UNIVERSITY OF KENTUCKY

COLLEGE OF DENTISTRY

2015-16

CLINIC MANUAL

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Section 1

Professional Behavior

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BEHAVIORAL STANDARDS IN PATIENT CARE
COMMITMENTS TO PERFORMANCE

Approved by Board of
Trustees University of
Kentucky
Albert B. Chandler Medical Center
September 16, 1997

Amended by
University Health Care Committee
Board of Trustees
University of Kentucky
October 13, 2008

Principles

Principle A - Each patient shall be treated as a whole, irreplaceable, unique, and worthy person.

Principle B -The patient's safety, health, or welfare shall be protected and shall not be subordinated to organizational, staff, educational, or research interests or to any other end.

Principle C - The privacy of the patient and the confidentiality of every case and record shall be maintained.

Principle D -Patients and/or responsible family shall be informed at all stages of care about personnel responsible for the patient's care; treatment plans and activities for the patient; facilities; services available to the patient; and responsibilities of the patient and family (referred to collectively below as "patient's care").

Principle E -Behavior reflecting the dignity, responsibility, and service orientation of health care professionals, worthy of the public's respect and confidence, shall be practiced by all individuals.

Principle F -Each patient shall have a responsible attending physician or dentist.

Commitments

Commitment:	I will recognize that patients and other customers are unique individuals, and I will be sensitive to their life experiences, circumstances and emotions when assessing needs and communicating information.
Commitment:	I will use my one opportunity to make an outstanding first impression.
Commitment:	I will knock, introduce myself, state my purpose and ask permission to enter a patient's room.
Commitment:	I will use language free from obscenities, profanities, and derogatory or abusive remarks.
Commitment:	I will value and respect our patients and other customers by honoring their perceptions, preferences and differences.
Commitment:	I will be attentive to patients' and customers' thoughts and feelings and adapt my responses to make them feel comfortable and understood regardless of their behavior.
Commitment:	I will reinforce verbal instructions and provide written explanation whenever needed.
Commitment:	I will anticipate and be sensitive to patients and customers with special needs.
Commitment:	I will make the customer's safety, health, privacy and welfare my first priority.
Commitment:	I will provide expeditious, courteous and flexible service.
Commitment:	I will honor and protect individual and organizational confidentiality involving service, research and teaching activities.
Commitment:	I will provide positive, professional and prompt responses and keep my facial expressions and tone of voice consistent with my words.
Commitment:	I will explain when there is a delay, provide an estimated wait time and apologize for any inconvenience.
Commitment:	I will write legibly for safe and effective communication.
Commitment:	I will provide helpful and caring assistance.
Commitment:	I will take initiative and be proactive, striving for continual process improvement.
Commitment:	I will promote the services available at UK HealthCare to meet the patient care needs of the Commonwealth.
Commitment:	I will keep all public areas clean and work with my co-workers to achieve a professional environment.
Commitment:	I will offer positive reinforcement, recognize accomplishments and provide resources.
Commitment:	I will protect privacy and health care information according to the Notice of Privacy Practices of the University of Kentucky; I will be sensitive to my patients' and customers' privacy.

Commitment: I will honor patient rights to confidentiality and modesty.

Commitment: I will communicate clearly so that patients and family members understand their plan of care and their role in its implementation.

Commitment: I will create an atmosphere of trust and honesty with open communication.

Commitment: I will follow-up to meet patients' and customers' needs.

Commitment: I will mentor and assist employees to develop exceptional skills.

Commitment: I will use resources wisely.

Commitment: I will demonstrate support and respect for my colleagues and handle all interactions in a professional manner.

Commitment: I will be available, never saying "that's not my job." I will be accessible, visible and easily approachable.

Commitment: I will constantly look for new or safer ways to deliver or improve the patient and family experience.

Commitment: I will constantly look for ways to improve our working environment.

Commitment: I will demonstrate integrity and professionalism at all times.

Commitment: I will comply with the University of Kentucky Ethical Principles and Code of Conduct.

Commitment: I will take action to resolve matters brought to my attention. If I am unable to resolve a matter, I will involve the appropriate person to achieve a resolution.

Commitment: I will be respectful, talk through issues and conflicts and address conflicts in a respectful way.

Commitment: I will comply with the University of Kentucky Corporate Compliance Program.

Commitment: I will adhere to the University of Kentucky standards for billing and collection.

Commitment: I will show others I value their time by assuming an appropriate sense of urgency.

Commitment: I will project a positive attitude and keep my work-related or personal frustrations separate from my patient care and professional activities.

Commitment: I will not discuss in public areas frustrations with another unit or another person.

Attending Commitment: I will recognize that my customers/patients' time is valuable and will make all efforts to provide my services in a timely manner and as scheduled.

Attending Commitment: I will be available for my scheduled clinical activities and avoid overlapping responsibilities that would create tardiness and delay of patient care as scheduled.

Attending Commitment: I will provide the highest standard of care to all patients, regardless of financial, social, or political status.

Attending Commitment: I will meet and follow the same standards for behavior and service that I expect from support/ancillary staff.

Attending Commitment: When I recognize potential areas for improvement in quality, I will provide feedback to the appropriate manager/supervisor director in a constructive and respectful manner and assist in the process for improvement.

Attending Commitment: I will review and understand billing and coding issues and appropriate documentation pertinent to my area of practice.

Attending Commitment: I will complete my clinical tasks in a timely manner, avoiding outside interruptions (i.e., conference calls, phone interviews, internet searches), to avoid inappropriate use of staff in overtime situations.

Attending Commitment: I will address and refer to all non-UK HealthCare providers and institutions with respect and in a positive manner.

UNIVERSITY OF KENTUCKY
CLINICAL ENTERPRISE UK
HEALTHCARE

BEHAVIORAL STANDARDS IN PATIENT CARE*
COMMITMENTS TO PERFORMANCE
SECTION I
PREAMBLE

The mission of the University of Kentucky clinical enterprise now commonly known as "UK HealthCare" (each of the University of Kentucky Hospitals (University of Kentucky Chandler Hospital, UK HealthCare Good Samaritan Hospital, and Kentucky Children's Hospital), UK HealthCare East, Kentucky Clinics, Markey Cancer Center, Gill Heart Institute, Kentucky Neuroscience & Orthopaedics Institute and the clinical activities of the Colleges of Medicine, Pharmacy, Nursing, Health Sciences, Dentistry and Public Health)† is to help the people of the Commonwealth and beyond, gain and retain good health through creative leadership and quality initiatives in education, research, and service.

UK HealthCare is committed to the pillars of academic health care - research, education and clinical care. Dedicated to the health of the people of Kentucky, we will provide the most advanced patient care and serve as an information resource. We will strengthen local health care and improve the delivery system by partnering with community hospitals and physicians. We will support the organization's education and research needs by offering cutting edge services on par with the nation's best providers.

It is well established that the "caring" aspect of treating patients has a therapeutic impact; the quality of the environment and the interpersonal relationships that surround patients appreciably affect the course of their recovery. From experience, we know that we cannot assume that all individuals hold acceptable attitudes or understandings regarding what is ethical, right, or appropriate in regard to relationships with patients, families, and colleagues. Because behavior in patient care, as in other areas, is learned, and the ultimate goal of an academic health sciences center is exemplary patient care as a teaching model, high standards of professional and humane behavior in patient care should be prominent among the values that are communicated through all learning experiences, formal and informal. This institution has the obligation and responsibility to formulate and implement such standards.

As a state institution, support of the community health care systems consistent with legal and ethical treatment of patients is part of the University of Kentucky UK HealthCare service mission. To fulfill this mission, UK HealthCare practitioners must work as a team with

* Referred to in this document as Standards

† Formerly known as the University of Kentucky Albert B. Chandler Medical Center.

community providers, hospitals, and other health practitioners throughout Kentucky. The following Standards are not intended to supplant existing professional codes of ethics where they exist for specific professions and applicable laws and regulations regarding the care and treatment of patients but rather to illustrate, specify, and make relevant these generally accepted ethical codes to our patient care programs. While the Standards are primarily the institution's goal to provide exemplary patient care and to serve as an instructional document, many of the Standards describe mandatory behavior.

To achieve excellence in customer service and customer satisfaction, commitments to service excellence are added to the Principles and Standards. The commitments are expected of each individual.

Supervisors, instructors and professionals shall have responsibility for introducing and maintaining an acceptable level of performance according to these Standards and Commitments in their individual areas of responsibility. They shall have the opportunity and responsibility to exercise discretion and judgment in whether a violation is minor and needs primarily counseling, reprimand, and/or warning or whether it constitutes a major violation requiring disciplinary action.

1. Approval of and Amendments to Standards

    1.1. The Standards and Commitments shall be established as policy for UK HealthCare by the University Health Care Committee of the Board of Trustees of the University of Kentucky in accordance with its responsibility in all matters involving the quality of patient care.

    1.2. Recommendations for amendments to these Standards may be made by any individual within UK HealthCare to the Executive Vice President for Health Affairs. Such recommended amendments will be presented to the UK HealthCare Medical Staff Executive Committee for consideration. Provided the UK HealthCare Medical Staff Executive Committee endorses the suggested amendment for adoption, the Executive Vice President for Health Affairs shall present the suggested amendment to the University Health Care Committee for consideration, together with the endorsement of the Medical Staff Executive Committee and the recommendation of the Executive Vice President for Health Affairs which need not be consistent with the endorsement. Upon approval by the University Health Care Committee, the amendment shall become effective.

    1.3. Recommendations for amendments to these Commitments may be made by any individual within UK HealthCare to the Executive Vice President for Health Affairs. With the concurrence of the UK HealthCare Medical Staff Executive Committee, the Executive Vice President for Health Affairs may approve amendments to these Commitments which shall be reported to the University Health Care Committee.

2. Applicability

    2.1. These Standards and Commitments shall apply to all individuals who come into contact with patients of UK HealthCare or participate in UK HealthCare activities associated with patient care, irrespective of location.

3. Interpretation of Standards

3.1. Standards have been expressed in terms of observable behaviors as much as possible to facilitate modeling, instruction, supervision, and evaluation in patient care programs.

3.2. These Standards are not to be constructed as exhaustive; other specific actions or behaviors not cited herein should be judged in light of the intent of the document.

4. Interpretation of Commitments

4.1. Commitments are to be interpreted consistently with the Governing Regulations and the Administrative Regulations of the University of Kentucky, the Medical Staff Bylaws and these Standards. Any inconsistency will be governed first by such regulations, then the bylaws and then by the Standards.

4.2. Commitments have been expressed in terms of personalized affirmations of observable behaviors to facilitate individual understanding of expected behavior.

4.3. These Commitments are not to be constructed as exhaustive; other expectations are set forth in the Governing Regulations, Administrative Regulations, Medical Staff Bylaws and other policies applicable to UK HealthCare.

5. Definitions

5.1. As used herein,

5.1.1. "shall" or "must" indicates mandatory behavior, the only acceptable method or level of performance;

5.1.2. "should" indicates commonly accepted methods or behaviors yet allows for effective alternatives;

5.1.3. "may" in the interpretation of a standard or commitment indicates an illustration of an acceptable method;

5.1.4. "individuals" means any and all persons (i.e., attending, faculty, medical staff, staff, house staff, student, or volunteer) involved in rendering patient care directly or indirectly;

5.1.5. "patient" includes any person receiving services such as a consumer, client, inpatient, or outpatient;

5.1.6. "customer" means each patient and every other person with whom an individual comes in contact during the work day.

5.1.7. "unit" means any organized administrative component of the University of Kentucky.

5.1.8. "minor violation" is one that does not compromise the general well-being of the patient and/or has minor legal implications for the institution;

5.1.9. "major violation" is one that compromises the health and well-being of the patient and/or his major legal implications for the institution.

5.1.10. "supervisor" shall mean all persons fulfilling supervisory roles at any level for faculty, medical staff, staff, house staff, or students.

6. Implementation and Enforcement of Standards

6.1. Procedures for reporting violations by faculty, medical staff, staff, house staff, or students to patient program supervisors, Chief Medical Officer, Dean of the applicable College, and the Executive Vice President for Health Affairs shall be consistent with procedures established herein.

6.2. Procedures for UK HealthCare notifying a house staff officer's or student's academic instructor and Dean of a violation shall be consistent with procedures established by the Deans of the Colleges.

6.3. Disciplinary action and appeals shall be consistent with existing procedures appropriate to the individual's status as faculty, medical staff or staff as stated within the Personnel Policy and Procedure Manual or the Medical Staff Bylaws or Rules and Regulations.

6.4. The Hospital Administrator, Chief Medical Officer, Dean, or the Executive Vice President for Health Affairs may remove any individual from the patient care setting to protect patient safety.

6.4.1. Any supervisor may remove any individual from the patient care setting or activity to protect patient safety. Reporting of the incident and disciplinary action shall be consistent with the Policies and Procedures applicable to the individual's status in patient care.

6.4.2. This action, if it involves a student, does not constitute disciplinary action against the student nor affect the student's academic status. This action, if it involves a student, must be reported promptly to the student's instructor and Dean. All action relative to the academic progress and status of the student shall remain the responsibility of the College.

6.4.3. Reinstatement of a student in a particular patient care setting from which they have been removed shall be on the recommendation of the student's Dean and with the consent of the Hospital Administrator or the Executive Vice President for Health Affairs.

SECTION II
STANDARDS

Principle A -

Each patient shall be treated as a whole, irreplaceable, unique, and worthy person.

Commitment: I will recognize that patients and other customers are unique individuals, and I will be sensitive to their life experiences, circumstances and emotions when assessing needs and communicating information.

1. Individuals shall interact with patients, their families or visitors in a courteous, considerate manner that shows respect uncompromised by such factors as religion, cultural background, national origin, race, color, age, sex, disability, or socioeconomic status.

Commitment: I will use my one opportunity to make an outstanding first impression.

1.1. Individuals should address adult patients by title and surname unless permission is granted by the patient to use a more informal form of address or unless it is clearly therapeutically beneficial to do otherwise.

1.2. On entering a patient's room, individuals should acknowledge the patient by an appropriate but simple greeting, state their purpose and ask permission to enter.

Commitment: I will knock, introduce myself, state my purpose and ask permission to enter a patient's room.

1.3. Individuals should avoid interrupting or intruding on situations that patients may feel are private, such as eating, bathing, speaking with family or visitors, or resting.

1.4. Individuals shall not refer to patients by their illness, injury, diseased organ, or by any other designation that fails to regard the patient as a whole person.

1.5. Individuals shall have an obligation to be respectful of the cultural, religious, ethnic, racial, and life style diversity of patients, their community, physicians, and other providers.

1.6. Individuals shall not use abusive, obscene, derogatory, or profane language with patients, families, or visitors.

Commitment: I will use language free from obscenities, profanities, and derogatory or abusive remarks.

1.7. Individuals shall treat patient's personal belongings carefully, including a patient's medications brought with them to avoid loss or damage.

1.8. Regulations regarding visitors shall be enforced, although special visitation arrangements may be made for special patient needs, with the patient's physician or nurse.

1.9. Individuals may use physical restraint on patients consistent with Hospital or UK HealthCare policy only when a patient behaves in such a way as to constitute a danger to the patient or others. Restraint must be applied with no more force than is necessary, and the patient must be held in such a way as to minimize injury to the patient.

2. The patient shall be treated as a unique person requiring an individualized care plan and individualized treatment.

Commitment: I will value and respect our patients and other customers by honoring their perceptions, preferences and differences.

2.1. Prior to and during any encounter, individuals should assess through questioning

and observation the patient's level of understanding, anxieties, or physical

disabilities that may influence what the patient hears or needs to know.

Commitment: I will be attentive to patients' and customers' thoughts and feelings and adapt my responses to make them feel comfortable and understood regardless of their behavior.

2.2. Individuals must explain administrative, diagnostic, educational, and treatment services when they are performed in accordance with Principle D of these Standards, although patients have given general consent when they are admitted designed to cover all procedures that are not of a nature to require special consent.

2.3. Individuals shall respect a patient's questions, complaints, requests or expressions of fear, and shall address these appropriately by direct response or prompt and appropriate referral, regardless of the varying abilities of patients to express themselves or to understand explanations.

2.4. Individuals should attempt to educate rather that dictate to the patient concerning the most appropriate means of meeting the patient's needs, taking into consideration the patient's individual abilities, cultural background, and emotional state.

Commitment: I will reinforce verbal instructions and provide written explanation whenever needed.

2.5. Individuals should make every effort to provide appropriate stimulation to patients who are in isolation, aphasic, brain-damaged, sensorial impaired, developmentally or intellectually disabled, disfigured, or in any way limited in their own needs for companionship, activity, or entertainment.

Commitment: I will anticipate and be sensitive to patients and customers with special needs.

2.6. Through designated channels, appropriate individuals shall solicit the family's wishes and permission regarding the disposition of a patient's body.

Principle B - The patient's safety, health, or welfare shall be protected and shall not be subordinated to organizational, staff, educational, or research interests or to any other end.

Commitment: I will make the customer's safety, health, privacy and welfare my first priority.

Commitment: I will provide expeditious, courteous and flexible service.

Standards

1. Any individual performing educational activities beyond what is medically indicated must inform the patient of the purposes and of the patient's right to participate without any effect on the patient's treatment.

   1.1. On any specific occasion, individuals shall honor a patient's request to refuse to be examined or observed by any person carrying out educational activities other than those directly involved in rendering the patient's care.

   1.2. In all procedures that are to be learned by performing on a patient, an individual must have a person skilled in that technique present, to supervise and to protect the patient's safety and comfort.

   1.3. Continuation of educational endeavors following the death of a patient is prohibited by law. Next-of-kin may give permission for instrument procedures or other learning as part of an autopsy permit.

2. Any individual engaging in research shall be sure that patient consent is obtained on a consent form approved by the University of Kentucky Institutional Review Board, signed, witnessed, and make part of the patient's medical record before any procedure is

carried out.

Commitment: I will honor and protect individual and organizational confidentiality involving service, research and teaching activities.

3. Members of the health care team should provide services to patients in an efficient, expeditious, and coordinated manner with sufficient flexibility to demonstrate respect for an individual patient's desires, comfort, and rest.

Commitment: I will provide positive, professional and prompt responses and keep my facial expressions and tone of voice consistent with my words.

3.1. Delay, transfers, or schedule changes involving patients should be avoided wherever possible; individuals responsible for services involving delays, transfers, or schedule changes for the patient should provide a timely and appropriate explanation to the patient.

Commitment: I will explain when there is a delay, provide an estimated wait time and apologize for any inconvenience.

4. Individuals must follow all standard procedures designed with the safety of the patient in mind to protect patients against injury or infection.

Commitment: I will write legibly for safe and effective communication.

5. Individuals shall not deliberately neglect or intentionally subject a patient to unnecessary treatment, stress, or anxiety.

Commitment: I will provide helpful and caring assistance.

6. Individuals must recognize that excessive fatigue, emotional stress, and some medications may impair judgment and physical performance and may jeopardize the quality of patient care and learning activities.

6.1. No individual shall knowingly participate nor shall supervisors allow participation in patient care activities under the influence of a situation or substance that may adversely affect the individual's ability to function with adequate reason and judgment in patient care activities or jeopardize patient confidence.

6.2. An individual shall report to the individual's immediate supervisor any condition that might interfere with performing patient care responsibilities competently and safely.

6.2.1. An individual's request to be removed from the patient care environment should be respected without prejudice. The supervisor shall make a decision as to the assignment of the individual.

6.2.2. A supervisor shall request an individual to relinquish patient care responsibilities if in the supervisor's judgment, reported or observed functioning might interfere with patient's care.

7. Individuals with any illness that may adversely affect patients must report this to their immediate supervisor.

8. Individuals shall maintain neat and clean personal grooming that does not endanger the health or safety of patients and shall dress appropriately for their clinical assignment following standards and/or uniform prescribed by their unit.

9. The clinical enterprise known as UK HealthCare as a part of the University of Kentucky shall maintain a patient-centered culture in which:

9.1. Individuals are empowered to anticipate, prevent, and solve problems at the point of service.

Commitment: I will take initiative and be proactive, striving for continual process improvement.

9.2. The patient service vision and standards are clear and communicated throughout UK HealthCare.

Commitment: I will promote the services available at UK HealthCare to meet the patient care needs of the Commonwealth.

9.3. UK HealthCare dedicates resources, e.g., time, training, and reward systems, to developing individuals, the human resources of UK HealthCare.

Commitment: I will keep all public areas clean and work with my co-workers to achieve a professional environment.

9.4. All those served are represented in decision making, i.e., from the point of care to strategic planning.

9.5. Collaboration among disciplines and across organizational boundaries, i.e., the various components of UK HealthCare, is the norm.

Commitment: I will offer positive reinforcement, recognize accomplishments and provide resources.

Principle C - The privacy of the patient and the confidentiality of every case and record shall be maintained.

Commitment: I will protect privacy and health care information according to the Notice of Privacy Practices of the University of Kentucky; I will be sensitive to my patients' and customers' privacy.

Standards

1. Individuals shall conduct every discussion or consultation involving patients in a discrete and confidential manner.

1.1. Individuals shall not discuss patients in public areas.

2. Individuals who interview and examine patients shall make every effort to provide the patient with reasonable audio and visual privacy.

Commitment: I will honor patient rights to confidentiality and modesty.

2.1. The individual shall provide the patient with someone of the same gender to be present during a physical examination, treatment, or procedure, at the patient's request.

3. Only individuals with appropriate authorization (under UK HealthCare, Hospital or patient care program policy), involved in a patient's treatment or in the monitoring of its quality, are permitted to have access to a patient's record. Other individuals require the patient's written authorization.
4. Students shall have access to patient records only for a specific assignment, in a duly constituted and specific course of clerkship.
5. Individuals shall not take patient records from the patient care program premises except under subpoena.
6. Only authorized individuals are permitted to give information regarding patients to agencies as prescribed by law, to authorized family members, or to others identified in the patient's chart by authorization of the patient.

6.1. Every effort should be made to provide family members an opportunity to ask questions and receive sufficient information about a patient's condition and diagnosis within the bounds of maintaining the privacy of the patient and the patient's record.

7. At the request of the patient and/or pursuant to a physician's order, individuals shall limit

access of visitors to the patient to ensure the privacy, proper rest, or enhancement of the healing process of the patient.

8.

Principle D - Patients and/or responsible family shall be informed at all stages of care about personnel responsible for the patient's care; treatment plans and activities for the patient; facilities; services available to the patient; and responsibilities of the patient and family (referred to collectively below as "patient's care").

Commitment: I will communicate clearly so that patients and family members understand their plan of care and their role in its implementation.

Standards

1. All individuals in patient care roles or present in patient care areas are expected to identify themselves and their function clearly.
   1.1. Individuals must be able to provide appropriate identification including name, status, department, or role upon request.
   1.2. Individuals must introduce themselves to the patient in any direct encounter by name and discuss their role.
   1.3. Individuals with supervisory or coordinating roles should introduce themselves, identify their area of responsibility, and leave their name in writing, if requested by the patient.
2. Any individual providing diagnostic, preventive, or therapeutic treatment shall provide the patient and family where appropriate, with concise explanation of the procedure.

Commitment: I will create an atmosphere of trust and honesty with open communication.

   2.1. The explanation generally should include the following: (a) the purpose or why it is necessary; (b) what is expected of the patient, i.e., position, etc.; (c) what the patient might expect, i.e., pain, pressure, drowsiness, etc.; (d) approximate time involved; (e) results, only if appropriate; (f) patient's right to refuse treatment.
   2.2. Even the most routine procedure, e.g., taking temperature, drawing blood, or bathing should not proceed without prior verbal announcement of one's intentions and solicitation of the patient's cooperation as necessary.
3. Individuals shall make prompt and appropriate referrals of patient requests for information on any aspect of the patient's care if unable to provide an accurate and useful response.
   3.1. Individuals shall make prompt and appropriate referrals of patient requests for legal, spiritual, financial, or any other type of assistance.

Commitment: I will follow-up to meet patients' and customers' needs.

4. Individuals responsible for the supervision or coordination of activities in specific units shall assure that relevant and sufficient information regarding their unit and the patient's care is available to the patient.

Commitment: I will mentor and assist employees to develop exceptional skills.

Principle E - Behavior reflecting the dignity, responsibility, and service orientation of health care professionals, worthy of the public's respect and confidence, shall be practiced by all individuals.

Commitment: I will use resources wisely.
Commitment: I will demonstrate support and respect for my colleagues and handle all interactions in a professional manner.
Commitment: I will be available, never saying "that's not my job." I will be accessible, visible and easily approachable.
Commitment: I will constantly look for new or safer ways to deliver or improve the patient and family experience.
Commitment: I will constantly look for ways to improve our working environment.

Standards

1. Individuals shall recognize and observe the professional code of ethics where such exists for their particular profession or the profession for which they are in training.

Commitment: I will demonstrate integrity and professionalism at all times.

Commitment: I will comply with the University of Kentucky Ethical Principles and Code of Conduct.

2. Individuals are responsible for their actions and judgments in patient care activities.
   2.1. Individuals shall have the responsibility to question and/or to refuse to proceed with directives for patient care when in their judgment inherent danger to the patient exists.
   2.2. The team concept shall not diminish or obscure individual's responsibility or accountability in patient care activities.

Commitment: I will take action to resolve matters brought to my attention. If I am unable to resolve a matter, I will involve the appropriate person to achieve a resolution.

3. Individuals making patient care assignments shall base the assignment on the individual's competence.
5. Individuals observing or knowing of incompetent, unethical, or illegal conduct that endangers a patient's health or general welfare shall report this through established channels.

Commitment: I will be respectful, talk through issues and conflicts and address conflicts in a respectful way.

6. Individuals shall report errors or omissions in patient care activity to their immediate

supervisor.

7. Individuals documenting in official records shall ensure that all relevant information is noted, accurate, and complete.

Commitment: I will comply with the University of Kentucky Corporate Compliance Program.

Commitment: I will adhere to the University of Kentucky standards for billing and collection.

6.1. Individuals shall not make any misstatement or act of intentional omission in official records for purposes of misrepresentation.

7. Individuals shall be punctual and thorough in meeting their patient care assignments. Repeated tardiness, absence, or a consistent pattern of lack of application, unreliability, or indifference will not be tolerated.

Commitment: I will show others I value their time by assuming an appropriate sense of urgency.

8. Individuals shall not share personal problems, frustrations, or negative comments about colleagues, supervisors, or the institution with patients or their families.

9.

Commitment: I will project a positive attitude and keep my work-related or personal frustrations separate from my patient care and professional activities.

10. Individuals shall not engage in any argument or altercation in the presence of or with patients, family, or visitors.

Commitment: I will not discuss in public areas frustrations with another unit or another person.

10. Complaints from the patient or family regarding individuals and institutional services should be received in a positive manner and referred promptly to the appropriate person.
11. Individuals shall avoid inappropriate intimacy with patients.

Principle F - Each patient shall have a responsible attending physician or dentist.

Standards

1. There shall be an attending physician or dentist for each patient.
   1.1. The attending and senior resident must be known by name and face to the patient.
   1.2. The attending and/or senior resident shall inform the patient of the overall plan for care.
   1.3. The attending shall discuss with the patient and family, except in emergencies, the treatment alternatives including procedures, rationales, consequences, and significant risks of proposed treatment and alternatives and the probable duration of disability.
   1.4. The attending must discuss with other team members the management of the

patient's care, including but not limited to the transfer of patients to other providers and the selection of secondary consultations.

1.5. The attending shall be free to make known to patients all care options and treatment plans.

1.6. The attending shall visit the patient at least once a day on an inpatient basis to answer questions, to clarify the patient's care plan, and to advise the patient and family of the patient's daily progress as well as of major decisions, unless the attending and the patient agree in advance that a daily visit is not necessary.

1.7. The attending shall provide explanation for any consultations requested and give the patient a coordinated view of the patient's care as treatment progresses.

1.8. The attending shall apprise the patient that this is a teaching institution and of the involvement of various levels of health professionals in training in the patient/s care, of the benefits this has for the patient, of the importance of the patient's role in the health care team, and of the patient's rights with respect to teaching activities.

1.9. The attending shall inform the patient how questions regarding the patient's condition or treatment can be addressed and how the attending physician or dentist can be reached.

1.10. The attending shall give clear and prompt explanation to the patient at the time when professional responsibility for a patient is transferred. Attendings to whom a patient has been transferred shall visit the patient as soon as possible to identify themselves and their role.

1.11. The attending must communicate in a timely manner during the course of the patient's illness with the referring physician regarding a patient's diagnosis, treatment, progress, and well-being including a specific report at the time of discharge.

PHYSICIAN AND DENTIST COMMITMENTS

SERVICE:

Attending Commitment: I will recognize that my customers/patients' time is valuable and will make all efforts to provide my services in a timely manner and as scheduled.

Attending Commitment: I will be available for my scheduled clinical activities and avoid overlapping responsibilities that would create tardiness and delay of patient care as scheduled.

Attending Commitment: I will provide the highest standard of care to all patients, regardless of financial, social, or political status.

Attending Commitment: I will meet and follow the same standards for behavior and service that I expect from support/ancillary staff.

QUALITY:

Attending Commitment: When I recognize potential areas for improvement in quality, I will provide feedback to the appropriate manager/supervisor director in a constructive and respectful manner and assist in the process for improvement.

RESOURCES:

Attending Commitment: I will review and understand billing and coding issues and appropriate documentation pertinent to my area of practice.

Attending Commitment: I will complete my clinical tasks in a timely manner, avoiding outside interruptions (i.e., conference calls, phone interviews, internet searches), to avoid inappropriate use of staff in overtime situations.

GROWTH:

Attending Commitment: I will address and refer to all non-UK HealthCare providers and institutions with respect and in a positive manner.

HEALTH CARE COLLEGES
CODE OF STUDENT PROFESSIONAL CONDUCT
(APPROVED BY THE BOARD OF TRUSTEES)

ARTICLE 1: INTRODUCTION

A. Rationale

The credibility of a health care professional is based, to a large extent, on maintaining a high degree of trust between the professional and the individuals he or she serves. Each health profession has a code of professional conduct administered by a professional organization or regulatory agency that prescribes and imposes high standards of conduct and principles of professionalism upon its members. Students must understand and adhere to these standards during their education in preparation for careers in which they must conduct themselves in the manner expected by their profession. Consequently, students in the health care colleges have a particular obligation to conduct themselves at all times in a manner that reflects appropriate professional moral and ethical character.

This Health Care Colleges Code of Student Professional Conduct (HCC Code) provides the standards of professional conduct and procedures to be followed when questions arise about the professional moral or ethical character of a student enrolled in courses or programs, including clinical programs, in the health care colleges. For guidance in matters of interpretation of standards or propriety of conduct in this HCC Code, the professional standards and interpretations of organizations representing the professions and bodies that grant licensure or certification were consulted and considered.

B. Applicability

The purpose of the HCC Code is to provide a professional behavior code that applies uniformly to all students enrolled in a degree program, leading ultimately to a profession requiring licensure or certification, offered by any of the health care colleges ("HCC students"). The health care colleges are: Dentistry, Health Sciences, Medicine, Nursing, Pharmacy, and Public Health.

This HCC Code shall also be applicable to students in professional or clinically-related programs for which there is joint responsibility between a health care college and the graduate school. Examples of such joint responsibility programs include, but are not limited to, Masters degrees in Clinical Laboratory Sciences, Communication Disorders, Dentistry, Nursing, Physician Assistant Studies, Public Health, Radiation Sciences, and Doctoral programs in Nursing and Rehabilitation Sciences.

Article II of the revised University of Kentucky Code of Student Conduct ("UKCSC") states: "The Code does not cover decisions of the faculty of a professional school as to character, moral or ethical, required of a student for purposes of awarding a degree or certificate, or for continuation as a candidate for such degree or certificate." The jurisdiction of this HCC Code extends to the commissions of acts on- or off- campus that reflect adversely on the professional moral and ethical character of the enrolled HCC student, independent of whether or not such acts are judged to be violations of the UKCSC.

ARTICLE 2: STANDARDS

A HCC student shall be expected to adhere to accepted standards of professional practice.

All HCC students must possess the qualities of appropriate professional moral and ethical character. Each student must apply these standards to his or her academic career as well as his or her

professional career. A student's continued enrollment shall depend on the student's ability to adhere to recognized standards of professional practice and conduct. The standards are drawn from the duly legislated practice acts of the professions that have educational programs in the health care colleges of the University.

Violation of one or more of the standards shall be sufficient grounds for the dean of the appropriate health care college to initiate a review of the status of the student's continued enrollment in courses or programs of the college.

ARTICLE 3: PROHIBITED CONDUCT

This Article summarizes a representative, but non-comprehensive, list of violations of this HCC Code that are punishable, disciplinary offenses. The list includes items specific to the training programs of the health care colleges as well as those in the UKCSC. Some overlap among items is to be expected. At a minimum, health care college students shall not:

1. Commit any offenses enumerated under the UKCSC to the extent that the violation reflects adversely on the student's professional moral and ethical character;

2. Misappropriate or illegally use drugs or other pharmacologically active agents;

3. Engage in any behavior that may endanger clients, patients, or the public, including failure to carry out the appropriate or assigned duties, particularly when such failure may endanger the health or well-being of a patient or client, or treatment is dispensed without appropriate faculty supervision;

4. Engage in behavior or action that deceives, defrauds, or harms the public or the public's perception of the profession;

5. Falsify or, through negligence, make incorrect entries or failing to make essential entries in health records;

6. Deliberately deceive a patient or client through failure of the HCC student to disclose his or her student's status unequivocally to the patient;

7. Fail to maintain client or patient confidentiality including failure to follow the Health Insurance Portability and Accountability Act (HIPAA) standards;

8. Obtain any fee or compensation by fraud or misrepresentation;

9. Engage in any course of conduct, act, or omission that would be considered unprofessional conduct as a basis for discipline under the professional standards recognized by the licensing, certifying, or professional association or agency of the health care college student's intended profession for which the health care college student is in training;

10. Fail to report a felony conviction pursuant to Article 4 in this HCC Code.

ARTICLE 4: STUDENT'S OBLIGATIONS

A student who is subject to the jurisdiction of this HCC Code shall report to the dean of the applicable health care college, prior to enrollment in classes for a semester, if the student has been convicted of a felony crime. Further, during the academic year, a student shall notify the dean of any

felony conviction within ten days of such conviction. Failure to make a timely notification under this Article shall be a violation of the "Prohibited Conduct" section of this Code.

ARTICLE 5: JURISDICTION

A HCC student enrolled in a course or program in a health care college shall be subject to the jurisdiction of this HCC Code, the UKCSC, and the Selected Rules of the University Senate of the University of Kentucky (hereinafter Selected Rules). If a violation of the UKCSC and also one or both of the other above referenced codes or rules allegedly has been committed in the same set of circumstances or facts, the dean of the health care college in which the student is enrolled and the University's Dean of Students or Academic Ombud, as applicable, shall consult, investigate the circumstances at issue, and pursue the case in accordance with the appropriate procedure(s) and authorities. An investigation of an alleged academic offense (plagiarism, cheating, or the falsification or misuse of academic records) shall be conducted in accordance with the policies and procedures established in the Selected Rules of the University Senate (SR 6.0, Section VI, Student Academic Affairs). Any levy of sanctions resulting from a finding of responsibility in an academic offense shall also conform with the policies and procedures established in the Selected Rules of the University Senate (SR 6.0, Section VI, Student Academic Affairs).

A decision taken by a dean of a health care college under this HCC Code shall not preclude or be precluded by any action for which the health care college student may be liable for the same or a related offense under the UKCSC, the Selected Rules, or behavioral standards that may have been established in any specific course.

A decision taken by a dean of a health care college under this Code shall not preclude any action by legal authorities outside the University.

ARTICLE 6: ADMINISTRATIVE PROCESS AND SANCTIONS

A. Preliminary Meeting with the Dean

When a dean or authorized designee of a health care college, after an appropriate, preliminary investigation into an alleged violation of the standards, believes a HCC student has violated the standards or engaged in a violation of the HCC Code, the dean or authorized designee shall notify the student by first class mail that the student is charged with one or more specific violation(s). A student accused of violations of this HCC Code is subject to an informational meeting with the dean of the student's college or authorized designee. When a student fails to respond to proper notification of an informational meeting or fails to attend a scheduled meeting within the specified period, the dean or authorized designee may deem that the student has denied responsibility for the pending charges and refer the matter to the hearing committee chair to convene a hearing panel.

At the informational meeting with the dean or authorized designee, the accused student shall be asked to state whether he or she is "responsible" or "not responsible" for the alleged violation. The student shall not be compelled to give testimony that might tend to be incriminating and a student's refusal to do so shall not be considered evidence of guilt. Information obtained from the student during this informal meeting is confidential and inadmissible in any disciplinary hearing of the University except in cases where the student withdraws his or her admission of responsibility or refuses to comply with the sanction proposed by the dean.

When a student accepts responsibility for an alleged violation, the dean or authorized designee shall counsel the student and outline proposed disciplinary action as defined in the section on Sanctions below of this HCC Code. When a student denies responsibility for an alleged violation or withdraws

from or refuses to comply with the proposed sanction, the dean or authorized designee shall forward the reports and evidence concerning the case to the hearing committee chair to convene a hearing panel.

B. Hearing Committee and Procedures

At the beginning of each academic year, the dean of each health care college shall appoint eighteen (18) members to serve on a college hearing committee, consisting of ten (10) college faculty members, at least six (6) of whom teach in patient-care settings and none of whom has an administrative appointment in the college, and eight (8) students in good standing who have completed at least one year of their professional or clinically-related degree program requirements and whose names are among those provided by the college's Student Advisory Council or equivalent body. In those health care colleges with smaller numbers of college faculty, the dean may appoint fewer faculty members to the college hearing committee. However, a hearing panel shall be of uniform size, as prescribed below, across all health care colleges. The dean shall designate a hearing committee chair and alternate chair from among the faculty appointees. The alternate chair shall serve in the absence of the chair.

1. The chair, or alternate chair in the chair's absence, shall appoint a hearing panel with representation from the following groups among the hearing committee membership:

    a. three faculty members, at least two (2) of whom teach in a patient-care setting, and none of whom has a current academic or supervisory relationship with the student;

    b. two students.

2. The chair, or alternate chair in the chair's absence, shall:

    a. convene the hearing panel within fifteen (15) working days of the dean's receiving the student's written request for a hearing;

    b. obtain but not share the previous disciplinary record, if any, with the hearing panel before the conclusion of the hearing;

    c. conduct the hearing but not participate as a voting member of the hearing panel except to cast a tie-breaking vote;

    d. provide the dean with a report of the hearing panel's actions, findings and recommendations.

3. A meeting with at least four (4) members of the committee, excluding the chair, present shall constitute a quorum of the panel. The chair or the alternate chair must be present for the hearing panel to conduct its business.

4. The hearing committee chair shall establish procedural rules that shall ensure the orderly conduct of the panels' functions. The chair shall maintain a record of the hearing panel's proceedings and, at the appropriate time, forward the record to the University Dean of Students, who shall determine its proper disposition.

5. The standard of proof that shall be applied in all cases brought before a hearing panel is that a finding of responsibility requires that the preponderance of the evidence against the accused student in the majority opinion of a panel warrants the finding. The burden of proof in disciplinary cases rests with the college that initiated the investigation.

6. A student shall be guaranteed the following rights in all proceedings of a hearing panel:

a. The student shall have the right to a fair and impartial hearing in all proceedings of any hearing panel.

b. The student shall not be compelled to give testimony and refusal to do so shall not be considered evidence of responsibility for an alleged violation.

c. The student shall be informed in writing of the reasons for appearance before any hearing panel and given sufficient time to prepare for the appearance.

d. The student shall be entitled to receive, upon written request, a copy of all rules and procedures governing the hearing panel within a reasonable time prior to appearance before the panel.

e. The student shall have the right to hear and question all witnesses and present witnesses of the student's choice.

f. The student may be present, if he or she desires, to listen to all individuals called by the Committee as part of its proceedings. One advisor of the student's choosing may attend the hearing and assist the student. The advisor may be an attorney. The role of the advisor shall be limited to providing advice to the accused student. Even if accompanied by an advisor, an accused student shall personally respond to inquiries from the hearing panel chair or panel members. In consideration of the limited role of an advisor, and of the compelling interest of the college to seek an expeditious conclusion to the matter, a panel hearing shall not, as a general practice, be delayed due to the unavailability of an advisor.

g. The student may request that any member of a hearing panel be disqualified on the ground of personal bias. The hearing officer shall make the determination either to retain or to disqualify the member.

h. The student shall have access to the record of the hearing.

i. The student shall be notified by the chair of hearing panel's composition with sufficient time before the date of the hearing to permit the student to identify any member of the panel who in the opinion of the student has a conflict of interest and recommend the member be recused. The chair shall have the authority to exclude any hearing panel member whom the chair determines has a conflict of interest or the appearance of a conflict of interest in a case.

7. The hearing may be open or closed, according to the accused student's choice as specified in the student's request for a hearing.

8. The hearing panel shall reconvene in a supplemental proceeding, not attended by the student or his or her advisor, to discuss and determine whether or not a violation of this HCC Code has occurred and if so, to recommend sanction(s). The college's Office of Student Affairs or equivalent shall obtain past records of offenses from the University Registrar and the Dean of Students. The information obtained shall be shared with the hearing panel, if the student is found responsible for a violation of this HCC Code. Both the accused and the complainant may submit relevant evidence or make relevant statements regarding the appropriateness of a specific sanction.

9. The hearing panel's meeting(s), but not the supplemental proceedings, shall be recorded.

10. The student shall enjoy all other rights specified at the time of notification of charges, cited above.

C. Reporting Procedures

Written correspondence is the preferred form of formal communication between a hearing panel and other parties participating in a case. Informal email correspondence among members of a hearing panel or between hearing panel members and other involved parties regarding a case under consideration is discouraged.

D. Hearing Committee Report

At the conclusion of its deliberations, the hearing panel shall provide a written report to the dean within seven (7) working days that summarizes whether or not a violation of the standards has occurred. If the hearing panel determines that a violation has occurred, it shall recommend an appropriate sanction to the dean in its written report. If the hearing panel determines that insufficient evidence exists to conclude that a violation of the standards has occurred, it shall also notify the dean in writing of this finding.

E. Role of the Dean

The dean shall accept and shall not reverse the determination of the Hearing Committee as to whether or not a violation of the standards occurred. The dean may impose a sanction that is less than, the same as, or greater than that recommended by the Committee. The dean shall notify the student in writing by first class mail of the decision within seven (7) working days following the receipt of the Committee's report. The dean shall also inform the hearing committee chair. The dean's decision shall be final unless appealed by the student.

F. Sanctions

All disciplinary sanctions imposed upon students are cumulative in nature. All prior disciplinary actions noted in a student's file may be used in the punishment phase of subsequent cases of code violations committed by that student and may result in more severe consequences than would otherwise have been the case. A student's disciplinary record shall be housed in the Office of the Dean of Students.

Sanctions imposed by a dean for violation(s) under this Code shall include one or more of the following:

1. a written warning, including statements on expectations for future professional conduct and consequences if a subsequent violation of the HCC Code occurs;

2. a requirement that the student consent to sanctions such as, but not limited to, restriction of access to specific areas of campus, monetary reimbursement, public or community service, research projects, compulsory attendance at education programs, compulsory psychiatric or psychological evaluation and counseling, such as alcohol and drug counseling;

3. suspension from the college or suspension from that college's courses or programs for a defined period;

4. dismissal from the college with possible readmission under conditions specified at the time of dismissal and with specified approval of the appropriate college committee and dean at the time of readmission; and

5. termination as a student or candidate for professional degree or certificate without the possibility of readmission to that college.

ARTICLE 7: APPEAL

A. A student who is found responsible for a violation of this HCC Code and is sanctioned with suspension, dismissal or termination from the health care college in which the student is enrolled may appeal in writing to the chair of the HCC Code Appeals Board (herein HCCCAB). The written appeal shall be submitted to the chair or postmarked, if mailed to the chair, within ten (10) days of the receipt of the decision rendered by the college dean.

The written appeal shall clearly state the reason(s) for appeal. Acceptable reasons for an appeal are an assertion and evidence that:

1. Due process rights have been violated through the HCC Code hearing process;

2. The sanction is inappropriate for the infraction for which the student was found responsible; or

3. There is information that was unavailable at the time of the original hearing which would alter the determination of responsibility, or which would alter the sanction.

B. Health Care College Code Appeals Board

1. Jurisdiction

The HCCCAB shall hold appellate jurisdiction over student matters involving alleged violations of the HCC Code, except that if the HCCCAB hearing panel, by majority of those present, decides the student's rights have been substantially violated, the HCCCAB hearing panel has original jurisdiction on the issue of responsibility.

2. Composition of the Health Care College Code Appeals Board

a. The HCCCAB shall consist of twenty-five (25) members from the health care colleges, comprised of fifteen (15) faculty members, at least ten (10) of whom teach in patient-care settings and none of whom has an administrative appointment in the college, and ten (10) students in good standing who have completed at least one year of their professional or clinically-related degree requirements and whose names are among those provided by the Student Advisory Council or equivalent body in each of the six health care colleges, and a hearing officer who shall be the chair.

b. A hearing panel of the HCCCAB shall consist of nine (9) members, at least five (5) of whom are faculty members, at least one (1) of whom is a student, and a hearing officer, who shall be the chair. No member of an HCCCAB hearing panel may serve on the college hearing panel and the HCCCAB hearing panel in the same case.

c. A quorum of the hearing panel for the conduct of business shall be seven (7) members. A quorum shall include at least five (5) faculty members (exclusive of the hearing officer) and at least one (1) student. The hearing officer must be present for the hearing panel to conduct its business.

3. Appointments to the Health Care College Code Appeals Board

a. The Hearing Officer

The hearing officer shall be the chair of the hearing panel and shall be a person with training in the law appointed by the Provost for a three-year term, subject to reappointment. The term shall begin on September 1, and end August 31. If possible, a hearing officer shall preside in a case(s) that extends beyond the hearing officer's service until the case is concluded. Similarly, the hearing panel members shall be asked to continue on cases that extend beyond their terms of service whenever feasible. The hearing officer shall establish a written set of procedures for the conduct of HCCCAB hearings, which is consistent with the policies enumerated in Article I, Section 7 of the UKCSC. The hearing officer shall convene and preside at all meetings of the hearing panel, but does not vote as a member of the hearing panel except to cast a tie-breaking vote. All questions of the law, either substantive or procedural, and all procedural questions shall be addressed to and ruled upon by the hearing officer.

The student appellant may request that any member of a hearing panel be disqualified on the ground of personal bias. The hearing officer shall make the determination either to retain or to disqualify the member.

b. The Student Members

(i) The student membership of the HCCCAB shall be appointed to one-year terms, subject to reappointment. Their terms shall begin May 1 and end April 30.

(ii) The student membership shall consist of eight (8) professional students and two (2) graduate students in clinically-related programs. The student members must be full-time students currently enrolled in a health care college, have been in residence at least one year and be in good academic and disciplinary standing.

(iii) The Provost shall appoint ten (10) student members to the HCCCAB from the recommendations submitted by the Student Advisory Council or equivalent body in each of the six health care colleges. At least three (3) names shall be submitted from each of the six (6) health care colleges, and the preponderance of the names submitted shall be those of professional students.

c. The Faculty Members

Faculty members of the HCCCAB shall be appointed to staggered three-year terms by the Provost upon the recommendation of the Senate Council. All terms shall begin on September 1 and end on August 31. To minimize the possibility of a conflict of interest, faculty members with primary administrative appointments (more than fifty percent of their assignment allotted to administration) shall not be appointed to the HCCCAB.

4. Temporary Appointments

a. If a sufficient number of the members of the HCCCAB are not available or have been determined by the hearing officer to have a conflict of interest or the appearance of a conflict of interest at any time when that Board has duties to perform, the Provost or, in the Provost's absence, the Executive Vice President for Health Affairs, shall make such temporary appointments as are necessary to ensure that the required number of members are present. Such temporary appointments need not be preceded by the recommendations otherwise provided herein. However, in no case shall a faculty member replace a student member or a student member replace a faculty member.

b. If, at any time, in the judgment of the hearing officer, there are sufficient cases pending before HCCCAB that it is unlikely that the pending cases can be processed within the time prescribed, the hearing officer shall notify the Provost of that fact. The Provost may, in accordance with the above provisions of the HCC Code, activate additional boards and appoint a hearing officer for each such additional board, or appoint additional boards and hearing officers for designated cases and time periods.

c. The authority, jurisdiction, and range of possible actions of, and the guaranteed rights of an accused person before any special board or panel appointed or activated under the terms of (a) or (b) above shall be the same as those applicable to the regularly constituted board or panel.

5. Disposition of Cases – Authority

The HCCAB shall render a prompt decision after receipt of the appeal. The HCCAB may uphold the decision of the dean or modify the decision by reducing or increasing the level of sanctions imposed or modifying any terms and conditions of the initial sanctions. The imposition of sanctions shall be deferred during the review unless, in the discretion of the Vice President for Student Affairs or authorized designee, the continued presence of the student on the campus poses a substantial threat to himself or herself, or to others, or to the stability and continuance of normal University functions. Decisions of the HCCCAB are final.

ARTICLE 8: DISCIPLINARY FILES AND RECORDS

The record of disciplinary cases shall be maintained in the Office of the Dean of Students

The file of a HHC student charged with or found responsible for any violations of this Code shall be retained as a disciplinary record for seven (7) years following the incident or five (5) years after the last semester enrolled, whichever is longer.

ARTICLE 9: AMENDMENT OF THE HEALTH CARE COLLEGES CODE OF STUDENT PROFESSIONAL CONDUCT

The Health Care Colleges Code of Student Professional Conduct shall be amended only by the Board of Trustees. Responsibility for proposing revisions to the HCC Code is delegated to a committee

consisting of students, faculty and administrators from the health care colleges. The exact composition and procedure of the committee shall be determined by the President of the University. The Committee shall accept and review recommendations from students, faculty and administrators regarding revisions of the HCC Code. The Committee shall prepare proposed revisions, and after consultation with the University Senate, forward them to the President for approval and, after approval, for presentation to the Board of Trustees for its consideration.

Nothing included above shall be construed as a limitation upon the President to propose changes without reference to the Committee.

Cellular Phone/Pager Protocol

Student dentists have an option to be issued University pagers or use personal cell phones. Cell phones and pagers are used during school hours as well as after hours. This protocol will provide the following benefits:

1. Faculty, residents, staff and other student dentists will have communication with student dentists during clinical and non-clinical hours regarding patient care issues.

2. Cellular Phones/Pagers provide a mechanism for student dentists to fulfill their ethical and professional responsibilities for patient care as part of their training and preparation to be responsive and responsible practitioners upon graduation.

3. Cellular Phones/Pagers provide an additional contact mechanism to the UK Alert System in the event of an emergency response.

The expectation is that each student dentist will respond to his/her cell phone or his/her pager from 7am to 7pm Monday – Friday. **It is expected that the student dentist will have their cell phone or pager turned on and respond quickly when communication from clinic administration is received.** Failure to comply with the Cell Phone/Pager protocol is outlined in the Management Syllabi (CDS 823, CDS 833, CDS 843) under Professional Behavior. Phones/Pagers should not be kept in purse, backpack, locker or other areas where they will not be heard or vibrations felt.

PAGERS SHOULD BE WORN ON WAISTBAND or IN POCKET. NOT RESPONDING TO PHONE/PAGER is a SIGNIFICANT VIOLATION (see Professional Behavior Patient Management Form)

Information for patients: Student dentists should inform their patients that pager numbers can be used for emergency purposes. Patients should be instructed to dial the pager number directly just like a phone number and enter a return contact number where he/she can be reached. Most patients will attempt to contact a provider generally 2-3 hours after the completion of a procedure if there seems to be a problem. Keeping the pager on until 7pm will generally be an acceptable time frame unless you are expecting a call from a patient or know that an unusually difficult treatment appointment had occurred on a given day.

Text messaging is an option with these pagers by accessing www.usamobility.com. The pager guide may also be found at that website.

Lost/Stolen Pagers- there is a $40 charge for each device reported as lost/stolen.

Damaged pagers must be returned to Ms. Diane McCord D232 and another pager will be activated with the same pager number as the damaged one. Note: There is no charge for a damaged pager unless it is not returned. 4th year student dentists must return these pagers to Ms. Diane McCord D232 as part of the check-out process for graduation.

Please keep pagers on silent alert when in clinic and class. *Good patient management allows a mechanism for patients to contact providers in the event of an emergency.*

CLINICAL DRESS AND PROFESSIONAL APPEARANCE STANDARDS

The University Of Kentucky College Of Dentistry supports the philosophy and expectation that all student dentists, faculty, and staff (dental hygienists, dental assistants, and dispensary personnel) will wear clothing in clinic and reception areas that conveys a professional image to patients and peers. In addition, the three groups must maintain high standards of personal appearance and hygiene befitting their roles and responsibilities in the clinics. University policies govern the standards of dress for employees in other settings.

Information regarding this policy will be provided to student dentists, faculty, and staff during the Clinic Orientation.

The following policies, although not inclusive, will be adhered to by student dentists, faculty, and staff in clinic and reception areas:

1. Surgical Gowns - In compliance with OSHA guidelines, persons are expected to wear surgical gowns when providing patient care. The gowns will be secured in back and tied at the neck to insure that shirt/blouse collars, sweater, or other parts of the clothing being worn are not exposed.

2. Scrubs - Persons in the clinic are encouraged to wear scrub tops under their surgical gowns. An optional combination of scrub tops and bottoms may be worn. For appearance's sake, student dentists, faculty, and staff are also encouraged, but not required, to wear clinic coats over scrubs when leaving the College to enter the Medical Center. However, clinic coats are not permitted outside of the Medical Center complex.

3. General - All personnel are expected to arrive at the clinic with a clean and neat appearance. Clothing must be in good condition and appropriate to the setting. Hair styles, jewelry, and cosmetics which may not be proper in the clinic must be avoided. Jewelry with stones or facets should not be worn as these may cause breaks in glove surface. Fingernails should be short and no artificial nails should be worn.

   Hair must be clean and well-maintained for reasons of hygiene and safety to insure that it is not in the patient's face when care is provided. Hair should not block provider's view and should be pulled back if necessary to keep field of vision clear. Denim jeans pants, shorts, sweat clothing, open-toed shoes and jogging outfits are unacceptable attire in the clinic. Shoulders must be covered. Leather shoes will be worn with skirts, dresses, or slacks. Personnel may wear clean tennis shoes with their scrub tops and bottoms. Socks or hose must be worn with leather shoes. If shirts or blouses are worn under the surgical gown, they must be tucked into slacks or skirts. T-shirts may not be worn in the clinic unless under scrub tops. Men are expected to be either clean-shaven or have facial hair that is well-maintained to convey a professional appearance. Student dentists must have access to a change of clothing for unscheduled times when they are called into the clinic to see patients on an emergency basis. Student dentists who are not treating patients are still permitted to enter the clinic or reception areas to speak with dispensary or scheduling personnel even if their dress does not comply with the College's policy. However, their visits should be brief because they do not meet the recognized standard of dress. The Clinical Dress and Professional Appearance Policy will apply whenever care is provided to patients. If the student dentist, faculty, or staff member's dress or appearance inconsistent with this policy, he/she will be notified immediately by the individual's Team Leader,

patient care administrator, or supervisor. The person will be told of the alleged infraction and will be asked to remedy the problem. The Team Leader, patient care administrator, or supervisor may excuse the student dentist, faculty, or staff member from the clinic until the policy violation is corrected.

If the person in question's appearance continues to be unacceptable, he/she will not be allowed to participate in clinical activities.

This policy is designed to provide a reasonable standard of dress and appearance appropriate for College of Dentistry personnel in clinic and waiting areas. At the same time, every effort will be made to accommodate individual tastes. Anyone wishing to appeal an alleged violation of the Clinical Dress and Professional Appearance Policy should be referred to the Dean of the College, or the Dean's designee.

ATTENDANCE POLICY

Attendance is mandatory for all clinical orientations, clinics, alternate clinic activities, seminars, rotations, CPR, clinical safety sessions and clinical conferences. Tardiness will not be tolerated. **If a student will be absent from clinic due to a sudden illness, they should notify Student Affairs office, his/her Team Coordinator and Team Leader.** Every effort should be made by the student to also notify his/her patient and to alert his/her Team Leader and Coordinator of patient desires (to be rescheduled or to see an alternate student that day).

In case of patient cancellations or no appointed patient, students should first see Team Leader or Team Coordinator for alternative assignment such as supporting urgent care clinic, OMFS clinic, assisting a classmate or treating a patient for an absent classmate.

STUDENTS ARE NOT ALLOWED TO LEAVE CLINIC WITHOUT PERMISSION. If permission is granted to work on lab work or go to library, CELL PHONE OR PAGER MUST REMAIN ON and WORN so that contacting the student is possible.

Unexcused clinical absences are unacceptable even if no patient scheduled. If unexcused absences occur, professionalism grades in clinical courses will be reduced and repeated violations will likely result in disciplinary action and in some cases course failure with further consequences.

Chronic issues of missed clinic sessions, even if excused for illness, will require consultation with Team Leader and Course Director. A medical consultation and physician notes may be required. Missed sessions may need to be made up either during breaks or after the semester ends. If determined that abuse of the attendance policy has occurred, a lower management grade or possible course failure may occur.

Professional Behavior – Patient Management

Grade reflects attendance in all required activities that support the clinical operation. These activities include participation in clinical safety seminars, clinical conferences, immunization updates as well as exercising all established protocol in the clinical setting. Student dentists who are not compliant with providing supporting documentation of current TB and Hepatitis immunization records will not be permitted to be in clinic until resolved. Students are expected to perform in a professional manner as outlined in the Clinic Manual and Course Syllabus. All deficiencies in this area will be communicated to the student and documented on a Professional Behavior/Management Incident Report (See Attachment III). Examples of Deficiencies and

Critical Deficiencies as well as point deductions are listed below:

Each deficiency results in 8 points being deducted from the Professional Behavior grade.

Examples of Deficiencies are: (but not limited to these)

1. Not responding to phone call, voicemail, text, verbal or electronic from Team Coordinator, Team Leader or any other clinical faculty or clinical staff member. Depleted batteries are not excusable. Fresh batteries are available from the Dispensary Windows on 2nd and 3rd floors in the clinic
2. Infection control violation. (Including but not limited to all items on Clinic Citation)
3. Requesting frequent appointment changes from Team Coordinator.
4. Failure to clean, disinfect and set-up operatory after patient appointment.
5. Failure to enter treatment into computer resulting in Missing Charge (AxiUm)
6. Violation of clinical dress and professional appearance policy.

Each critical deficiency subtracts 24 points from the Professional Behavior grade.

Examples of Critical Deficiencies are: (but not limited to these)

1. Chronic violation of any of the above.
2. Beginning patient treatment before faculty approval
3. Initiated treatment without informed consent.
4. Dismissing patient before faculty evaluation/approval
5. Initiating treatment without Informed Consent
6. Unexcused absence from clinic, clinical conference or seminars
7. Abuse of scheduling privileges.
8. Transfer of patient without permission of Team Leader or other faculty
9. HIPAA violation

Professional Behavior/Management Deficiency

Student Name _____ Team_____ Date_____

Behavioral/Management Incidents:- 8 points

__ Not responding to cellphone call, voicemail, text, overhead page from Team Coordinator, TL or other clinical staff or faculty member

__ Infection control violation (including but not limited to all items listed on the Clinical Citation cards)

__ Requesting frequent appointment changes from Team Coordinator

__ Lack of preparation for patient appointment. i.e. set-up, knowledge of procedure, etc.

__ Failure to clean, disinfect and set-up operatory after patient appointment

__ Failure to enter treatment and/or progress notes into computer.

Missing charges report will be generated daily, and recorded. If unusual circumstances exist, the student dentist must discuss with Team Coordinator and/or Team Leader for rapid resolution of missing charges. **ALL NOTES AND TX CODES MUST BE ENTERED BY END OF DAY.**

__ Dress code violation

__ Other: _____

_____

Critical Behavioral/Management Incidents:- 24 points

__ Chronic violation of any of the above Behavioral/Management Incidents (>3 incidents)

__ Beginning patient treatment before Start-Check/Faculty approval

__ Dismissing patient before faculty evaluation/approval

__ Initiated treatment without informed consent

__ Unexcused absence from clinic, clinical conferences, chart audits or seminars

__ Abuse of scheduling privileges. (e.g. Cancelling/Scheduling patient appointments without notifying Team Coordinator and/or Team Leader of the change or of your availability when cancellations occur.) It is a major violation to knowingly schedule a patient when no real appointment is planned (phantom appointment).

__ Transfer of patient without permission of Team Leader or other faculty

__ HIPAA violation

__ Other: _____

FACULTY SIGNATURE_____

University of Kentucky College of Dentistry		Policy: 06-06
Policy Name: Operations During Official University Holiday		
Created: 9/23/2008	Revised: 07/13/2009	Effective Date:
Purpose: To outline the process by which departments and/or clinical areas have the opportunity to request to remain open during recognized University holidays.		

Generally, the College of Dentistry observes all official University holidays providing faculty and staff official leave with pay. However, certain clinical and college operations may need to remain open for services during official University Holidays. Therefore, this policy outlines the procedure for requesting approval to remain open. This policy is consistent with University of Kentucky HR Policy 83.0 (Holiday Leave) which states the following:

- The University recognizes certain holidays by closing of all departments and offices except where continuous service is essential.
- When an employee is required to work or is normally off on any University holiday, equivalent time-off with pay shall be granted on another scheduled work day, within a specified period of six weeks, at the convenience of the department. Departments with special scheduling and staffing problems may extend this period with the approval of the department head and the Human Resources Office of Employee Relations.

The policy offers operational flexibility to College's clinics and operations that need to provide appropriate intervals for service and care of patients. Certain clinics of the College have functions that are associated with other health care services within the University and the community at large. Essential services for the College may be defined by the need to provide standard of care surgical follow-up of patients and or timely and appropriate patient access for emergent or urgent treatment or diagnosis of potential malignancies.

Clinics or operations seeking approval to operate during official University holidays must submit a written request to the Dean (or her designee) prior to the start of the academic year (special exceptions may be granted for unanticipated holidays or major changes in operations). Previously approved plans that have not changed do not have to be resubmitted annually. Written requests should include the following information:

- Why it is necessary for the clinic or operation to provide continuous service;
- How will you maintain the appropriate support structure for minimal operations;
- How are staff selected to work (i.e., are all required to work or do you have a voluntary process for determining); and,
- How will you provide equivalent time off to staff within a six week period of time without hindering operations.

IMPORTANT NOTES FOR STUDENT DENTISTS

THEFT OF UNIVERSITY AND STUDENT PERSONAL PROPERTY OR EQUIPMENT:

There is an ever increasing problem of theft of property and equipment from the College as well as from student dentist's lockers and cubicles.

If anyone is caught stealing, the University of Kentucky may press charges and prosecute that individual. If a student dentist is convicted of such a crime, there is little possibility that that person will be able to obtain a dental license in Kentucky or in other states. Many student dentists do not seem to be aware of the fact that a dental license will generally be denied them under these circumstances.

BORROWING DENTAL SCHOOL EQUIPMENT AND SUPPLIES:

Frequently, a student dentist will borrow equipment or supplies from Facility Maintenance or the second or third floor dispensaries. All equipment and supplies should be returned at the end of each clinic period or as soon as the student dentist is finished with it. If any equipment or supplies are not returned within 48 hours then no further instruments will be issued until the missing supplies are returned. (the exception may be impression trays and bite forks if the laboratory requires the impression and tray to be submitted). In that situation, students will have 5-6 weeks to return those trays.

Any items borrowed from Central Sterilization or the 2nd and 3rd floor dispensaries are scanned out to the student using Axium. It is the responsibility of the student to watch the monitor when returning items to see that the instruments/handpieces/cassettes are scanned back into Axium and removed from being checked out to the student.

RELEASE OF DENTAL RECORDS:

The College of Dentistry receives many requests from patients or their representatives for dental charts, dental radiographs and other information regarding the patient's dental status and/or treatment needs.

Patient records are considered confidential and no UK College of Dentistry personnel or departments are authorized to release these materials to patients, their representatives, or organizations. Requests for the above materials must be forwarded to Dental Records for appropriate action. Students should escort the patient directly to Dental Records for appropriate release forms for copies of the record and its contents. Inform the patient records are usually mailed to the address submitted on the release form and that Dental Records has 30 days to copy and mail the records although it will usually not take that long.

PATIENT RECORDS:

By UK HealthCare Behavioral Standards, students are authorized to access records of assigned patients. Through institutional policies, it is not permissible to access one's own record. The section above details proper procedures for obtaining a copy of your dental record.

CLINIC AND LABORATORY HOURS:

The 2nd floor clinic is closed to student activity from 9 PM until 7 AM daily. The 3rd floor will remain open. It is expected that most pre-clinical activity will be done in D-611. Should you work in an operatory which has already been disinfected, you will be responsible for disinfecting the operatory at the conclusion of your pre-clinical activity. In addition, adherence to the clinical dress and professional dress policy is required on Thursday evenings when Twilight Dental Clinics for Kids begins at 5:30.

PERSONAL MATERIAL:

No personal material will be displayed in the clinic operatories at any time. Examples of personal items are photos, posters, drawings, diagrams and personal memorabilia. Jackets and backpacks should be stored in the coat closet.

CELL PHONES and PAGERS:

Cell phones and pagers should be placed on "vibrate" during patient care hours.

PATIENT LABORATORY TESTS:

Patients requiring laboratory tests will be referred to the UK Hospital laboratories or the Veteran's Administration Hospital if appropriate. UK College of Dentistry student dentists are requested to observe the following guidelines:

1. Obtain the appropriate laboratory test requisition form from an O.D. instructor.
2. Complete the form as indicated.
3. All patients must register in the Admitting Office on the first floor of University Hospital.
4. Admitting Office Personnel will direct the patient to the Outpatient/Clinical Laboratory for tests.

If you have any questions about the above procedures or ordering tests, please consult an Oral Diagnosis instructor.

END OF YEAR CHECK-OUT:

All student dentists are required to go through the check-out process at the end of the academic year. This procedure is NOT OPTIONAL.

At the end of the spring semester, all graduating seniors MUST vacate all assigned locker spaces (clinical, student lounge, 6th floor and drawer in D611). Failure to do so could result in theft of equipment in which the College will assume no responsibility. Third year students/ new fourth year students MUST vacate their drawer in D611 before leaving for the summer.

July 1, 2011

2011 Social Media Guidelines

UK HealthCare recognizes the impact of social media websites like Facebook, Twitter and MySpace on our workforce. Our expectation is that faculty, trainees, students and employees know what is expected in our environment of health care and observe our policies on behavioral standards, patient privacy, use of personal electronic devices and hospital resources. Patient privacy is vitally important to us. We train regularly on our obligations related to privacy and security matters (HIPAA). Recent changes to the HIPAA rules require us to notify the federal government when patient privacy has been violated.

Below are some expectations when using social media sites.

Expectations:

- Do not "friend" patients
- Do not accept "friend requests" from patients or their family members
- Never share any patient information via Facebook or other social media
- Never post pictures of patients or pose with patients for pictures
- Never give medical advice via social media

Frequently asked questions:

Please view our Social Media Guidance 2011 FAQ for further information on UK HealthCare's social media guidelines. (See next page)

Summary:

Incidental and occasional use of Internet and Web resources are permissible, but personal use should not adversely affect the responsibilities/productivity of any employee; nor should it detract from the professional perception of the work environment. Use discretion when posting on social media sites; remember this is public information that can be viewed by the public and our patients. Your supervisor has the responsibility to determine excessive usage or negative impact of assigned responsibilities. The supervisor will determine if access should be revoked and any disciplinary action if warranted.

Reference:

HP08-01 Behavioral Standards
http://www.hosp.uky.edu/policies/viewpolicy.asp?PolicyID=897

HP01-12 Confidentiality
http://www.hosp.uky.edu/policies/viewpolicy.asp?PolicyID=779

A09-040 Use of Portable Personal Electronic Devices
http://www.hosp.uky.edu/policies/viewpolicy.asp?PolicyID=3368

UK HealthCare
Office of Corporate Compliance

Social Media Guidance

What do you mean by social media?
Social media can include any media that allows a person to socialize electronically. Some examples of social media include MySpace, Facebook, Twitter, text messaging, emailing, Google, LinkedIn, and similar communication tools.

Why do we need guidance on using social media?
The presence of social media in the workplace necessitates some reflection on the possible implications for patient privacy. The guidance is provided, as are these FAQ's, to help members of the UK HealthCare workforce make wise decisions regarding the use of social media and to ensure the privacy of our patients.

Why shouldn't I accept a friend request from a patient?
Your relationship to the patient is professional in nature, as the patient's caregiver, and should not cross over into your social circle.

What if I was already friends with the patient before I became the patient's caregiver?
It is appropriate to remain friends with the patient, but you should refrain from discussing anything regarding the patient or the patient's care via social media.

My patient is a juvenile and the mother sent me a friend request. Can I be friends with her?
No, it is not appropriate to accept a friend request from a family member of a patient in your care. If you were already friends with a family member of the patient prior to assuming care of the patient, you may remain friends with the family member but may not discuss the patient and/or the patient's treatment or care.

Why shouldn't I take pictures of my patients, or pose in pictures with them?
A photo graph of the patient represented protected health information that is not related to the treatment or care of the patient. Therefore, it is not appropriate to participate in this activity.

How could a simple comment become a violation of patient privacy?
One comment from you as caregiver might not contain identifying information, but the people who post in response after you might provide additional seemingly harmless pieces of information, all of which could add up to creating a privacy violation. For example, if you say "The Smiths are great people," and your friend adds "I hate that little Johnny has a broken leg," you've collectively identified John Smith as a patient, as well as a diagnosis.
updated – 7/7/11_JT

Section 2

Patient Management

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University of Kentucky

College of Dentistry

PATIENT RIGHTS and RESPONSIBILITIES

You have the right to:

- Considerate, respectful and confidential treatment
- Continuity and completion of treatment
- Access to complete and accurate information about your condition
- Advance knowledge of the cost of treatment, explanation of your treatment fees and informed consent to treatment
- Explanation of recommended treatment, treatment alternatives, the option to refuse treatment, the risk of no treatment and expected outcomes of treatment
- Emergency, incremental and total patient care
- Treatment that meets the standards of care in the profession
- Access to a patient advocate

Your responsibilities include:

- Providing accurate and complete information about your medical history
- Questioning treatment or instructions you do not understand
- Keeping scheduled appointments and providing at least 48 hours' notice if you need to cancel appointments
- Providing information about payment for services and working with the College of Dentistry to ensure that financial obligations are met

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TEAM CONCEPT FOR PATIENT CARE PROGRAM

The College of Dentistry Patient Care Program is founded on the principle of comprehensive care in an atmosphere that simulates the practice environment. Decisions related to the patient care program are guided by the College Mission and Goals. The College's commitment to comprehensive care as preparation to enter the profession is one of the major strengths of the College of Dentistry. The College continues to emphasize integrated diagnostic sciences and coordinated treatment planning with consultation from all specialties. Changes intended to strengthen patient care in all clinics are continuously introduced. Overall responsibility for the patient care program is vested in the Assistant Dean for Pre-doctoral Clinical Operations and the Team Leaders who meet twice monthly to discuss and make recommendations regarding patient care policies and other issues. In addition, the Assistant Dean for Pre-doctoral Clinical Operations along with Team Leaders and student representatives, meet three to four times per year or as often as necessary as a Student Clinic Advisory Committee. Student dentists are encouraged to talk with the classmates and bring constructive criticism to the meeting. After discussion, follow-up action is taken when possible. Students also offer compliments about protocols and specific staff members. These compliments are passed on to the appropriate staff members by the Assistant Dean for Pre-doctoral Clinical Operations, the Associate Dean for Clinical Affairs and the Dean. The committee composition is one student from each class year for each Team. These meetings have provided valuable insights regarding policy and operations and have effected many improvements.

The College has established four vertical student teams comprised of second, third and fourth year students as the basic organizational unit for its clinic operations. This team experience is supplemented by various rotations in specialty clinics. Each team is composed of approximately 13-17 students in each year of clinical education and is supervised by an attending faculty member (Team Leader) who, with staff assistance (Team Coordinator), assures that students have the opportunity to acquire and demonstrate clinical competence and that patient care and the coordination of this care is of the highest quality, provided in a timely manner, with appropriate sequencing. The strength of this method of clinic administration is that it affords one-on-one-on-one contact between student, patient and faculty, with faculty familiarity with both student and patient needs as well as the ability to identify strengths and weaknesses of students in a timely fashion.

Patients are assigned to the Team Leader who delegates responsibility for their care to individual students in the team. The Team Leader manages patient care from preadmission through treatment and into the recall system (Maintenance phase). A Team Coordinator assists each Team Leader and, among other responsibilities, helps to manage appointment scheduling and confirmation. Daily instruction is provided by faculty from the various clinical disciplines. Final course evaluation for each clinical discipline is assigned by a course director (refer to appropriate course syllabi for details). Management courses in years one, two, three and four include a clinical management component evaluated by the Team Leaders. Student dentists are required to attend all clinic sessions to which they have been assigned. Team Leaders manage alternative clinical activities for students should patient failures and cancellations occur.

The Team concept allows for comprehensive care of the individual patient within the Team or Group practice setting. For example, a fourth year student may develop the treatment plan with input from the faculty. The Team Leader may co-assign the patient so that the second year student provides the preventive procedures such as a prophylaxis and perhaps some simple restorative, but the fourth year student would provide the surveyed crowns and partial denture treatment.

Comprehensive patient learning experiences are supplemented with clinical rotations in Oral and Maxillofacial Surgery, Pediatric Dentistry, Oro-Facial Pain Clinic, OR/GPR rotation, Dental Auxiliary Utilization and the Urgent Care Clinic. These clinical experiences are also organized into and categorized as clinical courses. The College has always had a commitment to a patient care program based on a treatment philosophy of comprehensive dental care. All patients are given the opportunity to participate in comprehensive dental care. The preadmission appointment establishes the patient's needs and desires. The patient is informed of treatment needs and is encouraged to participate in decisions regarding treatment. Since the expectation of the system is that students will provide quality comprehensive dental care for their patients, incomplete dental care should not occur. The attending relationship assumed by Team Leaders eliminates fragmentation of dental care. Patient surveys indicate that they are well informed about institutional policies and procedures and understand their rights. Written policies describing the patient care programs are found in Behavioral Standards in Patient Care and Dental Services. At the preadmission examination appointment, patients receive printed material describing the College's Patient Care Program and policies. The preadmission examination appointment provides an opportunity to discuss patient care services available at the College.

Treatment plans are generally developed in phases: Emergency or Preliminary treatment, Phase I or Disease Control, Phase II more advanced restorative, orthodontic or other treatment and finally the Maintenance phase for periodic recall and established preventive services. At the end of each phase of treatment, a phase evaluation is completed to ensure the completion, quality and delivery of treatment in each phase. Upon completion of the comprehensive treatment plan, the completion, quality and delivery of care are evaluated through chart review and completion of the Treatment Evaluation Form. Cumulative data is collected through our computer information services and reviewed on a semester by semester basis to assure comprehensive care, completion of care and recall.

The Team Concept has proved valuable in the overall operation of the clinical program at the College of Dentistry. The Team Leaders continue to function as attending faculty working with 2nd, 3rd, and 4th year students. Approximately 52 students are assigned to each Team. The Team Leader, with the aid of a Team Coordinator, will be responsible for all assigned patients. All patient appointments, confirmation of all appointments, monitoring of patient progress, and monitoring of student dentist progress occurs with the assistance of the Team Coordinator.

Student dentists are expected to attend every clinic period unless excused by the Team Leader. Students must also notify Student Affairs any absence. Student dentists experiencing failures or cancellations are expected to report to their Team Leader to be assigned an alternate activity.

CLINIC AVAILABILITY

The number of clinical sessions available to students is set forth in the curriculum. The availability of time and supervision is established by the Office of Clinical Affairs. Students are scheduled to treat patients only during the hours of their clinical curriculum. In rare cases, when urgent problems arise in the management of a patient's treatment, students may consult with their Team Leader to arrange treatment time with appropriate supervision outside of their allotted clinical curriculum time. It is unacceptable to miss any other curricular obligations to treat patients.

ROTATIONS

DENTAL AUXILIARY UTILIZATION

Fourth year student dentists spend a pre-determined amount of time working with an assistant learning how to utilize DAU principles. The student will learn patient positioning, instrument transfer and motion economy techniques and patient management techniques.

URGENT CARE

Third and fourth year student dentists spend two weeks, one week in the fall and one in the spring, for selected students treating patients experiencing pain to gain experience and knowledge in the diagnosis and treatment of emergency patients. Second year student dentists spend one week during their second year. Three student dentists from each class are scheduled each week. Dr. John Lindroth is the Urgent Care Clinic contact person.

OPERATING ROOM/ SPECIAL NEEDS

Beginning in the fall semester, third year student dentists spend one clinic session in the operating room assisting and observing surgical procedures with faculty and residents. Two students are scheduled per session and report to Adult Dentistry in the Kentucky Clinic/General Practice Residency on the second floor. Susan Lundin, Clinic Manager, is the contact person for this rotation. Dr. Ted Raybould and Dr. John Burt are the dental faculty supervising in the O.R. Students must wear Operating Room issued scrubs and bring protective eyewear. Students may not take back packs or other personal items due to NO STORAGE AREA IN THE O.R.

ORAL AND MAXILLOFACIAL SURGERY

Third and fourth year student dentists spend one week in the fall and one week in the spring in OMS. Students are under the direction of residents and faculty, gaining experience in the assessment, diagnosis and treatment of patients requiring surgical procedures. Oral Surgery rotations are scheduled in both the mornings and afternoons unless students are scheduled to be in class during those times. Students are to attend an Orientation session in OMS on the Monday morning of their scheduled rotation week.

OROFACIAL PAIN CLINIC

All fourth year student dentists spend one-half day observing the newest techniques in the treatment of facial pain. Two student dentists attend each session. Dr. Jeff Okeson is the contact person for OFP.

PERIODONTOLOGY ASSIST

Third and fourth year student dentists are assigned two clinic sessions (spring and fall) in the Periodontal Graduate Clinic. Dr. Sam Jasper and Cheryl Huffman are contacts.

ORTHODONTIC ROTATION

Fourth year student dentists spend sessions in the Orthodontic Clinic working with Residents treating patients. There are two Options:

Option A – Treat an Active Patient; scheduling is done by appointment coordinator in Orthodontic Department

Option B – 3 Clinical Sessions:

Session 1 and 2 – clinical procedures

Session 3 – Box Case

These three rotations are scheduled by the Pre-Doctoral Clinic Manager during clinic times which are available both in Pre-Doctoral Clinic and in the Orthodontic Department.

PEDO VAN ROTATIONS

During the fall and spring semesters, third and fourth year student dentists provide dental care for pediatric dental patients on mobile vans in Fayette County. Third year students will be assigned on Mondays and fourth year students will be assigned on Tuesdays. Dr. Enrique Bimstein and Dr. Christina Perez are the Pediatric Dentistry faculty who will provide supervision. Angie Baxley will make the assignments.

RADIOLOGY ROTATION/ODM 820

Beginning in the fall semester, second year students spend two consecutive sessions in Oral Radiology. The student will learn the clinical aspects of oral radiology including patient positioning, use of the sensors, use of panoramic machines, the basics of imaging software, and patient management techniques. This rotation occurs during scheduled clinic sessions in addition to sessions outside clinic times, when students are not scheduled in class.

TWILIGHT DENTAL CLINIC FOR KIDS

On Thursday evenings, third year student dentists will be assigned patients on 3rd floor of the Pre-Doctoral clinic. The clinic coordinator will assign the patients. Students must be present for these clinical sessions and must review their schedules to see if a pediatric patient has been scheduled. Students are not allowed to cancel or reschedule pediatric patients independently; this must be facilitated by the Coordinator on the 3rd floor.

Pre-doctoral Clinic Implant Program Guidelines

Refer to the **Implant Treatment Manual** located in LINKS in Axium

Oral and Maxillofacial Surgery (OMFS) Treatment Planning and Referrals

Treatment Planning

Patients needing full mouth extractions, third molar extractions, or pre-prosthetic surgery (e.g. alveoloplasty, tori removal) require an OMFS consultation. Dental implant patients with odd numbered charts also require OMFS consultation. At the time of the pre-surgical evaluation, a determination of whether a resident or student will be performing the surgery* is made. The origin of the patient determines the fee schedule used for treatment planning. If the patient originates in the pre-doctoral clinic, then the fees will be student fees regardless of the need for residents to complete the more complex surgeries. Patients will be able to arrange a payment plan with the financial counselor. IV sedation or nitrous oxide administration may be included in the payment plan. When a consultation is required the OMFS Resident pager on-call list is posted at the front of clinic by the dispensary window. If a patient has a complex medical issue or difficult surgery they will likely need a separate consultation in oral surgery at an additional cost. On a rare occasion, a patient's medical condition may dictate surgery to occur in the hospital setting. In those instances fees will be higher usually at faculty fees and will be discussed with patient at the time of the surgical consultation.

*Implant therapy can be treatment planned and financial arrangements made in the Pre-doctoral clinic. These cases still require consultation for definitive treatment planning prior to scheduling the patient.

If a student dentist will perform the surgery, the treatment will be planned and financial arrangements made in the pre-doctoral clinic.

Referrals

If a patient of record or a patient who has been screened and not yet assigned has an urgent problem that requires an extraction, the tooth to be extracted should be treatment planned before the patient goes to OMFS. Patients who are referred to OMFS and are not treatment planned will not receive the pre-doctoral fee but will we assessed as a walk-in patient with walk-in clinic fees. Patients of record should typically not be sent through the Urgent Care Clinic unless permission has been given by the Team Leader and attending faculty in OMFS.

A. Appointment Preparation:

Prior to the arrival of the patient you should: 1) plan your activities, 2) review the procedures to be accomplished, 3) clean the operatory, and 4) arrange required sterile instruments and supplies.

► PLAN - Controlled use of your time dictates that you plan the activities of the appointment in order to be mentally and physically prepared. You should select the most pressing area needing treatment and estimate how much you can accomplish during the appointment. Be prepared to answer your instructor's questions regarding treatment rationale and sequencing. This is a learning experience and your instructor has a duty to ensure not only that the student understands the treatment plan but also that he(she) can effectively communicate it to the patient. It is considered poor planning to begin deciding which procedures to carry out after the instructor has arrived.

► REVIEW - Your memory may not be as good as you might think. Use previous class notes, texts and manuals to review all of the procedures planned for the appointment. You can learn more and gain better experience if you know what you are going to do and the instructor helps you to apply that knowledge.

► CLEAN - All exposed surfaces should be cleaned including the light, chair, bracket tray and air/water syringe. You must learn to look at the operatory from the patient's perspective. Be certain that there are paper towels and hand soap for you and the instructor. Students should observe universal precautions at all times during clinic sessions, wearing gloves, mask, protective eyewear and gowns. Care should be taken to remove and replace soiled protection when appropriate. Students should remove gloves that have had contact with the patient prior to leaving the cubicle.

► ARRANGE – The routine instruments needed for the appointment should be neatly arranged. You should always have the following basic instruments available when the patient is present: SHARP explorer, mirror, periodontal probe, cotton pliers, 2 x 2 gauze and cotton rolls. The instrument tray should be covered by the paper napkin that will be placed around the patient's neck. This will accomplish two things: 1) the instruments will be kept clean, and 2) the patient will not be able to see the instruments.

B. Beginning of Appointment:

When the patient arrives for the appointment you should: 1) seat the patient in the operatory, 2) update the medical history including current blood pressure, and 3) cue up the most current radiographs on the monitor and be prepared to produce updated medical history and completed and approved treatment plan and 4) obtain permission from the instructor to begin. (Failure to obtain permission from the instructor to begin treatment will be considered a serious offense.)

► Seating the patient. When the patient arrives for the appointment, the patient should be brought to the operatory and seated. Clear the pathway of chairs, lights, etc. to ensure that the patient does not harm himself/herself. Adjust the headrest and place the paper napkin onto the patient. DO NOTHING MORE THAN USE A MIRROR AND EXPLORER TO REVIEW THE PLANNED TREATMENT UNTIL THE INSTRUCTOR GIVES YOU PERMISSION.

► Permission to treat patient. The instructor will review with you the patient's condition, the proposed plan and your preparedness, and then permission will be granted to begin appointment. The instructor is responsible for the patient and your actions, so do no treatment until permission is given by the supervising faculty. This includes giving anesthesia.

C. Anesthesia:

The purpose of administering anesthesia to the patient is to control pain; therefore, adequate anesthesia must be obtained. To minimize patient discomfort, topical anesthetic should be applied to the injection site for 2-3 minutes. The anesthetic solution should be warmed and injected slowly to minimize tissue damage, aspirate before injecting. For most restorative dentistry procedures the following delivery techniques are recommended.

► Maxillary – infiltration and/or blocks using the short 27 gauge needle.

► Mandibular

- Inferior alveolar and the long buccal blocks are the preferred method of obtaining anesthesia may be obtained by using a long 27 gauge needle.
- Gow-Gates or Akinosi blocks are secondary methods for mandibular anesthesia for Restorative Dentistry procedures and a long 25 gauge needle is used for the injection.

► Because we all occasionally miss a block, please do not hesitate to call an instructor for assistance after having failed to achieve adequate anesthesia. The time to seek assistance is when two carpules have failed to produce profound anesthesia.

DO NOT GIVE ANESTHESIA BEFORE RECEIVING PERMISSION FROM THE INSTRUCTOR. THIS WILL RESULT IN SUSPENSION FROM THE CLINIC! SEEK INSTRUCTOR ASSISTANCE WHEN TWO (2) CARPULES OF SOLUTION HAVE FAILED TO PRODUCE ADEQUATE ANESTHESIA.

D. Isolation:

After obtaining adequate anesthesia, rubber dam isolation should be achieved. Alternative methods of isolation will only be used with instructor approval. The student is to assume that ALL situations will require dental dam. If a student begins a procedure without dental dam isolation approved by the supervising faculty a grade of 0 will be given for that category on the evaluation sheet. Sometimes rubber dam isolation is difficult to obtain when the operator is working alone. You will find it much easier for you and your patient if you have assistance during this procedure. Students are encouraged to assist each other during placement of the rubber dam.

E. Interim Approvals:

When doing preparations, proceed with the steps as directed by your instructor. Interim approval checks may vary from one instructor to another. Carry out only as much of that step of the procedure as you are sure of, then, seek direction from the instructor. For example , depending on the restorative material of choice, during an excavation you may be asked to first extend the cavity at "ideal"
depth and width if amalgam is to be used. If the restorative material is composite you may be asked to first remove only carious enamel in order to visually identify the caries beneath. If an exposure occurs, there should be minimal carious dentin left. The preparations should be completed to instructor approval. NO RESTORATIVE MATERIAL SHOULD
EVER BE PLACED PRIOR TO PREPARATION APPROVAL BY THE CLINICAL INSTRUCTOR. Once the preparation is approved, the appropriate restorative materials and order they are to be used should be reviewed with the instructor. This will include but may not be limited to the proper choice and placement of matrix, disinfectant, dentin desensitizer, dentin primer, adhesive, proper base and liner selection and application. After instructor approval, the cavity should be restored to proper anatomic and functional form (margins, embrasures, contact, marginal ridges, axial walls, axial line angles, occlusion, and anatomy). Instructor approval should be obtained before removing the rubber dam, then, a final approval must be obtained. The instructor is responsible for the patient's completed treatment. NEVER LET THE PATIENT LEAVE THE CLINIC BEFORE OBTAINING THE INSTRUCTOR'S APPROVAL.

F. Records

Prior to calling the instructor for final approval, you should have completed: 1) your evaluation sheet with your self-evaluation, 2) procedure codes and progress notes in the patient's EHR and 3) your plan for the next appointment. Your time and the instructor's time will be saved if you do this.

► "SHAPED" progress notes are customary.

► Completion of Daily Evaluation Sheet- every appointment should be accompanied by an evaluation for the day's procedures regardless of complexity

of the procedure. We will use these sheets to evaluate your progress in the course and to determine the number of clinical experiences you have to date.

► Plans – you should determine the activities for the next appointment to begin organizing your efforts and to inform the patient what to expect. The instructor can give you guidance in establishing priorities.

► Time – all of the above can be accomplished if you complete your patient treatment 30 minutes prior to the end of clinic.

G. Timely completion of treatment:

Since reappointing the patient, entering progress notes, completing evaluation forms and entering treatment into Axium takes considerable time please strive to complete all clinical procedures 30 minutes prior to the end of clinic.

► This gives the auxiliaries time to monitor the trays and not run over time.

► It allows the supervising faculty to evaluate the student dentist's performance and provide feedback for that clinic during the half-hour from 11:30-12:00pm and 4:30-5:00pm. This student-faculty dialogue can create a more favorable learning environment.

► This allows both faculty and students to leave the clinic at 12:00pm and 5:00pm.

H. Clean-up:

Someone else will be using the operatory at the next clinical session. DO NOT FORGET YOUR HANDPIECES!! They are expensive to replace.

I. Cancellations:

When you have a patient cancellation, please inform the supervising faculty at the beginning of the clinic session, then report to your Team Leader for reassignment.

Section 3

Practice Management

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INSURANCE INFORMATION

Resolution of the financial obligations accompanying dental treatment is an integral part of the services offered by the College of Dentistry. Patients who have insurance or another third-party payer often request assistance with claims filing and benefit reconciliation. The Billing and Collections Department is available during business hours to assist in resolving accounts in a timely and pleasant manner. Your assistance in this process, by obtaining and maintaining accurate addresses, telephone numbers and insurance information, is required to ensure proper billing and collection efforts can be provided to enhance patient satisfaction and clinical income. Patients may also be referred to the Billing and Collections Department if they have questions or concerns. Your Team Coordinator can assist you with proper entry of demographic information into axiUm.

The College of Dentistry is pleased to be a participating provider with a small number of dental insurance plans, including UK Dental Care and Delta Dental of Kentucky (Premier Plan only), and several medical plans. The College also participates with certain governmental agencies such as Medicare and Medicaid. There are various types of coverage under each plan with many different benefit options. Please contact the Billing and Collections Department or the Financial Counselor, if you or your patients have any questions with regard to a particular insurance plan.

The patient is ultimately responsible for payment of services provided, but as a courtesy to patients, the College of Dentistry will also submit claims to companies with whom we do not contractually participate. Due to the variety of types of insurance coverage and the differences in covered services and exclusions, the College strongly recommends that patients verify their own benefits and coverage with their insurance carriers.

If a patient requests a formal predetermination of benefits from the insurance carrier, you should work with the Financial Counselor to obtain copies of the treatment plan for your patient. This will need to include all required billing information including CDT code, tooth numbers and/or quadrants (known in axiUm as "site") and surfaces involved along with a duplication of radiographs, if necessary. Please provide this information to the Financial Counselor in a timely manner.

In order to accurately submit your patient's claim(s), all sites and surfaces need to be clearly recorded in axiUm. Failure to enter the proper procedure code(s) into axiUm on a timely basis and obtain the required faculty approval will have a negative impact on your management grade. When bridge, crown, or denture work is preformed, please indicate if this is an initial placement. If not, note the date of the initial placement and reason for replacement along with the date of any extractions.

PROPER HANDLING OF INSURANCE FORMS

1. In order for the Billing and Collections Department to process claims properly, they may request information from you. It is imperative that you promptly provide this information to them.

2. Any patient presenting with insurance claim forms is to be escorted to the Financial Counselor for proper handling. At this time appropriate patient information will be obtained or confirmed in order to process the claim. Insurance forms are NOT to be placed in the patient charts. Student dentists should neither fill out any section nor sign the form.

3. We cannot tell the patient whether their insurance will pay. Each employer has its own benefit plan with the insurance carrier. If the patient has a copy of their insurance booklet, we will be happy to go over it with them to explain their insurance coverage. However, the insurance carrier may refuse to pay if they do not agree with the treatment. Insurance coverage is a contract between the patient and the insurance carrier. Failure by the carrier to reimburse for services will result in patient financial responsibility.

4. We prefer to have the patient sign benefits over to the UK Dental Clinics; however, this is left up to the patient's discretion.

5. When requested, we will provide the insurance carrier with duplicate radiographs.

6. If a patient requests a predetermination, the student dentist should furnish the Financial Counselor with a copy of the treatment plan including all tooth numbers and surfaces, where applicable, along with the insurance form from the patient.

7. When all the information is obtained, the patient's claim will be filed with the insurance carrier.

FINANCIAL ARRANGEMENTS FOR STUDENT CLINIC PATIENTS

An important part of your dental education includes your ability to practice your profession in a manner which financially supports the facility, personnel and overhead. The Pre-Doctoral Clinic operates on a reduced-fee basis. In order for the clinic to operate it is necessary that all procedures be charged to the patient in a timely manner. Our clinic accepts cash, checks, Visa/MC, Discover, Kentucky Medicaid, and some dental insurances. Payments may be made in person, by mail, by phone or online. Payment plans are available for most patients requesting such arrangements. The following guidelines are to be applied when a student dentist is establishing a payment plan with his/her patient after approval of the treatment plan.

Preliminary Treatment Plan - Since this generally involves a small amount of treatment and few appointments, normally, no monthly arrangements will be made. The total cost is due and payable at the time of service and must be paid in full prior to the beginning of Phase I Treatment Planning. For preliminary treatment plans over $200, the patient should be escorted to the Financial Counselor to arrange a financial contract.

Phase I Treatment Plan - Total cost of this phase will require a 15% down payment with the remaining balance being paid in equal monthly installments. The Financial Counselor can set up payment plans for the patient.

Phase II Treatment Planning - Total cost of this phase* will require a 15% down payment with the remaining balance being paid in monthly installments. The Financial Counselor can set payment plans for the patient.
*Phase II treatment may be started if patient is current on Phase I payment plan.

Twilight Dental Clinic for Kids – The Financial Counselor can set payment plans up to and including twelve months. No payment arrangement should exceed twelve months. The Twilight Clinic only offers treatment cost based on parents' income.

Recall Examination - Any treatment identified at the recall appointment is treatment planned and the patient signs for informed consent. When there are treatment additions, the patient is to be escorted to the Financial Counselor for payment arrangements.

2nd Year Complete Denture Program - Patients assigned to the regular denture program will be permitted to take advantage of a special payment arrangement. The total fee is one-half the current denture fee plus the Oral Diagnosis fee. The payment plan will be set at a 15% down payment, followed by four monthly installments.

Pediatric Dentistry Access Program - This program is designed to provide affordable dentures, endodontic therapy and pediatric dentistry to low income individuals who are not enrolled in commercial insurance plans or other third-party payer programs. Fees for services provided within the Pediatric Dentistry Access Program through the College's Pre-Doctoral Clinics will be discounted using the a sliding scale based upon the Federal Poverty Guidelines established by the US Department for Health and Human Services. Proof of eligibility for this program may be obtained by providing any of the following: Copies of the most recent Federal Income Tax Return, IRS Form W-2, or other tax, homestead credit or other return filed with the federal or state government reporting annual income, and any of the following covering the immediately preceding three months: Wages and Earnings Statement, Pay Check Remittance, Social Security determination letter, Disability Notification Letter, Worker's Compensation or Unemployment Compensation Determination Letter, or a letter from the employer of the applicant or other person in the applicant's

household indicating gross income before taxes.

Additions/Deletions to the Treatment Plan –Any additions or deletions to a treatment plan may cause changes in the payment plan. It is the responsibility of the student dentist to bring the patient to the Financial Counselor for additions/deletions to the treatment plan. There may be exceptions to this payment plan and these will be handled in a manner that will be helpful to the patient and have the approval of the Team Leader. Updating the treatment and payment plans will ensure appropriate and accurate communication with the patient.

AxiUm Clinical Information System

In April of 2006, the College of Dentistry began using a Clinical Information System called AxiUm that was designed by Exan Academics, Inc. All of the patient care activities including registering patients, scheduling patient appointments, maintaining insurance information, and billing for services are captured in AxiUm. During the Spring 2009 semester we implemented an electronic patient record that included online charting, progress notes, and medical/dental histories. During the Spring of 2010, we implemented digital radiography. We have also implemented electronic consent authorization and plan on including electronic student evaluations as well. Of course, recording your clinical activity and billing treatment, as well as obtaining faculty approval for your work are still important tasks you will do in AxiUm.

At the beginning of your patient care experience, you will attend a training session to familiarize yourself with how to use the AxiUm Clinical Information System. At that time you will be given access to AxiUm and AxiUm training module. Each operatory on the third and second floors has a computer. At the beginning of each session you will log onto AxiUm and open your patient record. You will record or review medical history, dental history, and record findings concerning patient anxiety, soft and hard tissue examination. Faculty or Residents will "swipe" approval of data collection. At the end of each clinic session, you indicate what you have done for the patient during the clinic session. Every time you have a patient scheduled in the clinic, there needs to be an entry or procedure changed from "P" for planned to "I" or "C" (in process or completed). Most clinic sessions, you will complete treatment that has been treatment planned and is in the patient's Axium planned treatment area. Occasionally, a patient will present with an urgent need or a tooth that has fractured and you will need to add treatment. The procedure for doing will be reviewed in your AxiUm training. Please see you Team Leader for more clarification if needed.

At times you may be completing a procedure that was started by another student. In that situation, you will need help from your Team Leader to modify the AxiUm provider to you for that specific procedure. It is critical that the original procedure that was planned or "P" in AxiUm is the one that is continued. Do not add your own procedure code because that will result in extra fees charged to the patient that are outside of their payment plan.

In AxiUm you can check your schedule, check your list of assigned patients, view your patients' scheduled treatment, and other functions. If you ever have questions about using Axium, ask your Team Leader or supervising faculty. If you should make a mistake in Axium, see your Team Leader to correct the mistake. There will be a few occasions when treatment is to be done at no charge to the patient. Treatment that is to be completed at no charge should still be entered at a charge in AxiUm. You should talk to your clinic manager or team leader and they will advise you on completing an electronic Account Adjustment Request (AAR form). These requests will then be forwarded to the College of Dentistry Compliance Committee for review. **Only the Compliance Committee may approve Account Adjustment Requests.** Never indicate to a patient that you can provide services at no charge.

If your patient cancels or does not show for appointment it is imperative that you alert both your Team Coordinator (who will cancel or reschedule the appointment as well as track the number of missed appointments) and Team Leader. We need documentation if a patient does not show, continues to arrive late or cancel without adequate notice in order to dismiss them from the clinic. For these patients you also need to document in the electronic health record the patient has cancelled or failed the appointment.

PATIENT ASSIGNMENTS

ADULT PATIENTS

Assignments will be made by the Team Leader in order to meet patient, student dentist, college and departmental needs as closely as possible. Consideration will be given to the student's abilities and the patient's needs.

Patient assignments will be based on:

a. student dentist needs - as recommended by the Team Leader
b. student dentist needs - as recommended by the Clinical Course Director.
c. clinic utilization
d. availability of patients

PEDIATRIC PATIENTS

Pediatric Patient – You are assigned patients by a Team Coordinator. Student dentists should check your clinic schedule in axiUm each week for your scheduled pediatric patients and recall pediatric patients. It is your responsibility to look in axiUm at your schedule to verify patient appointment on Thursday's for Twilight Clinics for kids.

TO INACTIVATE A PATIENT

Adult Patient – Assigned patients will be inactivated with the approval of the Team Leader. An inactivation code will be entered appropriate for the reason for the inactivation and may require written notification to the patient.

Pediatric Patient - Pediatric Patient charts must be approved in axiUm by the appropriate Pediatric Dentistry faculty member. The Team Leader signature is not required.

TO DISMISS A PATIENT

The Associate Dean for Clinical Affairs may dismiss patients from the College utilizing the dismissal policy found in the UKCD Policy Manual:
http://www.mc.uky.edu/dentistry/faculty/Policies/Policy%20Manual%20Table%20of%20Contents.pdf

CLINIC DISPENSARY PROCEDURES

BORROWING SUPPLIES

Students will request an appointment through planned treatment in Axium while the patient is in the chair and cassettes/instruments/handpieces will be automatically ordered by the CDT code for the procedure. The cassette/instrument/handpieces will be scanned out to the student in Axium the day of the appointment using the student's ID Badge. It is important to return items in a timely manner and make sure all items are scanned back into Axium. Student dentists will be charged for any items still outstanding at the end of each year. Students abusing this privilege are at risk of receiving an unsatisfactory grade in CDS 823,833,843.

NITROUS OXIDE MACHINES

Nitrous oxide machines will only be loaned to student dentists who have completed the nitrous oxide course or who are under supervision of a faculty member who has had the course and should use a dental assistant throughout the procedure. Machines are checked out for one clinic period only and are not to be taken from the clinic floor from which it was checked-out. If the machine should run out of nitrous oxide or oxygen, a full tank may be obtained from the dispensary in exchange for the empty tank. The tanks and machines should be turned off immediately after use and the lines are to be bled. The nitrous oxide machine must be disinfected before being returned to the dispensary.

DENTURE TEETH DISPENSING

Check out denture teeth from the third floor dispensary as follows: A tooth order form, available at the dispensary, must be properly completed and signed by a Prosthodontic faculty member. The tooth order is kept on file in the dispensary. The teeth selected with shade should be entered into the patient's chart for future reference as these records are only kept by the dispensary for a limited period of time. Occasionally, teeth are not in stock and must be ordered from the supplier. If ordering is necessary, you will generally receive your teeth in one or two days.

CUBICLE PREPARATION AND CLEAN-UP

At the end of patient care, it is your responsibility to:

1. Turn off the patient light.
2. Dispose of all expendable materials, saliva ejectors, suction tips, etc.
3. Remove the plastic chair cover and place in trash.
4. Disinfect entire cubicle as demonstrated by DAU personnel. Including patient chairs, provider and assistant chairs, counter tops, computer, all hoses and connections for handpieces, air/water, suction and composite lights.
5. Replace plastic barriers on chair back, tray and light handles
6. Return all chairs to their upright and highest position.
7. Remove all materials (alginate, compound, stone, and wax) from the counter top and sinks.
8. Clean up spills on the floor.
9. All sharps (ie. Needles, scalpel blades, Ultradent metal tips, endo files, etc.) go in the SHARPS CONTAINERS located in each cubicle.

PERSONAL PROTECTIVE EQUIPMENT During all patient care procedures, students will:

1. Weargloves
2. Wear glasses
3. Side Shields
4. Wear masks
5. Wear clinic gowns

Patients must wear protective eyewear.

CLINIC GOWNS

Students are expected to wear clinic gowns at all times when providing patient care. Clinic gowns are not to be worn outside the College of Dentistry. Clinic gowns requiring repair are to be placed in the appropriate hamper at the back of the second or third-floor clinic.

PROTOCOL FOR FLUSHING WATER LINES

Handpiece lines, water syringes and cavitron lines must be flushed for three minutes prior to each clinic session and 20-30 seconds following treatment.

CLINIC CLEANLINESS

Student dentists are responsible for the cleanliness of their assigned cubicle. Students who are found to consistently disregard this responsibility may find themselves at risk in the Patient Management grade.

All "sharps" (needles, scalpel blades, endodontic files, etc.) are to be placed in the red sharps containers available in each cubicle. DO NOT PLACE SHARPS IN THE TRASH.

All used expendables (suction tips, cotton rolls, etc.) are to be placed in the trash.

All non-sterile items need to be disinfected prior to returning the items to the dispensary.

Section 4

Safety

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WORKPLACE HAZARD CONTROL

BLOODBORNE PATHOGENS

SHARPS, EYE, MUCOSAL, AND NON-INTACT SKIN EXPOSURES

Immediate, proper treatment, and recording of any exposure incident to eye, mouth, mucous membrane, non-intact or broken skin, or parenteral contact (via skin abrasion or penetrating injury) with blood, saliva, or other potentially infectious materials during performance of clinical or supporting tasks should begin immediately after the exposure occurs---you must not delay.

Post-Exposure Prophylaxis (PEP) must be initiated within two hours of the exposure incident if it is to be effective

First, do this…

Stop patient care or other task immediately. IF the exposure incident occurs during non-patient care activities, perform the next two steps, then proceed to the second section.

Perform basic first aid immediately. Allow the wound to bleed freely to flush out contaminants. Do not squeeze and "milk" the wound as this tends to massage contaminants into the wound.

Disinfect the wound using warm, running water and a germicidal hand washing solution.

Notify your supervisor or attending dentist that you have had an exposure incident (Dentists should proceed immediately to the next step).

Explain to the patient that you have had an accidental exposure; make the patient comfortable; but, do not dismiss the patient!

Temporize the treatment site. It would be best to ask another dentist, student, or staff member to do this so you can proceed to the second step immediately.

Second, do this---Report the exposure incident

Report the injury to your team leader and clinic manager (room 234X)
323-5876. Your team leader or clinic manager will assist you with reporting the incident to UK Healthcare Patient Safety Net Online Reporting System.

You are required to report the injury whether or not you choose to be evaluated.

BIOHAZARD INCIDENTS

Safety Glasses - Student Dentists

All student dentists and faculty must wear safety glasses in the clinics while treating patients and working on laboratory procedures.

Safety Glasses - Dental Patient

Safety glasses or other appropriate devices will be worn by all UK College of Dentistry dental patients during treatment procedures, unless otherwise directed by supervising faculty.

Sharps

All needles, scalpel blades, endodontic files and other sharps are to be disposed of in a puncture-resistant container (the red sharps container) that will be collected by Physical Plant for incineration.

Amalgam Disposal

Amalgam scrap must be disposed of properly. If incinerated, it will allow mercury vapor to permeate the environment. It may contribute heavy metal to the water system. Our procedure is to save all unused amalgam. A container (located under the sink nearest the door in the second and third floor lab) provides for storing amalgam in water.

In case of a mercury spill, mercury-collecting jars are available at the dispensary window.

In the clinics, amalgam fragments are to be suctioned by the unit suction apparatus. The traps will be cleaned by College staff and contents disposed of in a proper manner and the amalgam (and other contents) saved for proper disposal.

Eyewash Stations

OSHA demands that there be eyewash stations in any area where employees work and whose eyes may be exposed to chemicals. In our dental clinics on the second and third floors, there are eyewash stations in the laboratory and in the X-ray room (D206A). On the third floor the eyewash station is in the Laboratory and X-ray room (D306A). Before going on rotations in any other clinic, you should check with that clinic director as to the location of eyewash stations in those specific areas. After eye exposure to a chemical, the eye should be flushed by a continuous spray of water. The eye should be held open, with somebody assisting you and the eye moved around in various directions to assure complete flushing. To activate the eye wash station, turn on the water in the faucet and adjust the temperature then remove green coverings over the "eye wash" portion of the faucet then proceed as above.

Protocol for Flushing Water Lines

There is evidence that biofilms often form in dental unit waterlines. The source of most of these organisms is from the water supply. The health consequences of the biofilm is not known, but it

is clear that large numbers of bacteria are released into the water when such biofilms are present. Such organisms could, conceivably, pose a threat to patients or dental healthcare workers. Therefore, precautions must be taken to protect the safety of all concerned. The systems are tested periodically to ensure that the effluent meets EPA standards for drinking water quality, as specified in the CDC Guidelines.

The water systems may be divided into open and closed systems. Open systems are those that receive water from the city water system, while closed systems have a bottle that serves as a water source. The two systems require different protocols to maintain acceptable water quality.

Open systems. Open systems are connected to the city water supply. Open systems are found on the second and third floor clinics, and faculty patient care. Based on our research findings, the UKCD protocol for open water systems requires that the handpiece and air/water syringe be flushed for 3 minutes prior to each clinic session. Therefore, if you are scheduled to see a patient on the second or third floor clinic, you should flush the lines for 3 minutes shortly before the patient is seen. Following treatment, the lines should be flushed for 20-30 seconds. Periodically, the Safety and IC Committee monitors these lines microbiologically.

Material Safety Data Sheets

MSDS's are available for all chemicals used in the College of Dentistry. If you should be exposed to a particular chemical, initiate removal by flushing the area: You or someone in the area should look at the MSDS for the hazards of that specific material and, if there are special methods of cleaning the chemical, implement these. Ingestion of a chemical should be reviewed via the MSDS and appropriate action taken. The MSDS's are kept at the dispensaries on both clinical floors and in the urgent care room. Check with your clinical supervisor for MSDS location as you rotate through various other areas in the College of Dentistry. All students should be familiar with the MSDS's for any toxic chemical they may be using. These will be reviewed with you during your dental materials courses.

Monomer

Acrylic monomer has a highly flammable potential, does not disperse in air, and a cloud may travel 100 or more yards before exploding. There is also a risk of mutagenic or embryo toxic effects. When monomer is used in the technique laboratory, it is the policy of the College to turn off the re-circulating fans so that these noxious fumes do not travel throughout the Medical Center.

When using monomer, it should be dispensed from the original container or a dropper bottle (NEVER USE A PAPER CUP) to avoid spillage and evaporation. DO NOT USE MONOMER NEAR AN OPEN FLAME.

INSTRUMENT STERILIZATION

The Dental Sterilization Program (DSP) ensures sterile instruments and handpieces. There are a series of 19 procedure-specific trays that can be requested via color-coded cards. Your cooperation is crucial and very much appreciated.

I. Tray Requisition

A. Students will request an appointment through planned treatment in Axium while the patient is in the chair and cassettes/instruments/handpieces will be automatically ordered by the CDT code for the procedure. The cassette/instrument/handpieces will be scanned out to the student in Axium the day of the appointment using the student's ID Badge. If a patient calls in with an emergency the day of an appointment the student may request the cassette/handpieces at the clean room window. Students need to monitor their schedule so if a patient schedules an appointment by phone, instruments can be requested through Axium.

II. Tray Distribution

A. Requested items will be distributed at the second floor instrument dispensary

III. Instrument Return

A. Place instruments back into cassette using the color codes as a guide.
B. Remove excess wax, cements, materials and blood from all instruments.
C. Discard all expendable materials

D. Staff will be available to collect instruments outside Room D-236 XB from 9:45 AM to 12:30 PM and 2:45PM to 5:45 PM. Students finishing before or after these times should place instruments in an impermeable bag (bags are located at the back of each clinic floor) and bring them D-83.

E. Do not cassettes/instruments/handpieces unattended at the dispensary window or the soiled instrument return room (D-236XB). The staff members are not responsible for unattended cassettes/instruments/handpieces. Students will be held accountable for all items not returned and scanned back into Axium in a timely manner.

F. Retrieve all requisition cards submitted during the procedure. CARDS NOT RETRIEVED ARE VIEWED AS UNRETURNED INSTRUMENTS

Dental Sterilization remains open until 6 PM. In light of this, no trays should be kept out overnight.

IV. Broken or Contaminated Instruments

A. Place autoclave tape on worn or broken instruments to indicate the need for replacement.

B. Instruments which become contaminated during the procedure should not be exchanged at the instrument dispensing area. Instead replacement items should be signed out at the instrument dispensing area.

V. Dull or Worn Burs:

A. Invert burs in the bur block to indicate the need for replacement.

VI. Pre-Clinical Courses

A. Instruments for pre-clinical courses will be checked out for the total time required in the course.

B. Instrument requisitions should be submitted at distribution.

C. There are two types of locker space on the sixth floor where technique trays can be kept.

1. One requires a padlock which is provided by the student dentist.
2. Key locker - only one key is issued and available for these lockers.

VIII. Fees and Fines

A. Rental Fees -The fee(s) charged for rental does not allow for excessive breakage, loss or abuse. Improper care will necessitate an increase in fees.

B. Dental Sterilization has a limited supply of instruments. Therefore, it is necessary to institute a system for control of instruments.

C. Tray Control

1. Tray Set-ups
   - All instrumentation must be returned within forty-eight hours of appointment completion.
   - Beyond forty-eight hours, instrument privileges will be denied. Additional trays or handpieces will not be issued until the late item is returned.
   - If the tray set-up or handpiece is lost, the student dentist will be billed immediately for the lost item(s) by the Office of Administrative Affairs.
   - If financing is a problem at that time, payments may be arranged using a promissory note.

2. Dispensary Check-out

   - Five days will be allowed to return a borrowed item.
   - After five days, no additional dispensary items may be borrowed until the delinquent item(s) is returned. If the item is lost, the student dentist will be billed immediately for the lost item(s) by the Office

of Administrative Affairs.

3. Excessive billings for lost equipment will result in discussions regarding the student dentist's continuation in the program.

TIONS FOR PRESCRIBING DENTAL RADIOGRAPHS

lations are subject to clinical judgment and may not apply to every patient. They are to be used by dentists only after ent's health history and completing a clinical examination. Even though radiation exposure from dental radiographs is on to obtain radiographs is made it is the dentist's responsibility to follow the ALARA Principle (As Low as vable) to minimize the patient's exposure.

	PATIENT AGE AND DENTAL DEVELOPMENTAL STAGE				
ITER	**Child with Primary Dentition** (prior to eruption of first permanent tooth)	**Child with Transitional Dentition** (after eruption of first permanent tooth)	**Adolescent with Permanent Dentition** (prior to eruption of third molars)	**Adult, Dentate or Partially Edentulous**	**Adult, Edentulous**
oral	Individualized radiographic exam consisting of selected periapical/occlusal views and/or posterior bitewings if proximal surfaces cannot be visualized or probed. Patients without evidence of disease and with open proximal contacts may not require a radiographic exam at this time.	Individualized radiographic exam consisting of posterior bitewings with panoramic exam or posterior bitewings and selected periapical images.	Individualized radiographic exam consisting of posterior bitewings with panoramic exam or posterior bitewings and selected periapical images. A full mouth intraoral radiographic exam is preferred when the patient has clinical evidence of generalized oral disease or a history of extensive dental treatment.		Individualized radiographic exam, based on clinical signs and symptoms.
ries**	Posterior bitewing exam at 6-12 month intervals if proximal surfaces cannot be examined visually or with a probe			Posterior bitewing exam at 6-18 month intervals	Not applicable
no t at ries**	Posterior bitewing exam at 12-24 month intervals if proximal surfaces cannot be examined visually or with a probe		Posterior bitewing exam at 18-36 month	Posterior bitewing exam at 24-36 month	Not applicable

TYPE OF ENCOUNTER (continued)	Child with Primary Dentition (prior to eruption of first permanent tooth)	Child with Transitional Dentition (after eruption of first permanent tooth)	Adolescent with Permanent Dentition (prior to eruption of third molars)	Adult, Dentate and Partially Edentulous	Adult, Edentulous
Recall Patient* with periodontal disease	Clinical judgment as to the need for and type of radiographic images for the evaluation of periodontal disease. Imaging may consist of, but is not limited to, selected bitewing and/or periapical images of areas where periodontal disease (other than nonspecific gingivitis) can be demonstrated clinically.				Not applicable
Patient (New and Recall) for monitoring of dentofacial growth and development, and/or assessment of dental/skeletal relationships	Clinical judgment as to need for and type of radiographic images for evaluation and/or monitoring of dentofacial growth and development or assessment of dental and skeletal relationships		Clinical judgment as to need for and type of radiographic images for evaluation and/or monitoring of dentofacial growth and development, or assessment of dental and skeletal relationships. Panoramic or periapical exam to assess developing third molars	Usually not indicated for monitoring of growth and development. Clinical judgment as to the need for and type of radiographic image for evaluation of dental and skeletal relationships.	
Patient with other circumstances including, but not limited to, proposed or existing implants, other dental and craniofacial pathoses, restorative/endodontic needs, treated periodontal disease and caries remineralization	Clinical judgment as to need for and type of radiographic images for evaluation and/or monitoring of these conditions				

***Clinical situations for which radiographs may be indicated include, but are not limited to:**

A. Positive Historical Findings

1. Previous periodontal or endodontic treatment
2. History of pain or trauma
3. Familial history of dental anomalies

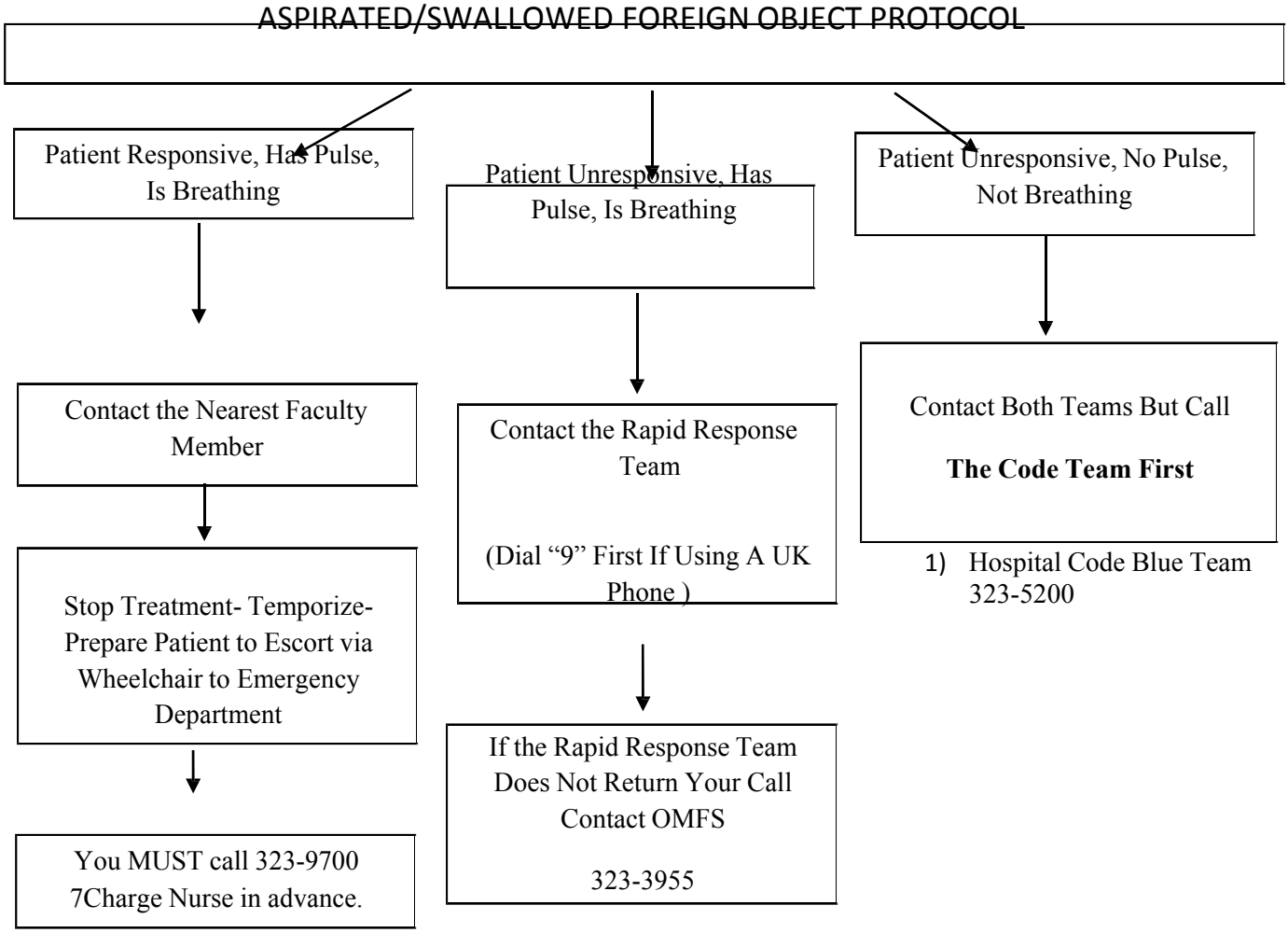
4. Postoperative evaluation of healing
5. Remineralization monitoring
6. Presence of implants, previous implant-related pathosis or evaluation for implant placement

B. Positive Clinical Signs/Symptoms

1. Clinical evidence of periodontal disease
2. Large or deep restorations
3. Deep carious lesions
4. Malposed or clinically impacted teeth
5. Swelling
6. Evidence of dental/facial trauma
7. Mobility of teeth
8. Sinus tract ("fistula")
9. Clinically suspected sinus pathosis
10. Growth abnormalities
11. Oral involvement in known or suspected systemic disease
12. Positive neurologic findings in the head and neck
13. Evidence of foreign objects
14. Pain and/or dysfunction of the temporomandibular joint
15. Facial asymmetry
16. Abutment teeth for fixed or removable partial prosthesis
17. Unexplained bleeding
18. Unexplained sensitivity of teeth
19. Unusual eruption, spacing or migration of teeth
20. Unusual tooth morphology, calcification or color
21. Unexplained absence of teeth
22. Clinical tooth erosion
23. Peri-implantitis

**Factors increasing risk for caries may be assessed using the ADA Caries Risk Assessment forms (0 – 6 years of age and over 6 years of age).

ASPIRATED/SWALLOWED FOREIGN OBJECT PROTOCOL



When you have a patient that has aspirated/swallowed a foreign object.

1. Notify Faculty(Attending)
2. Stop Treatment and Temporize
3. Call Charge Nurse 323-9700 (you need to be prepared to give information such as who you are (name), you are from UK College of Dentistry and what the patient aspirated/swallowed.
4. Escort the patient in a wheelchair to the Hospital Emergency Dept.
5. Complete incident report via http://careweb.mc.uky.edu/psn/

When you page the Rapid Response Team (if UK phone dial "9" first 330-6860) key in the phone number where you can be reached, then hang up the phone and WAIT for their return call. When they call provide any information they require, follow any instructions they give, remember to remain on the phone until the other party hangs up and make sure someone is present in the College of Dentistry first floor lobby and in the lobby of the floor where the emergency occurred to meet the Rapid Response Team and direct them to the proper location.

When you call the Hospital Code Blue Team (323-5200) and OMFS Team (323-3955) be prepared to give the following information:

1.) Your name and the phone number where you can be reached.

2.) Location of the emergency.

3.) Nature of the emergency if known (ex. allergic reaction, heart attack, etc.).

4.) Patient condition: are they breathing, are they responsive, do they have a pulse.

5.) Remember to remain on the phone until the other party hangs up and make sure someone is present in the College of Dentistry first floor lobby and in the lobby of the floor where the emergency occurred to meet the Team or Teams responding to the emergency and direct them to the proper location.

6.) Obtain Crash Cart from Oral Surgery on 5th Floor when calling Hospital Code Blue Team. (323-3955)

Clinical Gown Protocol

1. Ensure proper placement of soiled gowns into appropriate “soiled” bin.

2. When using adhesive name tags, remove from gowns prior to placing into “soiled” bin.

3. Remove any pens before placing in “soiled” bin.

4. Loosen all knots on gown before placing in “soiled” bin.

5. Any stained or damaged gowns in areas other than pre-doctoral clinics should be placed into the Damaged Gown bin.

6. In the event that a gown retrieved from the “clean gown” bin appears dirty, place into the “soiled” bin.

Section 5

Emergency Procedures

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Medical Emergency Procedures	85
Aspiration/Ingestion of Foreign Objects	87
After-Hours Injury Management Protocol	

AFTER-HOURS URGENT CARE SERVICE

GENERAL INFORMATION

The University of Kentucky College of Dentistry After-Hours Urgent Care Service is located in the Hospital Emergency Department. This area is shared with Ophthalmology, Plastic Surgery, and ENT. The facility is maintained and monitored by Kentucky Clinic Dental Personnel. A minimum $200 usage fee will be assessed all patients seen in this area by the Emergency Department of UK Medical Center. Depending on materials used in the emergency room, the fee may exceed $200.

The College of Dentistry After-Hours Urgent Care Service is in effect:

Weekdays: 5:00 PM to 8:00 AM the following morning
Weekends: 5:00 PM Friday to 8:00 AM Monday

IMPORTANT PHONE NUMBER

Hospital Operator (859) 323-5321

PATIENTS ELIGIBLE FOR STUDENT DENTIST URGENT CARE SERVICE

PROTOCOL

1. The Adult Dentistry Resident will be contacted for any patient of record who has an after-hours dental emergency. Patients are to be instructed to call (859) 323-5321 and ask for the adult dental resident on-call.

2. The Pediatric Dentistry Resident will see all children less than 18 years of age.

3. Oral & Maxillofacial Surgery will continue to provide consultation and treatment support as necessary.

PATIENT CATEGORIES

1. Patients registered in any of the College of Dentistry Doctoral or Postdoctoral Programs: The dental resident will notify the emergency department that the patient is arriving. The resident will treat the patients' dental needs and bill the patient appropriately.

2. Non-University of Kentucky College of Dentistry Patients: The triage nurse in the emergency department will determine if a physician or dentist should examine these individuals and treatment will be provided and fees charged accordingly.

PATIENTS UNDER CARE IN SPECIALTY CLINICS WILL BE REFERRED TO THEIR ATTENDING DENTIST FOR AFTER-HOURS CARE

1. Adult Dentistry Patients (Ky. Clinic) - contact the Adult Dentistry Resident on call.

2. Oral Surgery Patients - contact the Oral Surgery Resident on call.

3. Orthodontic Patients - contact the Orthodontic Resident assigned to patient.

4. Pediatric Dentistry Patients - contact the Pediatric Dentistry Resident on call.

5. Periodontic Patients - contact the Periodontic resident assigned to patient.

6. All Other Patients - refer to University Hospital Emergency Department where the on-call Adult Dentistry Resident, Oral Surgery Resident, or Pediatric Dentistry Resident will be contacted for consultation.

Billing for all dental procedures will be routed through the College of Dentistry enabling us to distinguish patients of record from those who are "walk-in."

MEDICAL EMERGENCY PROCEDURES

GENERAL PRINCIPLES

The recognition of a medical emergency is the most vital step in activating a response so that treatment can begin. In general, any faculty, staff, or student working in the College of Dentistry is empowered to recognize a medical emergency when it occurs and begin appropriate steps for management.

A faculty member must be notified when a medical emergency is recognized. This can be (and is most often) the faculty dentist providing clinic supervision on that floor. This faculty then determines if the emergency is self-limiting, if it requires additional help from the Rapid Response Team, Oral and Maxillofacial Surgery, or requires the assistance of the University Hospital Code Team.

Emergency equipment is available at the back of the 2nd and 3rd floor clinics.

Dental Sciences Building Medical Emergency Response Protocol

Patient **Responsive**, Has Pulse, Is Breathing

Patient **Unresponsive**, Has Pulse, Is Breathing

Contact the N
Mer

Contact **UK Emergency Communications** 323-6215

If No Faculty, Contact
UK Em
Commu
323-

If **UK Emergency Communications** Does Not Answer Your Call, Contact **OMFS**
955

If **UK Emergency Communications** Does Not Answer Your Call, Contact **OMFS** 323-3955

Patient **Unresponsive, No Pulse, Not Breathing**

Contact **Both** Teams But Call The

1) **Hospital Code Blue Team first at** 323-5200 Press 1 to be immediately transferred to the Central Monitoring Station

Then call

2) **OMFS** 323-3955 **and instruct them to bring the Crash Cart**

When you call the Hospital Code Blue Team (323-5200) (Press 1 to be immediately transferred to the Central Monitoring Station, you do not have to wait for the menu message to finish playing before pressing 1) or UK Emergency Communications (323-6515) or OMFS (323-3955) be prepared to give the following information:

1) Your name and the phone number where you can be reached.
2) **Location** of the emergency (be specific, **first** say "**College of Dentistry**," then the "floor #," then the "operatory # or the specific area").
3) Nature of the emergency, if known (example: allergic reaction, heart attack, etc.)
4) Patient condition: are they breathing, are they responsive, do they have a pulse, etc.
5) Provide any additional information they may require.
6) Follow any instructions you are given.
7) Remember to remain on the phone until the other party hangs up and make sure someone is present in the College of Dentistry first floor lobby and by the elevator of the floor where the emergency occurred to meet the Team or teams responding to the emergency and direct them to the proper location.
8) If you have called the Hospital Code Blue Team please be sure to call OMFS (323-3955) next and instruct them to
   Bring the Crash Cart (remember to give them the location of the emergency).

University of Kentucky
College of Dentistry

Dental Sciences Building
Aspirated/Ingested Foreign Object Protocol

Aspirated/Swallowed Foreign Object

- Contact attending and clinic manager, or compliance analyst.
- Stop treatment and Temporize.
- Call the Charge Nurse at 323-9700. Be prepared to tell the nurse 1) your name and that you are from UK College of Dentistry and what item was swallowed by the patient.
- Patient will be escorted via wheelchair to the UK Hospital Emergency Department
- Complete Incident Report with clinic manager or compliance analyst.

Swallowed Crown—Outside the College of Dentistry

Permanent Crown

- Follow protocol for aspirated/swallowed object above.
- Determine the date of cementation. If crown fabricated by College of Dentistry and is less than 1 year old, College of Dentistry will assume cost of chest radiograph.
- Consultation with Risk Management.
- If crown is retrieved by patient and the patient wishes to use crown, he/she should be instructed to clean crown and bring it to the appointment. It will be sterilized and

evaluated as to viability for re-use.

Permanent Crown that has been re-cemented by College of Dentistry

- Follow protocol for aspirated/swallowed object above.
- Determine date of original placement. If re-cementation is less than 1 year, College of Dentistry will assume the cost of chest radiograph.
- Consultation with Risk Management.
- If crown is retrieved by patient and the patient wishes to use crown, he/she should be instructed to clean crown and bring it to the appointment. It will be sterilized and evaluated as to viability for re-use.

Provisional Crown

- Follow protocol for aspirated/swallowed object above
- If provisional crown was fabricated by the College of Dentistry and patient is in on-going care (no lapse in treatment), College of Dentistry will assume the cost for chest radiograph.
- Consultation with Risk Management.

Permanent Crown that was fabricated outside the College of Dentistry

- If original fabrication was outside the College of Dentistry, patient should be informed to follow up with his/her primary care physician. If patient is experiencing discomfort or distress he/she should be advised to go immediately to the Emergency Department.
- We will facilitate fabrication of new crown utilizing the current fee schedule at the time of incident, or if crown is retrieved by patient and the patient wishes to use crown, he/she should be instructed to clean crown and bring it to the appointment. It will be sterilized and evaluated as to viability for re-use.

University of Kentucky
College of Dentistry

Dental Sciences Building
After Hours Injury Protocol

Severe accident/injury

- Follow Dental Sciences Building Medical Emergencies Response Protocol

Non-Life Threatening Injury

- Students with University Health Insurance
    - If a student has UHS insurance and he/she chooses to be treated in the Emergency Department of a UK network facility, he/she must understand that there is a $2,500 per condition, or per occurrence, per policy year limit. Any amount over $2,500 will be the student's responsibility. There is no pre-approval process for after hours care unless the visit progresses into a hospital stay.
    - If treatment of the injury can be delayed until the following day, the student should call University Health Service for an appointment.
    - There is an on-call physician who can be contacted to discuss the situation and receive advice. The number is (859) 323-5823.

- Students with private or other insurance
    - If a student has private or other insurance, he/she should follow the guidelines of his/her policy.

- Employees
    - Employees should contact Workers Care at 1-800-440-6785 to file an initial report. If an employee would like to speak to the physician on call inform the answering service and the physician will be paged.
    - The employee should call the following morning to verify that the initial report has been received. Workers Care will accommodate employees if an appointment or follow-up visits are necessary.
    - Employees may also utilize Urgent Treatment Centers. However, this should be communicated to Workers Care during the initial report.

All Faculty, Residents, Students and Staff must report any incident through the UK on-line incident reporting system at http://careweb.mc.uky.edu within 24 hours.

Section 6

Quality Assurance Program

Topic

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Quality Assurance Assessments Summary

Table 5A Standards of Care, Measurements, Results, and Corrective Actions

Standards of Care	Metrics	Method of Data Collection	Benchmarks	Actual Result	Corrective Action	Follow Up	When	Reviewed
Standard 1: Comprehensive Care The College of Dentistry will provide Comprehensive Care to all patients who desire it.	Treatment Plan Completed	Chart Audit, Phase Evaluations, AxiUm Report	100%		Faculty, Staff, Student notified for correction		Twice Annually, Ongoing	Twice a year
Standard 2: Timely Care The College of Dentistry will provide Timely Care to all patients.	Timely Care	AxiUm Report	80%		Faculty, Staff, Student notified for correction		Ongoing	Twice a year
	Procedure completion intervals(endo, fixed, ODTP)	AxiUm Report, Chart Audit	100%		Faculty, Staff, Student notified for correction		Twice Annually, Ongoing	Twice a year
	Timeliness Recall Rate	AxiUm Report, Clinic Coordinator Recall Report	100%		Faculty, Staff, Student notified for correction		Twice Annually, Ongoing, Monthly	Twice a year
Standard 3: Quality Care The College of Dentistry will provide the highest quality of care to all patients.	Phase Treatment Evaluation	Chart Audit, AxiUm Report	100%		Faculty, Staff, Students notified for correction. Post it note in chart for next visit		QA Committee twice annually, Ongoing	Twice a year
	Ceramics Lab	Surveys and Remake Report	85% surveys				Twice a year	Twice a year
	Prosthetics Lab	Surveys and Remake Report	85% surveys				Twice a year	Twice a year
	Radiology Documentation (need, findings, recommendation)	AxiUm report	100%		Division Chief, Faculty Notified for Corrective Action		Students twice annually	Twice a year

	Account Adjustment Request	AxiUm Report	Variable by Division		Compliance Committee and Analyst notify Clinical Divisions of outcome of Request		Monthly	Monthly
	Review cases with Inadequate Outcomes	Team Leader/Incident Reporting	Variable by Division		Team Leader with student as needed Division Chief and Dean of Clinics if issues		As needed	
	Chart Audit	QA Committee	100%		Dean of Clinic, Division Chief, Team Leaders and Clinic Manager		Ongoing	Maintain Log
	Review Quality Adjustment Codes Note Enhancement Codes EDTSPI, ETDSPP, ETDSPR	AxiUm Report					Monthly	Twice a year
Standard 4: Patient Satisfaction The College of Dentistry will strive to have the highest level of patient satisfaction.	Patient Satisfaction survey	Mail Survey from Press Ganey	80%		Quality and Safety Manager will notify Clinical Divisions for improved performance		Ongoing	Twice a year
	Patient Complaint/Grievance	Patient Concern Form	80%		QA Committee will notify Clinical Divisions for improved performance/Service Excellence Follow up		Ongoing	Twice a year
Standard 5: Regulations Followed The College of Dentistry will comply with all Federal, State and local regulations.	Confidentiality-Computer Shut off	AxiUm Report	100%		IT will notify Clinical Divisions		Ongoing	Twice a year
	Patient Rights & Responsibilities, Notice of Privacy provided	AxiUm Report	100%		QA Committee will notify Clinical Divisions for improved performance		Monthly	Twice a year
	Informed Consent	AxiUm Report, Chart	100%		QA Committee will notify Clinical		QA Committe	Quarterly

[Grab your reader's attention with a great quote from the document or use this space to emphasize a key point. To place this text box anywhere on the page, just drag it.]

		Audit			Divisions for improved performance		e twice annually, Ongoing	
	Dental Consults documented	AxiUm Report	100%		Division Chief, Faculty Notified for Corrective Action		Ongoing	Twice a year
	Biohazard Incidents	Reports to Clinic Manager Log Maintained	<5 incidents per semester		Students, Faculty notified of breaches as they are identified. Remedial action as necessary		Ongoing	Twice a year
	Blood borne Exposures	Incident Reports UK HealthCare Patient Safety Net	<5 Similar Exposures		Chair/Division Chief		Ongoing	Quarterly/Maintain Log
	Infection Control Spot checks/Walk-thru	Safety and Infection Control reports to QA			Division Chief, Faculty, Student, Staff Notified for Corrective Action		Ongoing	Maintain Log
	Blood Borne Pathogen Training	Other software	100%		Chair/Division		Ongoing	Quarterly/Maintain Log
	CPR Training	Other software	100%		Chair/Division Chief		Ongoing	Quarterly/Maintain Log
	HIPAA Training	Other software	100%		Chair/Division Chief		Ongoing	Quarterly/Maintain Log
	Hazardous Communication/Waste Training	Other software	100%		Chair/Division Chief			Quarterly/Maintain Log
	Vaccinations	Other Software	100%		Chair/Division Chief			Quarterly/Maintain Log
	Emergency Cart monitors drugs/oxygen	Log Maintained	100%		Chair/Division/Medical Emergencies Sub-Committee			Quarterly/Maintain Log
	Dental Unit Water Line Monitoring	Log Maintained	100%		Chair/Division			Quarterly/Maintain Log

PREDOCTORAL CLINIC QUALITY ASSURANCE PROGRAM

University of Kentucky

College of Dentistry

2011-12

The Quality Assurance Program at the University of Kentucky College of Dentistry student clinic is designed to evaluate the quality and appropriateness of care delivered to patients and to ensure a safe and compliant environment for education and patient care. The Quality Assurance Program (QAP) is intended to continually improve the quality of care provided in the student clinic.

The goals of the Predoctoral Clinic Quality Assurance Program are:

1) To ensure that quality patient care is provided in the student clinic;
2) To provide a safe environment for patients, students, staff, and faculty;
3) To provide a satisfactory dental experience for patients; and
4) To ensure a compliant and legal practice environment.

Several Quality Assurance Indicators are in place to ensure that quality care is provided to our patients. Assessments and Reviews include:

SELECTED QUALITY INDICATORS

General

1) Patients receive the College of Dentistry's Patient Rights and Responsibilities and Notice of Privacy Practices documents during their initial registration.
2) Patients provide consent to treatment prior to receiving dental treatment.
3) Providers follow the College of Dentistry's Infection Control Standards.
4) Patient complaints/grievances are timely managed and appropriately documented.
5) College of Dentistry clinical incidents are timely managed and appropriately documented.

Diagnosis/Treatment Planning

6) Providers review and document the patient's medical and dental history prior to initiation of dental therapy.
7) Patients presenting with urgent treatment needs receive a limited focused evaluation and treatment necessary to stabilize their condition.
8) Patients presenting with non-urgent treatment needs receive a comprehensive oral examination, including recording patient's chief complaint or complaints and this is given priority while addressing patient risk factors when developing the overall treatment plan.
9) A treatment plan is developed for each patient that is commensurate with his/her needs and desires along with estimated fees for treatment.
10) Patients receive the opportunity to receive periodic evaluations and treatment after the initial treatment has been completed.

Outcomes Assessment

11) The College of Dentistry measures patient satisfaction with its clinical programs.
12) The College of Dentistry documents when treatment has been redone/remade or a new procedure performed to correct a deficiency.
13) Patients receive a post- treatment completion clinical assessment examination by faculty within six months of completing the planned treatment.
14) Chart audits are performed in the DMD clinic biannually. At least 10% of students' patient records are evaluated by faculty and staff with student participation.

METHODS OF ASSESSMENT AND REVIEW

Patient Satisfaction/Complaints/Grievances

A. Patient Rights and Responsibilities and Notice of Privacy Practices
B. Press-Ganey patient Satisfaction Survey
B. UK HealthCare Office of Service Excellence

Chart Audit

A. Medical and Dental histories
B. Chief Complaint and Comprehensive Evaluation
C. Treatment Plan Development and Fee Estimate
D. Informed Consent (see attached informed consent documents at end of this document)
D. Phase / Treatment Evaluation
E. Periodic Recall

Treatment Deficiencies

A. Treatment Phase Evaluations
B. Account Adjustment Request
C. Active Treatment Evaluations

Infection Control Standards

A. Biohazard Incidents- reports to Clinic Manager, Compliance Analyst
    a. Clinical Citation
    b. Biohazard Log
B. Blood borne Exposure Incidents-documented through Patient Safety Net

Other
Assessments

A. Urgent Treatment / Walk in Evaluations
B. Ceramics Laboratory Quality Assurance
C. Prosthodontic Laboratory Quality Assurance

The Division of Comprehensive Care with the Compliance Analyst oversees the Quality Assurance Program for the Pre-Doctoral Clinic and reports outcomes of reviews and assessments to the College of Dentistry Quality Assurance Committee. Members of the QA Committee are selected to best represent the multi-specialty areas within the College of Dentistry. In addition, there is a student dentist representative.

The QA Committee meets quarterly or as necessary. As data is collected it is brought to the committee. The data is analyzed and corrective action is taken when needed. Appropriate students, faculty, and staff are notified of deficiencies and the corrective action to be taken in the future. Notification takes place in the form of memos, e-mail, class announcements, and direct contact. Deficiency reports are used to notify students of Quality Assurance deficiencies that include, but are not limited to infection control violations, mishandling of patient records, starting patient care without faculty approval, etc. Quality Assurance efforts are discussed in yearly orientations and clinical conferences with the students, Team Leaders, the Pre-doctoral Clinic Manager, and Assistant Dean for Clinical Operations. The Quality Assurance Chairperson reports the Quality Assurance Program results to the University of Kentucky Dental Care Board annually.

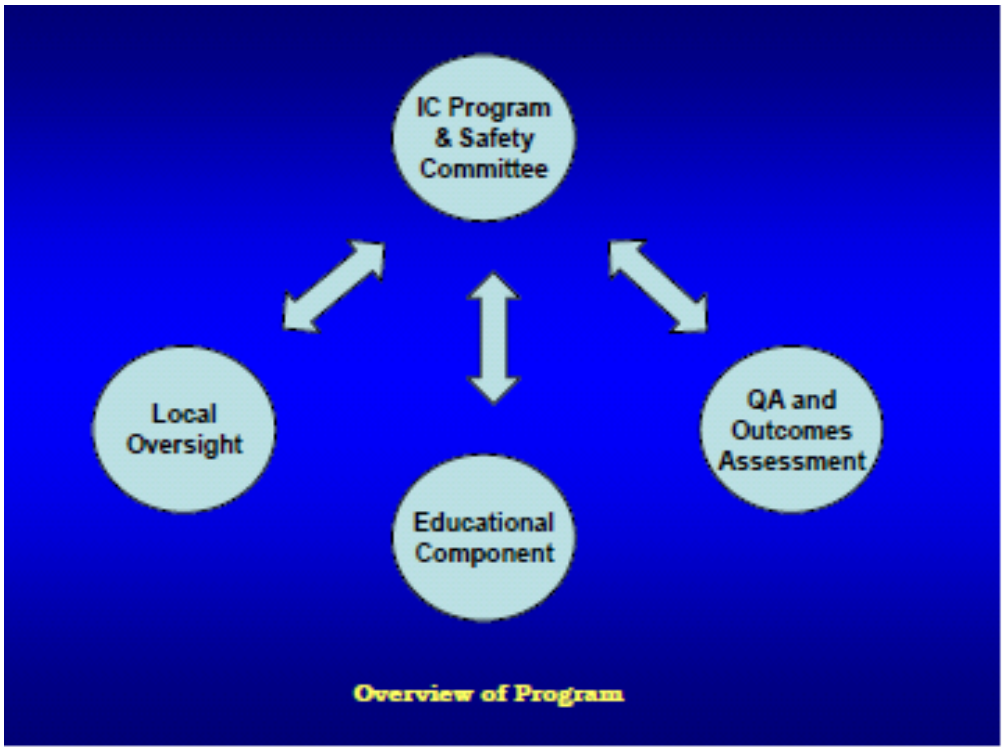

Figure 1: Overview of the Infection Control Program

The Infection Control Manual is available in Axium under Links>Manuals.

Student dentists will be most actively involved with chart audits and phase/treatment evaluations during their clinical experience while under the supervision of Team Leaders, Pre-doctoral Clinic Manager, and Compliance Analyst with assistance from Pre-doctoral Financial Counselor.

A description of the Selected Quality Indicators and protocols follows.

Patient Rights and Responsibilities and Notice of Privacy Practices

Objectives/Goals

1) Every patient receives a copy of Patient Rights and Responsibilities at initial registration
2) Every patient also receives a copy of Notice of Privacy Practices-HIPAA
3) Receipt of these documents are documented as captured in patient's EHR/axiUm

Process/Evaluation

At initial registration, patients receive printed material including the Patient Rights and Responsibilities and Notice of Privacy Practices-HIPAA document. The registration staff then scans the signed HIPPA document with the patient's signature into the patient's electronic health record in AxiUm into the attachments section. Also in the attachment section is a HIPAA form that documents that the patient received and signed or refused to sign the Notice of Privacy Practices.

A report can be generated through AxiUm to determine if all patients have received and signed the HIPPA document.

Thresholds

The threshold for Patient Rights and Responsibilities is 100%.
The threshold for HIPAA documentation is 100%

Corrective Action

The Quality Assurance Committee will take steps to improve any item that does not meet the threshold. The appropriate division will be notified or the appropriate protocol/policy will be evaluated to improve performance.

Follow-up

The Quality Assurance Committee will evaluate subsequent HIPAA and Patient Rights and Responsibility results for improvement. Additional action will be taken as needed.

University of Kentucky

College of Dentistry

PATIENT RIGHTS and RESPONSIBILITIES

You have the right to:

- Considerate, respectful and confidential treatment
- Continuity and completion of treatment
- Access to complete and accurate information about your condition
- Advance knowledge of the cost of treatment, explanation of your treatment fees and informed consent to treatment
- Explanation of recommended treatment, treatment alternatives, the option to refuse treatment, the risk of no treatment and expected outcomes of treatment
- Emergency, incremental and total patient care
- Treatment that meets the standards of care in the profession
- Access to a patient advocate

Your responsibilities include:

- Providing accurate and complete information about your medical history
- Questioning treatment or instructions you do not understand
- Keeping scheduled appointments and providing at least 48 hours' notice if you need to cancel appointments
- Providing information about payment for services and working with the College of Dentistry to ensure that financial obligations are met

NOTICE OF PRIVACY PRACTICES DOCUMENT

UKHealthCare

Notice of Privacy Practices

Effective April 14, 2003
Revised November 2011

THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

OUR PLEDGE REGARDING YOUR PROTECTED HEALTH INFORMATION (PHI)

We are committed to protecting the privacy of all health information we create and maintain as a result of the health care we provide you. Your "protected health information" (PHI) includes information about your past, present or future health, health care we provide you and payment for your health care contained in the record of care and services provided by University of Kentucky health care facilities. The purpose of this Notice is to explain who, what, when, where and why your PHI may be used or disclosed, and assist you in making informed decisions when authorizing anyone to use or disclosure your PHI.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

- To request in writing to the treatment area a restriction on the uses and disclosures of PHI as described in this Notice. We are not required to agree to the restriction you request. We may not be able to comply with your request in certain situations, which include emergency treatment, disclosures to the Secretary of the Department of Health and Human Services and uses and disclosures that do not require your authorization.
- To obtain a paper copy of this Notice and upon written request submitted to the UK health care facility maintaining the record, inspect and/or obtain a copy of your health record.
- To amend your health record by submitting a written request with the reasons supporting the request to the Medical Records department. We may deny your request if a) the record was not created by us, unless the person that created the record is no longer available to make the amendment; b) the record is not part of the health information used to make decisions about you; c) we believe the record is correct and complete; or d) you would not have the right to inspect and copy the record as described herein.
- To request in writing to the Privacy Officer a written list of disclosures we made of your health information, except that we are not required to account for disclosures for purposes of treatment, payment, operations, directory notification, disaster relief, as allowed under certain circumstances by law or pursuant to your authorization.
- To request in writing to the treatment area that we communicate with you by a specific method and at a specific location. We will typically communicate with you in person; or by letter or telephone.
- To revoke your authorization to use or disclose PHI at any time except, unless your authorization was obtained as a condition of obtaining insurance coverage, and except to the extent your PHI has already been disclosed pursuant to your authorization. Your revocation request must be made in writing to the Medical Records unit of the facility where you originally filed your authorization.

OUR RESPONSIBILITIES: We are required by law to:
Maintain the privacy of your PHI and provide you with notice of our legal duties and privacy practices with respect to PHI.
Abide by the terms of the Notice currently in effect. We have the right to change our Notice of Privacy Practices and we will apply the change to all of your PHI, including information obtained prior to the change.
Post notice of any changes to our Privacy Practices in the lobby and make a copy available to you upon request.

CONTACT FOR QUESTIONS/COMPLAINTS/REQUESTS
Direct your questions, complaints and requests made pursuant to this Notice to: **Privacy Officer, 2333 Alumni Dr., Suite 200, Lexington, KY 40517, (859)323-1184 or (859)323-8002**. You may also file a complaint with the Secretary of Health and Human Services. Filing a complaint will not result in retaliation.

HOW WE MAY USE AND DISCLOSE YOUR PHI
We may use and disclose your PHI for the following purposes:
Treatment: We may use and disclose your PHI to anyone involved in the provision of health care to you, including for example, University physicians, nurse practitioners, nurses and other medical professionals, including our medical students, residents and volunteers. We may also disclose your PHI to outside treating medical professionals and staff as deemed necessary for your health care.
Payment: We may use and disclose your PHI to billing and collection agencies, insurance companies and health plans to collect payment for our services.
Health Care Operations: We may use and disclose your PHI for our own health care operations. For example, we may use your PHI to assess your care in an effort to improve the quality of our service to you; to evaluate the skills, qualifications and performance of our health care providers; to provide training programs to students, trainees and other health care providers. In addition, our accountants, auditors and attorneys may use your PHI to assist our compliance with applicable law.
Business Associates: There are some services provided to our organization through contracts with business associates, such as laboratory and radiology services. We may disclose your health information to our business associates so that they can perform these services. We require the business associates to safeguard your information to our standards.
Individuals Involved With Your Care: We may disclose your PHI to family or others identified by you or who is involved in your care or payment for your care. We may also notify a family member, or another person responsible for your care, about your location and general condition, unless you object by contacting the caregiver at the facility providing your care.
Legally Required Disclosures & Public Health: We may disclose PHI as required by law, including to government officials to prevent or control disease, to report child, adult or spouse abuse, to report reactions or problems with products, and to report births and deaths.
Health Oversight Activities: We may disclose your PHI to a federal or state health oversight agency that is authorized to oversee our operations.
Workers Compensation: We may disclose PHI for workers compensation or similar programs.
Serious Threats to Health or Safety: We may disclose PHI if necessary to prevent or reduce the risk of a serious or imminent threat to the health or safety of an individual or the general public.
Law Enforcement & Subpoenas: We may disclose PHI to law enforcement such as limited information for identification and location purposes, or information regarding suspected victims of crime, including crimes committed on our premises. We may also disclose PHI to others as required by court or administrative order, or in response to a valid summons or subpoena.
Inmates: We may disclose your PHI to a correctional facility which has custody of you if necessary a) to provide health care to you; b) for the health and safety of others; or, c) for the safety and security of the correctional facility.
Information Regarding Decedents: We may disclose health information regarding a deceased person to: 1) coroners and medical examiners to identify cause of death or other duties, 2) funeral directors for their required duties and 3) to procurement organizations for purposes of organ and tissue donation.
Research: We may also disclose PHI where the disclosure is solely for the purpose of designing a study, or where the disclosure concerns decedents, or an institutional review board or privacy board has determined that obtaining authorization is not feasible and protocols are in place to ensure the privacy of your health information. In all other situations, we may only disclose PHI for research purposes with your authorization.
Marketing & Fund Raising: We may contact you with information about treatment alternatives or other health related benefits and services that may be of interest to you. We may also contact you as part of a fund raising effort.
Directory information: We may disclose your name, location and general condition to those persons who ask for you by name or to members of the clergy. You may object to such disclosure by contacting the Registration Office/Desk at the facility from which you received this Notice.
Appointment Reminders: We may use and disclose your PHI to provide a reminder to you about an appointment.
Treatment Alternatives: We may use and disclose your PHI to contact you about treatment alternatives that may be of interest to you.

DISCLOSURES REQUIRING AUTHORIZATION
All other disclosures of your PHI will only be made pursuant to your written authorization, which you have the right to revoke at any time, except to the extent we have already made disclosures pursuant to your authorization.

CHANGES TO THIS NOTICE
We reserve the right to change the terms of this Notice and to make new Notice provisions effective for all PHI that we maintain by posting the revised Notice at our facilities, making copies of the revised Notice upon request to the facility or the Privacy Officer, or posting the revised Notice on our website.

Revised 11.11

HIPAA CONSENT FORM DOCUMENTATION IN AXIUM

HIPAA

Form Question	Answer	Date
HIPAA CONSENT FORM		
Did the patient refuse to sign (or fail to return) the notice?	N	07/13/2011
Date Privacy Notice Given/Refused	07/13/2011	07/13/2011
Restrictions 1?		
Description:		
Restrictions 2?		
Description		

UKHealthCare

University of Kentucky Hospital A.B. Chandler Medical Center
UK HealthCare Good Samaritan Hospital
UK Healthcare Ambulatory Services

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that as part of *my* health care, University of Kentucky and its affiliates originates and maintains health records. These health records describe *my* health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning *my* care and treatment
- a means of communication among the many health professionals who contribute to *my* care
- a source of information for applying my diagnosis and medical treatment information to *my* bill
- a means by which a third-party payer (i.e. insurance company) can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

The University of Kentucky and its affiliates' *Notice of Privacy Practices gives* a more complete description of how *my* health information may be used or disclosed. The Notice also explains *my* rights regarding *my* personal health information, including the right to access *my* own records and the right to request restrictions as to how *my* health information is used or disclosed.

I understand it is *my* responsibility to notify University of Kentucky and its affiliates regarding *any* restrictions to disclosure of *my* health information regarding this or any subsequent visit.

I have been provided with *a Notice of Privacy Practices* and have been given the opportunity to review this notice.

Signature of Patient or Legal Representative Date

Witness Date

Patient Satisfaction Surveys

Objectives/Goals

1) Provide a satisfying experience for patients;
4) Survey patients' satisfaction with patient care and policies; and
5) Improve service when thresholds are not met.

Process/Evaluation

Assessment of patient satisfaction is an ongoing process conducted via surveys administered by the hospital's Press-Ganey Patient Satisfaction System. Between 130 and 150 surveys are mailed monthly to patients for each discipline with a return rate ranging from 10 to 30%. Our target patient satisfaction goal is set by UK HealthCare for the question, "Care provided by this office?" Random patients are selected to receive a satisfaction survey. Results are communicated to Clinic Manager, Team Leaders and Team Coordinator Supervisor for discussion with students and staff in the clinical areas.

Thresholds

The threshold for action on any survey item is less than an 80% positive response rate.

Corrective Action

Results are communicated to Clinic Manager, Team Leaders and Team Coordinator Supervisor for discussion with students and staff in the clinical areas. If necessary, a follow up phone conversation with the patient will be made and documented in the patient's contact notes section of their electronic record. If student professional behavior problem, appropriate remediation efforts will be made and the breach of professionalism will be documented as part of the student's course grade in CDS 823,CDS 833,CDS 843.

The Quality Assurance Committee will take steps to improve any item that does not meet the threshold. The appropriate division will be notified or the appropriate protocol/policy will be evaluated to improve performance. Additional survey questions will be developed as needed.

Follow-up

The Quality Assurance Committee will evaluate subsequent Patient Satisfaction Survey results for improvement. Additional action will be taken as needed.

PRESS-GANEY PATIENT SATISFACTIONSURVEY

UKHealthCare

DENTAL SERVICES SURVEY

we tnankyou In aavance ror compJetfng tnl8queetlonnalr&. v.llen you nave nrunea. pl$38& mu It . ,the enc10eeaenveJOp&.
Pl38rat& yoor v1Sit at:

THE SERVICE YOU RECEIVED (fill in one circle only - for example ●)

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- oae.nng
- RE91WROUtrl e Ex..-n
- Rest«a:on(rlmg. cwM\, onoge)
- Eoactron {lOOthpu:led}
- COSrne!le(Dieacttng, oon:dlng)
- own
- {gU'l\dr.ease)
- EnrlCxJ::Intlc (root ta'lal)
- Orthodontic (braces)
- Dentures
- Pediatric
- l. -__, -
- Oral Surgery
- Orafacial Pain
- Other

B:\CKCROD11 QUESTIONS (wri.ct ia u:wn or illiadrdt c•pproprUu)

1. Date of last visit: __ __ / __ __ / __ __ __ __ (month / day / year)
2. Time of day you arrived: __ __ : __ __ (hour : minute) O am. O p.m.
3. Was IJ'I'fiel F&-1:me yw na.euse<cupa:::t ce?.___ . OYes ONO
4. Did you have an appointment?.. O Yes O No
5. How many appointments have you had with us in the past 12 months?..... __ __
6. How many people in your household (including yourself) see this dentist? __ __
7. 01a)OUsee 1neoenoot on'el'f1tsll?— ...___ . OYes ONO
8. Dlasomeone ew)'Xlr medlcalti:siOl)'!. ..___ . QYes ONO
9. We-se-)01.11nany<IISCCl'IU'ett at.r:ng)Ol.f?...__ .QY$$ ONO
10. OO)'OUU'Icre>otanCl)OOr pt\Oeyflglll$?__...___ . .— OYes ONO
11. Have we respected your privacy rights?........................ O Yes O No
12. Il' -ro·to e : er dtMSe q.JeSI!Cn$. may we oontar:::t Y0J to <1:SCU6$ 0'11&?— OYes ONO

    IIIIIW — — — — — — — —

    Tum - - - - - - - - - - - - -
13. 1$<11ar.JIJilCCII'IlXEng IN$ SUW)'JI)raCh1Cl?•• •••.•— OYes ONO
14. Patient's sex .... O Male O Female
15. Patient's age.............................. __ __ __ years
16. M.Xn$0Urteotp.l)merttbr oau&eMC::e$:: l. . . . .__di'Cio oooj,
    - O Say
    - O PrtvateIn6U13'U
    - O Me<tcae;Mctcala
    - O UKDertt3"CarHMO

continued...

INSTRUCTIONS: Please rate the services you received from our facility. Fill in the circle that best describes your experience. If a question does not apply to you, please skip to the next question. Space is provided for you to comment on good or bad things that may have happened to you.

Please use black or blue ink to fill in the circle completely.
Example: ●

A. YOUR APPOINTMENT

(Skip any that do not apply)

	very poor 1	poor 2	fair 3	good 4	very good 5
1. Length of time between calling for an appointment and being seen by the provider	O	O	O	O	O
2. Helpfulness of the person who scheduled your appointment	O	O	O	O	O
3. Convenience of office hours	O	O	O	O	O
4. Availability of your provider	O	O	O	O	O
5. Courtesy of the receptionist	O	O	O	O	O
6. Length of wait before going into the treatment area/exam room	O	O	O	O	O
7. Ease of registration process	O	O	O	O	O

Comments (describe good or bad experience): _____

B. PROVIDER - PATIENT INTERACTION

	very poor 1	poor 2	fair 3	good 4	very good 5
1. Explanation of your options for treatment	O	O	O	O	O
2. Amount of time the provider spent with you	O	O	O	O	O
3. Provider's concern for your questions and worries	O	O	O	O	O
4. Caring shown by the provider	O	O	O	O	O
5. Thoroughness of exam and treatment	O	O	O	O	O
6. Your confidence in this provider	O	O	O	O	O
7. Degree to which the provider talked with you using language you could understand	O	O	O	O	O

Comments (describe good or bad experience): _____

C. DENTAL TEAM

	very poor 1	poor 2	fair 3	good 4	very good 5
1. Teamwork shown by the dental staff	O	O	O	O	O
2. Friendliness/courtesy of the dental assistant	O	O	O	O	O
3. Professionalism of the dental assistant	O	O	O	O	O
4. Friendliness/courtesy of the dental hygienist (person who cleaned your teeth)	O	O	O	O	O
5. Professionalism of the dental hygienist	O	O	O	O	O
6. Education provided by the dental hygienist on oral hygiene (e.g., brushing, flossing, etc.)	O	O	O	O	O
7. Waiting time before x-rays completed	O	O	O	O	O

Comments (describe good or bad experience): _____

Draft

D. FACILITY

	very poor 1	poor 2	fair 3	good 4	very good 5
1. Comfort of the reception room	O	O	O	O	O
2. Cleanliness of the facility	O	O	O	O	O
3. The infection control features used in the exam room	O	O	O	O	O
4. Degree to which equipment and facility are modern and up-to-date	O	O	O	O	O

Comments (describe good or bad experience): _____

E. PERSONAL ISSUES

	very poor 1	poor 2	fair 3	good 4	very good 5
1. Our concern for your comfort	O	O	O	O	O
2. Staff concerns/steps taken to protect you from infectious disease and excess radiation	O	O	O	O	O
3. Information provided on ways to avoid future dental problems	O	O	O	O	O

Comments (describe good or bad experience): _____

F. PAYMENT ISSUES

	very poor 1	poor 2	fair 3	good 4	very good 5
1. Information provided on cost of treatment	O	O	O	O	O
2. Availability of payment options	O	O	O	O	O
3. Degree to which the care provided was worth the money charged	O	O	O	O	O

Comments (describe good or bad experience): _____

G. OVERALL ASSESSMENT

	very poor 1	poor 2	fair 3	good 4	very good 5
1. Likelihood of your recommending this provider to others	O	O	O	O	O
2. Overall rating of the skill of this provider	O	O	O	O	O
3. Overall rating of care provided by this dental clinic	O	O	O	O	O

Comments (describe good or bad experience): _____

Your reasons for choosing this provider: **(fill in circles for all that apply)**

O Advertising (TV, radio)	O Location	O Professional Referral
O Recommendation of Friend	O Information in the Yellow Pages	O Insurance Plan
O Reputation of the Provider	O Price	O Web Site

Patient's Name: *(optional)* _____

Telephone Number: *(optional)* _____

Patient Concerns

Objectives/Goals

1) Provide a satisfying experience for patients;
2) Provide an avenue for patients to express concerns about care when issues cannot be solved by Team Leader and student; and
3) Quickly solve a patient's concern when possible.

Process

Patient dissatisfaction is usually resolved during regular clinic operations by the Team Leaders. Patients who are not satisfied with the Team Leader's decision are referred to the Office of Service Excellence. The Office of Service Excellence documents the complaint and works along with the Clinic Manager and Compliance Analyst to resolve the problem.

Evaluation

The Quality Assurance Committee evaluates the number and type of complaints at the recommendation of the Clinic Manager or Compliance Analyst.

Thresholds

Threshold for Patient Concerns is 80% as defined in UK HealthCare

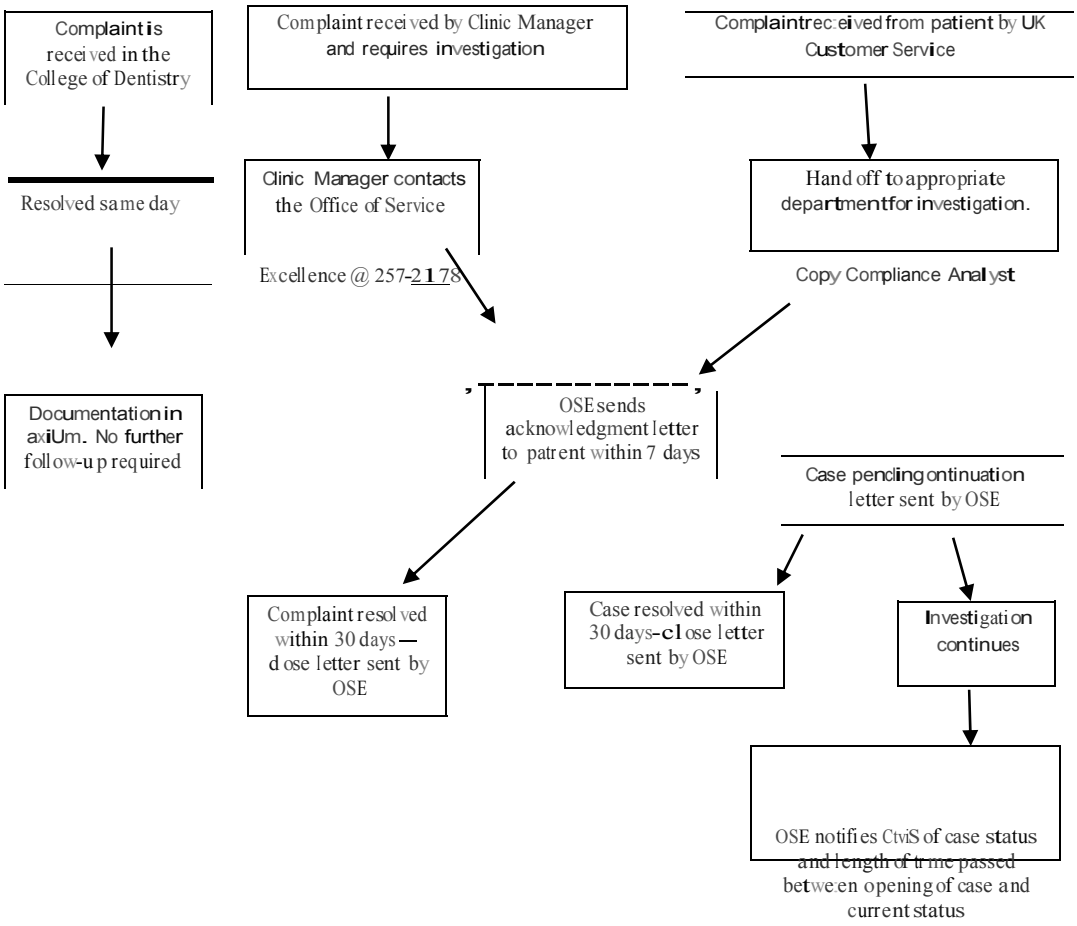
Corrective Action

If trends of specific problems are detected, the Quality Assurance Committee will involve the appropriate faculty, residents, staff, or students to prevent the problems from recurring. Policies and/or protocols that may be interfering with patient treatment and service will be evaluated.

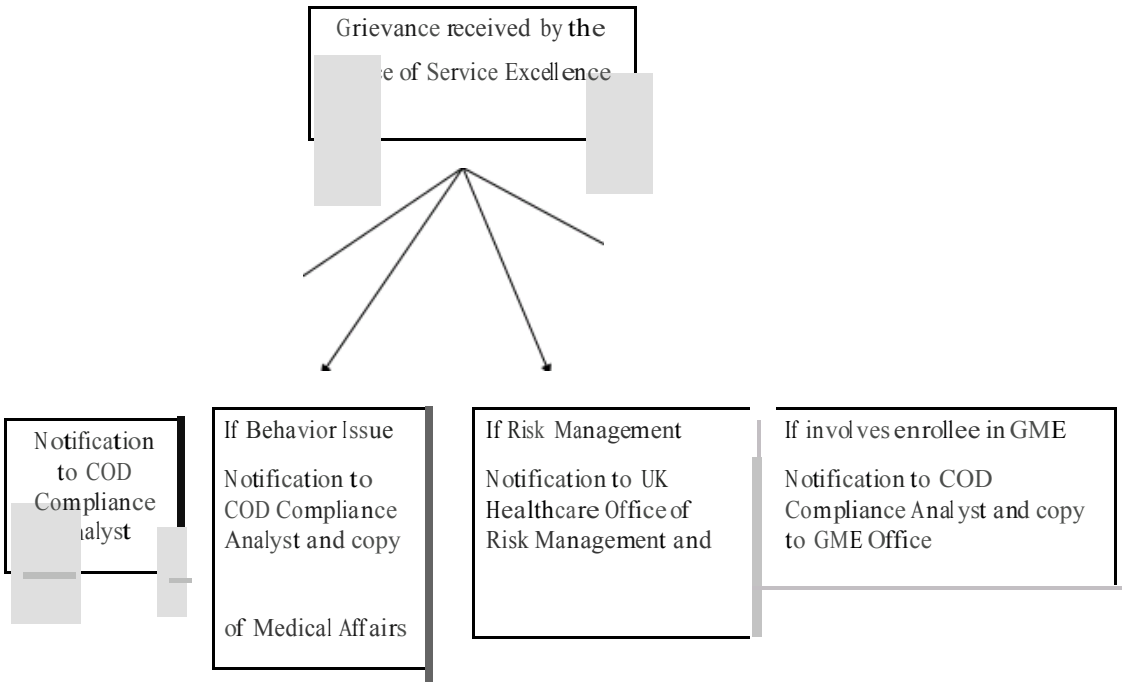
Follow-up

The Quality Assurance Committee will evaluate subsequent patient concerns for improvement or need for further action.

PATIENT COMPLAINTS AND GRIEVANCES PROCESS



OFFICE OF SERVICE EXCELLENCE



COMPLIANCE ANALYST PROCESS GRIEVANCE FOLLOW UP

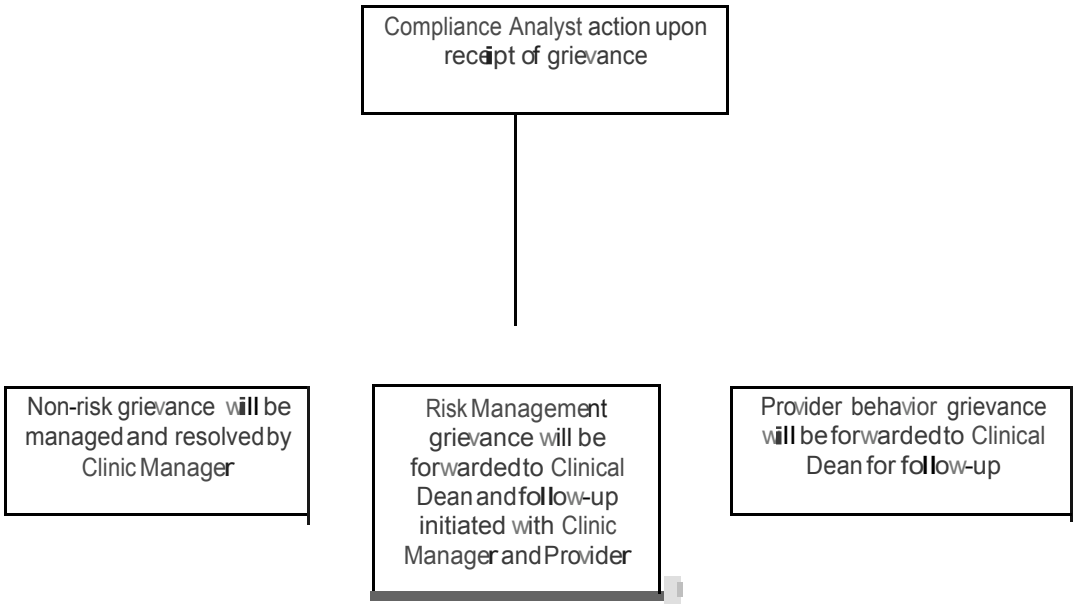


Chart Audits

Objectives/Goals

1) Maintain dental, legal and confidentiality compliance;
2) Examine charts for accuracy and completeness using predetermined criteria; and
3) Improve protocols.

Process

Team Leaders meet with their student members biannually for the purpose of chart review. In the fall, two charts per third and fourth year student are randomly selected by the team coordinator from the student's active patient pool. In the spring, two charts per second, third and fourth year student are randomly selected by the team coordinator from the active patient pool. The chart auditing process represents more than 10% of each student's active patients of record. The criteria for chart audit requirements are listed in the Clinic Manual. The nine areas audited include: medical history, radiographs, forms and worksheets, progress notes, treatment plan, treatment evaluation, informed consent and financial audit. The Team Coordinator selects two charts that each student must bring to each chart audit session. The chart audits will be graded and will factor into the student's management grade. Successful completion of these chart audits is required to receive a grade in (See the CDS 823, CDS 833, and CDS 843 syllabi for chart audit grading policies.

This review and its results are documented using the Predoctoral Clinic Standardized Chart Audit Form. The results are collected and analyzed and trends identified. The representative charts are immediately corrected for deficiencies and if trends are observed, additional charts are reviewed. Deficiencies that can be corrected during the chart audit will be completed by the Team Leader. An electronic post-it note will be placed in the axiUm patient record to remind the student of deficiencies that cannot be corrected at the time of the chart audit (vital signs, new Medical History, etc.). Deficient charts will be monitored regularly for completion by the Clinic Manager in consultation with the student, Team Leaders and Team Coordinators. Once deficiencies are corrected, the Clinic Manager removes the electronic reminder and a grade is entered for the chart audit. (See the CDS 823, 833, and 843 syllabuses for chart audit grading policies.)

The College of Dentistry is transitioning from paper audit forms to an electronic audit tracking system. The Quality Assurance Committee evaluates the results of chart audits and if trends are identified, a process has been established for bringing these clinical issues to the University of Kentucky Dental Care Board (UKDCB) if necessary. The UKDCB is the single forum in which all clinical care issues can be discussed with representation from all divisions and clinical areas within the College

Evaluation

The Team Leaders and Clinic Manager supervise the chart audits with the students. The Quality Assurance Committee evaluates the results of the chart audits for trends or high numbers of deficiencies.

Thresholds

Chart audit thresholds are 100%.

Corrective Action

If trends of deficiencies are detected, the appropriate Department Chair/Division Chief, students, faculty, or staff are notified by memo, e-mail, verbally, or any combination thereof, concerning the problem. Changes in protocols or procedures designed to improve the quality of patient care and record keeping will be implemented and disseminated to faculty, residents, staff, and students. Random chart audits can be performed at any time in the clinic, or if a student's previous performance warrants further attention.

Follow-up

The Quality Assurance Committee will monitor the results of subsequent chart audits for improvement in any deficiencies and for correction of previous problems. Further corrective action is taken if improvement is not seen. In addition, if remedial action is required a specific action plan will be developed for the student by the Team Leader in consultation if necessary with the Assistant Dean for Clinical Operations, Clinic Manager, Compliance Analyst and Associate Dean of Clinical Affairs.

Predoctoral Clinic Standardized Chart Audit Form

Patient Name _____ Chart Number _____ Date _____

Student Name _____AxiUm Number _____

Medical History

1) Complete in AxiUm**	□ Yes	□ No	□ N/A**
2) Medical History Approved by faculty	□ Yes	□ No	□ N/A
3) Medical History updated every 6 months or as needed if changed	□ Yes	□ No	□ N/A
4) Medical History update approved by faculty	□ Yes	□ No	□ N/A
5) Vital signs recorded (Med Hist or EHR notes)	□ Yes	□ No	□ N/A

Radiographs

1) Radiographic Interpretation completed and approved	□ Yes	□ No	□ N/A

Data Base and Clinical Examination

1) All appropriate forms approved by faculty	□ Yes	□ No	□ N/A

Check All Incomplete / Unapproved Forms

□	OD Data Collection Guide (ODDATA)	□	Perio Diagnosis/Tx Plan (PERIO)
□	Clinical Exam (CLEXAM)	□	Periodontal Charting in AxiUm
□	Dental History (ADHIST)	□	Prosthodontic Diagnostic Index (PDI)
□	Chief Complaint (CMPLT)	□	Implant Worksheet (5D)
		□	Consultation Notes

Progress Notes

1) SHAPED format followed	□ Yes	□ No	□ N/A
2) Approved by faculty	□ Yes	□ No	□ N/A
3) Progress note matches billed treatment	□ Yes	□ No	□ N/A

Treatment Plan

1) Treatment plan approved by faculty	□ Yes	□ No	□ N/A
2) Financial arrangements completed	□ Yes	□ No	□ N/A

Informed Consent(s)**

1) General Consent (completed and signed by patient and provider)	□ Yes	□ No	□ N/A**
2) Specific Consent(s) (completed and signed by patient and provider)	□ Yes	□ No	□ N/A

Missing_____

Treatment Evaluation

1) Treatment Evaluation Form completed in axiUm and approved	□ Yes	□ No	□ N/A
2) Recall interval current	□ Yes	□ No	□ N/A

Financial Evaluation

1) Patient account/payment plan current	□ Yes	□ No	□ N/A
2) Aged Balance By Provider reviewed with TL/Financial Counselor (Find in Personal planner- action required?)	□ Yes	□ No	□ N/A

Evaluation by _____ Grade_____

□ Deficiency correction required

Each Deficiency= 8 point deduction of 100 point total

****Each Critical Deficiency= 24 point deduction of 100 point total** July 2015

Phase/Treatment Evaluations

Objectives/Goals

1) Maintain and improve quality of patient care;
2) Evaluate patients at the end of active treatment for any deficiencies in care provided;
3) Correct any deficiencies detected in a reasonable amount of time; and
4) Improve teaching and performance when needed to decrease deficiencies.

Process

The Phase or Treatment Evaluation is performed at the last appointment of active treatment by the student and Team Leader or Oral Diagnosis faculty. The Treatment Evaluation Form (Form 6) guides the process. Any deficiencies are noted on the form and in the computer along with the procedure(s) that will correct the problem. Any deficiencies in treatment rendered will be noted in axiUm and an Account Adjustment Request (AAR) form will be generated. These forms are completed by the Team Leader or Clinic Manager. Any treatment that was completed but determined deficient within one year will be remedied at no additional charge to the patient. Other procedures noted to be deficient after one year of completion will be reviewed in monthly meetings by the Compliance Committee. This committee monitors the AAR reports and reviews each AAR record and renders a decision. An appointment is scheduled to correct the deficiency. After completion of the corrective procedure, the deficiency code and corrective procedure code are completed in the computer (AxiUm).

Evaluation

The Quality Assurance Committee will monitor the frequency of Phase Evaluations and deficiencies each semester. The Clinic Manager queries the database for the information. Multiple deficiencies or trends indicate the need for corrective action.

Thresholds

Corrective action is taken when five similar deficiencies (e.g. fractured porcelain restorations) are detected during the year.

Corrective Action

If trends of deficiencies are detected, the appropriate Department Chair/Division Chief, students, faculty, or staff are notified by memo, e-mail, verbally, or any combination thereof, concerning the problem. Changes in teaching or clinical practice will be implemented when needed. These changes will be carefully articulated to the appropriate students, faculty, and staff.

Follow-up

The Quality Assurance Committee will monitor the results of subsequent Phase Evaluations for improvement in the frequency of deficiencies. Further corrective action will be taken if improvement is not seen.

TREATMENT EVALUATION (Form 6)

(To be completed at the end of active Phase I and/or Phase II Treatment
Faculty- Team Leader should assess while student present. May be done at next recall)
Patient Name_____ Patient Chart #_____
Student_____Student #_____Team _____Date_____
Select which Treatment Phase is being Evaluated:
Phase I Disease Control _____ or Phase II Advanced Restorative _____

Discipline	Complete	Incomplete	Observation	Comments
Periodontics	D		DD	_____
Restorative	D		DD	_____
Prosthodontics	D		DD	_____
Endodontics	D		DD	_____
Risk Assessment	D		DD	_____
Informed Consent	D		DD	_____
Other_____	D		DD	_____

Oral Hygiene D Satisfactory
D Demonstrated Improvement
D Unsatisfactory

Treatment Deficiency (operator or previous student)
(Record AxiUm code in computer as planned; once resolved will swipe to completion)

Discipline	AxiUm Code (See back page for Details of Deficiency)	Tooth/Teeth/Area	*Deficiency
D Oral Diagnosis	ODDEF	_____	_____
D Periodontics	PERDEF	_____	_____
D Restorative	RESTDEF	_____	D
Endodontics	ENDODEF	_____	D
Prosthodontics	PROSDEF	_____	D
OMFSurgery	OMFSDEF	_____	D OTHER
OTHRSDEF	_____		_____

*AAR REQUIRED FOR ALL DEFICIENCIES

Chief Complaint Addressed? Yes___ In Progress___
No please comment_____

Disease Control Phase I Completed? Yes___ In Progress___
No please comment_____

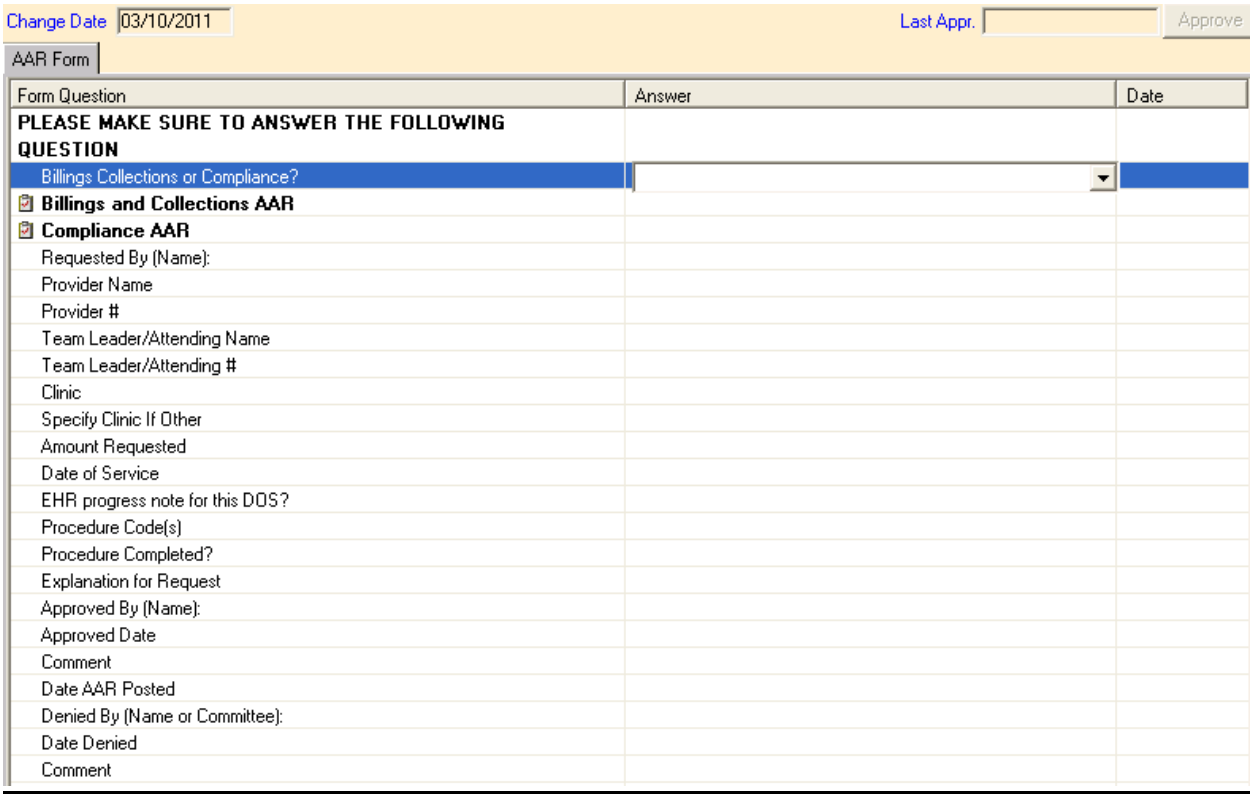
Phase II Completed? Yes (date)_____ In Progress____
No please comment_____

New Findings- (clinical or radiographic findings/diagnoses)_____
_____
New Treatment Needs (enter on treatment plan and have faculty approval)
_____
Areas to Monitor or Observe_____
_____
Patient Disposition (Record in AxiUm). ACTIVERECALL- Prophy, PerioM, Pros

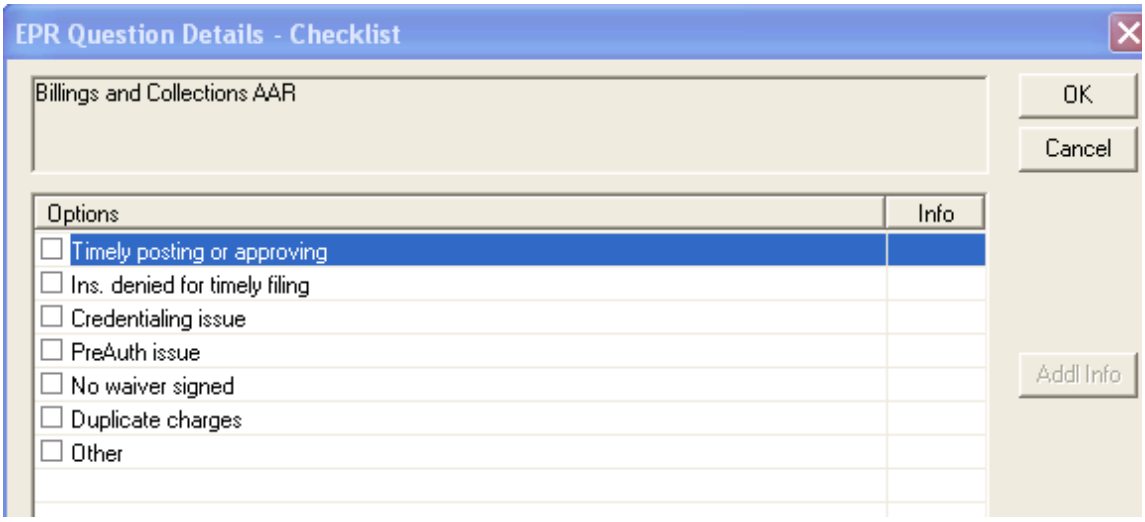
Recall Interval: D 3 mon. D 4 mon. D 6 mon. D12 mon. D Other_____

Faculty Signature_____Note: Phase I or II Eval change to Completed in AxiUm

ACCOUNT ADJUSTMENT REQUEST



BILLING and COLLECTIONS Account Adjustment Request



COMPLIANCE COMMI'ITEE Acconnt Adjustment Request

Active Treatment Review

Objectives/Goals

1) Maintain compliance with clinic policy, patient management, and quality of care;
2) Assess students on an as needed basis; and
3) Educate and improve performance of students (when necessary).

Process

Team Leaders conduct this activity on a random basis. It can be conducted at the operatory with the patient present or in the Team Leader's office. The active treatment review is done on an as needed basis, and is often initiated by poor student performance. The active treatment review process can be an informal or formal process at the Team Leader's discretion. Timeliness of treatment, patient management, documenting patient care, and appropriate and timely billing are some of the student's performance areas that can be evaluated.

Evaluation

Individual Team Leaders will assess the students in their team as needed. Poor performance will affect the student's management grade.

Thresholds

None established. Team Leaders will assess the student's performance and work with the student as needed.

Corrective Action

The Team Leader will work with the student to improve performance.

Follow-up

The Team Leader will monitor the student's performance. Additional corrective action will be taken if there is no improvement.

Biohazard Incidents

Objectives/Goals

1) Maintain a safe environment in the student clinic;
2) Record and evaluate for trends all biohazard incidents in the patient care area; and
3) Educate students, faculty and staff on proper disposal of sharps (i.e., endo files, needles, blades, etc.) when needed.

Process

Improper handling of biohazard materials and sharp objects are reported to the Clinic Manager. Reports are documented and appropriate faculty, staff, and/or students are notified of the problems.

Evaluation

The Quality Assurance Committee evaluates the number of incidents every semester or on an as needed basis for trends. Preventive efforts will be taken when new techniques are taught to students (e.g. the start of the 2nd year preclinical endodontics class usually brings an increase in endodontic files inadvertently deposited in the trash instead of the sharps container. The course director will educate students before and during the course and Team Leaders will counsel students who have been reported).

Thresholds

Corrective action will be taken when five similar incidents (e.g. five needle sticks or five lacerations) occur in a year.

Corrective Action

The appropriate faculty, residents, staff, or students are notified when problems are detected. Team Leaders will notify individual students when biohazard incidents have occurred in their operatory. Changes in policies or protocols will be implemented if needed.

Follow-up

The Quality Assurance Committee will evaluate subsequent reports for improvement of deficiencies. Further action is taken when needed.

IMMEDIATE ATTENTION REQUIRED

UK College of Dentistry Compliance Program

PPE	Infection Control	Behavior/Management
Safety Glasses—Self	Cross Contamination	Inappropriate
Safety Glasses—Pt.	Barriers missing	Failure to clean operatory after apt
Side Shields	Clinic gown outside clinic	Beginning pt. tx before faculty approval
Gloves	Failure to flush lines	Dismissing pt. before faculty evaluation
Mask	Rag wheel not sterile	Dress Code violation
Footwear	Pumice not fresh	Initiated tx without informed consent
Gown	Impressions not disinfected	Food or drink in clinic
Re-cap syringe/ safety shield	Gloves on at dispensary	
Sharps not in sharps container		

Provider Name

Cubicle/Department

BIOHAZARD INCIDENT LOG FOR STUDENT CLINICS

University of Kentucky College of Dentistry					LOG
OSHA Occurrences					
STUDENT CLINICS				At this location	
Date	Time	Clinic/Operatory	Item(s) Found- Describe issue	Students or Operators	Summary of Action taken

Blood borne Pathogens Exposures

Objectives/Goals

1) Maintain a safe working environment in the student clinic;
2) Compile records of all blood borne exposures and evaluate for trends; and
3) Revise existing policies when needed to improve safety.

Process

All blood borne exposure incidents must be reported online thru UHC Patient Safety Net® (PSN) is an easy-to use Web-based event reporting and management tool. The PSN captures information about adverse events, near misses, and unsafe conditions that involve employees, patients, students, residents, and visitors. Effective use of the tool improves communication and collaboration that are critical to patient safety.

A specific protocol is then to be activated which involves testing of the dental healthcare personnel and patient, as well as provision of treatment, if required. The compliance analyst will be notified of all exposures and the dental healthcare personnel will be referred to the University Health Service for evaluation and, if necessary, treatment. Patients will be asked to voluntarily submit blood sample for testing for HIV, and Hepatitis status. In addition, an analysis of the incident will be immediately undertaken by the local safety officer and compliance analyst and a report submitted to the Safety/IC Officer which outlines the incident and lists ideas as to how future incidents might be prevented; a log of these incidents shall be maintained by the exposure coordinator.

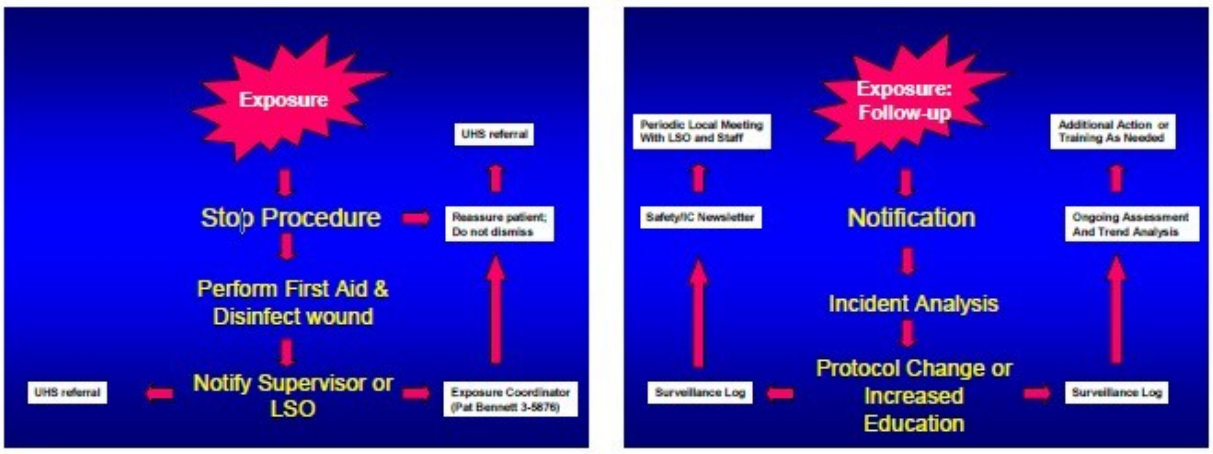


Figure 5: Post-exposure protocol

Evaluation

The Incident Review Team, a subcommittee of the Safety and Infection Control Committee, reviews all exposures on a quarterly basis to determine trends and educational opportunities. The Quality Assurance Committee reviews incident outcomes annually. In a teaching clinical environment, exposures will occur, but all attempts will be made to eliminate exposure incidents.

Thresholds

Corrective action will be taken when five similar exposures occur in a year.

Corrective Action

The Incident Review Team will notify the appropriate faculty, residents, students, and staff when problems are detected. Additional training or changes in protocol will be implemented when needed.

Follow-up

The Incident Review Team and Quality Assurance Committee will evaluate subsequent blood borne incident reports for improvement. Further corrective action will be taken if needed.

BLOODBORNE PATHOGEN OCCUPATIONAL EXPOSURE PROTOCOL Cltu Jarbot pagt.r N 330-?213

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Ptrfo1111 Basic First Aid

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KENTUCKY CLINIC OR COLLEGE OF DENTISTRY SOURCE PATIENT

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HIGH RISK EXPOSURES: It is important that you indicate either to UK Worker's Care or to the UHS appointment clerk and to the clinician that your exposure may be HIGH RISK.

YOU MAY BA\I'£ A HIGH tuSK EXPOSURE If:

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UK HealthCare Safety Net Incident Report

FOLLOWING FORM SHOULD BE COMPLETED ONLINE: http://careweb.mc.uky.edu/psn/
IF UNAVAILBLE HOWEVER CAN PRINT, COMPLETE and FAX.

Download and print the form, complete all relevant sections, and provide copy to your manager and also to Risk Management by faxing the form to 257-2498; OR save to your desktop under the patient or employee name, and email to your manager and Paula Holbrook (pjholbrook@uky.edu) with "CONFIDENTIAL PSES/PSWP" in the subject heading.

***Please select who was affected by the event:**

O Patient
O Staff
O Visitor
O Other

Name:

Last Name: **First Name** **MI**

***Date of Birth:**

Date (mm/dd/yyyy): _____/_____/_____OUnknown
Or
(International) Date (dd/mm/yyyy) ___ /___/_____OUnknown

***Gender:**

M F
Unknown

Medical Record or Patient Account Number (only when incident involves patient)**:**

Encounter Number (only when incident involves patient)**:**

Does patient have Hispanic or Latino ethnicity? (only when incident involves patient)**:**

M F
Unknown

Race: (only when incident involves patient)

American Indian or Alaska Native
Asian
Black or African American
Native Hawaiian or other Pacific Islander
White
More than one race
Unknown

Patient's principal diagnosis code: (Enter ICD-9-CM Code) (only when incident involves patient)**:**

Patient's principal procedure code: (Enter ICD-9-CM Code) (only when incident involves patient)**:**

Date of Admission or Ambulatory Encounter: (only when incident involves patient)**:**

Date (mm/dd/yyyy) _____ /_____/_____ **O**Unknown
Or
(International) Date (dd/mm/yyyy) ___ /___/_____ **O**Unknown

Event Basics

***Event Type:**

***Event Discovery Date and Time (military):**

Date (mm/dd/yyyy) ____/_____/_____**O**Unknown Time (military): ___:___**O**Unknown
Or
(International) Date (dd/mm/yyyy) ___/___/____**O**Unknown Time (military): ___:___**O**Unknown

***Event Occurrence Date and Time (military):**

Date (mm/dd/yyyy) ____/_____/_____**O**Unknown Time (military): ___:___**O**Unknown
Or
(International) Date (dd/mm/yyyy) ___/___/____**O**Unknown Time (military): ___:___**O**Unknown

***Primary Location where event occurred:**

Other Location or Service (if applicable):

Clinical/Hospital Service:

Was the event related to handover/handoff?

Yes No
Unknown

Was health information technology (HIT) implicated in this event?

Yes No
Unknown

How did you learn about the event? (Check all that apply)

- **O** Report by another staff member
- **O** Report by family or visitors
- **O** Report by patient
- **O** Review of record or chart
- **O** Witnessed / Involved
- **O** Other

Event Detail

Describe the event in your own words:

Describe any factors contributing to the event, lessons learned, and/or recommendations to prevent recurrence:

Harm Score

***Extent of harm:**

Physical harm:

9 Death
8 Severe permanent harm
7 Permanent harm
6 Temporary harm

No physical harm:

5 Additional treatment

4 Emotional distress or inconvenience

3 No harm evident, physical or otherwise

2 Near miss

1 Unsafe condition

***What prevented the near miss from reaching the patient?**

- **O** Fail-safe designed into the process and/or a safeguard worked effectively
- **O** Practitioner or staff who made the error noticed and recovered from the error (avoiding any possibility of it reaching the patient)
- **O** Spontaneous action by a practitioner or staff member (other than person making the error) prevented the event from reaching the patient
- **O** Action by the patient or patient's family member prevented the event from reaching the patient
- **O** Unknown
- **O** Other

How long after the incident was harm assesses (approx)?

Within 24 hours
After 24 hours but before 3 days
3 days or later
Unknown

Was any intervention attempted to prevent, reverse or halt the progression of harm?

Yes

No
Unknown

Which of these interventions (rescues) were performed? (Check all that apply): <

- O Transfer, including transfer to a higher level of care area within facility, or transfer to another facility, or hospital admission (from outpatient)
- O Monitoring, including observation, physiological examination, laboratory testing, phlebotomy, and/or imaging studies
- O Medication therapy, including administration of antidote, change in pre-incident dose or route
- O Surgical intervention
- O Respiratory support (e.g., ventilation, tracheotomy)
- O Blood transfusion
- O Counseling or psychotherapy
- O Unknown
- O Other intervention(specify):

Nature of Injury:

Abrasion
Allergic Reaction
Aspiration
Bite
Blister
Bruise
Thermal Burn
Electrosurgical Burn
Cellulitis
Compartment Syndrome
Contusion
Dental Injury
Dislocation
Edema
Extravasation
Fracture
Hematoma
Hemorrhage
Infection
Infiltration
Laceration
Pain
Phlebitis
Pulmonary Embolism
Punctured
Rash
Retained Foreign Body
Scratch
Skin Tear
Ulcer
No Injury
Other

Who else was involved (patient, staff, visitor)?

Last Name	First Name	Phone or email	Dept

Who was notified? (Check all that apply)

O Covering Physician Date (mm/dd/yyyy) ___/___/____OUnknown Time (military): ___:___
OUnknown

Or (International)

Date (dd/mm/yyyy) ___/___/____OUnknown Time (military): ___:___
OUnknown

O Patient or family Date (mm/dd/yyyy) ___/___/____OUnknown Time (military): ___:___
OUnknown
designated contact

Or (International)

Date (dd/mmyyyy) ___/___/____OUnknown Time (military): ___:___
OUnknown

OEmployee health
OHuman resources
ONurse
OManager/Supervisor
ORisk Management (by phone)
OSecurity/Police
OOther (specify):

Reporter Info

Reporter Role:

Reporter Name Last Name: **First Name** **MI**

Registered Nurse
Charge Nurse
Float nursing staff
Nurse's Aide
Nurse Practitioner
Nursing Student
LPN
CRNA
Pharmacist Pharmacy
resident Pharmacy student
Pharmacy technician
Physician – attending/staff
Physician – resident/intern/fellow
Physician Assistant
Medical Assistant
Medical student
Midwife
Respiratory therapist Radiation
Therapist Technologist/Technician
(lab, X-ray,
etc)
Security
Volunteer
Care Tech
Unit secretary/Clerk
Manager
Lab/Radiology Tech
Laboratory Coordinator/Supervisor
Specimen/pathology Coordinator
Phlebotomist
Mental Health Counselor
Clinic Director LCSW
Dietician/dietary aide
Paramedic/EMT
Patient Relations/representative
Social worker
Chaplain
PT/OT
Infection Control Practitioner
Anonymous
Other (specify) <Single Line Text Box
MAX 250 CHAR>

Reporter Contact Information:

Phone

Email:

O **Check here if you would like feedback from your manager and confirmation of report submission by email**

URGENT CARE/ WALK IN EMERGENCY CLINIC

Objectives/Goals

1) Patients presenting with urgent treatment needs receive a limited focused evaluation; and
2) Patients with urgent treatment needs receive treatment necessary to stabilize their condition.

Process

Each semester students have the opportunity to experience a one-week rotation in the Urgent Care Clinic during both 3rd and 4th year. Second year student dentists spend one week during their second year. This rotation teaches the clinical applications of risk assessment, diagnosing and treating patients that present to the walk-in clinic with episodic / acute dental problems. At the end of these rotations students will have gained the knowledge and clinical experience to efficiently manage the urgent dental care patient. They are supervised by faculty in the Division of Oral Diagnosis, Oral Medicine and Oral and Maxillofacial Radiology.

Evaluation

Individual faculty will assess the students in their Urgent Care Rotation. Query of the axiUm system will determine if each urgent care patient did receive a limited focused evaluation as well as treatment to stabilize their condition.

Thresholds

axiUm Reporting of missing documentation for Urgent Care Patients will be monitored. Threshold is 100% for documentation of evaluation and treatment of urgent care patients.

Corrective Action

The faculty in Urgent Care and Behavioral Sciences will follow up with the student to discuss performance and need for remediation.

Follow-up

The Team Leader will be notified of the student's performance if remedial activities are required. Additional corrective action will be taken if there is no improvement.

Ceramics Laboratory Quality Assurance Guidelines

Objectives/Goals

1) Maintain and improve the quality of the ceramic lab work to improve patient care;
2) Evaluate a random sample of lab work for quality; and
3) Correct deficiencies when identified.

Process

Each year the Ceramics Laboratory Supervisor will attach the quality assessment form to cases in a random manner that will ensure that each technician has an equal number of cases evaluated. The student dentist and faculty member will evaluate the fit, function, and esthetics of the lab work and fill out the quality assessment form. The form is returned to the Ceramics Laboratory Supervisor by placing it in with the Restorative evaluations in the back of the 2nd floor clinic. Remake rates of Ceramics Lab work will also be evaluated.

Evaluation

The Ceramics Laboratory Supervisor will evaluate each assessment form as they are returned to give the technicians immediate feedback on the quality of their work. The Assistant Dean of Clinical Affairs will evaluate the results twice a year for deficiencies in quality or trends.

Thresholds

Any areas that have deficiencies of over 15% will be reviewed for improvement.
Remake rate: <5%

Corrective Action

If deficiencies are detected, the Ceramics Laboratory Supervisor, the Ceramics Laboratory faculty liaisons, and the Assistant/Associate Dean of Clinical Affairs will meet to discuss strategies for improvement. Results will be discussed at the Quality Assurance Committee as well. Input will be solicited from any other faculty, staff, or students who may be able to help. Resulting changes in protocols or procedures will be disseminated to faculty, residents, staff, and students by memo, e-mail, verbally or any combination thereof.

Follow-up

The Ceramics Laboratory Supervisor, the Ceramics Laboratory liaisons, and the Assistant/Associate Dean of Clinical Affairs, along with the Quality Assurance Committee, will monitor the results of subsequent quality assessments for improvements in any deficiencies that have been identified. Further corrective action is taken if improvement to meet the threshold is not demonstrated.

University of Kentucky College of Dentistry
Ceramics Laboratory Quality Assessment

Faculty/Student Clinical Evaluation

Student_____ Faculty_____

Patient Name_____ Chart #_____

Type of Restoration_____ Tooth/Teeth_____

Student_____ Faculty_____

Please indicate tooth/teeth if multiple units are involved.

1) Occlusion

good high light out

2) Proximal Contacts

good tight open mal-positioned

3) Margins

good open short long bulky

4) Shade Match

Did the shade selected match the adjacent teeth?
yes no
Did the lab provide you with the shade you selected?
yes no

5) Contours

good over-contoured under-contoured

6) Case Cemented

yes no (please provide comments below if unable to cement.)

Comments

Prosthodontic Laboratory Quality Assurance Guidelines

Objectives/Goals

1) Maintain and improve the quality of prosthodontic lab work to improve patient care;
2) Evaluate a random sample of lab work for quality; and
3) Correct deficiencies when identified.

Process

Each year the Prosthodontic Laboratory Supervisor will attach the quality assessment form to cases in a random manner that will ensure that enough cases are evaluated. Removable partial dentures and complete dentures will be evaluated using different assessment forms. The student dentist and faculty member will evaluate the fit, function, and esthetics of the lab work and fill out the quality assessment form. The form is returned to the Prosthodontic Laboratory Supervisor by placing it in with the Removable Prosthodontic evaluations in the back of the 2nd and 3rd floor clinics. Remake rates of removable partial dentures will also be evaluated.

Evaluation

The Prosthodontic Laboratory Supervisor will evaluate each assessment form as they are returned to give the technicians immediate feedback on the quality of their work. The Assistant Dean of Clinical Affairs and the Division Chief of Prosthodontics, as well as the Quality Assurance Committee, will evaluate the results twice a year for deficiencies in quality or trends.

Thresholds

Any areas that have deficiencies of over 15% will be reviewed for improvement.
Remake rate: <5%

Corrective Action

If deficiencies are detected, the Prosthodontic Laboratory Supervisor, the Prosthodontic Laboratory faculty liaison, the Prosthodontic Division Chief, and the Assistant/Associate Dean of Clinical Affairs will meet to discuss strategies for improvement. Results will be discussed at the Quality Assurance Committee as well. Input will be solicited from any other faculty, residents, staff, or students who may be able to help. Resulting changes in protocols or procedures will be disseminated to faculty, staff, and students by memo, e-mail, verbally or any combination thereof.

Follow-up

The Prosthodontic Laboratory Supervisor, the Prosthodontic Laboratory liaison, the Prosthodontics Division Chief and the Assistant/Associate Dean of Clinical Affairs, along with the Quality Assurance Committee, will monitor the results of subsequent quality assessments for improvements in any deficiencies that have been identified. Further corrective action is taken if improvement to meet the threshold is not demonstrated.

University of Kentucky College of Dentistry
Prosthodontics Laboratory Quality Assessment
Faculty/Student Clinical Evaluation

Complete Denture

Patient Name_____ Chart #_____

Student_____ Faculty_____

Date_____

1. Denture processed with correct resin.
   YES NO

2. Denture resin free of porosity.
   YES NO

3. Denture base polished.
   YES NO

4. Occlusion-processing errors corrected.
   YES NO

5. Teeth broken or fractured.
   YES NO

6. Denture border finished properly.
   YES NO

7. Thickness of denture appropriate.
   YES NO

8. Comments

_____

_____

_____

_____

9. Overall quality of denture. (Circle one)

5	4	3	2	1
Good		Acceptable		Needs Improvement

University of Kentucky College of Dentistry
Prosthodontics Laboratory Quality Assessment
Faculty/Student Clinical Evaluation

Removable Partial Denture

Patient Name_____ Chart #_____

Student_____ Faculty_____

Date_____

1. Framework design followed accurately.
   YES NO

2. Clasp shaped properly.
   YES NO

3. Clasp positioned properly.
   YES NO

4. Framework smooth and polished.
   YES NO

5. Acrylic resin polished.
   YES NO

6. Teeth broken or fractured.
   YES NO

7. Occlusion-processing errors corrected.
   YES NO

8. Comments

_____
_____
_____
_____

9. Overall quality of RPD (Circle one)

5	4	3	2	1
Good		Acceptable		Needs improvement

Informed Consent Process

Objectives/Goals

1) Every practitioner in the College of Dentistry has obtained Informed Consent when treating a patient.

Process

Although a written consent form is not legally required to obtain informed consent, such a document serves to facilitate the discussion with the patient. In January 2011, the College transitioned to an electronic informed consent process through the electronic health record. The electronic format provided the introduction and management of customized informed consent forms for various dental procedures.

This effort recognizes significant enhancement over the blanket type informed consent forms utilized previously. This also demonstrates that the College understands that different procedures/types of treatment have different risk and benefits and thus we have developed multiple forms to cover the wide range of treatment provided within the College. Students are exposed to a variety of informed consent forms during their experiences in comprehensive care, urgent care, oral and maxillofacial surgery, orthodontic, orofacial pain, and pediatric dentistry clinics.

Evaluation

As we transition from paper to electronic health record we will be able to query the axiUm system for compliance with the informed consent process. In addition through the scheduled Chart Audits in the student clinic each semester as well as ongoing Phase Treatment evaluations we are able to monitor compliance. These evaluations and audits are a requirement of clinical courses CDS 823, 833, 843. Successful completion and remediation of deficiencies are required as part of these courses.

Thresholds

axiUm Reporting of missing documentation for Informed Consent will be monitored. Threshold is 100% for documentation of Informed Consent.

Corrective Action

If trends of deficiencies are detected, the appropriate Department Chair/Division Chief, students, faculty, or staff are notified by memo, e-mail, verbally, or any combination thereof, concerning the problem. Changes in protocols or procedures designed to improve the quality of patient care and record keeping will be implemented and disseminated to faculty, residents, staff, and students. Random chart audits can be performed at any time in the clinic, or if a student's previous performance warrants further attention.

Follow-up

The Quality Assurance Committee will monitor the results of subsequent chart audits for improvement in any deficiencies and for correction of previous problems. Further corrective action is taken if improvement is not seen. In addition, if remedial action is required a specific action plan will be developed for the student by the Team Leader in consultation if necessary

with the Division Chief of Comprehensive Care, Clinic Manager, Compliance Analyst and Associate Dean of Clinical Affairs.

LIST OF INFORMED CONSENTS AVAILABLE IN AXIUM ELECTRONIC HEALTH RECORD

axiUm Code	Descriptor
GENERL	General Consent (includes simple Restorative)
PEDO	Pediatric Dental Treatment
ENDO	Endodontics (non-surgical)
ENDOSG	Endodontics Surgical (Apicoectomy)
IMPLAN	Implant Surgical Placement
PRSIMP	Implant Restoration- Prosthodontic Treatment
ORSURG	Oral Surgery (Extractions)
SEDAT	Sedation
ORTHO	Orthodontic Treatment
PERIO	Periodontal Treatment- Non surgical (e.g. Scaling and Root Planing)
PERSUR	Periodontal Surgical Treatment
PROSTH	Fixed Prosthodontic Treatment
REMPAR	Removable Complete / Partial Dentures
OTHERS	
ORALAP	Oral Appliance for TMD SLEEP
	Sleep Apnea / Snore Appliance
BOTOX	Botox A Administration Injections
INJECT	Injection with Numbing Medication in Jaw or Neck for blocking a Nerve in Head/Neck area (Orofacial Pain)
NARCOT	Narcotic meds for Chronic Persistent Pain treatment (in use with Orofacial Pain)
PRO821	Denture Course Prosthodontics 821 Patient Contract

General Request & Consent To Dental Treatment

Performed by or directed by Dr. _____
other dentists, resident dentists or dental trainees may be involved. "My dentist" includes these other dentists.

_____ explained this consent form to me.

Instructions to patient: When this consent form is explained to you, please ask any questions you may have. If you do not understand the answers, please ask again until you do understand. If you have any questions at any time about the procedure, please ask.

My dentist has explained this procedure to me and has told me why I need it. I understand that this procedure may involve: the taking of dental x-rays, impressions for dental casts, photographs, and the use of such anesthetics as may be considered necessary or advisable by the clinical faculty to diagnose and/or treat my/the patient's dental problem(s). I am requesting and authorizing The University of Kentucky College of Dentistry to perform the treatment and procedures outlined on the Treatment Plan, or as discussed with me today prior to start of treatment.

My dentist has told me what other options I may have and what the risks of those options are. I understand that other forms of treatment or no treatment at all are choices that I have and the risks of those choices have been presented to me. I have decided to have the procedure that my dentist has recommended.

My dentist has told me that some problems (risks and complications) may happen if I have this procedure. These possible problems include: Pain or discomfort during and following treatment, development of swelling, infection, and/or bleeding following treatment, injury to adjacent teeth and surrounding tissues, development of temporary or permanent temporomandibular joint (TMJ) disorder, temporary or permanent numbness of the lip or chin, aspiration or swallowing of a dental instrument or dental material, adverse reaction to a prescribed drug, local anesthetic, dental material, or latex, and other possible problems that my dentist cannot predict. In addition, it has been explained to me that if I am taking or have taken medications for osteoporosis known as bisphosphonates (such as Fosamax® and Boniva® and Actonel®) I am at risk for developing a serious bone problem known as osteonecrosis of the jaws. This is a disease in which the bone of the jaw dies. Treatment can be difficult and is sometimes not successful. Cases have been reported in which jaw fractures and other problems have occurred. The risk of developing this is not entirely known, but appears to be low when patients are taking oral bisphosphonates for osteoporosis as opposed to having frequent infusions as part of therapy for cancer. It appears to be more common (although still rare) in patients who have taken the drug for longer than 3 years. If you develop this problem after treatment, we may refer you to another medical or dental specialist. This would involve increased treatment time and expense.

My dentist has also told me about the possible benefits of the procedure. My dentist has explained my chances of receiving these benefits. I understand the risks of not having this procedure.

No one has guaranteed me that this procedure will have certain results.

I have received the **Notice of Privacy Practices of the University of Kentucky**. My dentist has told me that any information that identifies me will be kept private. I understand that the Notice lets my dentist give my information to certain other people or groups. If this happens, I understand that my information may not be as private as it would be if no one received this information.

I consent to let my dentist perform other procedures in connection with this procedure, if the dental staff decides that I need these other procedures.

I consent to let the dental staff take any photographs, moving pictures, television images, or other pictures or videotapes during my treatment. I understand that these images will be used only to advance dental/medical knowledge and will not identify me.

If any life-threatening or serious condition causes a severe problem with my circulation, my breathing, or other organs, I consent to treatment and any procedures the medical staff decides are necessary for my care in the Intensive Care Unit at a UK HealthCare hospital.

My advance directives (such as a living will) will still be in effect AFTER I receive any treatment for a reversible condition (a condition that can be corrected) related to this procedure.

I consent to let the authorities of this facility get rid (dispose) of any teeth, tissues, or other parts that may be removed from my body.

I understand that the University of Kentucky College of Dentistry teaches and trains dentists and other health care providers. Dentists in training and other dental trainees may be involved in my care with the appropriate supervision of my dentist.

I understand that someone from the University of Kentucky may contact me in the future to ask me to take part in research.

I have read this consent form, and it has been explained to me. I understand the planned procedure(s) and the sedation and anesthesia that will be used. I have had the chance to ask all of the questions I have about this procedure(s), its alternatives, its risks, its benefits, and possible complications. I have been given answers to my questions, and I understand the answers.
Signatures

Witness	Patient
Dentist	Print Patient Name
	Date Time

Request & Consent for Pediatric Dental Treatment

Performed by or directed by Dr. _____
other dentists, resident dentists or dental trainees may be involved. "My dentist" includes these other dentists.

_____ explained this consent form to me.

Instructions to patient: When this consent form is explained to you, please ask any questions you may have. If you do not understand the answers, please ask again until you do understand. If you have any questions at any time about the procedure, please ask.

My dentist has explained this procedure to me and has told me why I need it. I understand that this procedure may involve: the taking of dental x-rays, impressions for dental casts, photographs, and the use of such anesthetics as may be considered necessary or advisable by the clinical faculty to diagnose and/or treat my/the patient's dental problem(s). I am requesting and authorizing The University of Kentucky College of Dentistry to perform the treatment and procedures outlined on the Treatment Plan, or as discussed with me today prior to start of treatment.

My dentist has told me what other options I may have and what the risks of those options are. I understand that other forms of treatment or no treatment at all are choices that I have and the risks of those choices have been presented to me. I have decided to have the procedure that my dentist has recommended.

My dentist has told me that some problems (risks and complications) may happen if I have this procedure. These possible problems include: The possibility of pain or discomfort during and following treatment, swelling, infection, bleeding, or injury to adjacent teeth and surrounding tissue, development of transient or permanent temporomandibular joint (TMJ) disorder, temporary or permanent numbness (due to potential nerve injury), aspiration or swallowing of a tooth, a dental instrument or dental material, allergic reactions to dental materials, and other possible problems that my dentist cannot predict. In addition, it has been explained to me that if I am taking or have taken medications for osteoporosis known as bisphosphonates (such as Fosamax® and Boniva® and Actonel®) I am at risk for developing a serious bone problem known as osteonecrosis of the jaws. This is a disease in which the bone of the jaw dies. Treatment can be difficult and is sometimes not successful. Cases have been reported in which jaw fractures and other problems have occurred. The risk of developing this is not entirely known, but appears to be low when patients are taking oral bisphosphonates for osteoporosis as opposed to having frequent infusions as part of therapy for cancer. It appears to be more common (although still rare) in patients who have taken the drug for longer than 3 years. If you develop this problem after treatment, we may refer you to another medical or dental specialist. This would involve increased treatment time and expense.

My dentist has also told me about the possible benefits of the procedure. My dentist has explained my chances of receiving these benefits. I understand the risks of not having this procedure.

No one has guaranteed me that this procedure will have certain results.

It is our intent that all care delivered in our dental office shall be the best possible quality that we can provide for each child. Providing a high quality of care can sometimes be made very difficult, or even impossible, because of the lack of cooperation of some patients. Among the behaviors that can interfere with the proper provision of quality dental care are: hyperactivity, resistive movements, refusing to open the mouth or keep it open long enough to perform the necessary dental treatment, and even aggressive or physical resistance to treatment, such as kicking, screaming and grabbing the dentist's hands or the sharp dental instruments.

All efforts will be made to obtain the cooperation of child dental patients by the use of warmth, friendliness, persuasion, humor, charm, gentleness, kindness, and understanding.

There are several behavior management techniques that are used by pediatric dentist to gain the cooperation of child patients to eliminate disruptive behavior or prevent patients from causing injury to themselves due to uncontrollable movement. The more frequently used pediatric dentistry behavior management techniques are as follows:

- Tell-Show-Do: The dentist or assistant explains to the child what is to be done using simple language and repeating the explanation, then showing the child what is to be done using instruments on a model or the child's or dentist's finger. Then the procedure is performed in the child's mouth as described. Praise is used to reinforce cooperative behavior.
- Positive reinforcement: This technique rewards the child who displays any behavior which is desirable. Rewards include compliments, praise, a pat on the back, a hug or a prize.
- Voice control: The attention of a disruptive child is gained by changing the tone or increasing the volume of the dentist's voice. Content of the conversation is less important than the abrupt or sudden nature of the command.
- Mouth props: A rubber covered metal device is placed in the child's mouth to prevent closing when a child refuses or has difficulty maintaining an open mouth.
- Physical restraint by the dentist: The dentist restrains the child from movement by holding down the child's hands or upper body, stabilizing the child's head between the dentist's arm and body, or positioning the child firmly in the dental chair.
- Physical restraint by the assistant: The assistants restrain the child from movement by holding the child's hands, stabilizing the head, and/or controlling leg movement.
- Papoose Boards and Pedi-Wraps: These are restraining devices for limiting the disruptive child's movements to prevent injury and to enable the dentist to provide the necessary treatment. The child is wrapped in these devices and placed in a reclined dental chair.
- Sedation: Sometimes drugs are used to relax a child who does not respond to other behavior management techniques or who is unable to comprehend or cooperate for the dental procedures. These drugs may be administered orally, by injection or as a gas (nitrous oxide and oxygen). The child does not become unconscious. Your child will not be sedated without your being further informed and obtaining your specific written consent for such procedures.

The above listed pediatric dentistry behavior management techniques have been explained to my satisfaction and I consent to their use with my child if deemed necessary by the dentist.

I have received the **Notice of Privacy Practices of the University of Kentucky**. My dentist has told me that any information that identifies me will be kept private. I understand that the Notice lets my dentist give my information to certain other people or groups. If this happens, I understand that my information may not be as private as it would be if no one received this information.

I consent to let my dentist perform other procedures in connection with this procedure, if the dental staff decides that I need these other procedures.

I consent to let the dental staff take any photographs, moving pictures, television images, or other pictures or videotapes during my treatment. I understand that these images will be used only to advance dental/medical knowledge and will not identify me.

If any life-threatening or serious condition causes a severe problem with my circulation, my breathing, or other organs, I consent to treatment and any procedures the medical staff decides are necessary for my care in the Intensive Care Unit at a UK HealthCare hospital.

My advance directives (such as a living will) will still be in effect AFTER I receive any treatment for a reversible condition (a condition that can be corrected) related to this procedure. I consent to let the authorities of this facility get rid (dispose) of any teeth, tissues, or other parts that may be removed from my body.

I understand that the University of Kentucky College of Dentistry teaches and trains dentists and other health care providers. Dentists in training and other dental trainees may be involved in my care with the appropriate supervision of my dentist.

I understand that someone from the University of Kentucky may contact me in the future to ask me to take part in research.

I have read this consent form, and it has been explained to me. I understand the planned procedure(s) and the sedation and anesthesia that will be used. I have had the chance to ask all of the questions I have about this procedure(s), its alternatives, its risks, its benefits, and possible complications. I have been given answers to my questions, and I understand the answers.

Signatures

Witness	Signature of Person Consenting to Treatment
Dentist	Relationship to Patient
	Patient's Name
	Date Time

Request & Consent to Endodontic Treatment

Performed by or directed by Dr. _____
other dentists, resident dentists or dental trainees may be involved. "My dentist" includes these other dentists.

_____ explained this consent form to me.

Instructions to patient: When this consent form is explained to you, please ask any questions you may have. If you do not understand the answers, please ask again until you do understand. If you have any questions at any time about the procedure, please ask.

My dentist has explained this procedure to me and has told me why I need it. I understand that endodontic (root canal) treatment is performed to preserve a tooth with a diseased pulp (nerve) that might otherwise need to be removed. I understand that root canal treatment is the process of cleaning, disinfecting, and filling the space occupied by the pulp in the crown and roots of the tooth. I understand that this procedure may involve: the taking of dental x-rays, impressions for dental casts, photographs, and the use of such anesthetics as may be considered necessary or advisable by the clinical faculty to diagnose and/or treat my/the patient's dental problem(s). I am requesting and authorizing The University of Kentucky College of Dentistry to perform the treatment and procedures outlined on the Treatment Plan, or as discussed with me today prior to start of treatment.

My dentist has told me what other options I may have and what the risks of those options are. I understand that other forms of treatment or no treatment at all are choices that I have and the risks of those choices have been presented to me. I have decided to have the procedure that my dentist has recommended.

My dentist has told me that some problems (risks and complications) may happen if I have this procedure. These possible problems include: soreness and discomfort, swelling, infection, tooth extraction, chipping, fracture, or loosening of existing tooth structure or restoration (filling, crown, bridge), muscle tenderness and soreness in the jaw, inability to clean completely all canal space due to obstructed or calcified canals, separation of cleaning instrument in canal, perforation (opening of a channel between the inside and outside of the tooth during treatment), adverse reactions to anesthetics and medications administered or prescribed, aspiration or swallowing of a tooth, dental instrument or dental material, and other possible problems that my dentist cannot predict. In addition, it has been explained to me that if I am taking or have taken medications for osteoporosis known as bisphosphonates (such as Fosamax® and Boniva® and Actonel®) I am at risk for developing a serious bone problem known as osteonecrosis of the jaws. This is a disease in which the bone of the jaw dies. Treatment can be difficult and is sometimes not successful. Cases have been reported in which jaw fractures and other problems have occurred. The risk of developing this is not entirely known, but appears to be low when patients are taking oral bisphosphonates for osteoporosis as opposed to having frequent infusions as part of therapy for cancer. It appears to be more common (although still rare) in patients who have taken the drug for longer than 3 years. If you develop this problem after treatment, we may refer you to another medical or dental specialist. This would involve increased treatment time and expense.

My dentist has also told me about the possible benefits of the procedure. My dentist has explained my chances of receiving these benefits. I understand the risks of not having this procedure.

No one has guaranteed me that this procedure will have certain results.

I have received the **Notice of Privacy Practices of the University of Kentucky**. My dentist has told me that any information that identifies me will be kept private. I understand that the Notice lets my dentist give my information to certain other people or groups. If this happens, I understand that my information may not be as private as it would be if no one received this information.

I consent to let my dentist perform other procedures in connection with this procedure, if the dental staff decides that I need these other procedures.

I consent to let the dental staff take any photographs, moving pictures, television images, or other pictures or videotapes during my treatment. I understand that these images will be used only to advance dental/medical knowledge and will not identify me.

If any life-threatening or serious condition causes a severe problem with my circulation, my breathing, or other organs, I consent to treatment and any procedures the medical staff decides are necessary for my care in the Intensive Care Unit at a UK HealthCare hospital.

My advance directives (such as a living will) will still be in effect AFTER I receive any treatment for a reversible condition (a condition that can be corrected) related to this procedure.

I consent to let the authorities of this facility get rid (dispose) of any teeth, tissues, or other parts that may be removed from my body.

I understand that the University of Kentucky College of Dentistry teaches and trains dentists and other health care providers. Dentists in training and other dental trainees may be involved in my care with the appropriate supervision of my dentist.

I understand that someone from the University of Kentucky may contact me in the future to ask me to take part in research.

I have read this consent form, and it has been explained to me. I understand the planned procedure(s) and the sedation and anesthesia that will be used. I have had the chance to ask all of the questions I have about this procedure(s), its alternatives, its risks, its benefits, and possible complications. I have been given answers to my questions, and I understand the answers.

Signatures

Witness	Patient
Dentist	Print Patient Name
	Date Time

Request & Consent to Endodontic Surgery (Apicoectomy)

Performed by or directed by Dr. _____
other dentists, resident dentists or dental trainees may be involved. "My dentist" includes these other dentists.

_____ explained this consent form to me.

Instructions to patient: When this consent form is explained to you, please ask any questions you may have. If you do not understand the answers, please ask again until you do understand. If you have any questions at any time about the procedure, please ask.

My dentist has explained this procedure to me and has told me why I need it. I understand that endodontic surgery (apicoectomy) is performed to preserve a tooth that may otherwise need to be removed. I understand that an apicoectomy is a procedure that involves reflecting a flap, removing the tip of the root, placing a filling over the root-end and suturing the gum tissues back together. I understand that at the time of surgical procedure, it is decided by the treating dentist that the tooth does not have a favorable prognosis, I will be informed and the procedure will be terminated. I understand that the tissue removed during the surgical procedure will be submitted for biopsy (histopathological examination). I understand that this procedure may involve: the taking of dental x- rays, photographs, and the use of such anesthetics as may be considered necessary or advisable by the clinical faculty to diagnose and/or treat my/the patient's dental problem(s). I am requesting and authorizing The University of Kentucky College of Dentistry to perform the treatment and procedures outlined on the Treatment Plan, or as discussed with me today prior to start of treatment.

My dentist has told me what other options I may have and what the risks of those options are. I understand that other forms of treatment or no treatment at all are choices that I have and the risks of those choices have been presented to me. I have decided to have the procedure that my dentist has recommended.

My dentist has told me that some problems (risks and complications) may happen if I have this procedure. These possible problems include, but not limited to: pain, swelling, prolonged bleeding, bruising and infection in the area after treatment; tooth often will become mobile but usually tightens after several weeks; recessing of gums away from crown exposing more tooth/root and crown margins may become visible; and temporary altered sensation in the area of gums, cheek and teeth.

For lower teeth, the altered sensation of the lip, cheek, chin, tongue may persist and for upper teeth, sinus opening, and infection may occur. Restrictive mouth opening, jaw muscle spasm, jaw muscle cramps, temporomandibular joint difficulty or change in bite, which occurs infrequently and usually last for several days but may last longer. Adverse reactions resulting from use of instruments, materials, medications, anesthetic and injections may occur. Aspiration or swallowing of a tooth, dental instrument or dental material, and other possible problems that my dentist cannot predict may occur. In addition, it has been explained to me that if I am taking or have taken medications for osteoporosis known as bisphosphonates (such as Fosamax® and Boniva® and Actonel®) I am at risk for developing a serious bone problem known as osteonecrosis of the jaws. This is a disease in which the bone of the jaw dies. Treatment can be difficult and is sometimes not successful. Cases have been reported in which jaw fractures and other problems have occurred. The risk of developing this is not entirely known, but appears to be low when patients are taking oral bisphosphonates for osteoporosis as opposed to having frequent infusions as part of therapy for cancer. It appears to be more common (although still rare) in patients who have taken the drug for longer than 3 years. If you develop this problem after treatment, we may refer you to another medical or dental specialist. This would involve increased treatment time and expense.

My dentist has also told me about the possible benefits of the procedure. My dentist has explained

my chances of receiving these benefits. I understand the risks of not having this procedure.

No one has guaranteed me that this procedure will have certain results.

I have received the **Notice of Privacy Practices of the University of Kentucky**. My dentist has told me that any information that identifies me will be kept private. I understand that the Notice lets my dentist give my information to certain other people or groups. If this happens, I understand that my information may not be as private as it would be if no one received this information.

I consent to let my dentist perform other procedures in connection with this procedure, if the dental staff decides that I need these other procedures. I understand that I will be billed separately for biopsy of the tissue and understand that if I have medical insurance then the lab will bill my medical insurance.

I consent to let the dental staff take any photographs, moving pictures, television images, or other pictures or videotapes during my treatment. I understand that these images will be used only to advance dental/medical knowledge and will not identify me.

If any life-threatening or serious condition causes a severe problem with my circulation, my breathing, or other organs, I consent to treatment and any procedures the medical staff decides are necessary for my care in the Intensive Care Unit at a UK HealthCare hospital.

My advance directives (such as a living will) will still be in effect AFTER I receive any treatment for a reversible condition (a condition that can be corrected) related to this procedure.

I consent to let the authorities of this facility get rid (dispose) of any teeth, tissues, or other parts that may be removed from my body.

I understand that the University of Kentucky College of Dentistry teaches and trains dentists and other health care providers. Dentists in training and other dental trainees may be involved in my care with the appropriate supervision of my dentist.

I understand that someone from the University of Kentucky may contact me in the future to ask me to take part in research.

I have read this consent form, and it has been explained to me. I understand the planned procedure(s) and the sedation and anesthesia that will be used. I have had the chance to ask all of the questions I have about this procedure(s), its alternatives, its risks, its benefits, and possible complications. I have been given answers to my questions, and I understand the answers.

Signatures

Witness	Patient
Dentist	Print Patient Name
	Date Time

Consent for Implant Treatment: Surgical Placement

Performed by or directed by Dr. _____
other dentists, resident dentists or dental trainees may be involved. "My dentist" includes these other dentists.

_____ explained this consent form to me.

Instructions to patient: When this consent form is explained to you, please ask any questions you may have. If you do not understand the answers, please ask again until you do understand. If you have any questions at any time about the procedure, please ask.

My dentist has explained this procedure to me and has told me why I need it. I understand that the purpose of my treatment is to place dental implant(s) upon which an artificial tooth can be cemented or a denture can be retained. I understand that the implant is anchored in the bone and penetrates the gums. I understand that the artificial tooth is cemented/screwed onto the implant or the removable denture fits over the implant. I understand that this procedure may involve: the taking of dental x-rays, impressions for dental casts, photographs, and the use of such anesthetics as may be considered necessary or advisable by the clinical faculty to diagnose and/or treat my/the patient's dental problem(s). I am requesting and authorizing The University of Kentucky College of Dentistry to perform the treatment and procedures outlined on the Treatment Plan, or as discussed with me today prior to start of treatment.

My dentist has told me what other options I may have and what the risks of those options are. I understand that other forms of treatment or no treatment at all are choices that I have and the risks of those choices have been presented to me. I have decided to have the procedure that my dentist has recommended.

My dentist has told me that some problems (risks and complications) may happen if I have this procedure. These possible problems include: Postoperative discomfort and swelling that may necessitate several days of home recuperation, persistent bleeding, postoperative infection, stretching of the corners of the mouth with resultant cracking and bruising, injury to adjacent nerves, especially of the nerve which goes to the lower lip and chin, that may result in prolonged/permanent numbness, tingling or pain of the lip an chin, opening into the maxillary sinus which may lead to increased chance of infection or failure of the implant, bruising of the chin, neck and other tissues in the area where the surgery will be performed, jaw fracture, aspiration or swallowing of a tooth, a dental instrument or dental material, orthodontic treatment to straighten teeth may be limited or impossible after implants are placed, and other possible problems that my dentist cannot predict. In addition, it has been explained to me that if I am taking or have taken medications for osteoporosis known as bisphosphonates (such as Fosamax® and Boniva® and Actonel®) I am at risk for developing a serious bone problem known as osteonecrosis of the jaws. This is a disease in which the bone of the jaw dies. Treatment can be difficult and is sometimes not successful. Cases have been reported in which jaw fractures and other problems have occurred. The risk of developing this is not entirely known, but appears to be low when patients are taking oral bisphosphonates for osteoporosis as opposed to having frequent infusions as part of therapy for cancer. It appears to be more common (although still rare) in patients who have taken the drug for longer than 3 years. If you develop this problem after treatment, we may refer you to another medical or dental specialist. This would involve increased treatment time and expense. I have also been told that if I am a smoker there is a greater chance my treatment will be less successful, including the possible loss of my implants.

With extraction of lower teeth: injury to nerves in tissues surrounding teeth, resulting in pain, numbness, tingling or other sensory disturbances in the chin, lip, cheek, gums, or tongue and may persist for several months or in rare instances permanently, dry socket (a loss of blood clot from extraction site).

With extraction of upper teeth: opening of the sinus (a normal chamber situated above the upper teeth) requiring additional surgery or treatment, dry socket (a loss of blood clot from extraction site).

My dentist has also told me about the possible benefits of the procedure. My dentist has explained my chances of receiving these benefits. I understand the risks of not having this procedure.

No one has guaranteed me that this procedure will have certain results.

I have received the **Notice of Privacy Practices of the University of Kentucky**. My dentist has told me that any information that identifies me will be kept private. I understand that the Notice lets my dentist give my information to certain other people or groups. If this happens, I understand that my information may not be as private as it would be if no one received this information.

I consent to let my dentist perform other procedures in connection with this procedure, if the dental staff decides that I need these other procedures.

I consent to let the dental staff take any photographs, moving pictures, television images, or other pictures or videotapes during my treatment. I understand that these images will be used only to advance dental/medical knowledge and will not identify me.

If any life-threatening or serious condition causes a severe problem with my circulation, my breathing, or other organs, I consent to treatment and any procedures the medical staff decides are necessary for my care in the Intensive Care Unit at a UK HealthCare hospital.

My advance directives (such as a living will) will still be in effect AFTER I receive any treatment for a reversible condition (a condition that can be corrected) related to this procedure.

I consent to let the authorities of this facility get rid (dispose) of any teeth, tissues, or other parts that may be removed from my body.

I understand that the University of Kentucky College of Dentistry teaches and trains dentists and other health care providers. Dentists in training and other dental trainees may be involved in my care with the appropriate supervision of my dentist.

I understand that someone from the University of Kentucky may contact me in the future to ask me to take part in research.

I have read this consent form, and it has been explained to me. I understand the planned procedure(s) and the sedation and anesthesia that will be used. I have had the chance to ask all of the questions I have about this procedure(s), its alternatives, its risks, its benefits, and possible complications. I have been given answers to my questions, and I understand the answers.

Signatures

Witness	Patient
Dentist	Print Patient Name
	Date Time

Request & Consent To Prosthodontic Treatment:

Dental Implant Restorations/Prostheses

Performed by or directed by Dr. _____
other dentists, resident dentists or dental trainees may be involved. "My dentist" includes these other dentists.

_____ explained this consent form to me.

Instructions to patient: When this consent form is explained to you, please ask any questions you may have. If you do not understand the answers, please ask again until you do understand. If you have any questions at any time about the procedure, please ask.

My dentist has explained this procedure to me and has told me why I need it. I understand that following successful placement and healing of dental implant(s) that implant(s) will be used as an anchor to replace missing tooth/teeth with a crown (cap), fixed partial denture (bridge), complete denture, or partial denture. I understand that this procedure may involve: the taking of dental x-rays, impressions for dental casts, photographs, and the use of such anesthetics as may be considered necessary or advisable by the clinical faculty to diagnose and/or treat my/the patient's dental problem(s). I am requesting and authorizing The University of Kentucky College of Dentistry to perform the treatment and procedures outlined on the Treatment Plan, or as discussed with me today prior to start of treatment.

My dentist has told me what other options I may have and what the risks of those options are. I understand that other forms of treatment or no treatment at all are choices that I have and the risks of those choices have been presented to me. I have decided to have the procedure that my dentist has recommended.

My dentist has told me that some problems (risks and complications) may happen if I have this procedure. These possible problems include: Breakage of some portion of the restoration (acrylic resin, metal, or porcelain) that requires removal and repair or re-placement, breakage of one of the screw components of the restoration that requires removal and replacement of the restoration and broken components, loosening of the implant-retained restoration, requiring tightening of screws, and resealing of the screw access openings, stretching of the corners of the mouth during restoration, impression procedures and placement appointments may result in cracking and/or bruising, injury to the crowns, roots, and fillings of adjacent teeth, aspiration or swallowing of a tooth, a dental instrument or dental material, inflammation of the periodontal (gum) tissues around the implants may require removal of the implant restoration and evaluation by a Periodontist, bone loss requiring bone grafting, and other possible problems that my dentist cannot predict. In addition, it has been explained to me that if I am taking or have taken medications for osteoporosis known as bisphosphonates (such as Fosamax® and Boniva® and Actonel®) I am at risk for developing a serious bone problem known as osteonecrosis of the jaws. This is a disease in which the bone of the jaw dies. Treatment can be difficult and is sometimes not successful. Cases have been reported in which jaw fractures and other problems have occurred. The risk of developing this is not entirely known, but appears to be low when patients are taking oral bisphosphonates for osteoporosis as opposed to having frequent infusions as part of therapy for cancer. It appears to be more common (although still rare) in patients who have taken the drug for longer than 3 years. If you develop this problem after treatment, we may refer you to another medical or dental specialist. This would involve increased treatment time and expense.

My dentist has also told me about the possible benefits of the procedure. My dentist has explained my chances of receiving these benefits. I understand the risks of not having this procedure.

No one has guaranteed me that this procedure will have certain results. No guarantee has been given to me regarding how long this implant-retained restoration will last.

I have received the **Notice of Privacy Practices of the University of Kentucky**. My dentist has told me that any information that identifies me will be kept private. I understand that the Notice lets my dentist give my information to certain other people or groups. If this happens, I understand that my information may not be as private as it would be if no one received this information.

I consent to let my dentist perform other procedures in connection with this procedure, if the dental staff decides that I need these other procedures.

I consent to let the dental staff take any photographs, moving pictures, television images, or other pictures or videotapes during my treatment. I understand that these images will be used only to advance dental/medical knowledge and will not identify me.

If any life-threatening or serious condition causes a severe problem with my circulation, my breathing, or other organs, I consent to treatment and any procedures the medical staff decides are necessary for my care in the Intensive Care Unit at a UK HealthCare hospital.

My advance directives (such as a living will) will still be in effect AFTER I receive any treatment for a reversible condition (a condition that can be corrected) related to this procedure.

I consent to let the authorities of this facility get rid (dispose) of any teeth, tissues, or other parts that may be removed from my body.

I understand that the University of Kentucky College of Dentistry teaches and trains dentists and other health care providers. Dentists in training and other dental trainees may be involved in my care with the appropriate supervision of my dentist.

I understand that someone from the University of Kentucky may contact me in the future to ask me to take part in research.

I have read this consent form, and it has been explained to me. I understand the planned procedure(s) and the sedation and anesthesia that will be used. I have had the chance to ask all of the questions I have about this procedure(s), its alternatives, its risks, its benefits, and possible complications. I have been given answers to my questions, and I understand the answers.
Signatures

Witness	Patient
Dentist	Print Patient Name
	Date Time

Consent for Oral Surgery

Performed by or directed by Dr. _____
other dentists, resident dentists or dental trainees may be involved. "My dentist" includes these other dentists.

_____ explained this consent form to me.

Instructions to patient: When this consent form is explained to you, please ask any questions you may have. If you do not understand the answers, please ask again until you do understand. If you have any questions at any time about the procedure, please ask.

My dentist has explained this procedure to me and has told me why I need it. I understand that this procedure may involve: the taking of dental x-rays, impressions for dental casts, photographs, and the use of such anesthetics as may be considered necessary or advisable by the clinical faculty to diagnose and/or treat my/the patient's dental problem(s). I am requesting and authorizing The University of Kentucky College of Dentistry to perform the treatment and procedures outlined on the Treatment Plan, or as discussed with me today prior to start of treatment.

My dentist has told me what other options I may have and what the risks of those options are. I understand that other forms of treatment or no treatment at all are choices that I have and the risks of those choices have been presented to me. I have decided to have the procedure that my dentist has recommended.

My dentist has told me that some problems (risks and complications) may happen if I have this procedure.

With extraction of upper and lower teeth, these possible problems include: Post operative (after surgery) discomfort, limitation of jaw movement, prolonged or heavy bleeding, bruising (greenish-yellow to black and blue color), injury to the crown, roots, or fillings of adjacent teeth, post operative infection, cracking and/or bruising of lips due to stretching of corners of the mouth during treatment, limited mouth opening during healing (sometimes related to swelling and muscle soreness, and sometimes related to stress on jaw joints (TMJ), especially when TMJ problems already exists), a decision to leave a small piece of root in the jaw when its removal would require extensive surgery or risk other complications, fracture of the jaw (usually in more complicated extractions or surgery), allergic reactions to any medications used in treatment, and other possible problems that my dentist cannot predict. Additional surgery or treatment may be required. In addition, it has been explained to me that if I am taking or have taken medications for osteoporosis known as bisphosphonates (such as Fosamax® and Boniva® and Actonel®) I am at risk for developing a serious bone problem known as osteonecrosis of the jaws. This is a disease in which the bone of the jaw dies. Treatment can be difficult and is sometimes not successful. Cases have been reported in which jaw fractures and other problems have occurred. The risk of developing this is not entirely known, but appears to be low when patients are taking oral bisphosphonates for osteoporosis as opposed to having frequent infusions as part of therapy for cancer. It appears to be more common (although still rare) in patients who have taken the drug for longer than 3 years. If you develop this problem after treatment, we may refer you to another medical or dental specialist. This would involve increased treatment time and expense.

With extraction of lower teeth, injury to nerves in tissues surrounding teeth, resulting in pain, numbness, tingling or other sensory disturbances in the chin, lip, cheek, gums, or tongue and may persist for several months or in rare instances permanently, dry socket (a loss of blood clot from extraction site).

With extraction of upper teeth, opening of the sinus (a normal chamber situated above the upper teeth) requiring additional surgery or treatment, dry socket (a loss of blood clot from extraction site).

My dentist has also told me about the possible benefits of the procedure. My dentist has explained my chances of receiving these benefits. I understand the risks of not having this procedure.

No one has guaranteed me that this procedure will have certain results.

I have received the **Notice of Privacy Practices of the University of Kentucky**. My dentist has told me that any information that identifies me will be kept private. I understand that the Notice lets my dentist give my information to certain other people or groups. If this happens, I understand that my information may not be as private as it would be if no one received this information.

I consent to let my dentist perform other procedures in connection with this procedure, if the dental staff decides that I need these other procedures.

I consent to let the dental staff take any photographs, moving pictures, television images, or other pictures or videotapes during my treatment. I understand that these images will be used only to advance dental/medical knowledge and will not identify me.

If any life-threatening or serious condition causes a severe problem with my circulation, my breathing, or other organs, I consent to treatment and any procedures the medical staff decides are necessary for my care in the Intensive Care Unit at a UK HealthCare hospital.

My advance directives (such as a living will) will still be in effect AFTER I receive any treatment for a reversible condition (a condition that can be corrected) related to this procedure.

I consent to let the authorities of this facility get rid (dispose) of any teeth, tissues, or other parts that may be removed from my body.

I consent to donating extracted teeth for educational purposes to the University of Kentucky. I understand that no matter what I decide about donating my extracted teeth for educational purposes, it will not affect my care.

I understand that the University of Kentucky College of Dentistry teaches and trains dentists and other health care providers. Dentists in training and other dental trainees may be involved in my care with the appropriate supervision of my dentist.

I understand that someone from the University of Kentucky may contact me in the future to ask me to take part in research.

I have read this consent form, and it has been explained to me. I understand the planned procedure(s) and the sedation and anesthesia that will be used. I have had the chance to ask all of the questions I have about this procedure(s), its alternatives, its risks, its benefits, and possible complications. I have been given answers to my questions, and I understand the answers.
Signatures

Witness	Patient
Dentist	Print Patient Name
	Date Time

Information About Donating Extracted Teeth for Educational Purposes

If teeth are removed and are not needed for your care, they may be disposed of. Another option is to use the teeth for educational purposes. These educational uses may help us learn about many dental problems. By learning about these problems we may also learn to prevent them, treat them, or cure them. If donated teeth are used for educational purposes, it will not help you, but it might help other people.

You will not receive any reports about educational uses of donated teeth. No reports will be put into your medical record.

When a dentist or dental student uses donated teeth he/she does not obtain any identifiable private information or any protected health information. When donated teeth are used for education, none of your protected health information is disclosed. Also, the teeth do not identify you.

No matter what you decide about donating your extracted teeth for educational purposes, your decision will not affect your care.

Donating your extracted teeth for educational purposes has only minimal physical risks for you, because they are collected as part of the procedure. Other risks include a loss of privacy or breach of confidentiality of information from your medical record. The University of Kentucky is committed to protecting the privacy of all your health information. The chance that your health information will be given to someone who is not allowed to receive it is very small.

Dentist can use the back of this page for illustration or additional explanation.

Dental Consent for Sedation

Performed by or directed by Dr. _____
other dentists, resident dentists or dental trainees may be involved. "My dentist" includes these other dentists.

_____ explained this consent form to me.

Instructions to patient: When this consent form is explained to you, please ask any questions you may have. If you do not understand the answers, please ask again until you do understand. If you have any questions at any time about the procedure, please ask.

My dentist has explained why anesthetics/sedative drugs may be necessary to assist the dentist in performing the dental treatment I am scheduled to undergo with increased patient comfort and cooperation.

My dentist has told me what other options I may have and what the risks of those options are. I understand that having my dental procedure with or without anesthetics/sedative drugs are choices that I have and the risks of those choices have been presented to me. I have decided to have the procedure with anesthetics/sedative drugs that have been recommended.

My dentist has also told me about the possible benefits of anesthetics/sedative drugs. My dentist has explained that benefits of sedation include relief of anxiety, increased patient comfort and reduction of stress. In some patients, certain procedures may be performed more safely under sedation than with simple local anesthesia alone. My dentist has explained that these drugs may be administered by injection in a vein, muscle, in the form of pills, or as a gas to be inhaled. My dentist has explained my chances of receiving these benefits.

No one has guaranteed me that this procedure will have certain results.

I have received the **Notice of Privacy Practices of the University of Kentucky**. My dentist has told me that any information that identifies me will be kept private. I understand that the Notice lets my dentist give my information to certain other people or groups. If this happens, I understand that my information may not be as private as it would be if no one received this information.

My dentist has told me how anesthetics/sedative drugs will be used. I understand that during the procedure I am to undergo the medical staff may decide that I need other anesthesia. I consent to let the staff use anesthesia for this procedure.

I understand that anesthetics/sedative drugs have risks. These risks can be mild or severe, temporary or permanent. Examples of risks are:

Numbness
Pain and inflammation at the injection site
Discoloration or bruising of tissue surrounding the injection site
Muscle tenderness and soreness at the injection site
Bleeding
Post-injection swelling and/or infection
The depth of sedation may not be sufficient to allow the procedure. If so, general anesthesia may be recommended (which would ordinarily require another appointment)
Nausea and/or vomiting
Adverse reactions to anesthetics and medications administered or prescribed, for example, numb lip or allergic reaction
On very rare occasions, more serious complications might occur including breathing difficulties, stroke, heart attack, brain damage, loss of function of a limb or organ. Any of these would require hospitalization and treatment by other medical professionals, and would involve increased treatment time and expense.
Other risks that my dentist cannot predict

In addition, it has been explained to me that if I am taking or have taken medications for osteoporosis known as bisphosphonates (such as Fosamax® and Boniva® and Actonel®) I am at risk for developing a serious bone problem known as osteonecrosis of the jaws. This is a disease in which the bone of the jaw dies. Treatment can be difficult and is sometimes not successful. Cases have been reported in which jaw fractures and other

problems have occurred. The risk of developing this is not entirely known, but appears to be low when patients are taking oral bisphosphonates for osteoporosis as opposed to having frequent infusions as part of therapy for cancer. It appears to be more common (although still rare) in patients who have taken the drug for longer than 3 years. If you develop this problem after treatment, we may refer you to another medical or dental specialist. This would involve increased treatment time and expense.

I understand that I will need to have a responsible adult accompany me to and from the appointment. This must be someone known and trusted by me. I cannot be put in a cab or other form of public transportation following my procedure. My dentist has given me instructions regarding eating or drinking prior to my sedation and I will follow those and all instructions given to me by my dentist. I understand that I will not be able to work, drive an automobile, operate dangerous equipment, or sign legal documents for some time following the procedure. The exact time will depend upon the drug(s) used and the way my body breaks these drugs down, but this period will at least include the entire day of surgery. I will contact my dentist if I experience any complications or problems after my surgery. I understand that I must see my dentist for any postoperative follow up visits that he/she recommends and will follow all postoperative instructions that I am given.

If any life-threatening or serious condition causes a severe problem with my circulation, my breathing, or other organs, I consent to treatment and any procedures the medical staff decides are necessary for my care in the Intensive Care Unit at a UK HealthCare hospital.

My advance directives (such as a living will) will still be in effect AFTER I receive any treatment for a reversible condition (a condition that can be corrected) related to this procedure.

I understand that the University of Kentucky College of Dentistry teaches and trains dentists and other health care providers. Dentists in training and other dental trainees may be involved in my care with the appropriate supervision of my dentist.

I have read this consent form, and it has been explained to me. I understand the planned procedure(s) and the sedation and anesthesia that will be used. I have had the chance to ask all of the questions I have about the sedation and anesthesia that will be used, the alternatives, the risks, the benefits, and possible complications. I have been given answers to my questions, and I understand the answers. I consent to the use of sedation and anesthesia agents during my dental procedure.

Signatures

Witness	Patient
Dentist	Print Patient Name
	Date Time

Request & Consent for Orthodontic Treatment

Performed by or directed by Dr. _____
other dentists, resident dentists or dental trainees may be involved. "My dentist" includes these other dentists.

_____ explained this consent form to me.

Instructions to patient: When this consent form is explained to you, please ask any questions you may have. If you do not understand the answers, please ask again until you do understand. If you have any questions at any time about the procedure, please ask.

My dentist has explained this procedure to me and has told me why I need it. I understand that this procedure may involve: the taking of dental x-rays, impressions for dental casts, photographs, and the use of such anesthetics as may be considered necessary or advisable by the clinical faculty to diagnose and/or treat my/the patient's dental problem(s). I am requesting and authorizing The University of Kentucky College of Dentistry to perform the treatment and procedures outlined on the Treatment Plan, or as discussed with me today prior to start of treatment.

My dentist has told me what other options I may have and what the risks of those options are. I understand that other forms of treatment or no treatment at all are choices that I have and the risks of those choices have been presented to me. I have decided to have the procedure that my dentist has recommended.

My dentist has told me that some problems (risks and complications) may happen if I have this procedure. These possible problems include: Pain, tooth decay, gum disease, decalcification (permanent markings on the teeth), aspiration or swallowing of a bracket, band, or other dental instrument or dental material during treatment, shortening of the length of the roots of some teeth, loosening of teeth, loss of teeth, ankylosis (fusion to the bone), abnormal growth of the jaws, temporomandibular joint (TMJ) pain, and other possible problems that my dentist cannot predict. In addition, it has been explained to me that if I am taking or have taken medications for osteoporosis known as bisphosphonates (such as Fosamax® and Boniva® and Actonel®) I am at risk for developing a serious bone problem known as osteonecrosis of the jaws. This is a disease in which the bone of the jaw dies. Treatment can be difficult and is sometimes not successful. Cases have been reported in which jaw fractures and other problems have occurred. The risk of developing this is not entirely known, but appears to be low when patients are taking oral bisphosphonates for osteoporosis as opposed to having frequent infusions as part of therapy for cancer. It appears to be more common (although still rare) in patients who have taken the drug for longer than 3 years. If you develop this problem after treatment, we may refer you to another medical or dental specialist. This would involve increased treatment time and expense.

My dentist has also told me about the possible benefits of the procedure. My dentist has explained my chances of receiving these benefits. I understand the risks of not having this procedure.

No one has guaranteed me that this procedure will have certain results.

I have received the **Notice of Privacy Practices of the University of Kentucky**. My dentist has told me that any information that identifies me will be kept private. I understand that the Notice lets my dentist give my information to certain other people or groups. If this happens, I understand that my information may not be as private as it would be if no one received this information.

I consent to let my dentist perform other procedures in connection with this procedure, if the dental staff decides that I need these other procedures.

I consent to let the dental staff take any photographs, moving pictures, television images, or other pictures or videotapes during my treatment. I understand that these images will be used only to advance dental/medical knowledge and will not identify me.

If any life-threatening or serious condition causes a severe problem with my circulation, my breathing, or other organs, I consent to treatment and any procedures the medical staff decides are necessary for my care in the Intensive Care Unit at a UK HealthCare hospital.

My advance directives (such as a living will) will still be in effect AFTER I receive any treatment for a reversible condition (a condition that can be corrected) related to this procedure.

I consent to let the authorities of this facility get rid (dispose) of any teeth, tissues, or other parts that may be removed from my body.

I understand that the University of Kentucky College of Dentistry teaches and trains dentists and other health care providers. Dentists in training and other dental trainees may be involved in my care with the appropriate supervision of my dentist.

I understand that someone from the University of Kentucky may contact me in the future to ask me to take part in research.

I have read this consent form, and it has been explained to me. I understand the planned procedure(s) and the sedation and anesthesia that will be used. I have had the chance to ask all of the questions I have about this procedure(s), its alternatives, its risks, its benefits, and possible complications. I have been given answers to my questions, and I understand the answers.
Signatures

Witness	Patient
Dentist	Print Patient Name
	Date Time

Request & Consent To Nonsurgical Periodontal Treatment

Performed by or directed by Dr. _____
other dentists, resident dentists or dental trainees may be involved. "My dentist" includes these other dentists.

_____ explained this consent form to me.

Instructions to patient: When this consent form is explained to you, please ask any questions you may have. If you do not understand the answers, please ask again until you do understand. If you have any questions at any time about the procedure, please ask.

My dentist has explained this procedure to me and has told me why I need it. I understand that nonsurgical periodontal therapy (also known as "scaling and root planning" or SRP) consists of the nonsurgical removal of bacteria and their deposits from the roots of the teeth I understand that this procedure may involve: the taking of dental x-rays, impressions for dental casts, photographs, and the use of such anesthetics as may be considered necessary or advisable by the clinical faculty to diagnose and/or treat my/the patient's dental problem(s). I am requesting and authorizing The University of Kentucky College of Dentistry to perform the treatment and procedures outlined on the Treatment Plan, or as discussed with me today prior to start of treatment.

My dentist has told me what other options I may have and what the risks of those options are. I understand that other forms of treatment or no treatment at all are choices that I have and the risks of those choices have been presented to me. I have decided to have the procedure that my dentist has recommended.

My dentist has told me that some problems (risks and complications) may happen if I have this procedure. These possible problems include: Soreness and discomfort following treatment, sensitivity of the roots of the teeth to hot, cold, or certain foods, swelling, infection, and/or discoloration or bruising of the face, the need for additional treatment if tissues do not respond to SRP, chipping, fracture or loosening of existing tooth structure or restoration (filling, crown, bridge) during procedure, muscle tenderness and soreness in the jaw, adverse reaction to anesthetics and medications that may be prescribed or administered, aspiration or swallowing of a tooth, a dental instrument or dental material, and other possible problems that my dentist cannot predict. In addition, it has been explained to me that if I am taking or have taken medications for osteoporosis known as bisphosphonates (such as Fosamax® and Boniva® and Actonel®) I am at risk for developing a serious bone problem known as osteonecrosis of the jaws. This is a disease in which the bone of the jaw dies. Treatment can be difficult and is sometimes not successful. Cases have been reported in which jaw fractures and other problems have occurred. The risk of developing this is not entirely known, but appears to be low when patients are taking oral bisphosphonates for osteoporosis as opposed to having frequent infusions as part of therapy for cancer. It appears to be more common (although still rare) in patients who have taken the drug for longer than 3 years. If you develop this problem after treatment, we may refer you to another medical or dental specialist. This would involve increased treatment time and expense.

My dentist has also told me about the possible benefits of the procedure. My dentist has explained my chances of receiving these benefits. I understand the risks of not having this procedure.

No one has guaranteed me that this procedure will have certain results.

I have received the **Notice of Privacy Practices of the University of Kentucky**. My dentist has told me that any information that identifies me will be kept private. I understand that the Notice lets my dentist give my information to certain other people or groups. If this happens, I understand that my information may not be as private as it would be if no one received this information.

I consent to let my dentist perform other procedures in connection with this procedure, if the dental staff decides that I need these other procedures.

I consent to let the dental staff take any photographs, moving pictures, television images, or other pictures or videotapes during my treatment. I understand that these images will be used only to advance dental/medical knowledge and will not identify me.

If any life-threatening or serious condition causes a severe problem with my circulation, my breathing, or other organs, I consent to treatment and any procedures the medical staff decides are necessary for my care in the Intensive Care Unit at a UK HealthCare hospital.

My advance directives (such as a living will) will still be in effect AFTER I receive any treatment for a reversible condition (a condition that can be corrected) related to this procedure.

I consent to let the authorities of this facility get rid (dispose) of any teeth, tissues, or other parts that may be removed from my body.

I understand that the University of Kentucky College of Dentistry teaches and trains dentists and other health care providers. Dentists in training and other dental trainees may be involved in my care with the appropriate supervision of my dentist.

I understand that someone from the University of Kentucky may contact me in the future to ask me to take part in research.

I have read this consent form, and it has been explained to me. I understand the planned procedure(s) and the sedation and anesthesia that will be used. I have had the chance to ask all of the questions I have about this procedure(s), its alternatives, its risks, its benefits, and possible complications. I have been given answers to my questions, and I understand the answers.

Signatures

Witness	Patient
Dentist	Print Patient Name
	Date Time

Request & Consent For Surgical Periodontal Treatment

Performed by or directed by Dr. _____
other dentists, resident dentists or dental trainees may be involved. "My dentist" includes these other dentists.

_____ explained this consent form to me.

Instructions to patient: When this consent form is explained to you, please ask any questions you may have. If you do not understand the answers, please ask again until you do understand. If you have any questions at any time about the procedure, please ask.

My dentist has explained this procedure (or procedures) to me and has told me why I need it. I understand that surgical periodontal therapy refers to a number of techniques used to treat various diseases of the gum and jawbones. I understand that this procedure may involve: the taking of dental x-rays, impressions for dental casts, photographs, and the use of such anesthetics as may be considered necessary or advisable by the clinical faculty to diagnose and/or treat my/the patient's dental problem(s). I am requesting and authorizing The University of Kentucky College of Dentistry to perform the treatment and procedures outlined on the Treatment Plan, or as discussed with me today prior to start of treatment.

My dentist has told me what other options I may have and what the risks of those options are. I understand that other forms of treatment or no treatment at all are choices that I have and the risks of those choices have been presented to me. I have decided to have the procedure(s) that my dentist has recommended.

My dentist has told me that some problems (risks and complications) may occur as a result of this treatment. These possible problems include: Soreness and discomfort following treatment, sensitivity of the roots of the teeth to hot, cold, or certain foods; swelling; infection; discoloration or bruising of the face; the need for additional treatment if tissues do not respond to surgery; chipping, fracture or loosening of existing tooth structure or restoration (filling, crown, bridge) during procedure; muscle tenderness and soreness in the jaw; adverse reaction to anesthetics and medications that may be prescribed or administered; aspiration or swallowing of a tooth, a dental instrument or dental material; nerve injury resulting in numbness or pain of the jaw or face (which can be temporary or permanent); and other possible problems that my dentist cannot predict. In some cases, treatment may result in problems with appearance and/or speech. Any complications could result in additional treatment time or expense.

While most patients respond well to therapy, some do not. Periodontal diseases are infections and sometimes cannot be controlled, despite treatment. I understand that I will need to do a good job of cleaning my teeth at home, and that I may need to be seen for professional cleanings often (every two or three months is common for periodontal patients). The failure to keep such appointments and/or clean my teeth will usually result in a worsening of my condition and possible infection and/or tooth loss.

Smoking will have an adverse impact on treatment outcomes and may lead to worsening of my condition and/or loss of teeth or implants.

There may be risks in avoiding or delaying needed treatment. These include, but are not limited to, infections of the mouth or other sites, loss of teeth, and problems with appearance and/or speech. I understand that it is possible (but not proven) that dental infections, including gum diseases, may have an effect on my health, including heart and lung disease, diabetes, and pregnancy.

In addition, it has been explained to me that if I am taking or have taken medications for osteoporosis known as bisphosphonates (such as Fosamax® and Boniva® and Actonel®) I am at risk for developing a serious bone problem known as osteonecrosis of the jaws. This is a disease in which the bone of the jaw dies. Treatment can be difficult and is sometimes not successful. Cases have been reported in which jaw fractures and other problems have occurred. The risk of developing this is not entirely known, but appears to be low when patients are taking oral bisphosphonates for osteoporosis as opposed to having frequent infusions as part of therapy for cancer. It appears to be more common (although still rare) in patients who have taken the drug for longer than 3 years. If you develop this problem after treatment, we may refer you to another medical or dental specialist. This would involve increased treatment time and expense.

My dentist has also told me about the possible benefits of the procedure. My dentist has explained my chances of receiving these benefits. I understand the risks of not having this procedure.

No one has guaranteed me that this procedure will have certain results.

I have received the **Notice of Privacy Practices of the University of Kentucky**. My dentist has told me that any information that identifies me will be kept private. I understand that the Notice lets my dentist give my information to certain other people or groups. If this happens, I understand that my information may not be as private as it would be if no one received this information.

I consent to let my dentist perform other procedures in connection with this procedure, if the dental staff decides that I need these other procedures.

I consent to let the dental staff take any photographs, moving pictures, television images, or other pictures or videotapes during my treatment. I understand that these images will be used only to advance dental/medical knowledge and will not identify me.

If any life-threatening or serious condition causes a severe problem with my circulation, my breathing, or other organs, I consent to treatment and any procedures the medical staff decides are necessary for my care in the Intensive Care Unit at a UK HealthCare hospital.

My advance directives (such as a living will) will still be in effect AFTER I receive any treatment for a reversible condition (a condition that can be corrected) related to this procedure.

I consent to let the authorities of this facility get rid (dispose) of any teeth, tissues, or other parts that may be removed from my body.

I understand that the University of Kentucky College of Dentistry teaches and trains dentists and other health care providers. Dentists in training and other dental trainees may be involved in my care with the appropriate supervision of my dentist.

I understand that someone from the University of Kentucky may contact me in the future to ask me to take part in research.

I have read this consent form, and it has been explained to me. I understand the planned procedure(s) and the sedation and anesthesia that will be used. I have had the chance to ask all of the questions I have about this procedure(s), its alternatives, its risks, its benefits, and possible complications. I have been given answers to my questions, and I understand the answers.

Signatures

Witness	Patient
Dentist	Print Patient Name
	Date Time

Request & Consent to Prosthodontic Treatment: Crowns and Fixed Partial Dentures

Performed by or directed by Dr. _____
other dentists, resident dentists or dental trainees may be involved. "My dentist" includes these other dentists.

_____ explained this consent form to me.

Instructions to patient: When this consent form is explained to you, please ask any questions you may have. If you do not understand the answers, please ask again until you do understand. If you have any questions at any time about the procedure, please ask.

My dentist has explained this procedure to me and has told me why I need it. I understand that the procedure involves altering the shape of the tooth or teeth involved. I understand that the purpose for the procedure is to replace missing tooth structure, improve appearance, help protect teeth with root canals, improve my bite, and, in the case of a fixed partial denture, replace a missing tooth or teeth. I understand that crown(s) or fixed partial denture(s) will be cemented to the prepared teeth upon completion. I understand that this procedure may involve: the taking of dental x-rays, impressions for dental casts, photographs, and the use of such anesthetics as may be considered necessary or advisable by the clinical faculty to diagnose and/or treat my/the patient's dental problem(s). I am requesting and authorizing The University of Kentucky College of Dentistry to perform the treatment and procedures outlined on the Treatment Plan, or as discussed with me today prior to start of treatment.

My dentist has told me what other options I may have and what the risks of those options are. I understand that other forms of treatment or no treatment at all are choices that I have and the risks of those choices have been presented to me. I have decided to have the procedure that my dentist has recommended.

My dentist has told me that some problems (risks and complications) may happen if I have this procedure. These possible problems include: Fracturing of materials (acrylic, metal, porcelain) of temporary or permanent crown or fixed partial denture that requires removal and repair, or replacement, post operative sensitivity or necrosis (death) of the pulp (nerve) that may require root canal treatment, damage to the periodontal (gum) tissues may occur and require surgical correction, fracture of the tooth requiring root canal therapy and core build up or removal, cracking and/or bruising of lips due to stretching of corners of the mouth during treatment, damage to crowns, roots, and fillings of adjacent teeth, recurrent tooth decay at the crown/tooth junction, changes in the occlusion (bite) of the restored teeth that result in muscle soreness or temporomandibular joint (TMJ) problems, temporary or permanent TMJ disorders, post operative infections of the mouth, tongue, or gums, temporary or permanent numbness to the lip or face following the administration of local anesthetics, allergic reaction to local anesthesia, topical anesthetics, gingival sulcus anticoagulants, and various restorative materials, impression materials and latex, aspiration or swallowing of a tooth, a dental instrument, or dental material, and other possible problems that my dentist cannot predict. In addition, it has been explained to me that if I am taking or have taken medications for osteoporosis known as bisphosphonates (such as Fosamax® and Boniva® and Actonel®) I am at risk for developing a serious bone problem known as osteonecrosis of the jaws. This is a disease in which the bone of the jaw dies. Treatment can be difficult and is sometimes not successful. Cases have been reported in which jaw fractures and other problems have occurred. The risk of developing this is not entirely known, but appears to be low when patients are taking oral bisphosphonates for osteoporosis as opposed to having frequent infusions as part of therapy for cancer. It appears to be more common (although still rare) in patients who have taken the drug for longer than 3 years. If you develop this problem after treatment, we may refer you to another medical or dental specialist. This would involve increased treatment time and expense.

My dentist has also told me about the possible benefits of the procedure. My dentist has explained my chances of receiving these benefits. I understand the risks of not having this procedure.

No one has guaranteed me that this procedure will have certain results.

I have received the **Notice of Privacy Practices of the University of Kentucky**. My dentist has told me that any information that identifies me will be kept private. I understand that the Notice lets my dentist

give my information to certain other people or groups. If this happens, I understand that my information may not be as private as it would be if no one received this information.

I consent to let my dentist perform other procedures in connection with this procedure, if the dental staff decides that I need these other procedures.

I consent to let the dental staff take any photographs, moving pictures, television images, or other pictures or videotapes during my treatment. I understand that these images will be used only to advance dental/medical knowledge and will not identify me.

If any life-threatening or serious condition causes a severe problem with my circulation, my breathing, or other organs, I consent to treatment and any procedures the medical staff decides are necessary for my care in the Intensive Care Unit at a UK HealthCare hospital.

My advance directives (such as a living will) will still be in effect AFTER I receive any treatment for a reversible condition (a condition that can be corrected) related to this procedure.

I consent to let the authorities of this facility get rid (dispose) of any teeth, tissues, or other parts that may be removed from my body.

I understand that the University of Kentucky College of Dentistry teaches and trains dentists and other health care providers. Dentists in training and other dental trainees may be involved in my care with the appropriate supervision of my dentist.

I understand that someone from the University of Kentucky may contact me in the future to ask me to take part in research.

I have read this consent form, and it has been explained to me. I understand the planned procedure(s) and the sedation and anesthesia that will be used. I have had the chance to ask all of the questions I have about this procedure(s), its alternatives, its risks, its benefits, and possible complications. I have been given answers to my questions, and I understand the answers.
Signatures

Witness	Patient
Dentist	Print Patient Name
	Date Time

Request & Consent to Prosthodontic Treatment:

Removable Complete & Partial Dentures

Performed by or directed by Dr. _____
other dentists, resident dentists or dental trainees may be involved. "My dentist" includes these other dentists.

_____ explained this consent form to me.

Instructions to patient: When this consent form is explained to you, please ask any questions you may have. If you do not understand the answers, please ask again until you do understand. If you have any questions at any time about the procedure, please ask.

My dentist has explained this procedure to me and has told me why I need it. I understand that complete and partial removable dentures are artificial teeth made to replace missing natural teeth. I understand that there are many types of removable dental prostheses that will be supported by gum, retained teeth or roots, or implants, and may be made from acrylics (plastic), metal, porcelain, or a combination thereof. I understand that removable complete dentures may require surgical alteration of my mouth to improve the fit or retention of the prostheses. I understand that this procedure may involve: the taking of dental x-rays, impressions for dental casts, photographs, and the use of such anesthetics as may be considered necessary or advisable by the clinical faculty to diagnose and/or treat my/the patient's dental problem(s). I am requesting and authorizing The University of Kentucky College of Dentistry to perform the treatment and procedures outlined on the Treatment Plan, or as discussed with me today prior to start of treatment.

My dentist has told me what other options I may have and what the risks of those options are. I understand that other forms of treatment or no treatment at all are choices that I have and the risks of those choices have been presented to me. I have decided to have the procedure that my dentist has recommended.

My dentist has told me that some problems (risks and complications) may happen if I have this procedure. These possible problems include: Shrinking gums, decreased chewing ability, altered speech, reduced taste, denture movement, fracturing of materials (acrylic, metal, porcelain) of temporary or permanent prosthesis(es) that requires removal and repair, post operative sensitivity or necrosis (death) of the pulp (nerve) that may require root canal treatment, damage to the periodontal (gum) tissues requiring surgical correction, fracture of tooth, cracking and/or bruising of lips due to stretching of corners of the mouth during treatment, damage to the crowns, roots, and fillings of adjacent teeth, recurrent tooth decay at the crown/tooth junction, changes in the occlusion (bite) of the restored teeth that result in soreness or temporomandibular joint (TMJ) problems, temporary or permanent TMJ disorders, post operative infections of the mouth, tongue, gums (oral tissue), temporary or permanent numbness to the lip or face following administration of local anesthetics, allergic reaction to local anesthesia, topical anesthetics, gingival sulcus anticoagulants, and various restorative materials, impression materials (any dental materials) and latex, aspiration or swallowing of a tooth, a dental instrument or dental material, soreness after placement, excessive saliva, and other possible problems that my dentist cannot predict. In addition, it has been explained to me that if I am taking or have taken medications for osteoporosis known as bisphosphonates (such as Fosamax® and Boniva® and Actonel®) I am at risk for developing a serious bone problem known as osteonecrosis of the jaws. This is a disease in which the bone of the jaw dies. Treatment can be difficult and is sometimes not successful. Cases have been reported in which jaw fractures and other problems have occurred. The risk of developing this is not entirely known, but appears to be low when patients are taking oral bisphosphonates for osteoporosis as opposed to having frequent infusions as part of therapy for cancer. It appears to be more common (although still rare) in patients who have taken the drug for longer than 3 years. If you develop this problem after treatment, we may refer you to another medical or dental specialist. This would involve increased treatment time and expense.

My dentist has also told me about the possible benefits of the procedure. My dentist has explained my chances of receiving these benefits. I understand the risks of not having this procedure.

No one has guaranteed me that this procedure will have certain results.

I have received the **Notice of Privacy Practices of the University of Kentucky**. My dentist has told me that any information that identifies me will be kept private. I understand that the Notice lets my dentist give my information to certain other people or groups. If this happens, I understand that my information may not be as private as it would be if no one received this information.

I consent to let my dentist perform other procedures in connection with this procedure, if the dental staff decides that I need these other procedures.

I consent to let the dental staff take any photographs, moving pictures, television images, or other pictures or videotapes during my treatment. I understand that these images will be used only to advance dental/medical knowledge and will not identify me.

If any life-threatening or serious condition causes a severe problem with my circulation, my breathing, or other organs, I consent to treatment and any procedures the medical staff decides are necessary for my care in the Intensive Care Unit at a UK HealthCare hospital.

My advance directives (such as a living will) will still be in effect AFTER I receive any treatment for a reversible condition (a condition that can be corrected) related to this procedure.

I consent to let the authorities of this facility get rid (dispose) of any teeth, tissues, or other parts that may be removed from my body.

I understand that the University of Kentucky College of Dentistry teaches and trains dentists and other health care providers. Dentists in training and other dental trainees may be involved in my care with the appropriate supervision of my dentist.

I understand that someone from the University of Kentucky may contact me in the future to ask me to take part in research.

I have read this consent form, and it has been explained to me. I understand the planned procedure(s) and the sedation and anesthesia that will be used. I have had the chance to ask all of the questions I have about this procedure(s), its alternatives, its risks, its benefits, and possible complications. I have been given answers to my questions, and I understand the answers.

Signatures

Witness	Patient
Dentist	Print Patient Name
	Date Time

Consent for an Oral Appliance for Jaw Muscle and / or Jaw Joint Pain or Headaches, or for Bothersome Jaw Clicking and / or Jaw Locking.

Performed by or directed by Dr. _____
other dentists, resident dentists or dental trainees may be involved. "My dentist" includes these other dentists.

_____ explained this consent form to me.

Instructions to patient: When this consent form is explained to you, please ask any questions you may have. If you do not understand the answers, please ask again until you do understand. If you have any questions at any time about the procedure, please ask.

My dentist has explained this procedure to me and has told me why I need it. I understand that oral appliance therapy may help reduce my jaw muscle or jaw joint pain, bothersome clicking and / or locking jaw joint, or headaches. I am requesting and authorizing The University of Kentucky College of Dentistry to perform the treatment and procedures outlined on the Treatment Plan, or as discussed with me today prior to start of treatment.

My dentist has told me what other options I may have and what the risks of those options are. I understand that other forms of treatment or no treatment at all are choices that I have and the risks of those choices have been presented to me. I have decided to have the procedure that my dentist has recommended.

My dentist has told me that some problems (risks and complications) may happen if I have this procedure. These possible problems include: Increased salivation, dry mouth, sore teeth, sore jaws, jaw joint pain, gum or cheek irritation, loosening of teeth, movement of teeth, bite changes, aspiration or swallowing or a tooth, a dental instrument, or dental material, dislodgement of ill-fitting dental crowns or restorations, and other possible problems that my dentist cannot predict. I understand that tooth movement or bite changes may or may not be fully reversible should they occur.

My dentist has also told me about the possible benefits of the procedure. My dentist has explained my chances of receiving these benefits. I understand the risks of not having this procedure.

No one has guaranteed me that this procedure will have certain results.

I have received the **Notice of Privacy Practices of the University of Kentucky**. My dentist has told me that any information that identifies me will be kept private. I understand that the Notice lets my dentist give my information to certain other people or groups. If this happens, I understand that my information may not be as private as it would be if no one received this information.

I consent to let my dentist perform other procedures in connection with this procedure, if the dental staff decides that I need these other procedures.

I consent to let the dental staff take any photographs, moving pictures, television images, or other pictures or videotapes during my treatment. I understand that these images will be used only to advance dental/medical knowledge and will not identify me.

If any life-threatening or serious condition causes a severe problem with my circulation, my breathing, or other organs, I consent to treatment and any procedures the medical staff decides are necessary for my care in the Intensive Care Unit at a UK HealthCare hospital.

My advance directives (such as a living will) will still be in effect AFTER I receive any treatment for a reversible condition (a condition that can be corrected) related to this procedure.

I consent to let the authorities of this facility get rid (dispose) of any teeth, tissues, or other parts that may be removed from my body.

I understand that the University of Kentucky College of Dentistry teaches and trains dentists and other health care providers. Dentists in training and other dental trainees may be involved in my care with the appropriate supervision of my dentist.

I understand that someone from the University of Kentucky may contact me in the future to ask me to take part in research.

I have read this consent form, and it has been explained to me. I understand the planned procedure(s) and the sedation and anesthesia that will be used. I have had the chance to ask all of the questions I have about this procedure(s), its alternatives, its risks, its benefits, and possible complications. I have been given answers to my questions, and I understand the answers.
Signatures

Witness	Patient	
Dentist	Print Patient Name	
	Date	Time

Consent for an Oral Appliance for Snoring and/or Sleep Apnea

Performed by or directed by Dr. _____
other dentists, resident dentists or dental trainees may be involved. "My dentist" includes these other dentists.

_____ explained this consent form to me.

Instructions to patient: When this consent form is explained to you, please ask any questions you may have. If you do not understand the answers, please ask again until you do understand. If you have any questions at any time about the procedure, please ask.

My dentist has explained this procedure to me and has told me why I need it. I understand that oral appliance therapy for snoring/obstructive sleep apnea assists breathing by keeping the tongue and jaw in a forward position during sleep. I understand that this procedure may involve: the taking of dental x-rays, impressions for dental casts, photographs, and the use of such anesthetics as may be considered necessary or advisable by the clinical faculty to diagnose and/or treat my/the patient's dental problem(s). I am requesting and authorizing The University of Kentucky College of Dentistry to perform the treatment and procedures outlined on the Treatment Plan, or as discussed with me today prior to start of treatment.

My dentist has told me what other options I may have and what the risks of those options are. I understand that other forms of treatment or no treatment at all are choices that I have and the risks of those choices have been presented to me. I have decided to have the procedure that my dentist has recommended.

My dentist has told me that some problems (risks and complications) may happen if I have this procedure. These possible problems include: Increased salivation, dry mouth, sore teeth, sore jaws, jaw joint pain, gum or cheek irritation, loosening of teeth, movement of teeth, bite changes, aspiration or swallowing or a tooth, a dental instrument, or dental material, dislodgement of ill-fitting dental crowns or restorations, and other possible problems that my dentist cannot predict. I understand that tooth movement or bite changes may or may not be fully reversible should they occur.

My dentist has also told me about the possible benefits of the procedure. My dentist has explained my chances of receiving these benefits. I understand the risks of not having this procedure.

No one has guaranteed me that this procedure will have certain results.

I have received the **Notice of Privacy Practices of the University of Kentucky**. My dentist has told me that any information that identifies me will be kept private. I understand that the Notice lets my dentist give my information to certain other people or groups. If this happens, I understand that my information may not be as private as it would be if no one received this information.

I consent to let my dentist perform other procedures in connection with this procedure, if the dental staff decides that I need these other procedures.

I consent to let the dental staff take any photographs, moving pictures, television images, or other pictures or videotapes during my treatment. I understand that these images will be used only to advance dental/medical knowledge and will not identify me.

If any life-threatening or serious condition causes a severe problem with my circulation, my breathing, or other organs, I consent to treatment and any procedures the medical staff decides are necessary for my care in the Intensive Care Unit at a UK HealthCare hospital.

My advance directives (such as a living will) will still be in effect AFTER I receive any treatment for a reversible condition (a condition that can be corrected) related to this procedure.

I consent to let the authorities of this facility get rid (dispose) of any teeth, tissues, or other parts that may be removed from my body.

I understand that the University of Kentucky College of Dentistry teaches and trains dentists and other health care providers. Dentists in training and other dental trainees may be involved in my care with the appropriate supervision of my dentist.

I understand that someone from the University of Kentucky may contact me in the future to ask me to take part in research.

I have read this consent form, and it has been explained to me. I understand the planned procedure(s) and the sedation and anesthesia that will be used. I have had the chance to ask all of the questions I have about this procedure(s), its alternatives, its risks, its benefits, and possible complications. I have been given answers to my questions, and I understand the answers.

Signatures

Witness	Patient	
Dentist	Print Patient Name	
	Date	Time

Request & Consent for Administration of Botulinum Toxin (Botox A) Injections

Performed by or directed by Dr. _____

other dentists, resident dentists or dental trainees may be involved. "My dentist" includes these other dentists.

_____ explained this consent form to me.

Instructions to patient: When this consent form is explained to you, please ask any questions you may have. If you do not understand the answers, please ask again until you do understand. If you have any questions at any time about the procedure, please ask.

My dentist has explained this procedure to me and has told me why I need it. I understand that Botulinum toxin (Botox A) injections are performed to relax muscles, reduce spasm, and in some instances to reduce pain. I understand that BOTULINUM TOXIN will be injected into the necessary muscle (or sites) to treat musculoskeletal and/or neuropathic symptoms as needed. I understand that Botulinum toxin injections have a temporary effect usually lasting from 2-4 months and that repeated treatments may be required to maintain the results, or attain further improvement. I understand that this procedure may involve: the taking of dental x-rays, impressions for dental casts, photographs, and the use of such anesthetics as may be considered necessary or advisable by the clinical faculty to diagnose and/or treat my/the patient's dental problem(s). I am requesting and authorizing The University of Kentucky College of Dentistry to perform the treatment and procedures outlined on the Treatment Plan, or as discussed with me today prior to start of treatment.

My dentist has told me what other options I may have and what the risks of those options are. I understand that other forms of treatment or no treatment at all are choices that I have and the risks of those choices have been presented to me. I have decided to have the procedure that my dentist has recommended.

My dentist has told me that some problems (risks and complications) may happen if I have this procedure. These possible problems include: Redness, swelling, mild pain, bruising, numbness, infection, flu-like symptoms, temporary muscle aching, paralysis of nearby muscle which can cause droopy eyelids, double vision, and facial or neck weakness, allergic reaction, erythema multiforme, difficulty swallowing, difficult or labored breathing, fainting, acute closed angle glaucoma, focal facial paralysis, heart attack, difficulty in speaking, irregular heartbeat, headache, neck pain, dry eye, cough, runny nose, dizziness, muscle weakness, dry mouth, injection site pain, speech or visual disturbance, skin rash , and other possible problems that my dentist cannot predict. I understand that Botulinum toxin injections contain human-derived albumin and carries a theoretical risk of virus transmission.

My dentist has also told me about the possible benefits of the procedure. My dentist has explained my chances of receiving these benefits. I understand the risks of not having this procedure.

No one has guaranteed me that this procedure will have certain results.

I understand that Botulinum toxin is approved by the Federal Drug Administration for the use of some but not all conditions. Many clinicians use Botulinum toxin for conditions not recognized by the FDA and if I have one of these conditions my dentist can explain the rationale for using Botulinum toxin.

I acknowledge that I do not have a known allergy to albumin, I am not taking a blood thinner (other than baby aspirin), I understand that Botulinum toxin should not be injected into the muscles of patients with any neuromuscular disorders like myasthenia gravis or amyotropic lateral sclerosis (ALS), a motor neuropathy, atrophy at the planned site or pre-existing ptosis. I do not have cardiovascular disease, and if female, I am not pregnant, nursing, or, if of childbearing age, I am using adequate contraception.

I have received the **Notice of Privacy Practices of the University of Kentucky**. My dentist has told me that any information that identifies me will be kept private. I understand that the Notice lets my dentist give my information to certain other people or groups. If this happens, I understand that my information may not be as private as it would be if no one received this information.

I consent to let my dentist perform other procedures in connection with this procedure, if the dental staff decides that I need these other procedures.

I consent to let the dental staff take any photographs, moving pictures, television images, or other pictures or videotapes during my treatment. I understand that these images will be used only to advance dental/medical knowledge and will not identify me.

If any life-threatening or serious condition causes a severe problem with my circulation, my breathing, or other organs, I consent to treatment and any procedures the medical staff decides are necessary for my care in the Intensive Care Unit at a UK HealthCare hospital.

My advance directives (such as a living will) will still be in effect AFTER I receive any treatment for a reversible condition (a condition that can be corrected) related to this procedure.

I consent to let the authorities of this facility get rid (dispose) of any teeth, tissues, or other parts that may be removed from my body.

I understand that the University of Kentucky College of Dentistry teaches and trains dentists and other health care providers. Dentists in training and other dental trainees may be involved in my care with the appropriate supervision of my dentist.

I understand that someone from the University of Kentucky may contact me in the future to ask me to take part in research.

I have read this consent form, and it has been explained to me. I understand the planned procedure(s) and the sedation and anesthesia that will be used. I have had the chance to ask all of the questions I have about this procedure(s), its alternatives, its risks, its benefits, and possible complications. I have been given answers to my questions, and I understand the answers.

Signatures

Witness	Patient
Dentist	Print Patient Name
	Date Time

Request & Consent for an Injection with Numbing Medication in Jaw or Neck Muscles or to Block a Nerve in the Head/Neck Area

Performed by or directed by Dr. _____
other dentists, resident dentists or dental trainees may be involved. "My dentist" includes these other dentists.

_____ explained this consent form to me.

Instructions to patient: When this consent form is explained to you, please ask any questions you may have. If you do not understand the answers, please ask again until you do understand. If you have any questions at any time about the procedure, please ask.

My dentist has explained this procedure to me and has told me why I need it. I understand that I am receiving an injection(s) to help diagnose the source of pain or to alleviate symptoms of pain in my jaw/neck muscle(s) or my jaw joint. I understand that this procedure may involve: the taking of dental x-rays, impressions for dental casts, photographs, and the use of such anesthetics as may be considered necessary or advisable by the clinical faculty to diagnose and/or treat my/the patient's dental problem(s). I am requesting and authorizing The University of Kentucky College of Dentistry to perform the treatment and procedures outlined on the Treatment Plan, or as discussed with me today prior to start of treatment.

My dentist has told me what other options I may have and what the risks of those options are. I understand that other forms of treatment or no treatment at all are choices that I have and the risks of those choices have been presented to me. I have decided to have the procedure that my dentist has recommended.

My dentist has told me that some problems (risks and complications) may happen if I have this procedure. These possible problems include: Bruising and/or bleeding from the injection, infection, increased pain, weakness of the muscles, numbness of the skin, adverse or allergic reactions to any of the medications used in the procedure, and other possible problems that my dentist cannot predict.

My dentist has also told me about the possible benefits of the procedure. My dentist has explained my chances of receiving these benefits. I understand the risks of not having this procedure.

No one has guaranteed me that this procedure will have certain results.

I have received the **Notice of Privacy Practices of the University of Kentucky**. My dentist has told me that any information that identifies me will be kept private. I understand that the Notice lets my dentist give my information to certain other people or groups. If this happens, I understand that my information may not be as private as it would be if no one received this information.

I consent to let my dentist perform other procedures in connection with this procedure, if the dental staff decides that I need these other procedures.

I consent to let the dental staff take any photographs, moving pictures, television images, or other pictures or videotapes during my treatment. I understand that these images will be used only to advance dental/medical knowledge and will not identify me.

If any life-threatening or serious condition causes a severe problem with my circulation, my breathing, or other organs, I consent to treatment and any procedures the medical staff decides are necessary for my care in the Intensive Care Unit at a UK HealthCare hospital.

My advance directives (such as a living will) will still be in effect AFTER I receive any treatment for a reversible condition (a condition that can be corrected) related to this procedure.

I consent to let the authorities of this facility get rid (dispose) of any teeth, tissues, or other parts that may be removed from my body.

I understand that the University of Kentucky College of Dentistry teaches and trains dentists and other health care providers. Dentists in training and other dental trainees may be involved in my care with the appropriate supervision of my dentist.

I understand that someone from the University of Kentucky may contact me in the future to ask me to take part in research.

I have read this consent form, and it has been explained to me. I understand the planned procedure(s) and the sedation and anesthesia that will be used. I have had the chance to ask all of the questions I have about this procedure(s), its alternatives, its risks, its benefits, and possible complications. I have been given answers to my questions, and I understand the answers.

Signatures

Witness	Patient
Dentist	Print Patient Name
	Date Time

Request & Consent for Treatment of Chronic Persistent Pain with a Narcotic Medication

Performed by or directed by Dr. _____
other dentists, resident dentists or dental trainees may be involved. "My dentist" includes these other dentists.

_____ explained this consent form to me.

Instructions to patient: When this consent form is explained to you, please ask any questions you may have. If you do not understand the answers, please ask again until you do understand. If you have any questions at any time about the procedure, please ask.

My dentist has explained this procedure to me and has told me why I need it. I have been diagnosed with a chronic persistent orofacial pain condition. I understand that the planned treatment for this condition is to begin therapy with a strong pain medication to alleviate symptoms of pain. I understand that this procedure may involve: the taking of dental x-rays, impressions for dental casts, photographs, and the use of such anesthetics as may be considered necessary or advisable by the clinical faculty to diagnose and/or treat my/the patient's dental problem(s). I am requesting and authorizing The University of Kentucky College of Dentistry to perform the treatment and procedures outlined on the Treatment Plan, or as discussed with me today prior to start of treatment.

My dentist has told me what other options I may have and what the risks of those options are. I understand that other forms of treatment or no treatment at all are choices that I have and the risks of those choices have been presented to me. I have decided to have the procedure that my dentist has recommended.

My dentist has told me that some problems (risks and complications) may happen if I have this procedure. These possible problems include: Nausea, dizziness, drowsiness, sleepiness or sleep disturbance, constipation, urinary retention, swelling of extremities, dry mouth, sweating, decreased sexual function, slowing of breathing rate, slowing of heart rate, lowering of blood pressure, dependence on the medication, addiction to the medication, withdrawal symptoms when stopping the medication abruptly, changes in electrocardiogram, and other possible problems that my dentist cannot predict.

My dentist has also told me about the possible benefits of the therapy. My dentist has explained my chances of receiving these benefits. I understand the risks of not having this therapy.

No one has guaranteed me that this therapy will have certain results.

I have received the **Notice of Privacy Practices of the University of Kentucky**. My dentist has told me that any information that identifies me will be kept private. I understand that the Notice lets my dentist give my information to certain other people or groups. If this happens, I understand that my information may not be as private as it would be if no one received this information.

I consent to let my dentist perform other procedures in connection with this therapy, if the dental staff decides that I need these other procedures.

I consent to let the dental staff take any photographs, moving pictures, television images, or other pictures or videotapes during my treatment. I understand that these images will be used only to advance dental/medical knowledge and will not identify me.

If any life-threatening or serious condition causes a severe problem with my circulation, my breathing, or other organs, I consent to treatment and any procedures the medical staff decides are necessary for my care in the Intensive Care Unit at a UK HealthCare hospital.

My advance directives (such as a living will) will still be in effect AFTER I receive any treatment for a reversible condition (a condition that can be corrected) related to this procedure.

I consent to let the authorities of this facility get rid (dispose) of any teeth, tissues, or other parts that may be removed from my body.

I consent to donating extracted teeth for educational purposes to the University of Kentucky. I understand that no matter what I decide about donating my extracted teeth for educational purposes, it will not affect my care.

I understand that someone from the University of Kentucky may contact me in the future to ask me to take part in research.

I have read this consent form, and it has been explained to me. I understand the planned procedure(s) and the sedation and anesthesia that will be used. I have had the chance to ask all of the questions I have about this procedure(s), its alternatives, its risks, its benefits, and possible complications. I have been given answers to
my questions, and I understand the
answers. Signatures

Witness	Patient
Dentist	Print Patient Name
	Date Time