.

- When taking a patient's initial medical history and at periodic updates, dental HCWs should routinely ask all patients whether they have a history of TB disease or symptoms indicative of TB.

- During clinical assessment and evaluation, a patient with suspected or confirmed TB disease should be instructed to observe strict respiratory hygiene and cough etiquette procedures. The patient should also wear a surgical or procedure mask, if possible. These patients should not be kept in the dental facility any longer than required to evaluate their dental condition and arrange a referral.

- Elective dental treatment should be postponed until a physician confirms that the patient does not have infectious TB, or if the patient is diagnosed with active TB disease, until confirmed the patient is no longer infectious.

- If urgent dental care must be provided for a patient who has suspected or confirmed infectious TB disease, dental care should be provided in a setting that meets the requirements for an airborne infection isolation (AI) room. Standard surgical face masks do not protect against TB transmission; dental HCWs should use respiratory protection (at least N95 disposable respirator) while performing procedures on such patients.

DEC5 Comment: The USAF Guidelines for Infection Control in Dentistry address measures to prevent the transmission of TB, including the need for education and patient assessment. Since community TB risk assessments will vary depending upon location, USAF dental clinics are required to follow their medical treatment facility's guidance regarding developing, maintaining, and implementing a written TB infection-control plan; managing a patient with suspected or active TB; completing a community risk assessment to guide employee tuberculin skin tests (TST) and follow-up; and managing dental HCWs with TB disease. The CDC Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health-Care Settings, 2005 are available by visiting www.cdc.gov/tb.
APPENDIX C
ADA Statement on the Treatment of Patients with Infectious Diseases of Uncertain Transmission

ADA STATEMENT ON THE TREATMENT OF PATIENTS WITH INFECTIOUS DISEASES OF UNCERTAIN TRANSMISSION

Infectious Diseases of Uncertain Transmission

The American Dental Association considers the delivery of necessary dental care to patients to be the fundamental responsibility of every practicing dentist. This obligation is expressed in the principles of beneficence and justice in the ADA Principles of Ethics and Code of Professional Conduct.

Occasionally, a dentist may be called on to provide care to a patient with an infectious disease for which there are no recommended infection control procedures to prevent or reduce the risk of disease transmission within an otherwise adequately equipped dental operatory. For example, during the outbreak of severe acute respiratory syndrome (SARS) in 2003, many questioned whether a dentist could safely treat an infected patient without endangering himself or herself, other patients or members of the dental team.

To maintain patient and provider safety in the delivery of oral health care, the dentist and the dental team should be adequately trained in infection control measures as recommended by the U.S. Centers for Disease Control and Prevention (CDC). When concerned about uncertain transmission of infectious disease, dentists are encouraged to consult the recommendations of appropriate public health authorities, such as the CDC. Dentists can also check with the local or state health department for the latest epidemiological information for their community.

In most circumstances, the decision to treat a patient with a suspected infectious disease depends primarily on the particular infectious organism and whether recommended infection control procedures will allow the dentist to treat the patient without compromising the safety of dental health care workers and other patients. For example, in the case of patient with suspected active tuberculosis, elective dental treatment should be deferred until a medical evaluation confirms that the patient is not infectious. Consulting with the patient’s current treating physician and/or facility to review the course and outcome of treatments rendered may inform the dentist as to the appropriate and safe time for providing dental treatment. In the case of a dental emergency, treatment of such a patient should be provided in a facility equipped with the capacity for airborne infection isolation.

As is the case with all patients, when an individual is suspected of having an infectious disease of uncertain transmission where effective infection control procedures have not been identified or scientifically supported, dentists should balance the needs of the patient with the safety of other individuals to arrive at an appropriate treatment decision. If it is believed that the patient may have an undiagnosed disease that poses a significant public health risk, the dentist should, while balancing and respecting the patient’s privacy rights, consider contacting the proper public health authorities.
Adopted by the Council on Scientific Affairs and the Council on Ethics, Bylaws and Judicial Affairs April 2012.

25. http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5417a1.htm?s_cid=rr5417a1_e
APPENDIX D

HIPAA Privacy in Emergency Situations

Patient rights to privacy are protected under HIPAA federal and state privacy laws. UW School of Dentistry faculty, staff, students, and volunteers are required to follow legal protocols to safeguard patient privacy, as detailed in the School’s Notice of Privacy Practices brochure, online at: http://dental.washington.edu/compliance/hipaa/

Protocols include: Never sharing protected health information (PHI) unless permitted to do so, and never accessing that information unless it is required to treat the patient. In addition, a general prohibition on disclosing information about an Ebola patient is for the patient or the patient’s personal representative has signed a valid HIPAA authorization/consent form.

According to the Department of Health and Human Services, disclosure of patient PHI is permitted for treatment and payment purposes, at the request of a public health authority for purposes of controlling disease, or to a person who may have been exposed to a communicable disease who is at risk of spreading it. Reference: November 2014; U.S. Department of Health and Human Services, Office for Civil rights; BULLETIN: HIPAA Privacy in Emergency Situations

http://dental.washington.edu/compliance/policies-guidelines-procedures/hipaa-privacy-policies/
Subject: Bloodborne Pathogens Exposure

PURPOSE

The purpose of this plan/policy is to clearly communicate the appropriate response to bloodborne exposures such as needle sticks and eye splashes, or anytime human tissues are handled, by addressing post exposure first aid, source patient counseling and event reporting.

GENERAL POLICY

This policy includes post exposure plans for all School of Dentistry sites of practice, including external and mobile rotations. School of Dentistry faculty, students and staff may provide patient care at non-UW School of Dentistry sites of practice. Copies of the post exposure plans for these non-School of Dentistry sites will be appended to this policy.

IMPLEMENTATION

I. Post Exposure Response

1. Provide Initial Treatment:

   a. Eye or facial exposure
      • Flush exposed eyes (while holding eyelids open) with water for 15 minutes soon as possible (prior to seeking medical care) using emergency eyewash stations if available.

   b. Needle sticks and non-intact skin exposure
      • Scrub exposed area thoroughly with warm water and sudsy soap for 15 minutes, perform first aid and seek medical care as soon as possible.

   c. Notify the appropriate staff/faculty
d. Call the **School of Dentistry’s Exposure/Incident Hotline at 206-351-2268.**

The Counselor answering the phone will assist with specific directions for medical care and support. Outside of normal business hours (M – F, 8am – 5pm) students, staff and faculty should leave a detailed message and proceed with seeking medical care.

4. Seek medical care immediately (Exposure/Incident Hotline Counselor will facilitate appropriate action. Details are included below for information).

   a. **Exposures on School of Dentistry Campus**
      - Between 8:00am and 3:15pm, Mon – Fri, report to UWMC Employee Health (NE 210).
      - Between 3:15 and 5:00pm, Mon – Fri, call Upper Campus Employee Health at 206-685-1026 to talk with the Employee Health Nurse on duty.
      - After 5:00pm Mon – Fri, go directly to UWMC Emergency Room (2NE).

   b. **Exposures at the Center for Pediatric Dentistry**
      - Seattle Children’s Hospital Dental Surgery Center RN staff will perform blood draws separately on the source patient and exposed provider or staff. The Center will utilize courier services to transport samples to UW Lab Medicine for testing.

   c. **Exposures at the following DECOD Treatment Sites:** Snohomish Chalet, homebound patients in King/Pierce County, Mt. St. Vincent, Keiro Nursing Home and Seattle Rehab (partial day rotations that return to UW around 1pm)
      - Between 8:00am and 3:15pm, Mon – Fri, report to UWMC Employee Health (NE 210).
      - Between 3:15 and 5:00pm, Mon – Fri, call Upper Campus Employee Health at 206-685-1026 to talk with the Employee Health Nurse on duty.
      - After 5:00pm Mon - Fri, go directly to UWMC Emergency Room (2NE).

      **Note:** The attending will make sure the source patient is counseled over the phone by utilizing the exposure hotline and will follow the patient to the nearest hospital/clinic/ER.

   d. **Exposures at the following DECOD Treatment Sites:** Mt. Vernon, Centralia, Yakima, Bremerton, Vashon Island, Walla Walla and Clarkston (full day rotations that continue until the end of the day).

      Go to the assigned hospital in the area:

      **Mt. Vernon**
      Skagit Valley Hospital
      1415 E Kincaid, Mt. Vernon, WA 98273
Centralia  Providence Hospital  
914 S. Scheuber Rd, Centralia, WA 98531

Yakima  Yakima Valley Memorial Hospital  
2811 Tieton Dr, Yakima, WA 98902

Bremerton  Harrison Memorial Hospital, 2520 Cherry Ave  
Bremerton, WA 98310

Vashon Island  Swedish Medical Center ER  
16233 Sylvester Rd SW, Ste 120  
Burien, WA 98166

Walla Walla  Providence St. Mary Medical Center  
401 W Poplar St, Walla Walla, WA 99362

Clarkston  Tri-State Memorial Hospital  
1221 Highland Ave, Clarkston, WA 99403

**Note:** The attending will make sure the source patient is counseled over the phone by utilizing the exposure hotline and will follow the patient to the nearest hospital/clinic/ER.

e. **Exposures on Mobile Geriatric Rotation**
   - Between 8:00am and 3:15pm, Mon – Fri, report to UWMC Employee Health (NE 210).
   - Between 3:15 and 5:00pm, Mon – Fri, call Upper Campus Employee Health at 206-685-1026 to talk with the Employee Health Nurse on duty.
   - After 5:00pm Mon – Fri, go directly to UWMC Emergency Room (2NE).

   **Note:** Attending will make sure the source patient is counseled over the phone by utilizing the exposure hotline and follow the patient to the nearest community health clinic or public health dept clinic for testing.

f. **Exposures on RIDE and Service Learning Rotations**
   The Student Bloodborne Pathogens (BBP) Policy for RIDE (Regional Initiatives in Dental Education), RUOPs (Rural/Underserved Opportunities Program), and Service Learning Rotations (SLRs), (see Student Bloodborne Pathogens Policy, Appendix A) is given and explained to students as part of training just prior to their rotation. As part of the affiliation agreement between the rotation sites and the UWSOD, the sites must have a BBP policy in place that is introduced to the student at the orientation on his/her first day. If an incident occurs while a student is on rotation, the site is required to give the student access to their identified exposure counselor and receive emergency medical care and counseling.
as needed. The site must also identify the source patient status and notify the student accordingly.

g. **Cost for Student Post-Exposure Medical Care**
   Students treated at UWMC Employee Health will not be billed. Treatment provided anywhere other than UWMC Employee Health will be billed to the student’s insurance and any remaining patient responsibility will be handled by the HSIP staff via email at myshots@uw.edu or by phone at 206-616-9074.

II. **Source Patient Counseling**

The School of Dentistry assigns bloodborne exposure counseling responsibilities to a limited number of School employees in order to assure full time coverage during clinic operating hours.

These individuals voluntarily agree to serve as Exposure Counselor and are trained and certified by Employee Health with annual re-certification requirements. The individuals assigned to this role may change at any given time dependent on changes in employment status, work duties and willingness to serve. Exposure counseling may only be performed by these individuals; no other School of Dentistry workforce members are authorized.

The cost of source patient testing performed at UWMC ER is covered by the University. Cost and billing of source patient testing performed outside UW must be coordinated by the external site/rotation.

1. **Source Patient Counseling Training/Certification:**
   Exposure Counselors must be trained and certified by Employee Health before performing exposure counseling duties. The training includes but not limited to:
   a. One hour orientation by the Employee Health nurse or designee and includes the following topics:
      • Review of WAC 296-823-16010 requirements for source patient testing explanation of what testing is being requested.
      • Instruction on consenting source patient including pre-test screening and obtaining consent.

2. **Source Patient Counselor Responsibilities:**
   a. Maintain and follow Exposure Control Plan implemented by UW School of Dentistry according to OSHA/WISHA standards.
   b. Guarantee students/providers who may be at risk of exposure to bloodborne pathogens are provided with and have access to Personal Protective Equipment (PPE).
   c. Perform exposure counseling as needed for the School of Dentistry utilizing and adhering to the Employee Health Bloodborne Exposure Source Patient
Testing Checklist and Guidelines.

d. Provide Post-Exposure evaluation and follow-up if needed.

e. Notify the following personnel directly via email following exposure counseling so that the Employee Health Clinic Manager is prepared to receive paper work and test results.
   - Suzanne Mason, Employee Health Clinic Manager (sfmason@u.washington.edu)
   - Sandra Phillips, Health and Safety Director (sandyp@uw.edu)

f. Send all required exposure counseling paperwork (checklist, consent form, lab slip) to:
   
   Employee Health  
   Attention: Clinic Manager  
   Box 354410

g. Attend quarterly meetings with Exposure Counselors, lead by the Safety Manager and Director.

h. Maintain mandatory certification/training annually through UW Employee Health.

i. Maintain accurate recordkeeping and documentation of incident.

j. Participate in post-exposure training (to be determined).

3. **School of Dentistry Exposure/Incident Hotline 206-351-2268:**

   *Note:* All digits must be dialed as this is a cell phone number.

   The exposure hotline will be used in the School of Dentistry to ensure a counselor is accessible for exposure incidents within 15 minutes of initial exposure.

   a. The exposure hotline will be the sole method of contacting a School of Dentistry exposure counselor directly.

   b. Counselors will be assigned weekly (M – F, 8am – 5pm, excluding holidays) to the exposure hotline for immediate response to onsite and offsite exposure incidents involving staff, faculty, and students. Outside of normal business hours, individuals involved in incidents should proceed to the assigned emergency department where patient source counseling will be conducted.

   c. Calls made to the exposure hotline during normal business hours will be addressed as follows:
      - Calls for onsite exposure incidents will trigger an exposure counselor to respond within 15 minutes of call to location within school.
      - Calls for offsite exposure incidents are required to assist with
completion of source patient counseling in addition to identifying what facility the patient will be directed to for lab testing.

d. The exposure counselor will communicate essential information during initial call to include but not limited to:
   - Instruct staff or student to ensure the patient does not leave the clinic or location of incident.
   - Directing staff or student member to wash site for 15 minutes and perform first aid as needed.
   - Ensuring staff or student document incident in Occupational Accident Reporting System (OARS).

III. Post Exposure Event Reporting
Washington State Department of Labor and Industries requires employers to record work related injuries and illnesses. Supervisors should make a detailed report about each incident, even if only a minor injury or near miss, resulting in no injury.

   - Report all workforce events involving students, staff and or faculty through OARS at: [http://www.ehs.washington.edu/ohsoars/index.shtm](http://www.ehs.washington.edu/ohsoars/index.shtm)
   - Supervisors are responsible for completely filling out the OARS report, including corrective action. The corrective action response should include confirmation that the workforce member involved in the exposure received post-exposure training/re-education.

Appendices:

Appendix A, Student Bloodborne Pathogens Policy

Dean of UW SOD:

Joel Berg, Dean of the UW School of Dentistry  Date

APPENDIX A
STUDENT BLOODBORNE PATHOGENS POLICY
STUDENT BLOODBORNE PATHOGENS POLICY

Bloodborne Pathogens (BBP) Exposure
At the start of your rotation at a Community Health Clinic (CHC) you must be oriented to the following procedures that are specific to your Site:

1. Safety Training – includes:
   a. The safety policies and procedures of the Site. It is your responsibility to comply with these policies and procedures.
   b. The location and use of all safety equipment.

2. BBP Exposure Process – includes:
   a. Identify the person at your Site who manages exposure incidences.
      Name: ____________________________
      Title: ______________________________
   b. The location of the clinic/emergency room that will see you after the incident.
   c. The location of lab that will do testing.
   d. The name of the pharmacy that will dispense prophylactic meds if necessary.

Process Following an Incident:
1. Immediately inform your contact at the Site of the incident. Your Site is required to give you access to their employee health service and/or emergency department as soon as possible after the injury. You and the source patient must get a blood draw and baseline labs taken immediately (within 2 hours if possible) of the incident.
2. Receive immediate first aid as needed.
3. It is required that you visit the Site's identified health care professional and receive the following emergency medical care following the injury:
   a. A blood draw and baseline labs taken for you and the source patient.
   b. Initiation of HBV, Hepatitis C (HCV) and HIV protocol as indicated.
   c. HIV counseling and appropriate testing as indicated.
4. Be sure to take with you:
   a. The name of the source patient.
   b. Information about the injury.
   c. Standard testing protocols (see below for approved lab testing schedule.)
   d. Your personal insurance information (see below for billing insurance info.)
5. Confirm that the source patient’s HBV, HCV and HIV status will be determined by the Site in the usual manner to the extent possible.
6. Contact the Regional Affairs and RIDE office to report incident (js49@uw.edu).
7. Submit OARS report as per UWSD policy. Please see the following link for Instructions: http://dental.washington.edu/health-and-safety/event-reporting/
   a. Note that for SLR/Regional RUOP students, Dr. Rachel Greene is your designated supervisor for the OARS report.
   b. Note that for RIDE/RIDE RUOP students, Dr. Mary Smith is your designated supervisor for the OARS report.
   b. For additional questions contact:
      Carol Harvey – UWSD Health & Safety Manager: 206-221-6839 or cjh Harvey@uw.edu
Billing Personal Health Insurance and HSIP Coverage:
Billing and Reimbursement for Services
If seen by a non-UW clinic (including any emergency room) for services, the charges for initial testing and preventive drugs related to the exposure visit are first billed to your personal insurance.

PLEASE NOTE:
Itemized bills showing any amounts not covered by insurance should be sent to HSIP with a request for payment within 60 days of the BBP exposure/needle stick incident. If billing information or receipts are not available within this timeframe, then HSIP must still be notified of the incident and your intent to request reimbursement within 60 days of the BBP exposure. Requests outside this timeframe will not be processed.

If your insurance does not cover all the fees, or if you have questions about being reimbursed for expenses related to BBP exposures or needle stick/sharps injuries, please contact HSIP staff by email at myshots@uw.edu or leave a voice mail message at 206-616-9074. If emailing myshots@uw.edu, please note in subject line of email: REIMBURSEMENT QUESTION.

Approved Laboratory Testing Schedule
Health Sciences students outside the University of Washington system who experience a BBP exposure should refer to the Approved Laboratory Testing Schedule (see attached) as a resource to avoid being charged unnecessary lab fees. Lab tests ordered must follow this schedule to qualify for reimbursement by the health fee.

Please note under baseline labs that it is unnecessary to draw the Hepatitis B Surface Antigen (HBsAg) or Hepatitis B Core Antibody (HBcAb) titers if there is a documented history of completed Hepatitis B vaccine series and a positive Hepatitis B Surface Antibody. Health Sciences students who have already satisfied their initial program requirements by proving their immunity to Hepatitis B, in most cases, do not need to have these labs drawn after a bloodborne pathogen exposure.

BBP Exposure: Approved Laboratory Testing Schedule for Reimbursement
Follow-up Care
Routine follow-up laboratory testing is often performed 4-6 weeks and 4 months after the initial post-exposure visit. Students who are in the Seattle area at the time their follow-up visit is needed may contact the UW Employee Health Center for an appointment at (206) 685-1026.

Students who are not in the Seattle area should follow-up as directed. NOTE: If seen by a non-UW clinic for services, any charges are first billed to your personal insurance. Itemized bills showing any amounts not covered should be sent to HSIP within 60 days of the visit. If billing information or receipts are not available within this timeframe, then HSIP must still be notified of the visit and your intent to request reimbursement. Requests outside this timeframe will not be processed.
# UW Campus Wide - Bloodbourne Pathogens Process

## Schedule for BBP Exposure lab and initial med dispensal

<table>
<thead>
<tr>
<th>During normal EHC clinic hours:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exposure occurs - employee walks into clinic</td>
</tr>
<tr>
<td>Employee/Student seen by EHC provider</td>
</tr>
<tr>
<td>Staff provide: Initial evaluation</td>
</tr>
<tr>
<td>Clinic operates under standing orders:</td>
</tr>
<tr>
<td>Prophylactic Meds: Truvada and Raltegravir (3 drug regimen)</td>
</tr>
</tbody>
</table>

**Employee/student baseline labs taken:**
- HIV 4th generation Ab/Ag, HCV Ab, Alt, Hep B sAg and sAb
- If no history of +titer or incomplete vaccination follow USPHS guidelines for Hep B exposure management

**Additional Labs if PEP is started:**
- CBC, Comp Chem, Pregnancy test

**Referral for further evaluation for PEP; starter pack given to cover until appointment:**
- HMC: Madison Clinic, UWMC & UW - EHC: Roosevelt Virology

**Documentation:**
- OHM preferred

## After hours exposures:

<table>
<thead>
<tr>
<th>Initial prophylactic med</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dispense enough PEP until follow-up appointment at UW-Roosevelt Virology or HMC Madison Clinics</td>
</tr>
</tbody>
</table>

**Source Patient involved**

| Source Testing: HIV 4th generation Ab/Ag, HCV Ab, HBVsAg (Consider HIV and/or HCV PCR if source has high risk and signs/symptoms consistent with acute HIV and/or HCV infection or severely immunocompromised that may not have Ab response), HBVsAg not needed if employee had +HBVsAb titer |

## Testing for Employee/Student

<table>
<thead>
<tr>
<th>Source = Negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>If source has high risk profile may do additional testing on employee or if employee very concerned will offer f/u testing</td>
</tr>
</tbody>
</table>

### Source Positive Hep C

<table>
<thead>
<tr>
<th>4-6 weeks</th>
<th>HCV Ab, HCV PCR, Alt</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 months</td>
<td>HCV Ab, HCV PCR, Alt</td>
</tr>
</tbody>
</table>
| *(12 months)* | *

*Consider HIV Ab, HCV PCR (if subject HIV infected or HCV seroconverts during follow-up)*

### Source Positive HIV and employee on PEP

<table>
<thead>
<tr>
<th>2 weeks</th>
<th>Comp. Chem., CBC</th>
</tr>
</thead>
<tbody>
<tr>
<td>4-6 weeks</td>
<td>HIV 4th generation Ab/Ag, Comp. Chem., CBC</td>
</tr>
<tr>
<td>4 months</td>
<td>HIV 4th generation Ab/Ag</td>
</tr>
</tbody>
</table>
| *(12 months)* | *

*Consider HIV 4th generation Ab/Ag (if subject HIV infected or HCV seroconverts during follow-up)*

### Source Positive HIV and employee not on PEP

<table>
<thead>
<tr>
<th>4-6 weeks</th>
<th>HIV 4th generation Ab/Ag</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 months</td>
<td>HIV 4th generation Ab/Ag</td>
</tr>
</tbody>
</table>
| *(12 months)* | *

*Consider HIV 4th generation Ab/Ag (if subject HIV infected or HCV seroconverts during follow-up)*

## Unknown Source

<table>
<thead>
<tr>
<th>4-6 weeks</th>
<th>HIV 4th generation Ab/Ag, HCV Ab, HCV PCR, Alt</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 months</td>
<td>HIV 4th generation Ab/Ag, HCV Ab, HCV PCR, Alt</td>
</tr>
</tbody>
</table>
| *(12 months)* | *

*Consider HIV 4th generation Ab/Ag, HCV Ab/HCV PCR (if subject HIV or HCV seroconverts during follow-up)*
Subject: Safe Handling of Extracted Teeth

PURPOSE

Extracted teeth are collected and frequently used in dental education settings. The purpose of this policy is to provide guidance on the safe handling and the decontamination process.

GENERAL POLICY

Individuals handling extracted teeth for pre-clinical training or clinical assignments must be aware of the potential exposure to Bloodborne pathogens. Therefore individuals who collect extracted teeth must decontaminate and handle teeth according to standards set by the Center for Disease Control (CDC) and Seattle-King County Public Health Department as well as the University of Washington School of Dentistry.

Excerpts from CDC Website accessed 4-13-15:  
http://www.cdc.gov/oralhealth/infectioncontrol/faq/extracted_teeth.htm

What are the recommendations for using extracted teeth in educational settings?
Extracted teeth are occasionally collected and used for preclinical educational training. The teeth should be cleansed of visible blood and gross debris and maintained in a hydrated state. Because the teeth will be autoclaved before clinical teaching exercises, using an economical storage solution (e.g., water or saline) may be practical. A liquid chemical germicide (e.g., sodium hypochlorite [household bleach] diluted 1:10 with tap water) could reduce bacterial accumulation during storage, although it does not completely disinfect/sterilize the tooth. Extracted teeth must be placed in a well-constructed container with a secure lid to prevent leaking during transport and
labeled with the biohazard symbol.

Prior to being used in an educational setting, teeth should be heat sterilized to allow for safe handling. Pantera and Shuster demonstrated elimination of microbial growth using an autoclave cycle for 40 minutes. However, since preclinical educational exercises simulate clinical experiences, students enrolled in dental educational programs should still follow standard precautions. Autoclaving teeth for preclinical laboratory exercises does not alter their physical properties sufficiently to compromise the learning experience. However, autoclave sterilization of extracted teeth does affect dentinal structure enough to compromise dental materials research.

The use of teeth that do not contain amalgam is preferred because they can be safely autoclaved. Extracted teeth containing amalgam restorations should not be heat sterilized because of the potential health hazard associated with possible mercury vaporization and exposure. If extracted teeth containing amalgam restorations are to be used, their immersion in 10% formalin solution for 2 weeks has been found to be an effective method of disinfecting both the internal and external structures of the teeth.

**PROCEDURE**

**Hazardous Waste Regulations and Safe Handling of Extracted Teeth:**

1. Under infectious waste disposal regulations governing dental offices and clinics, extracted teeth are considered as infectious waste and must be handled properly.

2. The CDC has issued guidelines for decontaminating extracted teeth for use in dental educational settings.

3. The objective of these recommendations is to minimize the risk of: transmission of Hepatitis B virus (HBV), human immunodeficiency virus (HIV), and other blood borne pathogens during the handling of extracted teeth for use in dental educational settings.

4. All extracted teeth should be considered contaminated because they contain blood.

5. All individuals who collect, transport, or extracted teeth should handle them with the same precautions as a specimen for biopsy.
6. Universal precautions must be adhered to whenever extracted teeth are handled. All persons who might come in contact with blood or blood contaminated patient material in an occupational setting should receive hepatitis B vaccine per UW School of Dentistry policy.

**The following precautions are recommended:**

1. Use recommended PPE for handling extracted teeth.

2. All extracted teeth should be stored in a well-constructed container, such as a glass jar, with a secure lid to prevent leaking during transport and labeled with a biohazard symbol.

3. Containers should have sufficient amount of either of the following:
   a. Common household bleach, diluted with water at a 1:10 ratio
   b. Other liquid chemical germicides commonly used for clinical specimen fixation (e.g. Formalin).

4. As per the CDC guidelines, if extracted teeth contain amalgam restorations, immersion in a 10% formalin solution for 2 weeks is an effective method of disinfecting both the internal and external structures of the teeth (CDC Guidelines for Infection Control in Health Care Settings, 2003).
   a. The CDC does not recommend the use of extracted teeth with amalgam for educational settings.

5. Before working with extracted teeth, they should be cleansed of visible blood and gross debris.
   a. Scrub with detergent and water or using an ultrasonic cleaner.
   b. Store in a fresh 1:10 solution of diluted bleach or suitable liquid chemical germicide (e.g. Formalin).

6. Work surfaces and equipment should be cleaned and then decontaminated with an appropriate liquid chemical germicide after completion of work activities.

7. Extracted teeth should be decontaminated in a 1:10 solution of bleach for 30 min. prior to giving to a patient who requests their tooth following surgery.

8. Extracted teeth containing restorations should never be heat processed.
9. Extracted teeth may be returned to the patients upon request and are not subject to the provisions of the OSHA Bloodborne Pathogens Standard.

**Transportation:**

The Seattle-King County Department of Public Health regulates hazardous waste in the Seattle area should teeth be transported to and from the UW School of Dentistry.

1. Teeth should be stored in a well-constructed container with a sealable lid for transport.

2. Teeth must be placed in a sealable, clear plastic sealable bag secondary to placing in the container in the event of possible leak.

3. The container and clear plastic bag must be adequately marked with a biohazard label. Labels are available from the course director.

4. In order to transport extracted teeth in a personal vehicle, compliance with these regulations are required.

5. In order to transport extracted teeth on airlines or ship via UPS, USPS or other mail, the bleach solution must be replaced with tap water for transport. (Bleach is considered a hazardous chemical, and is prohibited for commercial airlines or USPS transport.

Reference:
Centers for Disease Control and Prevention. Guidelines for Infection Control in Dental Health-Care Settings. (2003) *MMWR*; 52 (No. RR17)

Dean of UW SOD:

[Signature]

Joel Berg, Dean of the UW School of Dentistry

February 2, 2016