UNIVERSITY OF FLORIDA
COLLEGE OF DENTISTRY

UFCD CLINICAL PROCEDURE MANUAL

AUGUST 1977

Thirty-sixth Revision April 2023

Edited: February 7, 2024

Clinical Affairs and Quality Assurance Committee

2022-2023

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The Clinical Affairs and Quality Assurance Committee is grateful to all the contributing authors for their careful and generous cooperation in this new edition, and to other members of the UFCD staff who have provided significant volumes of time and labor during the critical review and collation of the 35th Revision of the UFCD Clinic Manual.

INTRODUCTION

The purpose of this manual is to provide pre-doctoral students, faculty, and staff with information regarding clinical policies and procedures at the University of Florida, College of Dentistry (UFCD). Although the instructions are primarily directed at pre-doctoral students, the manual also provides faculty, advanced education students, and clinic staff with information they need to perform their duties.

Policies and procedures to ensure delivery of quality care in a safe environment have been approved by the Clinical Affairs and Quality Assurance Committee. These are consistent with UF Health Science Center policies as appropriate, Florida Statutes, OSHA requirements, CDC guidelines, Americans with Disabilities Act, and HIPAA requirements.

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1.0 MISSION VISION AND VALUES OF THE COLLEGE

1.1 Mission

Provide innovative dental education and deliver the highest degree of patient centered care and service, while promoting discovery and the generation of knowledge through research, with strong commitments to community engagement, diversity and inclusion.

1.2 Vision

To be a global leader in dental education, research, patient care and service.

1.3 Values

We value excellence through high-quality comprehensive dental care, cutting-edge research and learner-focused education. We support a culture of dignity, respect, support and compassion fostered through a diverse and inclusive environment.

Hyperlink to UFCD Strategic Plan 2019-2024

2.0 STANDARD OF PATIENT CARE

2.1 Philosophy of Patient Care

The college philosophy of care is focused on the delivery of comprehensive patient-centered care that is evidence-based, appropriate and consistent with UFCD and American Dental Association (ADA) Standards of Care, and administered in concert with the educational and service missions of the college. Predoctoral patient care is delivered in multidisciplinary clinics within small group “team” based clinics. Specialty or graduate level care is available for pre-doctoral student patients when the case complexity requires. All pre-doctoral and graduate level patient care within the college is delivered under the supervision of faculty members in accordance with students' abilities.

2.2 Goal of Clinical Program

The University of Florida College of Dentistry clinical program is a blend of clinical opportunities and assessment challenges designed to graduate a competent "new" dentist who is scientifically knowledgeable, technically competent, socially sensitive and committed to the highest standards of professional conduct. Attainment of “competency” shall not interfere with patient-centered care. Attitudes and behaviors inconsistent with compassionate care, refusal by the student to participate constructively in learning or patient care, derogatory attitudes or unprofessional conduct directed at patients, peers, faculty or staff, can be grounds for dismissal.

A core component of patient –centered care and commitment to high standards of comprehensive care include the development of an individualized treatment plan developed through an accurate, objective examination which addresses the patients' physical, cultural, and economic needs and concerns. Benefits and risks of treatment and non-treatment are discussed and informed consent is obtained. Care is delivered in a prescribed sequential order, in a timely fashion, and in a professional manner that protects patients'

confidentiality. Equally important is student assessment of the outcomes of care and compliance with quality assurance measures and the UFCD Standards of Care document.

2.3 Standards of Care

The Standards of Care document was developed with input and consensus from the Dean, department chairs, directors, and the Clinical Affairs and Quality Assurance Committee. Students are introduced to these concepts in pre-clinical and clinical courses, and professionalism courses. Compliance with standards of care focused on treatment is reinforced by attending clinical faculty and staff and assessed by the quality assurance committees. The Standards of Care document is found in Appendix A of this manual.

2.4 Credentialing Standards for Clinical Faculty and Staff

1. CPR at BLS level
2. Annual HIPAA and Confidentiality Training
3. Annual Biosafety Training
4. Annual Physician Billing Compliance Training
5. Biennial Compliance Training
6. Continuing education requirements for dentists and registered dental hygienists equal to those required by the Florida Board of Dentistry
7. Maintenance of state issued licenses, permits to practice within the assigned position.

3.0 PROTOCOL FOR MANAGING CLINIC MEDICAL EMERGENCIES

The purpose of the protocol is to assure a prompt and appropriate response to a medical emergency in the College of Dentistry clinics.

3.1 Rules

1. Department chairs (or their designees) will be responsible for assuring that all assigned clinics are properly equipped and that all faculty and staff are properly trained according to the guidelines described herein.
2. All students, clinical faculty, and patient care staff will be current in CPR certification at the Basic Rescuer for Healthcare Provider (BLS) level.
3. Oral Surgery (OS) faculty members and residents will be responsible for providing primary and/or backup support for emergency problems as needed.
4. The Shands Code Blue Team (5-#-66) should be contacted if the seriousness of the emergency warrants.
5. Emergency phone numbers and emergency location room descriptions are placed on each phone.
6. Emergency phone number lists are posted centrally, near house phones in patient care areas.

3.2 Emergency Preparedness and In-Service Training

1. Unannounced emergency drills (simulated) may be held as needed, alternating among clinics. (These will not interfere with patient care procedures.)
2. At irregular intervals students may be summoned from chairside and presented with a simulated problem, such as respiratory arrest, shock, dyspnea, asthma, or cardiac arrest. Student rescuers will be selected at random. No attempt will be made to cover the entire student body.
3. Minimal requirements for students, clinical faculty, and staff will be current certification in CPR training (trained at the BLS for Healthcare Provider level), according to the College CPR Policy.
4. CPR courses are provided for students, faculty, and staff through a partnership with UFHealth and the “CPRTraning” program. (See APPENDIX Q for UF HEALTH SHANDS CPR TRAINING CENTER AMERICAN HEART ASSOCIATION COURSE REGISTRATION FORM form link

5. Clinic administration will inform faculty, staff and students when their certification is within 60 days of expiration. Individuals must enroll in the next available class or their clinical privileges will be suspended. (Exceptions, such as extended illness, a sabbatical, or extended leave for personal emergencies, will be considered on an individual basis.)
6. Inservice training is provided upon orientation to clinics and annually through myTraining with Course number: UFH_UFCDManagingMedicalEmergencies_OLT. Upon request clinic, administration will arrange with program and course directors for in-person/classroom training experiences.
7. Clinic Administration maintains training records in the axiUm user profile and personal planner.

3.3 Oral Surgery Emergency Protocol for Managing Emergencies in UFCD

1. Upon observing a medical emergency (See **APPENDIX R:** Medical Emergencies: UFCD Definitions), go to the nearest clinic phone and call Oral Surgery by dialing 9-413-1143. If using a cell phone or a telephone outside UFCD, dial 413-1143. This pager is reserved solely for medical emergencies.
2. This phone line is connected to pagers in Oral Surgery. The four digit room number entered will appear on each pager, and the OS team will respond.
3. As always, someone should stay with the patient and render supportive care until the OS team arrives.
4. Send someone to the main elevator on the first floor and the floor of occurrence to meet the OS responder. If the floor of occurrence is the first, second, third, or fourth floor, send someone to the OMFS Clinic door to direct the responders.
5. ***This is an unexpected outcome and should be reported as a clinical occurrence using the link in axiUm to IDinc (event reporting).***

3.4 UFHealth Code Blue Team Emergency Protocol (Direct Dial 5-#-66)

1. To contact UFHealth Code Blue Team from inside the College of Dentistry, dial **5-#-66** (pause briefly after the 5 and #). Tell the operator the location is the **Dental Tower**. Provide the operator with a phone number to call back (so a number for a manned phone) and do not hang up until the operator tells you she has all the information needed. **IMPORTANT**: Inform the operator that someone will be waiting at **elevators 21 and 22** (**Dental Tower front/main** elevators).
2. Simultaneously, while the UFHealth Code Blue team is being called by a member of the clinic team, a clinic leader (faculty or admin) will direct the following activities until either Oral Surgery responders or Code Blue responders arrive:
   a. Direct two team members to begin life support.
   b. Direct a team member to perform the role of "recorder". The recorder must document the time the emergency started, and all details regarding the treatment of the emergency victim.
   c. Assign a team member to call Oral Surgery pager 9-413-1143 and enter the four digit room location of the emergency.
   d. Send a team member to get the medical emergency kit and emergency oxygen.
   e. Send a team member to get the UFHealth Code Blue Crash Cart.
   f. Send at least two team members to the first-floor elevator banks to hold the elevator for the emergency responders and direct them to the floor of occurrence.
   g. If above the first floor, send at least two additional team members to the elevators at the floor of occurrence so one can remain at the elevators while the other escorts the team to the emergency location.
   h. Assign remaining team members to crowd control and arranging for the movement of non-essential persons from the area where the emergency is occurring (re-locate patients for completion of their treatment to another clinic location).
3. Following the emergency, the recorder will work with the patient's provider to make sure the event is properly documented in the patient record.
4. The unanticipated event must be reported as a safety event using IDinc, Event Management System (easily found in axiUm under Links on the toolbar)

5. Make certain that the details of the emergency are reported to clinic administration within 24 hours of the emergency (regular business days).

3.5 Emergency Medical Services (EMS) 911.

1. If the major cardiac event or the OMFS Team deems the event worthy of transport to the UFHealth Emergency Department (ED) and it occurs on the ground floor or floors four through eleven, 911 must be called. In any medical emergency on the Sun Terrace or in the Communicore, 911 must be called as neither UFHealth nor the UFCD OMFS Team respond to these areas.
2. In the case of a 911 call, UFCD staff should meet the emergency responders at the West Entrance of the UFCD building and guide them to the site of the emergency.

3.6 When to call the Emergency Department(s) Charge Nurse

If the patient has presented with or developed symptoms that require discontinuation of treatment and referral to the Emergency Department (See **APPENDIX R:** Medical Emergencies: UFCD Definitions) for further evaluation, contact 733-0815 to report that you are transporting a patient to the Emergency Department. Be prepared to offer a report regarding the Situation (What is the problem, duration, severity) Background (medical history) Assessment and Recommendations (what do you want the ED provider to do) this is called a SBAR handoff. Be prepared to transport the patient to the ED. This is an unexpected outcome and this patient safety event should be reported by way of a link from axiUm to IDinc (event reporting).

SBAR:

Situation—What is going on with the patient?

"*I am calling about a patient we need to transfer to the ED. Patient appears to be in hypertensive crisis"*

Background—What is the clinical background or context?

"*Patient is a 58 year old female presenting for routine dental treatment. No history of hypertension or cardiovascular issues, takes a statin drug for hypercholesterolemia.*

Assessment—What do I think the problem is?

"*Three consecutive manual cuff bp readings 5 minutes apart are as follows, 180/118, 182/118, 180/120 , rule-out risk of heart attack or stroke*."

Recommendation and Request—What would I do to correct it?

"I feel strongly the patient should be transferred to the emergency department and assessed immediately?"

3.7 Policies Regarding Basic Life Support (CPR) and Emergency Training

1. Overview

   UFCD is committed to providing a safe and secure environment for its employees, students, patients, and visitors. The College maintains the highest standards of care for its patients, which includes training of clinical faculty, staff, and students to recognize and appropriately manage medical emergencies.

   Maintaining Basic Life Support skills (BLS) is a national standard of care in dentistry and dental hygiene, is required by many state boards for licensure, and is an accreditation standard for dental schools in the United States. Properly managing life-endangering medical emergencies that may

occur within the College requires maintaining current BLS skills by all students, clinical faculty, and staff. The College must assure that all students, clinical faculty and staff maintain their BLS skills, i.e., Cardiopulmonary Resuscitation (CPR) and knowledge of medical emergency response protocols.

Healthcare Provider Course - teaches all aspects of 1- and 2-rescuer adult, child and infant CPR, obstructed airway management for the conscious and unconscious victim, use of bag-valve-mask, risk factors, and access to the EMS system. Instruction in the use of automatic external defibrillators (AEDs) is included. UFCD instructors are certified trainers.

2. BLS Provider Classes

   As part of the onboarding process predoctoral dental students, clinical graduate students, faculty and staff will provide a copy of their current BLS (CPR with AED training) certificate. Predoctoral and graduate dental students are required to complete the BLS training within two months prior to the start of their first semester in their program. The onboarding process of faculty and staff may allow the hiring manager to arrange for BLS renewal prior to access to the clinics and patient management system. BLS certification compliance will be entered into the patient management database for predoctoral and graduate dental student users.

   Any student who begins a program out of sync with their cohort, is responsible for scheduling their renewal training by contacting **CPRTraining@shands.ufl.edu** and attaching a completed UF HEALTH SHANDS CPR TRAINING CENTER AMERICAN HEART ASSOCIATION COURSE REGISTRATION FORM (AppendixQ). The student is responsible for sending the Office of Clinic Administration a copy (pdf) of the new BLS (CPR with AED training) certificate.

   Clinical faculty and staff will receive BLS renewal training at no cost. Note: supplementary materials (e.g., manuals) for personal use must be purchased by the user. The clinician is responsible to schedule the training session by contacting **CPRTraining@shands.ufl.edu** and attaching a completed UF HEALTH SHANDS CPR TRAINING CENTER AMERICAN HEART ASSOCIATION COURSE REGISTRATION FORM (Appendix Q) The clinician is responsible for sending the Office of Clinic Administration a copy (pdf) of the new BLS (CPR with AED training) certificate.

3. BLS Training Records
   a. The Office of Clinic Administration maintains a file of all predoctoral dental students, clinical faculty, and clinical staff reflecting the status of their BLS skills training. Clinic personnel are responsible for providing clinic administration with a copy of their AHA BLS course completion card. Clinic Administration will notify non-exempt personnel who do not have current training of the need to renew their cards within 60 days or risk suspension of clinical privileges.
   b. Students, clinical faculty, or clinical staff who cannot complete BLS training because of physical limitations or medical conditions must submit a *written* request for exemption, stating the reason for the request. In certain cases, the Associate Dean for Clinical Affairs and Quality may request physician verification. The exemption forms will be kept on file in the Office of Clinical Administration.
   c. Exempted personnel are encouraged to periodically attend BLS Provider classes for the information value, even though they may not be able to complete the motor skills portion of the class. A letter verifying attendance should be issued
4. Student Policies

   Predoctoral students must complete BLS training for Healthcare Providers within July or August of the first year (pre-admission requirement). Renewal will be scheduled during semester 6.

Advanced education dental student applicants must present evidence of a current BLS/CPR course completion card prior to beginning their first academic year. Predoctoral students must present evidence of current BLS/CPR certification completed within two months of entering the predoctoral program. Thereafter, retraining at the Healthcare Provider Level will be available as needed to maintain certification. Students who are in noncompliance or have expired cards will have their clinical privileges suspended by the Associate Dean for Clinical Affairs and Quality until they can show evidence of completing an approved course.

5. Faculty and Clinical Staff Policies
   UFCD Human Resources will assure that newly hired full- and part-time clinical faculty, dental assistant and dental hygiene staff personnel possess a current AHA or ARC Healthcare Provider course certification. If not certified upon hiring, they must register for a class or file for medical exemption prior to becoming involved in clinical patient care. The UFCD Office of Human Resources will assure that the Office for Clinical Administration receives notification of all new full- and part-time clinical faculty hired for addition to the database. Department chairs will likewise assure that all faculty undergo BLS CPR skills renewal at least every two years.
6. Non-Clinical Staff Policies
   Non-clinical staff, including administrative personnel, secretaries and receptionists are encouraged to maintain BLS/CPR skills, in the event their bystander skills might be needed in non-clinical areas or in the community at large. This training can be at the Heartsaver BLS level for non-healthcare providers.

3.8 Emergency Phone Numbers: Clinical Operations

MEDICAL EMERGENCIES: Using House Phone

Oral Surgery- First Responders within Dental Tower This is a digital pager; after you hear the series of beeps, you will enter the 4-digit room location. *Do NOT leave a voice message.* Example, for room D3-3 you would enter 0303.	9-413-1143
Medical Emergencies outside of clinics (floors 4-11 and ground)	911
Code **BLUE** Team from **UFHealth*** • For location of emergency, state to the operator "Dental Tower" • Stay on phone until operator indicates it is okay to hang up	5-#- 66
UF**Health** Emergency Rooms:	ADULT: 9-733-0815 PEDIATRIC:9-265-5437
Bloodborne Pathogen Hotline (SHCC)	9-265-2727

OTHER EMERGENCIES:	
FIRE	911
Facility Services (formerly PPD)	392-1121
University Police and Security	392-1111
UFHealth Operator	265-0111
Clinic Administration	273-6820
Dental Maintenance	273-8001
Housekeeping	273-9700

These teams (*) have been instructed to report to the floor to which they have been summoned. They should be met at the door of the UFCD main/front elevators on the first floor and the floor of occurrence and escorted to the exact location of the emergency.

3.9 Emergencies during Night and Off-Hours

1. Medical Emergencies – Call EMS – 911.
2. Other emergencies - Call 392-1121 (Facility Services) and give the location and the nature of the problem and /or your request.

3.10 General Emergency Numbers and Procedures

1. Security (UF Police)
   Call 2-1111, and tell the operator the problem, giving the location, the details, and the telephone number.
2. Fire
   If an alarm is heard or a fire is seen, pull the handle on a "pull box" and call 911.
3. Power Failure
   Call 392-1121 (Facility Services) and give the location and the details. Emergency power will come on; but if it fails, emergency light packs have been provided for all departments.
4. Elevators
   In the event of power failure, one elevator in each bank will operate on emergency power.
5. Elevator Breakdown
   If riding on an elevator when it fails, follow the instructions on the control panel. An operator will answer. Give the operator the details of the problem, the elevator number, and the floor on which the elevator stopped. If a failure occurs when not on an elevator, call the Dean's Office, 273-5800, and report the details, or call 392-1121 (Facility Services). **Any elevator malfunction should be reported (with details) to the Dean's Office.**
6. Minor Emergencies in the Clinic
   Notify the attending faculty and then provide supportive care, using the minor emergency kit, if needed. Contact Oral Surgery if necessary.

3.11 Accidents and Reporting

1. Management of Major (Life-Threatening) Emergencies
   Provide supportive care, and identify someone to call Oral Surgery Emergency at 413-1143 and/or the Code Blue Team (from UFHealth, 66; from the College of Dentistry, 5-#-66). Be sure to enter the four-digit room location when paging Oral Surgery, and to provide the "**Dental Tower**" location to the Code Blue operator. Have someone meet the emergency responders at the doors of the UFCD main elevators (front elevators) and on the floor of the emergency occurrence.
   IMPORTANT: Inform the operator that someone will be waiting at "Dental Tower" **elevators** (front main elevators, #21 or #22).
2. Management of Accidents
   a. Involving visitors
      i. When a visitor is injured or involved in an incident while inside or on the grounds of the Health Science Center, the employee witnessing or receiving the report of the incident to the Office of Clinical Administration (273-6820) who will notify the Insurance Coordinator's Office (273-7006), and then the employee should complete a patient safety report using IDinc-Event Management System,
      ii. If the visitor involved consents to emergency care, they should be taken to the UFHealth Emergency Dept. (ED) for examination and treatment if necessary. Do not coerce the visitor to go to the ED. Do not tell the visitor that the hospital's insurance will pay for ED charges as this is not always true.

iii. The Emergency Dept. physician will examine the visitor to determine the nature and extent of the injury, and will note the findings on the Incident Report form and in the Emergency Room Medical Record. The Emergency Room clerk will attach the charging document to the Incident Report and route it to the Insurance Trust Fund Office.

iv. In all cases, an event report for accidents involving visitors will be reviewed byClinic Administration.

b. Involving patients

These incidents will be handled in the above manner, except that examination and treatment may be done in the area in which the patient is being treated. Should the nature or extent of the injury require medical attention which is not available where the patient is being treated, the patient should be taken to the Emergency Dept for emergency services. For emergency services call 733-0815, to report that you are transporting a patient to the Emergency Department. Be prepared to offer a report regarding the Situation (What is the problem, duration, severity) Background (medical history) Assessment and Recommendations (what do you want the ED provider to do) this is called a SBAR handoff (see section 3.2). Be prepared to transport the patient to the ED. Routine Emergency Dept administrative procedures will be carried out in such cases and the completed Incident Report form will be sent to the Office of the Associate Dean for Clinical Affairs and Quality .

Appendix B contains flow diagrams for handling medical emergencies.

3. How to Report an Incident

a. Incidents should be reported by phone immediately to the Associate Dean for Clinical Affairs 273-6820.

b. When a patient or visitor is involved in an accident and declines or refuses to be transported to the Emergency Dept., a Patient Safety Report IDinc (Event Management System) should be completed immediately. In addition to the link in this section, this form is also available through the links button on the ribbon in axiUm. The involved staff is responsible for completing the Event Report and notifying clinic administration within 24 hours after the incident.

c. For incidents involving a patient of record, also complete the Patient Safety Event report in IDinc, found by way of a link from axiUm.

CAUTION: Event reports are legal documents and are not to be placed in a hospital or dental record. No reference to an event report is to be made in a patient's chart. Because reports may be subject to legal discovery, they should contain no subjective comments whatsoever. If there are any questions pertaining to Event Reports content or procedures, call the Insurance Trust Fund Office (273-7006). No unauthorized copies of Incident Reports should be made or retained.

3.12 Medical Emergency Kits and Supplies

1. Medical Emergency Kits

The medical emergency kits are checked on a scheduled basis for usage and expired supplies by a designee of the Associate Dean for Clinical Affairs and Quality . Used supplies are replaced upon notification to clinic administration by the clinic. New supplies are ordered, as needed, upon approval by the Associate Dean for Clinical Affairs and Quality . A demonstration kit is available for in-service training, for a list of kit contents please see Table 3-12.1. The use of clinic kits for routine training should be avoided. Please contact the Associate Dean for Clinical Affairs and Quality to obtain a kit.

Table 3-12.1

Medical Emergency Kit Contents			
Medications	**Dosage**	**Qty.**	**Packaging**
Ammonia inhalant	N/A	1	1 carpule
Aspirin- chewable	81mg	4	1 pack of 4
Diphenhydramine (Benadryl)	25mg	2	2 packs of 1 each
Insta-Glucose	31g	1	1 tube
Epinephrine auto-injector	0.3mg	2	2 pens
Nitroglycerin	0.4mg	1	1 bottle 25
Ventolin HFA (albuterol sulfate)	90mcg	1	1 inhaler
Supplies		**Qty**	
Gloves		6 pr	ziploc bags- S-M-L 2pr ea
Mask- earloop style		2	2 masks
Nasopharyngeal airway 26fr		1	1 ea
Nasopharyngeal airway 28fr		1	1 ea
Oral airway- 80mm/90mm/100mm		3	1 ea S-M-L
Pocket valve mask		1	1 ea
Surgilube- single tube		1	1 tube 2oz
Yankauer suction tip		1	1 ea
Paper bag		1	1 ea

In addition, a rescue oxygen kit consisting of bag-valve-mask, oxygen cannula, and "E" cylinder of oxygen is co-located with the medical emergency kit in every clinic.

2. Medical Emergency Kit Locations

The medical emergency kits and rescue oxygen kit are located in each clinic. *See Table 3-12.2 for the Locations of Medical Emergency Kits, Crash Cards and AED*

Security locks/seals are maintained for emergency kits, oxygen tank pressure, and equipment are checked daily by UFCD Maintenance. Deficiencies are immediately corrected. The security lock on the crash cart is checked daily by UFCD Maintenance. Maintenance staff notify the Office of Clinical Administration when the crash cart has been opened. All kits are replenished immediately after use.

Clinic administration has deployed and actively maintains the operation of nine (9) automatic defibrillation (***AED***) units throughout the clinical enterprise, see Table 3-12.2

Table 3-12.2

Locations of Medical Emergency Kits, Crash Carts and AEDs		
1st Floor	**Room #**	
Graduate Pros.	D1-19	Medical Emergency Kit-Rescue Oxygen Kit
Graduate Perio	D1-19	Medical Emergency Kit-Rescue Oxygen Kit **Adult Crash Cart *AED*(adult)**
Undergrad Endo	D1-17	Medical Emergency Kit-Rescue Oxygen Kit*AED*
Graduate Endo	D1-17	Medical Emergency Kit-Rescue Oxygen Kit***AED*(adult/peds)**
Implant Center	D1-68	Medical Emergency Kit-Rescue Oxygen Kit
Oral Maxillofacial Surgery	D1-70	Medical Emergency Kit-Rescue Oxygen Kit **Adult/Peds Crash Cart *AED*(adult/peds)**
Student Oral Surgery	D1-104	Medical Emergency Kit-Rescue Oxygen Kit
PDRC	D1-27L	Medical Emergency Kit-Rescue Oxygen Kit
Faculty Practice	D1-14	Medical Emergency Kit-Rescue Oxygen Kit ***AED*(adult)**
FP Ortho	D1-40	Medical Emergency Kit-Rescue Oxygen Kit
Oral Medicine	D1-18	Medical Emergency Kit-Rescue Oxygen Kit
Orthodontics	D1-30E	Medical Emergency Kit-Rescue Oxygen Kit
Pediatric Dentistry	D1-40	Medical Emergency Kit-Rescue Oxygen Kit **Adult/Peds Crash Cart *AED*(adult/peds)**
Radiology	D1-94	Rescue Oxygen Kit Only
2nd Floor	**Room#**	
2A Clinic	D2-19	Medical Emergency Kit-Rescue Oxygen Kit **Adult Crash Cart *AED*(adult)**
2B Clinic	D2-17	Medical Emergency Kit-Rescue Oxygen Kit
Grad Operative/Aesthe-Tech	D2-27	Medical Emergency Kit-Rescue Oxygen Kit ***AED*(adult)**
OPPERA	D2-143	Medical Emergency Kit-Rescue Oxygen Kit
3rd Floor	**Room#**	
SimLab	D3-15	***AED*(adult)**
3A Clinic	D3-19	Medical Emergency Kit-Rescue Oxygen Kit
3B Clinic	D3-17	Medical Emergency Kit-Rescue Oxygen Kit **Adult Crash Cart *AED*(adult/peds)**
Screening	D3-40	Medical Emergency Kit-Rescue Oxygen Kit

3.13 UFHealth/Shands Hospital Code Blue Team Crash Carts

The hospital Code Blue Team Crash Carts are monitored daily to insure the locks have not been broken, and weekly to check the expiry dates and test the electrical equipment. If you find that a cart or airway box lock has been broken, call clinic administration (273-6820) immediately so that a cart refresh may be initiated. For the locations of the hospital Code Blue Team Crash Carts (**Crash Cart**) see table 3-12.2 in the preceding section.

The **crash carts** are to be used for medical emergencies which have escalated to a higher level of emergency response, either by Oral Surgery responders or by the hospital Code Blue team responders; for example, heart attack, respiratory distress, and or stroke. Items that do not belong on the cart should never be placed on the cart (drink cups, etc.). The sharps container is for use only during a code blue type emergency and never for general clinic needle disposal. The cart must remain plugged into the electrical outlet between uses for emergencies (charging battery for suction machine).

Each cart has a manual with lists of the contents.

In the event of a Code Blue emergency, the crash cart is to follow "clean handling" protocols, meaning with clean hands only. No gloved or contaminated hands should contact the cart. If it so happens that contaminated hands are used on the crash cart, the crash cart must be labeled as contaminated and the exchange protocol should be amended to prevent cross contamination with the UFHealth Central Distribution Center.

3.14 Protocol for Prevention of Aspiration/Ingestion of Foreign Bodies

1. Rationale
   The University of Florida, College of Dentistry is committed to the highest quality of clinical care and safety for all patients. As part of ongoing quality assurance endeavors, this protocol is designed to facilitate a reduction in foreign body aspiration/ingestion events during dental treatment and to ensure appropriate patient management.
2. Prevention Protocol
   a. Patient Evaluation
   The clinician should review the health history of the patient to identify any neurological, psychological, systemic, and pharmacological problems that might contribute to the potential for aspiration or ingestion of an object and take measures to minimize the risk. Examples of these concerns, not intended to be all-inclusive, include the following:
   i. Neurological - seizure history, stroke, dementia
   ii. Psychological - extreme anxiety
   iii. Systemic - chronic cough, allergies, esophageal stenosis, scleroderma with restricted opening ability, trismus, GI reflux or nausea
   iv. Medications - Haldol can increase involuntary muscular activity as in tardive dyskinesia.
   b.
   The clinician (student, resident or faculty) should review the procedure with the patient, carefully explain the risks, and elicit the patient's cooperation. For example, the patient should be instructed to stop speaking during this time and signal if they need to cough or sneeze, to prevent aspiration.
   i. Dental Dam Utilization
   Whenever possible, a dental dam should be used during restorative and endodontic procedures to prevent aspiration/ingestion of broken teeth, instruments, and amalgam fragments. Floss should always be tied to the dental dam clamp before placing on the tooth.
   ii. Throat Protection
   II.a For all surgical procedures (e.g., extractions, periodontal surgery, implant placement and cementation procedures), a modified throat pack should be employed by placing a sterile gauze block as a barrier to block the oropharynx. Floss may be tied around a tooth in particular situations to avoid an accident with medically compromised patients.
   iii. Alternative Throat Protection Devices:

Providers and dental auxiliary who are properly trained to use ISOVAC, ISODRY, ISOLITE devices may select to use these when a dental dam is not indicated. Such as with nonsurgical periodontal treatments/therapies, or fixed prosthodontic procedures.

iv. Equipment Verification
Assure that handpieces are properly maintained to prevent parts from breaking away during use. Prophylaxis cups, brushes, and latch type burs must be properly attached to prevent dislodgment of a cup or brush or instrument breakage. Always verify the handpiece bur is properly engaged to prevent loss of a loose bur in the opearatory, and/or the patient's oral cavity. Ultrasonic tips must be set at the proper power level based on the tip being utilized.

v. Provisional Restorations
All provisional restorations (single units and fixed partial dentures) should be fabricated from a radiopaque material, when feasible, to facilitate radiographic identification in the event it is ingested or aspirated. Cements should also be radiopaque, when feasible.

vi. Restorative/Implant Procedures
Floss should be attached to all pin wrenches and implant hardware and screwdrivers when used on a patient in a supine position.

vii. Endodontic Procedures
Dental dam isolation must be employed at all times

viii. Cementation Procedures
The patient should be positioned with the head tilted toward the side receiving the restoration, instead of the head positioned straight upward. This position may protect the airway and help prevent aspiration.
When feasible for a fixed bridge, floss should be attached to the restoration or prostheses prior to beginning the "try-in," occlusal adjustment, cementation, and/or sectioning procedures. Floss embedded in Duralay may be beneficial when manipulating smaller castings such as onlays.

3.15 *Protocol for Referral to ED of Adult Patients Suspected of Ingesting a Dental Device during a UF Dental Clinic Procedure (Dental Swallow Protocol)*

Purpose: *The goal of this protocol is to improve efficiency, provide timely endoscopic procedures when indicated, and enhance patient care and satisfaction.*

Protocol: *When Dental faculty determines that (1) an item may have been ingested during a dental procedure, (2) the patient is clinically stable, and (3) the airway was not impacted, the following process will be followed:*

I. Referral to the ED for evaluation and treatment if necessary:

A. The Dental team calls the UF Health Shands Hospital Transfer Center at 352-265-0559 and initiates the "Dental Swallow Protocol"

B. The Transfer Center connects the Gl consult fellow (352-219-0328) or Gl consult attending (if fellow not available) to the dental team for discussion of the case.

C. The dental team sends a generic picture of the suspected item by email or text to the Gl fellow.

D. If the decision is made to proceed with evaluation, the Transfer Center connects the Gl attending/fellow to the ED PIC to notify her/him that the patient is being sent to ED for evaluation.

E. The patient is escorted by the dental service to the ED.

F. Upon arrival at the ED, the patient is registered and triaged in accordance with standing orders for

patients who are suspected of swallowing dental devices, to include.

1. *Consult placed to Gl*
2. *Order for an abdominal flat plate, upright and lateral x-ray on a STAT basis (standing order set containing the dot phrase "Ingested foreign body from dental procedure, contact Gl consult fellow if photo of object is needed)*

G. *The Gl team follows up on the x-ray and sees the patient in the ED and determination is made if an endoscopy is appropriate.*

1. *If not, the patient is provided instructions and discharged.*
2. *If so, the timing of the procedure is discussed and endoscopy is arranged by the GI team. The GI team will communicate this to the ED Physician. The procedure is handled as usual for ED patients needing an endoscopy. The patient is assigned a room, an iv is placed and anesthesia is contacted per routine. Discharge from the ED is anticipated after endoscopy. Note that an endoscopy order cannot be placed in EPIC unless there is a room assignment in the ED. This order activates scheduling, anesthesia, etc.*

H. *GI and the ED place notes in the patient's medical record indicating the event and actions.*

II. *Other issues*

A. *If the patient is unable to give procedural consent, the dental team will identify the person responsible and provide contact information to GI team.*

B. *The Dental faculty will enter a Patient Safety Report and notify SIP.*

C. *Not intended for nights, weekends, other ingestions or food impactions, pediatric patients (<18 yr)*

Pathway for Protocol Approval

Dental School: Dr. Cesar Migliorati, Assoc. Dean of Clinics and Quality Assurance of the Dental School (cmigliorati@dental.ufl.edu), and Richelle Janiec (rjaniec@dental .ufl.edu), 352-273-6820.
Gastroenterology: Ellen Zimmermann, Chris Forsmark, David Estores, and Vikas Khullar (GI fellow).
Transfer Center: Dave Hudson
Emergency Department: Wendy Swan, and Tom Payton
Radiology: Eric Thoburn
Legal: Christina Palacio
Contact Ellen Zimmermann (ezimmer2@ufl.edu or 734-358-3873 with any questions)

4.0 PATIENT INFORMATION AND PATIENT CARE

4.1 Patient Screening

The College provides an information sheet to patients at the screening appointment. Please refer to Appendix I.

4.2 Clinic Hours

1. The College of Dentistry TEAM student clinics are open from 8:30 a.m. to 4:30 p.m., Monday Tuesday, Thursday & Friday, and 2:00-4:30 p.m. on Wednesdays, except on holidays. Each care group will conduct a pre-clinic meeting or "huddle" from 8:15-8:30 am each day (1:45-2:00 p.m. on Wednesdays) that the clinics are open for patient care. Students, staff, attending faculty and team leaders are required to attend the huddles.
2. Patient treatment begins at 8:30 a.m. and 2:00 p.m. The lunch break provides adequate time to prepare for the afternoon session. (This includes preparation up to the point of obtaining a start check and opening sterile instruments.)
3. Plan clinic sessions so that any procedures can be finalized by 11:00 a.m. for the morning session and by 4:00 p.m. for the afternoon session. Patients should be out of the clinics by 11:30 A.M. and 4:30 P.M. each day. This schedule allows ample time to clean and complete records before leaving.

All students should be out of the operatory and the clinic by 11:45 am and 4:45 pm respectively. Chronic offenders will be suspended from the clinics.

4.3 Clinic Access

1. Advise patients that they cannot bring their children with them into the clinic while they are having dental treatment. The College cannot provide child care or assume responsibility for the safety of the child.
2. All minor patients and certain adult patients will require the presence of a third party or legal guardian to validate certain responses to the health questionnaire and to obtain informed consent. Adult patients presenting as poor historians or with evidence of inadequate decision-making capabilities should be identified during screening in order to insure that a responsible third party will be available to obtain informed consent. The third party will be needed at the initial data-gathering appointments and may be allowed in the treatment operatory for limited periods of time only for the recognized purposes listed above.
3. Also advise patients that, except for unusual circumstances (such as a recognized disability), they cannot invite their friends or family members into the dental operatory during dental treatment. This is due to OSHA and infection control regulations. If the patient has a question regarding this policy, please ask a faculty member or the Associate Dean for Clinical Affairs and Quality.

4.4 Patient Rights

The Patient Rights & Responsibilities document is part of our combined consent form which is reviewed with the patient during the intake process with patient services. The patient signs the combined consent prior to receiving any treatment with UF dental practices. A copy of the Patient Rights & Responsibilities document is offered to the patient at the initial appointment. Please see Appendix J to view an example of this form.

All students, faculty and staff receive training on the UFCD Patient's Rights while orienting to work in the UFCD clinics. Students are trained as part of their curriculum, and faculty and staff are trained through myTraining with Course number: UFH_UFCDPatientAdvocacy_OLT

4.5 UFCD Confidentiality Policy

1. Personal Health Information (PHI): Faculty, Staff and Student Privacy Training Requirements
   a. Privacy of Information
      All UFCD employees and volunteers in health care components are required to complete Privacy Training upon initial employment or volunteer date, and then annually thereafter. The College of Dentistry requires all students (pre-doctoral, post-doctoral, and graduate) to complete the training upon entering the program and then annually. Predoctoral students who are updating their training must upload the certification in CANVAS as part of their professionalism course stream during semesters three, six and nine.

      Failure to comply with the entry and annual training requirements is a Level II Privacy Violation. Repeated violations are grounds for disciplinary action, up to and including termination of employment for employees, and dismissal from the program for students.

      For more information regarding privacy and the patient record please go to UF Health Privacy » Privacy » University of Florida (ufl.edu)
   b. Confidentiality of Personal Health Information (PHI)
      i. Faculty, staff, and students must not discuss patients or their medical conditions in hallways, elevators, eating facilities, or any public areas.
      ii. Clinic computers must not be accessible by unauthorized users. Do not walk away from a computer without first "Locking Windows" (Press Windows key and L/or Ctrl-Alt-Del at the same time and selecting "lock this computer "to lock the computer). Clinic computers will

allow you to easily enter your password and return you to the most recent screen you were working in when you left the computer. Always log off the computer when finished with entries, before leaving the clinical area.

iii. Patient PHI must not be stored on portable electronic devices such as cell phones or laptops unless the devices are encrypted, and must not be shared outside the University of Florida, College of Dentistry.

iv. Financial data contained in the electronic record in the Patient Management System, as well as the patient medical record, is sensitive in nature and should not be divulged to unauthorized individuals. Financial data should only be released to the patient as identified by the full name, address and date of birth on file. In case of minors, financial data should only be released to the custodial parent(s), after confirming the full name, address and date of birth on file.

v. Third party payers must not be given patient financial information. Any discussion with a third party payer must be restricted to date of service, procedure code information or description, and charge information. There is no need to provide patient payment or secondary insurance information to a third party payer.

2. PHI: Faculty, Staff and Student Required Compliance

Medical/dental and financial information on UFCD patients is considered confidential. Patients have the right to expect that all communications and other records pertinent to their health care, including source of payment for treatment, will be treated in a confidential manner.

a. <u>Medical and Personal Information</u>

i. All data contained in the patient record is confidential and should not be disclosed to unauthorized individuals.

ii. Faculty, students, and staff are not to discuss patients in a manner that could breach confidentiality policies. (Special attention should be given to common areas such as eating areas, hallways, elevators, and restrooms.)

iii. Any photographs or videotaping performed that may allow a patient to be identified will require written authorization from the patient prior to use for educational purposes or scientific publications.

iv. Users of the electronic medical/dental data system shall comply with the following rules to maintain security of the system and patient confidentiality.

- Users shall access the system only with their assigned ID and password.
- Users will not reveal or loan a password to another person.
- Users will not leave a terminal unattended while signed on (lock Windows).
- Users shall only use their access to perform job functions.

b. <u>Financial Data</u>

i. Financial data contained in the electronic record in the patient management system should not be disclosed to unauthorized individuals. This includes account balances, insurance information, and contract information.

ii. Financial data should only be released to the patient as identified by the full name, address and date of birth on file. In the case of minors, financial data should only be released to the custodial parent(s), again after confirming the full name, address and date of birth on file.

iii. Third party payers should not be given patient financial information. Any discussion with a third party payer should be restricted to date of service, procedure code, procedure description as needed (by report codes), and charge information. There is no need to provide patient payment or secondary insurance information (i.e., Ryan White) to a third party payer.

c. <u>Records duplication and the protocol for adding documents forwarded from other dental/medical offices</u>

i. All requests for duplication of patient records will be sent to the Chart Room for processing

and copying.

ii. Release of any information contained in the medical record should not occur without the written consent of the patient or upon request from legal entities in the form of subpoenas and affidavits.

iii. Requests for records duplication from legal offices will be reviewed by the Associate Dean for Clinical Affairs and Quality or designee.

d. Non-Compliance Policy

i. Pre-doctoral Students: Non-compliance with chart confidentiality policies will result in counseling by the Privacy Office, Associate Dean for Clinical Affairs and Quality ,and the Associate Dean for Academic Affairs, and may result in suspension from clinical activities for a period to be determined based upon review of individual cases. Repeated non-compliance will result in failure of the Professionalism course (DEN 7017 or DEN 8018) and referral to SPEC.

ii. Advanced Education Students: Advanced education student and resident non-compliance will result in counseling by Privacy Office, the Associate Dean for Advanced Education, and the respective program director. Repeated non-compliance will result in counseling by the Associate Dean for Advanced Education, and sanctions as determined jointly by Privacy Office, Associate Dean for Advanced Education, and the program director. This will be assessed on an individual basis.

iii. Faculty: Faculty non-compliance will result in counseling by the Privacy Office, Associate Dean for Clinical Affairs and Quality, and Department Chair. Appropriate sanctions will be assessed on an individual basis. Repeated non-compliance will result in discussions with the faculty member's department chair for the appropriate action.

4.6 Student Requirements for Entering the Clinical Program

1. Before being assigned patients, students must have completed the following requirements: Completion of HIPAA, Confidentiality Statement, OSHA-Biosafety Training and Biomedical Waste (BMW); Physician Billing Compliance Training
2. Completion of Basic Life Support (BLS) Certification Training along with Medical Emergency Training.
3. Assignment into the TEAM Program
   During the spring of the sophomore year, students will be assigned to one of 8 teams. Each team will consist of one faculty team leader, a treatment coordinator, dental assistants and dental students. The TEAM Leader becomes the student's academic advisor for the remainder of the program.

   Each team will meet with their Treatment Coordinator and faculty TEAM leader to determine patient scheduling, discuss patient treatment progression, and participate in educational activities such as case presentations, journal reviews, and ethical dilemma discussions. The TEAM program must be viewed as part of a pedagogical philosophy of the College, supporting the philosophy of patient-centered comprehensive care.

4.7 Screening and Patient Assignment:

1. All patient assignments must be made by the appropriate designated faculty or staff member working in conjunction with the Office of the Clinical Administration. Assignments are entered in axiUm, EHR. With the exception of rotations, it is a violation of clinic policy to treat a patient that has not been assigned or transferred. Most of the assignments made to students at the University Of Florida College Of Dentistry are for TEAM comprehensive care management. This means that the student is responsible for all the dental needs of an assigned patient--from the stage of examination, diagnosis, and treatment planning to providing sequenced care, assessing outcomes of care, and establishing supportive periodontal therapy.

2. The Director of Screening and Patient Services will assign each student an initial family of patients. This family of patients is selected to meet, as closely as possible, the student's educational needs.
3. **Self-recruited Patient:** A friend or acquaintance can be assigned to the student to meet certain comprehensive care educational needs through a "self-recruitment" procedure. The patient will be scheduled in the Screening Clinic to complete a screening evaluation of the patient to assure that the prospective patient's dental needs meet the UFCD educational requirements and the student's current level of competency. The student will participate in the screening process through his attendance, exposing all appropriate radiographs (with faculty signature), and requesting the patient be assigned. The patient will be assigned to the student in axiUm as a comprehensive care patient.
4. All comprehensive care patients treated by students in the Department of Pediatric Dentistry are assigned to the Pediatric Dentistry faculty and maintained by that department. Students may treat patients during rotations in Pediatric Dentistry, Student Oral Surgery Clinic (SOS), and at off-site rotations that are not assigned to the student. However, all other comprehensive care patients for the pre-doctoral program must be assigned to the student by the Director of Screening and Patient services or designee.
5. If treatment needs warrant, patients may be referred to an advanced education student (resident) or a faculty member as applies.

4.8 General Pre-doctoral Clinic Policies

NEVER seat a patient in an operatory until at least one attending faculty member has arrived in the clinic. Be certain that the patient's name appears on the schedule.

1. It is mandatory for the dental student to obtain a "Start Check" from the supervising faculty member. The start check process includes a review of the medical history and recording vital signs, and case presentation by the student dentist to the faculty. At the "Start Check", the faculty supervisor must observe that your instrument pack is sterile and has not been opened. Start check needs to occur within the first 30 minutes of the clinic session.
2. Attempt to see the patient at least every 30 days (minimum). Every two weeks is preferable.
3. **Attendance:** **Link to Student Handbook- SECTION G, Student Attendance, Absence, Leave and Parking Policies- Leave Policy for the TEAM Clinic**

4.9 Appointing the Patient

1. Initial Contact

   Using the personal planner in axiUm, the student may open a list of their assigned patients by selecting "assigned patients" and the search button to populate the list. The list is an active page in the patient management system allowing the student to select the patient record directly from the list. The student will also be notified of patient assignments by the messenger module in axiUm (Patient Management System) and must treatment plan the patient within four weeks of assignment, however, two weeks is preferable. Be sure to advise the patient that children/ visitors are not allowed in the clinic due to safety concerns. The College cannot provide childcare or take the responsibility for child welfare.

   Also, advise the patient that except for unusual circumstances such as a recognized disability, friends or family members are not permitted in the dental operatory during dental treatment. This is due to privacy, safety and infection prevention standards. If the student or the patient has a question regarding this policy, please ask a faculty member or the Associate Dean for Clinical Affairs and Quality.

When contacting the patient by phone, always make sure to verify the patient's date of birth and/or phone number/address before communicating PHI with the patient. Document all telephone conversations or other contacts in the contact notes (located in the patient card in axiUm) on the date contacted, or as soon as possible thereafter.

2. Treatment Planning

The first appointment with a new patient will usually be for the start of treatment planning. Following the steps below will minimize confusion for the student and the patient:

   a. Obtain and review the new patient's record. Note previously reported health problems which may have been noted in the forms tab on the medical history form(s), screening assessment or in the contact notes, a history of "no-shows," or financial problems.
   b. If radiographs appear adequate and current, complete a radiographic interpretation. This must be done before presenting a diagnostic work-up. If additional radiographs are necessary, they can be scheduled and obtained during the initial appointment. Prior to completing a treatment plan, an interpretation of all new radiographs is to be completed.
   c. The patient will be scheduled for the first appointment with the assigned student dentist for a comprehensive examination, diagnosis and tentative treatment planning. This consists of a thorough review of the patient's medical/dental history, a comprehensive extra/intra oral examination (including periodontal evaluation), an oral health risk assessment, caries risk assessment, and endodontic consultation, followed by the development of a properly sequenced problem list, diagnosis list, and propose an appropriate treatment plan.
   d. When you call the patient to introduce yourself prior to the initial appointment, inform the patient that a medication history must be recorded. Therefore, remind the patient to bring all medications (labeled medicine bottles) or to bring a complete list of medications to the appointment. Also inform the patient that he /she will need to bring the Medicaid card, if appropriate, and the name and telephone number of their physician(s).
   e. Inquire as to whether or not the patient is in pain and establish any needed appointments in the Student Oral Surgery Clinic prior to initiating the examination/diagnosis/treatment planning appointment. Confirm the length of time of the appointment (approximately 3 hours) so that the patient can plan accordingly. Remind the patient of the anticipated fee. Since diagnostic casts will be required, plan on taking dental impressions on the first visit. Often, supplemental consults can be obtained in the patient's absence with quality casts, current radiographs, and the patient's record. The need for consults (other than Radiology) will be directed by the attending faculty at the initial appointment.
   f. The attending faculty's review (with approvals) is required on the medical history, extra/intra oral head and neck exam, caries risk assessment, oral health risk assessment, odontogram (dentition chart), periodontal health evaluation, and treatment plan before therapy can be initiated.
   g. Failure by the student to keep a scheduled appointment at the appointed time or to cancel an appointment without informing the treatment coordinator may result in a professional variance (please refer to section 8.0 of this manual).

3. Treatment Planning - Disease Control Evaluation

Upon completion of ALL initial phase operative treatment and periodontal therapy that includes scaling and root planning, every comprehensive care patient must receive a Disease Control Post-treatment Assessment. This assessment is required prior to moving to the definitive phase treatment. The re-evaluation should include a thorough review of the Disease Control Treatment Plan and validation of the completion of those treatments at a satisfactory level. The instructor may discuss the treatment rationale, antimicrobial treatment, future plans for outcomes

assessment (bacteriological culture), and health maintenance with the student and the patient as part of this evaluation.

4. Patient Communication - Form Letters
   The treatment coordinators will have computer-generated form letters for use in routine communication with patients. A copy of all correspondence with a patient will be maintained in the patient's record and notations must be made in the contact notes.
5. Cancellations and Broken Appointments
   Conversations or other contact actions (left message on voice mail) with the patient regarding cancellations and broken appointments must be recorded in the contact notes in the electronic record. If a patient calls any time before the appointment hour and explains inability to keep the appointment, an event is called a "cancellation." If a patient fails to call before the appointment hour or calls after the time for the appointment, this is a "broken appointment". An explanation for a broken or cancelled appointment should be documented in the contact notes. Before leaving the clinic, advise the treatment coordinator that the patient failed to keep the appointment.

   Student failure to keep a scheduled appointment or a "student no-show" will adversely affect clinical performance and could result in the loss of clinic privileges.

4.10 Limited Care Patients

1. Limited Care Endodontics
   Some patients (who are not Comprehensive Care, or otherwise assigned for care) may initially present to the Student Oral Surgery Clinic and receive a secondary referral for stabilization of a tooth by the Endodontic Clinic. The Endodontic Clinic may accept the patient by referral and initiate endodontic treatment to relieve pain and retain a tooth. If a patient is accepted for limited care by the Department of Endodontics, the following guidelines will apply:
   a. At the beginning of the endodontic procedure, a determination of tooth restorability must be made in the progress notes using the endodontic evaluation form. Prosthodontic and periodontal consultations should be obtained to confirm that the tooth is restorable.
   b. The patient is to be told (and will sign an appropriate release) that following the completion of the endodontic part of the treatment, the tooth should have a final restoration or the tooth may be lost due to fracture and/or recurrent caries.
   c. Upon completion of the endodontic therapy, the tooth must be temporized so as to be reasonably stable and maintained for a period of at least 3-4 months.
   d. The patient is informed regarding the need for definitive restoration.
2. Low Needs Patients please review Table 4.10-2 for the minimal paitent record compliance requirements for a patient who is categorized with “Low (dental) Needs”
   Table 4.10-2

Minimal Documentation Requirements	axiUm Process
Current Medical History	OSHHX or DMDHX
Oral Cancer Evaluation Findings	TxNote, Diagnostic Codes
Intraoral Exam Findings	Odontogram, PerioTab and TxNote
Radiographic Request and Findings	RADREQ, RADINT/TxNote
Signed Treatment Plan	TxPLan Module

4.11 Patient’s with Medical Risk

Health care professionals are responsible for providing comprehensive oral health care to all people; children (6-21 years), adults, (over 21 years), medically-compromised and disabled.

People with special needs are defined as individuals who have medical disorders, physical limitations, intellectual impairments, or psychological/social conditions that impact the delivery of oral health care. People with special health care needs, including those aged 0-5 years, often require more time, effort and accommodation by the dental team. In addition, the dental team may need to modify their routine treatment procedures in order to provide care that is appropriate for the needs of the individual. Dental students at the University of Florida provide comprehensive oral health care to people with special health care needs which include the following disorders or conditions. Any of the following would meet the definition of "special needs" in the UFCD pre-doctoral program.

- Developmentally Disabled
    - Disability occurred before the age of 22
    - Impairment of general intellectual functioning
    - Can be the result of cerebral palsy, seizure disorder, autism, or other neurological conditions
- Physically disabled
    - Long term loss of physical function that substantially limits one or more major life activities. This includes impairments of the sensory functions, neurological, skeletal cardiovascular, respiratory and endocrine systems.
    - Examples include vision loss, deafness, spina bifida, speech disorders and others
- Mentally disabled
    - A mental or behavioral pattern or anomaly that that causes impaired ability to function in ordinary life, which is not developmentally or socially normative.
    - Includes anxiety, major depression, bipolar disorder, schizophrenia, OCD, eating disorders and others
- Complex Medical Problems

  Any condition which is included in the axiUm electronic health record, as a "medical alert"*

  A summary by category follows.
    - Allergies to medications, medical dyes, dental materials
    - Alcohol abuse
    - Patients on antiresorptive medications: bisphosphonates oral and IV, denosumab subcutaneous, and antiangiogenics
    - Cardiovascular – (Congenital Heart Disease, Cardiac transplant, Prosthetic cardiac valve, Previous Infective Endocarditis)
    - Cancer/Malignancy
    - Endocrine disorder
    - GI disorder
    - Hematologic disorders /bleeding disorders
    - Hepatitis C - Active or chronic
    - Hepatitis B - Active or chronic
    - History of radiation therapy to head and neck area
    - Immune suppression (medication induced, chemotherapy, autoimmune condition, HIV/AIDS)
    - Premedication necessary for Cardiovascular issues or Prosthetic Joint Replacements
    - Prosthetic joints
    - Pulmonary /Severe COPD
    - Recreational drug abuse
    - Severe dementia
    - Unstable angina
    - Uncontrolled asthma
    - Uncontrolled seizure disorder

- Language deficient – Requires interpreter

4.12 Patient Transfer/Dismissal Process

Complete a Patient Transfer/Dismissal Summary form for all patients who have completed their treatment plan or who are being discharged for any reason. If for some reason a patient refuses to continue treatment, a registered letter must be sent to the patient with a return receipt requested in the following situations:

1. Patient has provisional restoration(s).
2. Patient is mid-treatment in an endodontic procedure.
3. Patient has been advised to have a biopsy procedure.

Patient discharges can be made only through the office of the Associate Dean for Clinical Affairs and Quality by the Patient Advocate. Discharge of all "routine" patients must be cleared as described above. Patient Transfer/Dismissal Summary forms are in axiUm and must filled out completely before sending to the faculty Team Leader for approval. Once the form is approved it may be sent to the Patient Care Coordinator (administrative staff aka Treatment Coordinator) for review before being sent to Clinic Administration for final review and assignment update. This is a three step quality and administrative review process to assure a patient centered approach is being honored.

Patients whose recommended treatment has been completed, and therefore are ready for discharge or maintenance, **must** be seen by faculty in the TEAM Clinic for a post-treatment assessment case completion exam. At this exam, with the student present, the patient will be evaluated to determine that the planned treatment was delivered, that the delivered treatment meets College standards, that the patient is satisfied with his care, and that no further treatment is necessary. Only then will the patient be discharged from the associate pair.

4.13 Urgent Care Needs of Comprehensive Care Patients

1. Patients that are actively assigned for care by a Student Dentist (SD) will be provided with contact information for the SD's Treatment Coordinator .
    a. During regular clinic hours the patient will be routed to the SDs Team/ Care Group (CG) for urgent care needs. If the SD is available, he/she will attend to the patient's urgent needs. If the SD is not available, then the Team Leader will assign another SD within the CG to attend to the patient's urgent needs
        i. Patients who call the Clinic Administration number (273-6820) will have their call forwarded to the appropriate TC.
        ii. Patients who present at the Patient Registration window with urgent issues will be asked to take a seat while the attendant locates the appropriate TC
    b. During Clinic Breaks: The patient will contact either Clinic Administration or the TC. If the TC for the SD is present she/he will coordinate with the Team on duty for the appropriate plan of care for the day; otherwise, the TC for the Team on duty for urgent care will handle the arrangements. Patients needing to be seen on these days will be scheduled in the pre-doctoral dental emergency schedule and attended to by the supervising faculty dentist and the dental students hired to help cover team patients' emergencies during the break.
    c. If it is determined that the patient may require an extraction, then the TC will coordinate with the Student Oral Surgery (SOS) front office to schedule the patient for care in the SOS clinic.
2. In the case of the screened and/or accepted patient for the TEAMs clinics, who has not yet been assigned for comprehensive care:
   Calls from this person for urgent needs go to the Student Oral Surgery (SOS) clinic, where he/she will be informed how to become a patient by participation in the lottery. This person should be present at the SOS clinic by no later than 6:45 AM on the days that SOS is open

a. SOS is generally open M-F, but the caller should be encouraged to check with SOS either by going online to our website, or by calling the clinic.
b. During breaks, SOS is generally open only Tuesday-Thursday. An exception occurs when a holiday falls within these days, or relatively close to these days.
c. Persons who call the college of dentistry after hours for emergencies that cannot wait until the next day will be encouraged to seek emergency care at the local Emergency Department. If the emergency is life threatening, then the caller will be instructed to hang up and dial 9-1-1; otherwise, he/she will be encouraged to call back during office hours to coordinate urgent dental care needs with an appointment coordinator (in the SD clinics it will be the TC).

4.14 Appointment Scheduling in Student Dental Clinics

1. Student Dentistry patient appointments are to be set by the Treatment Coordinator (TC) for each Team in the Care Group (or an approved designee). The student may assist the TC) with calling patients to set appointments only after he/she has attained a short list of dates the TC) determines are available for the student to see the patient. Students should use the provided clinic phones to contact patients, and provide the patients with the call back information for the TC.
2. The student dentist must enter planned appointments into axiUm from the approved and signed treatment plan in order for the Treatment Coordinator to be able to schedule appointments for the patient with the student.
3. Endodontic referral patients: The student dentist names will be maintained on an active rotational list in the Pre-Doctoral Endodontic List. As referrals from outside clinics come into the Endodontic Clinic, As referrals from outside clinics come into the Endodontic Clinic, the student and their TC will be contacted via an Axium message with the patient's demographics. The student then contacts the potential patient to introduce themselves and explain the procedure and associated fees. Once the potential patient has agreed to schedule an appointment, the student creates a Planned appointment and messages their TC to contact the patient for scheduling
    a. If the patient fails to make an appointment, then the student's name will return to the top of the list, and he/she will be in line for the next referral.
    b. If the patient presents for the appointment and is not treated (i.e. tooth gets extracted, pt. refuses treatment, etc.), the student's name will return to the top of the list.

4.15 Patient Care Procedures for Students Approaching Graduation

The treatment philosophy for the predoctoral program at the College of Dentistry is that of patient-centered comprehensive care. Consistent with that philosophy, students are strongly encouraged to complete all care for each assigned comprehensive care patient. Equally important is maintenance of continuity of care. As graduation approaches, transfer of care within the TEAM family is facilitated. One of the advantages of the TEAM Associates Patient Care Concept is seamless transfer of patients, with the approval of the TEAM leader.

Transfers are allowed, with the approval of the student's TEAM Leader, under the following circumstances:

1. The date of assignment is so close to the student's projected graduation date that the student could not complete the care specified by the treatment plan.
2. The planned treatment was interrupted by the patient's medical concerns.
3. The original treatment plan was subsequently changed to a more complex plan (requiring additional appointments) which exceed the student's remaining time in school.
4. There was an unavoidable delay in some phase of treatment not under the student's control, e.g., orthodontic treatment or substantial delay in healing.
5. Patient transfer from one provider to another will be approved when the timeliness and continuity of care is enhanced for the patient.

The TEAM leader or the Associate Dean for Clinical Affairs and Quality will review the proposed transfer of a patient. These individuals will determine if the patient's care should be completed by the student who

wishes to transfer the patient. If the decision is made that the student should complete the care, no transfer will be allowed and the student must complete the case to meet graduation requirements. If the graduating student has not completed care for reasons beyond his control, the TEAM leader will review the progress and attempt to reassign the patient to another TEAM member.

Graduating students should have a final disposition completed for each patient prior to two weeks before graduation, and only a few patients should require an additional disposition during that final two-week period.

Post-Treatment Assessment- Case Completion reviews are conducted prior to discharge for patients with completed care. In the event this cannot be arranged, the record shall be reviewed by the Director of Screening and Patient Services (or designee). The patient should be reassigned to a rising 3DN to complete the Post Treatment Assessment- Case Completion assessment. If that is not possible, the Director will review the case prior to patient discharge.

The student who receives the newly transferred patient must review the health history and complete an updated oral evaluation including head/neck exam, obtain appropriate departmental consultation and, if indicated, review and/or formulate a new treatment plan with the attending TEAM leader prior to commencing with additional patient care.

4.16 Treatment and Contact Notes

1. Treatment notes must only be used for treatment or assessments. Contact notes are available in the patient card, and are to be used for notes regarding contact with the patient.
2. Treatment notes must include specific information about the patient's status before the procedure was initiated, health history review and vital signs, medications and materials used, steps of the procedures performed, and the patient's condition at the termination of the appointment. The following criteria for treatment notes have been established.
    a. With the electronic record, it is a best practice to avoid using abbreviations. However, when abbreviating words in creating a treatment note, use only the College of Dentistry accepted abbreviations as listed in the Clinic Manual (Appendix F).
    b. Treatment note entries using a general note format , should be complete and concise, and should include patient’s chief complaint in their own words, a review of systems and the vital signs, a description of clinical findings, description of the procedure performed including materials and medications administered, comment regarding treatment outcome including the patient’s disposition, and brief description of upcoming planned care.
    c. A brief medical history review/update must be the initial entry for all clinical procedures.
    d. A brief medical history review/update must be the initial entry for all clinical procedures.
    e. Treatment note entries must list <u>all</u> materials used in a clinical procedure
    f. Medications, anesthetics and their dosages and sites/routes of administration must be recorded.
    g. Entries of prescription information must use the “prescriptions” tab in the electronic health record in axiUm and will include the following:
        i. Name of drug, dose form, and amount
        ii. Directions to the pharmacist
        iii. Directions to the patient
        iv. Refill instructions, labeling information, and permission for substitution
    h. All student dentist entries into the treatment record must be approved by supervising faculty.
    i. Treatment plan revisions must be recorded in the treatment notes as well as result in an updated treatment plan signed by the patient.
    j. Unexpected outcomes must be recorded in the treatment notes; however, there must not be any reference to quality assurance reporting (such as IDinc) in the patient’s treatment note.

4.17 Record Audits

1. Patient records are audited in all programs by individuals designated by the Associate Dean for Clinical Affairs and Quality.
    a. Pre-doctoral program - Chart reviews are conducted on all assigned active patients each semester, by the TEAM program
    b. Advanced education programs - Chart audits are conducted by the Associate Dean for Advanced Education or designee (Program Director)
    c. Peer Review Process- a predetermined number of patient records is randomnly selected by the chair of the peer review committed for a monthly review.
2. Random patient record audits may be conducted by the Assistant Director for Clinical Affairs and Quality, in all programs on a routine basis.
3. Focused audits are conducted on students' charts upon request of TEAM leaders or the Associate Dean for Clinical Affairs and Quality. Focused chart audits may be conducted by the Assistant Director for Clinical Affairs and Quality, if a routine audit suggests a concern that merits further review.

4.18 Informed Consent

1. Obtaining informed consent is a process whereby the patient is informed of the treatment proposed, the need for the treatment, risks of the procedure, alternative treatments, and the consequences of no treatment. This is an extremely important process which must be explained to the patient in words and language understandable to the patient. This should be performed by the assigned student who will perform the procedure(s), and re-enforced by the attending faculty. If staff initially provides the "consent form" to the patient for his review, it should be reviewed by the doctor performing the procedure to allow the patient the opportunity to ask questions of the doctor.
2. All patients receiving treatment must give informed consent in writing. Informed consents must be appropriately signed, dated, and witnessed. They must be obtained from individuals legally authorized to give consent.
3. For more information regarding obtaining proper consent refer to Appendix N.

4.19 Persons Who May Consent to Non-Routine Medical/Surgical Treatment and Sign the Permit

1. Patients 18 years of age or older or legally emancipated, are considered able to make their own decisions regarding health-care, and therefore no other consent is required (Florida Statute 743.07[1]).
2. The following individuals under 18 years of age may give consent if they are:
    a. Under 18 and ever married (Florida Statute 743.01).
    b. Under 18, female, and consenting for care or service related to her pregnancy or her child (Florida Statute 743.065 [2]).
    c. Under 18 and consenting to care for a sexually transmitted disease, alcohol, or drug dependency.

    NOTE: An unmarried male parent under 18 may not give consent for himself. He must have consent from a parent/guardian.
3. For minors under age 18, who cannot consent as described above, the following may consent:
    a. Either parent
    b. A court appointed guardian
    c. A person specifically designated in a court order as having capacity to consent to non-routine medical care.
    d. A relative who has been awarded an Order for Temporary Custody by Extended Family.
    e. HRS, but only if the child is permanently committed as a ward of the state (i.e., all parental rights have been terminated)

    NOTE: A grandparent or other relative who has custody of the child due to an informal arrangement or who has power of attorney from an absent parent may not consent to surgery or general anesthesia.

4. Consent shall not be obtained from a patient is who is not competent, and the health care provider responsible for obtaining consent shall determine if the patient is competent to consent. If the patient is not competent to consent, document such in the medical record and obtain an opinion regarding competency from a second provider or the primary care physician.
5. For an adult patient (except a developmentally disabled adult), when two providers document that the patient is not competent to grant consent, others may consent on his behalf in the following descending priority:
    a. A court appointed guardian, authorized to consent to non-routine medical/surgical care, after presentation of valid guardianship papers.
    b. A Health Care Surrogate designated by the patient prior to his incompetence.
    c. If the patient has no guardian and did not designate a health care surrogate prior to his incompetence, consent may be granted by the following individuals. (A note must be made in the chart, by the physician, indicating that the selected individual is acting as the patient's proxy, willing, and available to consent.)
        i. The patient's spouse
        ii. An adult child of the patient or, if the patient has more than one child, a majority of the adult children who are reasonably available for consultation, or a parent of the patient
        iii. An adult sibling of the patient, or if the patient has more than one sibling, a majority of the adult siblings who are reasonably available for consultation
        iv. An adult relative or friend of the patient who has exhibited special care and concern for the patient and has signed a Close Friend Affidavit
        v. For a developmentally disabled adult who is not capable of consenting for himself, only a court appointed guardian or guardian advocate may consent
        vi. A patient or patient's representative who is unable to write shall make a "mark" as his/her signature. The witness(es) to the signing shall use full signature.
        vii. In an emergency, when the patient is unable or an appropriate individual is not available to consent, two attending providers must document in the medical record (after independent examinations) the existence of the emergency and that the proposed procedure is necessary to preserve the life or health of the patient. Written notification of an appropriate individual shall be accomplished as soon as possible, and a signed written authorization for treatment will be requested.
        viii. In the case of a dental emergency, parental/guardian consent by telephone is permissible if witnessed by at least two college faculty or staff members. The conversation should be documented in the dental record and signed by the witnesses.

4.20 Patients with Disabilities

Every effort will be made to accommodate patients with disabilities. If a student or patient has questions or needs assistance (for example, to provide sign language interpretation for a hearing impaired patient), contact the Office for Clinical Affairs at 352-273-6820.

1. <u>Hearing Impaired Patients</u>
    a. UFCD recognizes that patients with hearing impairment have the right to emergency and elective dental treatment, and that this right may require UFCD to provide necessary assistance to the patient.
    b. UFCD will make every reasonable effort to provide patient assistance for emergency dental treatment. However, assistance may not always be available on short notice.
    c. To arrange for patient assistance, the dental student or faculty member providing treatment for the patient must contact the Patient Advocate in the office for Clinical Affairs as soon as possible before the appointment. Assistance can be assured only with at least a two week notice.
    d. When assistance is requested, Social Work Support Staff will be contacted. Patient assistance

will then be coordinated through the Social Work office

e. UFCD (Gainesville locations)will be billed as follows:
    - Business hours (Monday – Friday, 8:00 AM- 5:00PM) $170 for the first two-hours of service during regular business hours. Additional business hours time is charged at $21.25 per 15 minutes.
    - After hours (Monday – Friday between 5:00 PM and 8:00 AM, all day Saturday and Sunday, and all standard holidays) $180 for the first two hours of service and after-hours (after 5:00PM on a S/S/H) additional time is $22.50 per 15 mins f
    - Mileage is charged for trips greater than 110 miles from the Center for Independent Living of North Central Florida. The fee is 0.445 per mile round trip.

2. Adult Protective Services Act (Elder Abuse - "Vulnerable Adult" Fl statute 415.1034 http://www.flsenate.gov/Laws/Statutes/2012/415.1034

The Legislature recognizes that there are many persons in this state who, because of age or disability, are in need of protective services. Such services should allow such an individual the same rights as other citizens and, at the same time, protect the individual from abuse, neglect, and exploitation. It is the intent of the Legislature to provide for the detection and correction of abuse, neglect, and exploitation through social services and criminal investigations and to establish a program of protective services for all vulnerable adults in need of them. It is intended that the mandatory reporting of such cases will cause the protective services of the state to be brought to bear in an effort to prevent further abuse, neglect, and exploitation of vulnerable adults. In taking this action, the Legislature intends to place the fewest possible restrictions on personal liberty and the exercise of constitutional rights, consistent with due process and protection from abuse, neglect, and exploitation. Further, the Legislature intends to encourage the constructive involvement of families in the care and protection of vulnerable adults.

A health professional who knows, or has reasonable cause to suspect, that a vulnerable adult has been or is being abused, neglected, or exploited shall immediately report such knowledge or suspicion.

Management of patients who are suspected to be victims of abuse according to the Florida Adult Protective Services Act should be discussed with the Associate Dean for Academic Affairs and the Chief Executive Officer.

Any person 60 years of age or older who is suffering from the infirmities of aging or other physical, mental, or emotional dysfunction to the extent that the person is impaired in his/her ability to adequately provide for his own care or protection is eligible for these services.

A person 18 years of age or older who suffers from a condition of physical or mental incapacitation due to a developmental disability, organic brain damage, or mental illness, or who has one or more physical or mental limitations which restrict his ability to perform the normal activities of daily living is eligible for these services.

Florida Statutes mandate any person who knows or has reasonable cause to suspect that an aged person or disabled adult is being abused, neglected, or exploited shall immediately report such knowledge or suspicion to the Florida Abuse Registry on the state toll free telephone number: 1-800-96-ABUSE.

Adult protective services investigations will begin within 24 hours of receipt of a report of possible abuse. At the completion of its investigations, reports will be classified as Unfounded, Closed without Classification, or Proposed Confirmed.

Referrals will be made to criminal justice agencies, the state attorney, the Human Rights Advocacy Committee, Long Term Care Ombudsman Council, and the Office of Licensure and Certification as appropriate.

Adult Protective Services staff will evaluate and assess the need for ongoing protective social services, emergency removal, protective placement, and other necessary social service supports as deemed

necessary and appropriate in each individual situation.

Any person required by Florida statute to report a case of known or suspected abuse, neglect or exploitation of an aged person or disabled adult who knowingly and willfully fails to do so or who knowingly and willfully prevents another person from doing so is guilty of a misdemeanor of the second degree.

3. Children Abuse: FL statute 39.201 http://www.flsenate.gov/Laws/Statutes/2011/39.201
4. Service Animals in Practice:

POLICY NUMBER: UFCD 6.18
CATEGORY: Operations
DATE: January, 2015

POLICY: Service Animals will be permitted to accompany disabled patients in ambulatory care areas provided the animal is not disruptive and does not present a risk to other patients.

APPROVING AUTHORITY: Dean, University of Florida College of Dentistry

CUSTODIAN: Associate Dean for Clinical Affairs and Quality

DEFINITION/S: Service animal refers to any guide dog, signal dog, or other animal individually trained to do work or perform tasks for the benefit of an individual with a disability, including, but not limited to, guiding individuals with impaired vision, alerting individuals with impaired hearing to intruders or sounds, providing minimal protection or rescue work, pulling a wheelchair, or fetching dropped items.

REFERENCE/S:

- Americans with Disabilities Act (ADA): **www.ADA.gov**
- The Department of Justice published revised final regulations implementing the Americans with Disabilities Act (ADA) for title II (State and local government services) and title III (public accommodations and commercial facilities) on September 15, 2010, in the Federal Register

  http://www.ada.gov/service_animals_2010.htm
  http://www.ehs.ufl.edu/programs/ada/services/service_animals/

PROCEDURE/S:

- Employee's hands shall be washed before and after contact with a service animal.
- Clean up of the service animal is the responsibility of the handler. Service animal wastes may be discarded by flushing down a toilet or hopper. Housekeeping will be contacted for additional cleaning.
- The Clinic Manager, in conjunction with the provider may determine the appropriateness of the presence of other animals in the clinic, in accordance with ADA guidelines.
- Service animals must be on a leash, wear a harness, or be in a carrier while in the clinic.
- The care and supervision of a service animal is solely the responsibility of his/her owner.
- Staff is not required to supervise or care for a service animal in accordance with the ADA guidelines (Sec.36.302 (c) (2).
- The facility is not required to provide care, food, or a special location for the animal.
- Service animals may not enter areas where invasive procedures are being performed.
- A service animal may be removed from a clinic if that animal's behavior poses a direct threat to the health and safety of others.
- Non-service animals are not allowed in clinic for the protection of patients and staff.

4.21 Reporting of Injuries Resulting From Acts of Violence

The attending faculty directly involved in the discovery and treatment of the patient with injuries resulting from acts of violence shall immediately contact Patient Advocate and the Associate Dean for Clinical Affairs and Quality. Unless otherwise required or authorized by law, the reporting of injuries to law enforcement without patient consent may be considered a breach of patient confidentiality. The Associate Dean for Clinical Affairs and Quality, and the Patient Advocate will coordinate reporting with Legal Services.

790.24 Report of medical treatment of certain wounds; penalty for failure to report.—Any physician, nurse, or employee thereof and any employee of a hospital, sanitarium, clinic, or nursing home knowingly treating any person suffering from a gunshot wound or life-threatening injury indicating an act of violence, or receiving a request for such treatment, shall report the same immediately to the sheriff's department of the county in which said treatment is administered or request therefor received. This section does not affect any requirement that a person has to report abuse pursuant to chapter 39 or chapter 415. Any such person willfully failing to report such treatment or request therefor is guilty of a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

1. In accordance with Florida law, 790.24, the following injuries must be reported to the appropriate authority, the county Sheriff's Department:
    a. Gunshot wounds and other wounds indicating violence must be reported to the appropriate law enforcement agency.
    b. Incidents of domestic violence should only be reported if otherwise reportable as a gunshot wound or other wound indicating violence, or if the victim consents.
    c. Any such person willfully failing to report such treatment or request therefore is guilty of a misdemeanor of the first degree.
    d. Sexual assaults of adults, other than sexual abuse of elderly or disabled adults, must not be reported without the consent of the victim.
    e. Injuries suspected to be a result of abuse or neglect of a minor or disabled or elderly person should be referred to the Department of Patient and Family Services (352-265-0224) for reporting to the Abuse Registry.
    f. case the injury to be reported occurs on Shands or UFCD premises, the Shands charge nurse or the Associate Dean for Clinical Affairs and Quality, respectively, shall notify the Risk Management office (352-273-7006 or the Department of Legal Services (352-265-8051).
2. Procedures for handling foreign objects removed from patients that indicate an act of violence.
    a. Foreign objects, bullets, pellets, slugs, and wadding from firearms shall be placed in a sealable container. Reasonable care shall be taken not to destroy or alter the item being removed.
    b. Each container shall be labeled with the patient's name, medical record number, doctor's name, date, time, and signature of witness.
    c. Security shall be notified to take custody of the objects. Security shall label and place the objects in a security container and shall transport them to the security valuables room. Security shall sign the container and record the time of custody.
    d. Custody shall be maintained until disposition of the case is determined or the evidence is turned over to the appropriate law enforcement agency.
    e. Social Work Services can be contacted through the UF Department of Patient and Family Resources at 265-0224 during regular business hours or on the Shands at UF beeper (265-6966), evenings, weekends, or holidays.

4.22 Medication Prescribing/Dispensing Protocol for Antibiotic Prophylaxis and other Medications

1. If a patient has forgotten to take his antibiotic premedication, the options are as follows:
    a. The attending faculty may write a prescription and send the patient to Shands Outpatient Pharmacy or any pharmacy of the patient's choosing. After taking the medication and waiting the appropriate time, treatment can proceed.

b. The patient may be reappointed.
c. An individual department may wish to provide antibiotics for the premedication for that single appointment, following the appropriate guidelines.

2. In the event that a faculty member decides antibiotic prophylaxis is necessary after a procedure has been initiated or completed in a susceptible patient, the faculty member must obtain appropriate medication to be administered within the two-hour window recommended by the American Heart Association.
3. The attending faculty in each clinical area is responsible for prescribing medications for their respective patients.
4. All medications must be prescribed by a properly credentialed faculty and must be recorded in the electronic record and chart and in the medication log present in each clinic (Appendix K).
5. The medication container/envelope must also bear the following information: practitioner's name, patient's name, date dispensed, name and strength of the drug, and directions for use.
6. Medications dispensed according to these guidelines must be dispensed at “no charge” to the patient.

4.23 Management of Hypertensive Patients Requesting Elective Care

1. Patients presenting for elective dental care with a blood pressure reading > l65/95 mm. require a medical consult and/or physician referral prior to continuing treatment. The blood pressure reading should be verified via two accurate recordings with the proper cuff and at least 10 minutes apart. (In general, "rushing" to an appointment will primarily increase the systolic blood pressure but have much less effect on the diastolic pressure.)
2. Any patient with a diastolic reading >110 mm. should be immediately referred to their physician with a medical consultation as appropriate.
3. Any patient with a diastolic reading >120 mm. should be referred to Shands Emergency Department (ED). The attending dental faculty should contact the charge nurse in the ED (9-733-0815) and inform the ED of the transportation of the patient to the ED. An entry should be placed in the dental chart stating that patient was sent to the ED. A medical consultation request form must be completed and signed by the attending faculty to determine status, and all elective dental procedures are suspended until the physician consult request form is returned to the College.

4.24 Guidelines for Management of Pregnant Patients Requesting Elective Care

A pregnant patient, while not considered medically compromised, poses a unique set of management considerations for the dentist. Dental care must be provided for the mother without adversely affecting the developing fetus. The first trimester (first three months) is when organogenesis occurs. The fetus is most susceptible to malformations during this period. The goal of dental care is to minimize the risk of exposure or avoid it whenever possible.

The reference to Pregnancy Risk Factor (PRF) and the letter A, B, C, D, or X immediately following, signifies the Food and Drug Administration Pregnancy categories. (Refer to the list below for a summary of the categories.)

The recommendations listed below are only guidelines and may not always apply. Treatment decisions must be made based on the status and needs of the individual patient in consultation with her obstetrician as appropriate.

1. Treatment During Pregnancy Based on Trimesters
    a. First trimester
        i. OHI
        ii. Plaque control
        iii. Avoid elective treatment

iv. Urgent care, but the dentist must do whatever is necessary to relieve pain and infection. (Febrile illness and sepsis have been associated with miscarriage early in pregnancy.)
v. Local anesthesia: lidocaine, PRF B is acceptable,
vi. As mepivicaine (Carbocaine) is PRF C, consider carefully
vii. Analgesics: Tylenol or Tylenol with codeine. Avoid aspirin and NSAIDs.
viii. Imaging: All films necessary to establish the diagnosis should be exposed with appropriate shielding.
ix. Antibiotics: Penicillin and clindamycin are acceptable to use as both are PRF B.
x. Avoid tetracycline as it is PRF D.
xi. Avoid metronidazole in the first trimester, due to carcinogenicity in rats.
xii. Avoid benzodiazepines as they are PRF D. (Risk for clefts)
xiii. Avoiding nitrous oxide sedation during pregnancy is suggested.

b. Second Trimester
i. Emergency care
ii. OHI, Scale, polish
iii. Routine dental care – unless pregnancy has complications. Always monitor blood pressure.

c. Third Trimester
i. Emergency care
ii. OHI, Supragingival scaling
iii. Routine care is provided for the first 2-3 weeks of the third trimester. Beyond that, routine care is usually deferred until the baby is delivered. This is primarily for the comfort of the mother. This will avoid inferior vena cava syndrome, or supine hypotensive syndrome.

d. FDA Pregnancy Categories (Pregnancy Risk Factor)

Reference: *Drug Information Handbook for Dentistry*, Lexi-Comp, Inc. 2013-14

A Controlled studies in pregnant women fail to demonstrate a risk to the fetus in the first trimester with no evidence of risk in later trimesters. The possibility of fetal harm appears remote.

B Either animal reproduction studies have not demonstrated a fetal risk but there are no controlled studies in pregnant women, or animal-reproduction studies have shown an adverse effect (other than a decrease in fertility) that was not confirmed in controlled studies in women in the first trimester and there is no evidence of a risk in later trimesters.

C Either studies in animals have revealed adverse effects on the fetus (teratogenic or embryocidal effects or other) and there are no controlled studies in women, or studies in women and animals are not available. Drugs should be given only if the potential benefits justify the potential risk to the fetus.

D There is positive evidence of human fetal risk, but the benefits from use in pregnant women may be acceptable despite the risk (e.g., if the drug is needed in a life-threatening situation or for a serious disease for which safer drugs cannot be used or are ineffective).

X Studies in animals or human beings have demonstrated fetal abnormalities or there is evidence of fetal risk based on human experience, or both. The risk of the use of the drug in pregnant women clearly outweighs any possible benefit. The drug is contraindicated in women who are or may become pregnant.

IMPORTANT: These are only guidelines and do not always apply. Treatment decisions must be made based on the status and needs of the individual patient in consultation with her obstetrician.

4.25 Biopsy Specimens and Cytologic Smears

When patient history, clinical examination, or appropriate diagnostic tests indicate a need for microscopic examination of abnormal tissue, the tissue must be removed and submitted for histopathologic examination.

The decision to submit tissue for histopathologic examination is done according to the *UFCD Guidelines for Removal of Human Tissue.* All tissue which is submitted to the UFCD Oral Pathology Laboratory Service must be accompanied by a completed biopsy/cytology request form and signed by the attending faculty member.

Following microscopic examination, the original histopathologic report will be scanned into the patient's axiUm record. It is the responsibility of the submitting student dentist to notify the patient personally of the results of the histopathologic examination for patients of the pre-doctoral program. If the patient does not return for follow-up or cannot be contacted by telephone, the student dentist must send a registered letter to the patient's home address advising them to contact the student dentist to discuss the results of the biopsy procedure. Florida statues prohibit the mailing of biopsy results directly to the patient. All attempts to contact the patient and all discussions with the patient concerning the biopsy results must be documented in the patient record. Inform the patient that he will receive a separate bill from the Biopsy Service at UF for reading the pathology specimen. Pathology services are usually covered under medical insurance.

4.26 UFCD Guidelines for Removal of Human Tissue

Submission of tissue removed from patients for microscopic analysis is the established standard of care to ensure accurate diagnosis and optimal patient care. It also provides written documentation and confirmation of diagnosis, which may be important for risk management and medico legal considerations.

The following guidelines represent the accepted management parameters for UFCD patients:

1. Informed consent must be obtained prior to removing tissues from a patient. (The exception would be dentin and enamel removal during routine restorative procedures; dentin removed during endodontic preparation; and dentin, cementum, and associated pocket epithelium removed during periodontal scaling and root planning.)
2. Other than the tissues exempted in (1.) above, all patients will be given the option of submission of their tissue for histopathologic examination. (The patient will also be informed of the associated oral pathology lab fee
3. All tissues removed for the following indications must be submitted for histopathologic examination.*
    a. All procedures identified as hard or soft tissue biopsies
    b. Radiographic alterations or lesions in bone where tissue removal is indicated to determine or confirm the diagnosis includes but is not limited to:
        i. All hard or mixed hard and soft tissue removal
        ii. All apical or periradicular surgical procedures
    c. Soft and/or hard tissue alterations
        i. Where tissue removal is indicated to determine or confirm the diagnosis
        ii. When there is no response or resolution after conservative treatment to establish adequacy of surgical margins

**Tissues removed by UFCD faculty while treating UFCD patients must be submitted to the UFCD Oral and Maxillofacial Pathology Biopsy service or to the Shands Hospital Surgical Pathology service as appropriate.*

    d. In defined situations, at the discretion of the attending faculty, alterations to this policy could be applied.
        i. Extirpation of pulp tissue removed during non-surgical endodontic procedures. At a minimum, the tissue will receive a gross visual examination. If the tissue appears grossly consistent with the clinical diagnosis (e.g., irreversible pulpitis or pulpal necrosis), and the attending faculty determines submission for histopathologic examination is not indicated (will not alter diagnosis, treatment or prognosis), or the patient is offered but declines microscopic analysis, the attending faculty will so designate in the progress note and sign.
        ii. Extraction of Teeth : At a minimum, extracted teeth (without soft tissue attached)

should be described in the progress note to include tooth number, and diagnosis or reason for removal. The progress note should state that gross examination is consistent with the clinical diagnosis (e.g., non-restorable due to advanced caries).

1. If extraction is associated with orthodontic procedures, the progress note should indicate that the teeth were unremarkable in appearance.
2. If a periapical or periradicular radiographic lesion is associated with the extracted tooth, and/or if soft tissue remains on the tooth when delivered, appropriate tissue should be submitted for histopathologic examination. If the patient declines tissue submission, the gross visual description and the patient declination should be recorded in the progress notes and signed by the attending faculty

iii. Soft/hard tissue removal associated with periodontal surgical procedures including gingivectomy and/or gingivoplasty, tissue debulking and recontouring, clinical crown lengthening procedures to facilitate impression making or excessive donor tissue from grafting procedures may not require submission for histopathologic examination in the absence of signs or symptoms of pathology. If the patient declines, at a minimum, gross visual inspection confirming the tissue is consistent with the clinical diagnosis should be so noted in the chart and signed by the attending faculty.

iv. Pre-prosthetic surgery (e.g., alveoloplasty, tori removal) Tissues removed during pre-prosthetic surgery may receive histopathologic examination. If the patient declines, at a minimum, gross visual inspection verifying tissue was unremarkable in appearance should be entered in the progress notes and signed by the attending faculty.

NOTE: In instances where microscopic examination of tissue is offered and recommended to a patient but the patient declines such service, the record should document that fact and the patient should co-sign the entry.

Appropriate patient care is our primary concern. If the attending faculty determines a specimen should be submitted for histopathologic examination to confirm the diagnosis of a serious systemic disorder, a neoplasm, or a malignant condition, the specimen must be submitted regardless of the patient's financial status. In these rare situations, the College will assume financial responsibility for this service.

4.27 Guidelines for Removal of Restorative Hardware

1. Offer the removed restorative hardware to the patient
   a. IF the patient accepts the removed restorative hardware; then,
      i. Render removed restorative hardware non-biohazardous by following CDC/Florida Statutes-Guidelines (decontaminate) and,
      ii. Turn removed restorative hardware over to patient before departure (same day)
   b. If the patient declines the removed restorative hardware; then,
      i. Render removed restorative hardware non-biohazardous by following CDC/Florida Statutes guidelines (decontaminate) and,
      ii. Turn removed restorative hardware over to Clinic Administration (same day)
2. All “non-metal” restorative hardware is to be disposed of by following CDC/Florida Statues guidelines

4.28 What to do when you suspect a patient may be a victim of Human Trafficking

What is Human Trafficking? Human Trafficking is the recruitment, harboring, transporting, providing or obtaining, by any means, a person for labor or services involving forced labor, slavery or servitude in any industry, such as forced or coerced participation in agriculture, prostitution, manufacturing, or other

industries or in domestic service or marriage (Freedom Network, based on the federal criminal law definitions of trafficking).

Warning Signs of Human Trafficking: Chances are there's going to be nothing visible, nothing that you can see from across the room, or even from up close, that should alert you that a stranger is being trafficked. That may come as a surprise – especially if you have been to a training where you have been taught the 'signs' or indicators of trafficking, such as a person looking disheveled, upset or scared. But as we learn more about how trafficking really works, we are also learning that the best way to help is to pay attention to people you actually know or interact with – your students, your tenants, your children, your patients, your co-workers. It is all about two magic words: Context and proximity.

Research shows that the majority of human trafficking survivors had some contact with the health care system during the time they were being exploited. That means health care providers are often in the position to recognize that something is wrong and take steps to provide support. Potential red flags specific to a health care setting may include:

- A patient with reproductive or sexual health concerns and or potential signs of sexual violence and reporting an unusually high number of partners
- A patient with work-related injuries reporting that health and safety gear were not provided or conditions were otherwise unsafe
- A patient is unwilling or hesitant to answer questions about the injury or illness
- A patient Is accompanied by an individual who does not let the patient speak for themselves, refuses to let the patient have privacy, or who interprets for them

How to report Human Trafficking:

- If you have information regarding suspected Human Trafficking of a child in Florida please contact: Florida Abuse Hotline, 1(800)96-ABUSE or 1(800)962-2873
- If you have information regarding suspected Human Trafficking of an adult anywhere in the United States or of a child outside of Florida please contact the National Human Trafficking Resource Center: 1(888)373-7888.
- **Text HELP to 233733 (BEFREE):** To get help for victims and survivors of human trafficking or to connect with local services.
- Visit the National Human Trafficking Hotline online at: https://humantraffickinghotline.org.

5.0 FEES AND COLLECTIONS

5.1 Establishing Appropriate Fees

All students must adhere to the charges listed at all times. Any deviation from the listed fees may be challenged and corrected by a faculty member.

5.2 Patient Accounts and Student Collection Policy

1. Patients acceptable for student treatment must have a screening examination before assignment. These patients' accounts are verified with the Business Office or the treatment coordinator prior to assignment to ensure the balance is zero.
2. The student, with support from the treatment coordinator, is responsible for assuring the patient account is either current or treatment discontinued. Differences between student financial records and patient accounting reports must be reviewed and verified. Questions or problems concerning patient accounts and/or patient account reports should be directed to the Business Office located in D2-6.

3. All balances, regardless of the clinic where the services are rendered, should be collected. This is the responsibility of the treating student dentist. Patients are scheduled with no balance and if they do not pay after the first appointment a balance will develop. The patient should not be rescheduled unless the balance is paid prior to the next treatment. All efforts should be exhausted to collect first time balances, including phone calls and balance letters to the patient. Student dentists are responsible for any balance incurred after the first nonpayment procedure. (For example: if you have completed scaling and root planing on quadrants I and IV on June 1st and the patient does not pay, and you continue treatment (i.e. more scaling and root planing) you will be responsible for paying all charges since you added to the balance without having the patient pay for the previous balance.)
4. Correct fees and codes are in the patient management system. Review with the patient the plan, fees, and payment procedure. Ask the patient to confirm his understanding by printing a copy of the proposed treatment plan. Stress to patients that the fees quoted are estimates only and variations may occur if it becomes necessary to alter the treatment plan. If changes do occur, the patient must sign and be provided with a revised version of the treatment plan.
5. The patient is responsible for paying the appropriate fees for dental care. The student is responsible for collecting patient fees. Make all patient charges and collections on the day of treatment. When treatment is completed, escort the patient to Patient Services (in the lobby). The cashier will accept payment from the patient based on the amount recorded on the gold routing slip/or in the patient management system.
   a. Under no circumstances can the student accept payment from the patient for dental services performed. If the cashier's office on the first floor is closed, take the patient to the Business Office on the second floor.
   b. If a patient plans to pay at the next appointment, document this agreement. No patient paying on a "cash basis" should be allowed to continue treatment if fees from the last appointment have not been collected by the next appointment date.
   c. Bring patient payment problems or other special circumstances to the immediate attention of the TEAM leader, treatment coordinator, the Business Office, patient advocate or the Associate Dean for Clinical Affairs.
   NOTE: Written approval from the Associate Dean for Clinical Affairs and Quality, or his/her designee must be obtained before agreeing to personally pay for the dental care of a patient. As a general rule, this practice is not condoned. If a case should arise in which a patient requests that a student remunerate the patient for a particular procedure, or request that the student pay for the dental work, the Associate Dean for Clinical Affairs and Quality should be immediately informed.
6. Charges associated with multiple visit procedures (prosthodontics) should be submitted in full when treatment is initiated. This will not affect any payment arrangement established with a patient.
7. Patients will not be formally discharged from responsibility until the account balance has been verified as zero, without special approval from the Associate Dean for Clinical Affairs and Quality. Before graduation, all patient accounts must be verified as zero.
8. The student is responsible for ensuring that current patient information, including address, phone numbers, and copy of state identification card, is on file for each patient. Any changes should be submitted to the treatment coordinator or the Chart Room front desk in Patient Services.

5.3 Third Party Guarantors

If a patient is being sponsored by a social service agency or other third party, the student is still responsible for ensuring that payment will be collected. Before beginning treatment on a patient with Medicaid, verify the patient's eligibility (**this applies to every visit**). Medicaid has multiple managed care plans, and each is slightly different regarding covered services, pre-authorization requirements, and frequency limitations. The specific plan should be selected during registration in axiUm and the Business Office will assist with prior authorization approval after treatment needs are determined. Eligibility can be verified online at the Florida Medicaid website, as well as the various Medicaid managed care web sites. If the patient is not eligible,

students MUST inform the patient and make other payment arrangements before beginning treatment. Patients may be unaware that they are no longer covered and it is the student dentist's responsibility to verify this. If the patient loses coverage mid-treatment, students must make the patient aware. The patient will be responsible for non-covered charges, as long as a Non-Covered Services form is completed and signed by the patient prior to rendering the services. Omitting this step may result in the student dentist being responsible for the balance. **Assuring eligibility is the student's responsibility at every appointment**. If you have any concerns or questions you need to bring them to the attention of the Business Office, (273-5380).

5.4 Insurance

The insurances accepted in the pre-doctoral program are Medicaid and the Medicaid managed care plans. Any other insurances are not accepted as a form of payment in the pre-doctoral program. The student is responsible for collecting fees from his/her patients. However, the patient may be assisted in submitting their insurance claim and receiving reimbursement from their insurance provider once the services have been paid for in full and completed in axiUm. The patient must bring their insurance company's approved claim form for completion. The patient must complete the patient information section of the form. The student or patient must bring the form to the Business Office for completion. The Financial Assistance Counselor will complete and mail the form to the insurance company.

5.5 Contract Policy

Subject: *University of Florida College of Dentistry Title: Policy for Establishing a Financial Contract in the Clinical Care Groups*

Date: *August 18, 2008*

Approving Authority: *Associate Dean for Clinical Affairs and Quality.*

Custodian*: Associate Dean for Clinical Affairs and Quality, 273-6820*

Purpose:

Financial assistance is needed for many of our patients to continue their treatment in our student clinics. Once a treatment plan is established, many of our patients find themselves unable to afford the lump sum payment for treatment that has been established. This also affects our students and their progression through our clinical curriculum by decreasing the number of patients that will seek treatment. The purpose of this policy is to set up a mechanism for the patient to enter into a financial contract with the University of Florida, College of Dentistry to pay for planned treatment.

Policy:

The University of Florida, College of Dentistry will offer patients the option to pay for services through a contract establishing a payment plan with an appropriate down payment.

Procedure:

A. *Guidelines to establish a Financial Contract with a Clinical Care Group:*
   Two distinct levels of contracts can be established based on the total cost for the treatment that is planned.
   1. *When the treatment planned is, or will be, billed from $400.00 - $600.00 dollars:*
      a) *At the time the contract is accepted, a minimal down payment of ½ of the total amount being billed will be collected. The balance is to be paid in monthly installments.*
      b) *The contract will be for a set amount of time not to exceed six months. (Minimal payment in this level will be $35.00/month)*
      c) *There will be an administrative charge of $50.00 for contracts between $400.00 - $600.00. This fee will be added to the down payment.*
   2. *When the treatment exceeds $600.00 dollars and up to a maximum of $3,000.00:*
      a) *At the time the contract is accepted, a minimal down payment of 1/3 of the total amount being billed will be collected. The balance will be paid in monthly installments.*

b) The contract will be for a set amount of time not to exceed 12 months. (Minimal payment in this level will be $50.00/month.)

c) There will be an administrative charge of $75.00 for contracts of $601.00 and up. This fee will be added to the down payment.

B. To establish a contract, the Budget Payment Form must be completed and approved by a Team Leader. Once approved, the form is sent to the Patient Accounting Office in order for the budget payment to be established in axiUm.

1. *Contracts can be renegotiated if the treatment plan changes during the course of treatment.*
2. *Any treatment provided in a Graduate, Endodontic, Orthodontic, or Oral Surgery clinic will not be covered under the Clinical Care Group contract. These charges must be paid directly to the respective program. No contract will be written if there is an existing balance from another clinic.*
3. *Payments must be current in order for appointments to be scheduled.*
4. *The payment plan will be considered in default if one monthly payment is missed. The entire balance becomes due and is subject to collection after 120 days*
5. *Other options for paying for treatment charges is viaCredit Card (VISA, MasterCard, & American Express).*

5.6 TEAMS Payment Contract Process (per the Business Office)

1. Dental student completes the payment contract form, gets it approved in their clinic, and scans the document into axiUm.
2. The same day, the dental student brings the patient to the Business Office (D2-6) along with a copy of the patient's treatment plan. NOTE: The required down payment must be made before the payment plan can be set up in axiUm. If the patient is paying with cash, they must make the payment at the first floor cashier window before coming to the Business Office. Any other form of payment can be processed by the Business Office staff in D2-6.
3. The dental student will remain with the patient in the Business Office while the Business Office staff verifies that all procedures and correct charge amounts are on the patient's account.
    a. Any necessary corrections will be communicated to the dental student at this time.
4. After the payment contract has been set up in axiUm by the Business Office staff, the patient will then sign the original Budget Payment Agreement form and the axiUm printed contract.
    a. The Business Office staff will provide the student with 1 copy of the signed forms to be scanned into the patient chart.
    b. The Business Office staff will provide the patient with a copy of the signed forms.
5. The patient then pays the appropriate down-payment amount.
    a. Check and / or Credit Card payments will be processed in the Business Office by the Business Office Staff setting up the payment contract and a receipt will be provided to the patient.
    b. If the patient is paying by cash, they will be directed to the first floor cashiers accompanied by their dental student to make the appropriate down-payment and receive a receipt.
        i. Patient will bring their copy of the payment contract to the first floor cashier, along with the appropriate documented down-payment amount to be paid.
        ii. Cashier will attach the patient's receipt to the patient's copy of the payment contract.

NOTE: Any / all additional services performed outside of the contracted procedures must be paid in full at the time of service.

5.7 Voiding Charges

If a procedure/charge is entered in the patient management system that is incorrect for some reason, a faculty member must authorize an adjustment form. The "ADJST" form must be initiated in axiUm for an adjustment.

All patient visits must generate a treatment code entry in the patient management record whether a fee is charged or not. If the fee is to be waived, an adjustment form MUST be submitted with a rationale supporting the reason for the adjustment.

5.8 Missing Charges Policy

The College of Dentistry has the potential to lose many thousands of dollars in revenue each year if charges are not properly processed in the patient management system. **At any given time, there should be no missing charges over 24 hours in the patient management system**.

5.9 Treatment of Fellow Dental Students

Dental students are allowed to be treated by other dental students for one-half the normal student patient fee except for prosthodontics and implant procedures. For prosthodontic procedures, consult with the chair of the Department of Restorative Dental Sciences and/or division director of prosthodontics, regarding the appropriate fee. For castings in operative, consult with the division head of operative dentistry. This provision is strictly for student dentists being treated by student dentists in the teams clinics and does not extend to family members, dental assistants, Santa Fe College (SFC) dental hygiene students, or SFC dental assisting students, who must pay standard fees.

6.0 GENERAL CLINIC PROTOCOL

6.1 Sterilization

UFCD is committed to the highest quality of care and patient safety. All procedures outlined in the Infection Control Document, consistent with UF, state, and federal policies are followed. Students will be instructed in those policies and non-compliance will not be tolerated.

1. Central Sterilization is responsible for cleaning, disinfecting, packaging and sterilizing instruments and handpieces from the student leasing program and select post-doctoral clinics. The methods of sterilization utilized at UFCD are steam autoclaving. All sterilizer units are tested daily using UFCD's in-house biological monitoring service. Additionally, all loads which contain an implantable device are tested utilizing Assert Biological Indicator which provides results within 40 minutes The test results are logged and records maintained for three years. The UFCD Sterilization Manual is maintained in Central Sterilization. The manual outlines the procedures and policies which ensure the efficacy of processing, sterilizing, transport and storage of all critical items.
   Students are to check out leased instruments from Central Sterilization in all clinical floors(D1-28; D2-44 or D3-28).
2. <u>Start-check Procedure</u>
   As part of the start-check procedure in clinics, a faculty member will verify that the instruments to be used have been through a sterilization procedure. To accomplish this, the faculty member must see the unopened package of instruments before the dental procedure is started.
3. <u>Sharps Management</u>

NOTE: ALL USED NEEDLES AND SURGICAL BLADES MUST BE DEPOSITED IN SHARP BOXES IN EACH CLINIC OR OPERATORY. FAILURE TO COMPLY will result in counseling and Professional Clinical Variance, leading to a grade reduction in Professionalism. Repeat non-compliance may result in clinic suspension.

6.2 Use of Portable Nitrous Oxide Machines

To use a portable nitrous oxide/oxygen machine, the student must have a statement of approval from the attending faculty member responsible for the student and the patient during that period. This statement must be in the Treatment Notes and signed by the specific faculty member, who has the required qualifications for the use of nitrous oxide/oxygen.

Under **NO** circumstances may a student leave a patient unsupervised who is under nitrous oxide/oxygen inhalation.

6.3 Predoctoral Implant Protocol

1. Implant Screening: Screening for dental implant treatment in the student program is done by appointment. If the student identifies a potential implant patient, the student completes an Implant consult Pre-screen form to ensure the patient is disease free and has completed all outstanding treatment which then allows the Treatment Coordinator to schedule the implant consult appointment. Currently, implant consults are available on most Monday through Thursday mornings and Mondays through Wedensday afternoons. Consults are available in three clinics: Center for Implant Dentistry, Graduate Periodontics, and Graduate Prosthodontics. For partially edentulous patients, we are providing posterior tooth replacement (i.e. molar or premolar) only. For edentulous patients, we are providing two-implant mandibular overdentures only.

   Note: We do not provide care for patients who present with implants placed outside of the College of Dentistry. These patients must be referred to Graduate Prosthodontics for evaluation for treatment by a prosthodontic resident.
2. Radiographic/Surgical guides: Once the patient is approved for treatment in the student program, the student dentist will need to work with the assigned resident to fabricate a conventional or 3D printed surgical guide. The student will need to expose a periapical radiograph (or panoramic) with the radiographic guide which shows the roots of the adjacent teeth prior to fabricating the surgical guide. Alternatively, the surgeon may request a sectional or full arch CBCT in radiology to allow for a CBCT guided surgical template.
3. Surgery Appointments: Once the student dentist has completed the surgical guide, he/she may schedule the implant surgery. The student dentist should then go to the receptionist of the clinic where the implant consult was completed to make the surgical appointment. The student dentist must plan on being present for the patient's surgery and show the surgical guide to the surgeon in advance of the appointment.
4. Restorative Appointments: Restoration of implants is completed in the TEAMS clinics, after a suitable healing period, which is usually a minimum of 8 to 12 weeks, as indicated by the surgeon. Once the surgeon has cleared the patient for restorative treatment, the student will contact the Director of Predoctoral Implant Dentistry to order the restorative components at least two weeks prior to the appointment. Implant restorative kits for the Straumann and Astra implant systems are available through Central Sterilization. Prosthodontic faculty and TEAM leaders are available to supervise the restorative treatment. When removing healing abutments, use a throat pack and tie off any wrenches with dental floss prior to their use in the mouth.
5. Additional information: To learn more about the clinical procedures, refer to Canvas for DEN 7411 Overview of Implant Dentistry. In the "Documents" section, look for the implant lectures entitled "7&8 Fixed Rest Options (implant level) and "13&14 Treatment of the edentulous patient." For additional information on the radiographic and surgical guides, in the "Documents" section, look for the implant

lectures entitled “3&4 Guides.”

6.4 Laboratory Utilization

The simulation lab will be available for all scheduled courses and activities. The simulation lab will be available for scheduled and unscheduled practice as described below. Follow the Simulation Lab Scheduled posted outside the Simulation Laboratory doors.

1. Monday through Friday (8:00 a.m. to 5:00 p.m.), students may not practice during a scheduled laboratory session.
2. Monday through Friday (8:00 a.m. to 5:00 p.m.), students may practice when no class is scheduled. All students must be out of the lab 15 minutes prior to any scheduled activity even if it is for their own class. This is to allow cleaning, stocking, and dispensing of materials
3. Course activities or practice sessions with tutors after 5:00 p.m. on weekdays or during the weekends will require scheduling through the Office of Academic Affairs.
4. The lab is available for "walk-in" practice after hours and on week-ends when not reserved for scheduled activities from 6:00am until11:00 pm. While locked, students will use their ID card and "swipe" for entrance. For safety reasons, video cameras will monitor the lab.
5. The lab will be available for UFCD continuing education activities at times that do not conflict with the UFCD curricular requirements. Scheduling of the simulator lab for continuing education activities will be coordinated through the Office of Continuing Education, Office of Clinical Administration, and Office of Academic Affairs. The lab must be monitored by an individual trained in simulator usage and maintenance and also skilled in the operation of the computer technology.

6.5 Student Responsibilities for Simulation Lab Equipment

Students are responsible for certain aspects related to the care and function of the assigned simulators. These are described below. Students are assigned to one simulator for their entire pre-clinical curriculum. The student’s name will be affixed to the assigned station. Each student will be loaned a numbered key to correspond to his numbered drawer. Misplaced or lost keys should be immediately reported to the education resource manager. The replacement fee is $44.00.

1. White butcher paper should be placed on the workbench prior to any lab work.
2. Students are <u>not</u> to use another student’s simulator or station for assigned lab sessions or interchange any parts with another simulator unless reassigned by the educational resource manager or faculty, due to maintenance issues.
3. Students should inspect their simulator and station at the beginning of each lab period to verify that the units are functional and that the torso or other components have not been damaged or defaced. If damage is noted, the student should report this to the attending faculty and educational resource manager. (Refer to section on “Reporting Damage.”)
4. Students are given a shroud “rubber face” for simulator use and are responsible for replacement at their own cost if lost or damaged beyond use.
5. Shroudsare removed, cleansed, dried and locked in the assigned drawer at the close of each session. If replacement becomes necessary, the fee is $80.00.
6. If a student finds any equipment in their unit that does not belong to them, it is to be immediately turned in to the educational resource manager or the instrument leasing manager.

6.6 Reporting Damaged Simulator Components

If damage is noted, it should be immediately reported to the education resource manager. If the unit is still functional, the student may proceed with the lab exercise after appropriate reporting has been completed.

If the unit is not functional or the repairs cannot be made within 10-15 minutes, the student will be assigned to another unit, preferably an unassigned simulator. The problem will be reviewed and the student who previously used the unit will be contacted. Corrective action will be administered when indicated. Students are ethically and financially responsible for damage or defacement of the simulator torso.

For after-hours emergencies refer to the yellow signs in both labs S3-15 and D3-31. Please call, the Facilities Services number for after-hours maintenance emergencies.

6.7 Student Responsibilities for Simulation Lab Maintenance

The Simulation Lab will be closed and locked at the scheduled time for the class to end.

The following steps must be completed prior to leaving the lab:

1. Stop working 10-15 minutes before the close of the session to allow ample time to clean the area.
2. Remove the dentoform from the jaw assembly.
3. Remove, clean, dry, and store the face mask in the locked simulator drawer.
4. Clean the simulator torso and jaws with wet paper towels. If necessary, use hand soap and water and rinse well.
5. Do NOT use commercial cleansers, abrasives or solvents on the components. These could cause irreversible damage for which students would be responsible.
6. Clean and dry jaw assembly and place on the simulator base. Turn off the simulator power switch (green), the water pressure valve (up is off), the bench light, the composite curing light, and the computer monitor and help light.
7. Place the hoses on their proper holder.
8. Fill the water container (white liter jug) with fresh distilled water.
9. If the white collection tank is over 3/4 full, decant the water into the sink drain in the wet lab (D3-16), making certain the amalgam stays in the trap and does not go down the drain. (Allowing amalgam to go down the drain is a violation of federal hazardous waste disposal regulations.)
10. Leave the torso in a folded forward position, stored under the bench top.
11. Properly dispose of trash, and remove waste and debris from the bench top.
12. Leave the bench and work area neat, dry, and clean.
13. Push the stool under the bench upon leaving.
14. No student is permitted to remove any equipment or material, (i.e.; dentoform jaws and plates, curing lights or any material from the supply table) from the Sim Lab without explicit permission from the educational resource manager, instrument leasing manager, office of education, or clinic administration.

6.8 Contact Individuals for Assistance

For Scheduling

Office of Academic Affairs – 273-5950

Continuing Dental Education – 273-8480

For Computer/AV Support

AV Equipment Operator (D3-43) – 273-5711

For Simulator Maintenance

Dental Maintenance – 273-8001

6.9 Faculty and Staff Responsibilities for Simulation Lab Maintenance

1. Faculty using the lab will be issued keys so they may become more familiar with the computer technology and to allow them to set up lab activities at their convenience.
2. The lab will be opened at least 10 minutes before scheduled activities. (This will vary with individual faculty preference.)
3. At the beginning of each session, faculty will report any concerns, such as a lack of cleanliness or equipment malfunctions.
4. Faculty will conclude the class with 10-15 minutes remaining to allow students ample time for maintenance procedures.
5. When the educational resource manager is not available at the end of a scheduled course, the last attending faculty to leave the area will close the door.
6. At the conclusion of each session, the areas will be checked for student compliance with the maintenance protocols. Action regarding non-compliance will be initiated as appropriate and consistent with the severity of the incident.
7. Counseling and suggestions to manage initial acts of non-compliance and promote improvement may be offered by the Associate Dean for Clinical Affairs and Quality .
8. Continued violations and/or serious violations with the intent of misleading faculty or inflicting intentional damage to equipment may result in a lowered performance evaluation in the category of asepsis, patient management, or professionalism (as appropriate). Variance reports will be submitted as required.
9. In addition, a letter of reprimand from the Associate Dean for Clinical Affairs and Quality will be included in the student's permanent academic file.

6.10 Junior/ Senior Lab Utilization

1. The Junior/Senior lab will be available for authorized users from 7:00 a.m. to 11:00 p.m. daily (Monday – Sunday), unless reserved for special purposes such as state boards, mock boards, lectures, lab exercises, continuing education, or maintenance work. Advance notice (at least seven workdays) will be given regarding closures and reservations.
2. All efforts will be made to save some sections of the lab for clinical patient care when clinics are scheduled.
3. The lab doors will be locked when unoccupied during evenings, on weekends, and holidays. For security and safety, students and staff are to call UF Security if persons enter the lab without authorization or proper identification.
4. Food and drinks are not allowed in the lab.
5. No clinical procedures can be performed in the clinical lab, D3-31 (i.e., alginate impressions, face bows).
6. Sound or music systems may be used in the laboratory provided their volume, content, and use does not detract from the normal operation of the lab and its surrounding clinics.
7. Scheduling of the lab for continuing education activities will be coordinated through the Clinical Administration Office, activities will not be allowed to adversely impact patient care.

6.11 Lab Safety

The laboratories are considered hazardous work areas. The risk of injury from chemical, gas, heat, electrical sources, air-driven tools and mechanical equipment in this confined limited space must be understood by everyone. For these reasons, all users must:

1. Know the location of the telephone and emergency numbers in the lab (wall-mounted on the northeast corner, near the double doors). Know the location of fire extinguishers and exit doors and stairways from the lab

2. Know the location of the three emergency eyewash stations in the lab (one on the SE corner next to the single door and two on the model pouring and trimming station in the middle of the lab)
3. Wear eye protection in the lab at all times.
4. Know the location of the First Aid box in the lab (mounted on the second column, next to station number 32).
5. Dispose of broken glass, sharps, and instruments in the sharps container located in the middle of the lab. Large broken glass items must be disposed of separately in a box that is legibly marked "broken glass" and placed near trash receptacles.
6. Obtain proper training and instructions from faculty or staff members prior to operating or using any unfamiliar or never-used lab equipment.
7. Report any broken equipment, exposed electrical components, loose or missing parts, gas, air, or water leaks to the educational resources manager, leasing manager, dental maintenance (273-8001) and/or clinic administration.
8. Report any inappropriate behavior or actions by others that could lead to unsafe conditions to attending staff, faculty, or the Office of Academic Affairs.

6.12 Student Dentist Responsibilities for the Clinical Lab Equipment and Stations

Student dentists are responsible for certain aspects related to the care and operation of the lab. A degree of pride and ownership is expected from each assigned student so that the laboratory remains in good condition for continuous use. These responsibilities are described below:

1. Two student dentists (a Junior and a Senior) are assigned a working station with adjacent storage bins for their tackle boxes. In the event that both students would need to use their assigned station at the same time, a "first-come, first-serve" rule will be followed, with latecomers expected to use another station that may be vacant at that time. Staff members may move students to other stations at any time as various situations warrant.
2. Prior to working at their stations, students must lay down brown paper on the counter to prevent dirt and debris from accumulating on the workstations. In case of spills, splatters, wax, or acrylic deposits on workstation surfaces, students must wipe, scrape, or remove such deposits immediately to avoid build-up.
3. Each student dentist is responsible for collecting and depositing trash that he has generated in trash containers located throughout the lab.
4. Student dentists must know the proper care, operation, use, and settings of lab equipment. Contact the attending faculty or staff member for instructions and guidance prior to operating any equipment. Lab equipment is to be used for specified laboratory procedures only. Improper use could render the equipment unsafe for the next user. Use of lab equipment other than for its intended purposes constitutes misuse of state property and may result in follow-up disciplinary sanctions.
5. All lab equipment is to remain in D3-31.
6. When using gas or alcohol burners, ensure sufficient distance is maintained from nearby items to prevent accidental melting or burning. Do not place burners directly underneath lamps, shelves, or hoses.
7. Seal or cap all containers that could spill or leak fumes or chemicals in the air or working surfaces. To ensure efficient vacuum operation at student workstations, avoid suctioning moisture or moist items into suction units.
8. Casts and prosthesis must be dried prior to grinding or trimming with suction vents on.
9. Clean suction vents and shields after grinding or trimming.
10. Report occasions when "Check filter" indicator light comes on to the staff member or make an entry in the Repair Log.
11. Prior to leaving the lab, students must follow the checklist below. Make sure:
    a. All lathes, desk lamps, burners, and other equipment have been turned off.

b. Gas and air valves are closed.
c. Equipment and parts are returned or mounted in their original positions.
d. Chairs are rolled back into their respective stations.
e. Tackle boxes are locked and stored only in your assigned stations. No personal equipment or items are allowed on shelves, drawers, counters, and floors.
f. If the collection drawer was used, all debris must be removed and drawers must be wiped clean.
g. All work station trash is collected and deposited in trash containers located throughout the lab.

6.13 Laboratory Infection Control

In consonance with the Infection Control Document procedures outlined under Section 9.0 of this Manual, the following guidelines will be followed when working on prostheses that come from patient care clinics:

1. Polishing or the use of pumice and polishing compounds is not allowed in D3-31.
2. To polish prostheses, use the Polishing Lab in the predoctoral teams clinics and follow protocol. Since the Polishing Lab is open only during clinic hours, students must plan on polishing their prosthesis according to these hours.
3. Upon entering D3-31 with disinfected prosthesis, always wear full P.P.E. protection before doing any laboratory procedure. P.P.E. supplies are located within the student dentist's team clinic.
4. Rinse prosthesis again prior to performing any procedure. Dispose of transfer bag(s) and exposed paper towels in trash containers.
5. Disinfect all instruments with approved surface disinfectant prior to leaving the pouring station.
6. Dispose of gloves, masks, and gowns in trash containers.
7. Follow other laboratory disinfection and decontamination procedures outlined in Section 9.0 Infection Control.

6.14 Supervision of Maintenance and Cleanliness of Student Laboratories

Student dentists are responsible for cleaning and maintaining the Junior/Senior Student Laboratory (D3-31). The activity will be supervised by UFCD staff designated by the Associate Dean for Clinical Affairs and Quality. If the laboratories are not properly cleaned and maintained, the responsible students will be suspended from the clinics for up to one week. Failure to maintain the third floor clinical laboratory properly can also result in the closure of this laboratory to student use for any period of time deemed proper by the administration.

To keep the laboratories in the best usable condition, each person must exercise a professional "clean as you go" practice as they work in the Lab.

6.15 Student Responsibilities for Polishing Laboratory (in the TEAM clinics)

Wear gown, mask, eye protection (student's own), and gloves before working in the Polishing Laboratory.

Ensure every prosthesis has been properly decontaminated prior to entering the lab. To minimize cross contamination, keep each case in a separate sealed denture bag or cup issued by Clinical Staff dental assistants.

Collect polishing supplies and material prior to opening the bag containing the prosthesis. The use of a unit dose system is mandatory to minimize cross-contamination and waste.

1. Cover the black rubber polishing tray with a clear plastic bag before polishing.
2. Open and lay down supplies on the foam tray to avoid touching other items when polishing.
3. If using an ultrasonic cleaner, place the prosthesis in a separate re-sealable bag using appropriate cleaning solution before placing it in the ultrasonic tray.
4. Refer to posted charts on the wall for the correct cleaning solutions and time settings.
5. Allow sufficient vibrating time prior to removing the bag, and dispose of the cleaning solution immediately in the sink.
6. Dispose of the bag immediately in the trash receptacle.

7. When finished with the polishing, collect all used material and dispose as follows:

Place the prosthesis in a new zip-lock bag and seal it tight. Spray approved disinfectant on the sealed bag, all countertops, and equipment surfaces used during polishing. Wipe with paper towels. Spray the approved disinfectant again; leave the second spray to dry ("Wipe-Discard-Wipe"). De-glove and wash hands prior to using marking supplies. Report any equipment needing repair or servicing on the maintenance sheet posted on the wall or to the designated staff. Write down needed supplies on the supply request form next to the maintenance sheet.

6.16 Faculty and Staff Responsibilities for D3-31

Faculty will inform the staff responsible for the laboratories of the scheduled courses and lab exams requiring special needs. Faculty will conclude the class with 10 minutes remaining to allow students ample time for clean-up procedures. Faculty will remind students to clean their areas before leaving the lab.

6.17 Checklist for Clinic Maintenance

1. Operatories **(Expectations after use of clinic operatory)**
   a. Counters and sinks should be clean.
   b. Cabinet fronts should be clean
   c. Operator's chair, dental assistant's chair, and the dental chair should be clean.
   d. No calendars or cartoons should be pasted on walls.
   e. Suction tips should be removed from the unit.
   f. Saliva ejector tubing should be in place on the unit, without the disposable tip. Tubing should be free of debris.
   g. Trash bag should be deposited in clinic trash.
   h. Place individual small red bag containing any regulated waste (blood or saliva soaked gauze or cotton rolls) into the "red bag" trash.
   i. Paper towels should be in the dispenser.
   j. Only approved hand soap, hand sanitizer, and surface disinfectant is permitted near sink area.
2. General
   a. Instrument trays, laboratory trays, and other equipment and supplies checked out or borrowed from sterilization must be returned at the end of each clinic session.
   b. No linens, magazines, or other materials should be on the tops of the walls separating the cubicles.
   c. The oxygen tanks and masks are checked daily and replenished as needed.
   d. Emergency kit locks are checked daily. Emergency kit supplies are replaced immediately if used, or replenished when expired.
3. Maintenance

To ensure the saliva ejector and high volume evacuator (HVE) systems are properly maintained and continue to operate with maximum efficiency, the following care and maintenance shall be performed as indicated:

   a. After each patient, suction hoses (saliva ejector and HVE) shall have a cup of water drawn through each line that requires their use. After the water rinse, draw air through the system for a few seconds to clear water from the tubing (student responsibility).
   b. At least once each week, but more often if required by usage, all vacuum hoses (saliva ejector and HVE) shall be cleaned, deodorized, and sanitized by suctioning a quart of cleaner (i.e., OR-EVAC from Henry Schein Dental Supplies or PUREVAK from Sultan) prepared according to the manufacturer's instructions, through each hose (dental assistant responsibility).
   c. Each week, disposable solid traps shall be replaced. The proper protocol is to be followed for the disposal of the used trap. If suction is weak after the trap replacement, contact Dental Maintenance for assistance. (dental assistant responsibility)

6.18 Handpiece Maintenance and Sterilization Handpieces are among the most frequently used instruments in the dental operatory, thus making them highly susceptible to viral and bacterial contamination. Handpieces represent a considerable economic investment, and because they contain delicate parts and are used from patient-to-patient, handpieces have been described as the "weak link" in infection control. Air/turbine handpieces and electric handpieces leased by students are maintained and sterilized by Central Sterilization. All users should follow the sterilization guidelines found in this document for proper management of handpiece sterility. Laboratory handpieces must be maintained by the student and oiled after each use as recommended by the manufacturer.

6.19 Dental Maintenance Service Request

The procedure for reporting maintenance problems on all dental operating equipment is as follows:

1. Each clinical area has a clipboard with a Maintenance Request log sheet. If any item requires maintenance, list it on the log sheet. Maintenance personnel check this sheet daily and make the necessary repairs.
2. Report emergency maintenance requests by telephone (273-8001) or email (DN-Maint@dental.ufl.edu).
3. Any mechanical defect noted in an operatory must be reported to maintenance the same day, whether or not it is your assigned operatory.
4. Report any major physical maintenance problem immediately to the dental maintenance supervisor (273-8001) for correction.

6.20 Dress Code

Professional Attire (students, faculty and staff):Link to Student Handbook

All faculty members staff, and students must wear casual business attire or college-approved scrub top with dress slacks, or a scrub top and bottom. Shorts and denim jean slacks are unacceptable attire.

Students may wear a standard short/medium white clinic coat over the scrubs when not providing patient care. Clinic jackets or lab coats are to be worn buttoned, clean and unstained at all times and should be changed as frequently as necessary to maintain cleanliness. Wearing a clean white lab coat over scrubs while outside the preclinical or clinical area, such as going to the cafeteria, dining facilities, or patient reception areas, is encouraged. While working chairside in the clinics, faculty and students are required to wear the appropriate PPE, including a cover gown (which should replace the white lab coat in this event), when aerosol, splatter, or spray may be anticipated. In the Simulation Lab, or while in any clinic performing pre-clinical procedures, protective eyewear is required.

Skirts and dresses are **not allowed** in the clinical setting as proper ergonomics cannot be effectively achieved, and bare skin may be exposed to aerosol, splatter, or spray. An exception for skirts can be made for religious purposes, provided infection prevention and safety protocols are maintained. Shorts, divided short skirts, capris, and denim jean slacks are unacceptable attire. Plain or printed T-shirts will not be an acceptable substitute for a dress shirt or blouse. Dress shirts or blouses must be designed to preclude inappropriate chest or cleavage exposure during procedures.

Professional students must wear properly fitting garments and maintain seams and hems appropriately. For example, by the fourth year, the seam may become stressed and expose skin, or the hem may become frayed and present a less than professional appearance. In addition, frayed hems increases the possibility of

accidently tripping on the garment. Be aware of the fit of garments when positioned in operator and assisting stools, maintain coverage of skin and do not expose undergarments.

Shoes must be clean and in good repair. Appropriate business shoes would be expected with business attire. Clean athletic or health care professional shoes of vinyl or leather are acceptable with scrubs. To avoid occupational exposures, solid and closed toed shoes are required. Shoes must cover the top portion of the foot when in the clinic setting. However, work boots or hiking boots are inappropriate footwear. Open-toe shoes, thongs, sandals or "crocs" with holes and no heel closure are unacceptable attire. Everyone should wear appropriate socks so legs are covered by scrubs or socks during seated clinical procedures

Baseball caps and similar athletic headwear are inappropriate attire. Exceptions are made if the attire is for medical reasons, such as chemotherapy.

Personal Hygiene:

Dental professionals work in close proximity to the patient's face and hence must maintain awareness of how personal hygiene affects the patient experience. Use of strong fragrances such as perfumes, colognes and perfumed body lotions should be avoided when scheduled to care for patients. We enjoy living in a sub-tropical climate, but we need to remain mindful of the effects of this weather on our bodies, and be prepared to minimize its effects upon arrival to clinic. Likewise, consumption of some foods and spices may produce strong body odors and must be avoided prior to providing care to patients. Additionally, professional attire must be clean, tidy and odor free. Daily maintenance of personal hygiene combined with the use of commercially available fragrance free and odor reducing laundry detergents is recommended to help the dental professional practice patient centered care.

Hand-Hygiene: Fingernails must be kept short, clean and neatly trimmed. Fingernail polish, artificial nails (acrylic or gel) and hand jewelry may harbor pathogens and are not acceptable when delivering patient care. Providers should report breaks in skin (hands) that may affect the safety of the healthcare provider or patient. Hands must be effectively washed at the start and end of each patient care session. Use of hand sanitizer between hand washing is permitted so long as there is no visible debris on the hands. Hand hygiene

procedures are to be performed before donning gloves for patient care, and immediately after removing gloves following patient care.

Hair Maintenance: Hair must be neatly groomed at all times. In the clinical setting, hair should not touch the patient during procedures, nor should it fall in the field of the operator. Hair should be tightly secured, and/or contained in a head covering.

During patient care facial hair must be contained by appropriate face covering. When wearing a surgical N95 face covering, please refer to the guidelines for additional information regarding facial hair and use of filtering facepiece respirators: Facial Hairstyles and Filtering Facepiece Respirators (cdc.gov)

1910.134 - Respiratory protection. | Occupational Safety and Health Administration (osha.gov)

Clinic Scrubs Policy:

This policy allows students the option of wearing full scrubs along with the existing dress code options with the following guidelines:

1. The scrubs will be ceil blue in color (top and bottom) for all of the pre-doctoral classes. No other color of top or bottom is permitted for pre-doctoral students, with the exception of hospital call rotations.
2. The cost of scrubs is the responsibility of the student.
3. When outside clinical treatment areas, a white lab jacket may be worn over the scrubs. This includes the Communicore, COD hallways, and all dining areas.
4. Scrubs are considered as "street clothes" and are to be laundered by the student as regular clothing. They should be clean, neat, and well maintained. Scrub tops can be worn untucked but torso and undergarments may not be exposed (for example, when chairside).
5. For any aerosol or splatter-producing procedure in patient care clinics, a disposable or washable covergown must be worn in addition to the scrub or business attire. The covergown will be disposed/discarded of at the end of each clinic session. The professional white lab coat is not permitted to be worn during procedures involving aerosol, splatter, or spray, unless it is underneath a covergown.
6. For aerosol or splatter-producing procedures involving non-sterile, but disinfected extracted teeth in the simulation exercises, a covergown is required.
7. For aerosol or splatter-producing procedures involving plastic dentoform teeth in the simulation exercises, a covergown is optional.
8. For reasons of modesty and/or warmth, solid white (short- or long- sleeved) T-shirts may be worn under the scrub top. This practice is encouraged if inappropriate exposure of the chest area is in question. White T-shirts must be tucked in at the waist.

Personal Protective Equipment (PPE):

The purpose of the personal protective equipment listed below is to protect skin, eyes, nose, and mouth from any possible splashes, spray, spatter, or droplets of blood or saliva produced during simulation exercises or patient contact or treatment. The final decision as to the protective equipment required rests with Infection prevention and safety subcommittee in accordance with Florida Statutes, CDC, and OSHA requirements.
OSHA Rule 29 CFR 1910.1030
http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=STANDARDS&p_id=10051

Guidance as to protective equipment (PPE) usage is also available from the Associate Dean for Clinical Affairs and Quality, the Department Chair, and the Clinical Affairs Committee. Instructions for the proper donning and removal of PPE are available in Appendix L.

NOTE: Food and drink are not allowed in the simulation lab, clinics, or clinical labs.

1. General:

a. Fingernails shall be kept short and well groomed. Acrylic nails and nail polish harbor pathogens and are not allowed during the provision of clinical care.
b. Hand or wrist jewelry should be removed prior to hand hygiene and donning the protective cover gown and gloves.
c. Hair must be neatly groomed at all times. In the clinical setting, hair should not touch the patient during procedures, nor should it fall in the field of vision of the operator. Hair should be tightly secured, or contained in head covering.
d. Facial hair shall be covered by a surgical mask or N95 Respirator, and/or face mask or shield.

2. Disposable/Washable Protective Cover Gowns:
   a. When entering the clinic you will be dressed as described by the general dress codes described above. Before beginning any procedure which may produce contaminated aerosols, or involve any patient contact which could result in exposure to patient blood or saliva, you must don a protective cover gown.
   b. The same cover gown will be worn for the entire clinical procedure unless fluid or blood permeates the cover gown. At that time, the gown shall be changed. Cover gowns may be changed at any time when in the opinion of the person wearing the gown, or the faculty, that change is necessary. Neckties may need to be removed to avoid exposure to contaminated fluids.
   c. Protective cover gowns worn by faculty while covering student clinic do not have to be changed by faculty between patients unless visible contamination occurs.
   d. Protective cover gowns must be removed and properly discarded prior to leaving a clinic. The protective cover gowns must not be worn in hallways or other public areas.
3. Gloves:
   a. Disposable exam gloves shall be worn for any patient contact or procedure which could result in exposure to patient blood or saliva. Gloves will be pulled over the wrist so as to cover the cuffs of the disposable protective cover gown.
   b. Hand hygiene is to be performed (hands shall be washed with soap and water when visibly contaminated, otherwise an alcohol-based hand rub may be used) prior to donning gloves and immediately after removing gloves
   c. Gloves shall be changed if torn or contaminated.
   d. Gloves are to be removed and hand hygiene is to be performed when leaving the dental cubicle to use equipment (telephone, laboratory equipment, etc.). Hand hygiene is performed and new gloves are donned prior to returning to patient care
   e. Gloves shall be removed and hand hygiene must be performed prior to handling paper documents (for example: patient walk-out forms, or patient educational materials)
   f. Upon leaving the patient care operatory, gloves are to be removed and hand hygiene must be performed.
4. Eyewear:
   a. Protective eyewear must be worn by students, faculty, staff, and patients for any patient contact or procedure which could result in exposure to patient blood or saliva.
   b. Eyewear in the form of glasses or goggles must have solid side shields. Prescription eyeglasses are acceptable only if they include solid side shields.
   c. Chin length face shields may be substituted for glasses or goggles, and must be worn along with a surgical mask (or surgical N95 respirator)
   d. Eyewear shall be disinfected between patients following the guidelines and materials detailed in the Infection Control Document and in accordance with manufacturer's recommendations.
5. Masks: **Interim guidance for the COVID19 pandemic** (Protocol when the region is considered "High Risk"):
   a. During patient care, a disposable surgical filtering facepiece respirator such as a surgical N95 respirator must be worn. Alternative respirators may be considered on a case by case standard and in accordance with university policy and procedure through the office of Environmental

Health & Safety.

b. Surgical N95 must be worn when the operator or assistant is wearing a face shield for eye-protection.
c. Surgical N95 must be changed if clinician is unable to achieve a tight seal during the seal check when donning the respirator, or if it becomes torn, saturated with operator saliva, or otherwise contaminated.
d. Surgical masks are to be worn whenever the clinician is in the clinical floor setting (At a minimum, floors 1-3, and all of the first floor of the academic health center)
e. Surgical masks must fully cover from the bridge of the nose down under the chin.

6. Persons passing through clinics during clinics hours are required to don clinic attire and use proper PPE. This is not required when clinics do not operate and no patient treatment is rendered.
7. A translator or necessary adjunct individual, who remains in the operatory during a procedure, must don the appropriate PPE.

Identification Badges/Nametags:

1. Students, faculty, and staff are required to wear their UF picture ID's at all times.
2. Vendors, visitors and volunteer observers are required to check-in (and out) with clinic administration, where they will be provided with an identification badge to be worn at all time while present in the clinics.
3. Shands volunteers must be wearing their name badge at all times when volunteering in the dental clinics.

Compliance:

A violation of the UFCD dress code will result in one of the following sanctions pending the type and frequency of non-compliant behavior:

1. Counseling or dismissal from a lecture, seminar, or exam by the presenter
2. Counseling or dismissal from a clinic session by attending clinical faculty
3. Generation of a Professional Variance
4. Reduction in "professionalism" portion of clinical assessment
5. Dismissal from clinic by the attending faculty or department chair
6. Counseling by the Associate Dean for Clinical Affairs and Quality for repeated non-compliance.
7. Suspension from clinical activities for a period to be determined by the appropriate faculty in conjunction with the Associate Dean for Clinical Affairs and Quality.

Students should use discretion and present a professional image. If uncertainty exists, the lecturer, or attending clinical faculty should be consulted.

7.0 GUIDELINES AND POLICY REGARDING THE USE OF IONIZING RADIATION

7.1 Introduction

The following guidelines and policy regarding the use of ionizing radiation are to insure maximum radiologic yield of benefit to both the patient and diagnostician while reducing to a minimum the potential risk to the operator (faculty, students, and staff), patient and/or non-occupational personnel in adjoining areas.

7.2 General Policy Statement

This document is prepared in compliance with National Council on Radiation Protection, NCRP Report No.177 "Radiation Protection in Dentistry and Oral and Maxillofacial Imaging" (2019), and U.S. Food and Drug Administration Selection Criteria for dental radiographs, 2012, Federal Radiation Control for Health and Safety Act of 1969, and the Consumer-Patient Radiation Health and Safety Act of 1981.

The policy of the University of Florida College of Dentistry regarding the use of ionizing radiation will be that endorsed by the American Dental Association, American Dental Education Association, American Academy of Oral and Maxillofacial Radiology, American Board of Oral and Maxillofacial Radiology, the National Center for Devices and Radiological Health (NCDRH), and the State of Florida Department of Health and Rehabilitative Services, Office of Radiation Control. The College of Dentistry will therefore adopt and disseminate any policy changes these organizations may initiate in the future. The College of Dentistry adheres to the philosophy that every effort should be made to keep the dose to all individuals As Low As Reasonably Achievable (ALARA). If procedures are done that require exceeding ALARA recommendation, sufficient justification must be provided that needs to be approved prior to the procedure by the attending radiologist.

7.3 Radiation Safety Program Responsibility

The Director of the Division of Oral and Maxillofacial Radiology is responsible for UFCD policy development and oversight. This includes responsibility for the proper adherence to ADA/FDA patient selection criteria protocol, monitoring the use of ionizing radiation, equipment selection, purchase and calibration, annual inspections, and technical quality assurance. The Director serves as a consultant to all departments and communicates policy and compliance requirements to department chairs. The Director and University Radiation Control have oversight authority for radiation safety compliance in the central radiology area and in all clinical areas outside central radiology where ionizing radiation is used.

7.4 Training/Certification

Students are trained in the safe use of ionizing radiation via didactic and clinical courses, experiences and one competency conducted by the Division of Oral and Maxillofacial Radiology. (Refer to the Clinical Courses Syllabus for detailed course descriptions of DEN 7762L: Clinical Radiography - Radiographic Technique and Interpretation.)

On- the-job-trained dental assisting staff who wish to expose digital sensors are required to take a 1.5 day state mandated training course to expose films and digital sensors, which includes information on the safe use of ionizing radiation. Dental hygienists and certified dental assistants are qualified by virtue of their training. Diplomas and certificates of completion are kept on file in the Quality Assurance Office.

7.5 Physical Facilities

1. All existing radiographic facilities and equipment which are used for patients, or for any experimental or research application, must comply with all federal, state University and College regulations.
2. Radiographic facilities shall be designed or modified to provide student/operator/patient protection from unnecessary exposure to ionizing radiation.
3. No facilities or equipment used for the production of ionizing radiation shall be constructed, removed or altered without first notifying the Division of Environmental Health and Safety, Department of Radiation Control and Radiological Services (Radiation Control), and faculty in the Division of Oral and Maxillofacial Radiology (Radiology). No x-ray equipment shall be purchased, obtained, installed or used in The College without approval from Radiology and Radiation Control and the Radiation Safety Officer.
4. A complete inventory of all x-ray generators within the College of Dentistry will be kept on file in Radiation Control and in Radiology.
5. All x-ray generators will be annually registered with the State of Florida, Department of Health and Rehabilitative Services, as administered by the Department of Radiation Control and Radiological Services. All UFCD generators will be annually inspected. The State of Florida will inspect all generators every five years as per state law.

6. Digital sensors shall be monitored daily for defects, replaced if defective and cleaned once a month. Computer monitors shall be accessed for defects/functionality by Information Technology every six months. QA tests are performed using a QA phantom on all size 1 and size 2 sensors twice a year to evaluate contrast, spatial resolution, dynamic range, latitude and delamination defects.

7.6 Criteria for Radiographic Exposure

The following criteria will be required throughout the College of Dentistry:

1. All patients will be clinically examined and their medical and dental histories obtained prior to diagnostic radiation exposure. A faculty member (dentist) will prescribe the appropriate radiographs utilizing the ADA/FDA Guidelines for Patient Selection Criteria.
2. College of Dentistry patients will have appropriate x-ray examinations made based on the ADA/FDA's "The Selection of Patients for Dental Radiographic Examinations," Revision 2004, and NCRP Report No. 145, "Radiation Protection in Dentistry", 2003. New patients to the College will be encouraged to bring any recent x-rays, duplicates, or digital image CDs with them during their first visit.
3. The needs of each patient for diagnosis will determine the frequency of x-ray examinations and <u>not</u> the period of time elapsed since the last visit.
4. Digital sensors must be dispensed to students. Boxes PSP sensors or CCD/CMOS sensors will not be left out for students' unauthorized use. Sensors will not be dispensed to students unless radiographs are ordered in axiUm by attending faculty. Faculty computer entry will certify that requested images are appropriate for the diagnostic need(s) being addressed.
5. Students may re-make a radiograph once after consulting with faculty or trained staff. If additional remakes are needed, however, they must be performed under direct supervision of faculty or trained staff.

7.7 Pregnant Patients

Primarily for reduction of potential anxiety, elective radiography on pregnant patients at the College of Dentistry is recommended to be delayed until after at least the first trimester. Emergency radiographs are recommended when the dental risk to the patient outweighs the health and psychological benefit of waiting. Appropriate radiographs should be made as needed to diagnose an oral emergency problem.

As a general rule until 1987, elective exposures of pregnant women to routine x-ray examinations, particularly in the first trimester, were postponed until after delivery. In 1987, the Center for Devices and Radiological Health (FDA) concluded that arbitrarily avoiding elective dental radiography was not necessary. The concept of avoiding radiography during pregnancy generally applies to procedures in which a fetus or embryo would be in or near the primary x-ray beam (as in some medical procedures). For dental radiography, the primary beam is limited to the head and neck region.

Generally, the only radiation that a fetus or embryo could be exposed to is secondary radiation. Uterine doses for full-mouth intraoral radiography have been shown to be less than 1[μSv] (without a leaded apron). On the other hand, the uterine dose from naturally occurring background radiation during the 9 months of pregnancy can be expected to be about 75 mrem in view of average background doses on the order of 100 mrem per year. Accordingly, there appears to be no rationale to preclude a properly justified dental radiographic examination because of pregnancy. In embryo cases radiography may be arbitrarily deferred during pregnancy for purely psychological reasons (FDA Pub. No 88-8273).

Additionally, NCRP Report No. 1177, page 15, B2.2: Exposure to the Embryo and Fetus in Dental X-Ray Procedures: *"Radiation exposures in utero or to children pose a greater risk of stochastic effect than a comparable exposure in adults. However, given the extremely low in utero doses for most dental diagnostic imaging examinations (e.g., 0.009 to 6.9 µGy for a full-mouth examination) compared to ~2.25 mGy from natural background during the nine-month gestation, the risk to the developing embryo or fetus is negligible."*

7.8 Administrative Radiography

Administrative radiographs will **not** be acquired. These radiographs include those authorized or required by a third party for reasons other than diagnosis, treatment planning, or preventive services. Administrative radiographs are generally unrelated to professional problem solving, to specific oral and dental treatment needs, or to preventive needs of patients. Thus administrative radiographs often result in unnecessary exposure of patients to ionizing radiation as they do not provide a direct health care benefit to the patient.

NCRP Report No. 177, page 39, 4.44.1.3*: "Administrative use of radiation to provide information that is not necessary for the treatment or diagnosis of the patient shall not be permitted. Students or candidates for licensure shall not be compelled or permitted to perform radiographic exposures of humans solely for purposes of education, licensure, credentialing or other certification."*

In accessing the use of administrative radiographs, attention must be directed to **guard against the exclusive use of radiographs for the following purposes:**

1. Requirements of third-party carriers: To monitor or to verify reimbursement claims for treatment.
2. Requirements of Dental Specialty Boards: To provide comprehensive and complete documentation of cases treated, including periodic radiographic examination(s) obtained during the course of treatment, which exceed diagnostic/treatment needs of the patient.
3. Providing training and clinical experiences: Requirements for a specific number of radiographic examinations to ensure the competence of students regardless of the need of the individual patient for such examinations.
4. Certifying competence: Each student must be competent in the use of ionizing radiation prior to graduation as outlined in DEN 7762L.
5. Academic reasons: Repeat radiographic exposures must not be obtained for the exclusive purpose of demonstrating technical competence. Patients must not be exposed solely for the purpose of obtaining radiographs that are technically acceptable or perfect if other radiographs cover the area in question adequately and acceptably. "Routine examinations" will not be used on new patients to determine their acceptability as a patient, but will be decided on an individual basis.
6. Radiographic examinations must not be used **routinely** for the purpose of checking the adequacy of restorative, extraction, orthodontic or other procedures when clinical observations alone will suffice. Post-treatment radiographs are a necessary part of endodontic therapy, implant placement and restoration, and follow-up of treatment as dictated by need.
7. Exposure to ionizing radiation must not be used solely to develop or maintain departmental case records, to serve as a means for developing visual aids for teaching purposes or to conduct case studies. If patients are to be exposed to ionizing radiation for research purposes, or for clinical studies, the study has to be approved by the "University's Human Use of Radioisotopes and Radiation Committee."

7.9 Radiation Protection

Radiation exposure data is available in the patient's electronic health record. Calculation of effective dose is possible if required, using information contained therein that includes the clinic where exposure was made,

equipment used, exposure parameters, number of exposures, including remakes, collimation employed, sensor used and any patient related factors. Intraoral and extraoral exposures of patients do not mandate the use of a lead apron when appropriate radiation protection guidelines are followed, unless it is a pediatric patient up to 18yrs of age, or an expectant mother. Appropriate protection using lead aprons while acquiring cone beam CT studies. In addition, for cone beam CT procedures, it is imperative that lower-dose protocols programmed in the units by patient size and gender must be carefully selected to reduce the field of view, and employ exposure parameters that do not compromise image quality while lowering dose significantly.

NCRP Report No. 177, pages 43-44, 4.4.5*: "Radiation protective aprons for patients were first recommended in dentistry many years ago when dental x-ray equipment was much less sophisticated, image receptors were much slower than under current standards, and the primary risks were thought to be heritable effects. They provided protection in an era of poorly collimated and unfiltered dental x-ray beams. Gonadal (or wholebody) doses from these early full-mouth examinations, reported as high as 50 mGy (Budowsky et al., 1956), could be reduced substantially by radiation protective aprons. Gonadal doses from current panoramic or full-mouth intraoral examinations using state-of-the art technology and procedures do not exceed 5 µGy (White, 1992). A substantial portion of this gonadal dose results from internal scattered radiation arising within the patient's head and body. Technological and procedural improvements have eliminated the requirement for the radiation protective apron, provided all other recommendations of this Report are rigorously followed, unless required by state regulation. However, some patients have come to expect the apron and may request that it be used.. Thyroid shielding shall be provided for patients when it will not interfere with the examination."*

Patient protection will be used in accordance with NCRP Report No. 177 recommendations. All exposures will be performed using the posted appropriate kVp, mA, and time settings Digital images should be obtained utilizing the manufacturer's recommendations whereby the highest signal-to-noise ratio is achieved with the optimum contrast resolution. Users of x-ray generating equipment will follow good radiation hygiene practices. During exposures, users will stand in appropriate safe areas, will not hold sensors for patients, and will observe patients so that no unnecessary remakes occur as the result of tube, film, or patient movement. All radiology faculty, x-ray technicians and other departments' faculty and staff who routinely use ionizing radiation (>3 exposures per week) will wear radiation monitors that are provided by the Department of Radiation Control and Radiological Services. This department will maintain personnel records of exposure and will act accordingly if excessive exposure levels occur.

All supporting technical staff shall be certified in the State of Florida to use x-ray equipment. Radiology faculty should possess appropriate education in oral and maxillofacial radiology. Students shall be closely supervised by faculty or staff during all clinical radiographic procedures conducted on patients. Students shall not make radiographs on patients until they have shown competency in the pre-clinical course in radiology.

All College of Dentistry x-ray generators will be annually tested by the Department of Radiation Control and Radiological Services and every five years by the State of Florida Department of Health and Rehabilitative Services, Office of Radiation Control. These surveys will be kept on record in Radiology and in Radiation Control. Evaluations will include beam quality, geometry, exposure rates, and output. Each department in the College of Dentistry will receive approval from Radiology and Radiation Control and the radiation safety officer prior to the purchase or relocation of equipment.

X-ray beams for intraoral generators will be collimated to the smallest diameter (not greater than 2.75 inches in diameter) compatible with the techniques used. Long target-to- receptor distances (at least 8 inches; long "cone" technique using 12-16 inch target-to-film distances is preferable) are to be utilized when possible. Extraoral x-ray generators should be collimated so the beam size does not exceed the film by more than 2%. Minimum total filtration shall not be less than 1.5 mm aluminum equivalent for beams produced below 70 kVp, and 2.5 mm aluminum equivalent for beams above 70 kVp.

Use of rectangular collimation will be employed for intraoral radiographic procedures with the exception of occlusal radiographs using #4 size sensor.

All lead aprons and cervical shields must be visually inspected annually for cracks or defects and the results reported to Radiology. Aprons and shields will not be folded but rather hung or draped when not in use. These will be checked by the Quality Assurance Division. Departments will be notified if defective protective equipment is found that requires replacement.

Ultimately, the use of ionizing radiation should directly benefit patients. Its judicious use as a diagnostic tool is invaluable. This policy statement is designed to put the proper use of ionizing radiation into perspective. Itis the responsibility of the Division of Oral and Maxillofacial Radiology. Radiology will monitor the use of ionizing radiation, ensure equipment is properly calibrated and tested, and provide technical consultation and assistance to all departments where appropriate.

7.10 Radiology Clinic Protocol

Because of potential problems associated with the misuse of ionizing radiation in diagnostic services, the following procedures will be employed for x radiation used for dental radiographs. Universal compliance is expected.

7.11 Ordering Radiographs

1. A clinical exam of oral tissues must be performed prior to any initial baseline radiographs (new patients). A health history must be completed, reviewed and signed by faculty prior to exposing any radiographs on new predoctoral patients. An updated signed health history will be necessary for all other patients of record. A radiographic request form (RADREQ in axiUm) must be initiated in axiUm using the forms tab in the patient electronic health record.
2. Radiographs are to be ordered based solely on diagnostic need. The expected information that will be gained from ordered radiographs must be expected to affect the patient's treatment plan. **Ordering radiographs based solely on time intervals is not considered a diagnostic need.** **NCRP Report No. 177, page 38:** *"Maintenance of oral health may require radiographs in asymptomatic new patients or those returning for periodic reexamination without clear signs and symptoms of oral disease. Selection criteria that aid the dentist in selecting and prescribing radiographic examination of these patients have been published (ADA/FDA, 2004; 2012). These criteria recommend that dental radiographs be prescribed only when the patient's history and physical findings suggest a reasonable expectation that radiographic examination will produce clinically useful information."*

7.12 Operatory Preparation

1. After being dispensed sensors, the operator should identify an x-ray operatory for use. Before seating a patient, the operator should first cover (plastic bag and stick-on plastic sheets) all surfaces, knobs, and buttons as described by the Infection Control Policy. An excerpt from this document pertaining to radiology is included in this section.* Supplies are available on a cart in the hallway.
2. Collect any instruments, cotton rolls, etc., that will be necessary for the procedure. Place them on a patient napkin. Instruments should never come in direct contact with a counter surface.
3. Place a large plastic utility bag over both the headrest, chair back, and chair controls as a barrier.
4. Seat the patient and offer the patient the use of an apron. If elected, place the lead apron on the lap and chest. Utilize a thyroid collar when appropriate (18 years of age or less). This is particularly important in the Pediatric Dentistry Clinic. Lead aprons should be offered to all patients. They are recommended, not required, as stated in this document.
5. If using the XDR sensors, place the sensors in protective covers.
6. Use appropriate barrier techniques and personal protective equipment (PPE), including gloves and masks (as needed), during radiography procedures.

7. Begin the procedure. PSP sensors should be dried with a paper towel and collected in a "dirty" paper/plastic cup. The outer surface of the collection cup should not be touched by gloved contaminated hands. Sensors, exposed or unexposed, should never be placed in an operator's pocket.
8. Remove the protective covers from the sensors with gloved hands. The XDR sensors and cords need to be wiped with disinfectant.
9. After exposing sensors, return the patient to the waiting area. Before going to the darkroom or the digital scanning area with exposed sensors, the instruments and any uncovered operatory surfaces or controls should be cleaned/disinfected as outlined in the Infection Control Policy.
10. During exposures, radiology personnel will stand behind shielded walls or doors, will not hold the sensors for patients, and will observe patients through the glass shields

7.13 Processing

See the Infection Control Policy for additional guidance on film development protocol.

1. PSP Plates: Before going to the scanning area with exposed sensors, the black plastic over-wraps should be removed carefully in the darkened operatory, being careful not to contaminate the sensors with either saliva or white light. Sensors are placed in a carry box and then transported to the scanners where they are handled by bare hands for final processing, mounting, and archiving.
2. For CMOS or CCD based sensors, a sealed, disposable sleeve must be used for each patient, taking care to inspect it for tears between exposures. This will then be removed post image acquisition.

7.14 Recording of Exposures

After exposure(s), the x-ray unit operator will note any changes in the prescribed technique or number of images acquired in the electronic patient record as applicable. The operator should also indicate the date the images were exposed. Note that the radiology prescription form captures all of this information and can be closed by the operator post image acquisition, once such notes are entered and approved by the attending faculty or radiology certified staff. No images may be deleted from the patient record. With the exception of sensors exposed for endodontic therapy, the radiology procedure information will be maintained in the patient records (including Santa Fe Hygiene Program) in the manner described above. Endodontic faculty will record each exposure made during the course of endodontic therapy of a specific tooth. When therapy is completed, a total radiation exposure history for that tooth may be entered as one item in the patient's chart, especially if several remakes are made or excessive images are acquired for purposes of completing treatment, with appropriate justification. No images may be deleted.

7.15 Remakes

1. All requests for remakes of original exposures must be approved by radiology faculty or radiology staff in central radiology and/or by attending faculty in predoctoral clinics. Remakes are not to be made until the student identifies the error(s) on the original exposure and what steps will be taken to correct them. Second remakes will not be done without direct student supervision.
2. All remake images will be documented in the chart just as original exposures are recorded.

7.16 Patients with Known or Suspected Infectious Diseases

Patients with a known or suspected infectious disease will be treated the same as any other patient, using the normal and proper barrier techniques and appropriate medical consultations as detailed in this section. It is the policy of the Health Science Center and its clinics that students, faculty, and staff participate in the treatment of all patients. Refusal will result in expulsion of students (whether pre-doctoral or advanced education) from the academic program) or termination of employment.

7.17 Use of Radiography Operatories

1. Extraoral Radiographic Procedures
    a. Students, faculty and staff, hereafter referred to as operators, will employ barrier techniques at all times.
    b. When available, powder-free gloves should be used for all radiographic procedures.
    c. When applicable, operators shall cover with plastic (bags or stick-on sheets) those areas of the chin rest, head restraint apparatus, cassette holder, controls, tubehead and any other areas where contaminated gloved hands will be in contact during patient positioning and exposures.
    d. After each extraoral study with PSP or CCD/CMOS, the patient is returned to the waiting area. With gloves still on, all coverings are then removed, being careful not to touch any surfaces. Additionally, after each panoramic procedure, the operator, with gloves on, shall remove and dispose of the incisal positioning pin. Gloves are then removed.
    e. All operators should employ barrier techniques at all times. Staff will occupy shielded control room during acquisition to monitor the acquisition process, the patient, and to ensure operator protection from radiation. This will be applicable to cone beam CT and all other extraoral procedures. A member of the public will not be allowed into the acquisition area, without prior consent of the attending radiologist, and that too only if a by-stander is required for a pediatric patient. In such circumstances, the by-stander will be required to adhere to recommended safety protocols including use of appropriate lead aprons, under direct supervision of the attending or technologist.
    f. No contrast-enhanced studies are to be performed in the clinics. (What about sialography?) Do we do this procedure? If we do, please describe.
    NOTE: For direct digital systems, the patient is released before breakdown, disinfection and finalization of image(s) prior to final archiving.
2. Intraoral Radiographic Procedure
    a. Operators will employ barrier techniques at all times.
    b. When available, powder-free gloves should be used for all radiographic procedures.
    c. To minimize contamination in a radiographic operatory, the following steps shall be taken:
        i. Before seating the patient, the counter top where instruments and cotton rolls will be placed shall be covered with an opened patient napkin. Instruments should never come in contact with a bare counter.
        ii. Cover the chair headrest, chair back, and side controls with a large plastic utility bag. If large bags are not available, use an individual headrest cover and stick-on plastic sheet to cover the chair controls.
        iii. Cover the yoke and tube head with a large plastic utility bag. Use tape to keep the excess plastic from hanging down from the cone. If bags are not available then pre & post procedure wipes (utilizing an appropriately approved disinfectant) for disinfection shall be used.
        iv. Use stick-on plastic sheets to cover all controls including the exposure button, kVp knob, and timer.
        v. Once the patient is seated with lead apron in place, mask and gloves are put on. After the procedure has started, contaminated gloved hands shall only come in contact with covered surfaces. If by accident an uncovered area is contaminated, that area shall be wiped with disinfectant soaked gauze.
        vi. All exposed PSP sensors shall be dried with a paper towel and placed in a dirty" paper/plastic cup. Do not touch the outside of the cup with contaminated gloved hands.
        vii. After the completion of the procedure, have the patient remove and rehang the lead apron on the wall or leave it on the chair seat. Then dismiss the patient back to the waiting area..
        viii. With hands still gloved, all film holding devices shall be disassembled and washed with a brush, soap and water. They should be individually dried and placed in sterilization bags

that are provided in each operatory. Sealed bags containing instruments are then placed in a collection box located in the hallway.

ix. Once instruments have been cleaned and bagged, carefully remove all coverings so as not to touch any uncontaminated surfaces. Wipe any areas that are accidentally touched with disinfectant.

x. De-glove and carry the “clean” cup holding unwrapped ClinAsept films to the darkroom bare-handed. No darkroom infection control procedures will be needed.

xi. Before going to the scanner with the exposed PSP sensors, the following protocol should be followed to remove the PSP plastic outer covers:

- After sensors have been exposed, each having been dried and dropped in a cup, the "dirty" cup is placed on a patient napkin.
- The plastic covering of each sensor is opened gently, letting each uncovered "clean" sensor fall into a "clean" carry box which is next to (but not on) the patient napkin. Wrappers are collected on the "dirty" patient napkin. The napkin/"dirty cup" wrappers are then thrown into the trash case.
- The carry box of sensors are taken into the digital scanning area bare-handed and opened bare-handed. No new gloves need to be worn.

Sources:

NCRP Report No. 77, *“Radiation Protection inDentistry and Oral & Maxillofacial Imaging, 2019”*.

The Selection of Patients for Dental Radiographic Examinations, Revised 2012. American Dental Association, Council on Dental Benefits Programs, Council on Dental Practice, Council on Scientific Affairs, U.S. Department of Health and Human Services, Public Health Service, Food and Drug Administration.

An Update on Radiographic Practices: Information and Recommendations, JADA, Vol. 132, 234-238. February 2001.

8.0 COLLEGE OF DENTISTRY POLICY FOR PROFESSIONAL VARIANCES, SUSPENSION FROM CLINICAL ACTIVITIES AND CLEARANCE FOR GRADUATION

8.1 Professional Behavior

The College of Dentistry expects all dental students to behave as professionals in their dealings with patients, colleagues, faculty and staff and to exhibit caring and compassionate attitudes. These and other qualities will be evaluated during patient contacts and in other relevant settings. The behavior of a dental student reflects on a student’s qualification and potential to become a competent dentist. Attitudes and behaviors inconsistent with compassionate care, refusal by or inability of the student to participate constructively in learning or patient care, derogatory attitudes or inappropriate behavior directed at patient groups, peers, faculty or staff, or other unprofessional conduct can be grounds for dismissal.

In conferring the DMD degree, the University of Florida certifies that the student is competent to undertake a career as a dentist. It also certifies that in addition to competency in dental knowledge and skills, the graduate possesses those personal traits essential to the profession of dentistry. Professionalism encompasses altruism, accountability, compassion, duty, excellence and respect for others.

8.2 Monitoring, Reporting and Disciplining Variance in Student Professional Behavior

On occasion, a student may vary from the positive expression of the college’s core values by displaying unprofessional behavior. Their actions may be directed not only to individuals but also to property. On such occasions, these variances need to be reported, documented, feedback needs to be given to the student and action may be taken by the College.

8.3 Professional Variance Forms:
A form is available at the college website for reporting variances in student professional behavior: Link- Professional Variance Form
This form can be used to document and provide feedback for variances in professional behavior both in clinical and academic settings.

1. A faculty or staff member observing student deviating from expected behavior must complete the form.
2. Once the form is completed, the faculty/staff member must meet with the student to discuss the observed behavior and more appropriate alternative behaviors.
3. The student has the opportunity to respond as indicated on the form if s/he so desires.
4. Both the student and the faculty/staff sign the form.
5. Copies of the signed form are given to the student, faculty/staff, and Office of Academic Affairs.

Forms are maintained in the student conduct files in the Office of Academic Affairs.

All variances are cumulative over the entire course of enrollment in the DMD program.

8.4 Counseling and Disciplinary Action
First offense: The student and faculty or staff member completing the form must meet to discuss the incident and sign the form. The copy of the form distributed to the student will serve as a written warning and self-corrective action is anticipated. A copy of the first variance is placed in the student conduct file in the Office of Academic Affairs. A neutral third party, such as a department chair, Team leader, course director, clinical or education representative should also be part of this meeting.

Second offense: A counseling appointment is completed by the Assoc. Dean for Student Advocacy and Inclusion and appropriate faculty, including TEAM leader, or others as appropriate. At this meeting, the student, faculty or staff member and Assoc. Dean for Student Advocacy and Inclusion complete the form, discuss the incident and sign the form. A plan for corrective action is discussed with the student and documented. Record of second variance is placed in the student conduct file in the Office of Academic Affairs .

Third offense: A counseling appointment is completed by the Associate Dean for Education/Associate Dean for Clinical Affairs and Quality, and Assoc. Dean for Student Advocacy and Inclusion and appropriate faculty, including TEAM leader, or others as appropriate. At this meeting, the student, faculty or staff member and Associate Deans complete the form, discuss the incident and sign the form. A plan for corrective action is discussed with student and documented. Record of third variance is placed in the student conduct file in the Office of Academic Affairs . A suspension from school may be issued at the discretion of the appropriate Associate Dean (see above) or the Associate Dean may elect to issue a “U” grade in the enrolled Professionalism course. Student is referred to SPEC.

Any future variances will result in immediate referral to SPEC.

Some types of behavior may be so egregious as to justify immediate suspension or dismissal of a student. Such behavior might include criminal acts, persistent substance abuse, and blatant disregard for patient safety or flagrant academic dishonesty.

8.5 Off-Hour Use of Physical Facilities

Off-hour access to secured areas, such as clinics and classrooms, is prohibited except in dire emergencies. In those emergencies, contact security.. Security will record the caller's name, phone number, reason for access, and the room. If there is any question, security will contact the Associate Dean for Clinical Affairs and Quality for authorization. These records are maintained for future review. Access to the dental lab, D3-31 (Junior/Senior Lab), is permitted to juniors and seniors 24 hours per day, with the exceptions of special scheduled activities. After-hours access to the simulation lab is available through scheduled sessions with lab monitors providing oversight.

8.6 College of Dentistry Graduation Clearance

All UFCD students must obtain signatures from the various departments and all administrative units to be documented as cleared for graduation.

9.0 INFECTIOUS DISEASE POLICY

9.1 Introduction

The University of Florida, College of Dentistry has the right and the obligation to adopt policies which are designed to protect the health of the students, faculty, staff, and patients of the College. It has been well established that a medical history is not reliable for the detection of infectious diseases. To maintain maximum levels of protection, the following guidelines emphasize adherence to standard (universal) precautions that produce blood and saliva from dental procedures and other potentially infectious materials (OPIM) be handled in a manner consistent with state and federal guidelines. The College expects that appropriate professional judgment shall be used by the faculty in all matters related to infection control procedures in preclinical and clinical settings.

UFCD policies are in accordance with UF Health Shands Hospital Infection Control Policies and UF Environmental Health and Safety requirements. The following policy was designed based on the following references from the Centers for Disease Control and Prevention (CDC) guidelines, OSHA, and Florida State Statutes.

1. Center for Disease Control. Guidelines for Preventing the Transmission of *Mycobacterium tuberculosis* in Health-Care Settings, 2005. MMWR 2005; 54 (No. RR-17, 1-141.\
2. Center for Disease Control. Guidelines for Infection Control in Dental Health-Care Settings – 2003, MMWR 2003;52, No RR-17. 1-76.
3. Revision to OSHA's Bloodborne Pathogens Standard, April 2016
4. "Occupational Exposure to Bloodborne Pathogens Rule," Federal Register, April 8, 2001.
5. Florida Administrative Code, Department of Health.

The Bloodborne Pathogen Exposure Control Plan and Hazardous Waste Management Plan are in accordance with the University Environmental Health and Safety Policies. Copies of documents can be found on-line at http://www.ehs.ufl.edu/. Responsibility for review and update of these policies rests with the UFCD Associate Dean for Clinical Affairs and Quality , the Clinical Affairs Committee, the ad hoc Infection Control Committee and CQuIT subcommittee.

1. The College of Dentistry Occupational Health Requirements and Infectious Disease Policy is applicable to students, faculty, staff, and patients. The policy outlines the responsibilities of each group and consequences of non-compliance or inadequate performance.
2. The Infection Control Clinical Protocol is applicable to students, faculty, staff and patients. The policy outlines routine disinfection and sterilization procedures to be employed when treating all College of

Dentistry patients.

9.2 Patient Management

All patients shall be managed in a manner which preserves their dignity and provides for confidentiality.

By law and in accordance with University of Florida Health Science Center policy, patients may not be denied treatment for reasons of infectivity. It is unlawful to require any person to submit to an HIV-related test as a condition of treatment.

Patients with urgent dental care needs diagnosed with active infectious/contagious diseases, such as but not limited to chicken pox or measles, should be managed by appropriate (immune) faculty in the Oral and Maxillofacial Surgery Clinic. Non-emergency patients with transitory infection should be rescheduled subsequent to resolution of symptoms. Patients infected with HIV, or chronic carriers of Hepatitis B or Hepatitis C, may be treated in the student clinics after appropriate medical consultation. Patients with advanced HIV disease, acute hepatitis, or other medically compromised conditions requiring additional expertise may be referred to advanced education program clinics or to faculty, pending complexity of medical and dental needs. Patients with signs and/or symptoms of undiagnosed disease may be screened by dental faculty for laboratory markers of infectious disease as needed to deliver appropriate care or may be referred to the appropriate physician.

Patients with confirmed or signs and symptoms of active tuberculosis shall be managed according to the College TB Infection Control Protocol. Elective care shall be deferred pending medical evaluation and treatment. Patients requiring emergency care will be referred to UF Health Shands Emergency Department for immediate triage and treatment. On-call oral and maxillofacial surgery residents will be contacted as needed.

All dental records will be maintained in such a manner as to preserve patient confidentiality, following established HIPAA guidelines.

Patients with a known infectious disease will be accepted for treatment in the UF Dental Clinics under the same guidelines as non-infectious patients, except for any limitations which may be listed above. All patients will be seen for any emergency dental care and/or scheduled for consultation regarding routine dental care. Following the consultation appointment, every effort will be made to provide routine care. The provision of routine dental care for all patients is, however, dependent on space and faculty or student time limitations.

9.3 Hepatitis B Immunization Requirements

1. Students

The College requires all dental students (pre-doctoral and advanced education) to have the hepatitis B immunization or show proof of protection (HbsAb titer) prior to entering any clinical phase of their program. This is required of entering students. Completion of this immunization is a student responsibility

2. Clinical Faculty and Staff

   a. All clinical faculty and staff must be immunized against Hepatitis B. Within 10 working days after clinical assignment, they are required to either have the hepatitis B immunization, show proof of antibody protection (HbsAb titer) or have initiated the series.

   b. Hepatitis B vaccine and HbsAb titer tests will be provided at no charge to the employee and will be arranged through the office of the Associate Dean for Clinical Affairs and Quality. Special exemptions will require a letter from the employee's physician.

   c. The College may require employees whose contracts are renewed on an annual basis, with no expectation of continuing employment, to submit to the vaccination as a condition of their contract renewal.

9.4 Policies Regarding Infectious Disease Status

It is the policy of the University of Florida to assess the needs of students or employees with HIV infection or other communicable diseases on a case-by-case basis. If any such infection occurs in a dental student, any recommendations made or actions taken by the College of Dentistry will respect the confidentiality and welfare of the student, while also recognizing and responding to issues regarding the welfare of patients, the College of Dentistry and the hospital and outpatient clinics. Each student's situation will be evaluated by the College on a case-by-case basis. With the permission of the affected student, the Director of the Student Health Care Center (a physician) will assist in the coordination of resources and services.

Currently, the UF College of Dentistry does not require routine HIV testing of patients, students or healthcare workers. However, it is certainly prudent for individual healthcare workers, including students, to be aware of their own individual HIV status so that they can take appropriate precautions and measures. With current advances in treatment of HIV infection, early intervention can be crucial in maintaining well-being and delaying complications of the illness. If future state or federal legislation were to change guidelines or requirements for HIV testing of healthcare workers or healthcare students, the College of Dentistry will comply as required.

In the event of a potential bloodborne pathogen exposure in a student, the medical provider will recommend HIV testing as a baseline and also follow-up intervals of 6 weeks, 3 months and 6 months. When testing is medically advisable, it is subject to informed consent, and results are treated confidentially.

9.5 Procedures to Prevent Transmission of Infectious Diseases

1. Students, faculty, and staff shall routinely adhere to universal precautions including the appropriate use of hand washing, protective barriers, and care in the use and disposal of needles and other sharp instruments.

   a. Gloves, mask, and protective eyewear (goggles or protective face shields) shall be worn during all patient contacts and most preclinical procedures (at faculty discretion).

   b. Gloves shall be changed after contact with each patient or as procedures or glove defects dictate.

   c. Torn gloves shall be replaced as soon as discovered.

   d. Hand hygiene shall be performed with either a non-antimicrobial or antimicrobial soap and water when hands are visibly dirty or contaminated with blood or other potentially infectious material. If hands are not visibly soiled, an alcohol-based hand rub can be used.

   e. Masks shall be changed during patient treatment if the mask becomes wet.

2. Students, faculty, and staff shall routinely wear clean surgical scrubs or cover gowns for each patient contact that has the potential to disseminate blood and/or saliva. Protective clothing will cover personal clothing and skin (e.g., forearms) likely to be soiled with blood, saliva, or OPIM.
3. Students, faculty, and staff shall strictly adhere to the Clinical Protocol as outlined in Section 9.11 (below).
4. Students, faculty, and staff who have exudative lesions or weeping dermatitis shall refrain from all direct patient care until the condition resolves.

9.6 Non-Compliance with Infection Control Policy

1. <u>Students</u>
   a. Initial failure by a student to comply with infection control policies shall be recognized and handled immediately upon discovery by the attending faculty or staff. Faculty shall provide counseling and direct corrective action appropriate for the protocol violation. The health and safety of the faculty, staff, students, and patients must not be compromised. The Associate Dean for Clinical Affairs and Quality shall be notified of the incident.

b. Continued failure by a student to comply with infection control policies will result in generation of a Professional Variance and review by the Associate Dean for Clinical Affairs and Quality, clinical suspension, and possible referral to the Student Performance Evaluation Committee (SPEC). Non-compliance will be considered as academic incompetence.

2. Faculty and Staff
   a. Failure by the faculty or staff to comply with infection control policies will result in review by the Associate Dean for Clinical Affairs and Quality, with a report to the employee's supervisor, department chair, or College Dean as appropriate
   b. Non-compliance will be considered as inadequate job performance.
3. Patients
   a. Patient noncompliance or falsification of the historical medical record may result in dismissal from the College dental care program by the Associate Dean for Clinical Affairs and Quality .
   b. Follow-up measures will be coordinated by the Associate Dean for Clinical Affairs and Quality.

9.7 Management of Exposures

The Florida Legislature in the 1990 session addressed the concerns of injured medical personnel. "Medical personnel" shall include a licensed or certified health care professional; an employee of a health care professional, health care facility, or blood bank. In June, 2001, the CDC published "Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HBV, HCV, and HIV and Recommendations for Post-exposure Prophylaxis" MMWR (50 RR 11) p. 1-42 (Appendix A). More recently, the CDC published "Guidelines for Infection Control in Dental Health-Care Settings – 2003," Vol. 52, No. RR-17 and "U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HIV, Hepatitis B, and Hepatitis C," September 30, 2005 http://www.aidsinfo.nih.gov. These publications serve as the basis for the post-exposure management of percutaneous and mucous membrane exposures within the UFCD. Post-exposure management of percutaneous injuries and mucous membrane exposures will be handled by the University of Florida Student Health Care Center (SHCC) in accordance with the University of Florida Environmental Health and Safety Biological Safety Office "2021 Exposure Control Plan with Policies." These policies are in compliance with OSHA standard 1919.1030 and Florida Statutes. The UF College of Dentistry follows the same Occupational Exposure Protocol as UF Colleges of Medicine, Nursing and Pharmacy.

Because some treatment regimens for bloodborne pathogen exposures must be started within 1-2 hours of exposure, the following guidelines were established to ensure prompt and appropriate care for those who have sustained a potential exposure: needlestick, sharps injury, mucous membrane splash, or human bite.\

NEEDLESTICK HOTLINE NUMBER: (352) 265-2727

Call 24 Hours a Day, 7 days a week in the Gainesville area

9.8 Occupational Exposure Protocol for Needlestick

1. Stop procedure, cleanse skin with antibacterial soap, or flush eye with clean water.
2. Advise attending faculty of incident.
3. Call Needlestick Hotline **(352) 265-2727at SHCC (Student Health Care Center).** Identify yourself as a UFCD employee or student and report that you've had an exposure. Be prepared to leave a "call back" number with them so you can be reached. Keep that line open so they may immediately return the call.
4. Faculty may need to assist in bringing the procedure to safe closure.
5. Faculty will discuss the exposure event with the source patient and explain the UFCD protocol. The source patient may be asked to have their blood drawn if so directed by SHCC medical provider. This includes having their blood drawn and tested for Hepatitis B, Hepatitis C, and HIV at no expense to the source patient.
6. When SHCC calls back, give a description of the incident, including what is known about the source patient's history. If advised to proceed with protocol, follow the SHCC instructions.

7. If SHCC recommends proceeding with testing, the UFCD attending faculty will verbally confirm permission from the source patient for testing. The UFHealth exposure consent form must be signed by the source patient and attending faculty granting consent to be tested. The name of the exposed HCW should not be included in the record.
8. The exposed HCW and the source patient will be escorted by Clinic Admin representative to the UF outpatient lab on the the1st floor of UFHealth, to have blood drawn for lab tests requested by SHCC. SHCC will complete the "Exposure Ordering/Billing Form" for both the "Source Patient" and the "Health Care Worker" and provide both lab order sheets to the Clinic Admin representative.
9. The source patient may be verbally informed of their test results by the attending faculty.
10. Follow-up appointments for exposed HCP (employees and students) may be scheduled with SHCC in UFHealth satellite clinic, D2-49 (294-5700) or SHCC on main campus (392-1161, ext. 1-4212)
    NOTE: If the exposed HCP is faculty or a paid resident, they should contact Amerisys (Worker's Compensation) at (800) 455-2079 to open a claim so expenses will be covered by Worker's Compensation
11. Injured Health Care Worker (student, staff, resident, faculty) should submit Occupational Exposure IDinc event report.
12. Documentation of the incident and lab results will be maintained in a confidential file at SHCC. SHCC will provide annual reports to UFCD.
13. If an occupational exposure occurs while the student is participating in an extramural rotation, the student should follow the established protocol of the clinical organization overseeing the rotation. The student must call the needlestick hotline on the day of occurrence so that appropriate follow-up is arranged for the student by the Student Health Care Center (SHCC). Additionally, on the day of occurrence, the student will submit a report in the event reporting system (IDinc). The supervising dentist should contact the course director for external rotations on the day of the occurrence.

9.9 Patient Contact Health Requirements

1. Pre-doctoral, Advanced Education Students and employees: **For predoctoral dental program entry, immunization compliance is managed by the UF Health Compliance Office within the Student Health Care Center. https://healthcompliance.shcc.ufl.edu/**
Immunizations required for Health Professions Students:
https://healthcompliance.shcc.ufl.edu/wordpress/files/2022/02/HP-UPDATE.pdf (APPENDIX P)

a. MMR/MEASLES, MUMPS, RUBELLA VACCINE:
   Required For everyone born after December 32, 1956. Two doses are required. You must have received on or after 12 months of age AND in 1971 or later. OR provide lab evidence of immunity by doing a blood test to check for antibodies for Measles, Mumps and Rubella. If you do a blood test, you need to provide the results on the lab form that should be faxed or mailed with the completed Mandatory Immunization Health History Form (see link in above paragraph for the form).
b. HEPATITIS B VACCINE:
   Students are required to receive this vaccination. Three dose series is required. The first dose must be administered prior to start of the classes in order to lift the system hold on registration.
c. MCV4 (MENACTRA/MENVEO)/MENNINGOCOCCAL MENINGITIS VACCINE:
   The Advisory Committee on Immunization Practices (ACIP) currently recommends this vaccine for freshmen planning to live in campus dormitories/residence halls. Students are required to receive this vaccination OR read the CDC's Vaccine Information Statement and sign where indicated on the Form to decline. Read the VIS here: https://www.cdc.gov/vaccines/hcp/vis/vis-statements/mening.html. Signing the waiver indicates you understand the possible risk in not receiving this vaccine.
d. TD and/or TDAP VACCINE:

TD (Tetanus/Diphtheria) or/and Tdap (Tetanus/Diphtheria/Pertussis):Tdap = Adacel/Boostrix. Booster shot within last 10 years. May have TD but must have at least one instance of Pertussis. If TDAP or TD expire during the time the students enrolled, a booster may be required.

e. VARICELLA (CHICKENPOX):
Provide proof of two doses of Varivax OR provide results of a blood test on a lab form verifying immunity to Chickenpox/Varicella. All titers must include the lab report.

f. TUBERCULOSIS SCREENING:
REQUIRED FOR ALL STUDENTS. Refer to the grid below to determine appropriate timeframe for TB Screening and type of testing required. If either screening is returned positive, then you must get a chest x-ray and submit a copy of the report.
- Must complete TST(Mantoux) or IGRA(Interferon-based Assay, (QFT or Tspot))

2. Health Provider- Basic Life Support (BLS-CPR with AED) Certification
Each predoctoral student must complete a Health Provider-BLS (CPR /AED) certification prior to participating in the DMD Orientation. The certificate MUST reflect training between July 1 and August 31, of the year entering the program.
UFCD ***strongly*** recommends that you take the American Heart Association-Basic Life Support (BLS) for Healthcare Provider (CPR and AED) initial or renewal training. The course **MUST include hands-on demonstration of the skills** or online individual skills assessment. (American Red Cross courses **would not** be recommended as the certification expires in one year. There are other choices other than AHA that provide a **two-year certification**. Any of those would also be acceptable.)

3. Must consistently maintain medical insurance coverage:
All newly admitted or re-admitted domestic students who are enrolled at least half-time in a degree-seeking program along with all international students are required to purchase the Student Health Insurance Plan unless proof of comparable coverage is provided. Proof of comparable coverage is provided annually.
   a. UF Plan Rates and Dates: https://healthcompliance.shcc.ufl.edu/health-insurance-requirement/uf-plan-rates-dates/
   b. Proof of Comparable Coverage: https://healthcompliance.shcc.ufl.edu/health-insurance-requirement/comparable-coverage/

9.10 Guidelines to Reduce Exposure to Latex and Glove Powders

To protect the health of faculty, staff, students, and patients, the College has implemented practices to reduce (but not totally eliminate) exposure to potentially harmful allergens from latex and powdered gloves. Powder-free nitrile gloves are available in all clinical areas. These should be used exclusively for protection of patients, students, and employees.

9.11 Infection Control – Clinical Protocol

The 2003 CDC Guidelines are a comprehensive and evidence-based source for infection control practices developed for the protection of dental care workers and their patients (Centers for Disease Control and Prevention. Guidelines for Infection Control in Dental Health-Care Settings—2003. MMWR 2003; 52 (No.RR-17). The ADA Statement on Infection Control in Dental Settings released February 9, 2011 recommends all practicing dentists, dental auxiliaries and dental laboratories employ standard precautions as described in the 2003 CDC Guidelines. In 2016, the CDC produce a companion document Summary of Infection Prevention Practice in Dental Settings: Basic Expectations for Safe Care to help dental offices with practical application of the 2003 guidelines with the subsequent updates in 2008 and 2011.

Additionally, dental health care providers are expected to follow procedures as required by the Occupational Safety and Health Administration (OSHA). The OSHA Infection Control Standard OSHA Rule 29 CFR 1910.1030 website: http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=STANDARDS&p_id=10051

The UFCD Hand Hygiene Technique is provided in Appendix G.

Standard universal precautions are used for all patients. Barrier techniques and the clinical protocol outlined below will help ensure hygienic practices and infection control. Such activities shall become the routine modus operandi for all patients.

The following represents a general procedural outline for clinical infection control. Specific modifications unique to individual departments have been formulated and are published in course syllabi.

1. Surface Disinfection Surface disinfection will be accomplished with the SPRAY-WIPE-SPRAY (or Wipe-Discard-Wipe if using approved disinfectant wipes) method recommended by CDC between each patient. Surface disinfectants must be EPA registered and have the ability to kill TB organisms on room temperature surfaces in 10 minutes or less. Spray – wipe with paper towel and spray again. Let stand and remain wet for the amount of time recommended by the manufacturer. If the surface has not "air dried," a clean paper towel may be used to absorb the excess. Surface disinfectant wipes may be used for routine counter-top cleaning providing they are tuberculocidal and used according to the manufacturer's recommendations.
2. Operatory Set-Up
    a. Predoctoral student back packs, jackets, and books shall be placed in appropriate locations (student locker and/or the approved and lid secured plastic bin located in each operatory) so as not to become contaminated by aerosols or contaminate working surfaces or counter or mobile tops. (If this occurs, surfaces shall be disinfected again with an approved disinfectant.)
    b. Personal Protective Equipment (PPE) must be worn when disinfecting and preparing the dental unit (see Appendix L for PPE donning and removal guidance). A small red biomedical waste bag, found in each clinical area, must be affixed to the operatory cabinet. In addition, tape a clear trash bag next to the red bag for "non-biomedical waste". Clinical waste will be segregated as described in the chart entitled "Approved Methods for Disposal of Clinical Waste."
    c. Flush air/water syringe(s) for 20-30 seconds. Turn on the faucet and suction about a cup of water through the high volume evacuator and saliva ejector. *Once you have your start check from faculty, then you will set up your handpiece, and you will need to flush water through the handpiece for 20-30 seconds.*
    d. Disinfect the patient chair by utilizing the wipe-discard-wipe method or a spray-wipe-spray method with an approved surface disinfectant. Being certain to scrub the headrest, chair back, seat, and arms. Pay close attention to disinfect the chair controls. Wipe again with disinfectant and allow to air dry.
    e. Remove and dispose gloves. Perform hand hygiene. If foot/knee operated controls are not available, turn faucet handles on/off with paper towel or elbows when possible to avoid cross-contamination.
    f. Various items used during a procedure are not autoclavable, easily disinfected, or disposable. These are likely to include, but not be limited to, BP cuff, forms, keyboard, mouse and pens. These items should be kept in the uncontaminated area of the lidded box. To avoid cross-contamination, use over gloves or apply barriers to forms and pens.
    g. It is EXTREMELY IMPORTANT to take the time to plan the procedure and set it up properly, and utilize the provided supply container. It will save time and preserve the integrity of the operatory. Gather the instruments(s), disposable supplies, and equipment required for the procedure.
    h. Set up protective covers and supplies.

(1) Cover any tables and counter top(s) where instruments will be placed.
(2) Place chart, pencils, pens, and mask on counter top. Cover pens and pencils which you anticipate handling during the course of treatment with plastic wrap.
(3) Cover light handles and the switch with barrier.
(4) Place large plastic bags over the bracket table.
(5) Place a small plastic bag over saliva ejector and suction arm.
(6) Place headrest cover.
(7) Cover faucet handle(s) with barrier.
(8) Cover any device(s) to be used during the procedure.
(9) Place disposable barrier on air/water syringe tip, saliva ejector and high volume evacuator. Retain the barriers throughout patient's appointment.

NOTE: Do not instruct the patient during treatment to "close his mouth around the saliva ejector." Doing so may create a negative pressure and bring fluids from the hose back into the patient's mouth. Use the saliva ejector so air can circulate around it. Place UNOPENED sterile instrument tray(s) on mobile and arrange the UNOPENED bag of sterile cotton pellets, cotton rolls, gauze, floss, articulating paper, and devices on the mobile as appropriate. DO NOT place trays/instruments on the dental unit.

3. Dental Procedure

a. Prior to seating a patient, be certain an attending faculty is in the clinic.

b. Prior to treating a patient, obtain a start check from the attending faculty which will include verification of instrument sterility. (Do not open instrument trays or bags until they are checked by faculty.)

c. Request the patient to rinse with mouthwash to reduce the number of transmissible micro-organisms. Perform hand hygiene.

d. Seat the patient, adjust the chair, and place the patient napkin and patient protective eyewear (must provide top and side protection). Disinfected eyewear will be available from the central supply room in the clinic. Because normal prescription lens frames do not offer adequate protection for aerosol producing procedures, goggles, face shields, or prescription frames with solid side shields are required. Prescription lens frames with side shields are available from some optical companies. Students are responsible for purchasing their own eyewear.

e. Review medical history, take a blood pressure, and request any additional history.

f. Perform hand hygiene. Put on (don) gown, mask, eyewear, then gloves (in that order). Arrange instruments on the tray.

g. After presenting the patient's case for the day and obtaining the faculty approval at start check, unwrap instrument cover with clean gloved hands, so as to provide a clean field on the mobile table.

h. Begin the procedure. Apply topical anesthetic and administer the anesthetic injection(s) as required. All disposable needles, unless equipped with self-sheathing safety devices, will be recapped using the one-hand "scoop" method or needle-recap safety device.

i. When using an air driven highspeed handpiece, clean the fiber optic light transmitting surfaces of handpiece with a cotton swab wet with isopropyl alcohol.

j. Isolate the operative area by placing a rubber dam as appropriate. Confine instruments, devices, and supplies that come into contact with the patient to a limited area to reduce chance of cross-contamination and enhance clean up. Wipe instruments carefully during the course of treatment to minimize scrubbing. Keep instruments organized on the tray. Dispose of waste into patient cups or trash bags.

k. When the procedure is completed, remove the patient napkin and place it (plastic side up) over the

used instruments. Remove patient protective eyewear and place it on the patient napkin. Suggest that patients rinse mouth and/or wash hands at the termination of treatment as appropriate.

l. Remove gloves, eyewear, mask, and gown in that order. Perform hand hygiene. Finish required documentation in the patient record obtaining faculty approvals as required.

m. At any point during patient care, upon leaving the operatory to find faculty, de-glove and perform hand hygiene.

n. Escort the patient to the cashier.

4. Operatory Clean-Up
   a. Put on personal protective equipment (gown, mask, goggles, and gloves). Dispose of the patient napkin covering the instruments. Remove the saliva ejector and HVE and place them in the red biomedical waste bag.
   b. Flush the handpiece hose(s) and air/water syringe(s) for one minute. Turn on the faucet and suction about a cup of water through the high volume evacuator and saliva ejector hoses and handles.
   c. Do **not** immerse the handpiece in water. Shake the handpiece slightly to remove excess water. Dry the handpieces and attachments thoroughly using paper towel or air from a syringe. After removing bur, disc, brush, or prophy cup from handpiece, separate attachment(s) from motor and replace to the handpiece cassette. Replace cassette inside the carrying bin.
   d. Replace useful burs to the block(s) or holder(s). Dispose burs that are not useful in sharps container in the operatory.
   e. Return clinic equipment to the clinic's "contaminated items" cart for disinfection by clinic staff.
   f. Surplus amalgam and used amalgam capsules are considered biohazardous waste. These will be collected and placed in the large labeled plastic containers located in the center lab.
   g. Remove all coverings from chair, dental unit, and light and dispose of into clear plastic trash bag.
   h. All syringe needles, cartridges, suture needles, and scalpel blades will be discarded into a specially marked plastic "sharps" box, located in the operatory in plain view (most often on the counter) All non-glass or non-metal disposables will be placed into the appropriate trash bag.
   i. Clean and disinfect all eyewear.eplace instruments to the tray in order. Open all hinged instruments to permit a sterilizing agent contact to all surfaces. Place cassette inside the carrying case for central sterilization. Remove coverings from mobile(s) and counter top(s).
   j. Repeat disinfectant spray, paper towel wipe down, and respraying of the unit, patient, and operator chair(s), mobile(s), counter top(s), sink(s), faucet(s) and exterior of all carrying bins for central sterilization. Wipe the operating light and patient chair switches using a paper towel moistened with disinfectant. This procedure may be completed using disinfectant wipes using the wipe-discard-wipe method.
   k. Remove the clear plastic trash bag and red biomedical waste bag. Tape the clear plastic bag closed and dispose in the clear bag waste receptacles, located throughout the clinic. Close the red bag and place it in the "Biohazard Waste Only" receptacles, located in the clinic and clearly marked "Biohazard Waste Only." Remove gloves and perform hand hygiene. Place the instrument cassettes, handpieces, and bur blocks into the clear plastic bin with lid for transport to Central Sterilization.
   l. No contaminated instruments are to be left in the clinic over the noon break or after 5:00 p.m.
5. Dental Assistants Responsibility for Clean-up
   a. Daily: Disinfect equipment returned to the "contaminated items" cart, and return to the clinic storage room.
   b. Daily: Supervise the student dentists' compliance with infection control standards and OSHA regulations in the clinics. Address infection control variances with students as applies, and report the variance to the Team Leader.
   c. At least once each week, but more often if required by usage, all vacuum hoses (saliva ejector and HVE) shall be cleaned, deodorized, and sanitized by suctioning a quart of cleaner (i.e., OR-EVAC from Schein or PUREVACE from Sultan) prepared according to the manufacturer's

instructions, through each hose.

d. Each week, disposable solid traps shall be replaced and permanent solid traps, located at the bottom of units so equipped, shall be cleaned (more often if suction is weak.) Contact Dental Maintenance for assistance. Clinic staff must follow protocols to decontaminate the trap, process and label and place in the designated hazardous waste management satellite accumulation area in the clinic.
e. Schedule floor care as needed. Contact housekeeping to establish, and then maintain optimal condition of our floors on a regular basis (bi-monthly).

6. Laboratory Protocol

   The college advocates a "clean lab" policy to ensure effective dental laboratory infection control. All items entering the lab must be cleaned and disinfected before being transported to the lab. Disinfection can be achieved with an EPA registered disinfectant in accordance with manufacturer recommendations for compatibility and contact time. The brands Cavicide and Opticide3 are approved for use. Gloves are not allowed in the lab. Items that have been effectively disinfected can be handled with bare hands. Student compliance with lab protocols during patient care sessions shall be the immediate responsibility of the attending clinical faculty.

9.12 Management of Extracted Teeth (MMWR, May 28, 1993, Vol. 42, RR-8)

The CDC and Florida Statutes require that extracted teeth must be rendered non-biohazardous by disinfection so they may be returned to the patient or the patient's legal guardian. These teeth should be cleansed of adherent material by scrubbing with detergent and water or cleaned in an ultrasonic unit. Teeth should be immersed in a fresh solution of sodium hypochlorite (1:10 dilution) or any liquid chemical germicide suitable for fixation in 10 minutes.

If this method is used for teeth used in pre-clinical modules, appropriate personal protective equipment (PPE) will be worn and teeth will be treated as potentially infectious material. Alternatively, teeth used for practice in the simulation laboratory will be sterilized by steam autoclaving for 40 minutes at 121 degrees C and 15 psi to render them free of viable organisms. To avoid making the teeth brittle, the drying cycle should not be used during autoclaving or dry heat sterilization. Use universal precautions, gloves, mask, eye protection, and disinfect contaminated surfaces when handling extracted teeth.

9.13 Infection Control Variances

The UFCD clinics strive to maintain the highest level of infection control for the health and well-being of patients, students, faculty and staff. To enhance compliance with UFCD Infection Control Policies, the following protocol has been established in all pre-doctoral clinics. Attending faculty and clinical staff are to mentor students by encouraging appropriate compliance.

When an infection control variance is recognized by faculty or staff and addressed with the student the event is documented using the Professional Variance reporting mechanism. This process alerts the Office for Academic Affairs and the course director for the appropriate professionalism stream course (DEN6015, DEN7017, DEN8018). Additionally, sharps breaches that reach sterilization will be reported into the IDinc event reporting database in order to provide feedback mechanisms for training and orientation.

9.14 Other Examples of Non-Compliance

Behaviors that may result in faculty or staff initiating a variance include, but are not restricted to, the following:

1. Breach of any infection control policy
2. Failure to begin each clinical session with sterile instruments (even if the same patient is being seen morning and afternoon in the same clinic).
3. Improper management of instruments, sharps, or impressions, during a clinical procedure

4. Improper or inadequate barrier precautions
5. Cover-gown variance (these are not to be worn outside of the clinic)
6. Improper or inadequate hand washing/or gloving procedures (i.e., failure to remove gloves when leaving the operatory)
7. Lack of solid side-shields on eyewear for aerosol or splatter producing procedures
8. Lack of protective eyewear for patients
9. Personal hygiene variance (i.e., long fingernails, operator's hair touching a patient's face or shoulders, or excessively stained attire)

9.15 Administrative Procedures

If, during a start check procedure or anytime during a patient care session, faculty or staff observe non-compliance with clinic protocols, a Professional Variance (PV) may be generated (refer to Appendix H to view a copy of the Infection Control Variance form).

All Professional Variances are logged into a database maintained by the Office of Academic Affairs. Refer to Section 9.13 above for the Professional Variance Policy and subsequent administrative follow-up as appropriate.

9.16 Radiography Infection Control Procedures

Radiography Operatories

1. Extraoral Radiographic Procedures: Students, faculty and staff, hereafter referred to as operators, will employ barrier techniques at all times.
2. Appropriate PPE (gloves) will be used for all radiographic procedures. Interim CDC guidelines will be followed during a pandemic, such as universal masking in health care delivery environments, such as clinics and lobbies of clinical enterprises.
3. Extraoral images should be exposed and processed prior to any intraoral exposures, whenever possible.
4. When applicable, operators shall cover with plastic bags or stick-on sheets those areas of the chin rest, head restraint apparatus, cassette holder, controls, tubehead, and any other areas where contaminated gloved hands will be in contact during patient positioning and exposures.
5. After each extraoral study with conventional film, PSP, or CCD (direct digital), the patient is returned to the waiting area. With gloves still on, all coverings are then removed, being careful not to touch any surfaces. Additionally, after each panoramic patient, the operator, with gloves on, shall remove and dispose of the incisal positioning pin. Gloves are then removed. The cassette can then be removed and taken to the darkroom or scanning area in the case of PSP sensors. Note: For direct digital systems, the patient is released before breakdown, disinfection, and finalization of image(s) prior to final archiving.

9.17 Intraoral Radiographic Procedure

1. Operators will employ barrier techniques at all times.
2. When available, powder-free gloves should be used for all radiographic procedures.
3. To minimize contamination in a radiographic operatory, the following steps shall be taken:
    a. Before seating the patient, the counter top where instruments and cotton rolls will be placed shall be covered with an opened patient napkin. Instruments should never come in contact with a bare counter.

b. Cover the chair headrest, chair back, and side controls with a large plastic utility bag. If large bags are not available, use an individual headrest cover and stick-on plastic sheet to cover the chair controls.
c. Cover the yoke and tube head with a large plastic utility bag. Use tape to keep the excess plastic from hanging down from the cone. If bags are not available then pre & post procedure wipes (utilizing an appropriately approved disinfectant) for disinfection shall be used.
d. Use stick-on plastic sheets to cover all controls including the exposure button, kVp knob, and timer.
e. Once the patient is seated with lead apron in place, mask and gloves are put on. After the procedure has started, contaminated gloved hands shall only come in contact with covered surfaces. If by accident an uncovered area is contaminated, that area shall be wiped with disinfectant soaked gauze.
f. All exposed PSP sensors shall be dried with a paper towel and placed in a dirty" paper/plastic cup. Do not touch the outside of the cup with contaminated gloved hands.
g. After the completion of the procedure, have the patient remove and rehang the lead apron on the wall or leave it on the chair seat. Then dismiss the patient back to the waiting area..
h. With hands still gloved, all film holding devices shall be disassembled and decontaminated following the Wipe/Discard/Wipe protocol. They should be individually dried and placed in sterilization bags that are provided in each operatory. Sealed bags containing instruments are then placed in a collection box located in the hallway.
i. Once instruments have been cleaned and bagged, carefully remove all coverings so as not to touch any uncontaminated surfaces. Wipe any areas that are accidentally touched with disinfectant.
j. De-glove and carry the "clean" cup holding unwrapped ClinAsept films to the darkroom bare-handed. No darkroom infection control procedures will be needed.
k. Before going to the scanner with the exposed PSP sensors, the following protocol should be followed to remove the PSP plastic outer covers:
    - After sensors have been exposed, each having been dried and dropped in a cup, the "dirty" cup is placed on a patient napkin.
    - The plastic covering of each sensor is opened gently, letting each uncovered "clean" sensor fall into a "clean" carry box which is next to (but not on) the patient napkin. Wrappers are collected on the "dirty" patient napkin. The napkin/"dirty cup" wrappers are then thrown into the trash case.
    - The carry box of sensors are taken into the digital scanning area bare-handed and opened bare-handed. No new gloves need to be worn.

Sources:

NCRP Report No. 14577, "Radiation Protection in Dentistry," 2003." Radiation Protection in

Dentistry and Oral & Maxillofacial Imaging, 2019". National Council on Radiation Protection and Measurements.

The Selection of Patients for Dental Radiographic Examinations, Revised 20042012. American Dental Association, Council on Dental Benefits Programs, Council on Dental Practice, Council on Scientific Affairs, U.S. Department of Health and Human Services, Public Health Service, Food and Drug Administration.

An Update on Radiographic Practices: Information and Recommendations, JADA, Vol. 132, 234-238. February 2001.

9.18 Cone Beam Computed Tomography (CBCT): Radiation Safety and Operating Policy

Operation of the CBCT units is supervised by the Division of Oral and Maxillofacial Radiology. Specific written orders are required for imaging the procedures and only are conducted by central radiology faculty and technicians. The division ensures compliance with required accreditation standards as stipulated by the Intersocietal Commission on Accreditation of computed tomography. Appendix (O) includes the UFCD operating policy for CBCT units.

9.19 Staff Training

All new clinical staff employees must complete a comprehensive training program that includes the following on-line web based courses: The Bloodborne Pathogen (BBP) and Biomedical Waste (BMW) Management Trainings.

An annual update of BBP and BMW training is required by UF Environmental Health and Safety (EH&S). This is completed via the online web-based course or through direct training. Biosafety Training (course number EHS850D) either online, or in person when available. Biosafety Training includes Bloodborne Pathogen and Biomedical Waste training. The Safety Compliance Coordinator handles this program and reports compliance to UF Environmental Health and Safety and the Associate Dean for Clinical Affairs and Quality.

10.0 STERILIZATION, DISINFECTION, AND HAZARDOUS WASTES

10.1 Central Sterilization

Central sterilization has been utilized by the predoctoral program for many years. The development of the student instrument leasing program in conjunction with the central sterilization program ensures that all instruments are sterilized before patient care. The Clinical Manual describes the detailed procedures students must follow to obtain and return their instruments. Instrument processing is done by the Central Sterilization technicians.

All instruments and burs used for patient care are leased to the students. Cleaning, packaging, sterilizing, biological monitoring, inventory control and maintenance/replacement of all instruments, burs and handpieces fall under the purview of Central Sterilization in cooperation with the Operations Manager for SMILE (leasing).

Central Sterilization locations and hours are as follows:

1st floor D1-28 pick-up /7:30 AM – 4:00 PM Monday-Friday

1st floor D1-29 drop-off/ 7:30 AM -4:00PM Monday -Friday

2nd floor D2-44 pick-up /7:30 AM - 5:00 PM Monday – Friday

2nd floor D2-28 drop-off/ 7:30 AM - 5:30 PM Monday – Friday

3rd floor D3-26 pick-up/ 7:30 AM - 12:00 PM & 1:00 PM - 5:00 PM Monday – FridayMon, Tues, Thur, Fri

3rd floor Wednesday AM Closed 1:00 PM-5:00 PM

3rd floor D3-28 drop-off/ 7:30 AM – 12:00PM & 1:00 PM - 5:00 PM Mon, Tues, Thur, Fri

1. Checking out instruments: Present and swipe Gator1 card.
    a. Instruments will not be checked out without the Gator 1 card
    b. Students without Gator1 cards must see Leasing Manager immediately
    c. All items checked out by students are their responsibility
    d. All routine patient care items must be returned after each AM and PM session
    e. Students may not check out items using another student's Gator 1 card
2. Check trays and handpieces after obtaining start check from faculty.
    a. Open packaged equipment and locate the indicator strip to assure sterility was achieved.
    b. If an instrument is broken or missing from a tray, return the tray to sterilization. Notify sterilization staff of broken or missing item(s) and check out another tray. If you do not immediately return the tray, notify the staff when the tray is checked back in
    c. If a handpiece does not work, the entire cassette (all components) must be returned to sterilization before receiving another handpiece. . When returning the handpiece describe to the sterilization tech exactly what is wrong with the handpiece in detail.
    d. When checking out implant cassettes check to make sure all components are in the cassette using the cassette map provided at checkout
3. Prior to returning the equipment to central sterilization, the student dentist MUST remove disposable items and dental materials from instrument trays. Examples include but are not limited to: gauze, tofflemire matrix bands, Mylar matrix strips, used steam indicators, bend-a brush, dental floss, and paper products (i.e., cotton rolls, cotton pellets, and paper towels).
    a. All disposable blades and sharps must be removed from the cassette tray and properly disposed of in the sharps container located in the operatory, prior to returning any tray to sterilization. Failure to do so will result in a Professional Variance
    b. Burs must be removed from handpieces before being returned to sterilization. Failure to do so will result in a Professional Variance.
    c. Assure all instruments are securely locked in place so they will not poke out the sides and confirm that trays are closed on ALL sides
    d. Scissors and hemostats that are kept in trays should be open and placed in the clips
    e. The individual who checked out the equipment from central sterilization is fully responsible for the condition of the returned equipment; therefore, we strongly advise each student personally return equipment they have checked out.
    f. All components must be in handpiece cassette prior to returning the items to sterilization
    g. Be sure all other reusable equipment and instruments are returned to the appropriate trays
    h. Ensure that all cassettes and equipment are placed in the instrument carrying bin
    i. Instrument carrying bin must be disinfected for transport- gloves are not to be worn during transport from operatory to sterilization
    j. Do not leave either clean or contaminated instruments in the clinic for any reason
    k. If a patient does not show for an appointment, please return all items to sterilization on the decontamination side of sterilization immediately. Do not keep instruments for a different patient that may be treated later in the day.
    l. NOTE: Failure to return instruments in a timely manner will result in a Professional Variance

m. Clinical personal protective equipment (PPE) such as cover gowns, or gloves must not be worn out of the clinics. If this is worn when retrieving instruments from central sterilization, the clinician will be instructed to remove PPE and perform hand hygiene before being served.

10.2 Disinfectants

The following guidelines should be considered in selecting a disinfectant:

1. The disinfectant should be capable of rapidly killing pathogenic organisms, including tubercle bacillus, and be ADA and EPA or FDA approved as appropriate.
2. The disinfectant should not be toxic to human tissues.
3. The disinfectant should not be destructive to items to be disinfected.
4. The disinfectant should be simple and uncomplicated to use effectively.
5. The disinfectant should be appropriate for the intended purpose.
6. The disinfectant should be reasonably priced.

Chemical	Dilution	Contact Time	Activity Level	Shelf Life
Cavicide	none	5 minutes	intermediate	1 year
Opti-cide 3	none	3 minutes	intermediate	1 year

10.3 Hazardous Waste Storage and Removal

1. Amalgam
   Amalgam capsules and scrap amalgam shall be stored in empty and clean alginate containers (with original label removed) labeled "Scrap Amalgam and Amalgam Capsules Only." A yellow Hazardous Waste sticker must also be affixed to the container. Extracted teeth containing amalgam must be placed into a Ziploc bag and disinfected using an EPA- registered disinfectant (such as Opticide) then placed into the white amalgam bucket. The buckets and hazardous waste stickers are available free-of-charge from UF Environmental Health and Safety: 392-8400. They are checked by the Infection Control and Hazardous Waste Compliance Officer monthly. When full, pick-up and subsequent disposal is arranged through UF Environmental Health and Safety Hazardous Material Handling. On-line pick up requests are available at Online Chemical Waste Pick-up Request
2. Hazardous Waste (expired and /or unused supplies and medications)
   Examples: nitroglycerin tablets, epinephrine, isopropyl alcohol, acid etchant
   These products cannot be simply thrown away. They must be stored in a storage container labeled with a yellow Hazardous Waste sticker in a location that patients cannot easily access. Contact Clinic Administration at (352) 273-6820 when chemical products need to be picked up for disposal. Pick-up and subsequent disposal is arranged through UF Environmental Health and Safety Hazardous Materials Handling. Online pick-up requests are available at Online Chemical Waste Pick-up Request

10.4 Dental Mercury Protocol: The primary means by which mercury is absorbed by dental personnel is via inhalation of the vapor from ambient room air. Amalgam scrap and accidental mercury spills in the dental treatment room are sources of potential vapor releases. Other sources in the dental environment include:

1. Removing/polishing amalgam restoration
2. Leaking amalgam capsule

3. Faulty amalgamators
4. Capsules with residual mercury and amalgam
5. Improperly stored mercury and/or amalgam scrap
6. Exposure of mercury or amalgam to heat sources (sterilizers) or warm air

To reduce mercury vapor to the lowest possible levels, the following procedures shall be used:

1. Use high volume evacuation and water spray when cutting amalgam, removing old amalgam, or adjusting restorations. The rubber dam is to be placed whenever possible.
2. The amalgamator shall have an enclosure for the capsule and be periodically disassembled to look for and remove accumulated mercury. This will be done by dental assistants and dental maintenance personnel approximately every six months.
3. After dispensing the amalgam, the pestle and empty mercury "pillow" shall be replaced in the capsule and the capsule halves rejoined (closed). The closed capsule shall then be placed in a scrap amalgam container which consists of a white plastic container labeled "Scrap Amalgam and Amalgam Capsules Only".
4. All instrument trays shall be thoroughly cleaned and checked for amalgam scrap before sterilization.
5. Accidental spills shall be immediately reported to Dental Maintenance (273-8001). A commercially available spill kit is to be used, or a bottle of sulfur or zinc powder is to be spread immediately over any spilled mercury. The residue should be placed in the scrap amalgam container.
6. Always wear gloves, face mask, disposable cover gown, and proper eye protection when working with amalgam.
7. Amalgam carving scrap shall be collected and placed in the scrap amalgam container.
8. Suction traps are to be replaced weekly by dental assistants in each clinic. The used suction traps are to be placed into a Ziploc bag and disinfected with an EPA-registered disinfectant (such as Opticide) then sealed and placed into the amalgam bucket.
9. Containers shall be stored in each clinic.
10. Amalgam separators have been used to ensure environmental safety and are compliant with effluent limitations guidelines and standards.Are inspected weekly by the dental maintenance team who follow the manufacturers maintenance and replacement schedule.

Please review Appendix C.: Dental Mercury Hygiene Recommendations, ADA Council on Scientific Affairs (JADA, Vol. 134, November 2003) for additional guidance on the safe handling of mercury and dental amalgam, office engineering considerations for preparation and placement of dental amalgam, for mercury spill management, and for best practices to reduce mercury release into the dental environment.

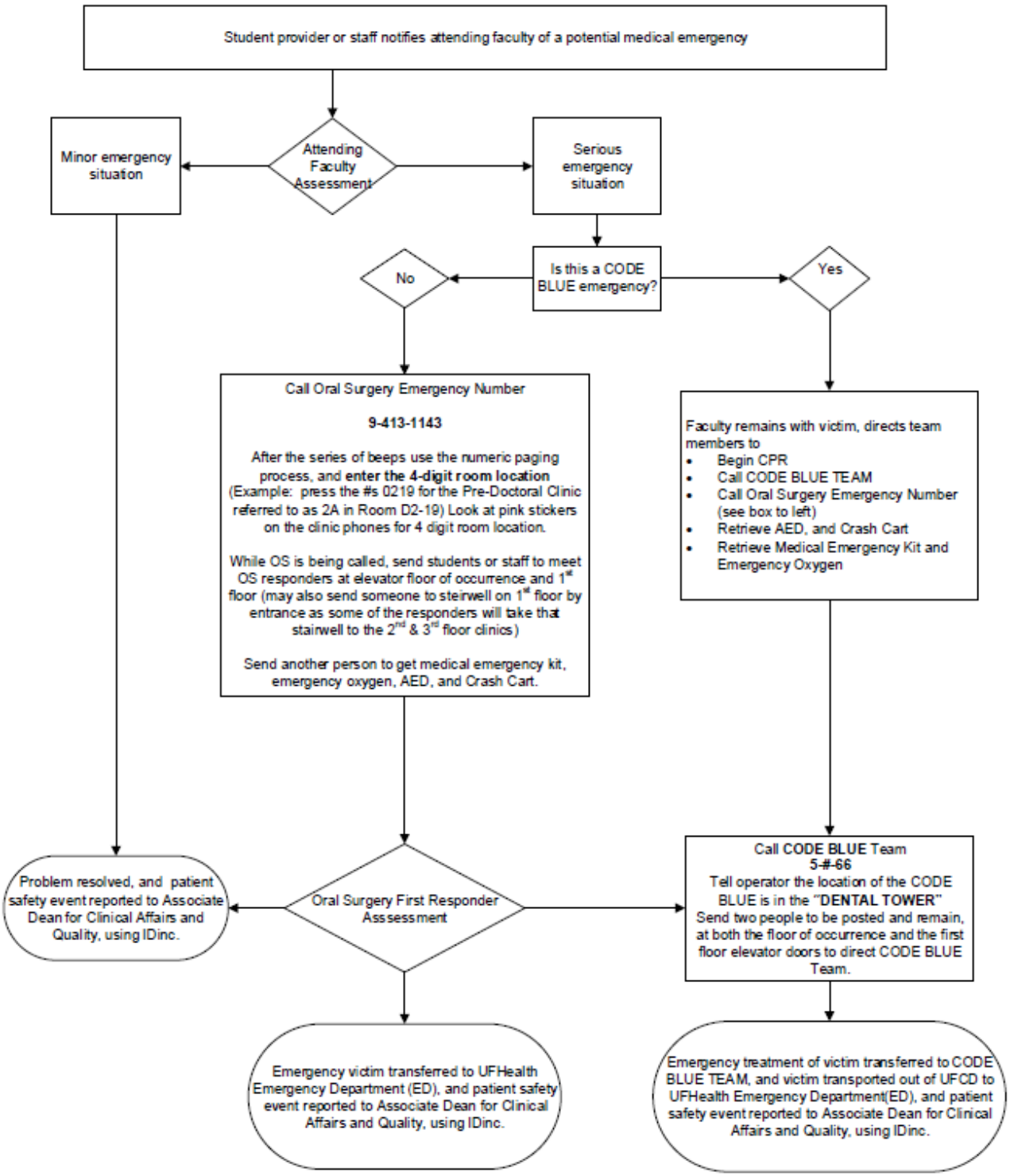
Appendix A: UFCD Standards of Care

STANDARDS OF CARE MATRIX FOR PREDOCTORAL PROGRAM	**Assessment Instrument**	**Threshold**
A. GENERAL STANDARDS: ACCESS TO TREATMENT		
1. Patients shall be notified of applicable school policies and procedures, Patient Rights and Responsibilities, and HIPAA, and sign the combined consent form prior to the initiation of treatment.	axiUm® Missing Consents report	100%
2. Patient assignment after initial screening should average no more than 45 days	axiUm® Patient Progression Audit	Average < 45 days
B. PATIENT CARE		
1. Comprehensive care patients will receive a complete medical history	axiUm® Patient Progression Audit	100% DMDHX
2. Comprehensive care patients will receive a complete head and neck exam (which includes an oral cancer examination).	axiUm® Patient Progression Audit	> 95% PHYMX
3. Patients accepted for comprehensive care patients will complete a customized, sequenced treatment planning process.	axiUm® Patient Progression Audit (D0150)	> 80%
4. The patient shall have treatment delivered in a timely fashion and in an appropriate sequence. Progression will be monitored.	axiUm® Patient Progression Audit	
• Days from assignment to completion of comprehensive oral examination (COE) and treatment plan	axiUm® Patient Progression Audit	Average < 60 days
• Days from completion of comprehensive oral exam (COE) to completion of Stabilization/Disease Control (DC) or Phase 1 care	axiUm® Patient Progression Audit	Average < 120 days
• Days from Stabilization / Disease Control completion to Rehabilitation/Case Completion (CC) or Phase II care.	axiUm® Patient Progression Audit	Average < 150 days
5. Confidentiality of the patient record and PHI shall be maintained.	Compliance with HIPAA and Confidentiality Agreement HIPPA or Privacy Breaches	< 1% /class Unintentional events per year 0 Intentional events per year

STANDARDS OF CARE MATRIX FOR PREDOCTORAL PROGRAM	Assessment Instrument	Threshold
6. Patients of record will have access to a 24-hour emergency service	UF Health & UFCD on-call	100%
C. PREVENTION & ORAL HEALTH MAINTENANCE		
1. Patients will be provided appropriate periodontal treatment during active care.	axiUm® Recall Compliance Report	> 85%
2. Patients will be offered ongoing maintenance/recall care in the (TEAMS or RDH) upon completion of active care.	axiUm® Patient Progression Audit	> 95%
3. Patients selected for ongoing maintenance/recall care will continue with care at UFCD.	axiUm® Patient Progression Audit	>20%
4. Patients dismissed will receive a letter and have access to emergency care for 30 days.	Discharge Letter is auto-generated by axiUm®	< 5.0% discharged
D. QUALITY CARE ASSESSMENTS		
1. Upon completion of phases of planned treatment in the comprehensive care program, each patient shall have a post-treatment assessment examination.		
• Post-Treatment Assessment – Disease Control (PTA-DC form) following comprehensive oral exam	axiUm® Patient Progression Audit	PTA-DC form >30%
• Post-Treatment Assessment – Case Completion (PTA-CC form) following disease control completion	axiUm® Patient Progression Audit	PTA-CC form >30%
2. Quality laboratory-fabricated fixed prostheses will be monitored	IDinc Pros Lab	< 8% remakes
3. Quality of laboratory-fabricated removable prostheses will be monitored	IDinc Pros Lab	< 8% remakes
4. Patients will be satisfied with the care provided.	Patient Satisfaction Survey	> 90% patients Rated Care as "Excellent" or "Very Good"
E. INFECTION PREVENTION & CONTROL		
1. Dental unit waterline quality shall be monitored.	Sample monitoring report	100%
2. Biological monitoring of sterilization cycles shall be conducted weekly.	3M Millipore	100%
3. All biomedical waste shall be segregated and disposed of as outlined in the UFCD Clinical Procedure Manual.	Environmental Health and Safety (EH&S)	100%

STANDARDS OF CARE MATRIX FOR PREDOCTORAL PROGRAM	Assessment Instrument	Threshold
F. MEDICAL EMERGENCY PREP		
1. All "able" clinical faculty, students, residents, and staff shall be certified biennially in CPR/BCLS.	axiUm® Tracking Database	100%
2. Medical Emergency (Code Blue) drills are performed in a manner to avoid disruption of clinical care.	Attendance Report	100%
3. Evaluation of patient risk factors for a medical emergency will result in minimal medical emergency events in the predoctoral clinic	IDinc Event Reports	<1% of patient visits
G. RADIATION SAFETY		
1. All dental radiographic equipment within the College shall be tested annually for radiation output, half-layer value, kVp, mA, timer accuracy, focal spot, and beam diameter by personnel registered with the Florida Department of Health.	Logs and Posted Certificate	100%
2. Appropriate shielding shall be available for all patients receiving radiographs.	Clinic Survey	100%
3. All operators of x-ray units shall be thoroughly familiar and trained with radiation safety standards and practices including federal, state, and local regulations.	UFCD Human Resources Database for certification	100%
H. ENVIRONMENT		
1. All nitrous oxide/oxygen delivery equipment shall be inspected daily for tank pressure.	Dental Maintenance Logs	100%
2. Air quality monitoring for the presence of formaldehyde and nitrous oxide shall be performed biennially by UF Environmental Health and Safety (EH&S).	EH&S Reports	100%
3. Amalgam scrap and capsules shall be disposed of in accordance with UF Environmental Health and Safety guidelines.	Clinic Survey	100%
4. Eyewash stations shall be accessible in clinical and laboratory areas where hazardous materials are or may be used. Eyewash will be monitored for proper function and flushed for five minutes every month.	Clinic Survey; Logs	100%
5. All medications and hazardous chemicals shall be appropriately labeled, stored, and dispensed in accordance with OSHA and EPA standards as outlined in the UFCD CM. They shall be disposed of in accordance with UF Environmental Health and Safety guidelines as outlined in the UFCD CM.	Clinic Survey; Logs	100%
6. Smoke and fire alarm systems shall be operational in all areas of the College.	Clinic Survey; EH&S Survey	100%
7. Fire extinguishers, periodically inspected for operability, shall be conspicuously located and accessible throughout the school.	EH&S Survey	100%

Appendix B: Emergency Response Flow Diagram



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Appendix C: Dental Mercury Hygiene Recommendations

Dental mercury hygiene recommendations

ADA COUNCIL ON SCIENTIFIC AFFAIRS

ABSTRACT

Background. The ADA has long recognized the importance of observing proper mercury hygiene practices for the safety of dental professionals. In 1999, the ADA Council on Scientific Affairs adopted mercury hygiene recommendations to provide guidance to dentists and their staff members for safe handling of mercury and dental amalgam. These mercury hygiene recommendations have been developed to update those previously adopted by the Council.

Overview. In addition to discussing sources of mercury in the dental office, this Council report describes office engineering considerations and hygiene recommendations to be used during preparation and placement of dental amalgam restorations. New information included in this report covers the management of mercury spills.

Practice Implications. These recommendations are intended to provide guidance to the dental practitioner in ensuring the safety of personnel who handle dental amalgam and in minimizing the release of mercury into the dental office environment.

The American Dental Association has long recognized the importance of observing proper mercury hygiene practices for the safety of dental health care workers. The following recommendations were developed as an update of the ADA Council on Scientific Affairs' 1999 recommendations[1] to provide guidance to dentists in adopting an appropriate mercury hygiene program, ensuring the safety of all dental personnel involved in the handling of mercury or dental amalgam and minimizing the release of mercury into the environment. They are not intended to establish a standard of care or to set requirements that must be followed in all cases.

The current update

- uses a new format to make the information more accessible;
- recommends against the use of carpeting in dental operatories, where a mercury spill might occur;
- provides more information on the management of mercury spills.

In February 2003, the ADA published Best Management Practices for Amalgam Waste.[2] Dentists are strongly urged to follow the ADA Best Management Practices, or BMPs, and any that may have been adopted by their state or local dental associations. The ADA BMPs are available online in the members-only portion of the ADA Web site ("www.ada.org"); interested readers also can obtain a copy of the ADA BMPs by sending an e-mail to "science@ada.org" or calling the ADA toll-free number, Ext. 2878, or 1-312-440-2878. Dentists are urged to include the ADA BMPs in their mercury hygiene training programs.

SOURCES OF MERCURY IN THE DENTAL OFFICE

Dental personnel potentially can be exposed to mercury through direct skin contact with mercury (or freshly mixed dental amalgam) or through exposure to the following potential sources of mercury vapors: accidental mercury spills; malfunctioning amalgamators, leaky amalgam capsules or malfunctioning bulk mercury dispensers (although the ADA recommends against the use of bulk elemental mercury); trituration, placement and condensation of amalgam; polishing or removal of amalgam; vaporization of mercury from contaminated instruments; and open storage of amalgam scrap or used capsules.

GENERAL MERCURY HYGIENE RECOMMENDATIONS

- Train all personnel involved in the handling of mercury and dental amalgam regarding the potential hazards of mercury vapor and the necessity of observing good mercury hygiene practices.
- Remove professional clothing before leaving the workplace.

OFFICE ENGINEERING

- Work in well-ventilated work areas, with fresh air exchanges and outside exhaust. If the work areas are air-conditioned, the air-conditioning filters should be replaced periodically.

- Use proper work area design to facilitate spill containment and cleanup. Floor coverings should be nonabsorbent, seamless and easy to clean. The Council does not recommend the use of carpeting in operatories, where an accidental mercury spill might occur. Chemical decontamination of carpeting may not be effective, as mercury droplets can seep through the carpet and remain inaccessible to the decontaminant. Removal of the contaminated carpet may be the only way to ensure decontamination.
- Periodically check the dental operatory atmosphere for mercury vapor. This may be done using dosimeter badges or through the use of mercury vapor analyzers for rapid assessment after any mercury spill or cleanup procedure. The current Occupational Safety and Health Administration, or OSHA, standard for mercury is 0.1 milligram per cubic meter of air averaged over an eight-hour work shift.[3] The National Institute for Occupational Safety and Health has recommended the permissible exposure limit to be changed to 0.05 mg/m^3 averaged over an eight-hour work shift over a 40-hour workweek,[4] but OSHA has not yet adopted this recommendation.

HYGIENE RECOMMENDATIONS DURING PREPARATION AND PLACEMENT OF AMALGAM

- Use only precapsulated amalgam alloys. The ADA recommends against the use of bulk alloy and bulk elemental mercury, also referred to as liquid or raw mercury, in the dental office. If you still have bulk elemental mercury in the office, it should be recycled (refer to the ADA BMPs[2]).
- Use an amalgamator with a completely enclosed arm.
- If possible, recap single-use capsules after use, store them in a closed container and recycle them.
- Use care when handling amalgam. Avoid skin contact with mercury or freshly mixed amalgam.
- Use high-volume evacuation systems (fitted with traps or filters) when finishing or removing amalgam.

MANAGEMENT OF MERCURY SPILLS

In case of an accidental mercury spill (regardless of size), the Council endorses the following recommendations[5]:

- Never use a vacuum cleaner of any type to clean up the mercury.
- Never use household cleaning products to clean up the spill, particularly those containing ammonia or chlorine.
- Never pour mercury, or allow it to go, down the drain.
- Never use a broom or a paintbrush to clean up the mercury.
- Never allow people whose shoes may be contaminated with mercury to walk around or leave the spill area until the mercury-contaminated items have been removed.

MANAGEMENT OF SMALL MERCURY SPILLS

A spill is considered small if there are less than 10 grams of mercury present (a pool no larger than the size of a quarter).[6,7] Small spills can be cleaned safely using commercially available mercury cleanup kits and by observing the steps listed in the Michigan Department of Environmental Quality's table entitled "Management of Mercury Spills."[8]

MANAGEMENT OF LARGE MERCURY SPILLS

A mercury spill is considered large if there are more than 10 g of mercury present (a pool larger than the size of a quarter).[6,7] Cleanup of large mercury spills requires the use of an experienced environmental contractor who specializes in toxic spill cleanup. Contact your state or local Environmental Protection Agency office for a list of contractors who clean up toxic spills. ■

This report was prepared on behalf of the ADA Council on Scientific Affairs by Division of Science staff members Dr. Yasser Elseweifi; P.L. Fan, Ph.D.; Kathleen Todd; and Roger Connolly.

Address reprint requests to American Dental Association, Council on Scientific Affairs, 211 E. Chicago Ave., Chicago, Ill. 60611.

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2. American Dental Association. Best management practices for amalgam waste. Chicago: American Dental Association; 2003.
3. Occupational Safety and Health Administration. Standard interpretations. (1996) PEL for inorganic mercury is a time weighted average, not a ceiling. Available at: "www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=INTERPRETATIONS&p_id=23866&p_text_version=FALSE". Accessed April 17, 2003.
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7. Prince Edward Island [Canada] Department of Fisheries, Aquaculture, and Environment. Guidelines for the safe clean-up of household mercury spills. Available at: "www.gov.pe.ca/photos/original/fae_mercury.pdf". Accessed April 8, 2003.
8. Michigan Department of Environmental Quality. (2003). Cleaning up small mercury spills. Available at: "www.michigan.gov/deq/1,1607,7-135-3585_4127_4175-11751--,00.html". Accessed March 24, 2003.

APPENDIX D: Bloodborne Pathogens Exposure Control Plan Addendum

PURPOSE: To provide for a safe environment and minimize or eliminate employee exposures to bloodborne pathogens, the University of Florida College of Dentistry (UFCD) has established the following exposure control plan based on scientific knowledge, recommendations from the Centers for Disease Control, and OSHA standards, including 29CFR 1910.1030.

The Exposure Control Plan shall be reviewed and updated annually and whenever necessary to reflect new standards to protect the health care worker. The review and update of the plan shall reflect changes in technology that eliminate or reduce exposure to bloodborne pathogens, and document consideration and implementation of appropriate commercially available and effective safer medical devices designed to eliminate or minimize occupational exposure.

UFCD is required to establish an Exposure Control Plan and to solicit input from non-managerial employees responsible for direct patient care who are potentially exposed to injuries from contaminated sharps in the identification, evaluation, and selection of effective engineering and work practice controls and shall document the solicitation in the Exposure Control Plan.

1. Definitions

    a. Engineering and Work Practice Controls: Controls such as sharps containers, safer medical devices such as sharps with engineered sharps injury protections and needleless systems, or practices, such as needleless system and safety syringes that isolate, reduce, or remove the risk of exposure to bloodborne pathogens in the work place.

    b. Sharps with Engineered Sharps Injury Protections: A non-needle sharp or needle device used for withdrawing body fluids, accessing a vein or artery, or administering medications or other fluids, with a built-in safety feature or mechanism that effectively reduces the risk of an exposure/incident.

    c. Needleless Systems: A device that does not use needles for the collection of bodily fluids or withdrawal of body fluids after initial venous or arterial access is established

        i. The administration of medications or fluids
        ii. Any other procedure involving the potential for occupational exposure to bloodborne pathogens due to percutaneous injuries from contaminated sharps.
        iii. Exposure management

2. Record Keeping

    a. Employee medical records shall be maintained by the UFCD Human Resources for the duration of employment, plus 30 years.

    b. The UFCD Clinical Quality Improvement Team shall establish and maintain an occupational exposure injury log. The information in the sharps injury log shall be recorded and maintained in such manner as to protect the confidentiality of the injured employee. The sharps injury log shall contain the device or vehicle producing the injury and a brief explanation of the incident.

References:

Enforcement Procedures for the Occupational Exposure to Bloodborne Pathogens.

Occupational Safety & Health Administration US Department of Labor; CPL 202.44D, November 5, 1999.

Needlestick Safety and Prevention Act and the Revised Bloodborne Pathogen Standard 29

CFR 1910.1030. September 19, 2000

APPENDIX E: Response to Suspected Bioterrorist Acts

The health and safety of our faculty, staff and students is a primary concern for the College of Dentistry. Please be assured that the Health Science Center has a program in place for responding to potential bioterrorist activities.

If you observe or suspect an act of bioterrorism within the Health Science Center, please do the following:

1. Call the University Police Department (392-1111) and ask them to come immediately to assess the situation.
2. Call the Dean's office (273-5800) and report the incident.

University Police should arrive quickly. The officers will assess the situation and make the determination regarding further measures. They may contact UF Environmental Health and Safety, the Hazardous Materials Departments, and the Fire Department pending the nature of the situation. UF Physical Plant will be contacted if the air conditioning system is to be shut down to minimize potential aerosolization of organisms.

If the University Police Department instructs that the area be vacated, do so immediately and in an orderly fashion. Do not disturb any objects or materials.

APPENDIX F: Dental Abbreviations, Symbols and Acronyms

ABBREV-IATION	WORD OR TERM
A	
a	before
A(LFH)	(Anterior) Lower Facial Height [anterior nasal spine-menton]
A(TFH)	(Anterior) Total Face Height [nasion-menton]
AAA	Abdominal Aortic Aneurysm
ab	abutment
abc	abscess
ABCD	Asymmetry, Borders, Color, Diameter
abf	abfraction
abn	abnormal
abr	abrasion
abs	abscess
abut	abutment
Ac	acute
ac	before meals
acc	accessory
ACM	Acetaminophen
acr	acrylic
acry	acrylic
AD	Alzheimer's Disease
ADD	Attention Deficit Disorder
ADHD	Attention Deficit Hyperactivity Disorder
adj	adjust(ed) (ment)
adv	advanced
AED	Automatic External Defibrillator
AG	attached gingival
Ag	silver
Ag pt	silver point
AIDS	Acquired Immune Deficiency Syndrome
air abr	air abrasion
AL	attachment loss
alg	alginate
algin	alginate
ALL	Acute Lymphocytic Leukemia
alv	alveol(us) (ar)
alvect	alveolectomy
alvy	alveolectomy
AM	before noon
am	amalgam
AM BU	amalgam buildup
Amal	amalgam
AMO	Anterior Maxillary Osteotomy
amp	amputation
An	Angle
ANB	A point Nasion B point
anes	anesthesia; anesthetic
ant	anterior
ante	before
ANUG	Acute Necrotizing Ulcerative Gingivitis
aob	alcohol on breath
AP	adult prophylaxis
AP	anterior-posterior
AP	Adult Periodontitis
AP	addicted patient
ap	apex
APAP	acetaminophen, paracetamol; N-acetyl-para-aminophenol
apeo	Apicoectomy
APF	acidulated phosphate fluoride
apico	apicoectomy; apical root canal surgery
appl	appliance
appl	application
appt	appointment
APT	Active Periodontal Treatment
aq	water
AR	amalgam restoration
ARC	AIDS Related Complex
as lib	freely; as needed
ASA	aspirin; acetylsalicylic acid

asap	as soon as possible
asst	assistant; dental assistant
asst	assorted
atr	atrophy
att	attachment
attr	attrition
atyp	atypical
Au	gold
ausc	auscultation
aux	auxilliary
av	avulsion
AVC	Active Vertical Corrector treatment
ave	average
aver	average
avg	average
aw	arch wire
aw adj	archwire adjustment
AZT	Azidothymidine
B	
B	buccal
b/u	build up
BA	broken appointment
bb	bad breath
BBTD	Baby Bottle Tooth Decay
bbti	bisque bake try in
BC	bone crest
BD	bony defect
BD	base of defect
BD	buccal distal
BDF - H	bony defect fill – horizontal
BDF - V	bony defect fill – vertical
bf	bone fragment
bg	bone graft
BGW	bigonial width
bi	bicuspid
BI	biologic indicators
bid	twice a day

BII	bridge supported by two implants
bil	bilateral
bis-gma	bisphenol-a-glycidyl methacrylate
bkt	bracket
BL	bone loss
bldup	build up
BMS	Burning Mouth Syndrome
bn	bon(e) (y)
BOP	bleeding on probing
bp	blood pressure
BR	by report
br	bridge
br	fixed partial denture
br bx	brush biopsy
brdg	bridge
brdg	fixed partial denture
brk	bracket
BRM	Biological Response Modifier
brux	brux(er) (ism)
BSSO	Bilateral Sagittal Split Osteotomy
BTI	bleeding time index
bu	build up
buc	buccal
BUN	Blood Urea Nitrogen level
bw	bitewing x-ray
bwx	bite wing x-ray
bwxr	bite wing x-ray
bx	biopsy
C	
c̄	with
C	coarse
C & B	crown and bridge
C & S	culture and sensitivity
C/	complete upper denture
/C	complete lower denture
c/o	complaining of
ca	approximately
ca	circa

CA	cancer
CAB	Coronary Artery Bypass
CAD	Coronary Artery Disease
CAD/ CAM	computer-aided design/ computer-aided manufacture
CAL	clinical attachment level
calc	calculus
canc	cancel(lation)
CaOH	Calcium Hydroxide
caps	capsules
car	caries
Car Prev Tx	Caries Prevention Treatment
carp	carpule
CAT	computerized axial tomography
cav	cavity
CBC	complete blood count
cc	caries control
cc	chief complaint
cc	cubic centimeter
CD	chemical dependency
CE	cervical erosion
CEJ	cementoenamel junction
cem	cement(ation)
ceph	cephalometric image
ceram	ceramic
CFA	craniofacial analysis
CHF	Congestive Heart Failure
chk	check
chk	observe
chr	chronic
cit acid	citric acid
CL	cleft lip
CL	crown lengthening
cl & sh	cleansing and shaping
cl I	classification of jaw relation; Angle Class I
cl II	classification of jaw relation; Angle Class II
cl III	classification of jaw relation; Angle Class III
CL/CP	cleft lip, cleft palate

CLD	complete lower denture
cldy	cloudy
CLP	cleft lip and palate
clr	clear
cm	centimeter
CMB	Chronic Mouth Breathing
cmpd	compound
CMV	cytomegalovirus
CO	centric occlusion
COC	Calcifying Odontogenic Cyst (Gorlin Cyst)
COD	condition on discharge
comp	complete
comp	composite
Comp BU	composite buildup
con bar	connector bar
conc	concentrat(e) (ion)
cond	condition
cong	congenital
cons	consultation
cons sed	conscious sedation
COPD	Chronic Obstructive Pulmonary Disease
COS	curve of Spee
COW	curve of Wilson
CP	centric position
CP	child prophylaxis
CPAP	Continuous Positive Airway Pressure
cpd	compound
CPEC	comprehensive periodontal examination and charting
CPF	coronally positioned flap
CPR	cardiopulmonary resuscitation
CPT	Caries Prevention Treatment
CR	centric relation
cr	crown
crl	cervical root lesion
crn	crown
crn lngth	crown lengthening
CRO	centric relation occlusion

CRP	C-reactive protein
crs	coarse
CS	coronal scaling
CS	conscious sedation
CT	computerized tomography
CTS	Cracked Tooth Syndrome
cu	cause unknown
CUD	complete upper denture
cur	curettage
CV	Curriculum Vitae
CVA	Cerebral Vascular Accident
Cx	control tooth
D	
d	day
d	depth
D	distal
d/c	discontinue
d/c	discharged
d/e	double ended instrument
d/w	discussed with
D/W	dextrose/water
da	dental assistant
daw	dispense as written
DB	distal buccal
DBA	dentin bonding agents
dbl	double
DC	dentigerous cyst
DD	differential diagnosis
DDR	direct digital radiography
debrd	debridement
dec	decrease
dec	deciduous
decid	deciduous
decid	primary
def	defective
del	deliver(ed)
demo	demonstrate
dent	dent(al) (istry)(ition)(ure)

denthx	dental history
desen	desentiz(ation) (e)
dev	develop
DFDBA	demineralized freeze-dried bone allograft
dfdg	differential diagnosis
DFMT	decayed, filled or missing teeth
dg	diagnosis
dh	dental history
dhr	dental health record
DI	distal incisal
DI	Dentogenesis Imperfecta
dia	diameter
diag	diagnosis
dias	diastema
DigA	anterior digastric muscle
dil	dilute
dir	direct
disc	discussed
dist	distal
div	divide
DJD	Degenerative Joint Disease
DK	caries
DK	decay
DL	distal lingual
DM	Diabetes Mellitus
dnka	did not keep appointment
DO	distal occlusal
dob	date of birth
DOB	distal occlusal buccal
DOF	distal occlusal facial
DOT	directly observed therapy
dpc	direct pulp cap
dr	drain
drn	drain
drs	dressing
drsg	dressing
dt	decayed teeth
dtr	denture

du	drug user
dup	duplicate(d)
DV	domestic violence
DVT	Deep Vein Thrombosis
dwt	pennyweight
dx	diagnosis
DZP	diazepam
E	
E	extraction
E&E	excavate and evaluate
e.g.	for example
ea	each
EAL	electronic apex locator
EBV	Epstein-Barr Virus
ECC	early childhood caries
ecf	extended care facility
ECM	extra-cellular matrix
ED	effective dose
EDA	Ectodermal dysplasia
edent	edentulous
EGF	Epidermal Growth Factor
EM	Erythema Multiforma
emerg	emergency
EMG	electromyogram
EMO	edentulous mandibular overdenture
endo	endodontics
EO	extraoral
EOP	Early Onset Periodontal disease
epi	epinephrine
epin	epinephrine
epith	epitheli(um) (al)
EPT	electric pulp test
eq pts	equal parts
equil	equilibrate; equilibration
equiv	equivalent
esp	especially
ESRD	End Stage Renal Disease
est	estimate

e-surg	electro-surgery
etch	acid etch
etiol	etiology
ETS	environmental tobacco smoke
eug	eugenol
eval	evaluat(ion) (e)
Ex	examination
ex.	example
exam	examination
exc	excision
excs	excision
exf	exfoliat(e) (ion) (ive)
exp	expos(ed) (ure)
ext	extract(ion)
ext bl	external bleaching
extr	extruded
F	
F	facial
f	fine
F	fluoride
F	failed appointment
F/	maxillary full denture
/F	mandibular full denture
F/C	fever or chills
F/F	full maxillary denture over full mandibular denture
F/L	full lower denture
F/P	full maxillary denture over partial mandibular denture
F/U	full upper denture
f/u	follow up
fa	failed appointment
fac	facing
famhx	family history
FAPA	Fever-Apthous ulcers-Pharyngitis-Adenitis
fb	foreign body
fc	flap curettage
fc	formocresol
fd	furcation depth

FDS	Flap Debridement Surgery
fem	female
ff	fine fine
FGC	full gold crown
fgg	free gingival graft
fgm	free gingival margin
fh	family history
FH	Frankfurt Horizontal
fl	fluid
fl	fluoride
FLD	full lower denture
FLK	Funny Looking Kid
fms	full mouth series
fmwk	framework
fmx	full mouth series
FN	false negative
FNA	fine needle aspiration
FNB	fine needle biopsy
FO	Flap with Osseous resection surgery
F-O	fiber optics
fom	floor of mouth
food imp	food impaction
FOTI	Fiber Optic Transillumination
FP	false positive
FPD	fixed partial denture
FR	Functional Regulator (Frankel Appliance)
frag	fragment
frenmy	frenectomy
freq	frequent
Ftx	fluoride treatment
FU(D)	full upper denture
func	function
fuo	fever of unknown origin
fur	furcation
furc	furcation
FX	fracture
fx	function
fx pros	fixed prosthodontics

fxd	fixed
Fxd	fixed prosthodontics
G	
g	gram
g ion	glass ionomer cement
ga	general anesthesia
gal	gallon
GBI	gingival bleeding index
GBS	gingival bleeding score
GCF	gingival crevicular fluid
gen	general; generalized
G-EOP	Generalized Early-onset Periodontitis
GERD	gastroesophageal reflux disease
gf	gold foil
GI	gastrointestinal tract
GI	Gingival Index
GI	glass ionomer
GIC	glass ionomer cement
ging	gingiva(l)
GIR	glass ionomer resin
GJP	Generalized Juvenile Periodontitis
gm	gram
gmh	general medical history
Gn	gnathion
Go	gonion
GP	general practitioner
gp	gutta percha
gplasty	gingivoplasty
grp	group
GTCS	Generalized Tonic-clonic Seizures (Grand Mal)
GTH	Gingival Thickness
gtmy	gingivectomy
GTR	guided tissue regeneration
gtt	drop
gvty	gingivectomy
H	

H	history
H	hour
H&C	hot and cold
H&P	History and Physical
h/o	history of
H_2O	water
H_2O_2	hydrogen peroxide
HA	hydroxyapatite
ha	headache
HAOS	hard acrylic occlusal splint
HAV	Hepatitis A virus
HBD	has been drinking
hbp	high blood pressure
HBsAg	Hepatitis B surface antigen
HBV	Hepatitis B virus
hci	home care instructions
HCV	Hepatitis C virus
hemr	hemorrhage
Hg	mercury
HGH	Human Growth Hormone
HH	health history
hh	hard of hearing
HHV	Human Herpes Virus
hist	history
HIV	Human Immunodeficiency Virus
HL	Hairy Leukoplakia
hl	hearing loss
HMO	Horizontal Mandibular Osteotomy
HNF	head-neck-face
hoh	hard of hearing
hoi	history of present illness
hosp	hospital
HP	handpiece
HPBL	horizontal probing bone level
HR	high risk
hr	hour
hrd	hard
HS	heavy smoker
hs	at bedtime

HSV	Herpes Simplex Virus
ht	height
htn	hypertension
htr	hard tissue replacement
hve	high volume evacuation
hw	healing well
hx	history
hyg	dental hygiene
	I
I	incisal
I & D	incise and drain
i.s.q.	no change
i.s.q.	in status quo
I/D	incise and drain
IA	inferior alveolar
IAL	incidental attachment loss
IBD	intrabony defect
IBF	ibuprofen
IBI	Eastman Interdental Bleeding Index
IC	informed consent
ic med	intracanal medication
icp	intercuspal position
ID	identification
id	interior diameter
IDDM	Insulin-dependent Diabetes Mellitus (Type 1)
IDU	injection drug user
IFPD	implant fixed partial denture
IM	intramuscular
imm	immediate
immed	immediate
imp	imp(acted)(action)(roved)(lant)(ression)
impl	implant
impr	impression
in	inch
IN	intranasal
inc	incomplete

incl	include
incr	increase
incs	incised
indir	indirect
inf	inf(erior) (ected)
infl	inflammation
inj	injection
inj	injury
inl	inlay
inr	intermittent
ins	inserted
INS	insurance
instr	instruct(ed) (ion)
int	Internal
int bl	internal bleaching
intr	intruded
io	intraocular
ip	intercuspal position
ipc	indirect pulp cap
IPD	Inflammatory Periodontal Disease
IRM	intermediate restorative material
irrig	Irrigation
iv	Intravenous
ivdu	intravenous drug use
ivrf	incomplete vertical root fracture
J	
JRA	Juvenile Rheumatoid Arthritis
K	
kg	keratinized gingival
KS	Kaposi's sarcoma
L	
L	left
l	length
l	liter
L	lingual
l	lower
LA	labial

LA	local anesthesia
lab	laboratory
lac	laceration
lat	lateral
LCR	light cured resin
LE	Lupus Erythematosus
les	lesion
lft	left
lg	large
Li	lingual
lido	lidocaine
lig	liga(ment) (ture)
ling	lingual
liq	liquid
LJP	Localized Juvenile Periodontitis
LL	lower left
LLQ	lower left quadrant
LP	lichen planus
lpa	loss of periodontal attachment
LPM	lateral pterygoid muscle
LR	lower right
lrg	large
LRQ	lower right quadrant
M	
M	mesial
m	male
m	medium
MAA	Mandibular Advancement Appliance
malig	malignant
maloc	malocclusion
man	mandib(ular) (le)
mand	mandib(ular) (le)
MAS	massester muscle
MAT	maxillary alveolar tenderness
max	maxi(lla) (llary) (mum)
MB	mesial buccal
mcg	microgram
mdl	midline

MDR-TB	Multiple Drug Resistant Tuberculosis
med	medium
med hx	medical history
medic	medicament
meds	medications
mEq	milliequivalent
mf	medium fine
MF	mesial facial
MFL	mesial facial lingual
MFP	myofascial pain
mg	milligram
mg	mucogingival
MGJ	mucoginival junction
mh	medical history
MI	maximum intercuspation
MI	mesial incisal
MI	myocardial infarction
MID	mesial incisal distal
min	minute
min	minimal
miss	missing
MjAU	Major Apthous Ulcers
ML	mesial lingual
ml	milliliter
mld	mild
MM	mucous membrane
mm	millimeter
MNVB	Mental Neurovascular Bundle
MO	mesial occlusal
mo	month
MOB	mesial occlusal buccal
MOD	mesial occlusal distal
mod	moderate
MODB	mesial occlusal distal buccal
MOL	mesial occlusal lingual
MP	mandibular plane (gonion-menton)
MPBI	Modified Papillary Bleeding Index
MPD	myofacial pain dysfunction
MPI	maximum permitted intake
MS	Multiple Sclerosis
MSBI	modified sulcular bleeding index
MVA	motor vehicle accident
MVP	mitral valve prolapse
MW	modified Widman surgery
N	
n/a	not applicable
n/c	no charge
n/d	not determined
N/S	no show
N/V	nausea and vomiting
N_2O	nitrous oxide
na	not applicable
NaCl	sodium chloride
NAD	no apparent distress
NaF	sodium fluoride
nar	narrative
nc	no change in condition
NCP	non compliant patient
ncr	necrotic
NE	norepinephrine
nec	necrotic
NED	no evidence of disease
neg	negative
NERD	no evidence of recurrent disease
NHL	Non-Hodgkins Lymphoma
ni	no insurance
nk	not known
NKA	no known allergies
NKDA	no known drug allergies
nl	normal limits
NNS	non-nutritive sucking
no.	number
non-vtl	non-vital
np	new patient
npc	no previous complaint
npe	new patient examination

nph	no previous history
npo	nothing by mouth
nr	next recall
nrc	nonrestorable caries
ns	non-smoker
ns	nothing significant
NSAID	nonsteroidal anti-inflammatory drug
nsf	no significant findings
NSPT	Non Surgical Periodontal Therapy
NUG	Necrotizing Ulcerative Gingivitis
nv	next visit
NVB	inferior alveolar neurovascular bundle
O	
O	occlusal
O_2	oxygen
OAT	Oral Appliance Therapy
obj	objective
OC	open contact
OC	oral contraceptives
occ	occlus(al) (ion)
occl	occlus(al) (ion)
occl xr	occlusal x-rays
OCD	Obsessive Compulsive Disorder
ocf	other clinical findings
od	outer diameter
OFD	Orofaciodigital Syndrome
oh	oral hygiene
ohi	oral hygiene instructions
ohr	oral health record
oi	occlusal interference
oint	ointment
OKC	Odontogenic Keratocyst
OMLP	Oral Mucosal Lichen Planus
OMSCC	Oral Mucosal Squamous Cell Carcinoma
onl	onlay
op	operat(ion) (ory)
ortho	orthodontics

OS	oral surgery
OSCC	Oral Squamous Cell Carcinoma
oss	osseous
OTC	over the counter
oth	other
ov	office visit
oxy	oxygen
oz	ounce
P	
P	palatal
p	prophylaxis
P & C	post and core
P & E	prophylaxis and exam
P & M	papillae and marginal gingiva
P(TFH)	Posterior Total Facial Height (sella-gonion)
P/	maxillary partial denture
P/F	partial maxillary denture over full mandibular denture
P/P	partial maxillary denture over partial mandibular denture
P:	Treatment Plan
pa	periapical
PA	posterior-anterior
PA	preparatory appointment
PACR	post and core restoration
PAL	probing attachment level
palp	palpation
pan	panoramic image
pano	panoramic image
PAP	periapical pathology
part	partial
PASS	Plaque Assessment Scoring System
pat	patient
path	pathology
pax	periapical x-ray
Pb	lead
PBI	papillary bleeding index
PBI	Periodontal pocket Bleeding Index

PBS	papillary bleeding score
PC	periodontal chart
PC	porcelain crown
PC	poor contact
pc	after meals
pc	pulp cap
pcap	pulp cap
PCD	Periapical Cemental Dysplasia
PCN	penicillin
PCO	periodontal chart only
PCR	pseudo centric relation
PCT	plaque control techniques
PD	partial denture
pd	probing depth
PDC	preventive dentistry counseling
PDI	periodontal disease index
pdl	periodontal ligament
pecor	pericoronitis
pedo	pedodontics; pediatric dentistry
PEN	penicillin
per os	by mouth
perc	percussion
perf	perforation
periap	periapical
perio	periodont(al) (itis) (ics)
perio main	periodontal maintenance
perm	permanent
PFG	porcelain fused to gold
PFM	porcelain fused to metal
pfs	pit and fissure sealant
ph	past history
ph	(tele)phone
PI	plaque index
pit-fis	pits and fissures
PJC	porcelain jacket crown
pk	pocket
pkt	pocket
PL	partial lower denture
PLD	partial lower denture

PLP	palatal lift prosthesis
plpts	pulpitis
plq	plaque
PLV	porcelain laminate veneer
PM	after noon
PMC	porcelain to metal crown
pmh	past medical history
pmma	polymethylmethacrylate
PMO	Posterior Maxillary Osteotomy
pmrc	polyacid-modified resin composite material
pnxr	panoramic radiograph
po	by mouth
PO	post operative
poc	pocket
POI	post operative instructions
pol	polish
pom	porcelain on metal
pon	pontic
porc	porcelain
POS	point of service
pos	Positive
post	After
post	posterior
post op	post operative
POT	post operative treatment
pow ch	power chain
PPD	probing pocket depth
PPE	personal protective equipment
ppm(b)	parts per million (billion)
ppt	paper point
PR	per rectum
pre op	pre-operative
prec att	precision attachment
prefab	prefabricated
prelim	preliminary
premed	premedicate
prep	prepar(e) (ation)
prev	prevention

prim	primary
prn	as needed
pro	prophylaxis
prog	prog(nosis) (ress)
prophy	prophylaxis
pros	prosthodonti(cs) (st)
prosth	prosthodonti(cs) (st)
prov	provisional
prox	proximal
PRP	plasma rich protein
PRR	preventive resin restoration
PS	past smoker
PSA	posterior superior alveolar
PSR	periodontal screening and recording
PST	post surgical treatment
pt	patient
PUD	partial upper denture
pulp	pulp(otomy) (ectomy)
pulpo	pulpotomy
pur	purulent
PVS	polyvinyl siloxane
pwdr	powder
Px	prognosis
px	prophylaxis
P-XR	panoramic radiograph
Pxs	prophylaxis
Q	
Q	question
q	every
q 4 h (q 4°)	every 4 hours
q 6 h (q 6°)	every 6 hours
q1d	every day
qam	every morning
qd	every day
qh	every hour
qid	four times a day
qod	every other day

qrtrs	quarters
qs	sufficient quantity
quad	quadrant
R	
R	right
R	recurrent decay
R & C	risks and complications
r/o	rule out
RA	right angle
RA	Rheumatoid Arthritis
rad	radiograph
RAP	recovering addicted patient
RAS	Recurrent Apthous Stomatitis
RAU	Recurrent Apthous Ulcer
RBFPD	resin-bonded fixed partial denture; Maryland bridge
rc	residual cyst
rc	root canal
rcf	root canal filling
rct	root canal therapy
RD	recession depth
R-D	rubber dam
RDH	registered dental hygienist
rdk	recurrent decay
re	regarding
reapp	reappoint(ment)
reappt	reappoint(ment)
reb	rebase
rec	gingival recession
rec	recommend(ed)
rec	record
recem	recement
recon	reconstruction
red	reduc(ed) (tion)
ReDK	recurrent decay
re-eval	re-evaluation
ref	reference
reg	regular
reimpl	reimplantation

rel	reline
rem	removable
rem pros	removable prosthodontics
repl	replac(ed) (ing)
res	resin
resp	respiration
rest	restor(ation) (e)
ret	retained
RME	rapid maxillary expansion
RMGI	resin modified glass ionomer
RMH	reviewed medical history
ro	radiopaque
ROH	alcohol
ROHic	alcoholic
ROM	range of motion
RP	retruded position
rp	root planing
rp/sc	root planing and scaling
RPD	removable partial denture
RPE	rapid palatal expansion
RPS	root planing and scaling
rrr	residual ridge resorption
rt	right
RTC	return to clinic
rw	recession width
Rx	Prescription
S	
$\overline{s}$	without
s	surface
s sut	silk suture
S&RP	scaling and root planing
S&Sx	signs and symptoms
S/D	systolic / diastolic blood pressure
s/e	single ended instrument
S/S	signs and symptoms
SAOS	soft acrylic occlusal splint
SARS	Severe Acute Respiratory Syndrome

SBE	Subacute Bacterial Endocarditis
SBI	sulcular bleeding index
SBP	systolic blood pressure
SC	subcutaneous
sc	scaling
sd	sterile dressing
seal	sealant
sed	sedative
sens	sensitive
sft	soft
sgl	single
SH	social history
sh	shade
Sig	directions; take as follows
sl	slightly
SL	sublingual; under the tongue
SLE	Systemic Lupus Erythematosus
SM	study models
SM	space maintainer
sm	small
SM	submucosal
SMA	study model analysis
SNA	sella-nasion-A-point
SNB	sella-nasion-B-point
SnF	stannous fluoride
SPT	supportive periodontal treatment
sr	silver restoration
SRP	scaling and root planing
ssc	stainless steel crown
ssn	social security number
st	student
st	smokeless tobacco
stat	immediately
std	standard
STD	sexually transmitted disease
STL	soft tissue lesion
STM	soft tissue management
sut	suture
sub	subgingival; submarginal

subcut	subcutaneous
subggv	subgingival
subging	subgingival
subl	sublingual
subling	sublingual
subm	submucosal
subq	subcutaneous
sugg	suggestion
sup	superior
super	above
super	additional
supnum	supernumerary
supp	supperation
supra ggv	supragingival
supra marg	supramarginal
sur	surface
surf	surface
surg	surg(ery) (ical) (eon)
surg ext	surgical extraction
susp	suspension
susp	suspect
SVOS	soft vinyl occlusal splint
sx	sometimes
Sx	symptoms
sxt	sextant
sym	symmetric
symp	symptoms
syr	syrup
sys	system (ic)
sz	size
T	
t cond	tissue condition(er) (ing)
T/t	time/temperature
tab	tablet
tb	toothbrush
TB	Tuberculosis
TBA	Tooth Brush Abrasion
TBS	tris-buffered saline
tbsp	tablespoon
tc	tissue conditioning
Tem A	anterior temporalis muscle
Tem P	posterior temporalis muscle
Temp	temperature
temp	temporary
TENS	transcutaneous electric nerve stimulation
th	tooth
TID	three times per day
TMD	temporomandibular joint disorder
tmj	temporomandibular joint
TN	trigeminal neuralgia
tng	tongue
top	topical
TP	treatment plan
TP	therapeutic pulpotomy
TPR	temperature, pulse, respiration
TPT	thermal pulp test
tr	treatment
trans	transitional
tsp	teaspoon
tt	temporary treatment
TTC	tetracycline
Tx	treatment
Tyl	tylenol
U	
U	universal color
u	upper
U(A)FH	upper anterior facial height
UK	unknown
UL	upper left
ULQ	upper left quadrant
uncoop	uncooperative
uner	unerupted
ung	ointment
unilat	unilateral
unk	unknown

unsvc	unserviceable
UR	upper right
URQ	upper right quadrant
V	
v.s.	vital signs
var	varnish
vaso	vasoconstrictor
VD	venereal disease
VD	vertical dimension
VDO	vertical dimension of occlusion
vert bw	vertical bitewings
vert def	vertical defect
vert dim	vertical dimension
vit	vitamin
vs	vital signs
vtl	vital
VZV	Varicella Zoster Virus
W	
w	width
w/	with
w/f	with fluoride
w/fl	with fluoride
w/n	within
w-d	well developed
wgt	weight
WL	working length
w-n	well nourished
wnl	within normal limits
wt	weight
X	
X	times
xc	extra coarse
xf	extra fine
XR	x-ray
xs	excess(ive)
xt	extract (ion)
xxf	extra extra fine
xylo	Xylocaine
Y	
y/o	years old
Z	
ZDV	Zidovidine
$ZnPO_4$	zinc phosphate
ZOE	zinc oxide eugenol

Commonly Used Dental Acronyms

Acronym	Meaning
A	
AAAHC	Accreditation Association for Ambulatory Health Care
AAE	American Association of Endodontists
AAFP	American Academy of Family Physicians
AAHD	American Association of Hospital Dentists
AAO	American Association of Orthodontists
AAOMP	American Academy of Oral and Maxillofacial Pathology
AAOMR	American Academy of Oral and Maxillofacial Radiology
AAOMS	American Association of Oral and Maxillofacial Surgeons
AAP	American Academy of Periodontology
AAP	American Academy of Pediatrics
AAPD	American Academy of Pediatric Dentistry
AAPHD	American Association of Public Health Dentistry
AARP	formerly known as the American Association of Retired Persons
ACE	ADA Clinical Evaluator
ACP	American College of Prosthodontics
ACP	American College of Physicians
ACS	American College of Surgeons
ADA	American Dental Association
ADAA	American Dental Assistants Association
ADABEI	ADA Business Enterprises, Inc.
ADAF	ADA Foundation
ADEA	American Dental Education Association
ADHA	American Dental Hygienists' Association
AGD	Academy of General Dentistry
AHA	American Heart Association
AHA	American Hospital Association
AHCPR	Agency of Health Care Policy and Research
AHIC	American Health Information Community
AHIP	America's Health Insurance Plans
AHRQ	Agency for Health Care Research and Quality
AIDS	Acquired Immunodeficiency Syndrome
ALARA	As Low As Reasonably Achievable (radiation)
AMA	American Medical Association
ANHB	Alaska Native Health Board

ANSI	American National Standards Institute
ANTHC	Alaska Native Tribal Health Corsortium
ANUG	Acute Necrotizing Ulcerative Gingivitis
APHA	American Public Health Association
ARC	Aids Related Complex
ASA	American Society on Aging
ASC	Accredited Standards Committee
ASDA	American Student Dental Association
ASO	Administrative services only
ASTDD	Association of State and Territorial Dental Directors
ASTM	American Society for Testing and Materials
AwDA	Americans with Disabilities Act
AWWA	American Water Works Association
B	
BAT	Best Available Technology
BBP	Blood Borne Pathogen Standard
BCLS	Basic Cardiac Life Support
BEIR	Biological Effects of Ionizing Radiation
BFE	Bacterial Filtration Efficiency
BLS	Basic Life Support
BMP	Best Management Practices
BMS	Burning Mouth Syndrome
BPHC	Bureau of Primary Health Care (HRSA)
C	
CAPMI	Computer Assisted Post Mortem Identification
CDA	Certified Dental Assistant
CDC	Centers for Disease Control and Prevention
CDHC	Community Dental Health Coordinator
CDHP	consumer-driven health plan
CDL	Certified Dental Laboratory
CDO	Chief Dental Officer
CDPMA	Certified Dental Practice Management Assistant
CD-ROM	Compact Disk-Read Only Memory
CDT	Certified Dental Technician
CDT	Current Dental Terminology
CE	Continuing Education
CERP	Continuing Education Recognition Program
CERT	Community Emergency Response Team

CFR	Code of Federal Regulations
CFU	Colony Forming Units
CG	Center of Gravity
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CHAP	Community Health Aide Program
CHIN	Community Health Information Network
CHIP	Children's Health Insurance Program/Medicare-Medicaid
CMS	Centers for Medicare and Medicaid Services
CN	cranial nerves
CNS	Central Nervous System
COA	Certified Orthodontic Assistant
COB	Coordination of Benefits
COBRA	Consolidated Omnibus Budget Reconciliation Act
CODA	Commission on Dental Accreditation
COHR	Computer-based Oral Health Record
COMSA	Certified Oral and Maxillofacial Surgery Assistant
CPR	Cardiopulmonary Resuscitation
CPT	Current Procedural Terminology
CQI	Continuous Quality Improvement
CRC	Code Revision Committee
CTS	Carpal Tunnel Syndrome
CTS	Cracked Tooth Syndrome
CV	Curriculum Vitae
CVA	Cerebrovascular Accident
D	
D/E	Double-ended instrument
DANB	Dental Assisting National Board
DARW	Dental Assistant Recognition Week
DAT	Dental Aptitude Test
DBA	Doing Business As
DC	Dentigerous Cyst
DDS	Doctor of Dental Surgery
DEA	Drug Enforcement Agency
DeCC	Dental Content Committee
DEF	decayed, extracted, filled
DFMT	Decayed, Filled or Missing Teeth
DFT	decayed, filled teeth
DHAT	Dental Health Aide Therapist

DHMO	Dental Health Maintenance Organization
DICAD	Digital Image Capture in Dentistry
DICOM	Digital Imaging Communications in Medicine
DIT	Dental Identification Team
DMD	Doctor of Dental Medicine
DNA	deoxyribonucleic acid
DPP	Dental Practice Parameters
DR	Direct Reimbursement
DRG	diagnosis-related groups
DSMO	Designated Standards Maintenance Organization
DUWS(L)	Dental unit water supply (line)
E	
EAP	Employee Assistance Programs
EAS	Emergency Alert System
EBD	Evidence-based Dentistry
ECF	extended care facility
ECP	electronic claims processing
ECP	exposure control plan
EDI	Electronic Data Interchange
EEOC	Equal Employment Opportunity Commission
EFI	Electronic File Interchange
EFT	Electronic Funds Transfer
EHR	Electronic Health Record
EM	Erythema Multiforme
EMG	Electromyography
EMS	Emergency Medical Services
EMT	Emergency Management Training
EOB	Explanation of Benefits
EOC	Emergency Operations Center
EPA	Environmental Protection Agency
EPSDT	Early and Periodic Screening, Diagnosis and Treatment Program
ERA	Electronic Remittance Advice
ERISA	Employee Retirement Income Security Act of 1974
ESAR-VHP	Emergency System for Advance Registration of Health Professions Volunteers
ESC	Electronic Study Club

F	
FAQ	frequently asked question
FDA	Food & Drug Administration
FDBI	Facial Dog Bite Injury
FDI	World Dental Federation
FDS	Federal Dental Service
FEMA	Federal Emergency Management Agency
FFS	Fee for Service
FGF	Fibroblast Growth Factor
FMV	Fair Market Value
FOTI	Fiber Optic Transillumination
FQHCs	Federally Qualified Health Centers
FTC	Federal Trade Commission
G	
GKAS	Give Kids A Smile
GLC	Gas-liquid Chromatography
GMT	Geometric Mean Titer
GPR	General Practice Residency
GRAS	Generally recognized as safe
GUI	Graphic User Interface
H	
HazMat	Hazard Communication Standard
HCPCS	Healthcare Common Procedure Coding System
HCQA	Health Care Quality Alliance
HCS	Hazard Communication Standard
HCW	health care worker
HEDIS	Health Plan Employer Data and Information Set
HHS	Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act of 1996
HITSP	Healthcare Information Technology Standards Panel
HMO	Health Maintenance Organization
HPSAs	Health Professional Shortage Areas
HRSA	Health Resources and Services Administration
HS	Head Start
HSA	Health Savings Account
HTML	Hypertext Markup Language

I	
IBWA	International Bottled Water Association
ICD	International Classification of Diseases
IG	Implementation Guide
IHCIA	Indian Healthcare Improvement Act
IHS	Indian Health Service
INDID	Individual Identifier
IOM	Institute of Medicine
IPA	Individual Practice Association
ISO	International Organization for Standardization
ISP	Internet Service Provider
J	
JADA	Journal of American Dental Association
JCAHO	Joint Commission of Accreditation of Healthcare Organizations
JCSMS	Joint Commission on Sports Medicine and Science
K	
L	
L(A)FH	Lower (Anterior) Facial Height
LAN	Local Area Network
LASER	Light Amplification by Stimulated Emission of Radiation
LD	lethal dose
LD_{50}	lethal dose expected to kill 50%
LDH	Licensed Dental Hygienist
LE	Lupus Erythematosus
LEAT	Least Expensive Alternative Treatment
LHD	Local Heath Department
LTC	long term care
LTG	long term goals
M	
MBTI	Meyers Briggs Type Indicator
MCHB	Maternal and Child Health Bureau
MCO	Managed Care Organization
MF	Mental Foramina
MM-DD_YYYY	month, day of month, year
MRC	Medical Reserve Corps
MRD	maximum recommended dose
MRI	magnetic resonance imaging

MSA	Medical Savings Account
MSD	Musculoskeletal Disorders
MSDS	Material Safety Data Sheets
MTD	month to date
N	
n	unspecified number
NADL	National Association of Dental Laboratories
NADP	National Association of Dental Plans
NAIC	National Association of Insurance Commissioners
NAOH	National Alliance for Oral Health
NAS	National Academy of Sciences
NCCHC	National Commission on Correctional Health Care
NCCSH	National Coordinating Committee on School Health
NCDHM	National Children's Dental Health Month
NCI	National Cancer Institute
NCOAL	National Council on the Aging
NCQA	National Committee on Quality Assurance
NCRP	National Council on Radiation Protection and Measurements
NCVHS	National Committee on Vital and Health Statistics
NDA	National Dental Association
NFAC	National Fluoridation Advisory Committee
NFDH	National Foundation of Dentistry for the Handicapped
NHBPEP	National High Blood Pressure Education Program
NHII	National Health Information Infrastructure
NHSC	National Health Service Corps
NIDCR	National Institute of Dental and Craniofacial Research
NIDR	National Institute of Dental Research
NIH	National Institutes of Health
NIMS	National Incident Management Systems
NLM	National Library of Medicine
NOEL	No Observable Effects Level
NOHC	National Oral Health Conference
NOHIC	National Oral Health Information Clearinghouse
NPDB	National Practitioner Data Bank
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
NPRM	Notice of Proposed Rulemaking
NPSF	National Patient Safety Forum

NQF	National Quality Forum
NRC	National Research Council
NRHA	National Rural Health Association
NRP	National Response Plan
NSAID	non-steroidal anti-inflammatory drugs
NSF	nonsufficient funds
NTP	National Toxicology Program
O	
OCR	Office for Civil Rights
OESS	Office of E-Health Standards and Services
OMSS	Organized Medical Staff Section (AMA)
ORGID	Organization Identifier
ORGTYPE	Organization Type
OSAP	Office Sterilization and Asepsis Procedures
OSAP	Organization for Safety and Asepsis Procedures
OSHA	Occupational Safety and Health Administration
OTC	over the counter
P	
P & L	Profit and Loss statement
P.A.N.D.A.	Prevent Abuse and Neglect Through Dental Awareness
PAHO	Pan American Health Organization
PARCA	Patient Access to Responsible Care Act
PBR	paper based record
PC	personal computer
PCP	primary care physician
PCR	polymerase chain reaction testing
PEL	permitted exposure limit
PHD	public health dentistry
PHI	Protected Health Information
POE	Place of Employment
POS	point of service
PPE	personal protection equipment
PPO	Preferred Provider Organization
PPT	partial prothrombin time
PRO	Professional Review Organization
PT	Normal Prothrombin Time; protime
PTAC	Professional and Technical Advisory Committee

Q	
QA	Quality Assessment
QC	Quality Control
R	
RAM	Random-Access Memory
RBA	Risks, Benefits and Alternatives
RBC	red blood cells
RCT	Randomized Clinical Trial
RDAEF	Registered Dental Assistant in Expanded Functions
RDH	Registered Dental Hygienist
REL	Recommended Exposure Limit
RFGD	Radiofrequency Glow Discharge
RFI	Request for Information
RFP	Request for Proposals
RFQ	Request for Quote
RMT	Retromolar Trigone
ROI	return on investment
RQ	Readiness Quotient
RR	Relative Risk
RUC	Relative Value System Update Committee
RVS	Relative Value System
S	
SAL	Sterilization Accuracy Level
SBE	Subacute Bacterial Endocarditis
SCD	Special Care Dentistry
SCDI	Standards Committee on Dental Informatics
SCDP	Standards Committee on Dental Products
SCHIP	State Children's Health Insurance Program
SDP	Survey of Dental Practice
SES	Socio-economic status
SNODENT	Systematized Nomenclature of Dentistry
SOAP	subject, objective, assessment and planning
SOP	standard operating procedure
SOPHE	Society for Public Health Education
SPT	Supportive Periodontal Therapy
STD	Sexually Transmitted Disease
STG	short term goals

T	
TDD	Telecommunication Device for the Deaf
TDP/TFD	Tricare Dental Program / Tricare Family Dental Program
Tfx	Toxic effects
TJC	The Joint Commission
TLV	Threshold Limit Value
TMD	Temporomandibular Joint Dysfunction
TMJ	Temporomandibular Joint
TOA	Table of Allowance
TPA	Third Party Administrator
TQM	Total Quality Management
TWA	Time-Weighted Average
U	
UCR	Usual, customary and reasonable
UEL	Upper Exposure Limit
UR	utilization review
URL	Uniform Resource Locator
USOC	United States Olympic Committee
USPHS	United States Public Health Service
UV	ultra-violet light
UVGI	Ultra-violet Germicidal Irradiation
V	
VA	Veterans Administration
VCD	Video Cephalometric Diagnosis
VDRL	Venereal Disease Research Laboratory Test
VDT	Video Display Terminal
VFO	Video Fiber-Optic
W	
WHO	World Health Organizations
X	
XML	Extensible Markup Language
Y	
YOB	year of birth
YTD	year to date
Z	
z	unknown quantity

Commonly Used ADA Acronyms

Acronym	Meaning	Division
A		
AADA	Alliance of the American Dental Association	
ACCTG	Department of Accounting	FINOP
ADABEI	ADA Business Enterprise, Inc.	Subsidiary
ADABFS	Business and Financial Services Division	ADABEI
ADAF	ADA Foundation (Charitable)	AS
ADAGAT	ADA Grassroots Action Team	GOVT
ADAPUB	ADA Publishing	
ADPAC	Department of Political Affairs/American Dental Political Action Committee	GOVT
AP	Acceptance Program	SCI
AS	Division of Administrative Services	
ASDA	American Student Dental Association	
B		
BFS	Business and Financial Services	ADABEI
BHM	Department of Board and House Matters	AS
BOT	Board of Trustees	
C		
CAPIR	Council on Access, Prevention and Interprofessional Relations	DENPR
CAS	Contract Analysis Service	LEGAL
CAS	Council on ADA Sessions	CMS
CC	Council on Communications	COMM
CDBP	Council on Dental Benefit Programs	DENPR
CDEL	Council on Dental Education and Licensure	EDUC
CDP	Council on Dental Practice	DENPR
CEBJA	Council on Ethics, Bylaws and Judicial Affairs	LEGAL
CELL	Center for Continuing Education and Lifelong Learning	DENPR
CERP	Continuing Education Recognition Program	EDUC
CGA	Council on Government Affairs	GOVT
CI	Council on Insurance	FINOP
CIDA	Center for International Development and Affairs	MDSS
CIPD	Committee on International Programs and Development	
CLA	Committee on Local Arrangements	CMS
CM	Council on Membership	MDSS
CMIRP	Council on Members Insurance and Retirement Programs	FINOP

CMS	Division of Conference and Meeting Services	
CND	Committee on the New Dentist	MDSS
CODA	Commission on Dental Accreditation	EDUC
COMM	Communication and Corporate Relations	
CRFA	Commission on Relief Fund Activities	ADAF
CSA	Council on Scientific Affairs	SCI
D		
DAD	Department of Application Development	ITSSM
DBIS	Dental Benefit Information Services	DENPR
DCA	Department of Congressional Affairs	GOVT
DCMS	Division of Conference and Meeting Services	CMS
DCS	Department of Central Services	FINOP
DCSMP	Department of Conference Services and Meeting Planning	CMS
DDI	Department of Dental Informatics	DENPR
DDSS	Department of Dental Society Services	MDSS
DEAG	Dental Ergonomics Advisory Group	POL
DEC	Department of Electronic Communications	COMM
DENPR	Division of Dental Practice	
DIIS	Department of Internet and Intranet Systems	ITSSM
DITP	Department of IT Projects	ITSSM
DLS	Department of Library Services	EDUC
DMCS	Department of Media and Creative Services	COMM
DMI	Department of Membership Information	MDSS
DMM	Department of Membership Marketing	MDSS
DMS	Department of Membership Services	MDSS
DOS	Department of Officer Services	AS
DPIE	Department of Public Information and Education	COMM
DR	Direct Reimbursement	
DSA	Department of Standards Administration	ITSSM
DSGA	Department of State Government Affairs	GOVT
DSM	Department of Salable Materials	
DSR	Dental Society Resources	
DT	Department of Technology	ITSSM
DTAP	Dental Team Advisory Panel	
DTS	Department of Testing Services	EDUC
DUPL	Duplicating	FINOP
DWAC	Dentists' Well-being Advisory Committee	

DWC	Department of Washington Communications	COMM
E		
EAC	Employee Advisory Committee	OED
EDSAC		
EDU	Executive Director's Update	
EDUC	Division of Education	
F		
FDI	Federation Dentaire Internationale (World Dental Fed.)	MDSS
FDS	Federal Dental Services Membership Office	MDSS
FINOP	Finance/Operations	
G		
GKAS	Give Kids A Smile	CAPIR
GOVT	Division of Government Affairs	
GSD	Guidelines and Standards Development	SCI
H		
HDQB	Headquarters Building	AS
HIPAA	Insurance Portability and Accountability Act	
HOD	House of Delegates	
HPA	Health Policy Analysis	
HPRC	Health Policy Resources Center	POL
HR	Department of Human Resources	AS
I		
IA	Internal Audit	FINOP
ITSSM	Division of Information Technology, Standards and Salable Materials	
J		
JCNDE	Joint Commission on National Dental Examinations	EDUC
L		
LARP	Department of Legislative and Regulatory Policy	GOVT
M		
MARCOM	Department of Marketing Communications	COMM
MDSS	Division of Membership and Dental Society Services	
MSC	Member Service Center	MDSS
MSOP	Membership Services Outreach Program	MDSS
N		
NCDHM	National Children's Dental Health Month	
NIDCR	National Institute of Dental and Craniofacial Research	

O		
OCOO	Office of the Chief Operating Officer	OED
OCPA	Office of the Chief Policy Advisor	POL
OED	Office of the Executive Director	
OS	Office Services	AS
OSA	Office of Student Affairs	MDSS
OSPC	Office of Strategic Planning and Consulting	POL
P		
PMC	Performance Management Cycle	
POL	Policy	
PRC	Paffenberger Research Center (ADA Foundation)	SCI
PSE	Products and Standards Evaluation	SCI
PUR	Purchasing	FINOP
R		
RES	Research and Laboratories	SCI
RI	Research Institute (ADA Foundation)	SCI
S		
SB	Safety and Biocompatibility	SCI
SC	Survey Center	DENPR
SCI	Division of Science	
SHRE	Shipping and Receiving/Mail Room	FINOP
SI	Scientific Information	SCI
SPC	Strategic Planning Committee	POL
T		
TGMI	Tripartite Grassroots Membership Initiative	MDSS
W		
WO	Washington Office (Location)	GOVT

Designations for Teeth

Permanent Dentition
(Universal National System)

Maxillary Right		Maxillary Left
1	Third Molar	16
2	Second Molar	15
3	First Molar	14
4	Second Premolar	13
5	First Premolar	12
6	Canine	11
7	Lateral Incisor	10
8	Central Incisor	9

Mandibular Right		Mandibular Left
32	Third Molar	17
31	Second Molar	18
30	First Molar	19
29	Second Premolar	20
28	First Premolar	21
27	Canine	22
26	Lateral Incisor	23
25	Central Incisor	22

Primary Dentition

Maxillary Right		Maxillary Left
A	Second Molar	J
B	First Molar	I
C	Canine	H
D	Lateral Incisor	G
E	Central Incisor	F

Mandibular Right		Mandibular Left
K	Second Molar	T
L	First Molar	S
M	Canine	R
N	Lateral Incisor	Q
O	Central Incisor	P

National Coordinating Council for Medication Error Reporting and Prevention

Council Recommendations

COUNCIL RECOMMENDATION

Recommendations to Enhance Accuracy of Prescription Writing

Adopted Sept. 4, 1996
Revised June 2, 2005

Personnel to whom this applies: Prescribers; Nursing or Pharmacy staff (who transcribe verbal prescription orders or rewrite transfer or admission orders when entering or leaving a health care facility); Health care administrators/managers.

Technology plays an important role in the delivery of healthcare. Utilize technology, as appropriate, but evaluate its effectiveness on an ongoing basis. While technology can reduce medication errors and enhance patient safety, it also has the potential to cause new types of unintentional errors.

The Council recommends:

1. ...all prescription documents be legible. Verbal orders should be minimized. (See the Council's Recommendations to Reduce Medication Errors Associated with Verbal Medication Orders and Prescriptions)

2. ...prescription orders include a brief notation of purpose (e.g., for cough), unless considered inappropriate by the prescriber. Notation of purpose can help further assure that the proper medication is dispensed and creates an extra safety check in the process of prescribing and dispensing a medication. The Council does recognize, however, that certain medications and disease states may warrant maintaining confidentiality.

3. ...all prescription orders be written in the metric system except for therapies that use standard units such as insulin, vitamins, etc. Units should be spelled out rather than writing "U." The change to the use of the metric system from the archaic apothecary and avoirdupois systems will help avoid misinterpretations of these abbreviations and symbols, and miscalculations when converting to metric, which is used in product labeling and package inserts.

4. ...prescribers include age and, when appropriate, weight of the patient on the prescription or medication order. The most common errors in dosage result in pediatric and geriatric populations. The age (and weight) of a patient can help

dispensing health care professionals in their double check of the appropriate drug and dose.

5. ...medication orders include drug name, exact metric weight or concentration, and dosage form. Strength should be expressed in metric amounts and concentration should be specified. Each order for a medication should be complete. The pharmacist should check with the prescriber if any information is missing or questionable.

6. ...a leading zero always precede a decimal expression of less than one. A terminal or trailing zero should never be used after a decimal. Ten-fold errors in drug strength and dosage have occurred with decimals due to the use of a trailing zero or the absence of a leading zero.

7. ...prescribers avoid the use of abbreviations including those for drug names (e.g., MOM, HCTZ) and Latin directions for use. The abbreviations in the chart below are found to be particularly dangerous because they have been consistently misunderstood and therefore, should never be used. The Council reviewed the uses for many abbreviations and determined that any attempt at standardization of abbreviations would not adequately address the problems of illegibility and misuse.

Abbreviation	Intended meaning	Common Error
U	Units	Mistaken as a zero or a four (4) resulting in overdose. Also mistaken for "cc" (cubic centimeters) when poorly written.
µg	Micrograms	Mistaken for "mg" (milligrams) resulting in an overdose.
Q.D.	Latin abbreviation for every day	The period after the "Q" has sometimes been mistaken for an " I, " and the drug has been given "QID" (four times daily) rather than daily.
Q.O.D.	Latin abbreviation for every other day	Misinterpreted as "QD" (daily) or "QID" (four times daily). If the "O" is poorly written, it looks like a period or "I."
SC or SQ	Subcutaneous	Mistaken as "SL" (sublingual) when poorly written.
T I W	Three times a week	Misinterpreted as "three times a day" or "twice a week."
D/C	Discharge; also discontinue	Patient's medications have been prematurely discontinued when D/C, (intended to mean "discharge") was misinterpreted as "discontinue," because it was followed by a list of drugs.
HS	Half strength	Misinterpreted as the Latin abbreviation "HS" (hour of sleep).
Cc	Cubic centimeters	Mistaken as "U" (units) when poorly written.

AU, AS, AD	Latin abbreviation for both ears; left ear; right ear	Misinterpreted as the Latin abbreviation "OU" (both eyes); "OS" (left eye); "OD" (right eye)
IU	International Unit	Mistaken as IV (intravenous) or 10(ten)
MS, MSO4, MgSO4	Confused for one another	Can mean morphine sulfate or magnesium sulfate

8. ...prescribers avoid vague instructions such as "Take as directed" or "Take/Use as needed" as the sole direction for use. Specific directions to the patient are useful to help reinforce proper medication use, particularly if therapy is to be interrupted for a time. Clear directions are a necessity for the dispenser to: (1) check the proper dose for the patient; and, (2) enable effective patient counseling.

In summary, the Council recommends:

Don't Wait . . . Automate!
When In Doubt, Write It Out!
When In Doubt, Check It Out!
Lead, Don't Trail

Alphabetical Index of Commonly Used Dental Abbreviations

Word or Term	Abbrevi-ation
A	
A point Nasion B point	ANB
Abdominal Aortic Aneurysm	AAA
abfraction	abf
abnormal	abn
above	super
abrasion	abr
abscess	abc, abs
abutment	ab, abut
accessory	acc
acetaminophen	ACM
acetaminophen, paracetamol; N-acetyl-para-aminophenol	APAP
acid etch	etch
acidulated phosphate fluoride	APF
Acquired Immune Deficiency Syndrome	AIDS
acrylic	acr, acry
Active Periodontal Treatment	APT
Active Vertical Corrector treatment	AVC
acute	ac
Acute Lymphocytic Leukemia	ALL
Acute Necrotizing Ulcerative Gingivitis	ANUG
addicted patient	AP
additional	add,super
adjust(ed) (ment)	adj
Adult Periodontitis	AP
adult prophylaxis	AP
advanced	adv
after	post
after meals	pc
after noon	PM
AIDS Related Complex	ARC
air abrasion	air abr
alcohol	ROH
alcohol on breath	aob
alcoholic	ROHic
alginate	alg, algin
alveol(us) (ar)	alv
amalgam	am, amal
amalgam buildup	AM BU
amalgam restoration	AR

amputation	amp
anesthesia; anesthetic	anes
angle	An
anterior	ant
Anterior (Lower Facial Height) [anterior nasal spine-menton]	A(LFH)
Anterior (Total Facial Height) [nasion-menton]	A(TFH)
Anterior digastric muscle	DigA
Anterior Maxillary Osteotomy	AMO
anterior temporalis muscle	Tem A
anterior-posterior	AP
apex	ap
apicoectomy; apical root canal surgery	apeo, apico
appliance	appl
application	appl
appointment	appt
approximately	ca
approximately equal	≈
archwire	aw
archwire adjustment	aw adj
as needed	prn
as soon as possible	asap
aspirin; acetylsalicylic acid	ASA
assistant; dental assistant	asst
assorted	asst
Asymmetry, Borders, Color, Diameter	ABCD
at bedtime	hs
atrophy	atr
attached gingiva	AG
attachment	att
attachment loss	AL
Attention Deficit Disorder	ADD
Attention Deficit Hyperactivity Disorder	ADHD
attrition	attr
atypical	atyp
auscultation	ausc
Automatic External Defibrillator	AED
auxiliary	aux
average	ave, aver, avg
avulsion	av
Azidothymidine	AZT

B	
Baby Bottle Tooth Decay	BBTD
bad breath	bb
base of defect	BD
before	a, ante
before meals	ac
before noon	AM
bicuspid	bi
bigonial width	BGW
bilateral	bil
Bilateral Sagittal Split Osteotomy	BSSO
biologic indicators	BI
Biological Response Modifier	BRM
biopsy	bx
bisphenol-a-glycidyl methacrylate	bis-gma
bisque bake try in	bbti
bite wing x-ray	bw, bwx, bwxr
bleeding on probing	BOP
bleeding time index	BTI
blood pressure	bp
Blood Urea Nitrogen level	BUN
bon(e) (y)	bn
bone crest	BC
bony defect fill - vertical	BDF - V
bracket	bkt, brk
bridge	br, brdg
bridge supported by two implants	BII
broken appointment	BA
brush biopsy	br bx
brux(er) (ism)	brux
buccal	B, buc
buccal distal	BD
build up	b/u, bldup, bu
Burning Mouth Syndrome	BMS
by mouth	per os, po
by report	BR
bony defect	BD
bony defect fill - horizontal	BDF - H
bone fragment	bf
bone graft	bg
bone loss	BL
C	
Calcifying Odontogenic Cyst (Gorlin Cyst)	COC
Calcium Hydroxide	CaOH
calculus	calc
cancel(lation)	canc
cancer	CA
capsules	caps
cardiopulmonary resuscitation	CPR
caries	car, DK
caries control	cc
Caries Prevention Treatment	Car Prev Tx, CPT
carpule	carp
cause unknown	cu
cavity	cav
Celsius	°C
cement(ation)	cem
Cementoenamel Junction	CEJ
centimeter	cm
centric occlusion	CO
centric relation occlusion	CRO
cephalometric image	ceph
ceramic	ceram
Cerebral Vascular Accident	CVA
centric position	CP
cervical erosion	CE
cervical root lesion	crl
change	Δ
check	√, chk
chemical dependency	CD
chief complaint	cc
child prophylaxis	CP
chronic	chr
Chronic Mouth Breathing	CMB
Chronic Obstructive Pulmonary Disease	COPD
Circa	ca
citric acid	cit acid
classification of jaw relation; Angle Class I	cl I
classification of jaw relation; Angle Class II	cl II
classification of jaw relation; Angle Class III	cl III
cleansing and shaping	cl & sh
clear	clr
cleft lip	CL
cleft lip and palate	CLP
cleft lip, cleft palate	CL/CP

clinical attachment level	CAL
cloudy	cldy
coarse	c, crs
compound	cmpd, cpd
complaining of	c/o
complete	comp
complete blood count	CBC
complete lower denture	/C, CLD
complete upper denture	C/, CUD
composite	comp
composite buildup	Comp BU
computerized axial tomography	CAT
computerized tomography	CT
concentrat(e) (ion)	conc
condition	cond
condition on discharge	COD
congenital	cong
Congestive Heart Failure	CHF
connector bar	con bar
conscious sedation	cons sed, CS
consultation	cons
Continuous Positive Airway Pressure	CPAP
Control tooth	Cx
coronal scaling	CS
coronally positioned flap	CPF
Coronary Artery Bypass	CAB
Coronary Artery Disease	CAD
craniofacial analysis	CFA
C-reactive protein	CRP
crown	cr, crn
crown and bridge	C & B
crown lengthening	CL, crn lngth
cubic centimeter	cc
culture and sensitivity	C & S
curettage	cur
Curriculum Vitae	CV
curve of Spee	COS
curve of Wilson	COW
cytomegalovirus	CMV
comprehensive periodontal examination and charting	CPEC
D	
date of birth	DOB
day	d

debridement	debrd
decay	DK
decayed teeth	dt
deciduous	dec, decid
decrease	dec
decreased	↓
Deep Vein Thrombosis	DVT
defective	def
Degenerative Joint Disease	DJD
degree of mobility	+ (number)
deliver(ed)	del
demineralized freeze-dried bone allograft	DFDBA
demonstrate	demo
dent(al) (istry)(ition)(ure)	dent
dental assistant	da
dental health record	dhr
dental history	denthx, dh
dental hygiene	hyg
dentigerous cyst	DC
dentin bonding agents	DBA
Dentogenesis Imperfecta	DI
denture	dtr
depth	d
desentiz(ation) (e)	desen
develop	dev
dextrose/water	D/W
Diabetes Mellitus	DM
diagnosis	dg, diag, dx, Δ
diameter	dia
diastema	^, dias
diazepan	DZP
did not keep appointment	dnka
differential diagnosis	ΔΔ, DD, dfdg
dilute	dil
direct	dir
direct digital radiography	DDR
direct pulp cap	dpc
directions; take as follows	Sig
directly observed therapy	DOT
discharged	d/c
decayed, filled or missing teeth	DFMT
discussed with	d/w
dispense as written	daw
distal	D, dist

distal buccal	DB
distal incisal	DI
distal lingual	DL
distal occlusal	DO
distal occlusal buccal	DOB
distal occlusal facial	DOF
divide	div
domestic violence	DV
double	dbl
double ended instrument	d/e
drain	dr, drn
dressing	drs, drsg
drifted distally	←midline
drifted mesially	→midline
drop	gtt
drug user	du
duplicate(d)	dup
discontinue	d/c
discussed	disc
E	
each	ea
early childhood caries	ECC
Early Onset Periodontal disease	EOP
Eastman Interdental Bleeding Index	IBI
Ectodermal dysplasia	EDA
edentulous	edent
edentulous mandibular overdenture	EMO
effective dose	ED
electric pulp test	EPT
electromyogram	EMG
electronic apex locator	EAL
electro-surgery	e-surg
emergency	emerg
Erythema Multiforme	EM
endodontics	endo
End Stage Renal Disease	ESRD
environmental tobacco smoke	ETS
especially	esp
estimate	est
etiology	etiol
eugenol	eug
evaluat(ion) (e)	eval
every	q

every 4 hours	q 4 h (q 4°)
every 6 hours	q 6 h (q 6°)
every day	q1d, qd
every hour	qh
every morning	qam
every other day	qod
examination	Ex, exam
example	ex.
excavate and evaluate	E&E
excess(ive)	xs
excision	exc, excs
exfoliat(e) (ion) (ive)	exf
expos(ed) (ure)	exp
extended care facility	ecf
external bleaching	ext bl
extra coarse	xc
extra extra fine	xxf
extra fine	xf
extra oral	EO
extra-cellular matrix	ECM
extract (ion)	E, xt, ext
extruded	extr
F	
facing	fac
Fahrenheit	°F
family history	famhx, fh
female	♀, fem
fever or chills	F/C
Fever-Apthous ulcers-Pharyngitis-Adenitis	FAPA
Fiber Optic Transillumination	FOTI
fiberoptics	F-O
fine	f
fine fine	ff
fine needle aspiration	FNA
fine needle biopsy	FNB
fixed	fxd
fixed partial denture	br, brdg, FPD
fixed prosthodontics	fx pros, Fxd
flap curettage	fc
Flap Debridement Surgery	FDS
Flap with Osseous resection surgery	FO
floor of mouth	fom

fluoride	F, fl
fluoride treatment	Ftx
follow up	f/u
food impaction	food imp
for example	e.g.
foreign body	fb
formocresol	fc
four times a day	qid
fracture	≠, FX
fragment	frag
framework	fmwk
Frankfurt Horizontal	FH
free gingival graft	fgg
free gingival margin	fgm
freely; as needed	as lib
frenectomy	frenmy
frequent	freq
full gold crown	FGC
Fahrenheit	°F
failed appointment	F, fa
false negative	FN
full maxillary denture over full mandibular denture	F/F
full maxillary denture over partial mandibular denture	F/P
full mouth series	fms, fmx
full upper denture	F/U, FU(D)
function	func, fx
Functional Regulator (Frankel Appliance)	FR
Funny Looking Kid	FLK
furcation	fur, furc
furcation depth	fd
full lower denture	F/L, FLD

G

gallon	gal
gastroesophageal reflux disease	GERD
gastrointestinal tract	GI
general anesthesia	ga
general medical history	gmh
general practitioner	GP
general; generalized	gen
Generalized Early-onset Periodontitis	G-EOP
Generalized Juvenile Periodontitis	GJP
Generalized Tonic-clonic Seizures (Grand Mal)	GTCS
gingival(l)	ging
gingival bleeding index	GBI
gingival bleeding score	GBS
gingival crevicular fluid	GCF
Gingival Index	GI
gingival recession	rec
Gingival Thickness	GTH
gingivectomy	gtmy, gvty
gingivoplasty	gplasty
glass ionomer	GI
glass ionomer cement	g ion, GIC
glass ionomer resin	GIR
gnathion	Gn
gold	Au
gold foil	gf
gonion	Go
gram	g, gm
greater than	>
group	grp
guided tissue regeneration	GTR
gutta percha	gp

H

Hairy Leukoplakia	HL
handpiece	HP
hard	hrd
hard acrylic occlusal splint	HAOS
hard of hearing	hh, hoh
hard tissue replacement	htr
has been drinking	HBD
headache	ha
head-neck-face	HNF
healing well	hw
health history	HH
hearing loss	hl
heavy smoker	HS
height	ht
hemorrhage	hemr
Hepatitis A virus	HAV
Hepatitis B surface antigen	HBsAg
Hepatitis B virus	HBV
Hepatitis C virus	HCV
Herpes Simplex Virus	HSV
high blood pressure	hbp

high risk	HR
high volume evacuation	hve
history	H, hist, hx
History and Physical	H&P
history of	h/o
history of present illness	hoi
home care instructions	hci
Horizontal Mandibular Osteotomy	HMO
horizontal probing bone level	HPBL
hospital	hosp
hot and cold	H&C
hour	h, hr
Human Growth Hormone	HGH
Human Herpes Virus	HHV
Human Immunodeficiency Virus	HIV
hydrogen peroxide	H_2O_2
hydroxyapatite	HA
hypertension	htn
I	
ibuprofen	IBF
identification	ID
immediate	imm, immed
immediately	stat
inch	in
increased	incr, ↑
intrabony defect	IBD
intracanal medication	ic med
intramuscular	IM
intranasal	IN
intermittant	inr
internal	int
internal bleaching	int bl
intruded	intr
intraocular	IO
intravenous	IV
intravenous drug use	IVDU
J	
Juvenile Rheumatoid Arthritis	JRA
K	
Kaposi's sarcoma	KS
keratinized gingiva	kg
L	

labial	LA
laboratory	lab
laceration	lac
large	lg, lrg
lateral	lat
lateral pterygoid muscle	lpm
lead	Pb
left	L, lft
length	l
lesion	les
lesser than	<
lichen planus	LP
lidocaine	lido
liga(ment) (ture)	lig
light cured resin	LCR
lingual	L, Ll, ling
liquid	liq
liter	l
local anesthesia	LA
Localized Juvenile Periodontitis	LJP
loss of periodontal attachment	lpa
lower	l
lower left	LL
lower left quadrant	LLQ
lower right	LR
lower right quadrant	LRQ
Lupus Erythematosus	LE
M	
Major Apthous Ulcers	MjAU
male	♂, m
malignant	malig
malocclusion	maloc
Mandibular Advancement Appliance	MAA
mandibular full denture	/F
mandibular partial denture	/P
mandibular plane (gonion-menton)	MP
massester muscle	MAS
maxi(lla) (llary) (mum)	max
maxillary alveolar tenderness	MAT
maxillary full denture	F/
maxillary partial denture	P/
maximum intercuspation	MI
maximum permitted intake	MPI
medical history	med hx,

	mh
medicament	medic
medications	meds
medium	m, med
medium fine	mf
Mental Neurovascular Bundle	MNVB
mercury	Hg
mesial	M
mesial buccal	MB
mesial facial	MF
mesial facial lingual	MFL
mesial incisal	MI
mesial incisal distal	MID
mesial lingual	ML
mesial occlusal	MO
mesial occlusal buccal	MOB
mesial occlusal distal	MOD
mesial occlusal distal buccal	MODB
mesial occlusal lingual	MOL
microgram	mcg
midline	mdl
mild	mld
mandib(ular) (le)	man, mand
minute	min
missing	miss
missing tooth or pontic	"X" or "="
Mitral valve prolapse	MVP
moderate	mod
Modified Papillary Bleeding Index	MPBI
modified sulcular bleeding index	MSBI
modified Widman surgery	MW
month	mo
motor vehicle accident	MVA
mucogingival	mg
mucoginival junction	MGJ
mucous membrane	MM
Multiple Drug Resistant Tuberculosis	MDR-TB
Multiple Sclerosis	MS
myocardial infarction	MI
myofacial pain dysfunction	MPD
Myofascial pain	MFP
N	
narrative	nar

nausea and vomiting	N/V
necrotic	ncr, nec
Necrotizing Ulcerative Gingivitis	NUG
negative	neg
new patient	np
new patient examination	npe
next recall	nr
next visit	nv
nitrous oxide	N_2O
no apparent distress	NAD
no change	i.s.q.
no change in condition	nc
no charge	n/c
no difference	↔
no evidence of disease	NED
no evidence of recurrent disease	NERD
no insurance	ni
no known allergies	NKA
no known drug allergies	NKDA
no previous history	nph
no show	N/S
no significant findings	nsf
non compliant patient	NCP
Non Surgical Periodontal Therapy	NSPT
Non-Hodgkins Lymphona	NHL
non-nutritive sucking	NNS
nonrestorable caries	nrc
non-smoker	ns
nonsteroidal anti-inflammatory drug	NSAID
non-vital	non-vtl
norepinephrine	NE
normal limits	nl
not applicable	n/a, na
not determined	n/d
not known	nk
nothing by mouth	npo
nothing significant	ns
number	no.
no previous complaint	npc
O	
objective	obj
observe	chk
Obsessive Compulsive	OCD

Disorder	
occlus(al) (ion)	occ, occl
occlusal	O
occlusal interference	oi
occlusal x-rays	occl xr
Odontogenic Keratocyst	OKC
office visit	ov
ointment	oint, ung
onlay	onl
open contact	||
open contact	OC
operat(ion) (ory)	op
Oral Appliance Therapy	OAT
oral contraceptives	OC
oral health record	ohr
oral hygiene	oh
oral hygiene instructions	ohi
Oral Mucosal Lichen Planus	OMLP
Oral Mucosal Squamous Cell Carcinoma	OMSCC
Oral Squamous Cell Carcinoma	OSCC
oral surgery	OS
Orofaciodigital Syndrome	OFD
orthodontics	ortho
osseous	oss
other	oth
other clinical findings	ocf
ounce	oz
outer diameter	od
over the counter	OTC
oxygen	Oxy,O_2
P	
Palatal	P
palatal lift prosthesis	PLP
palpation	palp
panoramic image	pan, pano
panoramic radiograph	pnxr, P-XR
paper point	ppt
papillae and marginal gingiva	P & M
papillary bleeding index	PBI
papillary bleeding score	PBS
partial	part
partial denture	PD
partial lower denture	PL, PLD
partial maxillary denture over	P/F
full mandibular denture	
partial maxillary denture over partial mandibular denture	P/P
partial upper denture	PUD
parts per million (billion)	ppm(b)
past history	ph
per	/
per kilogram	/kg
per pound	/lb
permanent	perm
personal protective equipment	PPE
pit and fissure sealant	pfs
pits and fissures	pit-fis
plaque	plq
Plaque Assessment Scoring System	PASS
plaque control techniques	PCT
plaque index	PI
pocket	Pk, pkt, poc
point of service	POS
preventive resin restoration	PRR
primary	1°,1',prim, decid
probing attachment level	PAL
pontic	pon
poor contact	PC
porcelain crown	PC
porcelain fused to gold	PFG
porcelain fused to metal	PFM
porcelain jacket crown	PJC
porcelain laminate veneer	PLV
porcelain on metal	pom
porcelain to metal crown	PMC
positive	pos
post and core	P & C
post and core restoration	PACR
post operative	PO, post op
post operative instructions	POI
post operative treatment	POT
post surgical treatment	PST
posterior	post
Posterior Maxillary Osteotomy	PMO
posterior superior alveolar	PSA
posterior temporalis muscle	Tem P
Posterior Total Facial Height (sella-gonion)	P(TFH)

posterior-anterior view	PA
powder	pwdr
power chain	pow ch
precision attachment	prec att
prefabricated	prefab
preliminary	prelim
premedicate	premed
pre-operative	pre op
prepar(e) (ation)	prep
preparatory appointment	PA
prescription	Rx
prevention	prev
preventive dentistry counseling	PDC
preventive resin restoration	PRR
primary	1° or 1', decid, prim
probing attachment level	PAL
probing depth	pd
probing pocket depth	PPD
prog(nosis) (ress)	prog
prognosis	Px
prophylaxis	p, pro, prophy, px, Pxs
prophylaxis and exam	P & E
prosthodonti(cs) (st)	pros, prosth
provisional	prov
proximal	prox
pseudo centric relation	PCR
pulp cap	pc, pcap
pulp(otomy) (ectomy)	pulp
pulpitis	plpts
pulpotomy	pulpo
purulent	pur
Q	
quadrant	quad
quarters	qrtrs
question	Q

R	
radiograph	rad
radiopaque	ro
range of motion	ROM
rapid maxillary expansion	RME
rapid palatal expansion	RPE
reappoint(ment)	reapp, reappt
rebase	reb
recement	recem
recession depth	RD
recession width	rw
recommend(ed)	rec
reconstruction	recon
record	rec
recovering addicted patient	RAP
Recurrent Apthous Stomatitis	RAS
Recurrent Apthous Ulcer	RAU
recurrent decay	R, rdk, ReDK
reduc(ed) (tion)	red
re-evaluation	re-eval
reference	ref
regarding	re
registered dental hygienist	RDH
regular	reg
reimplantation	reimpl
reline	rel
removable	rem
removable partial denture	RPD
removable prosthodontics	rem pros
replac(ed) (ing)	repl
residual cyst	rc
residual ridge resorption	rrr
resin	res
resin modified glass ionomer	RMGI
resin-bonded fixed partial denture; Maryland bridge	RBFPD
respiration	resp
restor(ation) (e)	rest
retained	ret
retruded position	RP
return to clinic	RTC
reviewed medical history	RMH
Rheumatoid Arthritis	RA
right	R, rt
right angle	RA
risks and complications	R & C
root canal	rc
root canal filling	rcf
root canal therapy	rct
root planing	rp

root planing and scaling	rp/sc, RPS
rotated clockwise	↻
rotated counterclockwise	↺
rubber dam	R-D
rule out	r/o
S	
scaling	sc
scaling and root planing	s&rp,SRP, S&RP
sealant	seal
secondary	2° or 2′
sedative	sed
sella-nasion-A-point	SNA
sella-nasion-B-point	SNB
sensitive	sens
sextant	sxt
sexually transmitted disease	STD
shade	sh
signs and symptoms	S&Sx, S/S
silk suture	s sut
silver	Ag
silver point	Ag pt
silver restoration	sr
single	sgl
single ended instrument	s/e
six month recall	6MR
size	sz
slightly	sl
small	sm
smokeless tobacco	st
social history	SH
social security number	ssn
sodium chloride	NaCl
sodium fluoride	NaF
soft	sft
soft acrylic occlusal splint	SAOS
soft tissue lesion	STL
soft tissue management	STM
soft vinyl occlusal splint	SVOS
sometimes	sx
space maintainer	SM
stainless steel crown	ssc
stannous fluoride	SnF
sterile dressing	sd
student	st

study model analysis	SMA
study models	SM
Subacute Bacterial Endocarditis	SBE
subcutaneous	SC, subq subcut,
subgingival	subggv, subging
subgingival; submarginal	sub
sublingual	subl, subling
sublingual; under the tongue	SL
submucosal	SM, subm
sufficient quantity	qs
suggestion	sugg
sulcular bleeding index	SBI
superior	sup
supernumerary	supnum
standard	std
supperation	supp
supportive periodontal treatment	SPT
supragingival	supraggv
supramarginal	Supra-marg
surface	s, sur, surf
surg(ery) (ical) (eon)	surg
surgical extraction	surg ext
suspect	susp
suspension	susp
suture	su, sut
symmetric	sym
symptoms	Sx, symp
syrup	syr
system (ic)	sys
Systemic Lupus Erythematosus	SLE
systolic blood pressure	SBP
systolic / diastolic blood pressure	S/D
T	
tablespoon	Tbsp
tablet	tab
teaspoon	tsp
telephone	ph
temperature	Temp
temperature, pulse, respiration	TPR
temporary	temp

temporary treatment	tt
temporomandibular joint	tmj
temporomandibular joint disorder	TMD
tetracycline	TTC
therapeutic pulpotomy	TP
thermal pulp test	TPT
three times per day	TID
time/temperature	T/t
times	x
tissue condition(er) (ing)	t cond
tissue conditioning	tc
tongue	tng
tooth	th
Tooth Brush Abrasion	TBA
toothbrush	tb
topical	top
transcutaneous electric nerve stimulation	TENS
transitional	trans
treatment	tr, Tx
Treatment Plan	P:, TP
trigeminal neuralgia	TN
tris-buffered saline	TBS
tuberculosis	TB
twice a day	bid
tylenol	Tyl
U	
uncooperative	Uncoop
unerupted	uner
unilateral	unilat
universal color	U
unknown	UK, unk
unserviceable	unsvc
upper	u
upper anterior facial height	U(A)FH
upper left	UL
upper left quadrant	ULQ
upper right	UR
upper right quadrant	URQ

V	
Varicella Zoster Virus	VZV
varnish	var
vasoconstrictor	vaso
venereal disease	VD
vertical bitewings	vert bw
vertical defect	vert def
vertical dimension	VD
vertical dimension of occlusion	VDO
vital	vtl
vital signs	v.s., vs
vitamin	vit
W	
water	aq, H_2O
weight	wgt, wt
well developed	w-d
well nourished	w-n
width	w
with	w/
with (insert line over c; can't find symbol)	c̄
with fluoride	w/f, w/fl
within	w/n
within normal limits	wnl
without	s̄
working length	WL
X	
x-ray	XR
xylocaine	xylo
Y	
years old	y/o
Z	
Zidovidine	ZDV
zinc oxide eugenol	ZOE
zinc phosphate	$ZnPO_4$

APPENDIX G: UFCD Hand Hygiene Techniques

MMWR
Recommendations and Reports
October 25, 2002 / 51(RR16);1-44

Guideline for Hand Hygiene in Health-Care Settings

Recommendations of the Healthcare Infection Control Practices Advisory Committee and the HICPAC/SHEA/APIC/IDSA Hand Hygiene Task Force

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The material in this report originated in the National Center for Infectious Diseases, James M. Hughes, M.D., Director; and the Division of Healthcare Quality Promotion, Steve Solomon, M.D., Acting Director.

Summary

The Guideline for Hand Hygiene in Health-Care Settings provides health-care workers (HCWs) with a review of data regarding handwashing and hand antisepsis in health-care settings. In addition, it provides specific recommendations to promote improved hand-hygiene practices and reduce transmission of pathogenic microorganisms to patients and personnel in health-care settings. This report reviews studies published since the 1985 CDC guideline (Garner JS, Favero MS. CDC guideline for handwashing and hospital environmental control, 1985. Infect Control 1986;7:231--43) *and the 1995 APIC guideline* (Larson EL, APIC Guidelines Committee. APIC guideline for handwashing and hand antisepsis in health care settings. Am J Infect Control 1995;23:251--69) *were issued and provides an in-depth review of hand-hygiene practices of HCWs, levels of adherence of personnel to recommended handwashing practices, and factors adversely affecting adherence. New studies of the in vivo efficacy of alcohol-based hand rubs and the*

antiseptics, hand lotions or creams, and wearing of artificial fingernails) are also included.

Definition of Terms

Alcohol-based hand rub. An alcohol-containing preparation designed for application to the hands for reducing the number of viable microorganisms on the hands. In the United States, such preparations usually contain 60%--95% ethanol or isopropanol.

Antimicrobial soap. Soap (i.e., detergent) containing an antiseptic agent.

Antiseptic agent. Antimicrobial substances that are applied to the skin to reduce the number of microbial flora. Examples include alcohols, chlorhexidine, chlorine, hexachlorophene, iodine, chloroxylenol (PCMX), quaternary ammonium compounds, and triclosan.

Antiseptic handwash. Washing hands with water and soap or other detergents containing an antiseptic agent.

Antiseptic hand rub. Applying an antiseptic hand-rub product to all surfaces of the hands to reduce the number of microorganisms present.

Cumulative effect. A progressive decrease in the numbers of microorganisms recovered after repeated applications of a test material.

Decontaminate hands. To Reduce bacterial counts on hands by performing antiseptic hand rub or antiseptic handwash.

Detergent. Detergents (i.e., surfactants) are compounds that possess a cleaning action. They are composed of both hydrophilic and lipophilic parts and can be divided into four groups: anionic, cationic, amphoteric, and nonionic detergents. Although products used for handwashing or antiseptic handwash in health-care settings represent various types of detergents, the term "soap" is used to refer to such detergents in this guideline.

Hand antisepsis. Refers to either antiseptic handwash or antiseptic hand rub.

Hand hygiene. A general term that applies to either handwashing, antiseptic handwash, antiseptic hand rub, or surgical hand antisepsis.

Handwashing. Washing hands with plain (i.e., non-antimicrobial) soap and water.

Persistent activity. Persistent activity is defined as the prolonged or extended antimicrobial activity that prevents or inhibits the proliferation or survival of microorganisms after application of the product. This activity may be demonstrated by sampling a site several minutes or hours after application and demonstrating bacterial antimicrobial effectiveness when compared with a baseline level. This property also has been referred to as "residual

activity." Both substantive and nonsubstantive active ingredients can show a persistent effect if they substantially lower the number of bacteria during the wash period.

Plain soap. Plain soap refers to detergents that do not contain antimicrobial agents or contain low concentrations of antimicrobial agents that are effective solely as preservatives.

Substantivity. Substantivity is an attribute of certain active ingredients that adhere to the stratum corneum (i.e., remain on the skin after rinsing or drying) to provide an inhibitory effect on the growth of bacteria remaining on the skin.

Surgical hand antisepsis. Antiseptic handwash or antiseptic hand rub performed preoperatively by surgical personnel to eliminate transient and reduce resident hand flora. Antiseptic detergent preparations often have persistent antimicrobial activity.

Visibly soiled hands. Hands showing visible dirt or visibly contaminated with proteinaceous material, blood, or other body fluids (e.g., fecal material or urine).

Waterless antiseptic agent. An antiseptic agent that does not require use of exogenous water. After applying such an agent, the hands are rubbed together until the agent has dried.

Food and Drug Administration (FDA) product categories. The 1994 FDA Tentative Final Monograph for Health-Care Antiseptic Drug Products divided products into three categories and defined them as follows (*19*):

- *Patient preoperative skin preparation.* A fast-acting, broad-spectrum, and persistent antiseptic-containing preparation that substantially reduces the number of microorganisms on intact skin.
- *Antiseptic handwash or HCW handwash*. An antiseptic-containing preparation designed for frequent use; it reduces the number of microorganisms on intact skin to an initial baseline level after adequate washing, rinsing, and drying; it is broad-spectrum, fast-acting, and if possible, persistent.
- *Surgical hand scrub*. An antiseptic-containing preparation that substantially reduces the number of microorganisms on intact skin; it is broad-spectrum, fast-acting, and persistent.

Part II. Recommendations

Categories

These recommendations are designed to improve hand-hygiene practices of HCWs and to reduce transmission of pathogenic microorganisms to patients and personnel in health-care settings. This guideline and its recommendations are not intended for use in food processing or food-service establishments, and are not meant to replace guidance provided by FDA's Model Food Code.

As in previous CDC/HICPAC guidelines, each recommendation is categorized on the basis

of existing scientific data, theoretical rationale, applicability, and economic impact. The CDC/HICPAC system for categorizing recommendations is as follows:

Category IA. Strongly recommended for implementation and strongly supported by well-designed experimental, clinical, or epidemiologic studies.

Category IB. Strongly recommended for implementation and supported by certain experimental, clinical, or epidemiologic studies and a strong theoretical rationale.

Category IC. Required for implementation, as mandated by federal or state regulation or standard.

Category II. Suggested for implementation and supported by suggestive clinical or epidemiologic studies or a theoretical rationale.

No recommendation. Unresolved issue. Practices for which insufficient evidence or no consensus regarding efficacy exist.

Recommendations

1. Indications for handwashing and hand antisepsis

A. When hands are visibly dirty or contaminated with proteinaceous material or are visibly soiled with blood or other body fluids, wash hands with either a non-antimicrobial soap and water or an antimicrobial soap and water (IA) (*66*).
B. If hands are not visibly soiled, use an alcohol-based hand rub for routinely decontaminating hands in all other clinical situations described in items 1C--J (IA) (*74,93,166,169,283,294,312,398*). Alternatively, wash hands with an antimicrobial soap and water in all clinical situations described in items 1C--J (IB) (*69-71,74*).
C. Decontaminate hands before having direct contact with patients (IB) (*68,400*).
D. Decontaminate hands before donning sterile gloves when inserting a central intravascular catheter (IB) (*401,402*).
E. Decontaminate hands before inserting indwelling urinary catheters, peripheral vascular catheters, or other invasive devices that do not require a surgical procedure (IB) (*25,403*).
F. Decontaminate hands after contact with a patient's intact skin (e.g., when taking a pulse or blood pressure, and lifting a patient) (IB) (*25,45,48,68*).
G. Decontaminate hands after contact with body fluids or excretions, mucous membranes, nonintact skin, and wound dressings if hands are not visibly soiled (IA) (*400*).
H. Decontaminate hands if moving from a contaminated-body site to a clean-body site during patient care (II) (*25,53*).
I. Decontaminate hands after contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient (II) (*46,53,54*).
J. Decontaminate hands after removing gloves (IB) (*50,58,321*).

K. Before eating and after using a restroom, wash hands with a non-antimicrobial soap and water or with an antimicrobial soap and water (IB) (*404-409*).
L. Antimicrobial-impregnated wipes (i.e., towelettes) may be considered as an alternative to washing hands with non-antimicrobial soap and water. Because they are not as effective as alcohol-based hand rubs or washing hands with an antimicrobial soap and water for reducing bacterial counts on the hands of HCWs, they are not a substitute for using an alcohol-based hand rub or antimicrobial soap (IB) (*160,161*).
M. Wash hands with non-antimicrobial soap and water or with antimicrobial soap and water if exposure to *Bacillus anthracis* is suspected or proven. The physical action of washing and rinsing hands under such circumstances is recommended because alcohols, chlorhexidine, iodophors, and other antiseptic agents have poor activity against spores (II) (*120,172, 224,225*).
N. No recommendation can be made regarding the routine use of nonalcohol-based hand rubs for hand hygiene in health-care settings. Unresolved issue.

2. Hand-hygiene technique

A. When decontaminating hands with an alcohol-based hand rub, apply product to palm of one hand and rub hands together, covering all surfaces of hands and fingers, until hands are dry (IB) (*288,410*). Follow the manufacturer's recommendations regarding the volume of product to use.

   When washing hands with soap and water, wet hands first with water, apply an amount of product recommended by the manufacturer to hands, and rub hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. Rinse hands with water and dry thoroughly with a disposable towel. Use towel to turn off the faucet (IB) (*90-92,94,411*). Avoid using hot water, because repeated exposure to hot water may increase the risk of dermatitis (IB) (*254,255*).

   Liquid, bar, leaflet or powdered forms of plain soap are acceptable when washing hands with a non-antimicrobial soap and water. When bar soap is used, soap racks that facilitate drainage and small bars of soap should be used (II) (*412-415*).

B. Multiple-use cloth towels of the hanging or roll type are not recommended for use in health-care settings (II) (*137,300*).

3. Surgical hand antisepsis

A. Remove rings, watches, and bracelets before beginning the surgical hand scrub (II) (*375,378,416*).
B. Remove debris from underneath fingernails using a nail cleaner under running water (II) (*14,417*).
C. Surgical hand antisepsis using either an antimicrobial soap or an alcohol-based hand rub with persistent activity is recommended before donning sterile gloves when performing surgical procedures (IB) (*115,159,232,234,237,418*).

D. When performing surgical hand antisepsis using an antimicrobial soap, scrub hands and forearms for the length of time recommended by the manufacturer, usually 2--6 minutes. Long scrub times (e.g., 10 minutes) are not necessary (IB) (*117,156,205, 207,238-241*).

When using an alcohol-based surgical hand-scrub product with persistent activity, follow the manufacturer's instructions. Before applying the alcohol solution, prewash hands and forearms with a non-antimicrobial soap and dry hands and forearms completely. After application of the alcohol-based product as recommended, allow hands and forearms to dry thoroughly before donning sterile gloves (IB) (*159,237*

APPENDIX H: Professional Variance Form

Link to Professional Variance Form: [Qualtrics Survey | Qualtrics Experience Management]

To complete the Professional Variance form:

1. Complete the required sections. Print for meeting with Student.
2. Meet with Student.
3. Faculty/Staff and Student sign the printed form.
4. Copies of the signed form should be sent to Student, Faculty and Office of Education.

Date of Professional Variance (mm/dd/yyyy):

Faculty/Staff Name: Last

Faculty/Staff Name: First

Student Name: Last

Student Name: First

Student UFID:

Next

APPENDIX I: Patient Information Form

UF UNIVERSITY of FLORIDA College of Dentistry

Thank you for considering the University of Florida College of Dentistry for your dental care. Below are some of the guidelines, policies, and information about the Student Dental Program.

Patient Screening
The screening appointment helps us to determine if your dental needs are appropriate for the educational goals for our dental students. Your acceptance into the program is based on these goals. If you are not accepted into the student dental program, you will be referred to one of our graduate specialty programs, our Faculty Practice Clinic, or to the private practice dentist of your choice. **Payment of the screening fee does not guarantee acceptance into the Student Dental Program.**

Patient Acceptance
After your screening appointment, the dentist who supervised your screening appointment will review your x-rays and the information gathered at your screening appointment and determine whether your needs are appropriate for skill level of a student dentist. **If you are accepted, you can expect to be contacted by phone within six to eight weeks**. We will make your first appointment, which will be a comprehensive exam and treatment planning. Your treatment planning may take two separate appointments. Occasionally, it may be determined at this point that your individual dental needs are more complex than initially anticipated. In this case, you will be referred to one of graduate specialty programs, our Faculty Practice Clinic, or the private practice of your choice.

As an accepted patient in the student dental program, you are an important part of the educational component of our student dentists' experience. When your treatment is complete, you may be referred to the private practice of your choice or another dental program for maintenance.

If you experience a dental emergency, such as pain and/or swelling, while you are waiting to be assigned to a student dentist, you may come to our Student Oral Surgery clinic for emergency care. You may find more about this clinic by calling (352) 273-6705.

Time Commitment
If you are accepted into the student dental program, your time commitment is essential. Please be prepared to be available for at least one three hour appointment twice monthly until your dental treatment is complete. Student appointment times are 8:30am and 1:30pm Monday through Thursday. If you don't have available time, or you must travel long distances to reach our clinics, this may not be the right place for you to pursue your dental care. Tardiness, multiple canceled or broken appointments, or not showing up for scheduled appointments will result in dismissal from the student dental program.

Payment for Dental Treatment
Payment is required for your treatment on the day it is performed. We accept cash, personal checks, or credit cards (Visa, MasterCard, and Discover). Advance payment of the total fee is required for certain procedures such as crowns, bridges, and partial or complete dentures. Some treatment plans may be eligible for a payment plan. Eligibility will be determined after treatment planning is completed. If you have dental insurance, we will assist you with claim forms, but payment for your treatment is due at the time of service. Failure to pay for treatment provided will result in discontinuance of treatment and possible dismissal from the student dental program.

I have read and understand the information on this form. I understand the screening process.

Patient signature_____ **Faculty signature**_____

Appendix J: Patient Rights & Responsibilities

UF UNIVERSITY of FLORIDA College of Dentistry

Patient's Rights & Responsibilities

Every patient has the right to competent, considerate, respectful care in a setting that fosters the patient's individual dignity and comfort at all times. You are an important member of your health care team. Knowing your rights and responsibilities is key to your full participation in your care.

Patients: Please read carefully. If you have any questions or concerns about your rights or responsibilities, do not hesitate to discuss them with your provider. If they are not resolved, you may contact the patient advocate: (352) 273-6820 or stop by Patient Registration/Cashiers for assistance. *Thank you!*

Your responsibilities:

- Keep all dental appointments. Failure to keep or appropriately cancel an appointment may result in a cancelation charge or discharge as a patient.
- Pay for your dental treatment when that treatment is delivered. Treatment will not continue if you fail to pay in a timely fashion.
- Do your part to maintain your dental health including brushing, flossing, etc; and returning for scheduled check-ups to help protect the life of your dental treatments.
- Provide the clinic with your accurate and comprehensive health information, demographics and contact information.
- Respect the rights of other patients, families, clinic staff and providers.
- Follow clinic rules and regulations that apply to patient conduct including:
  - Acting with respect for clinical property.
  - Refraining from the use of inappropriate language such as cursing or swearing.
  - Refrain from behavior or language that threatens anyone with bodily injury, fear or intimidation.
  - Do not use words, actions or behaviors that are threatening to yourself or others.
  - This includes words, actions or behaviors that reflect an intention to create fear in another person or the intent to cause physical or mental harm that could lead to psychological or physical harm of another person.

Your rights:

- Considerate, respectful and confidential treatment.
- Impartial access to dental treatment regardless of race, national origin, religion, sexual orientation or physical handicap.
- Special help if you have a disability.
- Have a sign language interpreter at no cost to you.
- Know the name, function and qualifications of the dental care provider who delivers your dental care, and the names and professional relationships of other providers involved in your care.
- A complete dental examination and the right to a thorough review of your medical history especially as your history may relate to your dental condition.
- A treatment plan that outlines your dental needs, explained completely to you in a way you can understand. You have the right to:
  - Provide input on your treatment plan to address any personal concerns you might have.
  - Be provided with treatment options, including an explanation of the risks and costs associated with proposed treatment, and the risks associated with no treatment.
- Have your treatment needs completed in a timely fashion and on a scheduled basis.
- You have the right to emergency dental care through your dentist of record or another provider if referred.
- Consult with a patient advocate if a problem develops during your treatment which you cannot resolve.

You may contact our patient advocate through UF College of Dentistry's Clinic Administration at (352) 273-6820 or at Patient Registration.

UF College of Dentistry May 2023

Appendix K

UFCD MEDICATION LOG

Medication: _____ **Mgs:** _____ **Amount:** _____ **Exp. Date:**_____ **Lot #:**_____

Patient Name:	Chart #	Total Tabs Dispensed:	Date:	Prescribed By:	Dispensed By:	Directions to Patient:

APPENDIX L: Sequence for Donning PPE

SEQUENCE FOR DONNING PERSONAL PROTECTIVE EQUIPMENT (PPE)

The type of PPE used will vary based on the level of precautions required; e.g., Standard and Contact, Droplet or Airborne Infection Isolation.

1. GOWN
- Fully cover torso from neck to knees, arms to end of wrists, and wrap around the back
- Fasten in back of neck and waist

2. MASK OR RESPIRATOR
- Secure ties or elastic bands at middle of head and neck
- Fit flexible band to nose bridge
- Fit snug to face and below chin
- Fit-check respirator

3. GOGGLES OR FACE SHIELD
- Place over face and eyes and adjust to fit

4. GLOVES
- Extend to cover wrist of isolation gown

SECUENCIA PARA PONERSE EL EQUIPO DE PROTECCIÓN PERSONAL (PPE)

El tipo de PPE que se debe utilizar depende del nivel de precaución que sea necesario; por ejemplo, equipo Estándar y de Contacto o de Aislamiento de infecciones transportadas por gotas o por aire.

1. BATA
- *Cubra con la bata todo el torso desde el cuello hasta las rodillas, los brazos hasta la muñeca y dóblela alrededor de la espalda*
- *Átesela por detrás a la altura del cuello y la cintura*

2. MÁSCARA O RESPIRADOR
- *Asegúrese los cordones o la banda elástica en la mitad de la cabeza y en el cuello*
- *Ajústese la banda flexible en el puente de la nariz*
- *Acomódesela en la cara y por debajo del mentón*
- *Verifique el ajuste del respirador*

3. GAFAS PROTECTORAS O CARETAS
- *Colóquesela sobre la cara y los ojos y ajústela*

4. GUANTES
- *Extienda los guantes para que cubran la parte del puño en la bata de aislamiento*

USE SAFE WORK PRACTICES TO PROTECT YOURSELF AND LIMIT THE SPREAD OF CONTAMINATION

- Keep hands away from face
- Limit surfaces touched
- Change gloves when torn or heavily contaminated
- Perform hand hygiene

UTILICE PRÁCTICAS DE TRABAJO SEGURAS PARA PROTEGERSE USTED MISMO Y LIMITAR LA PROPAGACIÓN DE LA CONTAMINACIÓN

- *Mantenga las manos alejadas de la cara*
- *Limite el contacto con superficies*
- *Cambie los guantes si se rompen o están demasiado contaminados*
- *Realice la higiene de las manos*

SEQUENCE FOR REMOVING PERSONAL PROTECTIVE EQUIPMENT (PPE)

Except for respirator, remove PPE at doorway or in anteroom. Remove respirator after leaving patient room and closing door.

1. GLOVES
- Outside of gloves is contaminated!
- Grasp outside of glove with opposite gloved hand; peel off
- Hold removed glove in gloved hand
- Slide fingers of ungloved hand under remaining glove at wrist
- Peel glove off over first glove
- Discard gloves in waste container

2. GOGGLES OR FACE SHIELD
- Outside of goggles or face shield is contaminated!
- To remove, handle by head band or ear pieces
- Place in designated receptacle for reprocessing or in waste container

3. GOWN
- Gown front and sleeves are contaminated!
- Unfasten ties
- Pull away from neck and shoulders, touching inside of gown only
- Turn gown inside out
- Fold or roll into a bundle and discard

4. MASK OR RESPIRATOR
- Front of mask/respirator is contaminated — DO NOT TOUCH!
- Grasp bottom, then top ties or elastics and remove
- Discard in waste container

SECUENCIA PARA QUITARSE EL EQUIPO DE PROTECCIÓN PERSONAL (PPE)

Con la excepción del respirador, quítese el PPE en la entrada de la puerta o en la antesala. Quítese el respirador después de salir de la habitación del paciente y de cerrar la puerta.

1. GUANTES
- *¡El exterior de los guantes está contaminado!*
- *Agarre la parte exterior del guante con la mano opuesta en la que todavía tiene puesto el guante y quíteselo*
- *Sostenga el guante que se quitó con la mano enguantada*
- *Deslice los dedos de la mano sin guante por debajo del otro guante que no se ha quitado todavía a la altura de la muñeca*
- *Quítese el guante de manera que acabe cubriendo el primer guante*
- *Arroje los guantes en el recipiente de deshechos*

2. GAFAS PROTECTORAS O CARETA
- *¡El exterior de las gafas protectoras o de la careta está contaminado!*
- *Para quitárselas, tómelas por la parte de la banda de la cabeza o de las piezas de las orejas*
- *Colóquelas en el recipiente designado para reprocesar materiales o de materiales de deshecho*

3. BATA
- *¡La parte delantera de la bata y las mangas están contaminadas!*
- *Desate los cordones*
- *Tocando solamente el interior de la bata, páse la por encima del cuello y de los hombros*
- *Voltee la bata al revés*
- *Dóblela o enróllela y deséchela*

4. MÁSCARA O RESPIRADOR
- *La parte delantera de la máscara o respirador está contaminada — ¡NO LA TOQUE!*
- *Primero agarre la parte de abajo, luego los cordones o banda elástica de arriba y por último quítese la máscara o respirador*
- *Arrójela en el recipiente de deshechos*

PERFORM HAND HYGIENE IMMEDIATELY AFTER REMOVING ALL PPE

EFECTÚE LA HIGIENE DE LAS MANOS INMEDIATAMENTE DESPUÉS DE QUITARSE CUALQUIER EQUIPO DE PROTECCIÓN PERSONAL

APPENDIX M: Budget Payment Agreement

FACULTY ASSOCIATES, INC
P.O. Box 100425
Gainesville, Florida 32610-0425

Budget Payment Agreement

Date: _____

Patient Name: _____ Chart#: _____

Student Name: _____ Student#: _____

Location/Team:_____

Treatment/Charges to be financed (include procedure codes, $ amt and tooth number):
_____

_____

_____

_____

Plan Total (including Admin Fee): $_____

Less Down Payment & Admin Fee: $_____

New Balance: $_____

Monthly Payment Amount: $_____

Total Due to establish contract: $_____ (down payment plus Admin fee)

Admin Fee-to be paid in addition to the down payment
$600 -$1,000 $50 fee
Over $1,001 $75 fee

Student Signature: _____

Faculty Approval: _____ Faculty #: _____

I agree to pay Faculty Associates, Inc, the sum of $_____ each month for _____ months until the balance is paid in full. I understand that the payment plan will be considered in default if three monthly payments are missed. The entire balance becomes due and is subject to collection after 120 days.
I understand that I will not be schedule for appointments if I am not current in my payments.
I also understand that if the above terms are not met, this could result in being discharged from the student program.

Patient Signature: _____

APPENDIX N: Essentials of Otaining Proper Consent

Contact your on-site risk management designee whenever you have questions about clinical issues that are risk management related.

Shands at AGH.....(352)733-0115 or 733-0111 x71113
Shands at Lake Shore ..... (386) 754-8128
Shands at Live Oak ..... (386) 362-0800
Shands at Starke ..... (904) 368-2300
Shands at Vista/Rehab .....(352) 265-5491 x70022
Shands at the University of Florida . (352) 265-0002
Shands Jacksonville ..... (904) 244-3477
Shands Clinics/Gainesville ..... (352) 265-0002
Shands Clinics/Jacksonville ..... (904) 244-3477
UF Clinics/Gainesville..... (352) 265-8067
UF Clinics/Jacksonville..... (904) 244-4094
UF Dental Clinics..... (352) 392-2911

Please refer patients with concerns to your facility Patient Representative.

Additional educational programs can be obtained through the Gainesville UF Self-Insurance Program office.

- Basics in Risk Management
- Informed Consent
- Good Care, Bad Documentation
- Capacity to Consent
- Credentialing, Peer Review and Medical Staff Monitoring
- Wrong Site Surgery
- Retained Foreign Bodies: Reducing the Risks
- Emergency Medical Treatment and Labor Act (EMTALA)
- Pressure Ulcer Prevention
- Disclosure of Adverse Events
- Florida's Baker Act

UF UNIVERSITY of FLORIDA
The Foundation for The Gator Nation

University of Florida
Self-Insurance Program
Risk Management and Loss Prevention
P. O. Box 112735
Gainesville, FL 32611
Phone: (352) 273-7006
Fax: (352) 273-7287
Website: www.sip.ufl.edu
e-mail: rmeduc@shands.ufl.edu

Essentials of Obtaining Proper Consent

04/06/09

Who can obtain consent?

Based on Florida Statute, consent can be obtained by a physician chiropractor, podiatrist, dentist, ARNP or PA. However, the Florida Board of Medicine views obtaining consent as a non-delegable physician duty regardless of what other regulatory boards deem appropriate for their own professionals. **Irrespective of what is included on a standardized consent template, it is critical that the physician has a discussion with the patient and then confirm in his/her own mind that the patient understands.**

Who may give consent?

A **competent** person who is:

- Over the age of 18.
- Under the age of 18 but married.
- Under the age of 18 and consenting for care or a service related to her pregnancy or child.
- Under the age of 18 and consenting to care for a sexually transmitted disease or alcohol or drug dependency.

Who may consent for minors? (under age 18)

- Either parent.
- Court appointed guardian.
- Person specifically designated by court order as having the capacity to consent to non-routine medical surgical care.
- Person with a power of attorney from parent, dated after July 1, 2001, granting authority to consent to medical treatment of the minor.
- A relative who has been awarded a Court Order for Temporary or Permanent Custody.
- DCF for routine medical care, but only if the child is permanently committed as a ward of the state, i.e., all parental rights have been terminated.

NOTE: A grandparent or other relative who has custody of a child due to an informal arrangement **MAY NOT** give consent for **surgery or general anesthesia**, or any other procedure or treatment requiring informed medical consent.

Who determines capacity?

If the patient's capacity to provide informed consent is in question, the **attending physician (M.D. or D.O.)** shall evaluate and determine whether the patient has the capacity to provide informed consent. If the patient is deemed to be incapacitated, the physician shall document it in the medical record. If the attending physician has a question as to the patient's capacity to consent, an opinion from a second physician will also be obtained and documented in the medical record.

If an adult patient is incapacitated, who can grant consent on his/her behalf?

- A court appointed guardian authorized to consent to non-routine medical/surgical care, after presentation of valid guardianship papers.
- A health care surrogate designated by the patient prior to his/her incapacity.
- If the patient has no guardian and does not have a designated health care surrogate, consent may be granted by a proxy in the following descending order:
  - A. Patient's spouse.
  - B. An adult child of the patient or, if the patient has more than one child, a majority of the adult children who are reasonably available for consultation.
  - C. A parent of the patient.
  - D. An adult sibling of the patient, or if the patient has more than one sibling, a majority of the adult siblings who are reasonably available for consultation.
  - E. An adult relative.
  - F. A friend of the patient who is 18 years of age or older and has signed a Close Friend Affidavit.
  - G. A licensed clinical social worker selected by the Ethics Committee who is not employed by the hospital.

What if the adult is developmentally disabled?

If the patient does not have a court appointed guardian, guardian advocate, or designated health care surrogate, then consent may be granted by a proxy as with any other incapacitated adult.

What if the patient cannot write?

A patient, or the patient's representative, who is unable to write may make a "mark" as his or her signature. The witness(es) to the signing shall use their full signature.

What do you do when a patient requiring emergency care is unable to consent and there is no one else available to give consent?

When the patient is unable to consent because of an emergency condition and there is not an appropriate individual readily available to give consent, the attending physician must document in the medical record the existence of the emergency and that the proposed procedure is necessary to preserve the life or health of the patient. Notification of the appropriate individual shall be accomplished as soon as possible.

For more detailed information refer to Shands policies on informed consent.

http://intranet.shands.org/licacc/Intranet/Patient%20Care/cp2.10.pdf

APPENDIX O: Cone Beam Computed Tomography (CBCT): Radiation Safety and Operating Policy

UF UNIVERSITY of FLORIDA

College of Dentistry
Department of Oral and Maxillofacial Diagnostic Sciences

Health Science Center
PO Box 100414
Gainesville, FL 32610-0414
352-273-6775
352-273-6553 Fax

Cone Beam Computed Tomography (CBCT): Radiation Safety and Operating Policy

Applies to: College of Dentistry clinical personnel, residents and students engaged in clinical activity

Purpose of the Operating Policy

The College of Dentistry is committed to a positive safety culture and expects that individuals performing regulated activities involving radiation-generating devices will establish and maintain a positive safety culture environment. The intent of a positive safety culture, like all other aspects of our organization's radiation safety program, is to minimize radiation exposure to worker, patients and members of the public.

As Low As is Reasonably Achievable (ALARA)

ALARA is a general operating philosophy and a necessary basis for a program of maintaining occupational radiation exposures as low as reasonably achievable. Even though current occupational exposure limits provide a very low risk of injury, it is prudent to avoid unnecessary exposure to radiation. The objective is to reduce occupational exposures as far below the specified limits as is reasonably achievable by means of comprehensive radiation protection practices. The ultimate goal of this policy is to operate under the ALARA concept with regard to radiation exposure.

This operating procedure governs the standards that are used to capture and interpret a Cone Beam Computed Tomography (CBCT) scan at the University of Florida, College of Dentistry Standardized guidelines and forms are used to justify and prescribe a CBCT scan with the correct resolution and field of view (FOV). A uniform and consistent process is used to train individuals to capture CBCT and calibrate the units at periodic intervals, when necessary. A consistent Health Insurance Portability and Accountability Act (HIPAA) compliant process is used to import all patient CBCT scans taken at an external facility and export any CBCT scans taken at the college.
This policy establishes mandatory protocols and procedures designed to:

1. Minimize radiation exposure to patients and operators in accordance to the ALARA principle
2. Promote sound radiological health practices
3. Promote proper infection control during radiographic procedures

Procedure Details

Basic recommendations for use of CBCT

1. CBCT imaging must be prescribed following a thorough clinical examination and review of patient medical history.
2. CBCT imaging must only be performed only for diagnostic and treatment purposes. CBCT should only be used when the question for which imaging is required cannot be answered adequately by lower dose conventional (traditional) radiography
3. CBCT imaging should be performed with the minimum exposure necessary for diagnostically acceptable image quality. Use exposure settings for dental CBCT exams that are optimized to provide the lowest radiation dose that yields an image quality adequate for diagnosis (i.e., radiation doses should be "As Low as Reasonably Achievable").
4. Only authorized persons are allowed in the CBCT controlled area. Audible links between patient and operator are present to maintain communication with the patient during the imaging procedure.
5. The technique factors used should be chosen based on the clinical indication, patient size, and anatomical area scanned. The kVp and mA will be adapted to each clinical application and patient
6. Aids to accurate positioning (light beam markers) must always be used
7. A CBCT request form must be completed prior to imaging the patient.
8. Cone-beam computed tomography (CBCT) should be used for cross sectional imaging as an alternative to conventional computed tomography (CT) when the radiation dose of CBCT is lower and the diagnostic yield is at least comparable.
9. CBCT imaging must be performed only by an appropriately trained and certified radiological operator or appropriately trained practitioners, including faculty and residents.
10. The operator should be located outside the X- ray room. In addition, the operator station should also be such that the patient and the X-ray room entrance can be clearly seen by the operator during the CBCT procedure. The operator can stop the procedure in the case of an emergency.
11. Passwords will be used on all CBCT computers to prevent the use of a CBCT machine by unauthorized persons.
12. Faculty, residents and dental students involved with CBCT imaging must receive acceptable theoretical and practical training.
13. The predoctoral, postdoctoral and clinical residency dental curricula shall provide all information necessary to ensure safe and appropriate use and radiation management in cone-beam computed tomography (CBCT).
14. An apron should be used for all CBCTs and a thyroid collar should be used in all appropriate situations.
15. All CBCT images (internal and external) must have an imaging report of the entire image dataset.
16. Calibration logs, equipment, techniques and quality control procedures must be maintained.

Selection Criteria and Justification

CBCT imaging exposes the patient to ionizing radiation. As such, there must be valid justification for each CBCT scan with minimum exposure for adequate diagnostic need. CBCT imaging must be prescribed following a review of the patient's medical history and clinical examination.
The current recommendations issued by the American Academy of Oral and Maxillofacial Radiology (AAOMR) along with other dental specialty organizations will guide the selection for the appropriate use of CBCT. Recommendations from the evidence-based guidelines of the European Commission, Radiation Protection No. 172, will also serve as a resource in the justification for selecting a CBCT examination. Oral and Maxillofacial Radiology faculty are available to consult in the selection of appropriate imaging parameters for a CBCT scan.

CBCT scan referrals:

Referring practitioners complete the electronic CBCT request form in axiUm. The form is located under Forms > Create a new Record > Cone Beam CT Order Form. CBCT scans will only be acquired following completion of the CBCT order form.
CBCT scan for patients referred by external practitioners:

Patients referred from external practitioners will be registered as CoD and DFP patients before performing the CBCT scan. The referring practitioner will complete and sign an online CoD CBCT Order Form for the appropriate CBCT scan. The CBCT order form is scanned into the patient's electronic health record in axiUm under: patient attachments > Radiology > Cone Beam Order.

Common applications of CBCT:

Airway assessment
Bone graft procedures
Bony evaluation of TMJ region
Bony pathosis in the maxillofacial structures
Cleft palate assessment
Complex root or root canal morphology
Cranio-facial anomalies
Dento-alveolar trauma
Endodontic treatment complications
Evaluation for root fractures
Evaluation of facial asymmetry
Image guided surgery and rapid prototyping
Infra-bony defects, furcation lesions
Internal/external tooth resorption
Localize impacted teeth
Orthognathic surgery
Surgical endodontic cases
Surgical extraction of impacted teeth

17. Annual radiation safety and calibration trainings are provided to all the staff who acquire CBCT.

CBCT Capture and Accessibility

All CBCT images taken at the college can be accessed with the MiPACS software in axiUm. All CBCT scans must have associated diagnosis and procedure codes entered into axiUm

Protection of the unborn fetus:

Every possible precaution will be taken to minimize radiation exposure to the unborn fetus of pregnant or potentially pregnant patients. All patients in the child bearing age must be screened for any possible pregnancy and documented in axiUm medical history form. If the patient is unsure, the x-ray procedure will be delayed until the pregnancy status is confirmed. For a confirmed pregnancy, the patient's referring dentist will be contacted to determine if the CBCT exam can be postponed until after the patient is no longer pregnant. If the consultation determines that the x-ray exam is immediately necessary for the mother's health, then every precaution will be taken to protect the fetus. The medical physicist or radiation faculty will be contacted prior to the exam to determine the best way to keep the dose to the fetus as low as possible and to determine the dose that is delivered to the fetus during the x-ray procedure. Signs are posted in the waiting room and the x-ray room reminding the patient to inform the staff if they are or suspect that they are pregnant. UF Shands policy RM 05-06 will be followed if CBCT is necessary in a pregnant patient. (Appendix 1)

CBCT and Pediatric protocols:

The college of dentistry will follow the recommendations by Image gently and will ensure that the dose to the children are justified and adheres to the ALARA policy. The Image Gently® in Dentistry campaign, launched in September 2014, is an education and awareness initiative focusing on radiation safety in pediatric maxillofacial radiology. The goal of this campaign is to raise awareness of the special considerations needed for pediatric dental radiology and to promote radiation safety by providing a six-step plan of considerations to standardize clinical workflow and encourage team responsibility.

1. CBCT will be only taken if necessary
2. Cone-beam computed tomography (CBCT) examinations shall not be obtained solely for the purpose of producing simulated bitewing, panoramic or cephalometric images.
3. Cone-beam computed tomography (CBCT) examinations shall not be used as the primary or initial imaging modality when a lower dose alternative is adequate for the clinical purpose and shall not be used for routine or serial orthodontic imaging.
4. The beam will be collimated to the area of interest
5. Lead aprons will be used on all patients and thyroid collars will be used whenever possible
6. Low-dose cone-beam CT option will be usedif available and appropriate

The report for medium and large CBCT volumes will be located in the patient's Electronic Health Record in axiUm under Patient Attachments > Radiology> Imaging Reports. Limited FOV CBCT reports will be entered as a treatment note in axiUm.

Quality Assurance Protocol for Optimal Image Quality

Weekly standardized calibrations are performed by designated staff on all CBCT units within the college. A written record is maintained by the staff performing the calibration. Calibrations will be performed immediately if there is clinical evidence of image degradation or suboptimal image quality. In accordance with state guidelines, all CBCT machines are inspected annually by a radiation expert for performance of the X-ray tube, the receptor and the generator. Records are maintained in the Radiology Clinic.

CBCT Education and Training

Training and learning opportunities are an ongoing process. Training material for CBCT scan exposure, image prescription and unit calibration will be developed by the Oral and Maxillofacial Radiology faculty and made available on a shared network drive. CBCT training to interpret findings and use of software will be provided as needed by the Oral and Maxillofacial Radiology faculty. Clinic personnel training needs (e.g., CBCT image capture) will be provided on an as needed basis by the Oral and Maxillofacial Radiology staff and faculty.

Excessive Radiation dose reporting guide:

Th authorized staff/faculty must file and "event report" within 5 working days from the notification that the radiation limits were exceeded, describing any conditions or activities which may have led to the exposure. This report is submitted to the radiation safety office

1. Document date the report is prepared.
2. Facility name and address (as it appears on the registration certificate).
3. Date of discovery of excessive dose (e.g., date of receipt of film badge report).
4. Body part affected (e.g. lens of the eye, whole body, etc.).
5. Dosimeter identification date (e.g. film badge number).
6. Time period during which the excessive dose occurred. If the time period involved is less than a calendar quarter also provide a
subsequent report to indicate the accumulated quarterly dose received.
7. A narrative description of the radiation dose involved and the method of determining the dose.
8. A description of the levels of radiation involved.
9. A narrative description of the cause of the excessive dose.
10. A narrative detailing corrective action taken or planned to prevent a recurrence.
11. Name and signature of individual preparing this report.
12. Name of the individual who received the excessive dose or whose radiation monitoring

Tooth & Periapical assessment (with negative findings in conventional imaging)
Treatment planning and implant placement

Dose reduction techniques:

Aprons are used with all CBCT images and thyroid collars are used in all appropriate situations. The FOV and the voxel size are some of the factors that determine the radiation dose given to a patient. In general, larger voxel size and smaller field of view expose the patient to lower doses of radiation. Low dose scan should be the preferred modality whenever possible especially in children.

Recommendations on volume of field of view (FOV):

The FOV is determined by the diagnostic concerns and the location(s) of interest.
Small FOV: Images of a limited region
1. Localization of an impacted tooth
2. External/Internal resorption
3. Root or root canal morphology
4. Surgical endodontic procedures
5. Periapical assessment
6. Periodontal infra-bony and furcation assessment
7. Symptomatic post endo treatment/endodontic complications
8. Suspected root fractures
9. Single implants

Medium FOV (Maxillofacial): Maxilla or mandible or both
1. Cleft palate
2. Implants
3. Assessment of osseous TMJ components
4. Dental trauma
5. Pathological lesions in the mandible/maxilla
6. Multiple impactions

Large FOV (Craniofacial): Entire craniofacial region
1. Orthognathic surgery
2. Complex orthodontic cases
3. Sinus and airway analysis
4. Facial reconstruction
5. Trauma
6. Developmental anomalies/syndrome

CBCT Image Report:

All CBCT scans are read by a board-certified oral and maxillofacial radiologist who will prepare a complete radiologic report within five (5) business days of the entire data set. The
CBCT Image report will include all significant findings, including pertinent information regarding the diagnostic concern for which the scan is requested, as specified in the CBCT request form.

dosimeter indicated an excessive dose.
13. Social Security number of the individual.
14. Date of birth of the individual.
15. Estimate of the extent of radiation dose
16. A statement dated and signed by the individual who received the excessive dose, indicating that he or she has received a copy of the report.
This statement should indicate that the individual understands the descriptions or conclusions.
17. Include verification that the individual has received the following statement along with his or her copy of the excessive dose report:

The Radiation Safety Office:

1. May change the dosimetry monitoring status to a more frequent interval if it is determined that the dose limit was actually exceeded.
2. Review the individual's radiation work procedures and determine the likelihood of the cause of exposure and ensure any unsafe practices are discontinued.

References:

1. NCRP Report No.177 "Radiation Protection in Dentistry and Oral and Maxillofacial Imaging" (2019)
2. American Dental Association Council on Scientific Affairs. The use of dental radiographs: Update and recommendations. J Am Dent Assoc 2006;137(9): 1304-12.
3. American Dental Association Council on Scientific Affairs, U.S. Department of Health and Humans Services Public Health Service Food and Drug Administration. Dental Radiographic Examinations: Recommendations for Patient Selection and Limiting Radiation Exposure. Chicago, Ill.; 2012:5-7. http://www.ada.org/~/media/ADA/Publications/ADA%20News/Files/Dental_Radiographic_Examinations_2012.pdf.
4. American Academy Pediatric Dentistry. Guidelines on prescribing dental radiographs for infants, children, adolescents, and individuals with special health care needs. Pediatr Dent 2017;39(6):205-7.
5. American Academy of Oral and Maxillofacial Radiology. Clinical recommendations regarding use of cone beam computed tomography in orthodontics. Position statement by the American Academy of Oral and Maxillofacial Radiology. Oral Surg Oral Med Oral Pathol Oral Radiol 2013;116(2):238-57. Erratum in Oral Surg Oral Med Oral Pathol Oral Radiol 2013;116(5):661.
6. American Dental Association Council on Scientific Affairs. The use of cone-beam computed tomography in dentistry. An advisory statement from the American Dental Association Council on Clinical Affairs. J Am Dent Assoc 2012;143(8):899-902.

7. The Alliance for Radiation Safety in Pediatric Imaging. Image Gently; 2014 https://www.imagegently.org/Procedures/Dental#35771807-introduction
8. European Commission. Item 4.2 the Developing Dentition in Protection Radiation No. 172. Cone Beam CT for Dental and Maxillofacial Radiology (Evidence-based Guidelines). 2011:45- 56. http://ec.europa.eu/energy/nuclear/radiation_protection/doc/publication/172.pdf.

APPENDIX P: Mandatory Immunization Health History Form- Health Professions

Mandatory Immunization Health History Form

❖HEALTH PROFESSIONS❖

UF UNIVERSITY of FLORIDA

Section A: Required Immunizations Information

Please note: All titers must include a lab report

1. **MMR / MEASLES, MUMPS, RUBELLA VACCINE:**
Required for everyone born after Dec. 31, 1956. Two doses are required. You must have received on or after 12 months of age AND in 1971 or later. The second dose must have been received at least 30 days after the first dose AND in 1990 or later. **OR** Provide lab evidence of immunity by doing a blood test to check for antibodies for Measles, Mumps and Rubella. If you do a blood test, you need to provide the results on a lab form that should be faxed or mailed with the completed Mandatory Immunization Health History Form.

2. **HEPATITIS B VACCINE:**
Students are required to receive this vaccination. Three dose series are required. You must get the first dose prior to start of classes.

3. **MCV4 (MENACTRA/MENVEO) / MENINGOCOCCAL MENINGITIS VACCINE:**
The Advisory Committee on Immunization Practices (ACIP) currently recommends this vaccine for freshmen planning to live in campus dormitories/residence halls. Students are required to receive this vaccination **OR** read the CDC's Vaccine Information Statement and sign where indicated on the Form to decline. Read the VIS here: https://www.cdc.gov/vaccines/hcp/vis/vis-statements/mening.html. Signing the waiver indicates you understand the possible risk in not receiving this vaccine.

4. **TD or/and TDAP VACCINE:**
Td (Tetanus/Diphtheria) or/and Tdap (Tetanus/Diphtheria/Pertussis):Tdap = Adacel/Boostrix. Booster shot within last 10 years. May have TD but must have at least one instance of Pertussis.

5. **VARICELLA (CHICKENPOX):**
Provide proof of two doses of Varivax **OR** provide results of a blood test on a lab form verifying immunity to Chickenpox/Varicella. **All titers must include the lab report.**

6. **TUBERCULOSIS SCREENING:**
Required for All Students. Refer to the grid below to determine appropriate timeframe for TB Screening and type of testing required. If either screening is returned positive, then you must get a chest x-ray and submit a copy of the report.

   - **FOR TST (Mantoux):** The result of the TST needs to be recorded in mm in the space provided on the form and whether considered negative or positive.
   - **For Interferon-based Assay, IGRA, (QFT or Tspot):** You must submit the lab report.

COLLEGE	*PRIOR TO CLASS START*	*ACCEPTED TEST TYPE(S)*
Dental	Within 12 months	TST (must complete 2-step) or IGRA
Medicine/DAT	Within 12 months	TST or IGRA
PA	Within 12 months	TST (must complete 2-step) or IGRA
Nursing	Within 12 months	TST or IGRA
Pharmacy	Within 12 months	TST or IGRA
PHHP	Within 12 months	TST or IGRA

Additional vaccines or screenings may be required after matriculation for participation in clinical residency or rotations.

Basic Instructions:

- ☐ **DO NOT WAIT!** Review your Student Self-Service Portal and submit missing documents at least three (3) weeks prior to orientation or registration.
- ☐ Include the student's UFID on all correspondence. Print all student information legibly (name, phone, etc.).
- ☐ **MINORS (students under 18):** Include a signed copy of the Minor Medical Treatment Consent Form
- ☐ Keep a copy for your records.
- ☐ Enter vaccine dates and upload form through Student Self-Service Portal
- ☐ **Check UF account to see if the immunization checklist has been cleared: one.uf.edu.** Health Compliance does not send confirmation that an individual form has been received.

Contact Us:

UF Health Compliance Office

Email: healthcompliance@shcc.ufl.edu
Phone: 352-294-2925
Fax: 352-392-0938
Mail: P.O. Box 117500 Gainesville, FL 32601-7500

****Please note:** Email sent over the Internet is not necessarily secure. Please be aware that the University of Florida (UF) Health Compliance Office and the UF Student Health Care Center (SHCC) cannot guarantee the confidentiality or security of any information sent over the Internet when using email. UF and/or the SHCC shall not be liable for any breach of confidentiality resulting from such use of email via the Internet.

OFFICE USE ONLY MRN:_____	UF UNIVERSITY of FLORIDA	Health Professions Immunization Form

REQUIRED – UFID NUMBER (8 digits):

☐☐☐☐-☐☐☐☐

Name: _____ Date of Birth: _____ Phone: _____

Health Profession *(check one)*: ☐ Dental ☐ DAT ☐ Medicine ☐ PA ☐ Nursing ☐ Pharmacy ☐ PHHP

Vaccine Name	Date (MM/DD/YYYY)	Date (MM/DD/YYYY)	Date (MM/DD/YYYY)	Titer Date & Result (Must include lab report)
1. MMR (Measles, Mumps, Rubella) (2 doses after 12 months of age)			--NOT APPLICABLE--	
2. Hepatitis B				
3. MCV4 (Menactra/Menveo) (must be from 2005 or later)			--NOT APPLICABLE--	--NOT APPLICABLE--
☐ I have read the information about MCV4 (Menactra/Menveo) / Meningococcal Meningitis and decline receipt of this vaccine. _____ _____ Student Signature Date				
4. ☐ Td and/or ☐ Tdap (Adacel/Boostrix) (Must have one instance of pertussis)		--NOT APPLICABLE--		--NOT APPLICABLE--
5. Varicella (Varivax)			--NOT APPLICABLE--	
6. Tuberculosis Screening: *(see instructions on p.1)*				
TB Skin Test by TST (Mantoux) #1	Date Placed	Date Read	MM	Result: Neg Pos
TB Skin Test by TST (Mantoux) #2	Date Placed	Date Read	MM	Result: Neg Pos
OR Interferon-based Assay (QFT or T-SPOT)	Date	Result	Submit copy of lab report	
Chest X-ray **(Only if positive TST or Lab Test)**	Date	Result	Submit copy of x-ray report	

SECTION B: Optional Immunization

COVID-19	Moderna				
	Pfizer				
	J&J				

Important! Make a copy of this page and all lab reports to keep for your records.

An official stamp from a doctor's office, clinic or health department AND an authorized signature must appear here or this form will not be approved.

_____ _____ _____

Official Office Stamp Here | Physician or Authorized Signature | Date

EMAIL: healthcompliance@shcc.ufl.edu | FAX: (352) 392-0938 (No cover sheet) | MAIL: UF SHCC Health Compliance, P.O. Box 117500, Gainesville, FL 32611-7500

APPENDIX Q: UF HEALTH SHANDS CPR TRAINING CENTER AMERICAN HEART ASSOCIATION COURSE REGISTRATION FORM (form link) ***form formatted to fit this page***

UF HEALTH SHANDS CPR TRAINING CENTER
AMERICAN HEART ASSOCIATION
COURSE REGISTRATION FORM

NAME: _____ **CLASS DATE AND TIME:** _____
CONTACT NUMBER: _____**EMAIL:** _____
ALL COURSE FEES MUST BE PAID PRIOR TO TAKING THE COURSE.
If paying out of pocket, payments may be made by debit or credit card only directly on square up website.
Payment will be made directly on this website: https://professionals.ufhealth.org/cpr-training/

Class Location: UF Professional Park
3300 SW Williston Rd
Gainesville, Fl. 32608

Registration form and/or receipt must be sent via email to CPRTraining@shands.ufl.edu to reserve a seat.

***Course fees** will not be refunded for cancellations less than **48 hours** before scheduled course or failure to attend. If the class is canceled you may reschedule for another class or your fee will be refunded. Notification of cancelation will be within **24hrs** of class.

Pre-test must be done for ACLS/PALS and printed or shown via picture prior to coming to class or the student will not be able to attend the class. **The American Heart Association (AHA) strongly promotes knowledge and proficiency in CPR and has developed instructional materials for this purpose. Use of these materials in an education course does not represent course sponsorship by the AHA and any fees charged for such a course do not represent income to the AHA.**

Course Type:	**Course Fee: Prices Effective as of March 2022**
BLS Healthcare Provider Training (new or expired)	**$55.00**
BLS Web Skills Check off	**$30.00**
ACLS(only) Training	**$120.00**
ACLS Web Skills Check off	**$50.00**
PALS(only) Training	**$120.00**
PALS Web Skills Check off	**$50.00**
BLS Challenge added to ACLS or PALS is an additional	**$30.00**
Heart Saver Infant/Child/Adult AED First Aid Training	**$85.00**
Heart Saver AED and or First Aid Web Skills Check off	**$50.00**
NRP Skills Check off	**$40.00**
PEARS	**$85.00**
Replacement Card BLS, ACLS, PALS. PEARS	**$9.00**
Replacement Card HS, HS FA, FA	**$22.00**
BLS Instructor Course	**$50.00**
ACLS/PALS Instructor Course	**$85.00**

Bill UF Dental:

Pretest links for ACLS and PALS are below:(There is no pre-test for BLS)

ACLS Pretest Info: How to access the pre-test: https://elearning.heart.org/course/423 Click on this link and it will send you directly to the ACLS Precourse Self Assessment test. The pre-test that must be completed prior to class date with at least an 80% and print or take a picture of certificate of completion to be able to present to the lead instructor.

PALS Pre-test Info: How to access the pre-test: https://elearning.heart.org/course/427 Click on this link and it will send you directly to the PALS Precourse Self Assessment test. The pre-test that must be completed prior to class date with at least an 80% and print or take a picture of certificate of completion to be able to present to the lead instructor.

One of these books should be purchased especially for ACLS/PALS. You should also have prior knowledge of EKG interpretation.
ecg-sim-page - SkillStat(resource for EKG interpretation)
ACLS Provider Manual | AHA (heart.org)
PALS Provider Manual | AHA (heart.org)
https://www.amazon.com/When-Every-Second-Counts-ACLS/dp/195477902X

For questions or concerns please contact Christian Diaz or Jason Hansen via email: CPRtraining@shands.ufl.edu

APPENDIX R: Medical Emergencies: UFCD Definitions

Medical emergency is defined by an acute exacerbation of an underlying medical condition that requires intervention in order to prevent subsequent deterioration of the affected individual's health/life status.

Asthma: Acute on chronic exacerbation of reactivity of the pulmonary airway resulting is difficulty breathing and the development of hypoxia. May be associate with decreased SaO2 and can lead to respiratory collapse. [www.cdc.gov > Asthma > FAQs]

Cardiac/Respiratory Arrest: Sudden cardiac death resulting from inadequate perfusion of the cardiac muscle leading to loss of systemic circulation. May be associated directly from a cardiogenic source or from a respiratory systems failure.

Hypoglycemia: Blood glucose levels below 70 mgs/dL resulting in altered mental status, heart palpitations, shakiness and a general felling of malaise. If severe enough hypoglycemia will lead to loss of consciousness.

Hypertension: As recently re-defined by the American Heart association, **Adult** patients with hypertension have BP's in the range of 130-139 /80-89 [Stage 1 Hypertension], 140 of greater /90 or greater [Stage 2 Hypertension], 180 or greater systolic and/or greater than 120 diastolic [Hypertensive Crisis]. At UFCD, the parameters for hypertension is defined as 165/95. Pts presenting with elevated pressures and systemic symptoms may be classified as requiring urgent or emergent attention. (www.AHA.org, *Hypertension*)

Pediatric patients with 3 repeated BPs greater than the 95% of age, sex, height norms measured at separate visits or measurements >120/80 (www.Hopkinsmedicine.org, *Pediatric Hypertension*)

Hypotension: Adult patients with BP less than 90/60. In situations where there are systemic symptoms (chest pain, shortness of breath, altered mental status). In **Pediatrics:** the definition will be according to the formula: systolic BP- <70 + 2 (age in years).

Allergic Reactions: Immune mediated hypersensitivity to a pre-processed antigen. When exposed to an allergen the patient first becomes sensitized to the allergen. The body then produces antibodies of the IgE class, which when re-exposed to the allergen binds IgE antibodies causing Mast Cells to release vasoactive amines and other agents of vasoactive chemicals. The bodies response may be delayed and mild or immediate and severe. Mild responses (**Delayed Hypersensitivity**) may include rashes, wheals and itching. Severe allergic reactions (**Anaphylaxis**) will include multiple systems of the body leading to cardiopulmonary collapse. [www.medlineplus.gov, *Allergic Reactions*].

Dyspnea/Shortness of Breath (SOB): A sensation where the patient is subjectively not getting enough air. This condition may be psychosomatic in nature leaving a frightening feeling to the patient or may be a symptom of a more ominous underlying disease process; either chronic or acute. It is usually associated objectively with a SaO2 of <92% but that may vary depending upon the subjective feelings of the patient. [www.mayoclinics.org, *Shortness of Breath*]

Seizure: Chaotic neuro-electrical activity that may cause physical symptoms ranging from momentary blank stares to more generalized Tonic-Clonic movements and loss of consciousness. These may be associated with benign physiologic issue (fever, anoxia associated with syncope), head trauma, brain masses or infections or become part of the Epilepsy complex of activity [www.mayoclinic.org, *Seizures-Symptoms and causes*]

Syncope: The progressive increase in parasympathetic/Vagal tone manifested by bradycardia, hypoperfusion to the cerebral cortex. This leads to a brief loss of consciousness and may be associated with excessive perspiration, loss of continence and in some cases, anoxic seizure activity. [https;//my.clevelandclinic.org, *Syncope: Symptoms, Causes and Treatments*]

Unresponsive patient: When a patient fails to respond to verbal or tactile stimulation, this patient is considered unresponsive. The causes may vary but attention must immediately be directed to the ABC's of evaluation and resuscitation.

Intravascular Injection of Local Anesthesia: Can create situations of distal-site necrosis (if epinephrine is utilized), cause seizure activity or global neurologic inactivity and/or potential cardiovascular collapse. [www.sciencedirect.com, *Intravascular Drug Administration- an overview*]

Sodium Hypochlorite injection into the Maxillary Sinus and Soft Tissues: Sodium Hypochlorite is a very basic (high pH) solution that if injected into the maxillary sinus may cause severe pain, and tissue necrosis of the Schneiderian membrane. If injected into the perioral soft tissues will cause a low pH burn and localized tissue necrosis. Accidental spillage into the eyes will cause tissue injury and possibly corneal damage. As with all toxic agents, the Molar concentration and length of exposure are directly related to the extent of soft tissue injury. [Ehrich DG, et al., JEndod. *Sodium hypochlorite accident: inadvertent injection into the maxillary sinus*, 1993 PMID:8326264]

Foreign body into the eye: Inadvertent deposition of a foreign material into the lid regions of the eye. Associated with a foreign body sensation, pain, excessive tearing and may cause abrasions to the cornea.

Agitated patient after injection of Local Anesthesia: IF vital signs are within normal rages for the adult or pediatric patient, these patients may present with agitation due to several possible causes: intravascular injection, fear/anxiety, hypotension, altered mental status.

Swallow/Aspiration of foreign body: The inadvertent loss of control of a tooth, material or instrumentation which passes beyond protective throat screens/rubber dams. It may be ingested or aspirated. Signs and symptoms may include, foreign body sensation upon swallowing, foreign body sensation in the low oropharynx or acute respiratory distress.