

APPENDIX II

CRITERIA FOR QUALITY ASSESSMENT BY THE DIRECT OBSERVATION OF PATIENT CARE

Criteria for Quality Assessment by the Direct Observation of Patient Care

GENERAL INSTRUCTIONS

- 1) This Technical review tool is designed to assess the quality of care provided by an individual provider by direct observation (by a trained evaluator) of the services being provided.
- 2) The provider being evaluated and the Service Unit/Facility director/Tribal Administrator must be notified of the review in advance of its taking place. A sample letter is provided in Appendix VIII. In all cases, the administrative authority of the clinic in question must give permission before the review can be performed.
- 3) Tact and discretion must be preeminent throughout the evaluation process. The dignity of the person being evaluated and of the patient must be preserved in all instances. The patient's consent is required before the evaluator can check the patient. This is most frequently accomplished by the dentist being evaluated introducing the evaluator to the patient, explaining the nature of the review, and asking if the patient minds having the evaluator observe the services being provided. Verbal consent is adequate for this purpose.
- 4) When the quality of a service provided is considered questionable by the evaluator, but is not definitely unsatisfactory, the decision must be in favor of the person being evaluated and rated satisfactory.
- 5) Differences in training backgrounds are recognized as sources of potential philosophical differences in criteria for dental procedures performed by dental practitioners. Differences may also arise between the evaluator and person being evaluated as to the extent or significance of a deficiency for any criterion. If concurrence of satisfactory or unsatisfactory cannot be agreed upon through discussion between the evaluator and person being evaluated, the criterion will be marked as "disputed" in the grid and the nature of the dispute concerning the criterion will be documented in a narrative summary.
- 6) The evaluation must include a confidential closeout meeting where all reports are signed by both the evaluator and person being evaluated.
- 7) The person being evaluated and responsible administrative authorities must be advised of all evaluation findings. Further dissemination of findings must be by mutual consent of the person being evaluated and responsible administrative authorities.
- 8) The person being evaluated has the right of appeal for a reevaluation by the same or a different evaluator.
- 9) All criteria must be met to score "Yes"
- 10) For each category, if procedures were not performed or are not applicable, mark NA

A. Patient Records

- 1) The patient dental records are part of the patient's primary health care record, and
 - 1.2) the health record is available for review.

Method to Assess Criterion: Review of the primary health record.

Note: Criterion #1 does not apply in certain locations where the dental clinic is not attached to an outpatient medical facility. However, the primary health record should still be accessible for review.

- 2) The patient's dental health record contains a current (completed within the last year) health questionnaire containing items of specific significance to dental practice.
 - 2.1) Documentation exists in the patient record that this information was updated annually and
 - 2.2) reviewed by the dentist at each visit, with documentation of changes or "no changes" in the patient's medical status.

Method to Assess Criterion: Review the patient dental record for a health questionnaire containing, at a minimum, questions on current M.D. care, recent illnesses, cardiovascular disease (including rheumatic fever), liver disease, diabetes, convulsions/seizures, drug allergies, latex allergy, bleeding tendencies, current medications, harmful habits, pregnancy, blood transfusions, and sexually transmitted diseases.

- 3) For each "Yes" response on the health questionnaire there is documentation that follow-up questions have been asked.

Method to Assess Criterion: Review the Dental Progress Notes for follow-up information related to each "Yes" response on the health questionnaire.

- 4) All entries in the patient dental record are recorded in ink.

Method to Assess Criterion: Review of patient dental record.

- 5) All entries recorded in the patient dental record follow instructions for completing Form IHS 42-1. Services rendered are recorded on the Dental Progress Notes (Form IHS 42-2) in sufficient detail to determine: date of service, tooth/teeth, quadrant/sextant, type of local anesthetic, local anesthetic dosage in milligrams, name and dosage of other drugs administered, materials used, complications, provider (signature and degree), procedure code, and fee, if applicable. Universally understood symbols or a key are provided in clinic protocols for understanding the recording. Abbreviations used are approved by the Medical Staff.

Method to Assess Criterion: Review of patient dental record.

- 6) For emergency visits the SOAP (or similar) format will be used in sufficient detail to document chief complaint, objective findings, diagnosis, and treatment plan.

- S – subjective findings, i.e., the chief complaint in the patient’s words (or paraphrased), such as “it hurts when I chew, patients points to #3.”
- O – Objective findings, i.e., the clinical and radiographic findings such as “tenderness to percussion tooth #4, or “apical radiolucency tooth #3.”
- A - Assessment or differential diagnosis, e.g., “acute apical Periodontitis tooth #4.”
- P - Plan, or treatment rendered, in adequate detail to stand up in court.

Method to Assess Criterion: Chart review.

B. Examination and Diagnosis

- 1) Existing hard and soft tissue findings obtained by clinical and radiographic examination are recorded in patient’s dental record.

Method to Assess Criterion: Immediately following the completion of the clinical examination provided by the attending dentist, the examiner refers to the patient’s dental record and clinically examines the same patient. The same light, mouth mirror, and explorer used by attending dentist are used by the examiner. Determine if radiographic findings are identified and recorded.

- 2) Other diagnostic aids such as pulp testing, cytology, biopsy, or blood pressure screening are used and recorded in the patient record when indicated.

Method to Assess Criterion: Review patient dental record for appropriate use of other diagnostic aids. Review patient dental record for appropriate use of other diagnostic aids. A blood pressure screening is to be performed on all patients at their first visit (exam or emergency) within one year of the last blood pressure screening. This applies to patients age 18 and older. For those patients with a history of hypertension, those currently being treated for hypertension, or those who are diabetic, the blood pressure screening should be performed at each visit regardless of age.

- 3) Diagnosis is consistent with findings.

Method to Assess Criterion: Chart review.

- 4) A plan of treatment is available in the patient dental record

4.1) and follows, in general, the following order:

- a. Relief of pain and discomfort, including nonelective surgery.

- b. Elimination of infection and factors predisposing to pathologic conditions.
- c. Thorough prophylaxis, instruction in oral hygiene, and other oral disease preventive therapies.
- d. Treatment of caries.
- e. Non-surgical periodontal treatment which is incremental and based on assessment of the patient.
- f. Elective care.
- g. Documentation of patient acceptance of treatment plan, including signed consent by patient, parent, or legal guardian.
- h. Scheduling of minimum of appointments to complete treatment.

Method to Assess Criterion: In evaluating the plan of treatment, take into account the choice of treatment, the types of restorations, and the age, sex, and general health of the patient. The plan should reflect progressive changes in the patient's dental status as each phase of treatment is to be completed. The plan should be sufficiently flexible so that it may be altered to accommodate unanticipated results of previous treatment. The plan should be considered tentative and subject to modification throughout the course of treatment. Any changes in the treatment plan require documentation.

- 4.2) Treatment plan is consistent with diagnosis.

Method to Assess Criterion: Chart review.

- 5) A Screening Exit Exam will be conducted during the last visit for all routine patients.

Method to Assess Criterion: Chart review and direct observation. It is strongly recommended that the Screening Exit Exam for both caries and periodontal status be included in the patient's initial treatment plan. The exit exam must include a final CPITN for those patients who were initially diagnosed with any sextants of CPITN 2, 3, or 4.

C. Radiographs

All radiographic exposures shall be ordered by the dentist according to patient conditions, or meet written criteria for type and frequency described in the clinic policy. The types and frequency of radiographs should meet the following broad classifications:

- 1.1) Initial Adult:

An initial radiographic examination, consisting of posterior bitewings supplemented with anterior and/or posterior films and/or panoramic radiographs, as required by oral conditions, is recommended for all individuals *15 years old and older*. Panoramic or full-mouth intraoral radiographic films are appropriate when the patient presents with clinical evidence of generalized dental disease or a history of extensive dental treatment.

1.2) Initial Child:

Prior to the eruption of the first permanent tooth, bitewing films (where interproximal surfaces cannot be visually inspected) are supplemented with anterior and posterior periapical films, as required by oral conditions. Individualized radiographic examinations consist of a periapical/occlusal or panoramic examination when clinical evidence or history indicate the need for additional radiographic examination. A full-mouth radiographic exam (panoramic or intraoral periapical) is performed *beginning at age 9*.

1.3) Recall:

1. Bite-wings and/or periapical radiographs should be taken at intervals as required by the patient's general condition.
2. In the absence of specific indications for more frequent radiographs, a panoramic radiograph or full-mouth intraoral periapical series should not be taken more often than once every five years.

1.4) Emergency Examination:

An appropriate diagnostic radiographic examination of the area in question.

Method to Assess Criterion: Review of patient dental record, clinic policy manual, and observation.

- 2) Dental radiographs are mounted,
- 3) Dental Radiographs are labeled with the patient's name, chart number, and date
- 4) Dental Radiographs are contained in the patient's dental record.
- 5) Density and contrast of radiographs are such that anatomical hard and soft tissue landmarks can be differentiated.
- 6) Radiographic image size is not distorted in the area of the mouth under study.
- 7) Radiographs disclose no overlapping of image in the area of the mouth under study, except where tooth alignment does not permit open contacts.
- 8) Radiographs disclose no cone-cutting.
- 9) Bitewing radiographs include the distal surface of the erupted cuspids and mesial surface of the most posterior erupted teeth.

Method to Assess Criteria C2 to C9: Assess the radiographs taken on patients present in the clinic during the evaluation visit and/or review radiographs taken within the previous

six months, selected randomly from the files. The radiographs should be viewed with a radiographic illuminator (view box). Apply the applicable criteria to each radiograph and determine diagnostic acceptability. The anatomy in the area under study should be visible and of diagnostic quality.

Criterion C7 is not applicable for the permanent dentition, unless the patient is in the clinic for observation of the dentition to rule out crowded teeth as a cause of overlapping.

Note: If a radiograph has a deficiency which does not compromise the diagnostic value, the radiograph will be considered acceptable. However, the deficiency should be pointed out to the person being evaluated.

D. Radiological Protection

- 1) All dental auxiliaries who take radiographs will be currently certified in radiology.

Method to Assess Criterion: Observe posting of current certificate or review documentation showing that auxiliaries are certified.

- 2) Lead protective devices are used on each patient during all exposures.

Method to Assess Criterion: Observe directly whether the lead protective devices are placed in a manner that will protect the patient. The IHS Manual, Section 3 (Professional Services), Chapter 21 (Medical Imaging Program), 5E(4) (Procedures Applicable to Dental Units) and IHS Circular No. 91-2 (Diagnostic X-Ray Radiation Protection) both state, "A thyroid protection shield shall be used on children and teenagers during dental radiographic examinations.". As existing lead apron devices need replacement, lead apron devices with integrated thyroid shields should be purchased. Thyroid shields shall be used if they are currently available in the dental clinic.

- 3) The tube housing or cone shall be stationary and
 - 3.1) positioned in close proximity to the film positioning device or skin of the patient when the exposure is made.

Method to Assess Criterion: Observe directly whether the tube housing or cone is stationary and within 1/4" or less of the film positioning device or skin of the patient when exposure is made. Also, observe processed radiographs for evidence of blurred images from movement of the tube head.

- 4) During exposure, radiographic film is not held in position by attending staff.

Method to Assess Criterion: Directly observe whether attending dental staff is holding film in position during exposure.

- 5) During exposure, tube housing or cone is not held by attending staff or patient.

Method to Assess Criterion: Directly observe whether attending staff or patient is holding the tube housing or cone during exposure.

- 6) Operator is at least six feet from patient and not in the path of the primary beam or stands behind protective barrier during exposure.

Method to Assess Criterion: Directly observe the distance and location of the operator when the x-ray machine is activated.

- 7) Only necessary persons are allowed in radiographic area during exposure.

Method to Assess Criterion: Directly observe whether unnecessary persons are in the x-ray area during exposure.

- 8) A warning signal is given prior to pushing the x-ray activator button.

Method to Access Criterion: Directly observe whether operator calls out “x-ray” or gives some other warning prior to activation of machine.

- 9) Dosimeters (film badges) are worn by all dentists, hygienists, and dental assistants.

Method to Access Criterion: Directly observe whether a dosimeter is worn by each dental staff member.

- 10) Protective devices are properly stored to reduce creasing and damage.

Method to Assess Criterion: Directly observe whether lead protective devices are properly stored to reduce creasing and damage.

- 11) Radiological reports are maintained: quarterly report of dosimetry, annual calibration of radiological equipment, annual evaluation of patient lead protective devices.

Method to Assess Criterion: Directly observe whether reports are on file and current.

E. Prevention

- 1) The patient dental record contains an individualized disease prevention plan based on the patient’s status and risk factors:
- a. Systemic fluoride
 - b. Professionally-applied topical fluoride
 - c. Self-applied topical fluoride
 - d. Fluoride toothpaste
 - e. Pit and fissure sealants
 - f. Preventive periodontal treatment

- g. Tobacco counseling
- h. OHI and other health education
- i. Recall

Method to Assess Criterion: Review of dental record for the above information.

- 2) Oral health education and
 - 2.1) self-care instructions are provided and
 - 2.1) are consistent with needs identified in the individualized prevention assessment.

Method to Assess Criterion: Observe what the patient is told during the appointment. If communication cannot be observed, question the patient about what they were told during the visit and ask if appropriate home-care aids were recommended (e.g., fluoride toothpaste, fluoride rinses, floss, Perio Aid, Proxabrush, floss threaders). Special instructions are given to patients with special needs and/or physical handicaps. Ask the patient to demonstrate flossing and brushing technique as taught by the provider.

- 3) Each dental prophylaxis provided meets the following standards:
 - a. The presence of plaque and calculus is demonstrated to the patient or parent before prophylaxis begins. Use of a disclosing solution is recommended.
 - b. All plaque and other soft debris are removed from tooth surfaces (includes flossing of interproximal surfaces to demonstrate plaque removal for the patient and/or parent).
 - c. All coronal calculus is removed (includes all supragingival calculus and subgingival calculus up to 3 mm. below gingival crest).
 - d. Each patient indicated for prophylaxis receives toothbrush prophylaxis unless rubber cup is required to accomplish stain removal.

Method to Assess Criterion: Observe whether prophylaxis procedures being provided are explained to the patient by the attending dental staff person. Following the completion of the prophylaxis, assess the quality of the procedure by inspection of the teeth using mouth mirror, explorer, and adequate light.

- 4) Persons with one or more new smooth-surface carious lesions, or whose prophylaxis includes a rubber cup polishing, will be given a professionally-applied topical fluoride application. A schedule of up to four applications per year may be followed, based on the presence of moderating factors listed below. Use currently accepted criteria found in Section IV of the *IHS Oral Health Program Guide* for determining the frequency of professionally-applied fluorides.

Note: Professionally-applied topical gel treatments are not recommended for patients under five years of age. Fluoride varnishes may be used.

Method to Assess Criterion: Chart review, including review of documentation of any moderating factors, and/or direct observation.

Note: Moderating factors for caries risk include: age, present caries activity, past caries activity, exposure to other sources of fluoride, sugar intake and frequency, amount of plaque, dental anatomy, medications, and family history.

- 5) Sealants are placed on susceptible unrestored or incipient carious pit and fissure surfaces of permanent first and second molars within two years of eruption.

Method to Assess Criterion: Chart review or direct observation. Criteria for the use of pit and fissure sealants include: Seal if deep, narrow pits and fissures, or other occlusal lesions are present. Do not seal if broad, well-coalesced pits and fissures, or frank caries are present. Frank caries is defined as gross cavitation with a break in the enamel, softness, and usually discoloration.

- 6) All sealants placed meet the following standards:

a. Adequate isolation of teeth is achieved for placement of sealants.

1. If four-handed technique is used, isolation with cotton rolls or Dri-Aids is acceptable.
2. If two-handed technique is used, proper isolation requires rubber dam or Vac-Ejector.

b. Adequate etching and rinsing techniques are used prior to application of sealant.

1. Etching solution is applied for 15 to 30 seconds to achieve a frosted appearance.
2. Etched surfaces are rinsed for at least 15 to 30 seconds or until etchant and precipitate are completely removed.

c. Sealants exhibit adequate retention by remaining intact following a reasonable effort to remove with an explorer.

d. No overt occlusal interferences are present due to placement of the sealants.

Method to Assess Criterion: Direct observation.

- 7) Patients who are tobacco users are asked if they want to quit using tobacco.

Method to Assess Criterion: Observe the patient record for evidence that all patients are asked if they use tobacco and documentation that tobacco users have been asked if they want to quit using tobacco.

- 8) Tobacco cessation counseling is recommended for patients who indicate they want assistance in quitting tobacco.

Method to Assess Criterion: Observe the primary health record to determine that the patient who wants counseling has been counseled by the dental staff or has been referred for counseling (if such services are available locally), unless it is documented that the patient requests deferment of counseling.

- 9) Each patient is placed in a recall program based on his/her individual risks (see Caries Risk) rather than arbitrary time intervals such as a 6-month recall. The patient's recall category is consistent with the diagnosis, treatment received, and medical condition, e.g., diabetes, rampant caries, pregnancy, and perio status.

Method to Assess Criterion: Review of dental record.

F. Restorative (Exclusive of Full Cast Restorations)

- 1) Treatment is explained to the patient (parent/guardian) before services begin.

Method to Assess Criterion: Observe whether the attending dentist or dental assistant explains to the patient (parent/guardian) the planned treatment services for that visit before those treatment services begin.

- 2) Rubber dam isolation is utilized unless contraindicated. There is documentation of the reason for non-use in the chart.

Method to Assess Criterion: Direct observation. All rubber dam clamps must be positively blocked (i.e., throat pack, ligation, rubber dam) from swallowing or aspiration.

- 3) Tooth preparation and restoration are designed to promote success and patient satisfaction.

Method to Assess Criterion: Ask the patient if he/she has experienced any problems with previous restorations, e.g., difficulty flossing, food impaction, or unusual discomfort. At a minimum, the following aspects of the restoration are observed by direct observation:

- a. Caries removal
- b. Preparation design
- c. Base placement
- d. Contacts
- e. Marginal ridge
- f. Lack of overhangs
- g. Embrasure
- h. Contour
- i. Occlusal anatomy
- j. Restorative material

Note: Any aspect of the restoration deemed by the evaluator as being unsatisfactory to the extent of promoting failure of the restoration will be identified to the person being evaluated. If the person being evaluated disputes the evaluator's conclusion that the deficiency is cause for considering the restoration to be unsatisfactory, there will be a discussion of the deficiency identified. If concurrence between the person being evaluated and evaluator cannot be reached after discussion, the disputed restoration will not be counted as unsatisfactory. However, the nature of the dispute will be noted in a narrative summary.

- 4) Esthetics of anterior restorations satisfy the requirement for concealment and/or harmony of the restoration.

Method to Assess Criterion: The anterior restoration should be esthetically acceptable, and not displeasing to the patient. Ask the patient to comment on the appearance of anterior restorations.

- 5) Instructions concerning restorative care are given to the patient (parent/guardian) postoperatively, and
 - 5.1) services planned for the next appointment are explained.

Method to Assess Criterion: Observe whether instructions concerning restorative care and an explanation of the services planned for the next appointment are given to the patient (parent/guardian) by the attending dentist or the dental auxiliary prior to dismissal of the patient.

G. Pediatric Dentistry

- 1) All carious teeth are addressed in the treatment plan.

Method to Assess Criterion: Chart review. The treatment of carious anterior deciduous teeth can be addressed either through the IHS treatment plan or by indicating that this treatment is to be provided at the patient's/family's own expense.

- 2) All primary posterior teeth with three or more carious surfaces, one or more carious proximal surfaces, or teeth receiving pulp therapy, are restored with stainless steel crowns, unless a reason for not using a stainless steel crown is noted.

Method to Assess Criterion: Chart review and direct observation.

- 3) Pulp therapy procedures performed in the primary dentition are consistent with the diagnosis. The diagnosis is supported by documentation of the clinical and/or radiographic findings in the patient's chart.

Method to Assess Criterion: Review of progress notes and radiographs.

- 4) Primary teeth receiving pulpectomy treatment shall have a postoperative periapical radiograph, or one scheduled within one month.

Method to Assess Criterion: Review chart and radiographs.

- 5) The child's behavior is documented in the chart for all children age 10 and under and for older children when the behavior is not age-appropriate.

Method to Assess Criterion: Chart review. The Frankl Scale is offered on the following page as only one example of behavior documentation which may be used.

FRANKL'S RATING SCALE
Categories of Behavior

- Rating 1:* Definitely Negative (- -). Refuses treatment, cries forcefully, is fearful, or portrays any other overt evidence of extreme negativism.
- Rating 2:* Negative (-). Is reluctant to accept treatment, is uncooperative, portrays some evidence of negative attitude but not pronounced, that is, sullen or withdrawn.
- Rating 3:* Positive (+). Accepts treatment, at times is cautious but willing to comply with the dentist, but follows the dentist's directions cooperatively.
- Rating 4:* Definitely Positive (++). Has good rapport with the dentist, interested in the dental procedures, laughs and enjoys the situation.

- 6) Behavior Management techniques (verbal, physical, and/or chemical) are documented.
- 6.1) Only behavior management techniques in which the dentist is trained and privileged are used.

Method to Assess Criterion: Direct observation and review of charts. Review of hospital or facility privileges for approval of privileges for the type of sedation being used or documented in the dental record as having been used.

- 7) Documentation of informed consent is present when chemical restraints (including nitrous oxide and/or other sedation) and physical restraints (including Hand Over Mouth, mouth props, and wraps) are used.

Method to Assess Criterion: Direct observation and chart review.

- 8) The response to behavior management techniques, if used for patients less than six years of age, is noted in the progress notes.

Method to Assess Criterion: Direct observation and chart review.

- 9) All sedations must conform to the guidelines published in Section V of the *Oral Health Program Guide*.

Method to Assess Criterion: Review of documentation in the Dental Progress Notes (42-2) or the Dental Outpatient Sedation Record (IHS-831) if used. A review of the documentation should address the following:

- a. Is the consent statement signed by the parent/guardian?
- b. Is the type and amount of local anesthetic recorded?
- c. Is the amount of each sedative drug used recorded?

- d. Is the indication for the use of sedation recorded on the sedation record or in the progress notes?
- e. Has the patient complied with the preoperative NPO instructions?
- f. Is there evidence that a physical assessment was done, i.e., that the patient is healthy, current medications are noted, and the airway is not obstructed?
- g. Were the respiratory and circulatory systems monitored continuously and findings recorded at an interval no longer than 15 minutes?
- h. Were the patient's condition and time of discharge noted?

If any one of these requirements are absent from the documentation, the criterion for sedation is considered unsatisfactory.

Note: The form IHS-831 is not required, but is strongly recommended. This form can facilitate complete documentation of monitoring when more than visual monitoring is required with certain dosages and combinations of drugs described in Section V of the *Oral Health Program Guide*. If the IHS-831 is used, all the second copies (pink) should be maintained as a log.

- 10) Only behavior management techniques in which the dentist is trained and privileged are used.

Method to Assess Criterion: Direct observation and review of charts. Review of hospital or facility privileges for approval of the sedation technique being used.

- 11) A space maintainer is placed when primary molars are prematurely lost prior to normal exfoliation, or reason for non-provision of a spacer is noted.

Method to Assess Criterion: Chart review. Determine whether indications or contraindications for placement of a space maintainer are documented in the dental record.

- 12) Arrangements are made for recall examinations for patients with spacers.

Method to Assess Criterion: Review the patient record for arrangements made for recall examination for patients with spacers.

- 13) The space-maintaining appliance spans the edentulous area adequately, allows for normal eruption of the permanent tooth, and does not impinge upon soft tissue. Orthodontic band-type space maintainers exhibit smooth marginal adaptation and adequate cementation.

Method to Assess Criterion: Direct observation.

- 14) Space maintainer design is appropriate for the stage of the dentition.

Method to Assess Criterion: Direct observation

- 15) Treatment plan for spacer includes when it should be removed

Method to Assess Criterion: Chart Review

H. Endodontics

Pulpcapping/Pulpotomy

- 1) Indirect Pulp Capping – There are no longer any biological indications for indirect pulp capping on permanent teeth (Put a reference to this statement).

Method to Assess Criterion: Direct observation and review of charts.

- 2) Direct pulp capping (indicate what size of exposure- “pin-point” or whatever) is indicated when all of the following criterion exists:
1. A clinically vital and asymptomatic pulp is exposed.
 2. Bleeding is controlled at the exposure site.
 3. Exposure permits the capping material to make direct contact with the vital pulp tissue.
 4. Minimal microbial contamination of the exposure site has occurred.
 5. Proper coronal seal can be maintained.
 6. Patient is fully informed that endodontic treatment is an alternative and may be an eventuality, and that direct pulp capping may preclude the option of endodontic treatment in the future.

Method to Assess Criterion: Recorded findings (subjective and objective data) support an assumption of normal pulp apical to the exposure/canal orifice(s) with a non-contaminated field. A pulp cap assumes an uncontaminated mechanical exposure. Radiographs of the involved permanent tooth reveal a radiopaque capping material in contact with pulpal tissue. Documentation exists that the patient has been placed on active recall to check for resorptive defects or accelerated canal calcification.

- 3) Pulpotomy may be appropriate if any of the following clinical conditions exists:
1. Exposed vital pulps or pulpitis confined to the coronal aspects of primary teeth.
 2. As an emergency procedure in permanent teeth until root canal treatment can be accomplished.
 3. As an interim procedure for permanent teeth with immature root formation to allow continued root development.

Method to Assess Criterion:

1. An appropriate coronal seal is required.
2. Radiographically there should be evidence of sufficient root development for endodontic treatment.

3. Periodic radiographic examination should show no resorptive defects or accelerated canal calcification.

Non-surgical Root Canal Therapy

- 4) Non-surgical root canal therapy for permanent teeth is indicated if any of the following conditions exists:
 1. Irreversible pulpitis.
 2. Necrotic pulp with or without evidence of periradicular disease.
 3. Teeth with a pulp that would be compromised during dental procedures.
 4. Teeth with a pulp that would be compromised due to adjunctive medial procedures.
 5. Traumatically displaced or avulsed teeth.
 6. Treatable resorptive defects.
 7. Cracked or fractured teeth with pulpal involvement (with or without clinical symptoms) that can reasonably be expected to maintain satisfactory periodontal health.
 8. Teeth with thermal hypersensitivity that significantly interferes with normal function, when alternative methods have failed to reduce the hypersensitivity.
- 5) Findings confirming the diagnosis are established, and competing diagnoses ruled out. Findings are recorded in the patient's dental record. A preoperative diagnostic radiograph is included. A pulpal and periradicular diagnosis is obtained and recorded.

Method to Assess Criteria 4 and 5: Observe the patient's dental record and determine whether support and documentation of the diagnosis is recorded. A preoperative, diagnostic radiograph is available. History, clinical signs and symptoms, and appropriate pulp and periradicular test results are noted in the patient's dental record.

- 6) Informed consent is obtained for root canal treatment. This should include a discussion of the nature of the treatment, reasonable foreseeable risks, reasonable alternatives, and consequences of non-treatment.

Method to Assess Criterion: Review patient record for the presence of an informed consent form indicating procedure, risk and benefit, treatment alternatives, patient's and dentist's signatures and date.

- 7) A rubber dam is placed to isolate the operating area and act as a barrier to prevent aspiration or swallowing of root canal irrigants and instruments. Use should be documented in progress notes.

Method to Assess Criterion: Observe endodontic procedures, determine documentation in patient chart.

- 8) Removal of coronal tooth structure provides adequate access to the pulp chamber and allow straight line access to the root canal system. A balance is maintained between conservation of tooth structure and straight line access.

Method to Assess Criterion: Observe the preoperative and postoperative radiographs to determine that the endodontic filling materials conform to the original size and shape at the apex and progress to a flared conical shape towards the pulp chamber. Observe working length and postoperative radiographs to determine whether sufficient coronal tooth structure was removed to allow straight line access to the root canal system.

- 9) CaOH is the interappointment medicament of choice for non-surgical root canal treatment (when a medicament is desired). Formocresol is not used as a medicament in permanent teeth (again put reference as to why not).

Method to Assess Criterion: Observe patient record for documentation when medicament is used.

- 10) Obturation of all root canals is three dimensional and the radiographic appearance shows a well obturated root canal system where the root canal filling extends as close as possible to the apical constriction of each canal. The root canal system is obturated with a biologically acceptable non-resorbable semi-solid or solid root canal obturating material (ADA approved). Root canal sealers are used in conjunction with the obturating material to establish an adequate seal.

Method to Assess Criterion: Observe the routine preoperative and postoperative radiographs and determine the adequacy of the obturation with a solid core primary filling material. Observe the radiograph for filling length, the canal for proper flare and orientation. Consider the density of the fill evaluating voids, spreader or condenser tracks and minimal amount of sealer extrusion. Obturation material should be as close as possible to the apical constriction of each canal. Observe the patient dental record for ADA approved obturation material and sealer. Postoperative instructions and recommended follow-up care must also be documented upon obturation.

- 11) Each case has a proper radiographic documentation. A minimum of two radiographs for cases with non-overlapping canals (i.e. single canals and maxillary molars), and a minimum of three radiographs of overlapping canals (i.e. mandibular molars, lower incisors, multicauald premolars) should be available. Thus documentation should include a preoperative, proper postoperative radiograph(s), and working radiographs of archival quality (void of fixer stains, underdeveloped, brown, etc.), mounted in one connective holder and labeled consistent with IHS guidelines.

Method to Assess Criterion: Observe the patient's dental record and determine if preoperative, working, and postoperative radiographs were made. Radiographs are of archival quality, placed in one connective holder and labeling consistent with IHS guidelines.

- 12) Esthetic restorative material is used on all lingual access preparations in anterior teeth.

Method to Assess Criterion: Direct observation, radiograph, or review of patient's dental record.

- 13) A cusp-protecting restoration is used on posterior permanent teeth when either marginal ridge is violated or when remaining enamel structure is unsupported by dentin and lacks strength.

Method to Assess Criterion: Direct observation, radiograph or review of patient dental record for provision of cusp-protecting restoration.

Traumatized Permanent Teeth

- 14) A thorough history of the trauma including diagnostic radiographs, vitality testing of all teeth in the involved area, soft tissue exam, status of occlusion, and proper recording of data are included in the patient's chart.

Method to Assess Criterion: Observe patient's chart for diagnostic data which include history, radiographs, pulpal and periradicular tests, occlusal status, and soft tissue exam.

- 15) Incisal trauma involving dentin on vital teeth with no pulp exposure is restored within 7 days of initial presentation with composites and a dentin bonding agent.

Method to Assess Criterion: Observe patient record to note time interval between trauma and restoration.

- 16) All patients with traumatized teeth are placed on sufficient recall status (1 month, 3 month, 6 month, 1 year) to evaluate pulpal and periradicular condition.

Method to Assess Criterion: Documentation exists that the patient has been placed on active recall.

- 17) Teeth in need of fixation are stabilized using acid-etch/resin alone or with soft arch wire, or using orthodontic brackets with passive arch wire. Semi-rigid splints are used for luxated and avulsed teeth while rigid splinting is used for horizontal root fractures and alveolar fractures. Arch bar splints are contraindicated in these specific situations.

Method to Assess Criterion: Observe post operative radiographs and patient record documentation.

I. Periodontics

- 1) The record contains a recording of CPITN scores (0,1,2,3, or 4) determined by probing and radiographic evidence of pre-existing conditions and a
1.1) written diagnosis by ADA-Case Type (Gingivitis, Early Periodontitis, Moderate Periodontitis, and Advanced Periodontitis) and. The initial recorded diagnosis is acceptable for the findings.

- 1.2) The diagnosis should be consistent with existing conditions observed in the mouth and/or documented.
- 1.3) When definitive periodontal therapy is planned for patients with CPITN of 3 or greater, a periodontal work-up should be conducted. This includes probing pocket depths, radiographic evaluation, furca involvement, mobility, occlusal evaluation, and plaque retentive features. *If definitive periodontal services are not planned, the periodontal work-up should not be conducted.*

Method to Assess Criterion: Chart review and/or direct examination of the patient.

- 2) All dentate patients 15 years or older being provided routine dental care are informed of their periodontal status, treatment needs, opportunities for self-care, and have a description of periodontal treatment planned. If a full scope of periodontal services is not available at the particular clinic, a chart notation should be made that the patient has been informed of his/her need for treatment at another facility.

Method to Assess Criterion: Observe the patient record to determine whether patients were informed of their periodontal status and treatment needs consistent with their CPITN and periodontal assessment.

- 3) Periodontal treatment is consistent with, the need indicated by the initial diagnosis and 3.1) documented

Method to Assess Criterion: Observe records of patients having all planned treatment completed within the last year to determine if the appropriate treatment plan was provided for sextants with CPITN scores of 2, 3, or 4, i.e., prophylaxis, supra and subgingival cleaning, surgical and/or non-surgical treatment.

- 4) Communication with the patient is professional and on a level so that the patient understands the educational information and accepts scaling and root planing procedures. The provider is attentive to the patient's comfort level.

Method to Assess Criterion: Observe the patient and the provider's interaction during the procedure and note if levels of agreement or disagreement are acceptable. Question the patient to determine if the treatment was acceptable and tolerable.

- 5) Supragingival and subgingival cleaning are performed adequately.

Method to Assess Criterion: Observe the patient immediately following the procedure to determine if the contents of the pocket have been debrided and that irregularities and roughness of the root surface adjacent to the pocket have been removed and smoothed. Determine whether tissue trauma from scaling procedures is within acceptable limits.

- 6) Hygienists who administer local anesthesia are appropriately certified to do so.

Method to Assess Criterion: Question the hygienist about training and certification in local anesthesia. Review clinic records to verify certification.

- 7) The hygienist's progress notes and referrals are countersigned by a dentist. The hygienist's signature alone is adequate only if covered by standing orders in the clinic policy and procedure manual.

Method to Assess Criterion: Review the dental progress notes for countersignature, or verify that standing orders exist in the clinic policy and procedure manual.

- 8) A screening exit exam will be included in all treatment plans for routine patients examined with CPITN scores of 2, 3, or 4.

Method to Assess Criterion: Observe the patient record for the presence of an exit exam in the treatment plan, or a final CPITN for those completed patients who were initially diagnosed with any CPITN scores of 2, 3, or 4.

- 9) The patient is placed on a recall based on patient's disease status.

Method to Assess Criterion: Observe the patient record for documentation of plans for recall. Discuss the clinic recall policy with the clinic staff.

- 10) Periodontal surgery has been effective.

Method to Assess Criterion: Observe the patient postoperatively to determine that periodontal pockets have been eliminated, the gingivae have been contoured to a morphologic and physiologic form, and deformities in the alveolar bone have been corrected to a physiologic form. Probe all sulcular areas with a calibrated periodontal probe to determine whether sulcus depths have been reduced (probe no sooner than 2 months post-surgery).

In the assessment, compare the pretreatment dental record findings with the post-treatment results.

- 11) Mucogingival surgery has been effective.

Method to Assess Criterion: Observe the patient postoperatively to determine that an increased zone of attached gingivae has been attained, undesirable muscle pull on the marginal gingivae has been dissipated, and/or the vestibular fornix has been deepened to allow for maintenance of health of the periodontium.

In the assessment, compare the pretreatment dental record findings with the post-treatment results.

J. Removable Prosthodontics

- 1) Pretreatment full-arch radiographs are available for all removable prosthetic patients (occlusal, panoramic, or full mouth intraoral series). Current (within 1 year) periapical radiographs are available for all abutment teeth.

Method to Assess Criterion: Review dental record.

- 2) The overall oral condition and the condition of selected abutment teeth promote success of the prosthetic case.

Method to Assess Criterion: A review of the radiographs, clinical exam, endodontic status, and perio charting will be used to determine the overall oral health and the probability of long-term success of abutment teeth selected to support a removable prosthetic appliance.

- 3) The appearance of the denture is esthetically acceptable to patient and examiner.

Method to Assess Criterion: The denture harmonizes with the patient's facial appearance. The positioning, shape, and shade of the teeth appear natural. Vertical dimension is within normal range. The acrylic base material is in good condition. Clasps are not unnecessarily visible. The patient expresses satisfaction with appearance of the prosthesis. Documentation should be made in the chart as to the patient's acceptance of the esthetic appearance of the prosthesis.

- 4) Stability/retention is acceptable.

Method to Assess Criterion:

- a. Ask patient if dentures stay in place while eating and speaking. The stability/retention of the prosthesis is consistent with the limitations imposed by the ridge anatomy present.
 - b. *Full denture test:* Place forefinger on incisal edge of either maxillary or mandibular denture with sufficient force to blanch the finger. If denture becomes dislodged, it is considered to lack retention/stability.
 - c. *Partial denture test:* Place forefinger on any segment of partial denture framework and press firmly. If partial denture becomes dislodged or tips, it is considered to lack retention.
- 5) Flange of prosthetic appliance adapts to the soft tissue borders of the oral cavity.

Method to Assess Criterion: Gently retract lip to minimum degree that will allow you to observe whether flange of prosthetic appliance approximates the soft tissue borders. Note if dentures spring away from borders or lift up.

Note: Not applicable when anatomic conditions make the assessment unfeasible. The reason(s) should be stated in the patient's dental record.

- 6) Occlusion is acceptable.

Method to Assess Criterion:

- a. *Check centric relation:* Close patient's jaw into centric relation (and/or acceptable habit position) by placing thumb on patient's chin and gently directing mandible to the most posterior position, with patient closing slowly at the same time. Note whether simultaneous bilateral contact of the teeth occurs, and whether substantially all of the teeth on each side touch. If not, or if shifting or sliding occurs, then occlusion is considered to be inadequate.

Note: For all tooth-borne removable partial dentures, the point of reference is centric occlusion (functional occlusion).

- b. *Check eccentric relation:* Ask patient to close and move jaw in all directions. Observe eccentric premature contact or lack of balancing contact on teeth from canine posteriorly and note any instability resulting from the eccentric relationship of the prosthesis. (Eccentric relation is considered adequate if none are noted.)
- c. *Check occluding material:* Determine if unglazed porcelain occlusal or incisal surfaces are contacting enamel, gold, alloy, or composite resin. If so, rapid wear of the softer occluding surface will occur and occlusion must be considered unacceptable.

- 7) Vertical dimension and anterior tooth arrangement are acceptable.

Method to Assess Criterion:

- a. *Check "S" sounds:* Ask patient to say key words, such as Mississippi, sixty-six, whiskey, seventy-seven. When making "S" sounds, teeth should not contact. If so, appliance(s) is (are) considered inadequate.
- b. *Check "F" and "V" sounds:* Ask patient to say key words, such as forty-four, fine food, vim and vigor, Vivian. When making "F" and "V" sounds, the incisal edges of #8 and #9 teeth should contact the wet-dry line of lower lip.
- c. Ask patient if teeth seem too long or too short.

- 8) All "Cardinal Rules" of partial denture construction are met.

Method to Assess Criterion:

- a. *Rest seats (depth)*: Ask patient to remove partial denture. Observe clearance for rest seats with patient in centric occlusion. If unable to visualize, then place utility wax in patient's mouth and have patient close to centric occlusion. Remove wax and insert periodontal probe through wax in central area of identified rest seats until point of probe is exposed evenly with wax surface of opposite side. Determine visually whether wax in rest seat area is 1 to 1 1/2 mm thick.
 - b. *Rest seat (width)*: Observe whether rest seats approximate one-third the width of the tooth (except in cingulum rests), and are positioned at a 90 degree angle to long axis of abutment tooth.
 - c. *Partial denture base*: Inspect removed partial denture and determine whether base material covers all supporting areas. Ask patient to replace partial denture in mouth and then use mouth mirror to observe whether retromolar pad(s) or tuberosity(ies) are completely covered without impingement of soft tissues in flange areas.
 - d. *Arms of clasps in undercut zones*: Attempt to dislodge partial denture from each abutment tooth by placing finger under retentive clasp and applying firm force occlusally. If there is no resistance to the force, then retention is considered inadequate. If too much force is required, excessive mobility of the tooth occurs, or if the patient expresses difficulty in removing it, then retention may be excessive.
 - e. *Guiding planes*: Visually determine whether all guiding planes on abutment teeth are reasonably parallel to one another.
 - f. *Abutment teeth*: Observe that abutment teeth are in a good state of repair and well-polished.
 - g. *The tissue-bearing area*: Note any areas of tissue impingement, inflammation, or hypertrophy related to the partial denture. The partial denture should not have caused any apparent tissue damage.
- 9) All pertinent information concerning the prosthesis is recorded in the health progress notes. This must include shade, mould, and lab used. Also include lab fee quoted to the patient if applicable. A copy of the lab prescriptions (work orders) should be kept on file in chronological order.

Method to Assess Criterion: Review progress notes and lab files.

K. Fixed Prosthodontics

Crowns (all types, including bridge abutments)

Note: A crown is unacceptable only if the examiner recommends replacement of the crown due to one or more deficiencies noted in the following criteria:

- 1) Smooth marginal adaptation.

Method to Assess Criterion: Inspect the margins of the crown to determine if the marginal adaptation is acceptable. The marginal adaptation of the crown should be

considered unacceptable if gingival irritation or blanching of the tissues is being caused by the crown or if the smaller end of the #17 explorer can be inserted between the inner surface of the crown and immediate tooth surface.

- 2) Occlusal functions are acceptable.

Method of Assess Criterion: Use articulating paper to assess premature contacts in centric and eccentric relations. Also observe whether there are heavy wear facets (or shiny areas) in any occluding surface by using mouth mirror and/or direct observation. If supra or infra occlusion was planned, it must be noted in the patients dental record.

Question the patient: "Does this give you any discomfort or pain when you eat? Does it seem higher than your other teeth?"

- 3) Contact is present.

Method to Assess Criterion: The contacts with the proximal teeth should be in the occlusal 1/3 of the proximal space and tight. Dental floss should pass through without tearing or shredding.

- 4) Crown contour is physiologic.

Method to Assess Criterion: Inspect the external contours of its cross-arch analog, if a natural tooth. If the mate is not present or grossly restored, utilize the contours of the tooth most nearly representative of the test tooth. Compare with the aid of mouth mirror:

- a) buccogingival contour
- b) linguogingival contour
- c) marginal ridge contour
- d) embrasure spaces have a v-shape which avoids tissue impingement
- e) total buccolingual width

The health of the tissue around the restored tooth (teeth) will not differ significantly from other tissue in the mouth four weeks after cementation.

- 5) Crowned, endodontically treated teeth have healthy characteristics which promote long term success of the case.

Method to Assess Criterion: Review the radiographs, clinical exam record, endodontic status, perio charting, and clinical appearance of the crowned tooth.

- 6) Porcelain or resin shade blends favorably with remaining dentition.

Method to Assess Criterion: Under natural light, inspect the crown with its cross arch analog using a Trubyte Bioform 24 button shade guide or Vita Lumen shade guide. If the mate is not present or is not a natural tooth, compare shades to the adjacent natural or opposing teeth. Shade blend should be within one shade of the matching button.

B. Fixed Bridges

- 7) Pontic(s) meet(s) the principles of form and tissue adaptation.

Method to Assess Criterion: Observe the form of pontic(s) by using mouth mirror and/or direct observation. Determine if:

- a. Facio-lingual width of the pontic(s) approximate(s) two-thirds of the normal width of the replaced teeth.
 - b. Facial contour of the pontic(s) approximate(s) the normal contour of the replaced teeth.
 - c. Gingival contour, approximating the alveolar process and mucosa is (are) convex enabling self-cleansing capability. Consider concave pontics unacceptable. Thread dental floss through the embrasure and pass the floss mesio-distally between the apex of the pontic and the mucosa of the alveolar process. For pontic to be considered acceptable, the floss should pass freely without impingement or bleeding of involved tissues.
- 8) Solder joints meet principles of adequate strength.

Method of Assess Criterion: Use mouth mirror and/or direct observation and apply following principles for determining adequate strength.

- a. Facio-lingual size of the solder joint should be about one-half of the facio-lingual width of the existing pontic, and
 - b. The occlusal gingival side of the solder joint should be about one-half of the distance from the occlusal (incisal) edge of the pontic to its gingival base.
- 9) The overall oral condition and periodontal structures of abutment teeth are adequate to support the prosthetic appliance(s).

Method to Assess Criterion: Clinically observe abutment teeth and review the radiographs, clinical exam record, endodontic status, and perio charting. Observe that the prosthetic service(s) received is compatible with the overall periodontal health and caries control, and that it promotes long-term success.

- 10) Esthetics are acceptable to the patient and examiner.

Method to Assess Criterion: Question the patient: "Are you satisfied with the appearance of the bridge?" Determine in your own mind whether the existing porcelain or resin surfaces of the pontic and crowns are in harmony with the remaining natural teeth. Determine whether there is unsightly show of metal when smiling and talking.

- 11) Occlusal functions are acceptable.

Method to Assess Criterion: Observe centric and eccentric movements; use articulating paper to assess premature contacts in centric and eccentric relations. Also, observe whether there are heavy wear facets (or shiny areas) on any occluding surface of the bridge by using mouth mirror and or direct observation. Question the patient: "Does the bridge give you any discomfort or pain when you eat?"

- 12) Pertinent information concerning the prosthesis is recorded in the dental progress notes. This includes the material used for fabrication and cementation, the shade, and dental lab used.

Method to Assess Criterion: Review dental record.

L. Oral Surgery

- 1) The diagnosis leading to extraction or other surgical procedures is written in the dental record and is consistent with clinical findings.

Method to Assess Criterion: Observe the patient's dental record and determine whether documentation for the diagnosis is recorded, including the availability of a preoperative radiograph. History, clinical symptoms, including temperature and soft tissue findings, and possible pulp test results are noted in the patient's dental record.

- 2) Appropriate diagnostic preoperative x-ray(s) is/are available in the patient's dental record.

Method to Assess Criterion: Review of radiograph to assess presence of the entire tooth, including apex of root(s) and surrounding anatomy.

- 3) All postoperative complications receive appropriate follow-up treatment.

Method to Assess Criterion: Chart review. Specifically note use of culture and sensitivity tests, antibiotic regimens, I & D procedures, and recording of patient temperature.

- 4) All pathology reports based on cytology or biopsy are present in the patient records and in a biopsy log.

Method to Assess Criterion: Review patient's dental and/or medical record. Results must be recorded in the patient's progress notes by the dentist. When a tissue biopsy is performed, the patient record must include documentation of indications for biopsy, a copy of the pathology report, and evidence that the patient was notified of the results and received proper follow up. An additional "Biopsy Log" should also be kept. For each case this log will include the patient's name, chart #, provisional clinical diagnosis, doctor's name, date, histopathological diagnosis, and date of patient notification of results and follow-up.

- 5) Appropriate preoperative systemic antibiotic therapy is provided patients requiring such, as specified by the American Heart Association.

Method to Assess Criterion: Review of patient primary health record. Observe that these patients have documentation and/or consultation to rule out need for antibiotic prophylaxis. If a prescription is written, it is documented that the patient has complied with regimen.

- 6) Standard principals of flap design have been accomplished, e.g., occlusal portion of flap design to extend at least one tooth adjacent to the interdental papilla both mesially and distally from the tooth to be extracted (exception to this would be extraction of the most distal tooth in the arch). Vertical incisions extend obliquely so that the base of the flap is wider than its margin, and the tissue of the retracted flap is not mutilated or torn.

Method to Assess Criterion: Observe the surgical flap procedure on patients present in the clinic receiving this service, or observe the flap design of revisit patients who receive this service and are present in the clinic for postoperative follow-up or suture removal.

- 7) Pathologic tissue is completely removed. There is no evidence of residual periapical or periodontal pathology, including root fragments at the surgical site, unless removal is contraindicated.

- 8) Alveolar margin is smoothed, and displaced fragments of the alveolus and foreign particles are removed.

Method to Assess Criteria #2 and #3: The examiner assesses these criteria by appropriate instrumentation and palpation, including a postoperative radiograph of the operative site when deemed necessary. On patients present in the clinic for postoperative follow-up or suture removal, the examiner may assess these criteria by palpation of the operative site and by viewing a postoperative radiograph. If root tips have been left, documentation exists for the decision, including postsurgical radiographs, and documentation exists that the patient has been informed and there is provision for recall.

- 9) Sterile saline or sterile water is used to irrigate all surgical sites, including routine extractions.

- 10) Soft tissue flap is repositioned into anatomical position and maintained there with suture or gauze pressure pack.

Method to Assess Criterion: Inspect the surgical flap site to make certain the soft tissue is repositioned appropriately over alveolar bone without excessive tension.

- 11) Oral and written instructions concerning postoperative care of surgical or extraction services are given to patient (parent/guardian) and documented in the record.

Method to Assess Criterion: Observe whether oral and written instructions concerning postoperative care of surgical and/or extraction sites are given to the patient before dismissal.

- 12) Informed consent is obtained for oral surgery procedures. This should include a discussion of risks, benefits, and alternatives to treatment.

Method to Assess Criterion: Review patient record for the presence of formal consent form indicating procedure, risks, benefits and treatment alternatives, patient's signature, dentist's name, and date.

- 13) All use of conscious sedation for oral surgical procedures is performed under guidelines listed in the *IHS Oral Health Program Guide*, Section V.

Method to Assess Criterion: Review the clinic's *Policy and Procedure Manual* and the *IHS Oral Health Program Guide* for a conscious sedation protocol. See that all providers are properly credentialed for procedures they perform, that adequate emergency back-up is available, that there is proper CPR/ACLS certification, and that the proper monitoring equipment is utilized. This may include the pulse oximeter, EKG, and blood pressure device. Also note that proper informed consent is present for sedation and that there is adequate patient recovery and escort service available.

M. Orthodontics

- 1) The dental record contains documentation that patients (and/or their guardian) ages 6 to 20 have been advised of their orthodontic status and the availability of treatment at the IHS/Tribal facility or the need to seek private care.

Method to Assess Criterion: Chart review.

- 2) Practitioners providing interceptive and corrective orthodontic care who have not completed long term training in orthodontics can demonstrate a program of systematic review of selected cases by an orthodontic consultant. Practitioners providing orthodontic care have been granted privileges to provide that care and have documented training to support the level of privileges requested.

Method to Assess Criterion: Review the log of orthodontic patients for evidence of review of selected cases by an orthodontic consultant. Review practitioner's request for privileges and supporting documentation.

- 3) The following records of each patient undergoing comprehensive orthodontic therapy, which is to be provided only by an orthodontic specialist, are available:
- a. Orthodontic examination (including the status of the TMJ), which is updated within six months of initiation of treatment.
 - b. Full mouth or panoramic x-rays.

- c. Study casts with bite registration recording centric occlusion.
- d. Cephalometric x-ray with the jaw in centric occlusion.
- e. Pretreatment photographs: 1) full face at rest and smiling; 2) right and left profile; 3) right, left, and anterior intra-oral; 4) maxillary occlusal, and mandibular occlusal.
- f. Treatment objectives established and recorded prior to treatment.
- g. Written informed consent signed by parent/guardian which lists treatment objectives, expected outcome and limitations, patient compliance expected, reasons for discontinuing treatment before completion, and anticipated need for further specialty care.
- h. Documentation of appropriately sealed teeth in children under age 14.
- i. All other treatment completed (PTC except orthodontics) within the last 6 months.
- j. Documentation that compliance with home care has been demonstrated prior to treatment.

Method to Assess Criterion: Review of patient's health record.

- 4) Assessment of completed cases must be made in conjunction with the treatment objectives established prior to treatment relative to findings in records and/or posttreatment cast concerning:
- a. Molar relationship and cuspid relationship.
 - b. Changes in cephalometric form.
 - c. Arch expansion.
 - d. Axial inclination of anterior and posterior teeth.
 - e. Interproximal spacing.
 - f. Rotations.
 - g. Arch form.
 - h. Overbite correction.
 - i. Overjet correction.
 - j. Soft-tissue profile.

Method to Assess Criterion: Review the hallmarks of a well-treated orthodontic case, which include:

- a. Good interdigitation of teeth.
- b. Cuspids in Class I relationship.
- c. Correction of rotations.
- d. Correction of overbite or open bite.
- e. Correct esthetic inclination of anterior teeth.
- f. Correct root position of teeth (parallel roots).
- g. Good arch form.
- h. General maintenance of cuspid and molar width.
- i. Minimal root resorption.
- j. Minimal gingival recession.

- k. Minimal occlusal interferences in centric relation, in balancing, and in working movements.
 - l. Minimal decalcification and no caries associated with the appliance.
 - m. Accomplishment of treatment objectives.
- 5) Orthodontic treatment and orthodontic extractions are preceded by an orthodontic consultation.

Method to Assess Criterion: Review patient dental record for evidence of orthodontic consult.

N. Adjunctive General Services

- 1) Drugs prescribed for and/or administered to dental outpatients or inpatients are recorded in patient's primary health care record.

1.1) Drugs administered or prescribed are consistent with the written diagnosis.

Method to Assess Criteria #1 and #2: Review the described health problem(s) and determine the appropriateness of the prescribed drug(s) and daily dosage. Acceptable references, such as *American Hospital Formulary Service* or *Physicians Desk Reference*, may be used to resolve any differences of opinion.

- 2) Appropriate preoperative systemic antibiotic therapy is provided patients requiring such, as specified by the American Heart Association.

Method to Assess Criterion: Review of patient primary health record. Observe that all patients who are at risk for Subacute Bacterial Endocarditis (SBE) have documentation of antibiotic prophylaxis and that at each encounter it is documented that the patient complied with the prescribed antibiotic regimen.

- 3) Any untoward reactions to medication(s) are recorded in the primary health record. Any allergies to medication(s) are prominently displayed on the primary health record.

Method to Assess Criterion: Review of patient's primary health record.

- 4) When a sedative agent or nitrous oxide is administered, the indication for use, duration, concentration exposure and or dosage, monitored vital signs, any untoward reactions, restraints used, and patient status upon dismissal are recorded in the patient record.

Method to Assess Criterion: Chart review.

- 5) Dentists or hygienists who administer sedative drugs (inhaled, oral, intramuscular, or intravenous) can demonstrate that they are appropriately trained to do so and that dentists have been granted privileges by the medical staff to perform the procedure(s).

Method to Assess Criterion: Review medical privileges and documentation of training in sedation for those dentists who administer sedative drugs. Review standing orders for hygienists and documentation of training in administering nitrous oxide/oxygen sedation.

O. Environmental Health and Safety

- 1) Basic emergency diagnostic and treatment equipment must be available in case of life-threatening episodes.

Method to Assess Criterion: Observe that any member of the dental staff can promptly locate and bring to the chairside the following equipment:

- a. Sphygmomanometer (infant, child, and adult sizes)
- b. Stethoscope
- c. Ambu-bag and oxygen with mask and bags capable of positive pressure ventilation for infants, children, and adults
- d. Oral pharyngeal airways (infant, child, and adult)
- e. Emergency drug kit/crash cart as specified in the operations manual of the dental clinic or facility with appropriate dosages for children and adults

- 2) Emergency drug kit is up-to-date.

Method to Assess Criterion: Inspect the locked emergency drug kit and assure that expiration dates have not passed on any medications.

- 3) The dental staff has received annual CPR training.

Method to Assess Criterion: Current certification card or list of CPR-certified staff should be available.

- 4) A clinic emergency plan exists for management of medical emergencies and is understood by the staff.

Method to Assess Criterion: Inspect the plans and interview staff for basic understanding of plan and procedures. Review documentation that the plan has been reviewed annually and/or question the staff on emergency protocol.

- 5) All housekeeping activities have been performed before clinical day begins.

Method to Assess Criterion: Observe the cleanliness and neatness of all areas of the dental clinic. If observation in the morning is not possible, then question the dental staff in accordance with the acceptability of the housekeeping activities being provided. Suggested areas to be considered are cleanliness of floors, walls, furniture, cabinets, dental chairs, dental units, wastebaskets, etc.

Note: The neatness and cleanliness of all working counter top areas are considered to be the responsibility of the dental auxiliary staff. Otherwise, supplies and/or materials may be disposed of accidentally by non-dental housekeeping personnel.

- 6) The current copy of the IHS Mercury Hygiene Guidelines (located in Section VI of the *IHS Oral Health Program Guide*) is on file and has been reviewed and/or studied by all dental staff within the current fiscal year.

Method to Assess Criterion: The dental officer will show the examiner a copy of the guidelines, as well as an attached page which contains signatures and dates of all dental staff indicating that they have reviewed the guidelines.

- 7) The possibilities of mercury toxicity are minimized by the dental staff through the practice of good mercury hygiene.

Method to Assess Criterion: Observe operations involving mercury transfer and determine whether the work surface is smooth, impervious, and suitably lipped to confine spilled mercury, and whether the floor covering is smooth and impervious. A mercury spill kit is available in the facility.

Scrap amalgam should be stored in a closed, labeled container under appropriate (e.g., x-ray fixer, commercial solution) liquid barrier. Water, mineral oil, or glycerin are not acceptable liquid barriers. Pre-encapsulated silver alloy is utilized to minimize the need to handle free mercury.

- 8) Concentration of mercury vapors in the environment should be below the threshold limit value (TLV) of 0.025 mg Hg/m³, or in compliance with the Area Office of Environmental Health (OEH) policy.

Method to Assess Criterion: Ask to see a copy of the most recent mercury vapor level survey, and the Area OEH policy concerning mercury surveillance for dental clinics. Determine whether the mercury vapor level is below 0.025 mg Hg/m³ and/or if the facility is in compliance with the Area OEH policy.

- 9) Nitrous oxide/oxygen administration logs are maintained which permit monitoring of the duration of staff exposure to waste anesthetic gas.

Method to Assess Criterion: Review nitrous oxide/oxygen log.

- 10) Concentrations of waste anesthetic gas are within accepted levels.

Method to Assess Criterion: Review copy of most recent certification by the IHS Office of Environmental Health waste gas survey/report or records of local monitoring of nitrous oxide.

- 11) An infection control policy for the dental facility has been reviewed and approved by

dental and medical staff.

Method to Assess Criterion:

- a. A copy of the most recent release of “Recommended Infection Control Practices for Oral Health Programs Serving Native Americans” should be available in the dental clinic. This document should contain the dated signatures of all dental personnel to verify their review of the document, as well as those of the Program Director or Service Unit Director and the Chairman of the Service Unit Infection Control Committee (or Clinical Director).
 - b. The reasons for any exceptions or significant variations to the recommended practices which the local facility has decided to adopt should be explained in writing, initialed by dental staff, and filed with the policy document.
- 12) The requirements of the “OSHA Bloodborne Pathogen Standard” are met by having documentation of an exposure control plan, training, and immunization record.

Method to Assess Criterion: Review of the dental staff, personnel records, and direct observation. Determine whether all dental staff have been given the opportunity to be immunized for hepatitis B and other diseases. Determine whether a surveillance record of the immunization status of each member of the dental staff is available for review. (The record should include sero-testing and dates of Tuberculin tests. Follow-up action is documented for employees with “positive” findings which require attention.)

Those staff members refusing the hepatitis vaccine must be informed of the risks and are required to sign a form stating that the vaccine has been offered and refused. Refusal of vaccine and notation of possible consequences must be recorded.

Written policy should exist to address the management of employees involved in patient care who have acute or chronic infectious conditions, including colds, flu, herpes or other skin infections, and any other known or suspected contagious condition.

- 13) Accepted infection control procedures are practiced prior to the delivery of care.

Method to Assess Criterion: Observe the performance of infection control procedures routinely practiced prior to the delivery of care for at least 10 patients, if possible. Evaluate each of the following components of practice relative to the infection control methods recommended by the Indian Health Service.

Prior to Treatment:

- a. *Health history:* A summary of findings is documented on Part II of IHS-42-1 (or other standard form if IHS forms are not used). Significant conditions should be noted clearly in the patient’s record and addressed prior to treatment.

- b. *Hand washing:* Hands are washed between patient treatment contacts and whenever gloves are changed. Nails are cleaned and without polish, jewelry is removed, and recent wounds are covered.
- c. *Protective barriers:* Handles and switches on dental lights, x-ray equipment, patient records and other noncritical items are covered or prepared as recommended in Section VI of the IHS *Oral Health Program Guide*.

- 14) Accepted infection control practices are maintained routinely throughout the delivery of care for dental patients.

Method to Assess Criterion: Observe the performance of infection control procedures used routinely during the delivery of care based upon at least 10 patients, if possible. Evaluate each of the following components of practice relative to the infection control methods recommended by the Indian Health Service.

During Treatment:

- a. *Protective barriers:* For protection of personnel and patients, gloves must always be worn when touching blood, saliva, or mucous membranes. Gloves must be worn by dental health-care workers when touching bloodsoiled items, body fluids, or secretions, as well as surfaces contaminated with them. Gloves must be worn when examining all oral lesions.
Surgical masks, in addition to eye protection with solid side shields or chin-length plastic face shields, are mandatory for operator protection when splashing or splattering of blood or other body fluids or solids is likely.

Fluid-resistant gowns must be worn when clothing is likely to be soiled with blood or other body fluids. Home laundering of gowns is prohibited. Gowns should be changed when visibly soiled.

A rubber dam is used unless contraindicated.
- b. *Handling of instruments and materials:* Adequate methods are employed to minimize “breaks” in aseptic technique during treatment. Four-handed dentistry is practiced when possible. The unit dose concept is applied and forceps are used to transfer or handle objects involved in treatment, especially when small items are removed from or placed into storage drawers, tray set-ups and other noncritical surfaces.
- c. *Patient records:* Adequate measures are taken to minimize the contamination of patient records during and after treatment, especially when entries are made in the record.

- 15) Accepted infection control procedures are practiced after the delivery of care.

Method to Assess Criterion: Observe the performance of infection control procedures used routinely after the delivery of care based upon at least 10 patients, if possible. Evaluate each of the following components of practice relative to the infection control methods recommended by the Indian Health Service.

After Treatment:

- a. *Operatory decontamination:* Environmental surfaces are disinfected with a suitable germicide before the next patient is seated. This includes the removal of “dirty” instruments and waste materials from the operatory, replacing protective barriers (e.g., headrest and bracket table covers), changing burs and handpieces, disinfecting control switches and other noncritical surfaces, and other measures recommended by the IHS (refer to “Recommended Infection Control Practices for Oral Health Programs Serving Native Americans.”) All “sharps” must be placed in an approved sharps container. Biohazardous waste materials must be disposed of in covered refuse containers labeled “BIOHAZARD.”

Air/water syringe tips must be autoclaved or disposable and changed between patients.

- b. *Use and care of sharp instruments and needles:* Sharp items (needles, scalpel blades, endodontic files, orthodontic wires, and other sharp instruments) must be considered as potentially infective and must be handled with extraordinary care to prevent unintentional injuries. A one-handed technique or mechanical capping device must be used for the recapping of needles.

Disposable syringes and needles, scalpel blades, worn out and broken burs, endodontic files, orthodontic wires, and other disposable sharp items must be placed into puncture-resistant containers located as close as practical to the area in which they were used.

Review of the last 12 months injury reports.

- c. *Instrument disinfection/sterilization:* In a designated cleanup area, dirty instruments are adequately cleaned (free of visible debris) before disinfection or heat sterilization methods are used. Persons involved in cleaning and decontaminating instruments must wear heavy rubber gloves to prevent hand injuries and eye protection with solid side shields. The lid should be in place on the ultrasonic cleaner during use to avoid splatter. Heat sensitive tape should be used on bagged or packaged instruments which are to be sterilized. Refer to “Recommended Infection Control Practices for Oral Health Programs Serving Native Americans” for the details of accepted practice regarding external/internal indicators. Sterilizer(s) are monitored on a weekly basis with biologic indicators

(review records on file). Disinfection solutions should be diluted and replenished according to product instructions and volume of workload.

- d. *Instrument storage:* Disinfected and sterilized instruments are placed in storage using accepted methods. The use of clear plastic autoclave bags is recommended when possible. Sterilized instruments/instrument packs must exhibit an expiration date (refer to “Recommended Infection Control Practices for Oral Health Programs Serving Native Americans” for instrument pack shelf life).
 - e. *Handpiece sterilization:* All surgical instruments including handpieces (high speed, low speed attachments, and prophylaxis angles) must be used as an alternative.
- 16) A written schedule should exist which describes general sanitation and housekeeping procedures for the dental facility. Housekeeping services should be available to remove refuse daily and to clean floor coverings (carpeting is not recommended in dental operatories).

Method to Assess Criterion: Review dental clinic policy.

- 17) Incoming or outgoing orthodontic or prosthetic appliances are disinfected, and impressions and casts are handled according to recommended IHS infection control practices for oral health programs.

Method to Assess Criterion: Direct observation. Laboratory instruments and supplies (e.g., rag wheels, case pans, model trimmer, knives, and other frequently used equipment) are disinfected or sterilized according to an acceptable policy.

Technical Quality Assessment by Direct Observation of Patient Care

**Y - Yes N - No N/A - Not Applicable D – Disputed Findings, Narrative summary needed
Record Number**

Criteria										
A. Patient Records										
1) Dental Record is part of Health Record										
1.1 Health Record present for review										
2) Current Health History present										
2.1) Updated Annually										
2.2) Reviewed/documentated each visit										
3) Health Questionnaire follow-up										
4) All Entries in ink										
5) Progress notes sufficiently detailed										
6) SOAP format for emergency visits										
B. Examination and Diagnosis										
1) Hard and soft tissue findings recorded										
2) Appropriate diagnostic aids are used										
3) Diagnosis is consistent with findings										
4) Treatment Plan exists										
4.1) Follows logical order										
4.2) Consistent with diagnosis										
5) Screening Exit Exam										
C. Radiographs										
1) Radiographs meet criteria based on patient conditions or type of exam:										
1.1) Initial adult										
1.2) Initial Child										
1.3) Recall										
1.4) Emergency										
2) Radiographs are properly mounted										
3) Radiographs are properly labeled										
4) Radiographs are in patient's record										
5) Density and Contrast are acceptable										
6) Image not distorted										
7) No overlapping										
8) No Cone-cutting										
9) Bitewings include proper landmarks										

Y - Yes N - No N/A - Not Applicable D – Disputed Findings, Narrative summary needed

Criteria	Record Number									
D. Radiological Protection										
1) Auxiliaries are certified										
2) Lead protective devices are used										
3) Tube head stationary										
3.1) Tube head properly positioned										
4) Film not held by staff										
5) Tube not held by staff										
6) Operator stands in proper position										
7) Area Properly cleared for exposure										
8) Warning before exposure										
9) Dosimeters worn										
10) Protective devices properly stored										
11) Radiological Reports maintained										
E. Prevention										
1) Prevention Plan										
2) Oral Health Education Provided										
2.1) Self-care Instruction provided										
2.2) Consistent with needs										
3) Prophylaxis meets standards										
4) Topical Fluoride appropriately provided										
5) Sealants appropriately placed										
6) Sealant technique meets standards										
7) Tobacco users asked about quitting										
8) Tobacco Cessation Counseling recommended										
9) Individualized Recall										
F. Restorative										
1) Treatment explained										
2) Rubber dam used unless contraindicated										
2.1) Documentation for non-use										
3) Prep and restoration meet criteria										
4) Esthetics of anterior restorations										
5) Care of restorations explained										
5.1) Next visit explained										

**Y - Yes N - No N/A - Not Applicable D – Disputed Findings, Narrative summary needed
Record Number**

Criteria											
G. Pediatric Dentistry											
1) All caries addressed in tx plan											
2) Stainless Steel Crowns used appropriately											
3) Pulp therapy is appropriate											
4) Pulpectomies have post-op PA											
5) Behavior documented											
6) Behavior management techniques											
6.1) Appropriate techniques used											
7) Informed consent documented)											
7.1) for restraints											
7.2) For sedation											
8) Response documented											
9) Sedations conform to current guidelines											
10) Training and privileges for sedation											
11) Space Maintainers used appropriately											
12) Recall provided for patients with spacers											
13) Spacer fits appropriately											
14) Spacer design is appropriate											
H. Endodontics											
1) Indirect Pulp Caps											
2) Direct Pulp Cap											
3) Pulpotomy											
4) Indications for endo exist and											
5) Adequate documentation											
6) Informed Consent											
7) Rubber Dam											
8) Access prep is appropriate											
9) CaOH medicament											
10) Proper Obturation											
11) Appropriate Radiographs											
12) Aesthetic restoration on anteriors											
13) Cusp Protection											
14) Traumatized teeth properly worked up											
15) Incisal trauma restored appropriately											
16) Traumatized teeth recalled											
17) Stabilization for teeth needing fixation											

Y - Yes N - No N/A - Not Applicable D – Disputed Findings, Narrative summary needed

Criteria	Record Number									
I. Periodontics										
1) CPITN present										
1.1) Periodontal Diagnosis present										
1.2) Diagnosis consistent with conditions										
1.3) Full work-up for definitive perio treatment										
2) Patients informed of periodontal status										
3) Periodontal Treatment is appropriate										
3.1) And Documented										
4) Communication with patient is appropriate										
5) Cleaning is appropriate										
6) Hygienist certified for Local Anesthesia										
7) Hygienist’s notes countersigned as needed										
8) Screening exit exam										
9) Appropriate perio recall										
10) Periodontal Surgery is effective										
11) Mucogingival surgery is effective										
J. Removable Prosthodontics										
1) Pre-treatment radiographs										
2) Oral condition is adequate										
3) Esthetics acceptable										
4) Stability/retention acceptable										
5) Proper flange adaptation										
6) Occlusion acceptable										
7) Vertical dimension acceptable										
7.1)Anterior arrangement acceptable										
8) Cardinal Rules are followed										
9) All info about prosthesis is recorded										

Y - Yes N - No N/A - Not Applicable D – Disputed Findings, Narrative summary needed

Criteria	Record Number									
K. Fixed Prosthodontics										
1) Smooth Margins										
2) Acceptable Occlusion										
3) Proper contacts										
4) Physiologic Contours										
5) Endodontically treated abutments										
6) Proper porcelain shades										
7) Pontics meet criteria										
8) Solder joints are adequate										
9) Abutment tooth condition is adequate										
10) Esthetics acceptable										
11) Occlusion acceptable										
12) Progress notes adequate										
L. Oral Surgery										
1) Diagnosis present and appropriate										
2) Appropriate radiographs										
3) Post-op complications properly treated										
4) Pathology reports present										
5) Antibiotic prophylaxis appropriate										
6) Flap design is appropriate										
7) Pathologic tissue completely removed										
8) Alveolar margins smoothed										
9) Sterile irrigant										
10) Flap properly repositioned										
11) Post-op instructions										
12) Informed consent										
13) Conscious sedation follows guidelines										
M. Orthodontics										
1) Patients advised of orthodontic status										
2) Practitioner has proper training/privileges										
2.1) Cases reviewed by orthodontic consultant										
3) Appropriate Ortho records are available										
4) Completed cases meet objectives										
5) Ortho consultation precedes treatment										

Y - Yes N - No N/A - Not Applicable D – Disputed Findings, Narrative summary needed

Criteria	Record Number									
N. Adjunctive General Services										
1) Drugs are recorded										
1.1) Consistent with diagnosis										
2) Prophylaxis provided when needed										
3) Medicine reactions and allergies noted										
4) Sedation properly documented										
5) Providers administering sedatives have appropriate training and privileges										
O. Environmental Health and Safety										
1) Emergency equipment available										
2) Emergency drugs up to date										
3) CPR Training										
4) Emergency Plan										
5) Housekeeping										
6) Mercury Hygiene Guidelines										
7) Mercury Hygiene										
8) Mercury Vapors										
9) Nitrous Oxide Log										
10) Waste anesthetic gases										
11) Infection Control Policy										
12) Blood Borne Pathogens Standard										
13) Infection Control Procedures prior to care										
14) Infection Control during Care										
15) Infection Control after										
16) Written schedule for sanitation										
17) Dental Appliances disinfected										

Summary

(Within each category subtract NA and D boxes from total number available to calculate denominator.)

Category	% Compliant Y/ (Y+N)	Comments
A. Patient Records		
B. Exam Diagnosis		
C. Radiographs		
D. Radiological Protection		
E. Prevention		
F. Restorative		
G. Pediatric Dentistry		
H. Endodontics		
I. Periodontics		
J. Removable Prosthodontics		
K. Fixed Prosthodontics		
L. Oral Surgery		
M. Orthodontics		
N. Adjunctive General Services		
O. Environmental Health and Safety		

TECHNICAL FEEDBACK AND RECOMMENDATIONS
(Provide to Person being evaluated at Close-Out Session)

Person being evaluated _____

Criterion considered unsatisfactory: _____

Describe deficiencies related to this criterion:

Criterion considered unsatisfactory: _____

Describe deficiencies related to this criterion:

Criterion considered unsatisfactory: _____

Describe deficiencies related to this criterion:

Criterion considered unsatisfactory: _____

Describe deficiencies related to this criterion:

Plan of action for correcting deficiency(ies):

Signatures: _____
Evaluator Person being evaluated Date

cc: Service Unit Director/Tribal Health Administrator